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**The case for social care reform – the wider economic and  
social benefits**

**Final report**

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With such a broad review, individual sections of this report draw on material and more detailed arguments presented in:

- Glasby, J. and Littlechild, R. (2009) *Direct payments and personal budgets: putting personalisation into practice* (2<sup>nd</sup> ed.). Bristol, The Policy Press
- Glasby, J. and Dickinson, H. (2008) *Partnership working in health and social care*. Bristol, The Policy Press
- Glasby, J. (2007) *Understanding health and social care*. Bristol, The Policy Press

## Data

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BHPS data used in this publication were made available through the ESRC Data Archive. The data were originally collected by the ESRC Research Centre on Micro-social Change at the University of Essex (now incorporated within the Institute for Social and Economic Research). Neither the original collectors of the data nor the Archive bear any responsibility for the analyses or interpretations presented here. Data from the LFS and the FRS were also made available through the ESRC Data Archive. Neither the original collectors of the data (ONS and DWP) nor the Archive bear any responsibility for the analyses or interpretations presented here.

# The case for social care reform – the wider economic and social benefits

## 1. The policy context – a growing consensus around the urgent need for reform

In the early twenty-first century, a number of commentators have essentially argued that the current adult social care system is fundamentally broken. Like the image in figure 1 below, there is a growing sense that something major has gone wrong at some stage in the process – and that something equally fundamental will be required to put it right. Tinkering round the edges – figure 1 suggests – is unlikely to be sufficient. This is not the fault of the people working in adult social care, nor of the people making social care policy (either now or under previous governments). It simply seems to be the case of a system designed with 1940s' assumptions and principles in mind that are now no longer fit for purpose in the early twenty-first century – even if the post-war desire for a welfare state which pools risk amongst all citizens remains just as strong.

**Figure 1**



Source: The authors are grateful to Simon Duffy and to In Control for providing this original image and analogy.

Although this may seem a harsh diagnosis, there has been a significant sense of dissatisfaction and a growing awareness of the deep-seated nature of the issues at stake for some time. For illustrative purposes only, very selected examples include:

- In 1988-1990, the Griffiths Report, the Caring for People White Paper and the subsequent NHS and Community Care Act argued that the social care system had grown up piecemeal over many years with no one really responsible for managing it or for containing costs (Griffiths, 1988; Department of Health, 1989).
- In the late 1980s and early 1990s, disabled people and their allies campaigned for the introduction of direct payments, arguing that directly provided services were too inflexible and poor quality to fully meet their needs (see Glasby and Littlechild, 2009 for a summary).
- From 1995 onwards a series of pieces of legislation have recognised the lack of support often perceived by carers and the negative impact that this can have, both on their own lives and on their ability to carry on in their role as carers.
- In 1999 and 2001, legislation sought to facilitate greater collaboration and integration between health and social care (albeit that this is a longstanding theme dating back at least as far as the 1960s and 1970s). As the Department of Health (1998, p.3) has recognised:

*All too often when people have complex needs spanning both health and social care good quality services are sacrificed for sterile arguments about boundaries. When this happens people, often the most vulnerable in our society... and those who care for them find themselves in the no man's land between health and social services. This is not what people want or need. It places the needs of the organisation above the needs of the people they are there to serve. It is poor organisation, poor practice, poor use of taxpayers' money – it is unacceptable.*

- In 2001, the Valuing People White Paper was clear that learning disability services have historically been characterised by “*poorly co-ordinated services*”, “*poor planning*”, “*insufficient support for carers*”, little choice or control for people using services and significant unmet health need (Department of Health, 2001, p.2).
- From 2003, In Control sought to achieve wholesale system change via the development of personal budgets and self-directed support, now at the heart of the personalisation agenda (HM Government, 2007).
- In 2005, the Prime Minister's Strategy Unit report on *Improving the Life Chances of Disabled People* argued that “*many disabled people feel isolated, unwanted and a burden to society. Their families... can also face negative*

*attitudes, poverty and social exclusion. Many feel that they spend far too much time fighting bureaucracy – when they should be receiving the support they need to help themselves” (p.11).*

- In 2006, the Wanless review (2006) of the funding of older people’s services argued that:

*[Despite considerable sums of public money], there is little information about whether this spending achieves the government’s desired aims for older people of promoting choice, independence and prevention... There is also widespread dissatisfaction with the current funding system (p.xxi).*

Of all previous reviews, this was a particularly detailed and rigorous attempt to set out a series of different options for the future funding and provision of adult social care (and the current report draws heavily on this and on other contributions by Derek Wanless – see below for further details).

- In 2007, a new Mental Health Act sought to achieve a delicate balance between protecting the rights of the individual and of the wider public.
- In 2008, a long-term review by the Law Commission concluded that “*the legislative framework for adult residential care, community care and support for carers is inadequate, often incomprehensible and outdated. It remains a confusing patchwork of conflicting statutes enacted over a period of 60 years*” (p.1). Unlike the Children Act 1989, adult social care arguably lacks a similar modern and overarching legal framework.

More recently, the government’s *Case for Change* document and its subsequent ‘Big Care Debate’ have set out a very clear critique of the current system (HM Government, 2008, p.8):

*Society is going through huge change. People are living longer than ever before, and the proportion of older people in our society is growing. We have different social values, and we expect more choice and control over all areas of our life, including public services. And too often the existing system does not live up to the expectations of those who depend upon it... A radical rethink of the care and support system is needed to address these challenges. Otherwise, it is likely that families, including dependent children within the family, will be under pressure to provide inappropriate levels of care, and in some cases people will go without support. If we fail to get a grip with these long-term issues we will fail to provide quality of life for potentially large groups of people, and consequently demand for NHS services will increase inappropriately.*

In many ways the strength of this summary echoes the findings of the previous Royal Commission on Long-term Care (1999, para. 4.1-4.2 – see also Box 1), which found that:

*The current system is particularly characterised by complexity and unfairness in the way it operates. It has grown up piecemeal and apparently haphazardly over the years. It contains a number of providers and funders of care, each of whom has different management or financial interests which may work against the interests of the individual client. Time and time again the letters and representations we have received from the public have expressed bewilderment with the system – how it works, what individuals should expect from it and how they can get anything worthwhile out of it. We have heard countless stories of people feeling trapped and overwhelmed by the system, and being passed from one budget to another, the consequences sometimes being catastrophic for the individuals concerned.*

**Box 1** Growing calls for reform – selected examples

*“The UK has not yet found a clear, fair and adequate system for financing the growing demand for long-term care as the population ages. In the 1990s it shied away from major reform which would have secured a sustainable and rational financing structure... The public finds the present system incomprehensible and considers its outcomes unjust”* (Joseph Rowntree Foundation, 2006, pp.1-2).

*“The current systems of funding are perceived to be inequitable, confusing for the consumer, and unsustainable in the long-term”* (Croucher and Rhodes, 2006, p.6).

*“There is a growing consensus that the UK care system is in crisis. A crisis of funding – can we afford to get old? A crisis of fairness – who pays for our care when we do? A crisis of confidence – is the care system one that people understand and have confidence in?”* (Counsel and Care, 2008, p.3).

*“All types of participant – older people, carers, professionals - ... said that they found the system irrational, confusing and unjust.”* (Caring Choices, 2008, pp.11-12).

While different stakeholders may not always agree on the best way forward, there is clear consensus – from government, policy commentators, think tanks, patient groups and others – about the nature of the problem and the key drivers, including:

- Rising demographic pressures
- Changes in family and social structures
- The impact of new technology
- Rising public expectations and a greater desire for more choice and control over how support is provided (with different generations of older people in particular having different expectations of state welfare)
- Increasing concerns about the potential for a ‘post-code lottery’ in terms of the support available, eligibility for services and the amount people are expected to contribute

Against this background, the 2009 Green Paper, *Shaping the Future of Care Together*, sets out a series of options for the future funding of long-term care and the creation of a new National Care Service (HM Government, 2009a) based around:

- Prevention services
- National assessment
- A joined-up service
- Information and advice
- Personalised care and support
- Fair funding

More recently, the Prime Minister has once again highlighted the long-term importance of these issues, pledging to offer “*free personal care*” in people’s own homes for those with the highest needs (Brown, 2009). Elsewhere, the debates taking place as part of the Green Paper have been likened to the need to create a “*Beveridge report for the twenty-first century*” (Ham and Glasby, 2008, p.6) – with a review of the underlying principles of the current system as potentially fundamental as that which created the post-war welfare state in the first place.

As the broader financial situation has become more challenging, moreover, there is increased emphasis on identifying and tackling significant variance in local outcomes and exploring the comparative effectiveness and cost-effectiveness of local whole systems. In health care, work by the NHS Institute on its Better Care, Better Value indicators has demonstrated significant scope to improve performance by reducing variations in clinical practice (see, for example, Ham, 2009a). Similarly, analysis by the Department of Health (2009a) suggests significant scope to improve use of adult social care resources by drawing on and learning from existing good practice. Unpublished data from the Care Quality Commission also confirms this analysis in both health and social care (personal communications). As money becomes tighter it will become even more important for local services to work together to make the best possible use of scarce resources across the whole system. Thus, whatever form adult social care reform takes in future (see below for further discussion), there is clearly scope for significant efficiencies by exploring potentially unacceptable local variations in practice and performance.

#### *The nature and structure of this review*

Against this background, the Department of Health commissioned the University of Birmingham to conduct “*a high-level overview of the social and economic benefits of social care reform, drawing on quantitative evidence, supported by the best available research.*” In particular, the review was designed to consider the wider benefits of reform that:

- (a) Reduces the number of people receiving high levels of care in acute healthcare settings, through greater investment in prevention services and care in the community.

- (b) Provides more support for those needing help with daily activities and personal care, and for those who provide informal care.
- (c) Provides a more effective approach to healthy ageing and to maintaining well-being and independence into later years through better prevention.
- (d) Ameliorates the financial burden on users and families at the point of care.
- (e) Supports informal carers in combining care with paid employment.
- (f) Enables a better mix of services to provide better and more effective choices for service users and carers.
- (g) Provides more effective support from increased integration of health and social care.

As part of this process, the brief was to include consideration of: the economic and social costs of continuing with the current system; the potential gains to NHS services, to the social care workforce, to rates of employment, and to service users, carers and families; and the potential gains from a greater focus on prevention, re-ablement and structural integration between health and social care.

Responding to this brief, the aim of this report is to review the potential social and economic benefits of ongoing and fundamental adult social care reform. After this initial introduction and a brief comment on the **politics of social care reform** (section 2), the report sets out and explores some of the **key rationales** (section 3) underpinning current and previous changes as well as some of the **key mechanisms** (section 4) that have been employed to carry out such reforms. Although our initial brief was very broad, we have selected these ten aspects of social care reform based on expert analysis of current and previous policy – essentially the ten key factors that seem to have shaped policy over time, that feature clearly in the present context and that seem likely to be relevant moving forward. The ten factors we have chosen also seem to fit closely with the initial brief from the Department of Health. These then form the basis of our subsequent **economic analysis** (section 5), and we set out **three scenarios** for future funding, each with different implications for future public expenditure and services (see also the final annex for technical details of this analysis). Building on the previous Wanless (2002) review of NHS funding, the three scenarios are:

- *Slow uptake*: under this approach, future policy and practice remain very much as they are now, with periodic attempts to more fully integrate health and social care, but without sustained and real change; little permanent reform of the adult social care workforce; some support for carers; ongoing preventative/rehabilitative pilots but a failure to really embed these in mainstream services; and low rates of technology uptake. Essentially, this scenario is about a system which tries to meet basic social expectations by providing a bare minimum, albeit with some aspirations towards higher quality and more responsive rights-based services. Despite a stated commitment to partnerships, commissioning, personalisation, workforce reform and greater

use of IT, action is limited and sporadic – with the commitment often rhetorical rather than reality.

- *Solid progress*: while the stated aims of policy remain similar, there is a much more concerted effort to improve outcomes and deliver savings through integration; a greater understanding and embedding of the principles of personalisation; a genuine and sustained attempt to rebalance mainstream services towards a more preventative and rehabilitative approach; a sustained commitment to a commissioning-led system; greater support for carers; significant workforce reform; and more innovative use of IT. In practice, the intended benefits are not fully realised to quite the extent that was envisaged (for example, integration does not deliver as much as expected and the impact of personalisation is reduced in practice by professional and cultural barriers). Over time, thinking retreats back towards meeting basic needs, extending some rights and trying to boost prevention/rehabilitation – but without fully realising the wider social and economic benefits of a fundamentally reformed system.
- *Fully engaged*: there is a sustained commitment to genuine change, motivated by a desire to realise in full the benefits for the health and social care system and for wider society. Where the evidence base is currently contested or unclear, the mechanisms used surpass expectations and start to really deliver. Thus, partnerships achieve the outcomes and the savings that intuition suggests they ought; commissioning proves an effective lever for reforming the system; personalisation is experienced as a lived reality by front-line staff and service users; there are high rates of technology take-up; and there is effective and ongoing workforce reform. This approach is underpinned by a genuine commitment to a rights-based approach, to mainstreaming prevention and rehabilitation, and to using social care funding in order to achieve a much broader range of social and economic benefits for users and carers.

Although this terminology derives from the Wanless review of NHS funding, a similar approach was also adopted in his 2006 review of older people's services (which explored 'current service model', 'core business' and 'well-being' scenarios).

Clearly our approach provides a very high level review of a much more complex reality – and the scenarios we set out below provide only a very broad-brush summary of some of the key issues, options and implications. On occasion, the evidence base that we have reviewed has also been fragmented or under-developed, and we have sometimes had to draw on local good practice examples as a possible indication of what might be possible in future. In reality, of course, such insights from local case studies may not be possible to implement nationally, and so the potential benefits for the system as a whole remain somewhat hypothetical. At the same time, some of the potential improvements that might result from future reform would also have their own costs associated – and so our financial assumptions/data are essentially for illustrative purposes only.

Overall, however, we hope that this review summarises some of the different directions of travel available to policy makers, and some of the potential consequences of the choices we make collectively about future social care reform.

## 2. Social care reform as a social and economic investment: the politics of social care reform

Despite such significant debates, there is always a temptation to view spending on adult social care negatively as a “*necessary evil*” and as essentially “*dead money*” – a burden on the public purse that we will no longer be able to afford in a period of financial restraint and with an ageing population. However, this thinking may well need to change on four main levels:

1. The global recession is seen by some as the result of too much ‘big government’, with the apparent solution lying in a significant reduction in public expenditure. However, others have argued that it was insufficient financial regulation (that is, a lack of ‘big government’) that produced the current situation and that *greater* public spending is required in the short-term to help kick-start the economy.
2. Several commentators have suggested that current economic problems were caused in part by the risk-taking and behaviour of some of those in the financial sector – those of working age who had previously benefitted from years of plenty. If this was indeed the case, it would seem somewhat ironic if it was frail older people and other already disadvantaged groups who now paid the price for this through reduced spending and state support. Potentially this could lead to a situation of ‘Robin Hood in reverse’ – taking from those in need to compensate for the actions of those with significant wealth.
3. Many recent debates about the funding of long-term care have arguably dismissed various options too quickly as ‘unaffordable’. Although this is often portrayed as an economic argument, such statements are inherently political. Something is only ‘unaffordable’ if we are not willing to pay for it. If we genuinely wanted to fund a particular level of service for adult service users, then we could afford to do so tomorrow – as long as we did not fund other activities that we decided to value less.
4. However, the main argument of this paper is that we need to see spending on adult social care as a form of social and economic investment that has the potential to save money in other parts of the system. As argued below, social care is not a “*necessary evil*” which uses scarce public resources to provide an (often very basic) safety net for those in substantial need. Instead, spending on adult social care is crucial in order to:
  - Maintain social and public expectations that the state will provide a degree of collective support to its most vulnerable citizens – a recognition that ‘we’re all in this together’, that none of us can predict who might one day need support and that a key aim should be to find a way of building as good a life as possible together.
  - Support people – who are after all voters, taxpayers and citizens – to be safe, be well and to have greater choice and control. Under this approach, decent social care is not a ‘professional gift’ from the state, but a citizen right for all (see, for example, Duffy, 2005).

- Enable people to remain independent and in control for as long as possible so that emerging and initial needs do not deteriorate into a future and costly crisis.
- Provide support to those in need so that they can contribute fully as active citizens (for example, through participation in the labour market, volunteering and/or caring for others). People using services work, vote, volunteer, care for family members and children and contribute to society and to social capital in a myriad of ways – and greater investment might enable them to do so to an even greater extent.
- Reducing some of the negative impact on families and individuals who care for others – so that they can have a good life in their own right, but also so that they can continue working and contributing to society and the economy in other ways.

According to this analysis, therefore, there are *five key rationales* for reforming and improving adult social care (each of which are explored in more detail in section 3 below):

- Meeting social expectations
- Meeting basic human rights
- Reducing costs by preventing future needs and helping people regain independence
- Freeing people up to contribute as active citizens
- Supporting carers to continue caring and contributing to society and the economy

### 3. Five key rationales for reform

Having set out five key rationales for adult social care reform (section 2), this section of the report reviews the underlying evidence base behind each of the five approaches. Sometimes, elements of our previous reforms have arguably been statements of belief – with some evidence to suggest that they may be a helpful way forward but also evidence that realising such potential benefits in practice could be difficult. Although the current review is very high-level, we attempt to (briefly) summarise these issues in order to inform our subsequent scenarios for future reform and provide a broader sense of what is and might not be achievable in practice. In section 5 of the report, we set out three potential scenarios for the future (‘slow uptake’, ‘solid progress’ and ‘fully engaged’) – and each review of the evidence below concludes with the financial assumptions which are used to inform these scenarios.

#### *Adult social care as a means of fulfilling social expectations*

While a more detailed account of the origins of social care is provided elsewhere (Means and Smith, 1998; Payne, 2005), social support for those in need has historically been most associated with the now notorious Poor Law and the equally infamous workhouse (see, for example, Englander, 1998; Rose, 1988). While ‘support’ for the destitute had been available since Tudor times, the principal response to such social need soon became the workhouse. From the beginning, there was a strong emphasis on punitive approaches and on deterrents, seeking to tackle a perceived link between poverty and crime and disorder. Over time, concerns that ‘generous’ support would encourage ‘fecklessness’ and ‘thriftlessness’ led to doctrines such as ‘less eligibility’ and the ‘workhouse test’ (essentially limiting support to institutional forms of care and making these deliberately harsh, so as to deter all but the most needy of people).

Such was the stigma associated with the workhouse, that the post-war welfare reforms sought to distance social care from its Poor Law origins in order to ensure that those in need could receive support free from such negative historical associations. While this was very much seen as a positive step at the time, it has resulted in a longer-term tendency to view social care and social security as separate activities, failing to recognise the financial problems which many social care service users face (see, for example, Becker, 1997; Becker and MacPherson, 1988; Burgess, 1994). This is unusual in other developed countries, where financial issues and social care are much more linked and where social workers have much more of a role in determining access to social security payments.

