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Integrating Carers into the Service System: Six Strategic Responses

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ABSTRACT

This paper discusses the mechanisms whereby the needs and interests of carers might be integrated into the service delivery system. Over the last decade, informal care has emerged as a major subject for research and discussion, and much work has been undertaken exploring the experiences, burdens and needs of carers. Carers are increasingly recognised as central to community care, but little work has so far addressed the means whereby their needs and interests might be integrated within mainstream service provision. The mechanisms for achieving this are underdeveloped. This paper puts forward six possible strategic responses, and discusses the merits and demerits of each. The responses are: taking evaluation a step further; consumerism; case management; performance or service indicators; rights; and targets. The issues raised in the discussion have relevance beyond the subject of informal care, and address questions that are central to the provision of welfare services generally.

The debate on informal care

This paper looks at the mechanisms whereby the needs and interests of carers might be integrated into the service delivery system. Over the last decade there has been a plethora of work on the subject of informal care. Some of this has been conceptual in character, attempting to extend our understanding of the nature of care through exploring its

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links to kinship obligation, paid work, the economics of household production and the gendered division of labour, as well as to debates concerning the social construction of the emotions. Examples of such work, much of which has been influenced by feminism, are found in Finch and Groves (1983), Finch and Mason (1992), Graham (1983, 1991), Ungerson (1987), Lewis and Meredith (1988) and Netten (1993). More empirical streams of work have described the experiences of carers – their burdens and needs – and analysed the role of specific services in supporting them. This work is reviewed in Parker (1990), Twigg *et al.* (1990) and Twigg (1992).

As a result of this work, we now know a great deal about the nature and experience of caring. Where our understanding is not well developed, however, is in relation to how the needs and interests of carers might be integrated into the service system. What models do we have for achieving this? So far there has been little in the way of strategic thinking concerning this issue. For various political and academic reasons, informal care has tended to be treated as a subject in itself. This was perhaps a necessary stage in its delineation and recognition. Now, however, we are at the stage where the need is to reintegrate the subject. The question of how carers might be incorporated into the service system needs to be addressed in the wider context of debates concerning the service system as a whole. The claims of carers have perforce to be set within the context of competing demands, and their needs and interests integrated into a service system that is primarily aimed at older and disabled people.

Of course, not all would regard such integration as desirable. Some would reject such an incorporation, arguing that it can lead only to the greater exploitation of carers. Integration is also open to criticism from another perspective that argues that concentrating on the service needs of carers diverts attention from those of disabled people, underwriting rather than transcending dependence. I have discussed the implications of this dual critique elsewhere when exploring the different models that service agencies employ in conceptualising their relationship with carers (Twigg 1989; Twigg and Atkin 1993). Here I am more concerned with debates relating to the service system in general and the implications of these for carers. Carers are pervasive within the service system – the subject cannot be confined to specialised carer services but has implications across the board – and carers thus illustrate, sometimes in more dramatic form, problems that are general in the provision of welfare.

This paper presents six strategic responses whereby the needs of carers might be integrated in the service system. These are: taking evaluation a step further; consumerism; case management; performance or service indicators; rights; and targets. Each has its merits and problems, and each to some degree redresses the limitations of the previous one. All need to be seen in the context of a service system where resources are limited.

i. Taking evaluation a step further

The first approach rests on taking academic evaluation a step further and attempting to develop from it an objective basis for the integration of the needs and interests of carers into service delivery. It is essentially a research based strategy. The aim is to refine the techniques of evaluation so as to yield data capable of resolving the tensions in practice around informal carers. Is there, in other words, a satisfactory way of assigning resources between competing demands; and can the techniques of evaluation achieve this?

The last decade has seen a steady growth in work evaluating the impact of services on carers (Twigg *et al.* 1990). Taking evaluation a step further would involve refining the associations that have already begun to emerge – for example exploring at greater levels of sophistication the ways in which factors such as stress are mediated through particular features of the person or the situation. It would also mean going beyond the rather crude understanding that certain services have a beneficial impact, to answer more refined questions of, 'for whom' and 'in what circumstances'. Who is most helped by respite care, and provided in what sorts of ways? Which carers would most benefit from one-to-one counselling?

At a simple level, the aim of this information would be to inform the practice of front-line service providers alerting them to particular constellations of difficulty and to the potential role of services in relieving them. Refined information on the patterns of stress or the impact of support would provide practitioners with useful and – to a degree – objective checklists against which to make assessments.

It is at the planning level, however, that the potential impact of the approach is greatest. Service planners need to know which services 'work' in order to make appropriate decisions about which should be provided. But what is at issue here is not simply the question of whether a service has a beneficial impact – which is as far as most evaluations go – but whether the impact is greater or less than other forms of support. In other words, which service offers the 'best buy'? That is the essential question that is posed to evaluators by service planners who want to use their work. It is a question in which costs play a central part, for it is not simply the differential impact of services that matters but the ratio of these to their costs. How do hours of home help compare with sessions of day care? Which is a 'better buy' for carers: intensive domiciliary help or rotational respite, and for which carers?

Few evaluations attempt to engage with the issue of cost in any thorough going way. At best, costing data is tagged on at the end of the evaluation; and the bases for the cost estimates are often extremely crude (Wright *et al.* 1981). Such data often only indicates the likely revenue costs of running a scheme; and it does not address the real question that lies behind the wish for costing data, which is essentially one of cost-utility: which services yield the greatest benefit per unit of cost?

Certain traditions of evaluation have attempted to provide such information. Health economists have developed the approach furthest in relation to the evaluation of health care. The work on global quality of life measures (QALYs), which are used in combination with cost estimates to measure the cost effectiveness of different health interventions, is perhaps the best known example of such an approach (Williams 1985; Torrance and Feeny 1989; Kind *et al.* 1990). In the field of social and long-term care, the 'production of welfare' approach developed by the Personal Social Services Research Unit at the University of Kent has also gone some way towards developing integrated comparative measures of cost and benefit in relation to services (Davies and Knapp 1981; Knapp 1984; Davies and Challis 1986).

