

Personalisation services and care: The case of England

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Abstract

Personalization services are developing in England as a social policy response to user demands for more tailored, effective and flexible forms of health and social care support. This process is being implemented under the personalization which is also seen as a vehicle for promoting service user rights through increasing participation, empowerment and control while also promoting self-surveillance by having users manage the costs of their health and social care. There has been an accelerating interest in the implementation of personalisation policies relying upon a relentless political campaign to legitimise an enforced obligation to care, i.e., UK Prime Minister Cameron's notion of a "Big Society". The use of personalisation that focuses on self-assessment and inspection, can, in this policy and austere climate, become a means of self-surveillance. It is argued that Michel Foucault offers a set of strategies [1] for understanding how the discourses on personalisation construct service user's experiences and their identities, as constructed subjects and objects of social policy and managerial knowledge.

Introduction

The thesis interrogated in this article is that an increasing interest in personalisation and care is central to understanding recent personal care policy in England. It will be argued that personalisation legitimates practice in which the state monitors and co-ordinates but does not intervene. This has led to a social situation that has transformed social care practice of its traditional rationale as 'caregiver'. One consequence of these policies has been to transfer the financial and emotional responsibilities for care to service users and informal carers under the aegis of 'personalisation' [2]. The price to be paid, however, is that the relationship between the State and older people has been reduced to one of surveillance and the enforcement of a notion of what community obligation might entail. As with other forms of implied control, generic methods of surveillance are presented as 'concern' models [3]. This act of observation confers a uniformity that emphasises the 'protective' role of the professional rather than the substantive requirements of service users.

The rise of personalisation and care

Personalization in social care is linked to both the principle and process that every adult who receives support, whether provided by statutory services or funded by them, will have choice and control over the shape of that support in all care settings. This adult social care policy agenda is firmly focused on the development of Personalization of support. Powell and Chamberlain [2] state that this has been repeatedly stated in key policy documents including *Improving the Life Chances of Disabled People* (published by former UK Prime Minister's Tony Blair's Strategy Unit in 2005), and the British 2006 Community Services White Paper, *Our Health, Our Care, Our Say*, which announced the piloting of Personal Budgets [4,5]. Personalization had its early beginnings in Direct Payments (introduced in 1997 when New Labour came to power), whereby people who are eligible for social care can choose to receive 'cash for care' in lieu of services [2].

Despite repeated efforts to encourage take-up, and extension of the legislation to include further groups of people within eligibility, direct payment expenditure still accounts for only 1% of local authority

spending on social care. Personal Budgets are being piloted in across English localities. Personal Budgets bring together a range of different funding streams- in addition to social care expenditure - to support independent living. The model for personal budgets was largely derived from work developed by In Control that instigated self-directed support for people with learning disabilities and is engaged in supporting Personalization developments in more than 90 local authorities [6]. Personal Budgets are central to the aim of 'modernising' social care policy and practice in England. They build on the experiences of direct payments and In Control and are intended to offer new opportunities for personalised social care [7]. Its overall aim is for social care service users to have control over how money allocated to their care is spent. It includes within its remit direct payments, Personal Budgets, user-led services, self-directed support. Self-assessment is a cornerstone of Personalization that gives service users the opportunity to assess their own care and support needs and decide how their Personal Budgets are spent that is a process transforming social care. At the same time, the coalition government of Cameron-Clegg in 2010-2015 had spoken of the importance of personalization in budget devolution as most important issue in social care (which has been replicated at press with the Cameron government) for personal budgets for pregnant women.

Indeed, public services in communities also face new demand side challenges in a global economic recession. At the same time, individuals and populations in western culture have expectations of the State to deliver to meet their health and care needs providing resources and services to provide support. These increased expectations are strongly felt in public services and challenge the traditional relationship between the State and vulnerable groups in modern societies such as older people, the physically, mentally and intellectually challenged and people who are frail and sick [7]. Significantly, the personalization agenda dissolved all these traditional user groups and their corresponding local authority specialist provider structure into a single entity of 'adult social care'.