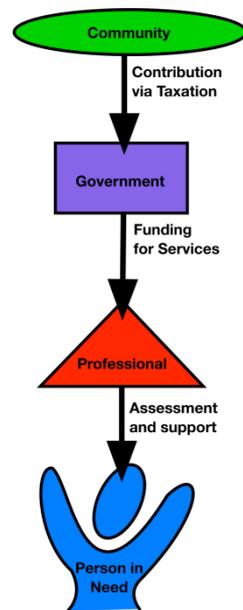
Arising out of this history, adult social care has made significant progress since the Second World War, with a much more comprehensive network of services and support provided initially in residential settings and, over time, in the community. As a result, there is now a much more general acceptance that the state should provide a basic safety net for all those in need – and the consultations which have taken place around the current ‘Big Care Debate’ underline the extent to which the public have come to view adult social care as a crucial public service that should be provided to as high a standard as possible. In particular, Nye Bevan saw the NHS as offering

“*freedom from fear*” – and this social contract between the state and the individual remains a crucial feature of British society.

While current services look outwardly very different to the nineteenth century Poor Law, however, many of the underlying principles remain unchanged. In particular, the current system remains highly discretionary and focused on those in greatest need and with the least financial resources, with a history of stigma that can deter people from seeking support at an early stage. Because of its origins, adult social care is still all too often seen as a ‘professional gift’ rather than as a basic citizen right (see below for further discussion; see also figure 2), and it arguably remains less popular, less understood and more ambiguous than more universal public services such as education or the NHS. While the introduction of care management as part of the 1990 community care reforms has had a number of impacts on keeping costs down and promoting more intensive support at home, these changes arguably failed to change the underlying philosophical assumptions behind the current social care system.

Against this background, our analysis suggests that the public now expect governments to spend a certain amount of public money on adult social care as a means of satisfying our collective obligations to provide support for some of the more vulnerable members of society. Of course, if spending on and reforming adult social care was *only* a means of satisfying basic social expectations, the issue might well be a pragmatic one of how much (or how little) is needed to satisfy these expectations. In other words, it might be tempting to ask ‘what is the basic minimum we can get away with?’ As we argue below, however, adult social care should be about much more than simply meeting basic needs, and so this is only the start rather than the end of the debate.

**Figure 2** Adult social care as a ‘professional gift’ (Duffy, 2005, p.153)



### *Financial assumptions*

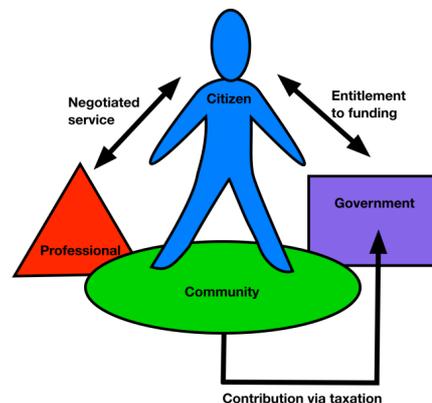
Essentially, our diagnosis of the traditional adult social care system is that it is based predominantly on a 1940s ‘professional gift’ model, still heavily influenced by the historical legacy of the Poor Law, of principles of ‘less eligibility’ and by a tendency to focus on providing a basic safety net. As a result, this rationale for reforming adult social care underpins the ‘slow uptake’ scenario set out below and is essentially the ‘do nothing’ option against which other approaches are subsequently judged.

At the same time, it is important to note that public expectations frequently change – often much faster than services. As a result, adult social care – like other public services – is often a victim of its own success and is constantly ‘playing catch-up’ as it seeks to meet public expectations that increase faster than its ability to respond. Thus, if future policy makers decided to do nothing else but provide basic services in order to satisfy public expectations, they would still be constantly challenged as these expectations increased over time. A good example of this is the current requirement to root out age discrimination within adult social care and other services – even if the system did nothing else, then responding to this requirement would undoubtedly bring extra costs (see, for example, Forder, 2008).

### *Adult social care as a basic human right*

In contrast to the ‘professional gift’ model described above, a number of commentators have argued for a more rights-based approach to the reform and delivery of adult social care. For In Control, such an approach involves a shift away from seeing the person as a passive recipient, grateful for the services that have been pre-purchased on their behalf, to a situation in which the person is an active citizen, with a series of rights and entitlements and much more in control of their own support (see figure 3). Certainly, a common critique of adult social care has been the lack of choice and control that many service users experience – and a shift towards a more rights-based, citizenship-focused system could be an important way of addressing this.

**Figure 3** A citizenship model (Duffy, 2005, p.155)



This argument fits well with the ideas and principles developed by the independent living movement, which has drawn on thinking from the civil rights movement in order to assert that disabled people should be seen as citizens, with a right to the same level of choice and control over their lives as non-disabled people (see, for example, Prime Minister’s Strategy Unit, 2005). Viewed from this angle, spending on social care is no longer a “*necessary evil*” or a question of providing a basic minimum, but much more a matter of providing citizens with the support they need to have the same quality of life as everyone else in society. This is now the stated aim of government policy, with a commitment that:

*By 2025, disabled people in Britain should have full opportunities and choices to improve their quality of life and will be respected and included as equal members of society* (Prime Minister’s Strategy Unit, 2005, p.7).

Unfortunately, all the available evidence suggests that adult social care currently remains a long way away from a fully rights-based approach. As a key illustration of the issues at stake, a 2005 review by the Prime Minister’s Strategy Unit identifies significant progress in recent years, but concludes that (p.69):

*Historically, disabled people have been treated as being dependent and in need of 'care', rather than being recognised as full citizens. This has meant that:*

- *Responses to needs have often created dependency, rather than promoting independence and extending opportunity; and*
- *Disabled people have been expected to fit into services, rather than services being personalised to respond to individual need.*

Behind this summary is a strong sense that:

- Services are not sufficiently personalised, with a fragmented approach that leads to unnecessary bureaucracy, artificially compartmentalises people's lives and leads to a failure to meet needs appropriately.
- Services focus on incapacity and risk, rather than on enabling people to be active citizens.
- The legislative framework is based on inappropriate assumptions and on a broader culture of dependency.
- Assessments are often service- rather than needs-led.
- People with significant cognitive and/or communication impairments are particularly at risk of being denied choice and control.
- Some people have to move into residential care against their wishes because of a lack of appropriate support.

### *Financial assumptions*

Analysis undertaken by the Office for Disability Issues (Hurstfield *et al.*, 2007) suggests that there is no systematic comparison of the costs and benefits of independent living compared to those associated with conventional adult social care support (particularly in terms of benefits at the system level). Despite this, the review was clear that:

*Investment in independent living would result in sizeable Exchequer long-term cost savings, due to the increase in tax revenue, a reduced state benefits bill and less pressure on health and acute social care services (Hurstfield *et al.*, 2007, p.101).*

Drawing on this analysis, our review makes no specific financial assumptions under this heading – but returns to this evidence when considering scope for a more preventative/rehabilitative approach and for an approach which seeks to gain broader social and economic benefits from investment in adult social care (see below).

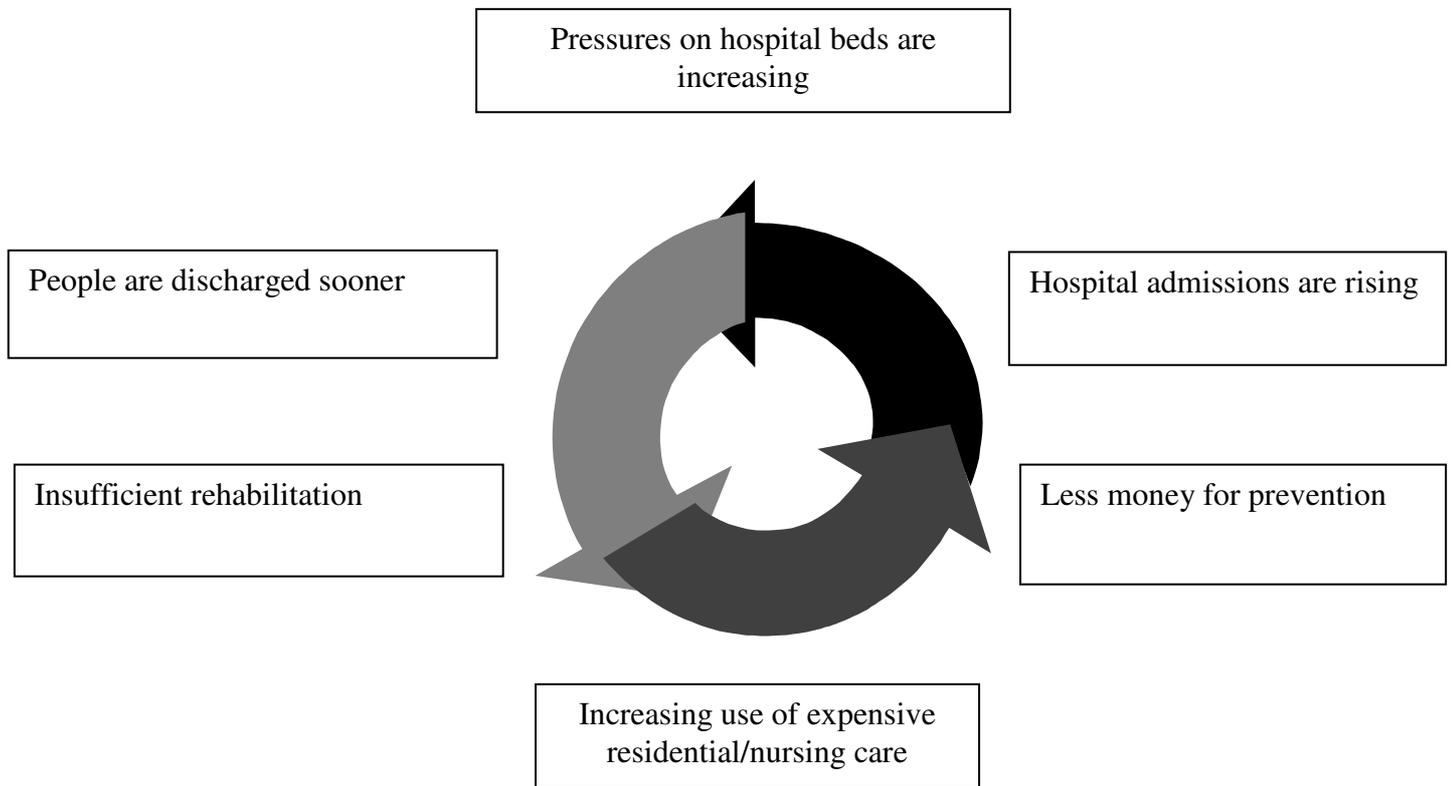
*Adult social care as a means of preventing future deterioration and helping people regain independence*

Unlike the other two approaches set out above, this rationale for reform sees spending on adult social care as a means of ‘investing to save’ – intervening early and promoting re-ablement in order to reduce future needs and costs. While this remains an aspiration rather than a practical reality, it nevertheless implies a much more positive and proactive role for adult social care where the benefits might start to outweigh some of the costs (in terms of savings elsewhere in the health and social care system). There has been significant national and local work in this area in recent years (see, for example, Department of Health, 2009a), with a growing number of good practice examples that are helping to develop the evidence base.

Despite a longstanding commitment to greater prevention and rehabilitation, the importance of these agendas has increased significantly in recent years. With growing numbers of very frail older people both now and in the future, there is growing recognition that the system has too often concentrated *only* on those with the greatest and most complex needs, leaving less and less resource to meet lower-level needs (before a crisis occurs in someone’s health and they qualify for formal support). At its worst, this has led to the counter-productive situation where people only requiring a small amount of support to remain independent have been denied access to assistance until a major crisis has occurred and they become eligible for state support. This has been summarised by the Audit Commission (1997, 2000) in terms of a ‘vicious cycle’ (see figure 4). As hospital admissions rise, it is argued, lengths of stay decline, opportunities for rehabilitation are reduced, there is an increased use of expensive residential and nursing home care, and less money for rehabilitation/preventative services - thereby leading to more hospital admissions. To break out of this situation, there is a corresponding need to invest more fully and strategically in both prevention and rehabilitation – helping older people to stay healthier, more independent and more socially included for longer and to recover all these capacities as fully as possible when they do require hospital treatment.

A similar approach has also been suggested by the former Association of Directors of Social Services and the Local Government Association, who emphasise the need to ‘invert the triangle of care’ (see figure 5). At present, it is argued, resources are most focused on a relatively small number of older people in crisis, with insufficient investment in preventative services. By inverting the triangle, it is hoped that services can begin to invest in preventative services for a larger number of older people, thus reducing future crises. In response to such calls for reform there have been a number of positive policy developments, including significant investment in intermediate care services (Barton *et al.*, 2005), a greater emphasis on well-being (Department of Health, 2005a, 2007) and a review of current adult social care eligibility criteria (Commission for Social Care Inspection, 2008).

**Figure 4** The vicious cycle (Audit Commission, 1997, 2000)



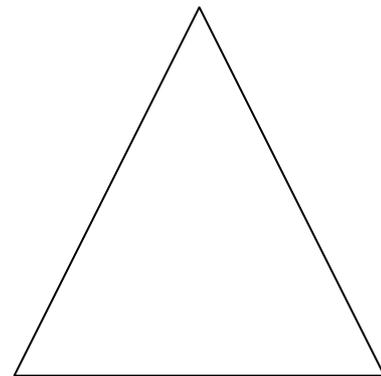
**Figure 5** Inverting the triangle of care (ADSS/LGA, 2003)

*Now*

Resources focused on acute health and social services at the tip of the triangle

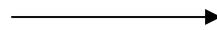


Insufficient investment in prevention and wider community services

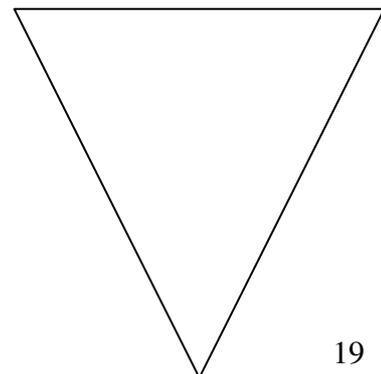
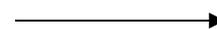


*Future*

All partners investing in well-being



Health and social care work with a much smaller group of people in crisis



Central to these models and to much recent policy is a desire to reduce the number of people (often frail older people with multiple needs) who need to receive high levels of care in acute settings and/or who are prematurely admitted to residential and nursing care. Arising out of this has been a series of policies designed to promote ‘care in the community’, ‘care closer to home’ and ‘the right care, in the right place, at the right time’ – essentially ensuring that people are supported to remain healthy and independent for as long as possible and, when they need support, that this is provided in the least intensive and least institutional form of service possible. Over time, this has led to a series of attempts to deliver fewer and shorter hospital stays, healthier and more independent older people, less reliance on residential and nursing care, and more focused care and housing-related services to provide better support in people’s own homes.

Despite numerous examples of good practice over time, successive governments have arguably struggled to fully embed prevention and rehabilitation (see Allen and Glasby, 2009 for a summary). This seems to be the result of a number of inter-related factors:

- The outcomes of prevention and rehabilitation are often very long-term – and political timescales often require much more immediate indications of success.
- Proving you have prevented something is very complex, and a number of potentially promising approaches remain under-researched.
- Investing in prevention and rehabilitation arguably requires a degree of double funding (to continue meeting the needs of people in crisis whilst gradually investing in longer-term approaches to reduce future demands).
- Prevention and rehabilitation are very difficult to conceptualise, and different agencies/professions may be working with different ideas about what these ways of working entail, the desired outcome and the best way forward.

For all these reasons, preventative and rehabilitative projects have often been very small, local and time-limited pilots (and therefore unlikely to change the system as a whole). Often, the level of need has been such that these pilots act more as a ‘sticking plaster’ solution or as a ‘bolt on’ to existing services and can therefore be the first hit if budgets are reduced.

Despite this, the scale of the challenges facing adult social care are such that the system will arguably *have to* find a way of more fully embedding prevention and rehabilitation if it is to be able to respond. Although many of the models outlined above remain essentially intuitive, current and future services will nevertheless find themselves forced to engage with such issues if they are to survive and prosper in the current financial context and in future. There are also broader policy initiatives which may not necessarily ‘prevent’ people from becoming frail or disabled in the first place, but which might be able to support people in lower level, more community-based services. This is discussed further in section 4 with regards to health and social care partnerships, but there is also evidence that greater investment in housing-based care and support can reduce use of services elsewhere in the system (for example, research into the financial benefits of Supporting People estimates net financial benefits of £3.41 billion per annum compared to an overall investment of £1.61 billion – see Department for Communities and Local Government, 2009). There has also been growing interest in a range of broader services and approaches, such as care and

repair schemes, lifetime homes and the decent homes standard (see, for example, [www.careandrepair-england.org.uk](http://www.careandrepair-england.org.uk); [www.communities.gov.uk](http://www.communities.gov.uk)) as a potential means of contributing to prevention and well-being.

### *Financial assumptions*

When exploring future scenarios, we have made a number of assumptions about the possible implications of greater prevention and the potential impact of rehabilitation and re-ablement.

### *Prevention*

In terms of prevention, the most recent pilots to explore these issues were the 'Partnerships for Older People Projects' (POPPs) programme. Between 2006 and 2008, 29 local authorities received funding of around £60 million in total, developing 146 core projects and providing services to just over a quarter of a million people (see Windle *et al.*, 2009). A key aim of the programme was to develop services for older people which would promote their health, well-being and independence and prevent or delay their need for higher intensity or institutional care. In addition to improving health-related quality of life, the projects were also found to lead to a reduction in the number of overnight hospital stays, use of A&E departments, physiotherapy/OT appointments and clinic/outpatient appointments. In particular, "*the reduction in hospital emergency bed days resulted in considerable savings, to the extent that for every £1 spent on the POPP services, there has been approximately a £1.20 additional benefit in savings on emergency bed days*" (p.vii). However, this figure assumes 10% management costs – with 30% management overheads, the saving falls to £1.00 for every additional £1 spent on POPP projects (Windle *et al.*, 2009, p.197).

Although POPPs projects were often small and time-limited, the broad nature of the programme and the availability of robust economic data make these helpful figures to consider when exploring the potential cost savings to be made via the reform of adult social care, and it is this that we use in our subsequent analysis. However, the national evaluation of POPPs also found that it was very difficult for local areas to extract such savings in practice from acute care – and significant attention may well be required from national policy makers to achieve this.

Building on the POPPs experience, the scenarios set out later in this report suggest that it may be possible to save £1 on emergency beds days for every £1 spent on prevention ('solid progress') and £1.20 saved for every £1 spent ('fully engaged').