As yet however such approaches are far from the goal set by the planners' question, not least for reasons that are philosophical as much as empirical. In order to take the evaluation of services forward into statements of cost-utility, a series of further questions need to be posed and resolved. How can one construct a single utility measure against which to judge the impact of services? Without such a single, global measure, the link across to costs cannot be made; but all we know of service impact suggests that single measures are rarely appropriate (Wright 1974). Wellbeing is sometimes used in this context, but it is a problematic measure in both epistemological and policy terms. Its moral and political status is unclear. How far can welfare services be seen to be in the business of producing wellbeing, and how would such an aim relate to other sectors of society or the economy? These approaches assume the legitimacy of such a pursuit, when this is far from clearly the case, even at the rhetorical level of public policy. They certainly never engage with the conflictual nature of society, and the degree to which the aims of policy are sectional and contended.

If one were to develop such a utility measure, how could it be made commensurate between individuals? Are units of wellbeing the same for different individuals? How, furthermore, would units of benefit be related to costs? How far does the market provide evidence of these forms of value? The approach requires an assumption that there exists an underlying coherence between valuations in society so that, for example, opportunity costs in relation to employment cross-relate to other spheres of value, whereas the example of womens' unpaid labour and the difficulties of incorporating it into economic analysis illustrate the problematic nature of such an assumption. These problems are familiar ones within welfare economics. The status of outcomes also poses difficulties. On what basis are individuals to be compared: in terms of final outcome states, or in terms of the ratio of the cost of inputs to the level of outputs? In general these approaches use average values, and these raise distributional issues. How do we cope with the marked inequalities between individuals in terms of social and cultural resources that might affect these ratios?

If these questions pose difficulties in relation to clients, all the more so do they in relation to carers, who occupy an oblique, off-centre relationship to service provision in which they are rarely the direct focus of an intervention (Twigg 1989; Twigg and Atkin 1993). Carers exist within the context of service planning by virtue of the relationship of obligation and activity that they have with the cared-for person. As a result it is not possible to consider their interest wholly apart from that of the person they look after. There is an essential duality of focus, and this adds further complications to the application of a cost-utility analysis. How, for example, would different units of wellbeing for the carer and cared-for person be related? Do they have equal status? What if they were in conflict? (In general, work within this tradition has circumvented the problem by taking the caring household as the level of analysis, though this does not adequately reflect the individual interests that are involved.) At the moment within the service delivery system these tensions are collapsed into individual negotiations at the micro level, and they thus remain hidden from view, and in general not subject to the overt policy formulations that are the goal of such approaches.

Taking evaluation a step further will potentially provide us with better information about whether certain services have a beneficial impact, and for whom in particular, and it can therefore feed into the development of policy and practice. What it *cannot* provide as yet – and arguably never will – is a mechanism or objective formula that can be applied in such a way as to integrate carers into a unitary scheme of costs and benefits.

ii. Consumerism or empowering choice

This brings us to the second response: that of consumerism, in the sense of the direct empowerment of individual choice. The essence of this involves providing widely, and letting people choose. In this it is in marked contrast to the directive approach of the previous strategy which rested on information or techniques that aimed to inform the decisions of planners. In this consumerist view by contrast, the problem is essentially one of lack of provision and lack of freedom of choice, rather than lack of information at the planning level. We should, according to this view, therefore, not be greatly concerned with refining the associations through further evaluative research or the pursuit of cost-utility analysis, but rather leave it up to individuals to reflect the particular forms of help that best assist them. If certain sorts of people find certain forms of, for example, nursing support particularly helpful, or if others find that in-house respite threatens their sense of space, it is up to them to decide and choose accordingly.

It is an approach that has several immediate attractions. First, you do not have to impose a solution that research or the opinions of professionals suggests, but can allow carers to choose for themselves. Second, consumerism recasts carers as active subjects: not just the passive receivers of welfare, but the choosers and directors of the help that comes to them. It thus attempts to redress the traditional imbalance of power in relation to services, providing a model whereby carers can access the welfare system without becoming subordinated to it.

Third, it provides a means to break up the monolithic service monopolies which have been, in the view of critics from both the left and right (Hoggett 1991), inflexible in their response, paternalistic, overdominated by the interests of providers and relatively indifferent to the views of carers or other users. In the past there has been no adequate means whereby the views and wishes of users could impact directly upon the system. A few individuals might complain or put pressure in certain areas (a particular example of this in relation to carers would be parent's groups), but by and large clients and carers have been quiescent. People tend to have low expectations: they believe that complaining will not help them; they are grateful for the little they get; and those who do not like the service vote with their feet, but not by going to another agency since there rarely is one, but simply by dropping out of the realm of services. This traditionally has been the extent of their power of 'exit' (Pirie and Butler 1989).

Enabling the expression of choice through consumer empowerment would in theory introduce an element of competition between services and thus require agencies to be more responsive to what users actually want. This might in relation to carers mean providing day care that extended beyond mid-afternoon and allowed the carer to take a job. Different sources of supply would in theory allow not only for competition but also for variety, with consumers choosing the ethos of service that they preferred. Some carers might prefer a very professionally-oriented sitter service, while others might prefer something more 'homely'. A consumer orientation would allow the expression of these choices and – to varying degree – their direct transmission into service delivery in ways that would operate cumulatively to determine the pattern of provision.

When referring to consumerism within the public sector, we are dealing with a mixture of ideas and influences. Some, particularly those of the New Right, derive directly from the application of neo-classical economic ideas to public provision. Such approaches emphasise the centrality of the market mechanism; the importance of competition between providers as a spur to both efficiency and consumer sensitivity; the aggregation of individual choices as the determinant of provision rather than the decision making of planners; and the maximisation of private as opposed to public provision (Flynn 1989). Theorists vary in the degree to which they would apply the principles of the market to public provision. Few advocate the fully marketised system of the libertarian right. The predominant approach attempts to introduce elements of competition through the creation of 'quasi markets', most notably in the field of health and social care through the purchaser/provider split (Le Grand 1990; Hoggett 1991; Price Waterhouse 1991). These markets exist at the level of agencies rather than individuals, and the choices exercised within them are not directly those of the user or 'consumer'.

Closely associated with these ideas, though not drawing directly on the mechanisms of the market, have been attempts to deploy the language of consumers and consumerism as a means of changing the culture of public sector organisations, making them more consumer oriented, more sensitive to the wishes of their users. Such approaches have been heavily influenced by private sector management texts, such as that of Peters and Waterman (1982), that emphasise the importance of being 'close to the customer' in determining the performance of organisations. The emphasis on responsiveness to the consumer need not rest solely on private sector values, but can also represent a recognition of the particular character of public sector provision and the existence within it of a public service orientation (Rhodes 1987).

