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## **Policies of Personalisation in Norway and England: On the impact of political context**

### **Abstract**

Within Europe the Norwegian and English welfare states represent two different welfare regimes. Due to common demographic challenges of an aging population as well as grass-roots pressures, particularly from disabled people, significant changes in the delivery of long-term-care services for older and disabled people have taken place. This article focuses on the change towards personalisation policies encouraging people's greater choice and control in regard to their care services and uses the case of 'cash-for-care', which gives people an allocation of funding to meet their needs, to discuss conditions and implications of personalisation policies within different contexts. Based on a theoretical framework exploring a democratic and a market discourse of personalisation policies the article provides a comparative analysis of the Norwegian and English cash-for-care schemes. While a crucial common change in the public sector's role towards at arm's length long-term-care services occurred, significant differences remain: while English residents are given greater choice and control from the beginning of the allocation of cash-for-care they also face more insecure circumstances due to the simultaneously stimulated care provider market. The Norwegian case, however, shows a possibility of increasing choice and control without a large diversity in a care provider market.

**Key-words:** Personalisation, choice, control, long-term-care, cash-for-care, Norway, England.

## **Introduction**

At the end of the 20<sup>th</sup> century the concept of independence had gained a high status in the Western world (Fraser and Gordon, 1994). Within long-term-care services for disabled and older people this high status of independence was mirrored by an increasing focus on changing the role of service users from passive (dependent) recipients of social care services to active (more independent) citizens (Johansson and Hvinden, 2007) who are expected to want to influence the services they are allocated. The policies of personalisation within social care, which is the topic of this article, are rooted in these ideas about independence, active citizenship and more user choice and control related to social care services. ‘Choice’ and ‘control’ are rarely defined, often used together and sometimes interchangeably, in policy documents and the literature. It is often assumed that ‘choice’ (the power to select out of a greater number) provides control. In essence, personalised services are about tailoring services to individuals’ needs and preferences rather than – as has historically been the case in earlier service-provision – fitting individuals into existing service provisions. Our aim is to analyse the impact of context on these personalisation policies by providing a comparative policy analysis using two different European cases in this matter: Norway and England. They represent in Esping-Andersen’s (1999:78, 87) terms welfare regimes that can be characterised respectively in the main as social democratic and ‘increasingly liberal’, (since Margaret Thatcher’s government from the end of the 1970s). Our question is: what difference does it make whether the policies of personalisation are implemented in a social democratic or liberal context? While the term ‘personalisation’ is primarily British, the concept, that is the phenomenon ‘personalisation’, is relevant to the analysis of social care service changes in both England and Norway. In England the term came into the long-term-care vocabulary together with the development in particular first of direct payments, then individual budgets and personal budgets. These English welfare schemes all belong to what are internationally

known as cash-for-care systems (Ungerson and Yeandle, 2007) because people are given, after an assessment of their needs, an allocation of funding, a personal budget from public money for meeting these needs. In particular when direct payments are taken, the workers employed are called personal assistants to underline that the idea is for the person to have control over their care rather than this being simply provided (see Christensen, 2010). However, the concept of personalisation in England goes beyond the use of personal budgets. It is about people being active participants in managing their lives rather than being dependent users, therefore sometimes also called ‘co-production’ in the sense that the users are ‘co-producing’ the services, being ‘more involved, responsible users’ (Leadbeater, 2004: 59). That is why this article analyses the historical political change towards policies encouraging peoples’ control and choices and focuses on the cash-for-care schemes. In Norway also the cash-for-care variant called user controlled personal assistance (BPA: Brukerstyrt Personlig Assistanse) is central to the personalisation policies, and in particular for disabled people.

