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Francesca Pozzoli – PhD candidate in Sociology and Methodology of Social Research – University of Milan

**The journey of *choice agendas* in disability policy and practice.**

**How do the UK and Italy compare?**

**Introduction**

Choice is a concept that during the past thirty years has entered the agendas of many welfare states, has influenced their public services reforms and has gained increased weight in the debate around best possible ways of delivering public services. From the rights of parents to choose their children’s school to that of patients to choose both hospitals and treatments to that of non-self-sufficient individuals to choose their support care services and staff.

A straightforward concept at a first glance, choice emerges as a powerful and often contested political notion when we consider its application in the context of public services. First of all, its popularity is the outcome of the interests and actions of different actors in the policy field and, as such, is a much more multifaceted phenomenon than its simple and apparent positive nature may suggest. Secondly, choice has not entered public policy on its own. Specific demand-side financing tools are associated to its implementation in different areas of public services and these tools are neither neutral not purely technical. On the contrary, they have the power to influence the conceptual frameworks of the specific policy field in which they are introduced and also the direction of the daily practices of the different actors active in the field.

The promotion and implementation of choice for users of welfare services through the use of demand-side financing tools is what I will refer to – in the rest of this paper - as *choice agendas* and I will argue that the analysis of their journey from policy into practice through the lenses of their actors will offer an innovative way to interpret their effects.

The paper focuses on the introduction and development of choice agendas in the context of care services for disabled people in England and in the Italian region of Lombardy and aims at offering – in regards to both contexts: 1) a reconstruction of the main debates associated with choice agendas, including their development over the last two decades; 2) a detailed description of the specific policies and tools which have supported such agendas; 3) an initial discussion about their effects on the lives of disabled people.

Disability policy and services offer a paradigmatic field to study choice agendas both because of the historical presence of many and different actors – and interests - calling for public policy to embed the concept of choice and because of the multifaceted nature of disability itself calling for a multidisciplinary approach. Even if integration is far from being a reality, similar agendas regarding choice travel between social, health and education services and a focus on disability allows to bridge field specific boundaries and to analyse the spread of similar policy across services.

**Main debates**

The origins of choice agendas in the context of care policy and services in the disability field, both in England and in the Italian region of Lombardy, are to be found in the connubium between disability activism and market-oriented reforms of public services. I use here the word connubium in a descriptive and value-neutral way, to highlight the union of two different logics of choice at a policy level. On the one hand, ‘positive freedom’ (Lister 2010) and ‘capabilities’ based theories (Sen 1985, 1999) are at the heart of a logic which considers choice in terms of autonomous participation and freedom from discrimination (Burchardt, Evans and Holler 2015). Free choice, in this sense, is about participation, recognition and autonomy. On the other hand, rational-choice theories applied in the context of public services (Le Grand 2005, 2007) inform a different logic of choice, a more libertarian one based on the confidence in individuals’ ability to make choices in a market-like environment and in competition to guarantee and respond to individuals’ choice.

The connubium of these two logics happened at some point during the 90s. This is when the claims of social movements in the name of de-institutionalisation and independent living entered welfare governments’ policy and a *discourse coalition* around choice developed. The term *discourse coalition* - coined by Marteen Allar Hajer (1995) in his work on the politics of environmental discourse – refers to how a common understanding – or a dominant perception – of a particular issue can be produced and mediated by a policy discourse. Hajer talks about *discourse coalitions* to refer to the ensemble of actors sustaining a particular discourse about a specific policy problem and highlights how the different actors of a discourse coalition don’t need to have a common strategy or share the same meanings while engaging in a specific policy issue but, on the contrary, they can have different interpretations and different interests while at the same time grouping around what he calls specific *storylines*. I will argue that the concept of *discourse coalition* well applies to the case of choice agendas in the disability filed. Different interests and different interpretations regarding choice have been at stake for different actors, nevertheless, they all sustained the same discourse coalition. Not only, governments have reworked the claims of disability activists within their own agendas in the same ways as disabled people movements have made used of governments’ policy to achieve their claims.

