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## Personalisation falls short

*Personalisation offers individualised treatment in circumstances where markets do not operate. The process of personalisation is described variously as a process involving an individualised assessment and response, the expression of individual preferences and choices, or a process in which users and professionals negotiate a common understanding of the needs of the individual.*

*The core arguments for individualised approaches are effectiveness, efficiency and responsiveness to need. However, personalisation sometimes falls short of the claims made for it. It is not always effective, because matching people to resources is time consuming, difficult and dependent on so many conditions that mismatches are inevitable. It may be inefficient, because it is difficult to deliver selective services without either misplaced provision or inappropriate denial of service. There is only limited support to be found for the belief that services have become more responsive to individual circumstances as a consequence of personalisation, or that they are better matched to need. The case for personalisation has to be argued and proved in the context where it is applied.*

Many economists believe that individualised responses are capable of maximising utilities in a way that collectivised services cannot (Kaplow, Shavell, 2001). There is now almost no support for the view, although it used to exercise considerable influence in the UK, that some issues, like housing supply or diet, are too important to be left to the vicissitudes of the market (see e.g. Clapson, 2000; Rose, Falconer, 1992); the restrictions on individual behaviour that were once associated with those views are much less likely to be accepted today. It is well understood that there are sometimes instances of market failure, and the market does not function effectively in every case (Barr, 2004; Glennerster, 2009); consequently there is sometimes the concession that it may be more appropriate to provide some things collectively - for example, roads and parks. Even in those cases, however, there are those who argue that individualisation would be preferable, with costs and charges distributed according to usage and personal choice (e.g. Seldon, 1977; Adam Smith Institute, 2005).

Personalisation is a variation of the individualist case. It refers to individualisation in a non-market context. In the market, the price mechanism is supposed to mean that individual utilities are expressed in people's choices about consumption. There are however situations where this cannot be realised in practice. Service users do not have access to individualised resources where, for example, there is control or coercion (as in provision for offenders, or the compulsion on benefit recipients to be "actively seeking work") or the competence or ability to choose of the service user is limited (for example, in services for children, or dementia care). If the market cannot operate, there may be difficulties in adjusting the response to the circumstances of the individual. Personalisation is advocated, in consequence, as a way of making services responsive to individual needs in circumstances where conventional markets do not operate. The crux of the argument is that even if it is not possible to duplicate market mechanisms, it may still be possible to duplicate some of the flexibility, choice and satisfaction of personal utilities that markets would otherwise achieve.

‘Personalised’ services, in the sense of responsive, individualised treatment, are supposed now to extend to the needs of elderly people, psychiatric patients, learning disability, people with addiction, offenders, school pupils, homeless people and the unemployed. The extension of the principle into the field of benefits administration (e.g. Freud, 2007; Gregg, 2008; Cm 7506, 2008; Cm 7913, 2010, pp 30-1) seems to suggest that the principle of personalisation can be extended generally across the social services. This paper considers what personalisation is supposed to mean, what the arguments for it are, and when it should be applied.

### **Personalisation defined**

There are three main competing interpretations of what personalisation implies for the consideration of individual circumstances. In the first place, personalisation can refer to individualised assessments and responses.

“Personalisation places an emphasis on providing social care services tailored to the individual needs of the user, rather than fitting people into existing services that may not deliver the right kind of support for their particular circumstances.” (Harlock, 2010, p 371)

The idea of “tailored” services, which comes directly from the Griffiths report, implies a process where professionals match services to needs. Professional assessment is used in many situations, including the circumstances of people who might be considered unable to make informed choices for themselves (for example, for medical care), but probably the most widely used application currently is assessment for community care, and the people who are subject to it are mainly autonomous individuals who may need some practical support. Individualised assessments depend on identifying the particular circumstances of the person being assessed. On occasion this is referred to as a “personalised assessment” (e.g. HM Government, 2007, p 33; Centre for Public Scrutiny, 2009), which seems tautologous; properly speaking it is an assessment for personalised services.