### *Rehabilitation*

In terms of rehabilitation, many local authorities have been increasingly refocusing their traditional home care services in order to achieve more preventative and rehabilitative ends through a more clearly defined re-ablement approach. Above all, re-ablement aims to maximise independence and quality of life in older age, whilst at the same time reducing costs by aiming for the lowest appropriate level of care for individuals (see Table 1).

**Table 1** The concept of re-ablement (CSIP, 2007)

Prevention	Rehabilitation	Re-ablement
Services for people with poor physical or mental health to help them avoid unplanned or unnecessary admissions to hospital or residential settings. Can include short-term emergency interventions as well as longer term low-level support.	Services for people with poor physical or mental health to help them get better.	Services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living.

Although definitions vary, re-ablement services often:

- Encourage individuals ‘to do’ rather than ‘doing it for’ them
- Focus on practical outcomes within a specified timeframe
- Involve a continuous rather than one-off assessment of need

To date, work on re-ablement has shown quite promising results in a small number of pilot areas (see, for example, Pilkington, 2008, 2009). One review suggests that a process of re-ablement was able to reduce the need for home care by some 28% (Kent *et al.*, 2000). As the reviewers note, however, success has been “*so spectacular that it caused the research team some worries*” (Kent *et al.*, p.23). Later research has also continued to find apparently very high rates of success, but qualifies this more in terms of a timing issue – “*the possibility that re-ablement service users fall into two broad groups: those who gain immediate but relatively short term (around three months) benefit from re-ablement; and, those for whom the impact is more sustained, possibly delaying their need for homecare by a year or more*” (Newbronner *et al.*, 2007, p.iv). This introduces more of a dynamic perspective, where the effect of the intervention may be mostly about delaying the need for ongoing support, rather than preventing or circumventing such needs entirely.

Another reason for being cautious about effects is that CSED (2009) note that a significant proportion of people do not complete the re-ablement phase, perhaps one quarter of those starting such an intervention. Moreover, whilst the benefits described in studies are substantial and provide a case for wider use of such services, there is little or no corresponding data on the costs of providing the re-ablement service. Clearly there is an invest-to-save argument, but at present there are few details on the costs of such schemes to weigh against the kinds of benefits being delivered. Overall we should therefore be cautious about translating some of these positive findings into potential cost reductions, and have therefore not included detailed financial assumptions about the potential impact of re-ablement in our subsequent analysis. However, if further research shows that longer-term positive outcomes can be obtained on a large scale and over time, at reasonable cost, then gains from re-ablement would add to some of the known positive returns from prevention and rehabilitation.

### *Adult social care as an investment in active citizenship*

This rationale for reform sees adult social care as a means of investing to save, but with scope to achieve wider social and economic benefits by promoting participation in the labour market and more active citizenship. Evidence on the strong relationship between disability and social and economic disadvantage (Hurstfield *et al.*, 2007; Prime Minister's Strategy Unit, 2005) is confirmed by research on the experiences of particular groups including older people (Social Exclusion Unit, 2006), adults with mental health problems (Social Exclusion Unit, 2004) and adults with learning difficulties (Emerson *et al.*, 2005). In terms of economic disadvantage, for example, the Spring Labour Force Survey (LFS) shows that only 50% of disabled people were in work, compared with 80.5% of non-disabled people (quoted in Hurstfield *et al.*, 2007, p.90). The LFS estimated that if the 830,000 disabled people who wanted a job were able to find employment, the Exchequer would save £5 billion alone on the payment of state benefits, regardless of additional revenue gained through taxes and national insurance payments. Similarly, in 2004 only 17% of people with learning difficulties of working age were in paid employment compared to 53% of all people in the same age group, despite nearly two thirds of those people stating they would like a job (Emerson *et al.*, 2005, p.47).

In view of the evidence of the link between employment and good physical and mental health (Black, 2008), the government is therefore concerned about getting a higher proportion of disabled people of working age into employment in order to:

- Reduce the cost of welfare benefits
- Increase tax revenue and national insurance contributions
- Lessen the pressure on health and social care services
- Increase the economic and social well-being of a significant proportion of the population

In addition, the mental health of the nation is of particular concern during a recession when people are under additional financial pressures (Royal College of Psychiatrists, Mental Health Network and London School of Economics and Political Science, 2009; Sainsbury Centre for Mental Health, 2009). The extent of mental ill health in the UK workforce as well as costs to employers and the economy have been well summarised by the Sainsbury Centre for Mental Health (2007), who estimate that:

- At any one time 1 in 6 people in the workforce will be experiencing mental distress (including both severe and enduring conditions and more common conditions such as depression and anxiety).
- This figure rises to 1 in 5 if problems of drug and alcohol dependency are included.
- Costs to the employer include absenteeism, reduced productivity (which they term "*presenteeism*" as the worker is present but not working at full capacity) and staff turnover.
- The total cost to UK employers is nearly £26 billion per year comprising:
  - £8.4 billion on absenteeism (representing 70 million working days per year)

- £15.1 billion on presenteeism (representing more working time lost than on absenteeism and more common amongst higher paid staff).
- £2.4 billion to replace those staff who leave due to mental health problems.

In addressing some of these problems the government has embarked on a number of measures including a radical reform of the Incapacity Benefit system, new schemes for supporting people with mental health back into employment and increased investment in psychological therapies (Sainsbury Centre for Mental Health, 2009). Whilst research suggests that employers generally underestimate the incidence of mental ill health within their workforce (Shaw Trust, 2006), there is evidence that effective work-based programmes can have significant impacts and lead to significant reduction of the costs attributed to mental ill health. For example, the Sainsbury Centre (2007, p.5) cites the example of BT “*which reported that its mental well being strategy has led to a reduction of 30% in mental health related sickness absence and a return to work rate of 75% for people absent for more than six months with mental health problems.*” If the same rate of effectiveness could be applied nationally they estimate this would produce a saving of £300 per year per employee or nearly £8 billion per year.

In considering how to facilitate adults with learning difficulties gaining employment, a recent review suggests a close examination of existing spending on services which currently comprises (HM Government, 2009b, pp.21-22):

- Local Authorities spending £3.45 billion per annum, of which £660 million funds day services costing £291 per adult per week and £1.52 billion funds residential care services.
- Learning and Skills Council spending of almost £330 million for training 19-25 year olds, few of whom then go on to employment.
- DWP spending of £70 million on employment support programmes.

A case example is also given of North Lanarkshire Council which has shown a strong business case for investment in an employment support programme (HM Government, 2009b, p.22):

- Since 1999 the Council and partners have supported 130 adults with moderate and severe learning disabilities into paid work with the result that their incomes have doubled.
- The council invests £783,000 on the Supported Employment Service for 220 individuals. The cost per job is estimated at half that of a day centre place.
- Wider savings to the taxpayer were also demonstrated.

### *Financial assumptions*

The recession means that it is important to look again at our starting point, and consider the differences in employment rates between disabled and non-disabled adults. As we show in the Table below, the gap in employment rates is now considerably less than five years ago. The employment rate of disabled men is 31 percentage points lower than for non-disabled men (down from 34 percentage points

five years ago); for women the gap has narrowed from around 28% down to 25% over the same period. Some recent research covering 1974-2005 has suggested that in previous recessions the employment levels of disabled people moved in parallel with overall employment rates (Berthoud, 2009) – in the more recent period this seems no longer the case. The employment gaps faced by disabled people are slowly reducing over time – perhaps due, in part, to legislation that now covers this group (the Disability Discrimination Acts of 1995 and 2005) and the increased emphasis on welfare to work policies for benefit recipients.

**Table 2** Employment rates 2004 and 2009, LFS, working age adults

<b>In employment</b>	<b>Per cent in employment</b>	
	<b>Jul-Sep 2004</b>	<b>Jul-Sep 2009</b>
Non-disabled men	86%	81%
Disabled men	52%	50%
Gap	34	31
Non-disabled women	75%	74%
Disabled women	47%	49%
Gap	28	25

Source: HSMC/IASS new analysis of the quarterly Labour Force Survey

Analysis of the latest Labour Force Survey data for July to September 2009 also shows that around 350,000 disabled people in work would like to work longer hours ('underemployment'), whilst a further 975,000 would like a paid job, even though they are not currently searching for a job.

Against this background, this review suggests that it might be possible to identify three scenarios. 'Slow uptake' is based on assuming that the employment gap remains where it is, which provides a baseline. A 'solid progress' scenario would be a continued improvement in closing the employment gap between disabled people and non-disabled people at broadly the current rate, say around 0.5% per year. In a 'fully engaged' future, that employment gap would close more quickly, say at around 1% per year. Naturally these are targets that are most relevant in the near future, rather than in the longer term as the gap closes.

In the 'solid progress' future, an additional 36,000 disabled people would move into work each year, compared with the baseline, and double that under a 'fully engaged' scenario. This is still quite a small fraction, around 4%, of those non-working disabled people who want to work (8% for the 'fully engaged' scenario). Let us assume, for simplicity, that many would currently be on Incapacity Benefit (now Employment and Support Allowance), and that they moved into jobs paying the national minimum wage (£5.80 per hour). Under the 'solid progress' scenario the gain in total earnings would be around £400 million in each year (of which over £50 million would be paid in tax and National Insurance) plus a reduction in benefits

spending of £150 million. These are relatively conservative estimates, as at least some of the new workers may earn rather more than the statutory minimum.

These monetary amounts would double if progress proceeded in the ‘fully engaged’ manner – reaching additional earnings of £800 million and reduced benefit spending of £300 million. Each additional year of achieving these outcomes would generate additional gains of the same magnitudes. Even progress at this rate may be a low aspiration, as each would imply more than a generation to eradicate the employment gap between disabled people and the rest of the population of working age.

In practice, there may well be additional costs of supporting people using social care services back into employment. However, for present purposes we have not been able to identify sufficiently robust data to include in our analysis – as with other sections of this review, the different directions of travel set out above and below are inevitably broad-brush.

Under this approach, spending on adult social care is once again a form of investing to save – but this time the benefits are not just for the health and social care system, but for wider society and the economy.

### *Adult social care as a means of supporting carers*

According to the 2001 Census, there are some 5.2 million carers in England and Wales, including over one million people providing more than 50 hours of care per week (National Statistics, 2003a, 2003b; see figure 6 for further data). While caring is often perceived as a negative activity (involving a considerable physical and emotional burden on the carer), there is clearly scope for caring to be a rewarding and fulfilling relationship – at its best, being a carer *for* someone implies caring *about* them, and many carers speak passionately about the strength of the relationship they form with the person they care for. Many ‘carers’ also do not conceptualise their role in this way, and simply see themselves as partners, parents, siblings, friends and neighbours rather than as ‘carers.’

#### **Figure 6** Carers and the 2001 census

In 2001, the Census included a specific question on caring for the first time. This revealed that:

- There are 5.2 million carers across England and Wales (10% of the total population).
- Some 4.4 million carers are of working age, over 116,000 are children (aged 5-15) and 1.3 million are over state pension age.
- The number of carers providing support for 20 hours or more every week is increasing, and 1.25 million carers provide over 50 hours per week.
- 58% of carers are women, with the peak age for caring 50-59 (more than 1 in 5 carers or around 1.5 million people).
- The proportion of carers reporting poor health increases as weekly hours of care rise (and caring is strongly associated with ill health).
- Over 3 million people combine work with caring (roughly 1 in 8 of all workers in the UK).

(Buckner and Yeandle, n.d.; Carers UK, 2002, 2004a, 2005) – NB some figures in this section vary, as some data applies to England and Wales and some to the whole UK.

However, in spite of many often unrecognised positives, there is also considerable evidence to suggest that being a carer (particularly when feeling unsupported and unvalued by health and social care services) can be a difficult and demanding role (see, for example, Baldwin and Twigg, 1990; Finch and Groves, 1983; Ungerson, 1987; Henwood, 1998; Department of Health, 2000). In response, a series of national policy initiatives have been developed to provide more and better support for carers –

both to enable them to continue in their role as carer and to enable them to live ordinary, fulfilling lives like other citizens. As a former Prime Minister has stated (Department of Health, 2000, p.3):

*When I talk about the importance to Britain of strong communities and of people having responsibilities towards each other, I'm not speaking of abstract ideas, but of real people and real events: the things many people do to make things better for those around them. The extraordinary work which carers do may well be the best example of what I mean. Extraordinary not in ways which make headlines, but in ways which really matter and which really make a difference to those they are caring for. Carers devote large parts of their own lives to the lives of others – not as part of a job, but voluntarily... For the sick, the frail, the vulnerable and the elderly, carers provide help and support in ways which might otherwise not be available. By their effort, their patience, their knowledge, their understanding, their companionship, their determination and their compassion, carers very often transform the lives of the people they're caring for... Carers are among the unsung heroes of British life.*

This emphasis on the needs of carers has also grown as social changes (for example, increased social mobility and greater female participation in the labour market) have meant that more and more people who use services live (potentially a long way) away from family members. Although social care has emerged out of nineteenth century attempts to respond to the 'problem' of poverty and to issues of 'fecklessness', support for carers potentially transcends all boundaries – carers can just as easily be very skilled and economically active people who are suddenly taken out of the labour market as from any other section of society.

Despite the official commitment to 'caring about carers', there remains substantial evidence to suggest that health and social care services frequently fail to provide sufficient support for carers to enable them to continue in their role and to live a full and satisfying life. At best, carers face financial disadvantage, added stress and exclusion as a result of a lack of support; at worst they face potential damage to their own physical and mental health, the deterioration of their relationship with the person they care for and a complete breakdown of formal and informal support (see figure 7 for examples). When this happens, there can be significant adverse consequences for people using services and their families – and the impact of caring on carers' own physical and mental health also have resource implications for the NHS.

### Figure 7 Carers' experiences of health and social care

Henwood's (1998) survey of some 3,000 carers found high satisfaction with health services for those who had received them, but also high levels of unmet need, substantial physical and mental health problems amongst carers themselves, a lack of information about NHS services, a lack of awareness of carers' issues amongst NHS staff and negative experiences of hospital discharge. When asked to indicate their priorities for the NHS, participants emphasised additional funding, better joint working between health and social care, greater awareness of carers' needs and improving access to primary care for people caring for someone who is frail, confused or immobile.

Carers UK (2005) suggests that only around one third of carers receive an assessment of their needs and that those assessments that do take place frequently fail to help carers plan what to do in the event of an emergency.

A study of carers' experiences of providing care to people with long-term conditions found that support for carers was very "*patchy*", with many services for carers "*aspirational rather than actual*" (Harris *et al.*, 2003, p.63). Carers can have very negative experiences of services and often feel that they are not listened to or valued. Carers also feel that they have to fight for services, and many people receive "*too little too late*" (p.64).

For present purposes, these findings are of interest for three main reasons:

- Carers save the state an estimated £87 billion per year (Buckner and Yeandle, 2007). Supporting carers is therefore essential (as the system could not afford to replace the contribution that carers make). Viewed from this angle, supporting carers could be a good way of supporting the person they care for. At the same time, there may also be scope to reduce demands on the NHS by improving the health of carers (see, for example, Carers UK, 2004b).
- Carers are citizens too and more recent policy has recognised their rights to as good a life as anyone else (for example, taking greater account of people's education, employment and leisure needs).
- Viewed more broadly, the evidence suggests that many carers may well be prevented from contributing more fully to the economy and to wider society through having to spend so much of their time caring and because of a lack of support.

#### *Working carers*

Evidence from the 2001 Census shows that in England and Wales, over 2.6 million people are undertaking both unpaid caring roles and paid employment (Yeandle *et al.*, 2006, p.8). The vast majority of these carers are aged 30-59, over half are in full time

employment and, in combining these roles, many experience difficulties which include inflexible working arrangements, lack of understanding from employers and support services which do not meet their needs (Yeandle *et al.*, 2006, p.6). In addition, many experience poor health, financial insecurity and a lack of training and educational opportunities as a result of taking on intensive caring responsibilities (Yeandle and Buckner, 2007). Research for the Alzheimer's Society estimates that carers of people with dementia alone who have to give up paid employment lose £690 million in income, representing a loss of £123 million in lost revenue to the government (Knapp *et al.*, 2007).

In the next 25 years, the UK will need 2 million more workers and 3 million more carers, which suggests that an increasing number of people will be managing the tensions of balancing work and caring responsibilities (Yeandle and Buckner, 2007). In response to these demographic changes, government imperatives and a changing labour market, some employers have already taken initiatives to address some of these issues. However, in reviewing the evidence on the benefits of support for working carers, Yeandle *et al.* (2006, p.7) observe that much of the early research only “*partially evidenced*” the business case for developing flexible employment policies and practices. Their research for Action for Carers and Employment (ACE National), examined the working practices of three organisations which they described as “*carer-friendly*.” They all operated in different ways but a key principle was that all the organisations had introduced greater flexibility for *all* employees, rather than identifying working carers as a separate group with special needs. The evidence from the employers showed the advantages to their businesses in terms of recruitment of staff (they became more attractive employers), improved retention and therefore lower recruitment costs, increased productivity and more appropriate service delivery (Yeandle *et al.*, 2006, p.21). Carers confirmed these benefits for the businesses and also reported greater happiness at home and improved staff morale. The report also includes evidence from 2005 from British Telecom, an organisation where three-quarters of the workforce work flexibly, which claims, “*the average increase in productivity for these workers is 21%..., annual staff turnover is below 4% - when the sector average is 17% - and sickness absence among home workers averages below 3 days per person per annum*” (Waters, 2005, cited in Yeandle *et al.*, 2006, p.24).

### *Financial assumptions*

The Family Resources Survey 2007/08 provides timely data on the links between employment and caring activities. As we show below, rates of paid work are lower, the higher the number of hours spent in informal care. For men, there is a large drop in rates of paid work once they do 10 or more hours of caring a week. For women there is a fall in employment rates particularly once they provide 20 or more hours of care each week. This difference in the point at which work is less likely may be reflecting a greater extent of part-time paid work among women carers, whereas men tend to work either full-time or not at all. Most informal carers (68% in the FRS 2007/08) provided care amounting to less than 20 hours a week.

**Table 3** Employment rates, FRS 2007/08, working age adults

<b>Hours of weekly care provided</b>	<b>Per cent in employment</b>	
	<b>Men</b>	<b>Women</b>
Non-carers	80%	71%
Carers, of which:	71%	63%
Under 4 hours of care	86%	78%
5-9 hours	81%	76%
10-19 hours	67%	71%
Varies, but <20 hours	69%	67%
20-34 hours	62%	54%
Varies, but 20-34 hours	58%	66%
35-49 hours	51%	45%
Varies, but 35+ hours	48%	32%
50-99 hours	50%	41%
100+ hours	27%	21%
<b>Total</b>	<b>79%</b>	<b>71%</b>

Source: HSMC/IASS new analysis of the Family Resources Survey 2007/08

If we compare rates of employment between 2004/05 and 2007/08, there is some evidence that male carers are now more likely to be in paid work. Differences for women appear to be relatively small over time. For both men and women the overall employment rate for non-carers, as measured in the FRS, does not appear to have changed.