The British case is exemplar. On the one hand, the ‘right to choose’ has been revendicated by disability activists in their fights against institutionalisation and in their campaigns calling for a social model of disability (Oliver, 1996) to replace the medical model which until the 1970s was dominant in the field of disability. The independent living movement and the social model of disability were based, respectively, on the principles that disabled people should have the same rights of choice and control over their lives as non-disabled people and that it is society that disables people by excluding and isolating them. The call for choice of disability activists was then a call for an anti-discriminatory approach recognising the right of every individual to participate in society and to be in control of their lives, starting from choosing where to live, who to live with and how to receive support if needed.

One of the items which disability rights campaigners lobbied for was that of the direct payments. The ‘technology’ of direct payments (Duffy 2010) in lieu of social care services was indeed seen as a key tool to allow for choice and control to be achieved in practice. In this sense, the independent living movement and the social model of disability nurtured the development of choice agendas.

Direct payments, however, as a demand-side financing tool, well fitted with the social policy agenda of the then governments. We need to make a step back to understand how.

Choice began to be seen as an important tool by politicians, economists and policy-makers in the context of the so called ‘mixed economies of welfare’ (Alcock 2012) and in line with the New Public Management (NPM) reforms of the 1980s. Under welfare pluralism and NPM principles, welfare states have been reformed, retrenched and reshaped (Clarke 2012: 266) and ‘choice’ used as a means to reform what was widely accepted as the passive, bureaucratic and inefficient nature of welfare states and welfare services. With the aim of improving the quality and efficiency of public services, NPM policies reduced the role of the state in welfare provision and introduced new accountability and market-like mechanisms in public services such as the split between purchaser and provider. The state became an enabler rather than a provider of services and users became consumers. The confidence on individuals’ ability to make choices as rational agents and on competition in a free market - of both for-profit and non-for-profit organisations - to respond to such choices have been the original pillars of this new policy turn. When evidence of both markets and behavioural failures (Glennerster 2009, 2013) emerged, this user-consumer policy model got adjusted. A condition got introduced for the choice and competition model to work, that of quasi-market, that is, a public sector market structure where the users-consumers are financed by state resources, choice can be supported and providers can operate in a competitive but regulated market (Le Grand 2005; 2007). Demand-side financing tools are at the heart of this model. And this is why – as mentioned above - direct payments perfectly fitted with the choice agendas of governments. A more recent development of demand side financing in the UK is represented by personal budgets.

The conjunction, in the context of care services for disabled people, of user-consumer models and quasi-markets structures with the revindication of disability rights campaigns have characterised also the Lombardian experiences. Choice agendas, however, have in this case been implemented through the use of different demand-side financing tools: vouchers and economic transfers.

An overview of what I defined as the union, at a policy level, of different logics of choice will be provided in the next section.

**Policies and tools**

England

In regards to England, the origins and developments of choice agendas can be analyses through the lenses of personalisation policies. Choice is indeed one of the key principle – if not the main – of personalisation, a policy agenda which in the past thirty years has radically transformed social care services in the UK and which is starting to have the same impact in health and - to a lesser degree – also in education services.

The entry of choice into the scene of British policy dates back 1996 when cash-for-care have first been introduced by the then Conservative Government with the Community Care (Direct Payments) Act. However, it is with the White Papers *Valuing People* (DH, 2001) and *Putting People First* (HM Government, 2007) that – under the New Labour administration - a vision for a personalised social care system centred around individuals and their right to have choice and control over their life has been rolled out across social care services in the UK. More recently, the vision of personalisation has continued to underpin both the Coalition and Conservative government strategy, culminating in its incorporation into the *Care Act 2014* (DH, 2014), one of the most significant reforms of care services in the UK as it brings together, for the first time, different Acts and care laws into a single framework for care and support. Beyond social care, increasing choice and control for people with disabilities through personalised care is a commitment which also the National Health Service (NHS) and the Department for Education (DfE) in the UK have embraced. The *Health and Social Care Act* *2012* (DH, 2012) and the *Children and Family Act 2014* (DfE, 2014) representing the alignment of, respectively, health and education departments to the personalisation agenda.

One feature that all the above-mentioned pieces of legislation have in common regards the specific toolkit that government policies envisaged in order to translate choice agendas in practice. This is made of person-centred-planning (PCP) approaches and self-direct-support (SDS) measures such as direct payments (DP) and personal budgets (PB).