The second main interpretation of personalisation is based on the expression of the preferences of the user, rather than on a process of assessment. The Audit Commission defines personalisation as “the flexibility or responsiveness of a service to accommodate people’s preferences or wants” (Audit Commission, 2006, 15). So, the Department of Health claims:

Personalisation ...will be the cornerstone of public services. This means that every person who receives support, whether provided by statutory services or funded by themselves, will have choice and control over the shape of that support in all care settings. (Department of Health, 2008)

The Scottish Government’s review of the educational curriculum argues:

*Personalisation and choice.* The curriculum should respond to individual needs and support particular aptitudes and talents. It should give each young person increasing opportunities for exercising responsible personal choice as they move through their

school career. (Curriculum Review Group, 2004, p.14)

Assessment by a professional usually implies that the professional, rather than the consumer, will make the decisions. Choice, in principle, is an alternative to assessment. Under market conditions, the person who decides what is appropriate is the consumer, and utility is expressed through the mechanism of choice. This should mean that services are appropriate to the individual. *In control* has argued for self-directed support, which is distinctly different from individually tailored provision managed by professionals (Hatton et al, 2008).

The third model attempts to reconcile these competing claims. There is an obvious tension between emphasising user choice, on the one hand, with a process on the other that is heavily dependent on professional judgment. That is partly because there is an imbalance of power, but also because choice and professional assessment often point to different outcomes - if they did not, there would be little point in assessment otherwise. The resolution can be presented in terms of a model where the task of professionals is to facilitate and inform personal choice.

Personalisation means that people become more involved in how services are designed and they receive support that is most suited to them. ... Personalisation means enabling people and professionals to work together to manage risk and resources. (Changing Lives Service Development Group, 2008)

The Improvement and Development Agency explains that

The words 'choice' and 'personalisation' are often used interchangeably, when focusing on trying to meet an individual service user's needs. But there is an important distinction to be drawn between choice and personalisation, where the exercise of 'choice' depends on the individual or group having adequate information, to make a decision between options. 'Personalisation' usually involves a dialogue between a service provider or adviser and often a single user, which then leads to the selection of a preferred solution. The clearer the information or advice given, the more likely it is that a personalised service will become one in which the user can make real choices. (Improvement and Development Agency, 2006)

### **The over-selling of personalisation**

The expectations of those who advocate personalised responses are high. Leadbeater claims that

Personalisation is ... simple: by putting users at the heart of services, enabling them to become participants in the design and delivery, services will be more effective by mobilising millions of people as co-producers of the public goods they value. Personalisation has the potential to reorganise the way we create public goods and deliver public services. (Leadbeater, 2004, 19)

He goes on to review a range of approaches, moving from responsiveness to users through to full co-production. The implication of a presentation where the specific method doesn't

really matter is that it is the approach in principle, rather than the process, which conveys the benefits. Leadbeater seems to be claiming here that personalisation will offer people a stake in the service; but if he is right about its ability to affect millions of people, it has also to be true that it is offering something that alternative routes to empowerment, such as rights, personal development, collective action, consumerism, normalisation, independent living, participation or voice, have not succeeded in delivering. This is a leap of faith; there is no basis or evidence on which to evaluate the argument.

Government documents are no less sweeping in their claims. Personalisation

enables the individual alone, or in groups, to find the right solutions for them ... Personalisation is about prevention, maintenance or intensive support – whatever is needed. ... Personalisation should lead to services which are person centred (both around individuals and communities), which can change when required, are planned, commissioned and sometimes delivered in a joined up way between organisations. (Changing Lives Service Development Group, 2008, p 1.)

The central proposition in this is the most plausible: that individualisation, and a person-centred approach, should in principle lead to the right solution for the person in question. I will return to that point in due course. There are three other propositions here, however, which do not seem to follow from the idea of personalisation. One is that personalisation is preventive. That might be true if we had a clear model of causation and an understanding of what works, and what does not, at the level of the individual, and personalisation was in a position to deliver services that complied with such a model. I see little reason or evidence to back up either assertion. If personalisation is based in a negotiation between provider and service user, the outcomes of personalisation must in principle be a compromise of several considerations, and there is no obvious reason why prevention should feature more largely in the balance than it does when professionals deliver services.

The second proposition is that personalisation leads to a flexible approach that is capable of subsequent change. It is not clear by what process this can happen. If a person is receiving domiciliary care, the level and pattern of service can be increased or reduced, but that has always been true - there has always been an element of negotiation with the person served. Other choices, like the decision to move into residential care, are choices for the long term; people cannot easily move back and forward between domiciliary care and residential care, and a decision that an frail elderly person might be better placed in another setting would usually excite concerns about disruption. The idea that residential care could provide a flexible response, with adaptable elements of support (National Institute for Social Work, 1988), was never realistic. Because support is organised in relation to accommodation, there is an identifiable pattern of services associated with particular residential units. Some of the difficulties are practical: the delivery of full-time, high-dependency services typically calls for particular patterns of building, staffing and service delivery. There are also good organisational reasons why residential units should offer a specific pattern of services, in terms of administration, competence, and control.