From a slightly different direction comes the influence of the consumer movement. Rather than endorsing the logic of the market, this attempts to redress the balance of power between the producers of goods and services and their consumers or users, emphasising action in relation to access, choice, information, redress and representation as a means of achieving this (Potter 1988). User-participation and consultation draw on these consumer movement ideas, presenting them within a public sector orientation that emphasises users as citizens rather than consumers.

Greater sensitivity to the wishes of users has obvious relevance to carers. One of the striking developments of the early nineties has been the growing inclusion of carers within public policy documents (Department of Health 1990; SSI 1991a, b, c). Requirements to consult users are increasingly extended to carers (Department of Health 1990); and many local authorities in drawing up their community care plans have attempted to incorporate the carers' voice either through formal consultation with local carer bodies or through meetings and events. (The Birmingham Special Action Project provided a pioneering example of the latter, see Jowell 1989; Barnes and Wistow 1991).

All of these approaches rest on strengthening the 'voice' option that critics of New Right regard as inadequate; and none represents the direct empowerment of carers at the level of individuals. Indeed 'consumerism' as an influence within the health and social services has generally stopped short of such mechanisms, preferring to confine the market to the level of agencies. One strand of thinking, however, has attempted to apply the logic of the market, through the use of either vouchers or money transfers to fund service use. The Independent Living Fund provides an example of the latter approach, though one that has been subject to government limitation in its scope and in its likely future (Craig 1992; Kestenbaum 1992). Its underlying philosophy has, however, found increasing support within the disability movement. Voucher systems have been advocated (Laing 1991), but have not been instituted, even in the field of education where the idea has had greatest currency. Although vouchers are primarily associated with the New Right, they have found advocates on the left also.

It is worth asking what such approaches might look like in relation to carers. What issues do carers in particular raise? The first question to be addressed is how such an approach might be financed. Long-term social care insurance may in the future provide some basis for the funding of social care for elderly and disabled people, though such schemes are still in their infancy (Davies and Goddard 1987; Oldman 1991); but there are no proposals as yet to offer insurance against the possibility of having to give care and the voluntaristic element in such 'obligation' makes it unlikely that such will be provided. Direct consumer empowerment would more likely have to rest on transfers from the state, whether in the form of money or of vouchers.

Setting the level of money transfers poses problems. Since the money would be intended to purchase actual services, a flat rate would be both too crude and too expensive. Benefits like Attendance Allowance and Invalid Care Allowance can be set at flat rates precisely because they are not intended to purchase services, but rather to provide income replacement or reflect the extra costs of disability. Funding that could actually pay for help would have to be much more finely tuned to needs. The variation in the sums would inevitably be great and the basis for them difficult to establish objectively since individual carers differ in their capacity to cope with the problems of caring. The 'problems' of caring themselves also have an inevitably subjective quality since they are rooted not only in the concrete difficulties that individual disabled elderly or otherwise frail people have, but in the negotiation of these within a relationship. For example, many carers suffer greatly from the restrictedness that caring imposes on their lives, but this does not simply arise from the concrete difficulties that mean a person cannot be left. Some carers' lives are limited because they share the limitations of the person they care for: if their spouse cannot attend a theatre or go on holiday, nor can they (Twigg and Atkin 1993). Carers vary in how they interpret obligation, so that the consequences of disability also vary. The stresses of caring are heavily mediated through factors particular to individuals, and this makes it hard for them to be established objectively in a form that could be used as the basis for a benefit-style transfer of money. It is precisely because these sorts of needs require sensitive and individual assessment that they have traditionally been provided for through the service-delivery rather than benefit system.

Determining the basis of funding raises the issue of who should properly be regarded as the consumer. Are carers consumers, or should the term be restricted to the people they look after? There is an increasingly coherent argument presented by the disability lobby that suggests that money should be directed towards the disabled person and not the carer and that the aim should be independence not the underwriting of dependence through support to the carer (Oliver 1990; Morris 1991). It is an argument that has force; though it is also the case that such transfers rarely enable the disabled person to transcend all need for informal care. Caring takes place in a relationship of obligation, and usually of love. This means that caring has consequences for the carer that will result in him or her having service needs separate from those of the cared-for person. By this token, I would argue carers are legitimately users and consumers in their own right.

Secondly, moving towards a money transfer or voucher system in relation to carers would have severe implications for costs. Current support for carers is extremely patchy and set at a very low level overall. If the transfers or vouchers were to be set in terms of current expenditure averaged across, they would be insufficient to fund any real service input. If they were to be set in terms of carers' needs – however determined – the cost implications would be considerable. We can, of course, from the perspective of our concern with the situation of carers, welcome such an escalation of cost as representing an appropriate response to carers' needs. It is, however, for obvious reasons unlikely to occur. Even the New Right advocates of free consumer choice in the public sector acknowledge the central reality of government control and rationing, and Laing in his promotion of vouchers accepts the need to: 'strike an acceptable balance between financial empowerment of individuals and public expenditure control' (Laing 1991, p. 8).

The issue of expenditure control exposes what Pollitt rightly identifies as a key difference between the private and the public sectors. In the private commercial sector, the more you supply the better will be your income. But this is not the case in relation to the public sector, where the more you supply the higher will be your costs. Managers are not here trying to increase the demand of the public for their products, but finding politically acceptable ways to limit demand and ration what they provide (Pollitt 1990). To this degree, the metaphor of consumerism is an essentially misleading one.

Empowering carers through vouchers or money transfers also raises the question of capacity. The problem is illustrated by the recent developments in the national health service. The introduction of greater consumer choice within the NHS requires a major expansion of capacity in order to allow effective choice between forms of provision. The health service has traditionally run on high rates of bed occupancy. A move to real consumer choice means that capacity would have to increase considerably, with a consequent lowering of occupancy rates.

Similarly the ability to affect by demand the way things are provided requires that there be losers in the system – providers whose services are not preferred. Some will be losers to the extent of bankruptcy and closure, others may avoid that, but will go through periods of great instability and with them varying levels of quality and cost. In the health sector doubt has been expressed as to the ability of the system to generate sufficient extra capacity; and the cost implications are, of course, considerable.