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The traditional focus for social care has been the role of the state and its effectiveness in the re-distribution of wealth and promotion of social justice for individuals and groups [8]. However, the later part of the twentieth century and first part of the twenty-first century has seen a re-casting of that relationship away from state directed resource allocation to user controlled support with the UK borrowing from the North American consumer led schemes such as “Cash and Counseling”. Consequentially personalization and consumer led support has become entrenched as a new language of responsibility in western culture regarding social welfare [7] providing new debates about how best to achieve the balance between civil liberties and self-constraint. Put simply personalization, using the language of sustainability namely, the effective use of resources, empowerment, participation, control, choice and human rights [9], re-casts the focus for health and social support onto the individual and away from the State. Users of welfare services are now reinvented as welfare citizens with responsibility for providing to meet their own needs from a ‘personalized’ individual budget while parallel processes of risk management and safeguarding protect the state from unnecessary exposure [6]. Using the UK as a case study, this paper will shed light on wider contemporary trends in social policy in general and personal support in particular in western society.

But is this too simplistic a conceptualization? Why and how is personalization relevant to social policy and modern society? How is it researched? How is personalization reconciled in a formidable structural climate of decreasing public resources and the globalization of health and social care provision? This is not just a global economic recession but one of which affects all nation states. Many of these questions can be connected to why personalization services are needed, what is provided and how it is coordinated. The personalization agenda offers an opportunity to make social care (and other services) more responsive and flexible so that it is actually doing what people who use budgets and services want and need, rather than being constrained in rigid task and time specifications [7].

Personalization is inextricably linked to process that every person who receives support, whether provided by statutory services or funded by themselves, will have choice and control over the shape of that support in all care settings Individual Budgets Evaluation Report [IBSEN report], [10]. Carr [11] suggests its overall aim is for social care service users to have control over how money allocated to their care is spent. It includes within its remit direct payments, individual budgets, personal budgets, user-led services and self-directed support [10]. Self-assessment is the cornerstone of personalization. It gives service users the opportunity to assess their own care and support needs and decide how their individual budgets are spent while at the same time providing the dynamic for transforming social care [11]. In circumstances where the service user has limited capacity to either engage in self-assessment or direct their support a range of possibilities arise such as, family and friends, community based organizations, community based advocacy groups, brokers and agency staff [12]. These in turn, highlight a set of relationships compatible with the new UK administration’s focus on the ‘Big Society’. However, it is also prudent to note the persistence of a moral undertone as people with substance and alcohol issues tend to be excluded from using individual budgets, as are those leaving custody.

In order to explore the conceptual, policy and research literature on personalization, this report attempts to set out in more detail what personalization is, what it will mean and how it may work, with the aim of exploring to what extent the objectives are likely to be realised. It considers the opportunities these changes are presenting service users and illuminates the key research findings from the IBSEN report [10]

that provides a series of research benchmarks to measure how pilots of personalization and individual budgets are being experienced.

A word of caution however; overall, it is fair to say that the evidence base in relation to the critical success factors of personalization is extremely scarce [10,11]. This also means that it is very difficult to bring evidence together in any cumulative sense to gain an impression of the overall or aggregate impact of personalization. A key point to state is that the available literature is on what the implications would be rather than what the implications evidentially are. Samuel [13] makes the cogent point that there has been such political enthusiasm for individual budgets from both New Labour and Conservative parties however; such enthusiasm has run ahead of the evidence with government adopting a whole new personalization approach to social care policy while investing at least £500,000,000 in making it happen before even its own research findings were available to offer an adequate evidence base [13]. Hence, greater use of methodological interrogation of experiences is required in tapping the narrative and experiential contours of personalization and Individual Budgets (IBs). There have been scarce longitudinal research designs [10], in which interventions and their beneficial/dystopian effects on IB can be studied over time [6,11]; or evaluation designs, for example where ostensibly similar interventions or the work of comparable agencies are undertaken in different settings as the process is only starting to unfold [10]. Nevertheless, it is easy to see the attractions of personalization in policy terms as governments look to distance themselves from decisions over the shape of welfare, how it should be delivered, who delivers and at what quality.