**Table 4** Employment rates, FRS 2007/08, working age adults

<b>Hours of weekly care provided</b>	<b>Per cent in employment</b>	
	<b>2004-05</b>	<b>2007-08</b>
<b>Men</b>		
Non-carers	80%	80%
Carers	68%	71%
<b>Women</b>		
Non-carers	71%	71%
Carers	62%	63%

Source: HSMC/IASS new analysis of the Family Resources Survey 2007/08

Overall there is about an 8-9 percentage point gap in employment between carers and non-carers. Building on the above data, our subsequent analysis assumes there is no change under the ‘slow uptake’ scenario. For a ‘solid progress’ scenario we propose that the gap in employment rates is reduced by a further 2%, and for a ‘fully engaged’ scenario we look at the implications of reducing this employment gap by four percentage points. This might be achieved by additional support to all carers, or particularly focused support to those providing the level of care associated with diminished employment prospects.

Since the FRS identifies around 3.3 million informal carers of working age, such an approach would mean moving either 66,000 carers into paid work (‘solid progress’) or 132,000 (‘fully engaged’). These are clearly small numbers in the context of the overall labour market, but they recognise some of the difficulties faced in combining work and care, and the relatively small gap in employment rates between carers and non-carers. The former case would add £750 million to the earnings of this group, and the latter case £1500 million – and this is taking a very cautious approach of assuming wages at the national minimum.

In practice, it is important to stress that there is a risk (as with supporting social care service users back to work – see above) of such activity simply displacing other workers, without an increase in aggregate employment. Much of the above analysis also tends to imply that carers are a homogenous group, when in practice policy solutions will need to address a wide range of circumstances and needs (see, for example, Yeandle *et al.*, 2007).

As suggested above, this is in many ways a hybrid approach which sees support for carers as a way of reducing future care costs, a way of supporting carers to have a good life *and* as a means of freeing carers up to contribute in other ways to the economy and society. As Glasby (2007) has suggested, this leads to a dilemma for policy makers and practitioners: should health and social care be supporting carers because this will improve the lives of people who use services (and hence reduce use of services), or should we support carers because they are citizens who deserve as meaningful and satisfying a life as everyone else? At present, different aspects of policy and practice seem to combine these two approaches, and there is certainly some early mileage in arguing that better support for carers has the potential to achieve both these aims. In the longer-run, however, an approach which tries to support carers in order to reduce the cost to formal services is potentially very different in terms of its underlying value base to a citizenship/human rights agenda, and there is clearly scope for the two to come into conflict. At the same time, there is also some evidence from research into the impact of individual budgets on carers that shows improved outcomes at no extra cost (see Glendinning *et al.*, 2009) – and it may be that there are ways to seek better value for money while at the same time promoting a more rights-based approach (provided there is sufficient policy commitment and innovation).

### *Practical implications*

Taken altogether, the five rationales set out above imply slightly different but overlapping reasons for reforming adult social care (see Table 5). Perhaps part of the difficulty in the past has been that different policies have been developed with different implicit rationales. Thus, on one occasion we might be trying to ensure a basic minimum while at another time we are adopting a more rights-based approach. At the same time, we might be supporting carers to provide them with a basic safety net, to reduce the cost of supporting the person they care for and/or to generate wider social and economic benefits. Often individual policies have combined several of these different rationales, and the underlying tensions this can generate may have created a degree of ambiguity for front-line staff and their managers.

However, the implication of our analysis is that it *might* be possible to design a social care system which:

- Meets basic needs, provides a safety net and satisfies social expectations;
- AND ensures that people’s human rights are met;
- AND works preventatively/in a rehabilitative way in order to reduce future costs;
- AND enables people to contribute as active citizens;
- AND supports carers to continue caring, to have a good life and to contribute more broadly to the economy and society.

Whether or not this is possible in practice will be a key test of current debates – and recent trends suggest these are likely to remain significant challenges irrespective of which government is in power or what happens to the economy. In this sense, there may well need to be a political consensus about the nature of the problems to be solved (at the very least) – if not necessarily of the solutions being developed.

**Table 5** Five key rationales for social care reform

<b>Rationale</b>	<b>Implications of this approach</b>
Meeting social expectations	Basic safety net – what is the minimum we can get away with?
Social care as a human right	Bar is set higher, but what is the threshold where services become good enough to meet fundamental human rights?
Prevention/rehabilitation	Investing to save by intervening early, rehabilitating and reducing future costs
Active citizenship	Investing to save by freeing people up to contribute more to the economy and society
Supporting carers	Promoting the rights of carers whilst also reducing costs by supporting carers to continue caring/freeing them up to be active citizens too

#### 4. Five key mechanism for reform

Alongside the key rationales for reform set out above, current policy (in England) has adopted at least five key mechanisms for trying to deliver reform:

- Strategic commissioning – rather than delivering all services in-house, there is increasing focus on securing best value for money by securing services from a much more mixed economy of care.
- Greater collaboration between health and social care – in theory, local agencies working together could meet needs more effectively and may be able to reduce the costs of operating independently of each other.
- Personalisation – emerging evidence suggests that direct payments and personal budgets may be able to achieve better outcomes for either the same or potentially slightly less money for some user groups.
- Greater use of IT – with potential to provide better support to people through a system of telecare as well as to improve the efficiency of current working practices.
- Workforce reform – at present, there are a series of costs associated with unfilled vacancies, use of agency staff and absenteeism which might be reduced by successful workforce reform.

While these have all been relatively longstanding aspirations, our analysis suggests that our ability to reduce future costs and/or to realise the social and economic benefits of investment in social care may well depend on our ability to fully embed these agendas and secure the benefits that should, in theory, arise in each of these five areas. Although this section of the report reviews the evidence behind each of these five mechanisms below, it is possible to categorise current and previous policies by cross-referring these five mechanisms with the five key rationales for social care reform set out above (see figure 8). Thus, governments might pursue a policy of partnership working (as one example) in order to meet basic social assumptions, in recognition that people have a basic right to good quality co-ordinated care and/or as a means of embedding prevention and rehabilitation. Equally they may also view partnership as a good way of realising broader social and economic benefits from health and social care investment and/or of providing more effective and joined-up support for carers. Similarly, policy makers may view personalisation as a means of meeting basic needs more effectively, as a way of meeting fundamental human rights, as a means of freeing up money to reinvest in prevention, as a way to improve outcomes for carers and/or as a means of securing broader social and economic benefits from social care spending. Where previous policy has sometimes seemed to imply multiple rationales (sometimes potentially in conflict with each other), we have found this approach a helpful way of unpicking such complexity – and this analysis helps form the basis of the scenarios reviewed later in this report.

**Figure 8** A possible policy matrix

	<b>Commissioning</b>	<b>Collaboration</b>	<b>Personalisation</b>	<b>Use of IT</b>	<b>Workforce reform</b>
<b>Meeting public expectations</b>					
<b>Rights-based approach</b>					
<b>Investing to save via prevention and rehab</b>					
<b>Achieving wider social &amp; economic benefits</b>					
<b>Supporting carers</b>					

Clearly, this is a very linear way of portraying a much more complex reality – and there may also be a more dynamic way of illustrating such issues (which could also portray some of the different potential directions of travel).

Building on this matrix, the remainder of this section reviews the evidence behind each of these five key mechanisms in more detail, making clear the financial assumptions that underpin our subsequent policy scenarios. In practice, the amount and rigour of evidence available varies significantly across each of the five mechanisms reviewed, so our future scenarios remain very much projections rather than actual predictions.

### *Strategic commissioning*

The commissioning of public services has received increasing attention in a number of countries as part of a worldwide process of reform. In this process, governments have separated the provision of public services from commissioning in the belief that this will result in improvements in performance. Reforms based on the commissioner/provider split have been used to introduce greater competition into the provision of public services. This includes encouraging new providers to compete for contracts as services are market tested (see Greve, 2008 for a recent review of international experience). While the initial interest in introducing competition into the provision of public services was led by governments of the centre right, this approach has since been taken forward by politicians of different persuasions as the pace of reform has quickened.

Within social care, a review of ten years of social care markets in England (Knapp *et al.*, 2001) has summarised the experience of changes introduced in the 1990s under which local authorities became the commissioners of care and stimulated the development of a mixed economy of social care. These authors show how debate about social care reform shifted from a focus on ideological objections to the use of markets in public services to practical concerns about how to realise the potential benefits of commissioning and contracting out. In relation to commissioning, local authorities adopted a variety of approaches and contract types and these continued to evolve. Knapp and colleagues argued that “*choice, quality and cost effectiveness improvements seem to be following*” (p.304), although no hard evidence is provided to support this statement. They also drew attention to the challenges involved in developing social care markets, including asymmetry of information between commissioners and providers and the dangers of risk exploitation.

Since this review, there has been surprisingly little systematic research into the performance of social care markets and the impact of commissioning. However, the most recent assessment of the experience of local authorities in using competition and contestability to improve performance carried out by the Audit Commission (2007) paints a mixed picture. On the one hand, the review found that up to £80 million of efficiency improvements in corporate services could be attributed to the use of market mechanisms. On the other, it highlighted a series of challenges facing local authorities, including lack of sufficient people with procurement, risk or contract management skills, a shortage of information about local public service markets, and inexperience in deciding when to use outsourced provision or in-house services. Overall, the Audit Commission recommended adopting a pragmatic mindset and seeking to fill gaps in skills and information in order to use competition and contestability more effectively.

Alongside longstanding experience in local government, the UK also has experience of health care commissioning dating back to the internal market reforms of the 1990s. Although local government has in many ways a much longer track-record in this area, there is nevertheless a more substantial literature on health care commissioning than in relation to social care - and the key messages from this literature are relevant to the theme of this paper. Thus, a review of the evidence funded by The Health Foundation (Smith *et al.*, 2004) found that:

- Primary care-led commissioning (where clinicians have a clear influence over budgets) can secure improved responsiveness such as shorter waiting times for treatment and more information on patients' progress.
- Primary care-led commissioning made its greatest impact in primary and intermediate care, for example in developing a wider range of practice-based services.
- Given a sustained opportunity to innovate, highly determined managers and clinicians are able to use their commissioning role to change longstanding practices in the local health system.
- Primary care commissioners can effect change in prescribing practice, with financial incentives playing a key role.
- Primary care-led commissioning increases transaction costs within commissioning.
- *There is little substantive research evidence to demonstrate that any commissioning approach has made a significant or strategic impact on secondary care services (emphasis added).*

The need to make available adequate resources to support health care commissioning is a recurring theme in the literature and is underlined by evidence indicating that Total Purchasing Pilots with higher levels of management cost achieved the best outcomes (Mays *et al.*, 2001). The difficulty in acting on this evidence is that recent reforms to the NHS were designed to *reduce* management costs.

To support NHS commissioners, the Department of Health has now put in place the world class commissioning assurance programme and this is now entering its second year. A report on the outcome of the first year's experience showed that Primary Care Trusts (PCTs) had achieved mixed performance on the commissioning competences identified by the Department (Department of Health, 2009b). Support to NHS commissioners is also available in a programme under which the expertise of approved private sector organisations can be accessed by the NHS. In this context, it is relevant to note that the views expressed by the Director of Commissioning in BUPA:

*The private sector has no 'magic bullet' to deliver effective commissioning overnight, nor is it an alternative to the role of NHS commissioners who must ultimately make choices on behalf of patients and citizens... Capable private sector companies can supplement the capabilities of NHS commissioners as they seek to exert their influence in an increasingly commercially savvy health system (Macdonald, 2006).*

Internationally, the most comprehensive study of the experience of health care commissioning in Europe (Figueras *et al.*, 2005) found that:

- One size of commissioning organisation will not fit all needs, and devolution of decision making has advantages; however, some functions require a national approach (for example, public health and equity).
- The appropriate level of commissioning will depend on conditions such as the type of services to be purchased, the incidence and prevalence of different conditions, the number of places where the necessary services can be provided efficiently, and the appropriate size of the risk pool to handle risk.
- Active contracting is a fairly new activity in many countries, having only really developed during the 1990s, and its development is uneven.
- For contracting to work, providers must have management and financial flexibility to respond to the contract's demands and incentives.
- Needs assessment is not routinely carried out in many systems, and when it is it may not be incorporated into commissioning decisions.

Figueras and colleagues emphasised that a central lesson from European experience is that if policy makers are to achieve desired results they need to take a broad systems approach to commissioning and act upon all the various components of this function. They particularly stressed the need for commissioners to have the skills to commission care effectively, commenting:

*Overall, the political, technical and financial ability to implement strategic purchasing is the single most important factor in determining its success or otherwise. Most, if not all, strategies reviewed here are very complex and require a high level of technical and managerial skills together with wide ranging information systems that are lacking in many countries (p.7).*

These findings are echoed in studies of health care commissioning outside Europe. For example, a review of experience in New Zealand reported that lack of good information on costs, volumes and quality made it difficult for commissioners to compare providers' performance and negotiate contracts. Together with the legalistic approach taken in New Zealand, this encouraged an adversarial environment. Negotiations were often acrimonious and transaction costs were high. These challenges were compounded by shortage of skills among commissioners and providers, especially legal expertise and contract negotiation skills. A further consideration was that competition law concerns were at odds with other objectives, making it difficult to develop longer-term contracts or co-operative relationships. The development of these relationships was hindered by repeated structural reorganisations and changes in personnel (Ashton *et al.*, 2004).

In the United States, there has been recent interest in the development of 'value based purchasing' defined as:

*The concept of value-based health care purchasing is that buyers should hold providers of health care accountable for both the cost and quality of care. Value-based purchasing brings together information on the quality of health care, including patient outcomes and health status, with data on the dollar*

*outlays going towards health. It focuses on managing the use of the health care system to reduce inappropriate care and to identify and reward best-performing providers (Silow-Carroll and Alteras, 2007, p.18).*

Research into early examples of value-based purchasing concluded that it was too early to measure in a quantifiable way their impact. At an anecdotal level, there was evidence of positives, such as health plans and providers using information on comparative performance to improve the quality of care they offered. At the same time, a number of challenges were noted, including getting consumers to use such information. In summary, the authors noted:

*A considerable amount of time must be available for VBP initiatives to gain significant participation and reach the critical mass needed to make an impact on their local market. The case study sites highlighted in this report have a good head start, but replication in other regions that have different histories and cultures may be more challenging. The value-driven health care movement will be further slowed by attempts to address the technical and other formidable challenges described in this report (Silow-Carroll and Alteras, 2007, p.19).*

Further grounds for caution are to be found in a recent analysis of the travails of health care in the US by the chairman and chief executive officer of the country's largest integrated delivery system. This analysis argues that a fundamental weakness of the health care market in the US is the absence of effective buyers:

*Car manufacturers purchase component parts for their cars all the time with a very high level of competency. The specifications for purchasing hubcaps extend to a thousandth, even millionths, of an inch, to the actual molecular composition of the hubcap material, and to error rates and delivery times for the hubcaps production process... Health care purchasing has not been held to similar standards. But when we have reached the point where the costs of health care at GM exceeds the cost of steel in a car and the cost of health care coverage at Starbucks exceeds the actual cost of coffee, then it's time for the major buyers to stop thinking of health care as a cost-plus, unengineered, externally shaped, seller-defined, completely unmanaged purchasing expense. It's time for buyers to subject health care to the same kind of detailed performance expectations or specifications as they use for their core business products, and to introduce a whole new level of expertise and leverage into the purchase of both health care coverage and health care delivery (Halvorson, 2007, p.20).*

Halvorson's comment underlines the difficulties of commissioning complex services like health care (and it might be added social care).

Overall, evidence from different sources underlines the difficulties in commissioning public services, including health and social care. In summary, two points should be emphasised. First, as Figueras and colleagues (2005) noted in their review of experience in Europe, the impact of commissioning will be affected not only by the skills and competences of commissioners and the resources available to them, but also by the architecture of the markets that are put in place. This includes how these

markets are regulated and the payment systems that are used. Second, as Knapp and colleagues (2001) commented in their review of social care markets, there are also fundamental questions to be asked about whether the conditions exist for markets to function effectively in complex public services like health and social care. These conditions include the availability of information to enable commissioners to carry out their functions, and the ability to write service specifications and contracts to avoid provider dominance. In the absence of these conditions, an argument can be made for the use of integration to drive performance improvement rather than commissioner/provider and market-like arrangements (see below for further discussion).

### *Financial assumptions*

Against this background, it is difficult to make meaningful financial assumptions about the potential impact of strategic commissioning. According to research by Hodge (2000), international evidence around the savings to be made from contracting services out may be between 6 to 12%. This was based on a meta-analysis of all available studies on contracting out that had statistically based results. However, most of these studies were in refuse collection or cleaning, rather than in 'human' services such as social care. It was also not clear whether quality of service was higher or lower in contracted out services. Arising out of this, we have focused on Hodge's (2000) 6% finding - assuming that it may be possible to achieve 2% savings in a 'solid progress' scenario and 4% in a 'fully engaged scenario'. However this remains a very broad assumption in the absence of detailed evidence from research or from previous experience that such savings may actually be achievable in practice in a social care context. Thus, even relatively modest savings such as these should be viewed as extremely challenging – and the actual impact of strategic commissioning could be much less.

At the same time, much of the previous evidence has been based primarily around very task-based commissioning and/or around approaches essentially designed to minimise costs. In future, it is possible that current trends towards commissioning for quality and for outcomes might continue - and start to yield broader results (see, for example, CSIP 2008; Kerslake, 2006; Cairncross, n.d.). However, at the current point in time, too little is known about the potential impact of this for us to consider the detailed financial implications of such approaches.

### *Partnership working*

In the UK, inter-agency collaboration has been a key theme in government policy, both for adults and for children. Despite this, our knowledge of what works when it comes to collaboration and integration remains limited by a number of key weaknesses in the existing literature, in current approaches to research/evaluation and in current UK policy and practice (see, for example, Audit Commission, 2005; Cameron and Lart, 2003; Dowling *et al.*, 2004; Glasby *et al.*, 2006; Glasby and Dickinson, 2008; Powell and Dowling, 2006):

- Most studies focus on issues of **process** (how well are we working together?) rather than on **outcomes** (does it make any difference for people who use services?)
- Most research fails to fully involve people who use services and (sometimes) front-line staff.
- Many UK policy makers assume that integration and inter-agency collaboration are inevitably a 'good thing' (that lead to better services and hence to better outcomes).
- Most research focuses on the potential positives of integration, without necessarily considering some of the negatives.
- Most studies only consider a narrow range of quantitative indicators (rather than adopting a broader approach that combines qualitative and quantitative research with consideration of the expertise of front-line practitioners and the lived experience of people who use services).
- Most research finds it hard to identify the specific impact of the integration or collaboration (as opposed to the many other services and changes underway at the same time).
- Above all, most integration/collaboration becomes an end in itself rather than a means to an end.