The application of consumer ideas to social care faces similar problems. Providing carers with choice and flexibility, so they can, for example, use respite how and when they want and not only when certain prescribed patterns of allocation become available, requires a major expansion of capacity, as well as the acceptance of much lower levels of occupancy. For example, at the moment respite is often created out of marginal resources within institutions, with carers getting respite when there is some spare capacity or when a bed becomes temporarily vacant (Twigg and Atkin 1993). Consumer choice, by contrast, means turning those assumptions round: accepting that beds will often be vacant and that services should be formed around the needs of the carer and not vice versa. The problem of capacity is particularly acute in relation to carers because of the historically very low levels of provision. There is at the moment little leeway for the exercise of consumer choice by carers. Those choices are also likely to be constrained by what is on offer. To what extent will it be a real choice for carers if the range of services available is limited to those that can be provided on a cost-effective basis?

Lastly we turn to the imperfect nature of choice in these areas. Consumerist models assert that consumers are the best judges of their own interests, and that they above all are in a position to assess the quality of a service. Problems arise, however, either when the service is technical in nature, as with health care where individuals cannot judge adequately between different treatments (Culyer 1973), or where the consumers are themselves frail or vulnerable, as is the case with many, though not all, clients of social services (Wagner and Sinclair 1988; Hoggett 1991). Laing (1991) responds to the latter form of criticism by arguing that while some frail elderly people may not be equipped to exercise consumer choice, it is not necessary for all consumers to be fully informed and able to do so, since most consumers in the private sector 'free ride' on the informed choices of a few opinion leaders.

Such comment does not, however, meet the particular needs of many carers, where the issue is not simply one of the quality of rival forms of provision, but of the recognition of the appropriateness and legitimacy of their use. There are certain features of the dynamics of caring that make a straight consumer response a particularly inadequate one. The essence of much caring lies in secondariness – in the process whereby carers become secondary to the needs of the person they look after. This dynamic can be reinforced by various features of caring: for example, the isolation; the decay of social contacts that result in the disappearance of alternative activities; the logic of adjustment that means that some carers cease to allow themselves to dwell on their own wishes or losses. These common features of caring mean that carers are peculiarly badly placed to articulate their needs or interests, even sometimes to themselves.

Purchasing and managing support services in the open market also requires confidence and not inconsiderable personal and managerial skills. The Bexley Project which empowered carers to purchase help through employing people on a local and individual basis is the best known example of such an approach. The project did, however, give carers individual support and encouragement in taking on this employer role (Foster and Maitland 1986; Maitland and Tutt 1987). Not all carers would be able to manage without such support. The skills needed to employ workers are likely to be class- and gender-related; and many of the carers will themselves be frail or elderly – far from the pro-active purchasers of the consumerist model.

iii. Case management

This brings us on to the third option: that of case, or as it is termed within UK government documentation, care management. Once again this resolves some of the problems presented by the previous one. It does this in three ways. First, direct allocations of money to *carers* appear to be too crude, and necessitate some finer assessment of carer need. Case management provides a framework for doing this. Second, case management faces up to the fact – in ways that consumerism does not – that service provision is not essentially about doing what people want (though this has *some* relevance) but is about the pursuit of certain policy aims. Resources in this field are not requested or purchased, but allocated, and this is done within the context of organisational rather than client goals. Thirdly, case management, potentially at least, redresses one of the primary limitations of consumerism: its reliance on unassisted individual choice. Case management, by building in professional assessment, provides a structure within which service provision can be discussed and negotiated. As we have noted this process of negotiation can be particularly important in relation to informal carers who may need assistance in formulating and articulating their needs.

The concept of case management has become widely influential in the last decade; and under the guise of care management, forms a central plank in the government's conception of the new community care (Department of Health 1990; SSI 1991a,b,c). The term case management has been used in varying senses; and I do not intend to review these fully here. Challis and Davies (1986) and Renshaw (1988) provide overviews of the issues and of the related American literature. I will, however, draw a distinction between three major models.

The first treats case management as a version of advocacy, although one specifically linked to the social work tasks of assessing and identifying need. This model has been particularly influential in North America in relation to service brokerage for people with learning disabilities. In such an approach the case manager makes an assessment, and then discusses with the client or carer where and how they might obtain the relevant support. Sometimes the case manager will refer on to services, or act as a broker on the client's behalf. In some versions the case manager is independent of the agency and acts outside it as an advisor or advocate. The essence of the situation, however, is that the case manager does not have direct command over resources, but can only advise and perhaps refer on for a second assessment.

In the second version, the case manager does have command over resources, but only by the agreement of agencies. This approach has frequently been employed in special projects, where a scheme is set up and endowed with access to a specified level of services: thus a certain number of home help hours or level of district nursing assistance is being guaranteed as available for the case manager to draw upon. (An example of such an approach is the Scarcroft Project in York described by Meethan and Thompson (1992).) The major limitation of the approach arises from the range of services available: these tend to be the standard services that are currently provided. This inhibits the flexibility of the response, as case managers are unable to transcend the limitations of the current options by going outside them. The service sectors that are covered also tend to be restricted. Typically such case management approaches do not extend to acute medical care or to GP services; and this once again limits the comprehensiveness of the approach.

Thirdly, there is what should perhaps be regarded as the full case management model. Here the case manager is given a budget either to buy services directly or operate a shadow price system. The best known example of this is the Kent Community Care scheme and its various offspring (Davies and Challis 1986; Challis *et al.* 1989, 1991a and b). This allows for a maximum of flexibility, as the case manager is able to use money to purchase whatever form of care is most appropriate, though in practice options tend to be more limited. In theory it allows the case manager to juggle the different inputs with their prices in such a way as to maximise their marginal productivity both in each case and across cases.

What would these three versions of case management look like if applied to informal carers? The first issue to resolve is whether one can appropriately have a case manager for the carer. In essence this would mean having a specialist worker for carers at the individual case level, someone whose responsibility and remit would be to look after the interests and wellbeing of carers, and who would be directly involved in marshalling and arranging services for their support. Such specialisation would ensure that the interests of the carer were kept central.

But there are difficulties in such a focus. First, as we have already noted, caring takes place in a relationship. Concentrating exclusively on the carer misses the reality of what is being discussed. It is precisely the duality of focus – the fact that we focus on the carer because of and within the context of the relationship with the cared-for person – that has to be kept central. Secondly, it is clear that the majority of help that comes to carers does so from services that are primarily aimed at the cared-for person. Services such as day care, community nursing, social work support, would continue to be provided and negotiated by other practitioners – possibly other case managers – and a case manager for the carer would have no particular control over them. Lastly, providing a case manager for the carer implies *two* case managers for the household or caring unit, and this clearly undermines the integrative principle of the approach.