A growing literature since the late 1990s analyses cash-for-care schemes in Norway (e.g. Andersen et al., 2006; Johansen et al., 2010) and England (e.g. Glendinning, et al., 2008; Jones et al., 2012; Ungerson, 1999). But only a few provide comparative analyses (e.g. Askheim, 2005; Christensen, 2010; Ungerson and Yeandle, 2007). A central discussion within this literature in England has been about potentials as well as of barriers to achieving independent lives, including mostly disabled people (Morris, 1993) and sometimes older people (Newbrunner et al., 2011). In Norway, cash-for-care schemes, although available for all ages, have played an important role in the lives particularly of Norwegians with disabilities (Johansen et al., 2010). However, our article is not a contribution to the discussion of whether the personalisation policy inspired welfare schemes are contributing to individuals’ independence. It is rather a contribution to a classical comparative policy discussion on the conditions needed for and the development of personalisation policies within Norway and

England as two different welfare regime contexts for the implementation of these public welfare policies.

Theoretically, a core theme of personalisation policies concerns the concept of ‘public’ as these policies represent a change first about taking over some tasks previously provided primarily by the family, and later ‘public’ is shaped differently due to an increasing openness towards a private market. While the different ideas and manifestations of ‘public’ versus ‘private’ historically have illuminated many key social and political issues (Weintraub, 1997) we will focus on ideas, or rather chains of ideas, relevant to the discussion of a welfare policy with its point of departure in different ‘welfare regimes’ (Esping-Andersen, 1999). We will then – based on legislation, national governance documents and research – analyse comparatively, first the shaping of ‘public’ in terms of structural changes that make possible an implementation of the personalisation policies and then compare further details, as they appear in practice, of these policies in the two countries. One concerns the support organisations, placed between the public authorities and the welfare user and therefore of crucial interest to our ‘public’ policy discussion. Another concerns the interchange of public welfare ideas with private market ideas, thereby moving away from our theoretical point of departure for the two countries. In other words, public welfare policies in current times seem easily to turn into mixtures of public and private market based ideas.

### **Citizen or consumer – developing a democratic and market discourse of personalisation policies**

Central to Esping-Andersen’s (1999) comparative analysis of welfare regime types are the three basic institutions for covering peoples’ welfare needs: the state, the market and the family. In the social democratic variant, that Norway represents, the intention is that welfare policies should support people in being as independent as possible of the market as well as the

family; therefore welfare services are generally generous and comprehensive. In contrast liberal welfare regimes 'reflect a political commitment to minimise the state, to individualise risks, and to promote market solutions. As such, they 'disfavour citizens' entitlements' (Esping-Andersen, 1999: 75). This points to a difference concerning the political understanding of the role of the state that is important in regard to the way personalisation policies are implemented.

By highlighting the personalisation policy as what Newman and Clarke (2009) call a politic of public, variations regarding 'public' (as more than state responsibility) are brought to the front. Based on the different ways 'public' has been constructed (Newman and Clarke, 2009: 14-15), they present so-called discursive chains (summarising key institutions and factors), of which two are relevant here. One equates 'publicness' with the state (public=public sector=state) while another (public=legal and democratic values=public sphere) equates public as a domain clearly differentiated from private beliefs and interests and commercialised relations of the market. The first chain deals with the issue of accountability and emphasises public (state) responsibility, opening discussions about how this is challenged by e.g. including into this public responsibility private business ideas about management, market mechanisms and hybrids like public/private partnerships. The other chain represents the idea that specific values are related to the public sphere and that democratic values are central and different from private interests. The idea is that these democratic values will strengthen equality. Very different values such as private interests, including e.g. (individual) consumer interests, will therefore challenge this chain. These discursive chains represent a way of clarifying different angles of politics of publics and their challenges; in brief these angles concern the *accountable state* and *democratic values* respectively. Both elements are part of what we refer to as a democratic discourse in the following, a discourse that is simultaneously challenged by a market discourse. Within the policies of personalisation these

discourses have their historical origins in discourses pointing out different roles of the user: citizen or consumer.