DP and PB are cash-for-care schemes, hence forms of economic transfers in lieu of services (Glasby, 2012). DP are cash payments made to individuals who can spend them for support and services they have been assessed as needing. DP for instance can be used to purchase support from personal assistants. DP were first introduced for disabled adults under the age of 65 with the Community Care (Direct Payments) Act 1996. They have then been extended to other users’ groups: older people, people with mental health problems and parent and carers of disabled children. The Health and Social Care Act 2001 mandated local authorities to offer DP to all those with an assessed need. A step further was made when Putting People First called for the use of PB as a way to provide more choice and control to those eligible to social care support. PB differs from DP in that they can be used more flexibility for support and services the individuals themselves choose. PB are not cash equivalent of services but money allocated based on an assessed level of need of individuals. The introduction of PB was to be supported by a new assessment system and a new Resource Allocation System (RAS) able to link assessed levels of need to a monetary equivalent. With the Care Act 2014, LA have been required to provide a PB to all adults with eligible needs. Both DP and PB are tools promoted to encourage PCP practices, an approach to support planning placing individuals – rather than services – at the start of the process and aiming at shaping services around them and their choices, rather than fitting them into services.

Personal Health Budgets (PHB) have also been piloted in England between 2009 and 2012 and, since October 2014, all individuals eligible for continuing health care[[1]](#footnote-1) have the right to have a PHB. A PHB is an amount of money that, following an assessment, is identified as suitable to support the healthcare and wellbeing needs of an individual and that the individual can decide to spend for a range of therapies, equipment and personal care services in line with agreed health and wellbeing outcomes. PHB could be one of the most radical changes for NHS services if they are rolled out beyond continuing health care services. There is an expectation that their use will increase among people with long-term conditions, learning disability, autism and mental health problems. Moreover, PHB have been used in the context of end of life care and have recently been piloted in maternity care services.

To conclude our section of the toolkit of choice agendas in the UK, we refer to the Children and Family Act 2014 and its proclaimed objective of giving young people with special education needs (SEN) and disabilities greater choice and control over the entire realm of their education, health and care support, transforming the SEN system for children and young people aged 0 to 25 years old introducing Education Health and Care Plans (EHCP). In addition to PB and PHB, EHCP imply also the possibility of requesting Education Budgets.

The region of Lombardy

In the case of the region of Lombardy, the origins and development of choice agendas are to be found in the context of the changes brought about by the reform of social welfare in Italy and which law no. 328/2000 (Legge quadro per la realizzazione del Sistema integrato di interventi e servizi sociali) initiated.

One of the main changes which this law brought about regards the introduction of quasi-markets and voucher-style mechanisms in health and social care services and, through these, the institutionalisation of horizontal subsidiarity between public and private welfare actors (Bifulco & Vitale, 2005). This means that citizens, whether as individuals or as associations, together with third sector organisations and the private sector are called to take part in the production, planning and delivery of social welfare services. Different regions in Italy implemented such horizontal subsidiarity in different ways, the region of Lombardy – among other measures - by requiring municipalities to spend in cash rather than in services and to convert some of their socio-medical care interventions into vouchers (Bifulco & Vitale, 2006) or *buoni*, this last one representing a form of cash for care similar to a direct payment and generally used to purchase domiciliary care from informal personal assistants, including family members and friends.

Freedom of choice for individuals and their families has been the ideological driver for the introduction of vouchers and *buoni* (Pasquinelli 2006; Marotta 2010) by the Lombardian centre-right wing government since 2000 and this same path has been followed even in successive legislations. Individuals are trusted to make rational choices and markets are supposed to widen their range so to meet the different needs and wants of a diverse population of users-consumers. To support such mechanisms, the region of Lombardy introduced - between 2001 and 2003 - both *buoni* and social vouchers administered by municipalities(Monteleone 2005; Pasquinelli 2006; Bifulco 2016) and socio-medical vouchers administered by local health authorities (Gori 2005; Giunco 2010).

Both social and socio-medical vouchers required the region to set up an accreditation system through which suitable providers could be identified. Also, to unleash the role of both users, families and the private sector, the region – while strengthening its role as funder and regulatory body - assumed only a very weak directing role in regards to the way local areas would implement and deliver such reforms.