Thus though it is possible to have a case manager for the carer, it is really only so within the first model of case management – that of the advocate/advisor. Certain local and health authorities have moved towards setting up such posts or funding voluntary agencies like the Carers' National Association to provide an advice and advocacy role, though these are rarely involved in detailed case work. The advocate version is, as we have seen, the weakest of the three models of case management, and does not face up to the heart of the issue, which concerns balancing needs and resources at the level of the individual case. Advocates by their nature are not involved in this balancing act. The approach would thus strengthen the ability of individual carers to press for support, but it would provide no mechanism for necessarily achieving that support.

It is clear, therefore, that case management for carers, if it is to be applied fully, has to be so in the context of case management for the cared-for person. The question then becomes one of how to ensure that the carer's needs and interests are protected and acted upon within a shared process of case management. Case managers are here in the same position in regard to carers as social workers and other professionals have been in the past. The tensions and dilemmas of practice remain the same, except that in case management systems there is a tendency for them to be more focused, and for policy aims made more explicit. Case management provides a structure for negotiation, but not the competing valuations that are fed into that negotiation. Just as case management can be run on high budget levels or low ones, so too it can be run in regard to carers or in neglect of them. If in the definition of valued outcomes, the wellbeing of carers *per se*, as opposed to the simple continuance of their caring, is explicitly included as a goal, then case management will provide an important form of support for carers, but there is no *necessary* basis for this inclusion. For that, we need to look to policy formulations. We shall return to this point below when we discuss the option of targeting.

Some caution, however, should perhaps be expressed concerning the likely drift within case management systems towards a residualist approach to informal care (Parker 1990). Maximising the effectiveness of budgets is bound to produce a tendency to regard carers as a form of free good whose input can be assumed. As we have seen this is not a necessary part of the logic of the approach, but it may be a common feature of its practice.

This brings us to three further approaches, all of which share a concern with establishing more explicit levels of service support in relation to carers. The first of these is performance or service indicators.

iv. Performance or service indicators

One of the difficulties facing case management when relying on the second model – that of negotiated access to services rather than direct purchase – is that of ensuring an adequate level of provision on which to call: there is little point in having a case manager if there are no services to manage. How can one ensure an adequate level of resources in a locality? Earlier work on carers (Moore and Greene 1985) demonstrated the uncertain and patchy nature of services for this group, with certain forms of support being available in one sub-locality but not another. One of the ways of resolving such difficulties is through the use of performance or service indicators to establish guidelines for levels of provision.

The 1980s saw an explosion of interest in the use of performance indicators within public services. Carter (1991) and Pollitt (1988) have reviewed the various forms they took and suggested some of the reasons for the growth – or rather revival – of interest in their use. Despite their considerable political appeal, a number of problems have been identified in their construction and employment. First, although the full impact of the argument in favour of performance indicators has always been in terms of measures that relate to the final outcomes of performance – for example, the degree to which a policy has been achieved or an intervention resulted in appropriate change – the majority of performance indicators developed within the public sector have in practice been concerned with measuring resource inputs – for example, expenditure on services for the mentally ill – or with outputs in terms of service delivery – for example, hours of home help or numbers of patients seen by the chiropody service. Many performance indicators do not even measure the direct output of services, but concentrate on intermediate outputs in the form of levels of service personnel – for example, the number of specialist social workers for the deaf or consultant psychogeriatricians. Few performance indicators succeed in measuring final outcomes in the sense of the impact of the service on the recipient.

Secondly, criticism has been made of the limited character of much of the literature on performance indicators, with its emphasis on the practicalities of measurement rather than issues of their philosophical bases. Pollitt (1988) argues for the need for more sophisticated understanding of the conceptual difficulties involved in defining and measuring performance. Although these problems are common to attempts to measure performance, there are particular difficulties that arise when they are applied to the public sector. The three Es traditional in this field – Economy, Effectiveness and Efficiency – are far from adequate measures by which to judge the public sector, where other criteria such as equity, acceptability, equal opportunities, representation and accountability are also of central relevance. Carter (1989) also points to the nature of policy within the public sector, where objectives are often imprecise, multiple, of their nature vague and highly political; and where these features make the straightforward definition and measurement of performance extremely difficult.

Furthermore, performance indicators tend to be partial in the views and interests that they reflect, containing a strongly managerialist bias. They rarely enshrine the perceptions of users, and they reflect their interests at best only indirectly. While this may be acceptable within private enterprises, it is less so in the public sector.

Thirdly, there are difficulties of a more practical character. Performance indicators tend to be data led. They draw on information that is easily gathered, often already gathered, rather than information that is tailor-made for the purpose; and this limits their pertinence. Lastly, there are problems in relation to the ways in which indicators are commonly used. Often they are regarded, particularly in the context of a top-down view of management, as offering precise measures that can be used to enforce policies and control performance. They are rarely successful in doing this. As Carter (1989) argues, they are more appropriately regarded simply as interim, indicative evidence of a situation, suggesting a need for further investigation.

Returning now to the application of these approaches to the support of carers, I shall discuss here only those performance indicators that are defined in terms of service provision, and which I shall refer to as service indicators. Issues concerning indicators in relation to final outcomes, in the sense of impact on recipients, will be discussed below in the section on targeting.

What would such service indicators look like in relation to carers? Typically such indicators are set in terms of units of provision, adjusted by a measure of local demand or need. Thus one could say, for example, 'x number of respite beds per head of the population', or 'y day care places per estimated population with Alzheimer's disease'. Since such indicators are intended to relate to carers, they should properly be adjusted by reference to the number of carers in the locality, rather than by the numbers of disabled people, not all of whom will have carers. Following the national survey undertaken by the Office of Population and Census data, we now have such estimates of the number of carers (Green 1988); but there are no systematic data that would predict local variations. As a result, service indicators would have to remain set in terms of disabled people rather than carers.

What would be the challenges entailed by such an approach? First and most obviously, how would such levels of service be set? The dominant tradition in the field of welfare services has been one of using averages as the basis for norms. Thus bed norms within the NHS were traditionally set in terms of the national average, though such averages bear no necessary relationship to need, and there is no reason to assume that average levels of provision are correct ones. Similarly in relation to the personal social services, when the Social Services Inspectorate prepared the initial set of key indicators, they simply recorded comparative levels of provision and presented averages for various subcategories of authority (Warburton 1988). No claims were made for the normative status of such averages, but they were clearly intended to provoke self scrutiny and comparison. It should be noted that neither the standard NHS nor the social services indicators included any relating to informal care (Warburton 1988; DHSS with Coopers and Lybrand 1988).