‘Taking Aim’ at personalization

In the UK, the Brown administration (2007-2010) identified personalization as a mechanism to promote individual rights and as a vehicle to transform the shape of adult health and social care services. Following the principle that the relationship between the service user and the State is one where citizens are encouraged and enabled to take control of their needs, the service user has a budget through which they can purchase goods and services to meet a range of self-assessed needs in ways they choose [14]. In the process social care will transform from a system where people have had to accept what is offered and professionally driven definitions of need, to one where people have greater control, not only over the type of support offered, but also how and when it is offered, how it is paid for and how it helps them achieve the outcomes that are important to them [15].

The effect of service users participating to meet their own needs will be the transformation of social care. Indeed, Leadbetter [16] suggests that in order to understand personalization we must locate it in its broad political context of ‘participation’ as service users become actively involved in selecting and shaping the services they receive. According to Carr [11], personalization has the potential to reorganize the way we create public goods and deliver public services. Leadbetter [16] in a report for Democracy Think Tank ‘DEMOS’ suggests that personalization, by engaging the tradition of participation, makes the connection between the individual and the collective, connecting the public and the private spheres of life by allowing users a more direct, informed and creative say in ‘rewriting the script’ by which the services they use is designed, planned, delivered and evaluated. Leadbetter [16] identifies a number of over-arching principles related to personalization that link to sustainability and in particular the level to which the state impinges on individual autonomy. Furthermore, he raises the cogent point that service users should be supported and enabled by

professionals rather than be dependent on their judgements. They should be able to question, challenge and deliberate while also making suggestions about and making demands for more appropriate forms of support. Nor are users merely consumers, choosing between different packages offered to them, providing the paradox between discourses of consumerism and participation that lies at the heart of the policy. Rather, service users should be intimately involved in shaping and “co-producing” the service they want. The question this raises is what does this actually mean? The answer is fivefold: (i) finding new collaborative ways of working and developing local partnerships, which (co) produce a range of services for people to choose from and opportunities for social inclusion; (ii) tailoring support to people’s individual needs; (iii) recognising and supporting carers in their role, while enabling them to maintain a life beyond their caring responsibilities [17]; (iv) access to universal community services and resources - a ‘total system’ response; (v) and early intervention and prevention so that people are supported early on and in a way that’s right for them.

It will be argued that these social policy initiatives have a number of common threads which establish a shift in services away from care and support and toward the self-surveillance of those being cared for. The form that this shift has taken varies depending upon the site of interaction and subsequent power relations between professional workers and service users. For mental health services, surveillance is directly aimed at the nominated ‘consumer’ or ‘patient’.

Increased surveillance is often presented in social policy as a tactical response to crises at margins of personalisation policy, the accidental accretion of responses to unintended consequences. The argument pursued, here, however, will suggest that increased surveillance is part of a strategic agenda of wider questions of morality and control. It is not that personalisation has made more of an awareness of the fragmented variants of social care, but that personalisation gives meaning to care and before its advent, technologies such as “care assessment” were the welfare equivalent of a solution looking for a problem. Personalisation, in particular, fills a vacuum at the centre of social care policy, giving it an ideological legitimisation function it had previously not had; a policy flag for Cameron to hide behind in terms of ideology and cuts in public services.

Self-surveillance, personalisation and care

This article will explore personal care issues in a number of ways. First, the methodological ‘box of tools’ drawn from the work of Michel Foucault [1] will be used to expand upon discontinuities between personalisation policy and its consequences. Two themes will then be expanded, firstly, questions of morality to highlight change and the social policy technology available to execute it, namely, care management. Secondly, the relationship between overt concerns and covert consequences will be analysed in order to examine how benevolent intentions, without critical analysis, can result in negative outcomes for the recipients of state intervention.