Freedom of choice and trust in quasi-markets have continued to animate the direction of the Lombardian centre-right wing government also after its first legislation, when vouchers and buoni were introduced, and independently from any evidence and analysis regarding required reforms (Gori 2005).

Key initiatives introduced in 2006, 2015 and 2016 – *Fondo Nazionale per le Non Autosufficienze* (Fna), *Reddito di Autonomia* (RdA) and *Dopo di Noi* – attest the routing of the *voucherisation* in Lombardy. These have in fact been implemented through the use of vouchers and buoni. However, it is also true that such initiatives emphasise the need for better planning at the individual level through person-centred-practices and that, more recently, proposals for the voucher system to be replaced or combined with other models of personalised care have been advanced. These look at the *care budgets* as the tools to personalise care systems around individuals and their choices.

The policy developments just described exemplify how both England and the Italian region of Lombardy represent contexts in which choice agendas have been institutionalised (Carabelli and Facchini 2013; Glasby 2012) in the field of care services for disabled people: the trust in individuals’ willingness and ability to make choices in their best interest and the trust in competition, private provision and quasi-markets to provide suitable responses are in fact at the basis of the toolkit made of direct payments, personal budgets and vouchers that will be analysed in this project.

**Current state of research**

Choice agendas in the context of care services for disabled people have been widely researched. In the British case, the literature on the topic is considerable and works such as *Debates in personalisation* (Needham and Glasby 2014) and *Personalising public services: understanding the personalisation narrative* (Needham 2011) well summarise the debates around personalisation and, as part of this, about choice as one of its key underpinning elements. Glasby and Littechild (2016) provide instead a thorough summary of the most relevant research studies on direct payments and personal budgets. Most of these studies are dedicated to the analysis of what works and what doesn’t, for whom, under what conditions and on measuring outcomes. It is beyond the scope of this paper to provide a detailed analysis of current literature on direct payments, personal budgets and/or personalisation. What I would like to highlight, however, is that personalisation has big supporters (Leadbeater 2004, Pool et al. 2006, Hatton et al. 2008, Duffy 2010, Tyson et al. 2010) but also big critics (Beresford 2014, Slasberg and Beresford 2016). The enthusiasm with which the government and its partners organisations have promoted personalisation has been seriously put into question by scarce and mixed results (ADASS 2010, NAO 2016) regarding the success of DP and PB in delivering more person-centred care and in giving people choice and control. Many sympathetic analysts adopted, over the course of the years, a more cautious positions regarding the potential of direct payments and personal budgets (Glasby and Littelchild 2016) and prominent disability activists in the UK have heavily criticised the government’s personalisation agenda (Slasberg and Beresford 2015) and also some of the literature produced in its support (Slasberg et al. 2013).

Regarding the Lombardian case, Gori (2005, 2010) offers a thorough analysis of regional policy making over the decade between 2000 and 2010, including a debate on choice as the ideological driver of the Lombardian social policy reforms over this period. Pasquinelli (2006) and Giunco (2008) provide instead evidence regarding the implementation of, respectively, social vouchers and socio-medical vouchers in the region. Their overall conclusion is that, in both cases, these measures allowed for an expansion in terms of service coverage, both in the sense of more services and more hours. Dedicated resources have indeed been allocated to the introduction of vouchers in social and health care services in Lombardy. However, within such expansion, freedom of choice has often felt to be limited, sometimes inevitable and in some cases perceived as a burden. Monteleone (2005) and Bifulco (2011) have pointed at how markets’ perverse incentives and users/providers behavioural and informational failures apply to the wave of *voucherisation* which invested the region of Lombardy, bringing many to question the potential of these measures in delivering more choice and control. The voucher system – nevertheless – still underpins the provision of care services in the region, coexisting with more recent policy trends which, as already mentioned, claim to be informed by the logic of ‘care budgets’ (*budget di cura e/o di progetto*), at least in their intent.

What my project aims to add to existing literature is an analysis of choice agendas’ effects which goes beyond their evaluation in terms of outcomes measurements and implementation studies and which focuses instead on the role of policy actors in determining or influencing policy effects. To this purpose, I will follow choice agendas in their journey from policy into practice through the lenses of their actors. The next paragraph provides a description of the theoretical framework which informed my research design.