Difficulties in using averages are compounded in relation to carers by the extremely low levels of provision that have historically existed for this group. Any attempt to construct norms based on averages would, therefore, look pretty pitiful. There are, of course, examples of localities where greater attention has been paid to the needs of carers and where provision has been at a higher level, and these could provide models for good practice. But these responses have rarely been coherent or systematic ones. Typically they have been isolated and fragmentary, resting on the commitment of individuals or on particular, often small scale, innovations. It would be possible to use these as a means of developing a recommended standard suite of services for carers in each area, and to set service indicators for authorities in terms of this. Such an approach would bring obvious benefits for carers, although it has significant resource implications, in that it would require a major expansion of services.

A second problem concerns the interaction of service sectors. It is clear that certain forms of support for carers – for example respite care – are potentially provided by a number of agencies operating in different service sectors, and that there is potential substitution between agencies in this regard. Respite during the day, for example, can be provided in a day hospital, in a day centre, whether run by social services or by the voluntary sector, or by other more flexible forms of relief that fulfil the function of day care but in a different form, for example, a sitter service (Twigg and Atkin 1993). These interactions and substitutions pose difficulties for the setting of service norms, at least when these are confined to a particular sector or agency, as they typically are. Service indicators would need to be adjusted to reflect a variety of local sources of provision. With co-ordination and inter-agency working, it would be perfectly possible to do this.

Problems of a more conceptual nature arise over uncertainties as to what counts as a service for carers. As we have noted there are few services that are provided directly to support the carer. In the majority of cases, service support comes to carers obliquely, as a by-product of their contact with services for the cared-for person. Often support for the carer takes the form of either extra support to the cared-for person – for example a visit from the community nurse to give a bath – or the discretionary use of a service for the cared-for person as a means of supporting the carer – for example the use of a day care place to provide respite for the carer. As a result of this pattern of discretionary allocation, it is difficult to establish exact levels of provision in relation to carers. For example, the official number of 'respite beds' in a locality may be very different from the number of beds that have been *used* on a discretionary basis for the purpose of giving respite. Attempts by researchers to establish exact levels of provision for carers have so far foundered as a result of these difficulties (Twigg 1988), and the problem is carried over into attempts to set service indicators expressed in these terms.

Fourthly there are issues of a more political nature concerning the relationship of the centre and periphery. Central government, for a variety of reasons, has traditionally avoided becoming involved in setting directly prescriptive levels of service, at least in regard to community care. Although the new community care structures include the scrutiny by central government of local community care plans, there has been no suggestion of national prescriptive levels of service. If this is true of established client groups such as the elderly, it is likely to be all the more so in regard to carers, who are not a client group and whose relationship to service agencies is more vague and ill-defined.

Finally, service indicators inevitably offer a service-bound view. Their goals are service defined, and as such are cast at the level of intermediate outputs rather than final outcomes. They assume that we know what services we want to provide and that we want to aim at certain levels of these, rather than at the alleviation of certain problems or the achievement of certain outcomes. To that degree it is an approach that is consequent on the first strategy: that of refining evaluation, in that it is assumed that we know what services work best and wish to ensure their adequate provision. But this may not be the case. Furthermore, closely service-defined goals tend to stifle innovation, prescribing established *ways* of doing things rather than the objectives at which the interventions should aim.

v. Rights

We now turn to two final approaches: those of Rights and Targeting. Although they rest on very different bases, they have certain features in common. Both are concerned with establishing normative levels of support for carers, and in ways that overcome some of the difficulties presented by service indicators. Their aims are defined at the level of individuals rather than agencies, so that rather than setting goals in terms of overall levels of provision in an area, the Rights and Targeting strategies attempt to establish these in relation to the levels of support for individuals. In the Rights model, these are defined in terms of the legitimated demands that the carer can make for support: in the Target model the goals are defined either in terms of the alleviation of certain problems or the achievement of certain states. Both strategies are about achieving outcomes at the level of the individual rather than the agency, though the second retains a more straightforwardly agency perspective.

What would a Rights approach look like in relation to informal carers? At a simple level it would involve setting out legitimate 'rights' for carers to receive certain forms of support: for example, the right of carers whose lives are badly restricted to receive some kind of respite, or the right to receive help in order to have two weeks holiday a year. It would in effect establish 'terms and conditions' for caring.

Attempts have been made to formulate such rights for carers. During the 1980s a number of voluntary agencies, led by the King's Fund Informal Carers Unit and the – now – Carers National Association, were involved in exploring the possibilities of such an approach through the medium of the Carers' Charter. In its early stages this included a possible strategy centred around the assertion of particular rights for carers. These included both rights to autonomy and independence, and rights to forms of support that could ensure these. This aspect of the Charter, however, was soon abandoned. There was a lack of support from carers themselves who were reluctant to assert rights in the context of what they saw as a personal relationship. Such responses are unsurprising, and Gilligan's (1982) work suggests that women in particular rarely negotiate personal relations through concepts of rights. Carers also rejected the employment model that was implied by words like 'terms and conditions': they did not see their caring in that way. The language of rights was also rejected by practitioners who felt the approach was inappropriate, at odds with the bases on which services have traditionally been provided in Britain. As a result the Carers' Charter, when it finally emerged, was couched in weaker and more general language that made no reference to rights.

There are a number of philosophical positions that can be taken in relation to the existence of rights. In the social policy context, much of the debate has turned around whether social and economic rights – the principle focus of social policy debate – should be distinguished from civil and political ones, and the potential consequences of doing so for their assertion (Cranston 1976; Watson 1977). More recently there has been a revival of interest in Marshall's concept of citizenship and its three stages of development, through civil rights in the eighteenth century, political in the nineteenth and social in the twentieth (Marshall 1965; Turner 1990).

The tradition of rights is relatively weak within British social and political discourse. Most of the social policy literature that has appealed to the language of rights has done so within a welfare rights tradition that has emphasised rights in relation to income support or the right to work. There has been much less use of this language in relation to service support, although the subject has been touched upon obliquely in arguments concerning the rights of individuals to minimal provision needed in order to secure personal autonomy (Weale 1983); and for certain individuals such rights could have implications for service support. Concepts of rights to services that would ensure a level of independence and personal autonomy are beginning to be developed within the disability movement. In the context of carers, a 'right to respite' could be seen in a similar light, as a service needed in order to allow the carer to achieve a level of personal autonomy.