One historical origin is related to the Independent Living Movement in the United States in the late 1960s. This social movement aimed at achieving civil rights and full social inclusion for disabled people, that is, independence (Morris 1993, Oliver 1990, Shakespeare 2006). It fought against the situation faced by disabled people in society: that the only care services offered were places in long-term-care institutions and that professionals held all the power in regard to both their medical and social needs. The basic ideas of this discourse are therefore social justice, rights for minorities and self-determination giving disabled people, not experts, power over their lives. This discourse relates to the social interpretation of disability (Oliver 1990) and requires public (state) responsibility in creating a social environment providing opportunities for all people. From the start, the Independent Living Movement focused on daily assistance in disabled peoples' lives as one key issue for independence. The disability movements in both the UK and in Norway, therefore, became key actors in developing cash-for-care schemes (Andersen et al., 2006; Shakespeare, 2006; Zarb and Nadash, 1994). Inspired by the idea of discursive chains we find that the one constructed by the Independent Living Movement is the following chain:

citizen=rights=(welfare)state.

In contrast to this from below grass-roots pressure on a citizen=rights=state chain another, that we suggest calling a consumer=choice=market chain, is constructed from above. This was a result of dominating policies responding mainly to two challenges in many European countries; one concerning the need to provide support for older people with increasing longevity (accompanied by increasing labour market participation by women and consequently fewer women available to provide unpaid care) and another concerning the increasing costs related to these future circumstances, making it important to look at welfare



services promising cost reductions. The political ideas that inspired many European countries' response to these demographic and economic issues came to be known as New Public Management (NPM). NPM ideas were found in the private market sector, thereby transferred to the public sector and strongly influenced the (new) ways of delivering public services. This development seems to have started in the UK but spread to many OECD countries (Hood, 1991). In the public sector, NPM involved separation of the purchaser from the provider role, growth of contractual or semi-contractual arrangements, creation of a market or quasi-market, performance assessment and emphasis on the public as customers offered choice (Stewart and Walsh, 1992). Though this was highly developed in the UK it affected even strongly social democratic Norway. As already mentioned, one of the key NPM ideas is the market inspired idea about the customer role. And because the field in which the customer acts is a private market, the discourse relevant here is a market discourse. In contrast to the *democracy discourse*, the *market discourse* puts the welfare recipient into the role of a customer who should always have the option of choosing between different services in a (free) market, and importantly, should have sufficient choices. The public authorities should be limited and access to a market should be available so that the individual can act as a customer. In the democracy discourse in contrast there is no intention of limiting public responsibility but rather that of making the public authorities responsible for the social inclusion of all people.

Summarised, the key elements of our theoretical framework consist of a democratic discourse pointing to a citizen=rights=state chain and a market discourse pointing rather at a customer=choice=market chain. However, while the discourses have very different ideological and political roots, they are basically pointing at one common idea: the idea of individual freedom. Both discourse chains provide a suggestion of how to encourage individual freedom, but they suggest two very different routes: one through the state, the other through the market. They also suggest two very different contents to freedom, one about

democratic values and inclusion in society and the other about making individual choices within a free market. Our following context analysis (based on empirical evidence) of the cash-for-care welfare scheme (Norway/England comparison) will show that these conceptual distinctions are ideal typical constructs (Weber, 1994). While separated as theoretical ideas, in policy practice they are mixed, thereby crossing the discourses. We will begin our comparative analysis by indicating important changes in the role of the public sector as state, crucial for the development of personalisation policies in the long-term-care sector.

### **A changing public sector=state role: providing welfare services at arm's length**

Due to major pieces of legislation in the 1980s and early 1990s, starting with the The Municipal Health Act of 1982, Norway developed a strong municipal responsibility for long-term-care services. Two important characteristics of the Norwegian municipalities have been developed by these reforms. One is the development of municipal autonomy representing a large degree of freedom for the many (in 2013: 428) Norwegian municipalities to organise their services so that they could fit local choices, conditions and political orientations. The other development concerns a change in their type of responsibility, which became very clear in a preparation paper for the new common law for social and medical long-term-care services (Municipal Health and Social Service Act of 2011) passed in 2012. In the preparation paper the role of municipalities was explicitly called a 'make sure' role, stressing a supervisory role (Prop. 91 L 2010-2011: paragraph 1.2). While the municipality has full responsibility for securing the services that people need, including their quality, it is not necessarily the municipality itself that provides these services. This is an important legislation based option that makes it possible to contract external actors, including for-profit companies to provide or support the services municipalities are obliged to offer by law; thereby gradually opening up the possible development of a care market. The previous laws indeed also incorporated this