As one systematic review of the factors promoting and obstacles hindering joint working suggests (Cameron and Lart, 2003, p.15):

*Disappointingly, the vast majority of the studies in the review focused their attention on the process of joint working and the perceptions of those involved as to its success. Very few of the studies looked at either the prior question of why joint work should be seen as a 'good thing' and therefore why it should be done, or at the subsequent question of what difference joint working made. This makes the literature somewhat circular, and almost silent on the question of effectiveness. The circularity of the literature led us to the disappointing conclusion that our knowledge... has hardly moved on since the studies carried out in the late 1970s and early 1980s.*

A similar finding also emerged from one of the most detailed studies into the integration of health and social care following the creation of the Somerset Partnership Trust (believed to be the first integrated health and social care organisation in England):

*The establishment of the combined Trust did not – at the conclusion of the evaluation period – appear to have delivered significant benefits that have not been delivered elsewhere in England without the transfer of social care staff to NHS employment. There is no way of knowing whether comparable changes would have been achieved in Somerset without the creation of the combined Trust... Further, this is not to say that other, and perhaps more profound, changes will not follow, especially as Somerset has already put in place the transfer of employment of most social care staff that other localities may have to undertake in time (Peck et al., 2002, p.41).*

This lack of evidence regarding outcomes is deeply to be regretted, as integration can be extremely disruptive and can have significant negative effects for both staff and service users. Indeed, research suggests that (Fulop *et al.*, 2002, 2005; Peck and Freeman, 2005; SSI/Audit Commission, 2004):

- Structural change alone rarely achieves its stated objectives.
- In addition to stated drivers for integration, there are usually unstated drivers (such as addressing managerial or financial deficits and responding to local or national politics).
- The economic benefits of integration are modest at best, and may be out-weighed by unanticipated direct costs and unintended negative consequences (such as a decline in productivity and morale).
- Senior management time is often focused on the process of integration, and this can stall positive service development for at least 18 months (if not longer).
- The after-effects of integration can continue for many years after the change has taken place.

As a result, it is crucial that policy makers, managers and practitioners are clear about what outcomes they are trying to achieve, are ready for the upheaval integration can cause and are sure that the outcomes at stake are worth it. In one interpretation, structural approaches to improving collaboration might be seen as part of the ‘professional gift’ model in section 3 above, motivated by a desire to try to do something to help those on the receiving end of services, rather than because there is evidence of genuinely improved outcomes.

Despite the ambiguity of the current evidence base, there are national and international examples of collaborative and/or integrated approaches which have led to real and significant benefits (see, for example, Audit Commission, 2002; Barton *et al.*, 2005; Ham, 2009b; Ham *et al.*, 2008; Johri *et al.*, 2003; Kodner, 2006 for further illustrations). Thus, it is not that partnership working *cannot* lead to better outcomes – but more that current research has struggled to demonstrate this in practice.

Although it remains unproven, the assumption that more joined-up working could and should lead to improved outcomes and/or a better use of scarce resources seems to have considerable merit. In particular, two reviews of the international evidence have highlighted a range of potential benefits as well as some of the practical elements of service delivery believed to be most helpful in supporting more integrated care. In Kodner's (2006) review of North American models, these are:

- Umbrella organisational structures to guide integration at strategic, managerial and service delivery levels.
- Case managed, multi-disciplinary team care, with a single point of contact and co-ordinated care packages.
- Organised provider networks, with standardised referral procedures, service agreements, joint training and shared information systems.
- Financial incentives to promote prevention, rehabilitation and the downward substitution of services.

Similarly, Johri *et al*'s (2003) review of international experiments in integrated care for older people identified the key features as:

- Case management, geriatric assessment and a multi-disciplinary team.
- A single entry point.
- Financial levers to promote downward substitution of care.

In the UK, a high profile example of the potential benefits of integration comes from Torbay Care Trust in evidence supplied as part of its membership of a Beacon sites programme to test out learning from ongoing links with Kaiser Permanente in the US (see Ham, 2010 for all data in this paragraph, supported by unpublished CQC data). In Torbay, the creation of the Care Trust and the development of more integrated approaches seem to have led to a significant impact on the use of hospitals, with data suggesting that Torbay has the lowest use of hospital bed days in the region and the best performance in terms of lengths of stay. For example:

- Use of emergency beds for the 65 and over population is 2025/1000 population in Torbay compared with an average of 2778/1000 population in the south west as a whole.
- Overall for those aged 65+ in Torbay there are 1.14 hospital admissions per person per year compared with 1.47 for England as a whole. If England was like Torbay, there would be 2.7 million fewer hospital admissions among the over-65s each year, which is a 22% reduction overall.
- After adjusting for deprivation, the standardised admission ratio for emergency admissions for the 65 and over population is 87.7, the third lowest in the south west.

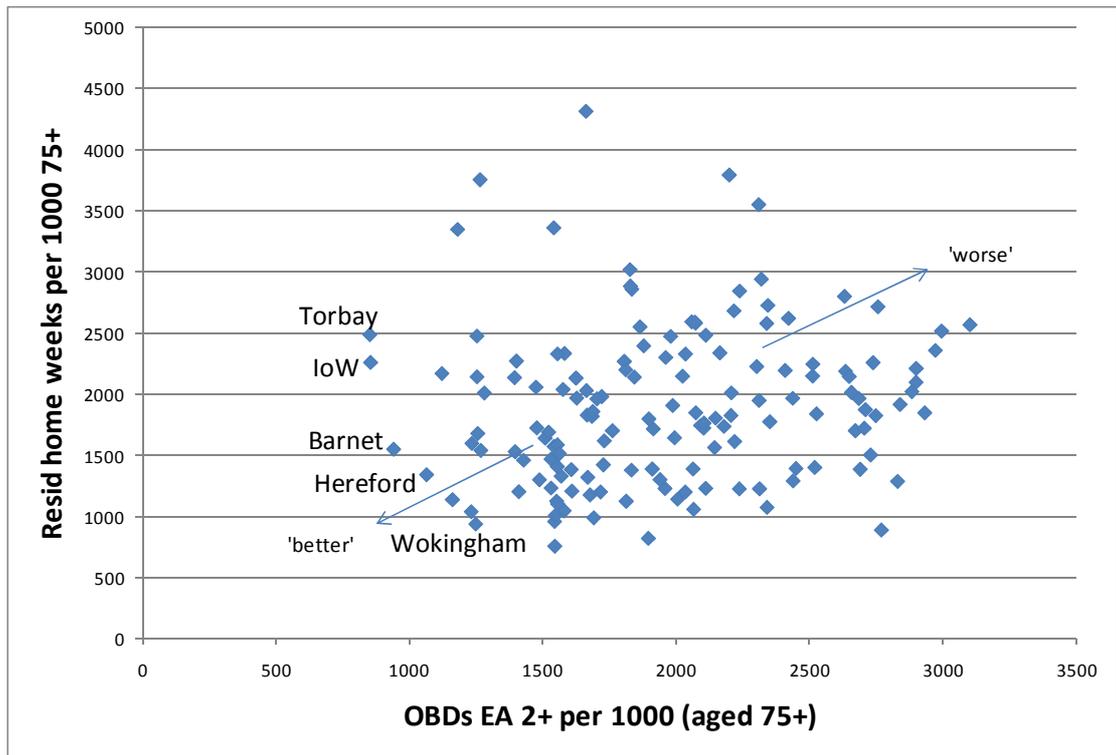
- For the population aged 85 and over, Torbay uses only 47% of emergency bed days for people experiencing two or more admissions for its benchmark group.
- According to the Better Care, Better Value indicators produced by the NHS Institute, the local Foundation Trust ranked fourth in England for use of beds and fifth for day surgery rates at quarter 3 in 2008/09.
- From a commissioner perspective, Torbay had the lowest use of beds per 1000 population in 9 out of 19 HRG chapters.
- This has enabled the health community to reduce the average number of daily occupied beds it uses in both the district general hospital and community hospitals from 750 in 1998/99 to 528 in 2008/09.

Whilst Torbay has achieved excellent results in reducing use of NHS beds, it continues to have above-average use of residential care for older people (the same also being true of some other areas doing well around the use of NHS beds, such as the Isle of Wight). Whilst we might expect those local authorities with lower use of NHS beds to have higher use of residential social care on average, in fact the link is weak (see figure 9). Perhaps the clearest conclusion from this chart is the considerable diversity in the use of NHS beds and residential care for the over-75s, with some authorities having more than double the bed occupancy levels **and** double the use of residential care than others.

There are only a few other local authorities where there is much lower use of residential care, but only slightly higher use of NHS beds, than in Torbay and the Isle of Wight (for example, Barnet). Nevertheless, in Torbay the recent trends have been towards reducing use of residential care over time. As shown below (figure 10), most local authorities were using a lower rate of residential care in 2007/08 compared with 2003/03, but one of the greatest reductions was in Torbay (albeit from a high base).

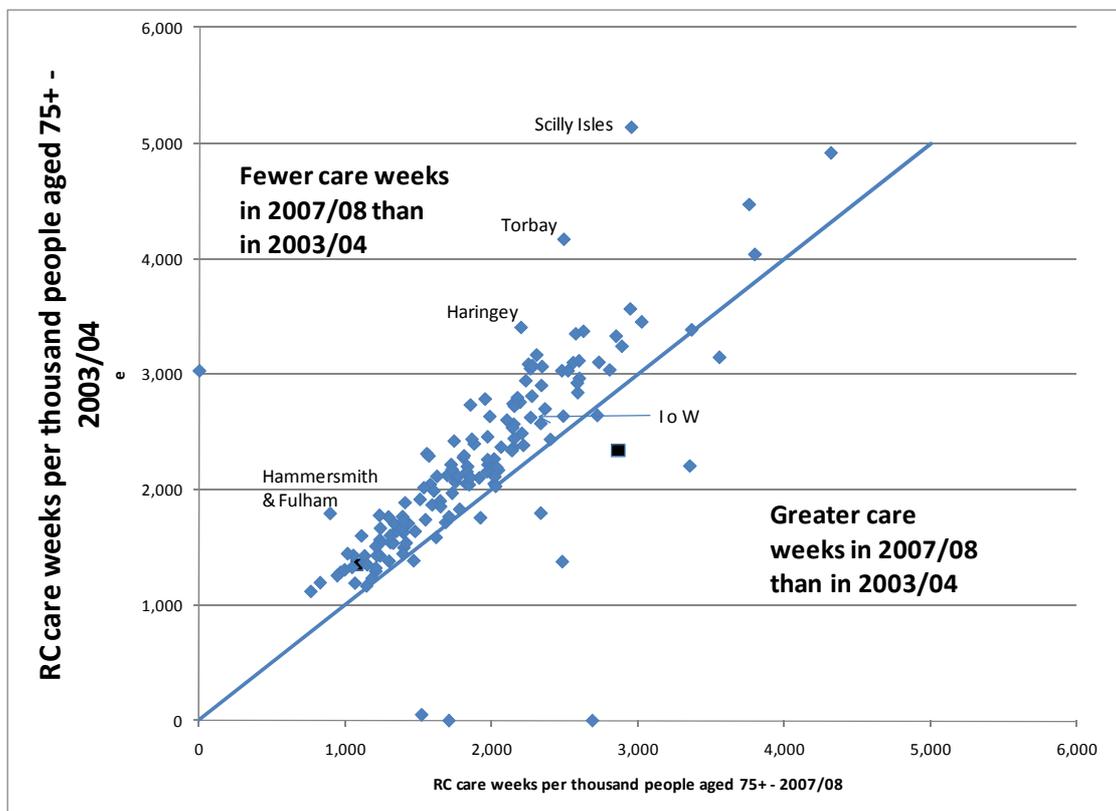
Of course, in the longer-run, a fuller analysis would also need to factor in: the differential costs of different kinds of care, and its effectiveness; the level of spending on other kinds of care; and the costs of establishing a set of more joined-up arrangements to enable progress to be made. Curtis (2009) shows the high cost of a spell in hospital, even compared with the weekly cost of residential care.

**Figure 9** NHS occupied bed days and use of residential care, for those aged 75+



Source: based on data supplied by DH to this report.

**Figure 10** NHS bed occupancy rates and use of residential care



Source: based on data supplied by DH to this report.

### *Financial assumptions*

If it was possible to ‘roll out’ the same level of hospitalisation as found in Torbay to the rest of the country, there would clearly be massive savings from the NHS budget. Moreover, Torbay has also shown a strong reduction in the use of residential care for the over-75s in the last few years. However, as with our analysis of approaches to prevention earlier, any resulting savings might occur primarily in the hospital budget and might be difficult to extract in practice without more sustained policy attention. There is also insufficient evidence to date on the costs of integration or the start-up costs of new approaches.

To date, anecdotal evidence suggests that some integrated health and social care communities that may make apparent progress around health-related targets may not always have managed the same success to date with regards to social care priorities (for example, around rates of care home admissions for older people). As a result, it remains to be seen if a more joined-up approach can genuinely achieve different and better results for both health and social care at the same time, without causing unintended consequences elsewhere in the system. We also know relatively little about why some integrated services seem to be able to achieve very good results, whilst other apparently struggle. It is also difficult to isolate the key causal factors – and it may be that local and contextual issues (such as leadership, culture, geography, interpersonal relationships or the history of local services) might be more important than integration per se. Finally, there are very few fully integrated organisations (despite greater partnership working being an ongoing policy theme for decades), and it is important that gains from local experience are considered against the reality of national rollout.

In the longer-term, an approach which was able to support closer joint working between health/social care and more universal services (such as leisure or community safety etc) might also be expected to bring benefits for the recipients of adult social care. However, the evidence base behind the potential impact of this broader well-being agenda is even more complex and incomplete than the evidence behind health and social care partnerships, and the current review focuses on the health and social interface in the first instance.

## *Personalisation*

With the advent of personal budgets and the continued expansion of direct payments, there remain high hopes that more individualised forms of funding could lead to better outcomes for either the same or even for less money. Although the evidence behind such aspirations is reviewed in detail elsewhere (see Glasby and Littlechild, 2009 for a summary), opinion varies about the potential impact of personalisation. Certainly, when the possibility of direct payments legislation was first being debated in Parliament in the mid-1990s, initial opposition was based at least in part on fears about the cost implications of making payments to individuals instead of providing services. When direct payments were formally introduced, therefore, the accompanying guidance emphasised that:

*A local authority should not make direct payments unless they are at least as cost-effective as the services which it would otherwise arrange... Local authorities may, if they choose, make direct payments at a greater cost than the cost of arranging the equivalent service, provided they are satisfied that this is still at least as cost-effective as arranging services, i.e. that the increased cost can be justified by the greater effectiveness arising from enabling the person to manage his or her own services and live independently (Department of Health, 1997, p 16).*

As a result, much of the research to date has included a consideration of value for money, and there is now a substantial body of literature that suggests that direct payments are more cost-effective than directly provided services and, in some studies, may sometimes even be cheaper. Certainly, this was felt to be the case with the Independent Living Fund, which has been suggested to be around 30% cheaper than direct services (quoted in Mandelstam, 1999, p.233). Prior to the implementation of direct payments, moreover, Morris wrote that “*enabling people to employ their own personal assistants is a more cost-effective way of meeting personal assistance needs than using local authority home care services*” (Morris, 1993, p.168). This assertion appeared to be based primarily on research conducted as part of an evaluation of the Personal Assistance Advisor post at Greenwich Association of Disabled People (Oliver and Zarb, 1992) which found that the scheme appeared to be cheaper than providing services directly. As Conservative Minister, Nicholas Scott, wrote in his foreword to the evaluation:

*This report on Personal Assistance Schemes in Greenwich shows that as well as being cost effective, such schemes offer disabled people a greater degree of independence when compared with traditional forms of provision (Oliver and Zarb, 1992).*

Perhaps the most influential early study was carried out by Zarb and Nadash (1994), specifically seeking to address issues of cost-efficiency in response to the then government’s reluctance to legalise direct payments (see also Evans and Hasler, 1996). In order to compare the care packages of service users receiving some form of payment with those of people receiving direct services, the study sought to calculate unit costs for both types of support, taking account of all the expenditure involved. Although the methodology for compiling and comparing this data was complex, the researchers concluded that care packages financed by direct/indirect payments were,

on average, some 30-40% cheaper than directly provided services. In addition to this, the researchers also noted that the concept of 'cost-efficiency' should incorporate not only issues of cost, but also a consideration of quality. That direct payments resulted in higher quality services had already been demonstrated earlier in the study, where payment recipients suggested that:

- Payment schemes met a wider range of needs than traditional services and led to fewer unmet needs.
- People receiving payments had more reliable support and experienced fewer problems with their care.
- Payment recipients expressed higher levels of satisfaction than people using directly provided services.

Overall, the researchers were adamant that:

*Every pound spent through a payments scheme not only goes further than a pound spent on services, but also purchases assistance of a higher quality... Direct/indirect payments clearly represent better value for money than direct service provision (Zarb and Nadash, 1994, p 143).*

More recently, the growing literature continues to suggest that direct payments enable a more effective use of scarce resources – but with opinion divided as to whether this actually reduces overall costs, or merely achieves better outcomes for the same amount of money (see Glasby and Littlechild, 2009 for more detailed discussion). In evidence submitted to the Wanless Review on the funding of older people's services, for example, Poole's (2006) analysis of direct payments and older people cites local evidence of potential savings, with one case study local authority reducing costs by around 17% of direct service costs (p.11). Elsewhere, the Audit Commission (2006) has suggested that introducing choice can lead to higher quality services, increased control and greater user satisfaction, but that there is a trade-off to be made between start-up costs and any longer-term efficiency gains.

Since the advent of personal budgets, the emerging evidence suggests that this way of working may also be more cost-effective than the traditional system, largely because it helps to unleash the creativity of people who have previously been passive recipients of services. In early In Control pilots, authorities saved a minimum of 12% (see Poll *et al.*, 2006). In the second phase of In Control (2005-2007), detailed costings for 104 people who had previously used traditional social care prior to receiving a personal budget revealed a reduction in average costs by 9% (Hatton *et al.*, 2008, p 47). These people came from across 10 different local authorities, and included a range of different adult service user groups. More recently, the national IBSEN evaluation found that individual budgets are at least cost neutral, costing slightly less than direct services (but not necessarily in a statistically significant manner – see Glendinning *et al.*, 2008). More recent local examples from In Control suggest a range of potential savings (for example, around 16-19% in places such as Worcestershire and Northamptonshire, albeit with very small numbers of people – see [www.in-control.org.uk](http://www.in-control.org.uk) for further details of local evaluations).

While these figures are often hotly debated, a helpful contribution to the debate comes from In Control's paper on *The Economics of Self-Directed Support* (Duffy and

Waters, 2008). Although this stresses that current data is incomplete, Duffy and Waters argue that the previous system is inherently inefficient because of the extent to which it is shaped by the pre-purchased services it has inherited from the past. This, it is claimed, leads to a potentially massive waste of resources, in a number of different ways (Duffy and Waters, 2008, pp.49-54):

- Resources are misdirected (as people have to have what there is rather than what they want or need).
- Multiple funding sources and assessment processes duplicate effort.
- The system forces people to inflate their needs in order to get help and to play down their strengths and family networks.
- The current system rarely innovates as decisions are taken too far away from the individuals they affect.
- There are very high transaction costs (perhaps as much as 30% of the current budget is spent in this way, including high spending on contracts and commissioning, care management and service management/administration etc). However, it remains too early to know how much of this infrastructure is necessary and how much resource could be freed up in an era of self-directed support.