The social policy literature draws a common distinction between legal/positive rights and human/moral rights (Weale 1983; Spicker 1988). Legal/positive rights are enshrined in legal codes or customary practices. Human rights are less tangible, and are claimed by reference to a moral code. Rights in regard to carers would certainly make appeal to the second, though the aim in promoting a rights approach would be to ensure their expression in the first form – ideally as statutory obligations to which legal recourse could be made, and certainly as concrete government guidelines. In either case the aim would be to empower carers by allowing them to appeal to rights that were formally codified.

What difficulties are posed by asserting rights in relation to carers? First and most obviously, how would these rights be established, both in the sense of how would one elicit them, and what would be their status: where would they come from and how would they be legitimated? This poses genuine difficulties. At an empirical level, it may be the case that certain outcomes in relation to services – such as allowing the carer to have a break or go on a holiday – command sufficient legitimacy both within society generally and among policy makers and managers for them to be used as the basis for an assertion of a moral right. They could be regarded as rights in a similar, though lesser, way as are other social and economic rights such as the right to work; indeed the right to 'rest and leisure' and to 'periodic holidays with pay' are included among the articles of the United Nations' Universal Declaration of Human Rights (Watson 1977). Empirical work suggests that having a holiday does indeed command wide support as a legitimate aim among both service providers and carers (Twigg and Atkin, 1993); although it is also the case that such legitimate aims are negotiated through different relationships, and what is a legitimate 'right' for sons is often not so for wives.

Secondly, the assertion of rights in this area is an approach that assumes that people share common needs – indeed that is the basis of its universalism – and by implication that they find the same things equally difficult to bear. But this may not be the case. Not having a holiday may be a trivial matter to some people, and rights cast in these terms may consequently be of little use. But unless they are formulated in directly concrete terms, like having a holiday, they will provide little purchase on the situation. Generalised statements about allowing the individual to develop their potential or be autonomous provide too weak a basis for an appeal to be made. If carers are to gain from an assertion of rights, the rights must be concrete and practicable.

Thirdly, the rights approach suffers from the same difficulties as does the consumerism one, in that it rests on principles that are very different from those that actually underpin the welfare system, and are in many ways in direct contradiction of it. We have already noted how the debate on rights within social policy has tended to be confined to areas like social security where allocation is made on a quasi-legal basis according to principles of entitlement. Services, by contrast, have traditionally been allocated on a different basis, one of discretion exercised in relation to individual cases by professionals. Thus although rights have sometimes been asserted in this context, they have been so against the grain of the reality rather than in terms of it. It would not, of course, be impossible to inject a concept of user rights into this service context; and some of the new developments in community care consequent on the purchaser/provider split support at least the expression of such principles. These developments are, however, only in their early stages and the implications of their inclusion within a service system organised on different principles has yet to be explored. Extending them to carers adds further complexities.

vi. Targeting

This brings us to targeting. In this approach the agency would set target models in relation to informal care, determining which carers are to be the focus of resources. It is an approach that circumvents some of the difficulties posed by the issue of rights. It does not require the same philosophical underpinning; it rests simply on the general responsibility of agencies to define the purposes of their activities. Targeting also cross-relates to the case management approach, since it involves making the aims that underlie allocation explicit. Although case management provides a mechanism for making judgements about and between cases, it does not of itself provide the valuations underlying those judgements. In practice these are left to individual case managers who make choices drawing on a mixture of professional values and individual assumptive worlds (Twigg and Atkin 1993). Targeting by contrast introduces elements of explicit direction in which practitioners are guided in making choices by the target models of the agency.

How then would one establish such target models in relation to carers? There are two aspects in this. One is empirical and relates to our knowledge of carers: the other is conceptual and relates to political, ethical and policy issues around appropriate aims of services in supporting carers. Work on targeting in relation to elderly people has rested on a tradition of research that has identified need-related characteristics in elderly people (Davies and Challis 1986; Davies, Bebbington and Charnley 1990). These characteristics have been used to form a basis for developing target models for intervention, an assessment to be made of the target efficiency of different agencies.

In relation to carers, work has been less developed, though as we noted in the section on refining evaluation, there has been a growing body of work that has explored the links between features of the situation and either stress or care collapse. As a result we now have some grasp on the factors that might make up need-related characteristics in carers. It is well established, for example, that behavioural difficulties pose particular problems for carers, and are often implicated in the collapse of care. Their presence, therefore, can be seen as a significant need-related characteristic. As yet, evidence concerning such characteristics is stronger in relation to features of the cared-for person – such as incontinence or confusion – than of the carer, although as we have seen further work refining evaluation is likely to produce more systematic information. We already know, for example, that the physical and social restrictedness imposed by caring is particularly hard to bear. Reflecting needs-related characteristics of the carer may however pose problems of public acceptability and equity if they include, as they are likely to do, features extraneous to the caring situation, and whose legitimacy may therefore be put in question, particularly if they are to be made publicly explicit.

The task of establishing target models is not simply an empirical one. Target models enshrine policy assumptions concerning the proper response of agencies to carers. As yet these assumptions have received little attention. Most of the policy debate on carers has gone no further than to assert the importance of supporting carers, but to what end and according to what pattern of priorities is little discussed. In the absence of a detailed policy debate, I can only suggest some of the possible variations in target models.

The first of these might involve focusing resources exclusively on situations that are 'on the brink', where there is a strong possibility of the carer collapsing or withdrawing. In this approach support for the carer is seen instrumentally as a means of achieving positive outcomes in relation to the cared-for person, and there is little concern with the needs of the carer *per se*. It is a principle that is often articulated by managers or policy makers as a means of justifying interventions on behalf of carers. The cost-effectiveness of such support to carers in maintaining dependent people in the community is frequently asserted. The full implications of the argument – which involves supporting *only* those on the brink of collapse – is, however, rarely endorsed; and empirical work shows that this target model is never applied by practitioners in a thorough-going way (Twigg and Atkin 1993).

Targeting resources exclusively on those who are on the brink will not necessarily mean targeting on the most heavily burdened or stressed. There is likely to be *some* association since subjective stress and the physical burden of caring are known to be related to an inability to continue caring, though the association is not a complete one; and there are many intervening variables. Some carers who are at the point of withdrawing support may be so less because of the burdens of caring than from other factors, such as the rival claims of other family relationships, or simply a low level of commitment to caring. Targeting resources on those about to withdraw may involve supporting some carers who are not heavily burdened or stressed and who are at the light end of caring. It may also involve failing to support certain carers who are heavily burdened or stressed but whose commitment to the relationship, for whatever reasons, is such that they will never withdraw their support. These possibilities clearly violate commonly held ideas of equity.