option of including private actors, and some of the externalisation of services to for-private actors had already started in the 1990s. At this time an important organisational preparation for the externalisation option in long-term-care-services came from the NPM inspired purchaser-provider model separating the administration and the carrying out of the services into two different units. One unit, always municipal, orders the services, including the preparation of legally based requisitions. The other unit provides the services, and this unit can be either municipal or private (Nesheim and Vathne, 2000: 7). The ‘make sure’ role includes the maintenance and control of contracts with external actors. In other words, municipalities place themselves at an arm’s-length distance to services for which they are fully responsible (Christensen, 2012).

At the heart of these changes in Norwegian long-term-care services, therefore, is this trend towards the municipalities being ‘enablers’ rather than ‘providers’. Put together with the increasing pressure for user involvement, sometimes called user empowerment (Askheim and Starrin, 2007) during the 1990s and 2000s this crucially shapes the platform for personalisation policies like cash-for-care as there is no barrier to including also the user herself in this process of externalising responsibility.

Before we describe an English enabling role we will stress two more Norwegian characteristics. One is that the externalisation of long-term-care services is still at a very low level. According to the latest national statistics (SSB 2012a) only 8.1% of the sector’s services are purchased from private actors, even including non-profit providers. The other characteristic is that although the NPM inspiration of e.g. the purchaser-provider split plays a crucial role in the changes in Norwegian long-term-care, and more than half of people in Norway live in a municipality with a purchaser-provider split, many municipalities do not use it for externalisation to private companies but rather for monitoring the services (Gammelsæter, 2006).

A change comparable to the Norwegian ‘make sure’ role was introduced much earlier in England. In December 1986 Sir Roy Griffiths, deputy Chairman and Managing Director of Sainsbury’s was commissioned by Margaret Thatcher’s Conservative government to undertake an overview of community care services and to make recommendations on how resources might be used more effectively. In line with the government’s policy of market liberalism he advocated an ‘enabling’ role: *‘It is vital that social services authorities should see themselves as the arrangers and purchasers of care services – not as monopolistic providers.’* (Griffiths, 1988, 5: para 3.4). The Griffiths recommendations provided the foundation for the 1989 White Paper (Secretaries of State for Health, Social Security, Wales and Scotland) *Caring for People: Community Care in the Next Decade and Beyond* and for future developments in social care. The White Paper endorsed Griffiths conception of the local authority as an enabling authority, stating that stimulating non-statutory service providers would produce a wider choice of services, meeting individual needs in a more flexible innovative way, and competition between providers, resulting in more cost-effective services. Local authorities would be expected to make clear in their community care plans how they would make increased use of, and stimulate, the non-statutory sector, especially in non-residential care, where it was little developed. Most of the Griffiths recommendations were implemented in the National Health Service and Community Care Act, 1990. After the passing of this Act, the UK government produced several guidance documents emphasising the importance of separating purchasing and provider roles, explaining that need could be better assessed when this was not carried out by the provider. There was to be more choice of provision, but the choice was to be made by the local authority professionals ‘taking into account’ the wishes of the individual and carer. Nevertheless these changes provided the basis for the possibility later, under pressure from disability campaigners, that individuals might choose what should be purchased with the budget allocated to them.

Since the Act local authorities have increasingly purchased services from independent providers. In 1991/2 93% of local authority spending on services in England and Wales went to their own services (public support for independent residential care was at this time centrally funded) (Audit Commission, 1992). In 2010-11 only 31.6% of English local authorities adult services expenditure (including assessment and care management) went on their own services (HSCIC, 2012). Unlike in Norway, marketisation dominates care provision. There are some noteworthy similarities regarding the change toward a state responsibility at an arm's length, with Norway. However, there is a time difference as well as a difference in scope, and the political faith in markets and choices – a market discourse – is much deeper.