Quite what this means in practice is difficult to interpret. For some, self-directed support offers the opportunity to free up significant wasted resource in order to reinvest this money in meeting the needs of an ageing population, providing support to people with lower-level needs and investing in prevention. For others, this money could be reinvested in other priorities (essentially reducing the overall social care budgets as money is moved elsewhere). For a third group, however, there is a potential counter trend. As Duffy and Waters have argued (2008, p 54):

*At present, the unattractiveness of the current social care system acts as a vicious form of rationing – rationing by not offering appropriate services. For some people, this lack of confidence in the quality of services acts as a significant deterrent... If they can afford to stay away from services... they do. However, when Self-Directed Support is available and authorities offer people choice, flexibility and control, 'new' eligible people [may] come forward and claim their right to a service.*

In addition to this, there remain a number of unanswered questions about the extent to which the potential impact of self-directed support might be limited in practice by cultural barriers to implementation; about the impact of personalisation on user groups such as older people (who may typically have much smaller care packages with less room for manoeuvre/flexibility and who may need more support to self-assess and to make different choices about future support); and about the extent to which a more personalised approach will reduce the costs of care management in practice.

#### *Financial assumptions*

Overall, the scenarios for future reform which we set out in section 5 below are based on data from initial monitoring by In Control and on the national IBSEN study (see Table 6). Of the possible figures available, we have chosen findings from IBSEN for

our ‘solid progress’ scenario and from In Control’s second phase for our ‘fully engaged’ scenario – both of which include data from a range of different service user groups. Although results from In Control’s first phase were very impressive, the economic data collected was not always directly comparable and the initial pilots were focusing on people with learning difficulties – making broader generalisations difficult. However, some more recent local pilots with a range of user groups have generated very high cost savings (albeit with very small numbers), so we have focused on the In Control second phase report as providing a helpful middle ground. In doing so, we are aware that some would see these assumptions as overly optimistic (particularly given the ambiguous nature of some of the previous direct payments evidence).

Also crucial to all this discussion is the improvement in outcomes/quality of life that greater personalisation appears to achieve. At worst, this way of working seems to be able to achieve better outcomes for the same money – and this is a major achievement by itself. While this review tends to focus on future spending patterns, it is important not to lose sight of the additional choice and control inherent in the personalisation agenda.

**Table 6** Economic data and self-directed support

Source	No of PB recipients	Change in cost of support
In Control (phase 1)	60	- 12% (lowest saving made)
In Control (phase 2)	104	- 9%
IBSEN	268	- 6%

At this stage, we have made no assumption about the potential impact on transaction costs. Whereas In Control argues that 30% of the social care budget may be spent on transaction costs (and that this might be substantially reduced in a system based on self-directed support and with significant restructuring of the current system), early data from the national IBSEN study suggests that *additional* care management costs may be incurred in the short-term – and it is unclear whether this is temporary or long-lasting (Duffy and Waters, 2008; Glendinning *et al.*, 2008). In practice, people are likely to choose a variety of mechanisms by which to receive a personal budget. Where the local authority remains the budget holder, they will continue to incur costs. Where the person manages their own budget, there will also be additional costs from providing support and additional responsibilities devolved to the person themselves.

Whatever happens, a key test for future governments will be to implement the personalisation agenda in a way that remains sufficiently flexible and to prevent an over-provision of support for people who want to receive support from elsewhere – if not, there is a danger that the system adopts the language of personalisation but allows the previous care management approach (and its costs) to continue under the guise of the new agenda. If this happened it would not only prevent cost savings, but also potentially reduce the creativity and scope for innovation of individuals, families and workers. Based on this analysis we have assumed a potential cost saving of 6% in the ‘solid progress’ scenario and 9% in the ‘fully engaged’ scenario.

### *Greater use of IT*

This mechanism for reform is based on the expectation that IT is rapidly changing many aspects of our lives – and might also be expected to do the same in public services. At least in principle, therefore, they may be scope to bring about benefits in terms of effectiveness and efficiency – both through improved information sharing and greater use of assistive technology.

### *Improved information sharing*

Building on the work of the Single Assessment Process and the Care Programme Approach, the government is introducing a Common Assessment Framework into adult services which will help improve information sharing for front-line practitioners. To this end, nine local authority-led partnerships have been selected by the Department of Health as part of the Common Assessment Framework for Adults (CAF) Demonstrator Site Programme (Department of Health, 2009c). The demonstrator sites have not yet produced any evaluation of their work, but the anticipated results will be both improved outcomes for practitioners, service users and carers, as well as cost efficiencies from reduced duplication of efforts and less time and resources spent on administration. However, previous practical experience of large scale IT projects has sometimes been that the anticipated benefits prove harder to realise in practice than might be assumed in advance – and the demonstrator sites offer a helpful way of exploring potential impact in more detail.

### *Use of assistive technology*

Assistive technology includes a broad spectrum of systems or devices that are designed to enable disabled or older people to maintain their independence. A research review by the Social Care Institute of Excellence (SCIE) identifies three types of assistive technology which are currently used in both health and social care – supportive (which help people undertake tasks which would otherwise cause them difficulties, such as door entry systems); responsive (which help people manage risks, such as pendant alarms) and preventative (which may prevent dangerous situations arising such as devices to monitor long term medical conditions) (Beech and Roberts, 2008).

Between 2006 and 2008 the government allocated £80 million via the Preventative Technology Grant, with an additional £80 million committed from 2008 – 2010 (Department of Health, 2005b). There are high expectations of the outcomes for service users in terms of greater independence and improved quality of life; for carers in terms of greater freedom and peace of mind; and for social care and health organisations in terms of reducing the need for residential, nursing or hospital care and freeing up resources in one part of the system to invest elsewhere.

The annual report from Department of Health on research and development work relating to assistive technology indicates that there is much activity at local level (Department of Health, 2009d). However, evaluations of such projects are complex,

as it takes time to show benefits and it is often difficult to attribute changes or improvements in people's situations to particular interventions (Department of Health, 2009e). A systematic review of nearly 100 studies identifying the benefits of telecare for frail older people and patients with chronic medical conditions (two thirds of which were from the United States) concluded that there is evidence of improved care and health outcomes for older people, but that evidence on cost effectiveness is not yet established (Barlow *et al.*, 2007). The Department of Health is awaiting results from the Whole System Demonstrator Programme which began in 2008 in Kent, Cornwall and Newham. These will evaluate the extent to which assistive technology has worked effectively with integrated health and social care services for people with long-term health conditions and/or people who are at risk of being admitted to hospital.

Meanwhile, there is *some* case study evidence to show that there are efficiencies to be made from assistive technology. For example:

- North Yorkshire County Council piloted a telecare approach in 2005/6 with 42 people with good results. In September 2008, all new telecare users were subject to evaluation. The cost of packages with telecare were compared to a calculation of costs without telecare. There was an overall reduction of home care hours with a net average annual efficiency saving per person, resulting in a 38% reduction in care package costs across the county (Department of Health, 2009a, p.39).
- Northamptonshire County Council compared the outcomes for a group of older people with dementia who received assistive technology in their Safe at Home scheme with a group of matched older people from Essex who did not. Over the 21 month period of the study, the Safe at Home group received fewer services, remained more independent and their carers reported greater confidence about the safety of the older person. Forty two per cent of the Safe at Home group left the community to enter residential or nursing home care, were admitted to hospital or died compared to 76% of the Essex group. The estimated saving over the whole of the period was £1.5 million (Woolham, 2006).
- Other new IT initiatives for accessing support and assistance 'online' are in the early stages of development. For example, Shop4Support is a social enterprise offering an online information service about, and a place to buy services from, local social care providers. Shop4Support was set up in September 2008 with 5 local authorities which are implementing in different ways the concept of online information and support for service users in receipt of individual budgets. Initial evaluations suggest high consumer support, enthusiasm by social care providers and efficiencies in administrative costs (Shop4Support, 2009).

### *Financial assumptions*

Although greater use of IT should intuitively lead to a range of benefits for social care (given its impact on other aspects of life), the evidence base behind such assumptions

remains significantly underdeveloped. This section of the review is shorter than the others, with much fewer direct research findings on which to draw – albeit that case study evidence is emerging to suggest that there may be some scope for reduced use of services and/or fewer admissions to residential homes, nursing home or hospital. While this remains an area of great potential (Accenture, 2004), there is limited overall information about the effectiveness of past reforms. There are also concerns that the benefits of IT within the public sector have not always been realised in practice (Cats-Baril and Thompson, 1995), and that impacts have tended to be incremental overall, and not of the transformational kind (West, 2006). As a result, we have not built detailed financial assumptions about the potential impact of greater use of IT into the analysis in section 5 – as the evidence to date seems inconclusive.

### *Workforce development and reform*

The adult social care workforce is a valuable resource in delivering effective social care services in the twenty-first century and, in recognition of this, the government has already put in place initiatives to both increase and develop the people who work within it. However, the close examination of the social work profession following concerns about safeguarding issues in children's services has revealed some social care services which are stretched beyond capacity with high levels of absenteeism, large numbers of vacancies and extensive use of agency staff (Department of Health and Department of Children, Schools and Families, 2009a). In order to realise some of the social and economic benefits of investment in adult social care, some of the costs associated with these issues across the whole of the adult social care workforce will need to be addressed and reduced.

There are estimated to be just over 1.5 million people working in adult social care in England, including social workers, care workers, allied health professionals, managers and administrative/ancillary staff who may work in residential, domiciliary or day care settings or within the community (Commission for Social Care Inspection, 2009, p.104). Approximately 71% of people are employed within the independent sector, 19% within local authorities or the NHS and the remaining 10% employed by people receiving direct payments who are recruiting their own staff. However, it is worth noting that this total estimate does not include workers who are employed by people holding personal budgets or by those funding their care privately. The actual number of people employed within adult social care is therefore more than 1.5 million.

The vacancy and turnover rates for staff are indicators of how stable a workforce might be and, in times of economic downturn, one might expect to see a low level of turnover as staff seek some financial stability. CSCI (2009, p.106) report that in June 2008 within *all* sectors, the vacancy rate was 3.8%, with care worker vacancy rates at 4.6%. The turnover rate for all jobs was 17.9%, with the highest rates of 23.6% amongst care workers in the private sector compared to 9.6% in the statutory sector. However, more recent data from the United Kingdom Homecare Association (UKHCA) suggest that the turnover rate for domiciliary workers may be higher at 24.9% (UKCHA, 2009, p.9). For 2007-8, councils reported overall vacancy rates of 8.4% and staff turnover of 10.3% in their adult social care workforce. There was considerable regional variation, with London reporting the highest vacancy rates of 11.1% and with the highest turnover rates in East Midlands (12.2%) and the South East (12%) (LGA, 2009).

The Local Government Association Workforce Survey identified a number of challenges facing local authorities in their employment of adult social care staff (LGA, 2009). Whilst the number of councils facing difficulties with recruitment and retention in general in 2009 has dropped to 52% from 83% in 2008, difficulties in the recruitment and retention of professionals working in adult social care have increased. Forty six per cent of those authorities reported difficulties in recruiting adult social workers, compared to 36% in the previous year, (surpassed only by difficulties in recruiting children's social workers in 72% of those authorities), 32% in recruiting mental health social workers and 25% in recruiting occupational therapists. Difficulties in retention of those same adult care professionals were reported by 28%, 17% and 11% of those local authorities respectively.

The interim report of the Social Work Task Force reported vacancy rates for social workers in England of 9.4% for adult field social workers with a turnover rate of 7.8%, comparing them to the relatively low vacancy rates in, for example, teaching, at 0.7% (Department of Health and Department of Children, Families and Schools, 2009a, p.16). UNISON (2009) has set the average UK vacancy rate for social workers as higher at 12%, with the top rate at 39%. The Social Work Taskforce commented on the lack of robust data on levels of staff vacancies, turnover and sickness levels in frontline social work but received evidence from managers and workers of a vicious cycle of staff shortages leading to work overload, additional stress, staff sickness and further staff shortages (Department of Health and Department of Children, Schools and Families, 2009a, p.17). According to the latest report by the Chartered Institute of Personnel and Development (see Boorman, 2009b, p.13), the average rate of absenteeism within the public sector is 9.6 days per year compared to a national average of 8 days per year, a rise from the previous year's average which has coincided with people feeling more stressed at work and experiencing a less satisfying life-work balance.

Of the total 1.5 million staff in adult social care, 1.41 million are directly employed and the remainder (6%) are made up of agency, bank or pool staff (CSCI, 2009, p.104). The government expects social care employers to reduce their reliance on temporary staff and, in *Options for Excellence*, has set an ambitious target that by 2020 employers will no longer need to employ agency staff to fill a role which a permanent social worker could fulfil (Department of Health, 2006). As part of the Social Care Workforce Research Initiative, the Department of Health commissioned a research study to assess what progress is being made to meet this target, and to identify what role, if any, employment businesses may have in the future for the adult social workforce (Cornes *et al.*, 2009a).

The study included a survey of 150 local councils in England which achieved a response rate of 37%. Of the responding councils, 92% said they had used agency workers in the financial year 2008-9. While nearly all of these had employed social workers, around two thirds had also employed administrative or care staff (Cornes *et al.*, 2009a, p.5). The average spend per council on agency staff was 8% of the adult social care workforce budget, but with large regional variations (with London Boroughs having the highest spend and authorities in the North East the lowest). The reasons given by councils for employing agency staff were difficulties in recruiting permanent staff, the chance to fill a post quickly or to cover for sickness and also to do specific identified tasks.

The evidence from Cornes *et al* (2009a) and other research (see, for example, Kirkpatrick *et al.*, 2009) concludes that, whilst the obvious benefits of agency workers are that they keep the service going, there are other drawbacks including higher employment costs of recruitment and support of workers and concerns about lack of continuity in service provision. A number of strategies to reduce the use of agency staff have had some limited effects - including some efficiency savings. However, it is not clear whether this is a result of addressing the underlying problems of recruitment and retention or of managing agency staff as a “*variable cost*” (that is, agency workers sometimes report that toward the end of a financial year, if budgets are tight they will be released from their contracts only to be brought back in the new

financial year to tackle the waiting lists that have built-up in their absence – see Cornes *et al.*, 2009a, p.46).

Based on a total workforce of 1.39 million in 2006, Skills for Care have predicted an additional 50%-80% growth in the size of the adult social care workforce by 2025 (Eborall and Griffiths, 2008). If this is the case, then employers in the future are unlikely to dispense entirely with agency staff. However, if employers are willing and able to adopt a framework for assessing and maintaining the ‘health’ of their organisations, including the development of national systems of support and supervision of workers as recommended in the final report of the Social Work Task Force (Department of Health and Department of Children, Families and Schools, 2009b), then one could expect the rate of sickness, absenteeism and therefore the use of agency workers to reduce.

The Department of Health has recently published an independent review of the NHS workforce (Boorman, 2009a) which put forward a strong case for investing in and promoting staff health and well-being (with evidence that low rates of sickness absence, staff turnover and use of agency staff positively correlates to patient satisfaction, quality of care and good use of resources - Boorman, 2009b, p.11). The review estimates that if the average absence rate of 10.7 days per year in the NHS were reduced by a third, the benefits would be (Boorman, 2009b, p.44):

- “ a gain of 3.4 million working days a year
- equivalent to 14, 900 WTEs
- with an estimated annual direct cost saving of £555 million.”

There would also be additional indirect savings – for example, some reduction of the £145 billion per year (representing 3.8% of the total wage bill) which the NHS currently spends on agency staff and temporary staff (Boorman, 2009b, p.46).

### *Financial assumptions*

Using the evidence from the national survey conducted by Cornes *et al.* (2009a-b), councils are thought to spend an average of 8% of their adult social care workforce budget on agency staff – but reaching 17% in London boroughs. Clearly, if local authorities are going to positively address the difficulties of recruiting and retaining staff, and focus on the health and well-being of their staff, their spend on agency staff may well reduce. Indeed this is the picture found by Cornes *et al.* (2009a-b), with reductions anticipated, and with 60% participating authorities reporting a declining spending on agency workers in 2008-2009 compared with the previous year.

In a ‘solid progress’ scenario, we have assumed a potential saving of 2% of the workforce budget. In a ‘fully engaged’ scenario we have assumed a potential saving of 4% - halving the current spend, though allowing for a still significant level of spending, on agency workers. Such a level is already reflected in spending in the North East (Cornes *et al.*, 2009, p.55). Statistics for 30 September 2008 show that there were 202,200 Whole Time Equivalent (WTE) staff employed in Social Services Departments in England. At pro rata rates, 4% of the adult component of this workforce number gives a good idea of the magnitude of spending on agency staff.

Another perspective is provided by looking at sickness absence and how this may be managed. Evidence from the Labour Force Survey tends to suggest that those working in health and social care have slightly higher risks of having sickness absence in the week before being interviewed, with about 1 in 37 having done so compared with an overall average of around 1 in 50 – though the average length of leave was more typical.

**Table 7** Sickness absence rates, LFS 2009, working age adults

<i>Industry division</i>	<b>Had sick leave in reference week</b>	<b>Average number of days sick leave that week</b>	Per cent in employment	
			<b>Sample size (unweighted)</b>	<b>Grossed workforce numbers</b>
Human health activities	2.4%	2.4	4,091	2m
Residential care activities	2.7%	2.0	1,462	750,000
Social work without accommodation	2.8%	2.4	1,921	975,000
All workers	1.9%	2.4	56,663	28m

Source: HSMC/IASS new analysis of the Labour Force Survey January – September 2009, removing rotating sample elements

Using the evidence from the recent review of the health and well-being of NHS staff (Boorman, 2009b), a ‘solid progress’ scenario might aim for a reduction of the average absence rate in the adult social care workforce of 10%. In a ‘fully engaged’ scenario, it might be possible to achieve a reduction of 30%. The latter change would be needed to bring down the results for those working within social work to the average across all employees.

At the same time, there are a number of caveats to bear in mind. If current trends for some support to be provided by the independent sector continue, then local authorities may have less direct control over absenteeism and spending on agency workers – making some of the potential savings above appear overly optimistic. Similarly, some of the data from the NHS may not necessarily be applicable to adult social care (where there is a very different workforce), and future policy will continue to need to focus on the specific nature of the social care workforce and measures to strengthen it.