The third claim is that services will be joined up. That may be true, and it may not be, but there is nothing in the process of personalisation that guarantees it. Indeed, one of the

original arguments for the idea of the quasi-market was precisely that the exercise of free individual choice in the market obviated the need for the emphasis on cooperation, joint action and planning that had been seen as central to service delivery in the 1970s. What seems to have happened here is that individualisation and the language of person-centred casework has become the focus for the long-standing hopes and aspirations of social welfare services.

### **Arguments for personalisation**

The first, and strongest, claim that is made for personalisation is that it is effective - that it leads to the right response for each individual. Whatever the aims are for the people involved, selecting responses that are tailored to their circumstances should work better than offering services more generally.

Getting it right for every child provides the framework within which all services will deliver a personalised, effective response to young people. (Scottish Government, 2008, p 15)

Personalisation should in principle make better, more appropriate use of the services available than alternative patterns of service delivery - getting the right services to people. The most obvious difficulty in evaluating the claim is conceptual. Personalisation is not expressed through one pattern of delivery, but many, and some patterns will be just what they were before. There are at least three models implied by the preceding discussion: personalisation as a process of individual assessment, as the exercise of choice, and as a negotiation between the service user and the professional. These models are expressed through a range of methods - for example, holistic assessment, professional advice and facilitated choice, or individual budgets. As they do not always deliver the same outcomes, they cannot be said to “get it right” in equal measure. The ambiguity of “getting it right” makes the claim difficult to evaluate. That is not to say that the outcomes of these methods are not beneficial, or that they deliver the “wrong” service. It does, however, suggest that the very idea of “getting it right” is flexible, and that justifying personalisation as something that maximises individual utility, or that could be uniquely and distinctively effective, is over-stated.

The second claimed advantage for personalisation is that it is cost-effective, achieving results that are at least as good as the alternatives at lower cost. Zarb and Nadash’s early work claimed that direct payments were 30-40% cheaper than service packages (Zarb, Nadash, 1994): “every pound spent through a payments scheme not only goes further than a pound spent on services, but also purchases assistance of a higher quality” (p143). Leadbeater claims “For the most expensive services - such as packages for adults with learning and physical disabilities - the savings can be as high as 45%” (Leadbeater, 2008). Individual budgets, Beresford comments, “were sold on being cheaper” (Beresford, 2008), and there are certainly indications that the desire to make savings has driven the reforms (Samuel, 2011). However, there are growing doubts that the levels of provision are comparable, or that there are savings to be made. As a general principle, Thaler and Sunstein suggest, “the more choices you give people, the more help you need to provide”.(Thaler, Sunstein, 2008, 158). That implies that personalisation should in principle be no cheaper than the alternatives, and may be more expensive.

The third claimed advantage for personalisation is efficiency: that the effect of failing to take into account individual needs is either to devote resources where none should be given, or to fail to give them where they should be. This argument is familiar in the study of social policy - it is the case for selectivity (Spicker, 2008, ch 7). Selectivity is often criticised on ideological grounds (e.g. Townsend 1976), but the most basic objection is that even if it is necessary to have some level of selectivity in practice, it does not work very well. Some of the most notorious cases relate to income testing, which combines the general problems of selectivity with the problem that users cannot easily tell whether or not they are entitled, and beyond that the tortuous task of monitoring unstable, rapid changing circumstances. The process of assessing needs is administratively costly and burdensome. Selective services often misidentify prospective users; they fail to reach the people they are intended for; there are persistent problems in maintaining equity across boundaries. Timing is a critical issue: if selective provision is not delivered in good time, it is failing to meet need, but if it is delivered after the need has ceased to apply, it is a “spillover”, another form of inefficiency. Selectivity works best in a limited number of special cases, where a degree of flexibility and responsiveness are needed at the margins. When it is rolled out across a larger population - as it was, for example, in the operation of Supplementary Benefit (Walker, 1993) - it becomes unworkable unless it sacrifices the very level of individuation that is used to justify it. The same arguments seem to apply, with no less force, to the current trend for personalisation - which makes it baffling that it has not been opposed with the same vigor as selectivity in other fields.