#### **At arm's length services – new manager and employer roles for users**

The user controlled personal assistance model in Norway, BPA, became legalised in 2000, when it was added to § 4-2, a of the Social Services Act: The services include 'practical support and training, including user-controlled personal assistance, to those with special needs of assistance due to illness, impairment, age or for other reasons'. This means that the municipalities should offer BPA in line with other social care services in § 4-2, such as home help services. When the new Health and Care Act was passed in 2012, BPA obtained its own article: § 3-8, obliging municipalities to offer BPA 'in terms of practical support and training, organised as user controlled personal assistance'. Of interest here is that the concept of 'personal assistance' now appears as the main concept in the article where the different care services are mentioned (§ 3-2, 6 b): 'personal assistance, including practical support and training...'. Apparently therefore, the philosophy of personalisation has influenced how future care services should be understood: as services where people take on more responsibility for themselves, that is at an arm's length from public responsibility. Until 2006 the decisive criterion for BPA was whether the user could act as manager for their assistants. Since 2006

another person can take on the managerial role for or with the user (Rundskriv I-15/2005).

This extends the group for whom there is arm's length responsibility, but it is the municipality that judges managerial competence.

According to the latest figures from 2010 (Johansen et al., 2010) most BPA users<sup>1</sup> in Norway had either the municipality (54%) or the user-led cooperative Uloba (33%) employing their personal assistants, while 11% did this on their own, or by using private companies (2%). In Norway the emphasis is on the person (or someone on their behalf) managing their care, employing their personal assistants being only one option for doing this. This can be interpreted as a way of making the at arm's length service available to many people. Cash-for-care services in Norway, still let the public (here the municipalities) play a key role, by carrying out the employer role, though less so when people choose the non-profit (contracted) support organisation Uloba, and even less when the user takes over the employer role her-himself. The Norwegian case shows the possibility of personalising services without making 'the arm' too long for the majority of the users, but this is obviously easier in a context with an undeveloped care provider market.

In England cash payments to disabled people under the age of 65 were legalised in the Community Care (Direct Payments) Act 1996. Worries about a cost explosion were mitigated and the policy fitted in with the Conservative government's agenda of emphasis on the consumer and transfer of provision to the private sector. Although the Labour government, which came into office in 1997, criticised the previous government's 'devotion to privatisation of care provision' (Secretary of State for Health, 1998) there was no radical change in the social care agenda. It emphasised independence and encouraged direct payments as a means of achieving this, including their extension to older people. In 2003/4 it became mandatory for local authorities to offer direct payments to people assessed as being in need of community services (changes were made in 2009 so payments could be made to a

nominated 'suitable person' where the service user lacks capacity). Direct payment users have mainly been employers of their personal assistants, though some have used the money to contract with care agencies or to meet their social care needs in other ways.

Research has indicated very positive views of direct payments users (Glendinning, 2008), similarly to Norway. In *Improving the Life Chances of Disabled People* (Prime Minister's Strategy Unit, 2005) the Labour Government launched the idea of *individual budgets*, which would give greater choice to people who did not want to manage a budget, and bring together different sources of funding. The government was strongly influenced by In Control, a partnership inspired by the Independent Living Movement that set up pilots of what they termed 'self-directed support', initially for people with learning disabilities with a few local authorities. The idea was for service users to play an active role in determining the services needed to support them, from assessment to planning the meeting of needs. Crucially, to exercise control, they should know how much funding they were to be allocated, and this should be related to need, not service cost, and used flexibly. A programme of individual budgets pilots in England had largely positive findings (Glendinning et al., 2008) but it was found that integrating the various funding streams could not happen without legislative and administrative changes.

Remarkably different from the Norwegian policy is the focus on social care money, and in December 2007 a commitment to provide *personal budgets* (using social care funding) in England was set out in *Putting People First* (HM Government, 2007). Personal budgets can be taken as direct (cash) payments by the person (or since 2009 a 'suitable person' where they lack capacity), or held by the council (or a third party provider) but the individual should have choice and control over how the budget is used (ADASS, 2009). This policy was endorsed by the Coalition government which came into office in 2010, and which called for there to be 100% take-up of personal budgets by 2013 (amended to 70%, 31/10/2012), preferably as

direct payments (Department of Health, 2010a). While there has been a large increase of people receiving community care in England in terms of ‘self-directed support’ between 2009-10 and 2012-13, from 11.5% to 55%, still only 14% were receiving direct payments in 2012-13 (HSCIC, 2013).