## 5. Future scenarios

Building on this analysis, the next section of the paper sets out a number of potential scenarios for future reform in order to explore the policy, practice and financial implications of different options available. In the process, we draw heavily on the previous analysis of Derek Wanless (2002) from his review of NHS funding. In much greater depth than is possible in a very high level paper such as this, Wanless outlined three scenarios, using these to explore future costs and key policy/practice implications (p.35):

- ***Slow uptake*** – “*there is no change in the level of public engagement: life expectancy rises by the lowest amount in all three scenarios and the health status of the population is constant or deteriorates. The health service is relatively unresponsive with low rates of technology uptake and low productivity.*”
- ***Solid progress*** – “*people become more engaged in relation to their health: life expectancy rises considerably, health status improves and people have confidence in the primary care system and use it more appropriately. The health service is responsive with high rates of technology uptake and a more efficient use of resources.*”
- ***Fully engaged*** – “*levels of public engagement in relation to their health are high: life expectancy increases go beyond current forecasts, health status improves dramatically and people are confident in the health system and demand high quality care. The health service is responsive with high rates of technology uptake, particularly in relation to disease prevention. Use of resources is more efficient.*”

Building on this, our three scenarios are:

- ***Slow uptake***: under this approach, future policy and practice remain very much as they are now, with periodic attempts to more fully integrate health and social care, but without sustained and real change; little permanent reform of the adult social care workforce; some support for carers; ongoing preventative/rehabilitative pilots but a failure to really embed in mainstream services; and low rates of technology uptake. Using the five rationales for reform outlined above, this scenario is essentially about ‘meeting basic social expectations’ and providing a ‘basic safety net’, with some aspirations towards higher quality and more responsive rights-based services. Despite a stated commitment to partnerships, commissioning, personalisation, workforce reform and greater use of IT, action is limited and sporadic – with the commitment often rhetorical rather than reality.
- ***Solid progress***: while the stated aims of policy remain similar, there is a much more concerted effort to improve outcomes and deliver savings through integration; a greater understanding and embedding of the principles of personalisation; a genuine and sustained attempt to rebalance mainstream services towards a more preventative and rehabilitative approach; a sustained commitment to a commissioning-led system; greater support for carers;

significant workforce reform; and more innovative use of IT. In practice, the intended benefits are not fully realised to quite the extent that was envisaged (for example, integration does not deliver as much as expected and the impact of personalisation is reduced in practice by professional and cultural barriers). Over time, thinking retreats back towards meeting basic needs, extending some rights and trying to boost prevention/rehabilitation – but without fully realising the wider social and economic benefits.

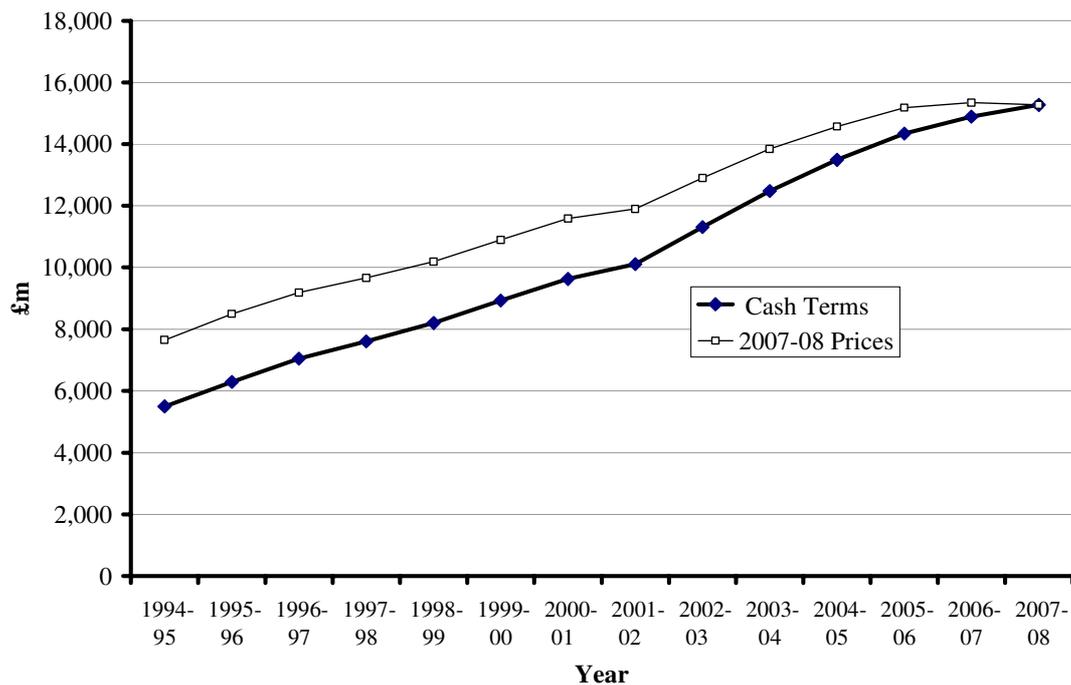
- *Fully engaged*: there is a sustained commitment to genuine change, motivated by a desire to realise in full the benefits for the health and social care system and for wider society. Where the evidence base is currently contested or unclear, the mechanisms used surpass expectations and start to really deliver. Thus, partnerships achieve the outcomes and the savings that intuition suggests they ought; commissioning proves an effective lever for reforming the system; personalisation is experienced as a lived reality by front-line staff and service users; there are high rates of technology take-up; and effective and ongoing workforce reform. This approach is underpinned by a genuine commitment to a rights-based approach, to mainstreaming prevention and rehabilitation, and to using social care funding in order to achieve a much broader range of social and economic benefits for users and carers.

Clearly, reducing the complexity of the adult social care system down to three basic scenarios is inevitably an oversimplification of a much more nuanced reality. However, for present purposes, we believe that such an approach can be a helpful way of highlighting the key issues, exploring the scale of the challenges ahead and providing a very high level overview of potential future costs.

### *The costs of adult social care*

Gross spending on adult social care is on an upwards trajectory. In the recent past, spending has risen both in cash terms and in real terms. Spending was close to £16 billion in 2007-08, or almost double the figure of 1994 - even after allowing for inflation. The pace of increase grew considerably after 2001/02, though was considerably slower in the most recent data available. Over the period as a whole, spending grew by 5½% in real terms per annum.

**Figure 11** Growth of social care spending on adult services (gross)



Source: NHS Information Centre, *Personal Social Services Expenditure and Unit Costs England, 2007-08*

The largest area of spending continues to be on older people, at over half the spending on adult social care. In the last four years, however, there have been faster rates of spending growth related to people with learning disabilities and physical disabilities – where spending has grown by about one-third in cash terms, against an overall budgetary increase of 22%. In real terms – after allowing for inflation – the total budget grew by a little over 10% over this four year period. The latter equates to real terms growth of 3.2% per annum.

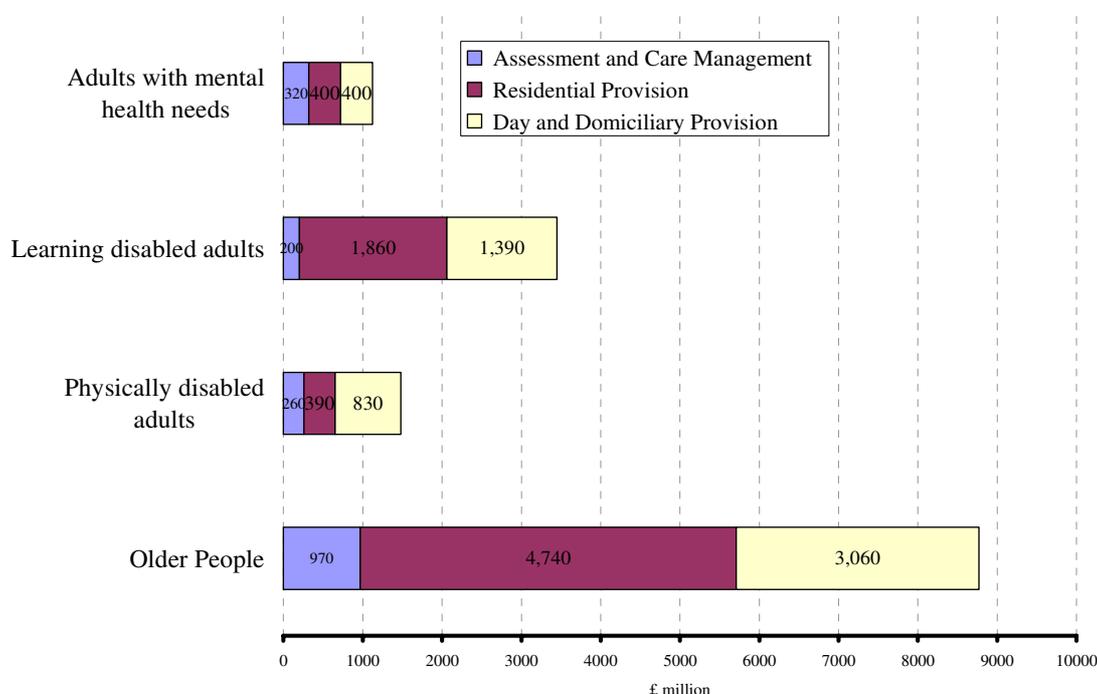
**Table 8** Areas of spending and their recent growth

Major spending area	£ million in 2007-08	Rate of increase, 2003/04-2007/08	
		Cash terms	Real terms
Older people	£8,770	18.8%	7.2%
Physically disabled adults	£1,480	29.8%	16.5%
Learning disabled adults	£3,450	32.2%	19.4%
Adults with mental health needs	£1,120	19.2%	6.7%
<b>Total</b>	<b>£15,270</b>	<b>22.4%</b>	<b>10.3%</b>

Source: NHS Information Centre, *Personal Social Services Expenditure and Unit Costs England, 2007-08*

These areas of spending may also be broken down into the elements comprising residential and non-residential provision, and relating to assessing and managing cases. Overall residential provision represents 48% of spending, day and domiciliary provision a total of 39%, and assessment and care management the remaining 12%.

**Figure 12** Areas of main social care spending on adult services (gross)

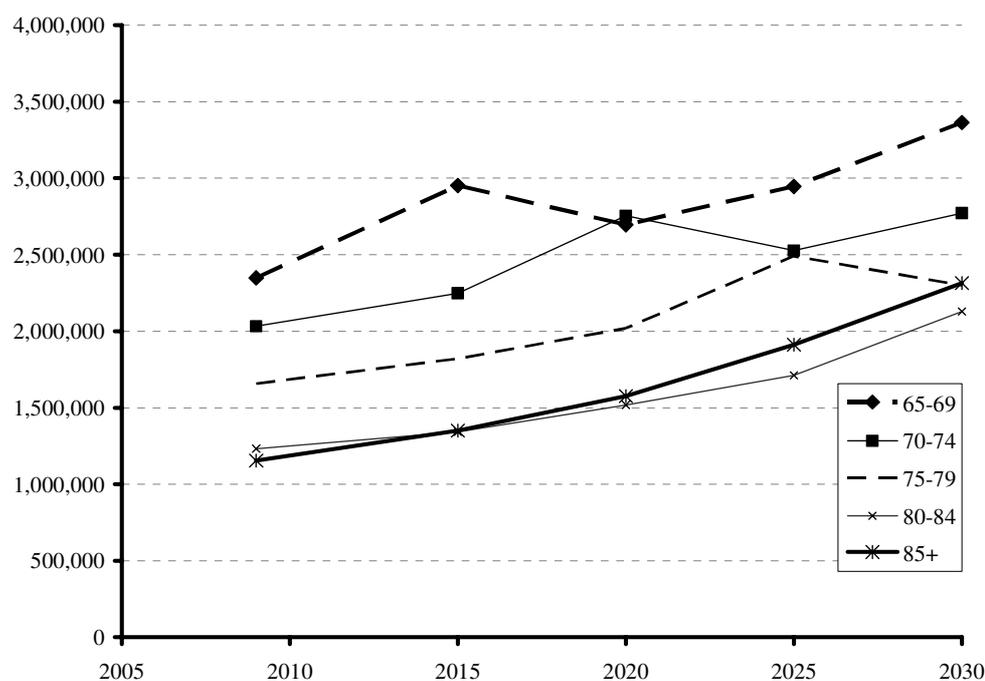


Source: NHS Information Centre, *Personal Social Services Expenditure and Unit Costs England, 2007-08*

### Projecting the costs of adult social care

When we look to the future, however, there are two important sources of future spending growth. First is demographic. The numbers of older people are projected to increase, reflecting higher life expectancy of those who are already old, and the ageing of the ‘baby boom’ group born from around 1946-64. Higher life expectancies among older people are associated with more people living into their 80s and 90s (if not longer) where spending on adult services is concentrated. Between 2009 and 2030, the number of people aged 85 or older is projected to double from 1.15 million to 2.3 million – and this is the group most likely to be in residential care or receiving services of other kinds. The number aged 80-84 is also projected to increase by 75%. Conversely, the adult population aged under 65 will exhibit much less change in total growth, on ONS projections increasing by around 7% over this period, whilst the total population may grow by 16% with this growth concentrated among the older population.

**Figure 13** Population projections for those aged 65+



Source: ONS population projections 2006 – Crown Copyright

Whilst the younger population is growing much less quickly than the older population, there are still important demographic influences among those of working age which may act to increase the groups likely to be receiving adult care services, in particular the group with learning disabilities. Emerson and Hatton (2008, p.i) note the declining rate of mortality (higher life expectancy) among this group, including those with the most severe needs. They also look to increased future needs of the baby boomer group, with a relatively high rate of learning disabilities. Overall they conclude that “*all scenarios suggest sustained growth in the need for social care services for adults with learning disabilities over the period 2009-2026. Average*

*estimated annual increases varied from 1.04% (lower estimate of eligibility, services only provided to new entrants with critical or substantial needs) to 7.94% (upper estimate, services are provided to new entrants with critical, substantial or moderate needs)”* (p.ii). These are somewhat above the estimates that have been previously used, of around 1.1% per year, based on past work by Emerson (see Wittenberg *et al.*, 2008b, and also Emerson, 2009). Instead they propose a minimum rate of growth of 3.2% in those likely to qualify for assistance, assuming services are not rationed only to those with the most critical needs.

The second source of increased spending on social care may well be increases in costs. Those projecting the future for social care have generally factored in cost growth of 2% ahead of inflation (see, for example, Wittenberg *et al.*, 2008a, p.3). Even this may be cautious, as the increased demand for social care services (from population ageing) will have to be supplied from a workforce that is not increasing at the same rate. Whilst 2% real growth sounds relatively small, the effect of compounding that rate over time can quickly increase the overall change. A 2% increase continued for twenty years would mean an overall increase of about half, and an overall doubling within 35 years. If we assume that costs are almost doubling in over thirty years, and that some groups (like the over-85s) are also doubling in number over that time, the scale of the overall increase quickly becomes very clear – potentially a four-fold increase in the spending on such a group. Forder (2008) has also suggested that the costs of tackling age discrimination within social care could be very high – in a multivariate analysis, controlling for disability and health, older people are less likely to be receiving home care or to have access to a social worker. His results are arguably also consistent with a strong element of gender discrimination.

We may take the demographic information (from ONS projections) and apply to it different rates of people receiving residential care for different groups, those receiving other kinds of adult social services (from Census and survey data), and cost data from the Department of Health, to project forward likely trends in spending.

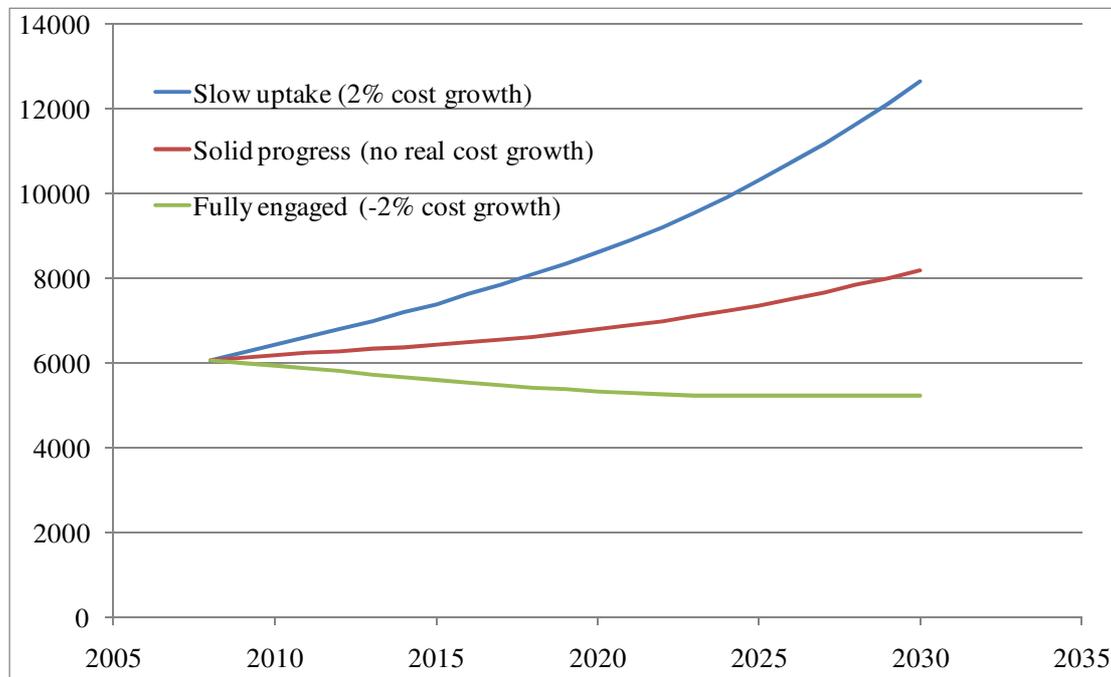
It is crucial to emphasise that these models produce *projections*, subject to a large number of assumptions, and not *predictions*. There are several reasons to be cautious. Most existing models do not take account of possible increased health at older ages, although projections of longer life expectancy tend to have more non-disability years. Instead we assume that rates of care are fixed by groups defined across gender, age and relationship status. In other words, a single woman aged 75 is regarded as having the same ‘risk’ of receiving care both in 2007/08 and in 2029/30. This assumption of constant rates over time (fixed by some combination of age, gender and marital status) is common to most approaches to projecting care needs for older people (see, for example, Wittenberg *et al.*, 2008a). It should also be added that the evidence base for estimates of the extent and severity of disability is mixed, with some data over ten years old. These models would not have predicted the recent rise in spending on social care, for instance (at least not without introducing assumptions additional to the ones generally used for forward projections).

We use Emerson (2009, Table 2) for estimates of the numbers of adults with learning disabilities. For the other adult groups (not the older group) we use population projections of total numbers, assuming similar levels of spend across those groups.

On current trends – 2% cost growth, and projected increases in numbers – the level of real spending on these groups could approximately double before 2030 – from £6 billion to £12 billion. This is a faster rate of growth than found by Wittenberg *et al* (2008b), but probably reflects the use of Emerson’s later figures with a faster rate of growth of those with learning disabilities.