Fourth, there is the view that users manage their affairs better than public services do. Many of the arguments for personalised responses are based in a criticism of the alternatives. *In Control* mounts a blistering attack on the inefficiencies of the current (post-Griffiths) system: misdirected resources, multiple funding streams, inflated needs, stifled innovation and over-management, and calls for “total transformation” (Hatton et al, 2008). Harlock writes:

The current system has long come under criticism for its top-down approach to service planning and provision with little say for service users over the services they receive and how they receive them. Personalisation is proposed as a means to move away from a one-size-fits-all approach towards provision which meets the individual needs and requirements of users. (Harlock, 2009, p 4.)

It is hard to recognize a picture of contemporary social care based on “one size fits all”, but hyperbole aside, the core of the argument is that greater individual responsiveness is almost always better. Without personalisation, the argument goes, services are liable to be monolithic, unresponsive to need, forcing people to fit the mould. If a service is not personal, it must be impersonal; if it is not responsive, it must be unresponsive; if it is not individually tailored, it must be ill-fitting. These are false dichotomies. If a service is not personalised, it may be because it is generalised, collective or universal - like schools or pensions. If it is not responsive, it may be because it is stable, consistent or reliable: even if some services, such as social baths or respite care, should be withdrawn when needs change, continuing to deliver others, like sheltered housing provision or emergency cover, may be appropriate regardless of the level of need. If a service is not individually tailored, it may be because it is better provided for groups, or even that generalised provision of specific services

- like adult education, community centres, advice agencies or meals on wheels - is the foundation on which individual tailoring subsequently relies. None of these points is fundamentally an argument against personalisation; but they do weigh against the presumption that individualised responses are intrinsically superior to all the alternatives. Even if there are circumstances where a personalised, individually sensitive response is best practice, there are other cases where good practice calls for services that are not personalised.

### **Personalisation and markets**

Personalisation has been represented as a new idea (Ferguson, 2007). The term may be relatively new, but the idea is not; arguments for personalised care were an integral part of arguments for a quasi-market in social care in the 1980s and 90s (Hudson, 1992; Le Grand, Bartlett, 1993). The Griffiths report brought those arguments into the mainstream, arguing for services to be developed responsively, with “packages of care” (Griffiths, 1988, p 1), “taking full account of personal preferences (and those of informal carers)” (para 1.3.2), “tailored ... to meet the needs of individuals”(para 6.5). Those terms are recognisably the same as those now being taken as the basis of personalisation.

Griffiths laid the foundations for an approach which, while it would not work to market principles, would be as much like the market as possible. He argued:

care and support can be provided from a variety of sources. There is value in a multiplicity of provision, not least from the consumer’s point of view, because of the widening of choice, flexibility, innovation and competition it should stimulate. The proposals are therefore aimed at stimulating the further development of the ‘mixed economy’ of care. (Griffiths, 1988, para 3.4)

The system which grew out of the Griffiths report was less individualistic, and arguably less market-oriented, than Griffiths proposed. What emerged instead was a system substantially focused on planned local authority purchasing, and a role for providers as agencies sub-contracted by the purchaser. Nevertheless, the quasi-market principles behind the Griffiths reform have become the guiding light for service provision in many related fields. Personalisation has been represented as

“transforming social care to give people greater choice, control and flexibility over the publicly funded support they receive and providing greater advice and assistance to people paying for their own care.” (Manthorpe, Stevens, 2008, 8)

Twenty years after Griffiths, then, the emphasis is still on choice, flexibility and marketisation.

One of the key methods used to maximise choice has been the establishment of individual budgets, giving users the power to act as consumers in a market. Despite spirited assertions from some quarters that this is a new idea (*In Control*, 2011, claims to have pioneered the idea since 2003), individual budgets have been in operation in some fields since the 1970s (e.g. in the Family Fund, later to be the Independent Living Fund). At the time of the Griffiths reforms, the decentralisation of budgets was focused on the social worker, as a “case

manager”; the 1989 White Paper saw a case for “linking case management with delegated responsibility for budgetary management” (Cm 849, 1989, para 3.3.5). The principle of devolved budgets was extensively piloted and tested within that context (Huxley, 1993). The PSSRU at Kent found key practical limitations: that beyond the pilots, the local authorities were not prepared in practice to delegate responsibility for budget allocations to social workers. (Netten, Beecham 1993) Those restrictions persisted through the 1980s and 90s; direct payments, as a means of implementing individual budgets, developed gradually, often relying on creative interpretation of the rules, and becoming available as a matter of policy only after 1997 (Pearson et al, 2005).