**Theoretical framework**

The purpose of my analysis is that of following the trajectory of choice agendas as they translate from policies into practices and, by doing so, that of understanding their effects through the lenses of policy actors. My main assumption in this project is indeed that the role of actors acting on and acted by specific policy ideas, and their tools, becomes relevant if we are interested in understanding the effect of policies as they get implemented into the field. For this reason, I will draw on sociological approaches to the study of policy actors and their role in influencing policy effects.

Constructivist approaches of social process such as Guba and Lincoln’s (Guba and Lincoln 1989) and realistic evaluation theories such as Pawson and Tilley’s (Pawson and Tilley 1997) offer the ground on which to analyse the role of actors, stakeholders and their interpretation of policy programmes in shaping policy outcomes and policy effects. On the one hand, the interplay between policy programmes – in the sense of both policy ideas and tools - and actors’ individuality can produce mechanisms that influence the way certain policies are acted upon (Stame 2004). Policy programmes can get transformed during their implementation and this is not only due to the interaction between programmes and contexts but also on the one between programmes and actors’ interpretations and beliefs. An example of this can be found in the work of Lipsky (1976, 1980) and his theory of *street-level-bureaucracy*: street-level bureaucrats, in the definition given by Lipsky, work mid-way between the users of public services and the higher hierarchy of public officials. Having to deal with often unstable environments and resources and ambiguous if not contradictory demands from the bottom and from the top, they put in place a series of coping strategies to face such challenges. Another example – highly relevant for the contexts of my analysis - is that of *policy practice* first coined by Bruce Jansson and analysed by John Gal and Idit Weiss-Gal (2014) in their recent work on social workers and their role in influencing policy from an international perspective. The underpinning ideas of policy practice are that all social workers do engage in activities within their professional settings which do influence or should influence social welfare policy at different levels. The extent to which this happens is proportional to their role in reinforcing, transforming or challenging specific policy programmes. Street-level-bureaucracy and policy practice theories are useful approaches in the analysis of actors’ role in determining the effects of social policy. Both theories, however, have first emerged in a welfare context which is different from our current one. In particular, the idea of welfare states as unitary and hierarchical systems – an idea which remined somehow valid until the 90s – does not match anymore with the reality of welfare systems increasingly characterised by network forms of organisation, hence by form of *governance* more than *government* (Bevir and Rhodes, 2003; Goldsmith & Eggers 2004; Eggers 2008). The consideration of governance dynamics and network systems in the study of public policy demands, first of all, that attention is given to traditional welfare actors (such as social workers, as per the theories above) but also to new actors in the policy networks. Furthermore, it also means that both these new actors, and the structures of the networks in themselves, do influence and play a role in regards to specific policy agendas. It is for this reasons that I will include *governance and network theories* in my analysis. In particular, I will draw on the re-elaboration of such theories by Ball (2006, 2015, 2016) and Peck and Theodore (2012) and on their ideas of, respectively, ‘policy as text and discourses’ and ‘policy mobility’. The first one has to do both with the way policies are enacted by the different actors of a policy network and also with the way policies act on actors themselves. The second one regards instead the way policies move between, among and across actors. As such, the works of Ball, Peck and Theodore are useful compasses for the understanding of the changing role of actors in the policy process at the crossroads between agency and interpretations on the one hand and subjectification and discourses on the other.

**Preliminary Findings**

The need for translation

Preliminary findings are currently available only for the English context and, in this paper, my aim is that of providing a tentative systematisation of part of the material I have so far collected through my fieldwork in England and based on the theoretical framework I presented above.

Regarding the fieldwork, I have spent over a year in England investigating how choice agendas have, and still are translated into practice. Drawing on Ball (2015), I focused on the ‘labor of network actors’ in regards to choice agendas and, through ‘network ethnography’, I followed choice agendas in their journey from policy into practice through the lens of their different actors.