Contrasting with the English cash-for-care variants that all stress the importance of knowing the amount of the cash payments/*the budget* available and having some choice and control over how this is used, the Norwegian system rather stresses peoples’ *control* of their help: they are managers of their care workers (sometimes with the help of a relative if they are mentally disabled), but they do not have the same decision making over how services are to be provided (see below p.) and they are less likely to be employers in terms of budget administrators. In England the budget administration role is accommodated by a market of providers.

### **Money or control – the role and impact of support organisations**

One user-led organisation, Uloba, was for almost a decade, the only external organisation contracted by municipalities in Norway to provide support for BPA users, a third of all municipalities developing contracts with it. While Uloba employs the personal assistants BPA users have full control over their management. This situation of homogenous support, including furthermore half of it being public in-house, over a long period, is very different from the much more variable cash-for-care support in England.

A survey of support organisations for direct payment users carried out in 2004-2005 (Davey et al. 2007) found a diversity of organisations, two-thirds in England commissioned by the council, mostly local groups serving one council (including Centres for Independent Living and other user-led organisations) or member groups or affiliates of national organisations; none at the time were for-profit organisations, though some have been since.



Some councils contracted more than one organisation; a few provided in-house support. The types of services offered varied widely, depending largely on specification by the council, most focussing on promotion of direct payments and support with their initial set-up. Less than a quarter in England contracted and paid the care workers and placed them under the control of the service user. A survey (IFF Research, 2008) of direct payment users in England found that only 42% received ongoing support in legal and financial aspects of employing personal assistants, about a quarter receiving this from direct payment support organisations.

Think Local Act Personal (2012), a national partnership organisation promoting personalisation in England, has called for growth and increased diversity of direct payment support, adapted to the needs of particular groups, with the drive towards personal budgets, particularly direct payments. They found a need for greater availability of information about different ways to use direct payments, of ways to reduce or remove employer responsibility, and of a continuing source of support in case things go wrong. They also found, as had Davey et al., a reluctance by councils to fund external organisations to provide support at the initial stages in determining a person's budget, as this might lead to challenging the council's offer.

It is an important but paradoxical context characteristic of the drive towards personal budgets, that they are accommodated by a requirement for a variety of support organisations but simultaneously, in the government preferred case of direct payments, a majority of people are taking on the responsibility themselves (or with assistance). At the end of the day the English personalised policy, contrasting with the Norwegian, in the case of direct payments means either oneself (or one's representative) taking on all the duties, or being a customer in the care market, or a mix of this. The option of managed personal budgets was meant to provide choice and control without this responsibility, moving nearer to the Norwegian model, though this may not work out in practice.

Users are increasingly choosing Uloba as employer in Norway. They are found to be significantly more satisfied with this employment model than those who have chosen the municipality as employer (Johansen et al. 2010: 59-60). Uloba users also experience more influence on which services they are allocated by the municipalities (as this sometimes consist of a package of different kinds of services) and on the tasks of their personal assistants (Johansen et al. 2010: 52 and 54). These figures seem to confirm that the choice of employer has an impact on how much personalisation the user will experience. The municipality may treat BPA more in line with traditional services – as this is their expertise – while Uloba is rooted in a different Independent Living ideology and is therefore fully oriented towards the requirements of an independent life. However, BPA more generally, when compared to traditional services, seems to have an impact on the amount of hours allocated: Johansen et al. (2010: 22) found that 62% of BPA users in 2010 received more hours when they transferred from traditional to BPA services, although this number was much lower than in 2002, when 90% reported this. Thus, an at arm's length service aiming at more personalised services can positively impact on the hours allocated and on the influence of the services.