Individual budgets are, very visibly, a move in the direction of the market. Market mechanisms are believed to offer, flexibility and choice; they are presumed to offer a highly quality of service. The rationale for the movement, like the Griffiths reform itself, is the ideological belief that markets do things better, and that the relationship which best balances conflicting priorities and preferences is that of producer and consumer. The “Second Fundamental Theorem of Welfare Economics” states (contentiously) that “No matter which Pareto efficient state we specify, it is possible to have a competitive market equilibrium yielding precisely that state, by choosing the initial distribution of resources appropriately.” (Sen, 1993) Individual budgets are a way to achieve that, by choosing a distribution which reflects people’s needs; and they are supposed, like the market, offer choice, flexibility and responsiveness to need.

Competitive market equilibriums do not actually lead to optimal outcomes; as soon as elements of uncertainty are introduced, including imperfect information and risk management, the theory fails to deliver. (Stiglitz, 1994, ch 3). There may be cases in practice where the market does seem to offer what the theorists suppose - for example, in the distribution of basic foods. There are flaws, sure enough, but no-one would seriously prefer government-led distribution on the basis of professional assessment. However, there are many other cases where markets do not work - where imperfect information, locational costs, externalities and disadvantage conspire to limit choice, control and responsiveness. It is possible to imagine that the market will serve in circumstances where people are in stable circumstances over a period of time, requiring regular arrangements: for example, in providing community alarm systems or domestic help. For a market to work, it is not enough to have independent providers; there also has to be competition and multiple purchasers. Realistically, no conceivable payment is going to draw a range of alternative suppliers into competition to provide innovative services for small numbers of people in geographically remote areas. Giving people money to spend only works if there is something to spend it on.

That points to a further problem. Personalisation and individual budgets cannot replicate a market in principle; they can only replicate a part of it. On the supply side, a free market should have not only competition through alternative providers, but free entry to the market, free exit and the removal of locational barriers. On the demand side, there has to be the ability to exercise choice, the option to use resources for alternative actions - if people in a market want to transfer resources from living expenses to holidays, that is up to them - the use of price signals to indicate opportunity costs, and the exercise of choice in terms of what is foregone. The Audit Commission observes that local authorities have no clear criteria to set budgets, that part of the management burden (such as finding carers) is transferred to

users, but that users have no incentive to limit or restrain expenditure (Audit Commission, 2006). The implication of a quasi-market is not that it will deliver services that are nearly as good as a market; it is that it will do something different.

None of this means that Individual Budgets will not deliver some benefits. The same Audit Commission report suggests that

Choice can, if managed properly, provide better matching of limited supply to preferences and needs. It can make small but very important changes, which users greatly value, in how and when services are offered. Choice can give users more control and therefore increase their level of satisfaction with local services. But we also found that choice might not improve the quality of services if the local authority lacks the capacity to implement it effectively. (Audit Commission, 2006, p 6)

Those comments need, however, to be viewed with a critical eye. Of course there is always scope for improvement; that is true of any professional activity. Choice improves the matching of services to needs “if managed properly”. But conventional social work, expert assessment and a range of responses might also improve matching “if managed properly”. Equally, saying that the quality of public services is not improved if services do not have the capacity to deliver tells us very little.

### **Managing scarce resources**

Personalisation depends centrally on the belief that effect of a personalised process is to make it possible to match provision to a person’s needs. Regardless of whether the selection is being made by a professional, or by the service user, or by the two together, developing a response tailored to the needs of the person depends in principle on providers offering a sufficiently varied or adaptable range of options to meet those needs. From this range, it should be possible to adapt services to the needs of the individual. The fundamental problem with that proposition is that it depends on there being a range of possible responses and a set of available choices. There has to be enough excess provision for a choice to be possible. That rarely happens. Choices, whether they are individual or professional, are inevitably made under constraints. The options which are available to be selected for any individual are not, in real life, tailored to the needs of the individual. Necessarily, there is a process of compromise. In the case of housing for people with intellectual disabilities, Wiesel and Fincher comment that scarce supply, competition for resources and limited social networks create considerable limitations: “the problem of mismatches in group-homes are so common now all across the system, that even if new residents coming in were given a choice, they are not likely to find any appropriate option anyway” (Wiesel, Fincher, 2009, p 622). When older people find themselves in hospital and unable to return home, they suffer from a range of limitations - partly because of their physical condition, partly the result of local options and provision, and partly reflecting the concerns of professionals and carers. Both service users and carers tend to feel that crucial decisions have been made by other people (Davies, Nolan, 2003; Arksey, Glendinning, 2007), decisions are made under considerable constraints (see e.g. Allen, Hogg, Peace, 1992; Hardy, Young, Wistow, 1999), and regardless of the existence of formal choices there are frequent mismatches of people’s needs with the provision they receive (see e.g. Tucker et al, 2008; Andrews et al, 2009). Budgets may in principle allow

for more imaginative provision within the constraints, but nothing in the mechanism makes it possible to escape from those constraints altogether.