Network ethnography – paraphrasing Ball – uses the analytical device of the policy network to map and provide a representation of a policy filed and of the mobilities and interactions within it (*Ibidem*). For instance, the relationship between actors, their exchanges, their history and the evolution of their activity can be captured. In my case, these actors are both organisations, groups and individuals. More specifically: local authorities, consultancy organisations, services, professional categories such as social workers, individual social workers, service users, users’ led organisations. Focusing on the labor of these actors implies visiting, mapping and questioning the filed in which choice agendas apply. It also implies capturing mobilities and interactions between actors and, also, interactions between what we have described above with the concepts of *policy as text* and *policy as discourses*.

I allowed my methodology to be very open and exploratory at the beginning. I hence conducted exploratory interviews with the different actors of choice agendas and I participated in network events such as conferences, training, forums. The combination of exploratory interviews and observation at key events gave me a hint of the ‘sticky’ reality of choice agendas beyond policy documents and guidelines. ‘Best possible scenarios’ (Ball 2012) for implementation are usually assumed by policy-makers. But policies cannot just be implemented into practice, they need to be translated first. In this sense, the operation of translation emerges as quite different from that of implementation. Translation involves interpretation, negotiation, sense-making, mediation and struggle (*Ibidem*). It is after these operations have taken place that policy can be implemented. The ‘need for translation’ clearly emerged from my fieldwork.

All actors of a policy network do some translation work. This applies to choice agendas too: all the actors I listed above somehow do some translation work. However, some more than others influence the way policies gets implemented into practice and, as such, some more than others play a vital role in influencing policy effects.

In the case of choice agendas in England, I identified in consultancies – both from private and third sector organisations - actors with a very high degree of influence in the work of policy translation.

A common practice in English local authorities is in fact that of contracting out choice agendas’ translation to external organisations both from the private for-profit and non-for-profit sector. The resort to such organisations is usually explained by the need to make use of external expertise at a time when local authorities have to cope with pressing agendas and scarce resources.

Translation: three different policy models

‘Network immersion’ (Peck and Theodore 2012) allowed me to better analyse the role of these actors. I interviewed managers and workers from consultancy organisations involved with policy translation on the behalf of local authorities, I attended some of their events and I analysed some of the documentary material (training, blogs, articles, podcast) they produce.

A preliminary conclusion I can draw from the material so far collected and analysed is that these organisations are both social enterprises, charities and private for-profit organisations of different dimensions. They act as policy influencers with national-level targets rather than as local-partners for specific local authorities. Their work is in fact based on the identification of policy models to be spread and sold to local authorities across the country.

I identified so far three main policy models which have travelled (and are still travelling) across the country and which I named as follows: the rational individual model, the brokerage model and the informal network model of choice.

The *rational individual model* draws on the work of *InControl*, the charity that can be considered as the champion of Personalisation in the entire UK and which invented and developed the indicative budget (IB) and resource allocation system (RAS) tools as *conditio sine qua non* for choice and control to be offered to and exercised by users of services. The idea is that for real choice to be exercised, users of services should be given an upfront allocation, or indicative budget, hence an indication of the resources available in order for their needs to be met. Choice, in this model, belongs to single individuals who can exercise it in a market – or quasi-market – of care services. The trust in individual’ ability to make decisions in their best interest - with support if needed - and in markets to respond to such choices goes together, in this model, with the mistrust in public services in influencing users-providers dynamics. Upfront allocations (IB), however, in order to be provided, rely on the development by local authorities of new resource allocation systems capable of ‘costing personal needs’ or, in other words, of matching individual needs with a money equivalent. *InControl* has supported since 2007 - and still it is supporting, despite dubious results – local authorities all over the country to work out suitable resource allocations systems and also ways to convert their commissioning models from block contracts with services to spot purchasing. Under block contracts, providers are paid through contracts and based on an estimation of local population needs. Under spot purchasing, providers are instead paid based on activity and directly by users of services with their personal budgets (or by local authorities on their behalf should users decide they don’t want to manage their own budgets). *InControl* is also supporting LAs across the country to train their staff for the ‘cultural change’ (a term which emerged several times in my interviews) which their model demands and, with their own research team, they are also creating and spreading the evidence that their model works. *InControl* leads in fact on the POET surveys together with Lancaster University and TLAP – the government’s arm committed to transform health and care through personalisation. The POET surveys are today the largest surveys available looking at the impact of personal budgets on people’s lives.