While surveys in England (Poll and Duffy, 2008; Hatton and Waters, 2011; 2013) have found a majority of people reporting improvements in a number of aspects of their lives since having a personal budget, it should be noted that in the 2011 Hatton and Waters study those with direct payments paid to them directly had more positive outcomes than other groups, and there was also a tendency in this direction in their 2013 study. As they point out in the latter study only 11% in the sample of personal budget holders had a council-managed budget unlike the situation in England in 2012-13, where this was 77% (HSCIC, 2013). The earlier Hatton and Waters study provides evidence of the benefits of support from an organisation independent of the council/NHS at the support planning stage, those receiving this (only 15%) having more positive outcomes, though the later study found little difference

in the benefits of support from different sources. However, a demonstration project comparing user-led-organisation (ULO) support planning and brokerage with that of the council in three localities (Office for Disability Issues, 2011) found ULO planning gave people a greater feeling of control and freedom (as in Norway), that more people using ULOs chose direct payments, and that ULOs were felt to be more helpful in all aspects of managing a personal budget.

### **‘Right’ and ‘choice’ crossing discourses**

As a politically strongly social democratic country, with a centre-left government recently ended its second period, one should expect the citizen=rights=state chain to be fully developed in Norway, but it is not. People in Norway so far have not had a right to BPA, only the right to be assessed for social services, among them BPA. Although the municipalities have to provide information about BPA (according to the 2000 guidelines (Rundskriv I-20/2000) and also the new Health and Social Care Act) it is still the municipality that makes the decision on BPA. It also decides which services are appropriate for each individual based on an assessment of their needs, and the amount of hours to allocate, on ‘an acceptable level’ according to the municipal assessment. Interestingly, although user involvement and user influence is stressed clearly in the legislative history of the new Health and Social Care Act (Prop. 91 L 2010-2011) there is no direct wording of this in the new law except in the Objects clause (§ 1-1, 5 and § 1-1, 6) where it says that the service should be ‘adapted to the individual’s needs’ and that ‘the service offer shall take into account respect for the integrity and dignity of each individual’. This means that the personalisation process for the user starts after the municipality’s decision to allocate BPA, whether BPA shall be included in a package of different kinds of services and the amount of help to be provided. In this sense the Norwegian system represents a paternalistic bureaucratic system, giving power to

municipalities (here equalling the state) primarily and only secondly to the users, at the end of an assessment process.

In England people, if eligible for social care, have the right to direct payments (or an approved 'suitable person' if they lack capacity and with a few exceptions mainly for people subject to certain criminal justice orders), and have entitlement to a personal budget under the forthcoming Care Act in England. However, the eligibility for social care in England depends on means as well as assessment of need (while in Norway only needs). Financial assessment is supposed to happen only after assessment of need (Department of Health, 2010b) but research documents that people with financial ability to pay are only rarely assessed or offered support (Henwood and Hudson, 2008). So in reality they often cannot make an informed choice about how best to provide for their care needs. While currently guidance is provided to English councils on needs eligibility by *The Fair Access to Care Services Framework*, introduced in 2003 (updated 2010), councils decide on the level of need at which they will provide support, most applying very restrictive criteria (AgeUK, 2013).

Local authorities have a duty to carry out an assessment of need for any person who may require adult social care services under the NHS and Community Care Act 1990. While self-assessment has recently been encouraged (e.g. in *Putting People First*), 'pure' self-assessment by the individual is not legal. ADASS have recommended that assessment should be led by the person as far as possible, with appropriate support and lead to an 'indicative budget' linking levels of need to money, giving the person rough guidance on the amount they can expect to receive from the council. So, in contrast to Norway, personalisation should start with assessment and resources to meet needs expressed in a budget, not hours of support (ADASS, 2009). However, in some councils there may be large differences between indicative and actual budgets (Slasberg, Beresford and Schofield, 2012). Councils vary

considerably in how the personal budget process is carried out and a lack of clarity is common, particularly on how the budget can be spent (Hatton and Waters, 2011; 2013).

Comparing the access to cash-for-care in Norway and England, there is so far no BPA right in Norway but a right to be assessed on the basis of one's needs only while a contrasting situation is in force in England: there is a right to cash-for-care but barriers to support in terms both of financial circumstances and eligibility of needs. This definitely crosses the (theoretical) discourse borders between citizen-rights and consumer-choices and takes us to our discussion of the borders of personalisation policy.