If it was possible to keep costs fixed in real terms, then the demographic momentum would still take costs above £8 billion. It would only be possible to reduce real spending (which would still be a large increase in cash spending) if costs were able to be cut by 2%, year-on-year. That would be an extremely challenging outcome – and would make total costs slightly lower than at present in real terms.

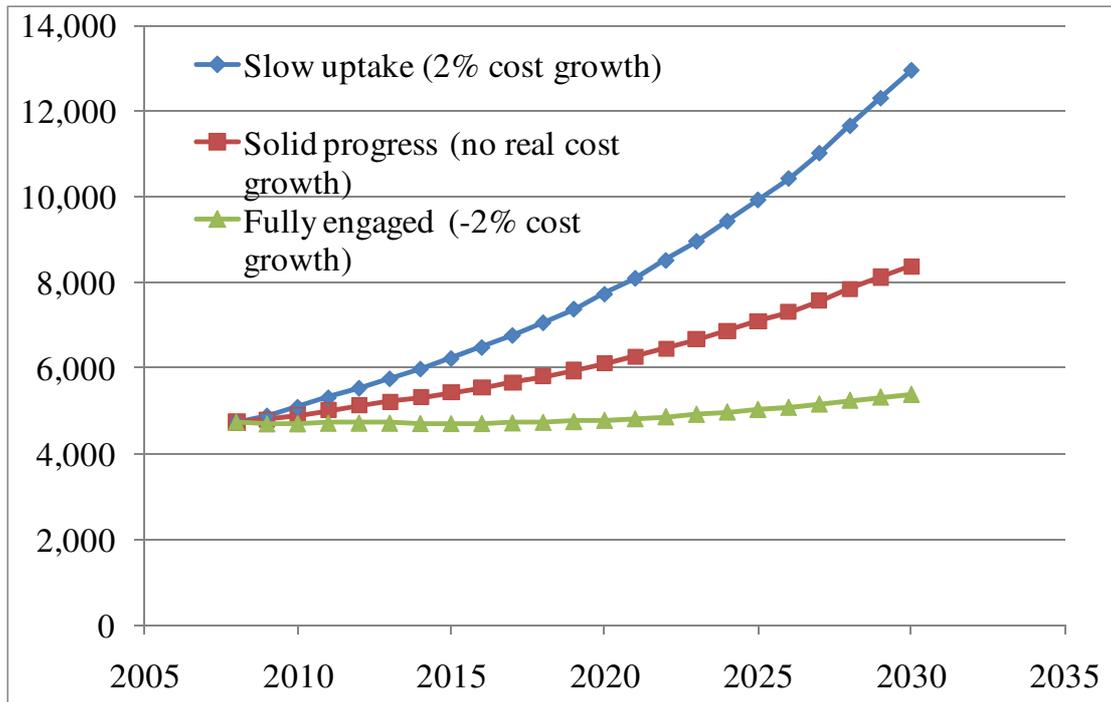
**Figure 14** Gross spending on adults (£m in real term) who are physically disabled, learning disabled or with mental health needs



Source: HSMC/IASS projections

For older groups we use population numbers from the 2006 ONS projections, and take the size of the residential population from the 2001 Census for groups defined by age, gender and relationship status. The growth of the total older population, particularly those at the older ages with higher care needs, means that costs are projected to increase substantially – from around £4.7 billion in 2007/08, to reach closer to £13 billion by 2030. Gross spending would double even if unit costs were held constant in real terms, and indeed would still increase in the longer-term even if year-on-year reductions were made in costs.

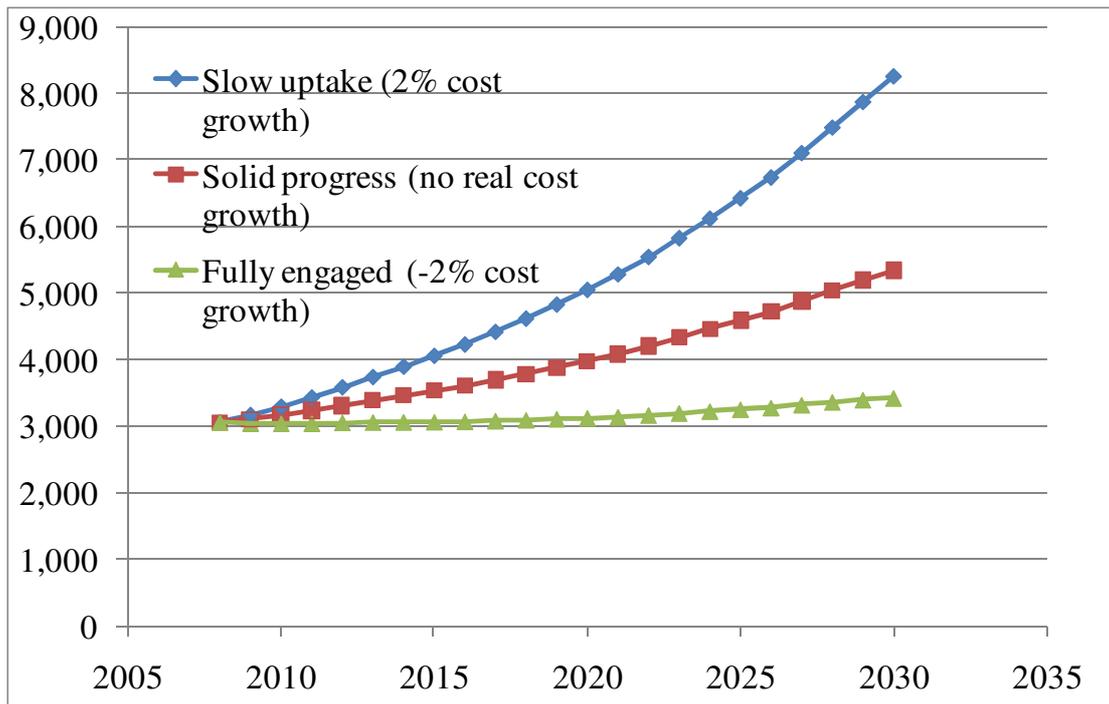
**Figure 15** Spending on residential/nursing care for older people (£m in real terms)



Source: HSMC/IASS projections

The picture looks very similar when considering spending on community services for older people (domiciliary care, day care etc) – since both representations reflect to a large degree the demographic momentum built into an ageing population. It differs owing to the relative spending on different age groups within the older population. (This projection draws on an analysis of who receives social work assistance in the British Household Panel Survey – analysed by age group and marital status).

**Figure 16** Spending on community services for older people (£m in real terms)



Source: HSMC/IASS projections

One of the main conclusions that may be drawn from this is the **high cost of inaction**. The real cost of adult social care is set to increase very rapidly, owing to increases in the number of older people, increases in those with learning disabilities, and the expectation that costs of provision will also rise in real terms.

## 6. Conclusion

Having briefly reviewed current calls for fundamental change within adult social care, this report has sought to explore the potential social and economic benefits of future reform. Rather than viewing spending on adult social care as essentially ‘dead money’, there is scope to re-conceptualise this as a form of social and economic investment – meeting basic needs and providing more of a rights-based approach, but also investing to save via greater prevention/rehabilitation and delivering significant wider benefits for society and the economy by providing better support to users and carers.

### *Future social care spending and reform*

Using our three scenarios (‘slow uptake’, ‘solid progress’ and ‘fully engaged’), we conclude that ‘doing nothing’ is not a feasible option (see also Wanless, 2006; Forder and Fernandez, 2009 for similar analysis). The 2009 Green Paper and the 2008 *Case for Change* have already set out compelling evidence about the cost of inaction. To supplement this, our analysis suggests that our ‘slow uptake’ scenario could lead to continuing increases in the costs of the existing pattern of service provision. On existing demographic trends and with standard cost assumptions, the *real* costs of adult social care (that is, after allowing for inflation) could double within two decades – and this would be the case for current services and approaches (which have already been strongly criticised for failing to fully and appropriately meet need). Thus, this option would lead to real cost increases and do nothing further to tackle the quality of services – reform, after all, is about much more than just costs, and is more about improving services and hence people’s lives.

We have, in this report, listed a number of rationales for reform, and mechanisms for bringing about reform. Where possible, we have indicated the kinds of cost savings that each may be expected to generate, both in a ‘solid progress’ and a ‘fully engaged’ scenario. In some cases the evidence base has been too weak to sustain alternative assumptions. It is always difficult to generalise from a small number of specific areas to what might be possible with a national roll-out. It is also unclear how far the savings achievable in the short-term would be sustainable in the longer-term. Even so, for many of the mechanisms we have discussed, there is promising evidence emerging of the kinds of cost savings that may be practicable – if meaningful and sustained reform can be achieved in practice.

If ‘doing nothing’ is not an option, then neither is continuing with current policy priorities but failing to fully embed them in mainstream services or to deliver current aspirations. Under our ‘solid progress’ scenario, we project forward the implications of maintaining costs at their current level in real terms. This would be a strong achievement, compared with the expectation of rising real costs. Even with this scenario, the overall costs of the system continue to rise, given the momentum built into demographic change. They do, however, rise rather more slowly than for the baseline.

Given current financial, demographic and social pressures, the only credible option for adult social care appears to be our ‘fully engaged’ scenario - in which we seek to

develop a more rights-based approach, to mainstream prevention and rehabilitation, and to use social care funding in order to achieve a much broader range of social and economic benefits for users and carers. This is extremely challenging – it implies both a sustained commitment to significant change and an ability to deliver the potential benefits of such an approach in practice (in a way that has not always proved possible in past). If this were to be achieved, our analysis suggests that we would expect to see costs of adult social care contained at broadly their current level as well as significant benefits for other departments and services (for example, the NHS, social security and revenue from taxes). This is based on the very demanding premise that it would be possible to see year-on-year decreases in the unit costs of service provision, or similar reductions in the demands made on social services through earlier and smarter interventions. We have not assumed that all the various policies could be implemented simultaneously, leading to very large cost savings overnight. Instead we have projected forward a very demanding scenario that would only be achieved by systematic reform across a number of areas.

Of course, much of this report has focused on the potential for cost savings – either in current social care or in broader services (see below). Despite this, many of the approaches reviewed below are just as much about improvements in well-being, independence, choice and control than they are about the resources being expended – and it is crucial not to lose sight of this.

#### *The broader impact on other services*

In addition to the impact on future social care spending, this review argues that social care reform/investment also has the potential to reduce spending in other areas of the welfare state. While the evidence base is sometimes incomplete and fragmented, there is a clear suggestion that spending on adult social care can have a knock-on effect on spending in other areas. For example, our earlier analysis has suggested that:

- It may be possible to save £1.00 on emergency beds days for every £1 spent on prevention ('solid progress') and £1.20 saved for every £1 spent ('fully engaged').
- If some of the gains from high performing integrated sites could be achieved more generally, there may be scope to achieve 2.7 million fewer hospital admissions among the over-65s each year (a 22% reduction overall).
- Supporting social care service users to engage in paid employment could generate additional earnings of £400 million each year (of which over £50 million would be paid in tax and National Insurance) plus a reduction in benefits spending of £150 million ('solid progress'). This would double under a 'fully engaged' manner – reaching additional earnings of £800 million and reduced benefit spending of £300 million.
- Greater support for carers could lead to additional earnings of £750 million for working carers ('solid progress') or £1500 million ('fully engaged'), with extra revenue gained through tax and National Insurance. At present there

seems a key ‘tipping point’ of being outside the workforce at around 20 weekly hours of caring, for women. For both service users and carers, previous research has also indicated the important non-monetary benefits of remaining in work, rather than being out of the workforce.

Viewed from this angle, social care reform is necessary not just in response to pressures on the current system, but also as a form of **social and economic investment** that might impact positively on other areas of expenditure (producing better value for money as well as better outcomes for people using services).

### *Emerging messages for implementation*

Over many years, policy has continued to promote values and more detailed models of care that emphasise:

- Independence and well-being
- Prevention and rehabilitation
- Care closer to home
- Choice and control
- Joint approaches between health and social care
- Greater collaboration between health/social care and broader, more universal services

In the words of previous policy initiatives, an ongoing aim has been to provide ‘the right care, in the right place, at the right time’, intervening early to keep people independent and well for longer. Although there has also been a strong emphasis on more joined-up approaches to service delivery, this is likely to acquire even greater significance in the current financial context, when scarce resources may force even greater collaboration than in the past. Against this background, there has been a degree of consistency over time in terms of the broader direction of travel and some of the outcomes that the system is trying to achieve. Despite this, there has been less clarity about how actually to do this in practice.

While not a formal aspect of our initial brief, the evidence above suggests a number of potential messages with regards to future policy implementation. Reviewers reading early drafts of our report have also asked us to comment in more detail on some of the underlying themes that emerge from our analysis for future policy and practice – helping to place the more detailed analysis above in a broader context.

Based on the evidence assembled here, and our analysis of options for the future, it is clear that there are many opportunities to use existing resources more efficiently. These opportunities need to be exploited in parallel with debate about more radical social care reform. The ‘postcode lottery’ in the use of current resources is arguably indefensible and unsustainable – particularly in the current financial context. The consequence is not only unacceptable variations of access to care services, but also poor value for the taxpayer. At a time when the resources available for public services are under huge pressure, it is imperative that concerted efforts are made to tackle variations in care and to spread best practice more effectively. More specifically, the evidence shows that:

- There is wide variation in levels of spending on adult social care and the composition of this spending (see, for example, Department of Health, 2009a).
- There is also wide variation in the use of hospital services by older people with much higher rates of emergency hospital admission and bed use in some areas than others (see our earlier discussion about the potential impact of health and social care integration).
- Analysis of routine data by the Care Quality Commission (unpublished, personal communication) and others (Department of Health, 2009a) shows that some areas appear to be using their resources more efficiently than others.
- Linked to this, our review of the evidence around scope for greater prevention, rehabilitation, personalisation and integration suggests that more efficient use of resources might mean lower than expected use of institutional forms of service provision; this is beneficial because such services are expensive and – in the case of hospitals - not especially safe places for older people to be.

In the face of this evidence, one of the policy challenges is how to generalise best practice, and particularly to free up resources that are spent in more institutional forms of support (for example, hospitals) for use on care closer to home, prevention, personalised support and independent living. In our view, this might best be tackled through greater transparency in existing variations in use of resources, with the Care Quality Commission and/or the Audit Commission publishing available data and raising further awareness of inequities in care. The regulators also have a major part to play in drawing attention to these issues and stimulating action at a local level to reduce the variations that exist. It is also essential that lessons are drawn from areas that have made most progress and are shared more systematically.

As this and other work (Ham, 2009b) suggests, there are different ways of making improvements in care and shifting resources away from institutional provision and into the community. It would therefore be unhelpful for government to prescribe a single pathway to reform and this should remain a matter for local choice making use of the legislative flexibilities already available. Instead, government should be prescriptive about the desired outcomes of care and hold local authorities/PCTs accountable for delivering these outcomes. Intervention by regulators and others should then follow from the consistent failure to deliver acceptable outcomes of care. It is likely that a basket of outcomes will be needed encompassing not only the use of health and social care services, but also outcomes that matter to service users themselves (see, for example, Glendinning *et al.*, 2006).

### *Final thoughts and next steps*

Ultimately, this review suggests that doing ‘more of the same’ is unlikely to be successful – even if we do it a little more efficiently and effectively in future. Returning to the image in figure 1 at the start of this report, the challenges facing adult social care seem so significant that something equally radical seems to be required if the system as a whole is to be able to respond.

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## Annex on cost projections

### *Sources of data*

The cost projections discussed throughout the report are based on a number of simplifying assumptions, applied to data of various kinds. The data underlying the projections is drawn from:

- ONS population projections – for numbers of people of different ages, and of different living arrangements (couple versus single). Such data is crown copyright (ONS, 2001)
- Census 2001 – for proportions of older people living in residential settings.
- BHPS 2007-08 (wave 17) for receiving services among those living at their own residences (BHPS, 2009)
- PSS expenditure data of different kinds, from the DH Information Centre
- Estimates of the number of disabled people with learning disabilities (from Emerson and Hatton, 2008)
- Estimates of the work patterns of informal carers, from the Family Resources Surveys of 2003/04 and 2007/08 (the latest available) – DWP, 2009
- Analysis of the work participation rates of disabled and non-disabled people, from the quarterly Labour Force Surveys of Jul-Sep 2004 and Jul-Sep 2009 (ONS 2009)
- Analysis of sickness absence rates from the same source

### *Methods*

Separate ad hoc approaches were used to estimate the potential cost savings from having more disabled people and carers back in the labour force. The main assumptions were of pay rates at the minimum wage (pessimistic) and full-time employment (optimistic).

The methodology used to analyse overall spending projections is that of cell-based simulation. This is a robust approach that has often been deployed to project future spending (see, for example, Wittenberg *et al.*, 1998, 2008a, 2008b). It is based on attributing outcomes to pre-specified groups in the population – such as the chances of being in residential care for groups defined by age, gender and marital status. The numbers of people in each group change each year, drawing on data from population projections. The product of the size of the group, and the associated incidence of care needs, multiplied by a cost factor, generates the components of the cost projections.

An alternative approach – micro-simulation – may be used to look at results at the level of individuals, but imposes greater requirements in terms of data and of programming the models (Wittenberg *et al.*, 1998). Developing new micro-simulation models was not possible given the short duration of this review. However it was possible to construct simple cell-based simulations to suggest how spending might develop in future *if a host of assumptions about the incidence of care and its costs continue to be met*. These are projections, not predictions.

### *Selecting the scenarios*

In this report we have outlined a number of strategies that might generate cost savings, and improved outcomes. These have been quite substantial in some instances, but more limited in other areas. There are also strong and important differences in the robustness of the evidence, and the confidence that may be placed in different estimates of areas of saving.

Even given these factors, it is not possible to simply ‘add up’ the kinds of savings proposed to reach an overall figure. Some of the savings are in different areas of spending and so it would be double-counting to include both sets (for example, greater personalisation of care budgets, and the role of commissioning). There is also limited data on whether the cost savings achievable may be regarded as a ‘one-off’ reduction or instead may be treated as *dynamic factors* that continue to reduce future costs by similar proportions. In many cases the future savings may require upfront investment, in new procedures or infrastructure, that need to be included in the round.

For these reasons the *overall* scenarios modelled (equating to a 2% reduction on the baseline for steady progress, and a 4% reduction against the baseline for fully engaged) are based on the kinds of figures found within each strategy and are not attempts to naively sum up the sets of individual financial assumptions<sup>1</sup>.

What the projections demonstrate is the large momentum built into the future costs of social care by population change. The overall costs in real terms continue to increase quite sharply even if there is no change in the real unit costs of care provision. Even if costs could be cut by two per cent annually in real terms - a demanding challenge - the effect is barely to constrain real levels of spending to their current level.

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<sup>1</sup> For information, ten sets of 2% reductions would equate to an overall reduction of 18%, and ten sets of 4% reductions would amount to an overall reduction of close to 34%.