Foucault’s main interest is in the ways in which individuals are constructed as social subjects, knowable through disciplines and discourses. The aim of Foucault’s work has been to ‘create a history of the different modes by which, in our culture human beings are made subjects [18]. In *Madness and Civilisation* [19], Foucault traces changes in the ways in which physical and mental illness was spoken about. Foucault employs a distinctive methodology for these studies, archaeology, which aims to provide a ‘history of statements that claim the status of truth’ [20]. Foucault’s later work, *Discipline and Punish* focuses on the techniques of power that operate within an institution

and which simultaneously create ‘a whole domain of knowledge and type of power’ [1]. This work is characterised as genealogy and sets out to examine the ‘political regime of the production of truth’ [20]. Both archaeology and genealogy are concerned with the limits and conditions of discourses but the latter takes into account political and economic concerns relevant to personalisation policy.

Indeed, the work of Foucault has engendered an awareness that modern institutions operate according to logics that are often at excessive variance with the humanist visions embedded in policy analysis [21]. In other words, the overt meanings given to a certain policy of activity may not correspond to their consequences. Whether these outcomes are intended or accidental was less important to Foucault than the analysis of power. As Smart [22] points out, Foucauldian analysis asks of power: ‘how is it exercised; by what means?’ and second, ‘what are the effects of the exercise of power?’ Within those strategies, investigation would need to be centred on the mechanisms, the ‘technologies’ employed and to the consequences of any social momentum for change.

An example of the discordance between social policy, the philosophy that overtly drove a certain initiative and its effects, comes from Foucault’s analysis of utilitarianism. Indeed, a pervasive theme of Foucault’s [1] work is the way in which the panopticon technique ‘would make it possible for a single gaze to see everything perfectly’ [1]. Foucault describes how panopticism (based on the design of Jeremy Bentham) becomes a process whereby certain mechanisms permeate social systems beyond actual, physical institutions. Techniques are thus ‘broken down into flexible methods of control, which may be transferred and adapted ..(as)... centres of observation disseminated throughout society’ [1].

The mechanisms used to extend the reach of centres of power will vary depending upon the ground upon which they are required to operate. Their function is to evoke and sustain moral interpretations of particular social behaviours throughout intermittent observation such that their objects come to internalise their own surveillance.

One important facet of Foucauldian analysis is the author’s preoccupation with historical periods in which conventional values are in flux as in the case of madness, discipline and sexuality [1,19,22] and how the emergence of professional discourses interpenetrate the evolution of new commonsensical understandings of ‘normality’. There are, in other words, periods in which particular sites of control, for example, institutional care, family relations, intimate relationships are subject to novel mechanisms and technologies in order to facilitate the transition from one state of affairs to another. These technologies may be overtly applied during periods of flux until moral relations have been accepted, and, during the process of their application they both modify and are modified by the professional groupings charged with their implementation. Whilst Foucault does not impose any sense of causality on the development of such discourses, it is possible to discern the need for both an explicit moral reason and a method of operation, shaped to whatever new contexts are appropriate. Government morality would act as permission for activities such as surveillance. A professional technology would provide a means of implementation depending upon the site (for example, in institutions of the state) of the targeted activity.

As Rouse [23] has pointed out, an examination of the relationship between power and knowledge is central to interpret and understand social phenomena through a Foucauldian gaze. This is particularly apposite where there is an attempt of a disaggregation of a stated policy and its mechanisms in order to discover what is thereby hidden or

obscured. One of the consequences of power and knowledge is that rather than the focus on the explicit use of a particular technique of knowledge by someone in power to cause a certain effect, attention is drawn to the reflexive relationship between both elements. There is a concern then: 'with the epistemic context within which those bodies of knowledge become intelligible and authoritative. How statements were organised thematically, which of those statements counted as serious, who was empowered to speak seriously, and what questions and procedures were relevant to assess the credibility of those statements that were taken seriously. ...The types of objects in their domains were not already demarcated, but came into existence only contemporaneous with the discursive formations that made it possible to talk about them' [23].

So, just as knowledge shapes what action is possible, what power is exercised, those actions shape the creation of new knowledge and what is thereby given credence. Over time legitimate 'domains' are established which both define what is real and what can be done about it. Other possible interpretations are simultaneously discounted and delegitimised. The result is a self-contained common sense world in which power and knowledge support each other. These domains, for example, not only sustain certain professional discourses, they mould what those professions might become. This analysis of power and knowledge emphasises their entwinement and the processes that occur as a particular domain takes shape. It also marks a distinction between what a method for obtaining knowledge produces and the relationship between the shaping of that product and the distribution of power.