An alternative approach that would avoid some of these moral difficulties would be to target more narrowly on those cases where there is a likelihood of carer withdrawal *and* an inability of the cared-for person to survive in the community even with the sorts of formal services that are commonly available. This would remove those carers whose involvement was minimal, in that we could assume that their input could be replaced by standard services. It would thus avoid the morally disquieting situation where support was targeted on the lightly burdened. It may be wrong however to assume that standard services can always substitute for these minimal forms of carer support. Certain tasks performed by carers, such as keeping an eye on the cared-for person, are difficult to provide in a formal service context. Services substitute most successfully where there is a specific task, and ideally one, like housework, that is not closely time-defined. (Taking someone to the toilet is an example of a task that is closely time-defined in that it cannot be postponed or done at the convenience of the helper.) Low levels of carer input may still be vital in maintaining the overall support system of the cared-for person.

The main problem is that this modified response does not meet the principal moral unease that arises from targeting only on those on the brink. Of greater concern than supporting the lightly burdened is the possibility of failing to support the heavily burdened. It is here that moral anxieties arise, and charges of exploitation can be raised. In response to this, a rival principle of targeting can be proposed, one that does not treat the carer instrumentally as a means to the wellbeing of the cared-for person, but responds to their needs *per se*. In this approach increasing the wellbeing of the carer is regarded as a proper aim of the service system, and support would be targeted on the most stressed, regardless of their propensity or otherwise to end caring. What difficulties are entailed by such an approach?

First, as we have noted, there are problems around the moral status of wellbeing. The sources of stress or low morale in life are multiple. Why should those in relation to caring be privileged above other sources? Welfare agencies have only a limited remit in these areas; and there is no general mandate from society to increase happiness or wellbeing. In response to this it can be argued that although carers are not clients of welfare agencies, their circumstances are sufficiently closely linked to those of clients as to fall within their remit. In certain cases, the levels of stress experienced will be such as to make them the objects of concern for welfare agencies. By either count their wellbeing is a proper concern of the system.

Recognising the moral implications of these close interconnections, however, raises a second issue: that of the ending of care. It is clear from empirical evidence that the single most effective factor in increasing wellbeing in heavily burdened carers is the ending of care (Levin *et al.* 1989; Twigg *et al.* 1990). Taking the interests of the carer seriously may involve supporting them in the decision to give up care. Targeting on the wellbeing of the carer may in certain cases only be achievable at the expense of that of the client, at least in the sense that they will no longer be cared for by their relative and may, perforce, have to go into institutional care.

Thirdly there are potential difficulties over the marginal productivity of interventions. Should resources be targeted on the most needy or those where the ratio of input to level of improvement is the greatest? The problem is a familiar one in social work: do you focus your attention on those clients who are most distressed and whose circumstances are most problematic despite the fact that it may be very hard to improve their essential situation, or do you concentrate on those with lesser problems, but ones that may be amenable to improvement? In the terms of welfare economics this represents the tension between the arguments of equity and of efficiency.

Finally there is a serious question about the capacity of the political process to negotiate the choices openly here. Targeting on defined groups requires that the principles of who gets help – and perhaps more significant who does not – should be made clear. This is the issue of transparency. The history of provision in these areas does not suggest that this is easily achievable. By and large the political system has avoided making explicit such rationing of help: this is particularly the case in relation to health services, but it applies also to social welfare. It may indeed be that the nature of choices in these areas are such that they cannot be openly made – that the system is only sustainable by consistently obscuring the processes of selection involved.

Conclusion

I have discussed six strategic responses whereby carers might be incorporated into the practice of welfare agencies. Each has its own merits and demerits, and each in turn redresses some of the problems presented by the previous ones. Refining evaluation is a strategy that underpins a number of the approaches, and the systematic understanding of the impact of caring and of services is clearly a vital element in any strategic response. Attempts to take evaluation a step further, however, so that it can become prescriptive science, based on cost utility analysis, remain unconvincing largely for theoretical reasons.

By contrast consumerism, through direct consumer empowerment, attempts to circumvent the need for the prescription of solutions, freeing individuals to choose the forms and sources of support that best suit them. They, rather than planners, should determine what is provided. As we have seen, however, 'consumerism' within the public sector has rarely pursued the logic of such approaches; and there are features of public sector provision and of the 'problems' that it attempts to redress that mean that the response remains largely one of metaphor rather than mechanism. Although money transfers or vouchers have their attractions, they also pose problems where needs are complex and clients frail.

Case management, by contrast, offers a basis for finely tuned assessments in ways that a money transfer or benefit model system is unable to provide. It engages with the need of some carers to explore the possibilities of their situation and the potential role of services in supporting them. And it recognises the degree to which the aims of interventions are as appropriately structured by public policy as by the wishes of individual consumers. Case management, however, does not of itself guarantee an adequate response to the needs of carers. It provides a structure for negotiation, but not the valuations that are fed into the negotiation. It can thus be run in regard to carers or in neglect of them. Ensuring an adequate supply of services remains an issue.

Service indicators go some of the way towards addressing this, setting criteria to ensure local availability through prescriptive levels of service; but determining such levels remains problematic. The Rights approach gets away from the limitations of the service indicators, with its service-bound nature and potential to inhibit innovation, and recasts the debate concerning levels of service in terms of the individual carer. The establishment of rights, however, poses problems of both a theoretical and a methodological kind. Targeting, by contrast, while retaining the focus on final outcomes in terms of individual carers avoids the philosophical problems posed by rights and bases its prescriptions in the more straightforward obligation of agencies to clarify their objectives.

What then is the way forward? How can we hope to see carers' needs integrated into the service system? Much clearly depends on the way community care in general develops. Many of the issues and problems I have addressed here are not exclusive to the situation of carers, but apply as much to that of elderly or disabled people. Carers expose – sometimes in more acute form – tensions current in the provision of welfare at a more general level. What we are likely to see, and what probably offers the best way forward, is a development of the case management approach, although one perhaps shorn of its full impact in the form of the devolvement of individual budgets. Ideally such an approach would draw heavily on evaluation studies and be informed by some at least of the values that underlie the expression of rights, although it is likely that these will be seen through the prism of targeting and of specificity of objectives, rather than directly in the form of encoded rights.

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