### **Personalisation policy in practice – risks of crossing discourse borders**

While the separation of a democratic discourse comprising a citizen=rights=state chain and a liberal consumer=choice=market= chain ideologically and theoretically make sense and also represent a good point of departure for the analysis of a welfare scheme within different welfare regime contexts, the policy when implemented is complex. There is no doubt about the stronger English market discourse and emphasis on the cash-for-care user as a consumer given a budget to control (with/without support), but this is not the end of the story. Borrowed from the democratic discourse, the English case gives people a right – as called for also by the disability movement – to get cash-for-care but simultaneously creates barriers to access this right. This 'right' when forcing the cash-for-care model on all social care users furthermore implies that the consumer role is seen as relevant as a prototype for social care users. While the origins of the cash-for-care welfare scheme was strongly supported by physically disabled people and later advocates for people with learning disabilities, it is no coincidence that the take-up of direct payments among younger people (18-64) in these groups has been the highest with that among older people much lower. Research evidence suggests that this group has the least positive outcome of cash-for-care (Glendinning et al., 2008; Hatton and Waters,

2011; 2013). The 2013 survey found that though outcomes were generally positive for older people they were less so than for other groups in crucial aspects such as mental wellbeing and having control over support. In most aspects people with council-managed budgets were less likely to report positive outcomes and these are currently predominant in England, particularly for older people. Other studies have found that in practice there may be little difference between council-managed budgets and traditional services (Equality and Human Rights Commission, 2011; Newbrunner et al., 2011). Reasons suggested for lower take-up of direct payments by older people include assessment being at time of crisis, making decision-making more difficult, concern over responsibility of managing the budget, fears of abuse (Alzheimer's Society, 2011; Equality and Human Rights Commission, 2011), or being discouraged from taking them up by the council (Newbrunner et al., 2011). In this context this is about more than a disadvantaged group of older people. This is about a system not fitting all, as the original intention was to support younger disabled people in living a more independent life, while for some older people what is most important is continuity of care, and for this to be at times that fit in with the person's routine (Sykes and Groom, 2011). Although the Norwegian paternalistic bureaucratic model can be criticised this is also a way of protecting those clients (particularly some older people) this system does not fit. The English policy way of interpreting 'choice' has a strong focus on the choice of provider, but to live an independent life may not be dependent on this choice but rather on getting control of one's individual life. If they lived up to their original conception, council-managed budgets would provide this. In this sense the (Norwegian) democratic case borrows the 'choice' originally related to the market discourse chain and creates what could be called a 'citizen choice' due to a context without a care market. While the context risk of borrowing the 'right' in the English case is the market, creating potentially inequalities of accessibility, the risk of borrowing the

‘choice’ in the Norwegian case is the development of bureaucracy that makes it difficult to influence in particular the allocation of services.

## **Conclusion**

Supported by the independent living inspired disability movement both Norway and England were keen on implementing policies empowering their welfare clients through more choice and control, the buzz words of the personalisation rhetoric. Both countries, with England a decade ahead of Norway, constructed an enabling role for local authorities, and used the organisation of a purchaser-provider split as an opportunity for developing a care provider market. The central context differences, however, concern the scope of this market and also the political inspiration in England relating to reducing the state and the public role and reaching cost-effective solutions which the cash-for-care scheme promised to do. Both the development of a care market and the political belief in a consumer=choice=market chain solution has made the English interpretation of personalisation a question of (personal) budgets and choice of providers while the Norwegian case has concentrated on control and choice in everyday life developed primarily through public and user-led support stressing the manager role. So although there are stronger (consumer) rights in England, there are more citizen choices in Norway as the concentration is on users choosing how to manage/control everyday life, although after municipal assessment of their needs. Gaining independence in everyday life is a complex project. For the future of personalised welfare schemes their context will be crucial as to whether vulnerable people will be supported in gaining independence or whether they will only face more challenges in their lives.

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<sup>1</sup> According to SSB 2012(b and c) the number of BPA users increased by 284% from 2002 to 2011 (2904 users), but comprises only 1% of all long-term-care service recipients.