Returning to an earlier theme, the process by which a particular domain is established may not be the same as the reasoning given to explain what events take place and their effects. Indeed, as his understanding of this relationship developed, Foucault [18] indicated that 'power is tolerable only on condition that it mask a substantial part of itself. Its success is proportional to its ability to hide its own mechanisms'.

Furthermore, in personalisation policy, there is an open intention to 'empower' through allowing older people to live in their own communities and monitoring support, may have become a means of policing informal care and through that the conduct of older people. Throughout the past 15 years, community care policy has drawn upon a number of sources of flux to achieve momentum. These have included a concern over familial obligation to care and changing social work practices, from a traditional providing role to that of managing and purchasing of services; to movements from directed care to personal budgets. However, the 'no-cost' option of a social policy reliant on personal budgets comes to look increasingly fragile. It is therefore in need of a shift to the moral ground of obligation and personalisation into which the Cameron administration continually attempts to tap through the 'Big Society' [24].

However, another complicating factor to an 'obligation' based personalisation and social policy manifests from the idea that informal care is at root a voluntary activity. It is not, therefore, bound by any formal code of social practice, as would be the case for paid workers. Hence, there is no formal reason for intervention should a policy of informal care meet resistance. Thus, a social policy exists that contains fiscal policy and morality and makes informal care legitimate responsibility. The threat of 'personalisation' provides the excuse for this invasion of the private sphere, a shift from 'consent' to 'coercion' and from 'support' to 'surveillance'. However, to be fully effective, a technology would also need to be found that would implement the logic of that policy.

The technologies of care management to facilitate personalisation?

The core technology by which community care can be implemented exists in the role of care management. It can be conceptualized as the co-ordination of services into a 'package of care' in order to maintain 'clients' in community settings. The managerial technology is indirect in three ways. First, the pivotal function of the care manager is seen as being the management of a package that draws on services made available through a 'mixed economy of welfare'. Second, there is a shift toward supporting informal carers rather than directly working with the nominated client. Third, there is the emphasis on assessment and monitoring of provision that is supplied by service providers.

This quality of indirectness 'makes sense' as a means of managing a 'mixed economy of welfare' which requires that those who purchase care, or their agents, are separated from those who provide it. Because of the intensification of marketization, this limits the development of cartels, allows purchasers to choose between competing alternatives, thus placing them in the role of 'honest brokers' who assess need, supply information on the alternatives and then co-ordinate purchases. It does not, however, make sense in terms of direct care, intervention or interaction between older people and social workers other than as a sort of 'professional travel agency', advising clientele on the options, best deals and cash options. Care assessment and monitoring have now become an integral feature of social work practice and reflect a trend toward justifying welfare activities in terms of quality assurance [24]. By replacing direct intervention with management systems, the technology fails to provide guiding theoretical principles for interpreting and acting on conflict in social relationships. 'Techniques of resistance' [1] by older people to managerial techniques was found by Powell [25] who claimed older people 'were particularly adamant that they did not want to be 'cases' and no-one needed to 'manage' their lives'.

However, despite this resistance, the introduction of the 'mixed economy of welfare' in the U.K has consequences for the surveillance of older people. The mixed economy reflects political rationalities and technologies of government. Welfare pluralism is used to mobilise the use of resources - and thereby embody power relations - and thereby supply an economic vocabulary to legitimise the allocation of those resources and associated schemes of inspection and surveillance of services for older people. Chua [26] notes that 'social actors', such as care managers, try to translate values into their own terms, to provide standards for their own actions and in so doing, facilitate 'rule at a distance'. A mixed economy of welfare is a means of doing this, it fabricate representations of 'empowerment' for older people. As Chua [26] points out, not dissimilar to the social construction of health care accounting software, services become devices which transform real relations. In a sense, 'older people' become 'consumers', 'social workers' become 'managers', 'social service departments' become 'purchasers' all crystallised by the formation of community care policies [27]. In this case, services provide schemas for the 'conduct of conduct' [28] dominated by power/knowledge and characterised by the discretionary autonomy of care managers. It is within this disciplinary matrix of policy, practice and autonomy that power operates on older people, ultimately reinforcing the fragmentation that surveillance engenders in the psyches of older people at the centre of the professionals' gaze. This form of surveillance: 'clearly indicates the appearance of a new modality of power in which each individual receives as his status his own individuality, and in which he is linked by his status to the

features, the measurements and gaps, the 'marks' that characterise... and make him a 'case' [1].