The *brokerage model* is a second model I identified. *Brokerage* has interestingly been associated in the past with *InControl* as it was part of its original model. The idea was that an independent broker would support individuals in receipt of indicative budgets to decide how to spend them. Simon Duffy was at that time the lead of InControl. However, when Simon Duffy left *InControl* and, amidst fierce debates, publicly apologised for having invented a self-directed-support model based on indicative budgets and resource allocation systems (Duffy 2012), brokerage also got questioned (Duffy and Fulton 2009). Nevertheless, brokerage has not disappeared and today, in a reimagined way, it gets promoted by organisations such as the National Brokerage Network (NBN), its sub-organisation in London - the London Brokerage Network (LBN), and by private companies such as MySupportBroker. What I call the brokerage model sees in the work of independent brokers the means for true choice and control to be offered and exercised. The so-called failures of welfare states – according to this model – justify the need for independent actors to carry out part of the work which is normally provided by social workers within local authorities. Brokers sits midway between local authorities (representing the state) and users. Their independence is seen as a proof of their impartiality: brokers are seen as having no interests and, as such, they are considered as better placed to support real choice and control for vulnerable people. In an ideal world, according to this model, SUs would choose their own broker and use part of their personal budget to pay for the broker of their choice to support them with planning their support.

In a 5-days training I attended on brokerage and which was commissioned by a local authority for its council workers (manly social workers and commissioners), the attendees were considered as potential future brokers and, as such, they were thought the kind of marketing strategies upon which brokerage is based. For instance, they were thought - among other things - how to write a CV as brokers, how such CV should sound personal rather than professional, what strategies could be adopted to appeal to ideal users/clients, how to work out consultation fees and how to advertise brokers’ profiles.

Finally, the last model I identified is what I called the informal network model. As the name suggest, this is less centred on single individuals, their consumer and monetary powers and more focused instead on the relational dimension of their resources. For instance, the Three Conversations (3Cs) model, developed and pioneered by the company Partners4Change (P4C), is built around the concept of good conversations, real listening to people, real life questions and chats as opposed to social care assessments. The choice of what to buy with a PB is left as the last, and not necessarily required stage, of a process which start with Conversation1 (C1). In the words of one of my interviewees ‘*I listen hard to you, I don’t assess you, I listen hard, I understand what really matters to you in your life, understand what a good life means to you, good life to you might be very different from good life to me, and I connect you, I know your community resources..I know what’s going on..and I connect you. So I don’t give you services, I don’t assess you, I warmly introduce you to things in your locality..that would help make your life much better, because I know what would make life better if I start listening very hard to you..that C1*’. And only if C1 is not enough, because people are in a situation of crisis, the model envisages a move to Conversation2 (C2). Again, in the words of the same interviewee: ‘*So it’s a mentality, it’s a mode, it’s a purpose where my purpose is to understand what needs to change for you so that you came away from crisis…and crisis might be you end up in hospital, dependent on formal care services, your life is really really crap, so C2 I work very hard with you, I stick to you like glue, for a period of time, so we get intensively involved in working together, to see if together you can get to the point where you say I had a bad time, things were tough, I didn’t think I was able to carry on but I’ve got to a different place now and I feel much better and goodbye thank you very much. That’s C2…*’. From C2, only in few cases, there will then be the need to move to Conversation3 (C3): ‘*C3 is a classic InControl Self-Directed-Support, that’s your PB, what you wanna do with your life?’*. The citizen-costumer-consumer is the last step of a process which start with just the citizen, their relations and communities. In addition to P4C, other organisations, charity and social enterprises, are also developing more ‘relational’ and ‘community-based models’. To name the most widespread: Community-Led-Support (CLD) – pioneered by NDTi, Local Area Coordinators (LAC), Community Catalysts.

An interesting aspect regarding the origins of the 3Cs model is that the director of P4C used to work for *InControl* in the past and, after having left the company, he developed a more refined and ‘up to date’ version of the model. Austerity has hardly hit social care in the UK since 2010-11, and choice through personal budgets is not anymore an option to be promoted for all users of care services.