Hence, the older client is marked out for perpetual surveillance throughout the remainder of his or her care service. Carers and professionals also come under scrutiny as part of the continuous review of the client's needs through monitoring of personalised budgets. All are caught by a gaze who is 'always receptive' [1] to older people and provides a further rationale for surveillance of the 'elderly population'.

The panoptic culture

Why personalisation that is arguably essentially empty of interpersonal meaning is being 'legitimised' by the accretion of surveillance? The answer to this measure lies in the fact that it was not created as a philanthropic metaphor but as a mechanism for engineering the cost and structure of social welfare. Personalisation has been part of a strategy to reduce the costs of state welfare by adopting market principles [29]. Attempts at cost reduction have taken on two forms. First, there is the active encouragement of a private welfare economy in order to depress wages and related costs. Second, a hollowing out of the local state, through mechanisms such as care management and inspection, so that the primary role of social service departments has become that of monitoring and supporting direct care rather than provision itself. These trends may not simply reflect a flow through from market ideology but also wider pressure on the nation state as a consequence of globalization [24].

Awareness that the welfare state can be understood, not so much as a series of social service institutions and neo-liberal responses to social problems, but as an instrument of wider state power and governance is not new [30,31]. What is perhaps striking is the extent to which the techniques used by welfare workers have been drained of creative and radical meaning concerning resistance with marginalised groups and had drawn workers into the day to day management of scarce resources in personal budgets [32].

Until the advent of a panoptic culture, personal budgets with older people lacked a convincing unifying metaphor for its activity. With its instigation, a previously inchoate accretion of initiatives around 'community care' achieves harmony and force. Once the vigilance advocated by the Department of Health's guidelines on personalisation, are added to the indirect functioning of care management technology and the moral backdrop of obligation, the discourse of community care acquires a coherence of power/knowledge [33]. It is, however, a power/knowledge to be deployed against older people's voices rather than for their emancipation.

Indeed, once older people are established as a socially significant object of power/knowledge, managerial techniques deem it necessary find the 'truth' about their care needs; to analyse, describe and to understand. The focus towards personalisation takes place in a wider process in which attention is being directed towards individual bodies and control of 'ageing populations'.

Conclusion

This paper has explored a number of factors in personalisation and care. It has been argued that the delivery of personalisation has lent coherence to a number of nascent tendencies in this policy that reinforce each other. These tendencies include an increased morality toward informal care and a move toward indirect monitoring of the locative sites of such care. The development of a surveillance culture helps stabilise community care policy at a time of considerable

underlying uncertainty. Such uncertainty has arisen from the changing structure of informal care and of specific services.

The neo-liberal strategy, to socialise care, has become an extension of the techniques of observation, monitoring and control into community settings. A new system for the surveillance of informal carers has replaced the idealistic dream of freedom with an extension of constraint [34].

Indeed, the shift in the focus of assessment contains a number of alignments. First, assessment decisions seem to be taking place within an existing discourse on abuse rather than user need. Whilst 'need' is given recognition, the dominant decisions to be made would seem to concern risk of personalisation. Second, the focus of monitoring seems to have moved from the performance of elements of the purchased package of care to the 'conduct of conduct' [28] of older people and informal carers. Third, parallels with child protection are clearly alluded to through at-risk registers and the value of records as evidence.

Following Foucault's [1,28] analysis of the relationship between power and knowledge, this change can be seen as the development of a matrix in which to speak seriously about the support of informal care, the employment of discourses of surveillance and abuse would have to be entailed. Personalisation serves to reconfigure power relations during a period of flux and 'makes sense' of a previously disjointed care policy formulation. How it plays out in the next five years, only time can tell.

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