Preliminary reflections

The models I just described are to be intended as ideal types and exchanges or movements of ideas are common. This becomes quite obvious if we consider that individual actors move across these organisations and borrow, move and rework ideas. We saw the example of Simon Duffy and of the director of P4C but there are many others. This confirms the position of Peck and Theodore when they confirm that ‘influential models are rarely, if ever, the work of a single architect’ and that policies are ‘co-constituted through the networks, and across the landscapes, through and over which they travel’ (Peck and Theodore 2015, p. xxiv).

The actors we have considered so far are obviously not the only actors inhabiting the networks and landscapes of choice agendas. Local authorities, and their social services’ teams made of social workers, commissioners, care managers and other health and social care professionals; services and their workers – whether from private, public or third sector organisations; service users and service users’ groups; unions and, finally, professional organisations are the other actors of the policy network. One thing, however, seems to distinguish the actors of the above described three policy models from the other actors I just listed: their ability to influence policy. The power of the charities, social enterprises and companies we have seen above is indeed not limited to the translation of policy agendas, as while they do policy translation, they also do policy steering. While they do policy translation, they also expand their influence, they set certain directions for policy, they influence other actors’ behaviour. For these reasons, they can be considered as charismatic and entrepreneurial policy (choice) enthusiasts whose mission is to defeat bureaucracy and professionalism with innovative and creative practices, in line with the spirit of choice agendas.

Looking at the network connexions of these charismatic and entrepreneurial policy actors, it emerges that they don’t establish relationships with all the other mentioned actors. Managers and commissioners within local authorities are their favourite interlocutors. Simplifying, we could say that charismatic entrepreneurs meet managers and commissioners. Leadership, enterprise and managerialism represent their way of working. Choice agendas require leadership, enterprise and managerialism to be translated into practice.

This has two main effects. On the one hand, the connubium between leadership, enterprise and managerialism implies that only certain versions of choice are legitimated. For instance, the particular vision of choice which these actors are willing and eager to promote is an individualistic and consumeristic vision of choice, even when vested by a more relational dimension. One which give lot of weight to the needs and wants of individuals and much less to those of communities. One which tends to privilege individuals’ satisfaction over collective needs. One which tends to associate choice with consumers’ power. Finally, one which privileges the private (independent) sector (whether for profit or non-for-profit) to public services. And we are not just talking about private sector delivery of services, which is a well dated phenomenon. We are talking about the opportunities for the private sector to do some social work and policy work and for doing business while doing so.

On the other hand, the connubium between leadership, enterprise and managerialism also implies that all the other actors of the policy network seem to have weaker translation powers. Their vision and their ideas of choice struggle to get through the policy network. Their translation powers seem to be confined with the kind of coping strategies which are coherent with those of streel-level-bureaucracy theories: creaming, gaming, categorisation and rationing. Some examples are: social workers cherry picking those for whom real investments in PB are worth for; local authorities calling PB what in reality does not really differ from traditional services (research has also found that the majority of PB are in the form of council managed budgets); social workers allocating similar budgets to people with similar conditions (as opposed to tailoring budgets to individuals’ needs); managers within local authorities using PB and DP as ways for managing scarce resources by setting budgets limits.

What’s next?

The conclusion that only certain versions of choice are legitimated to circulate through the policy network of choice agendas and that there are power asymmetries among their different actors is a first step in the investigation of choice agendas’ effects. These conditions influence in fact the kind of choice that can be offered to and exercised by users of social services. However, in order to draw more definite conclusions in this respect, the role and activities of those actors who appear to be less powerful within the network require further attention. Are these actors really less powerful and, if so, why? Have they become passive policy receivers? Or are they maybe policy critics engaged in maintaining some kind of counter-discourses?

These are the kind of questions which informed the second phase of my project and which I tried to answer by means of in-depth interviews conducted with social workers and service users involved in the choice agendas policy network. I am still in the process of analysing the data I have so far collected and I endeavour to provide a preliminary overview of this second stage of my research in occasion of the second Transforming Care Conference, hence by the end of June 2019.

In the meantime, I am conducting the fieldwork also for the Lombardian case and, again, in occasion of the Transforming Care Conference, I will offer some preliminary reflections on this work too.

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1. NHS continuing health care is a package of ongoing care for people with long-term health needs and which is solely funded by the NHS. [↑](#footnote-ref-1)