If the problems are problems of scarcity, lack of resource and lack of choice, it is difficult to see what there is in the process of personalisation that could overcome them. Some of the savings may have tended in the opposite direction. The implementation of “self-directed” budgets has been taken in some cases to imply a reduction of the engagement of trained social workers in the process. (Williams, 2009; Community Care, 2011) This may imply that fewer options are investigated, not more, and that would imply a lower quality of service. The reservations that are beginning to be made currently about personalisation in practice seem to be based in the level of funding that is available, rather than the validity or effectiveness of the method (Dunning, 2011). That seems naive. The purpose of any system of distribution is to manage the allocation of resources, under conditions of scarcity, to best effect. The process of personalisation was intended, at least in part, to save money. The test for personalisation, then, is that it is able to produce better results, in conditions of scarcity, than the alternatives. There is some evidence that personalisation has been associated with reductions in cost (Glasby et al 2010) - but that is not the same thing.

### **Evaluating personalised services**

When the possibility of direct payments was opened up, the Department of Health instructions in 1997 specified:

A local authority should not make direct payments unless they are at least as cost-effective as the services which it would otherwise arrange... Local authorities may, if they choose, make direct payments at a greater cost than the cost of arranging the equivalent service, provided they are satisfied that this is still at least as cost-effective as arranging services. (DoH, 1997; cited Glasby et al, 2010, p. 47)

The practice has been selective - as it should have been. If direct payments were going to be more expensive in any individual case, they should not have happened. So it is not surprising that some studies are now able to point to some cases where direct payments have been cost-effective. The Audit Commission identifies a range of implementation costs in direct payments, including costs of training and regulation, and some transfer of costs to service users. They report that

In the services we examined we found that, properly introduced and under the right conditions, choice can produce higher-quality and more efficient services. When choice is introduced inefficiently, it can add to costs and reduce value for money. (Audit Commission, 2006, p 2)

This is circular. Using money more wisely will always improve services or cost less - that is how we know it is being used more wisely. Apart from there being room for improvement, it tells us very little.

Arksey and Kemp point to some of the difficulties of evaluation: studies do not compare alternative approaches, agencies select clients who are most likely to benefit, most

evaluations are based on perceptions and experience rather than service received, qualitative studies dominate and few studies are longitudinal (Arkesey, Kemp, 2008). To this, I think we can add a common problem with pilot studies, identified by Pawson and Tilley (1997). Pilots are often undertaken by committed professionals who are active innovators. Positive results are liable to be generated not by the character of the programme so much as the energy and enthusiasm that goes into them. As the programme is extended, that energy is not always shared by those who are less committed or less convinced; and so, as a scheme is rolled out, its results become less and less positive. Of course the early studies, like Zarb and Nadash (1994), show that innovative treatment works: that's what early studies do.

All this means that after more than twenty years of mainstream practice, the evidence for the cost-effectiveness of personalisation in these terms is still rather uneven (Samuel, Dunning, 2010). We are liable to be offered uncritical evangelism (Leadbeater, 2004) and case studies of enthusiastic professionals doing a wonderful job (Carr, 2008, Harlock, 2009) - some of them difficult to relate to personalisation at all. The best evidence so far lies in the evaluation of Individual Budgets. The evaluators' summary of the findings reports as follows:

- “• For people with learning disabilities, there is a cost-effectiveness advantage in terms of social care outcomes but only really when we exclude people without support plans in place from the analysis. ... the potential is there to achieve cost-effectiveness, but ... we did not observe this...
- Cost-effectiveness evidence in support of IBs is strongest for mental health service users ...
- For older people, there is no sign of a cost-effectiveness advantage ...
- There appears to be a small cost-effectiveness advantage for IB over standard support arrangements for younger physically disabled people ...” (Glendenning et al, 2008, p 111)

That does not say that personalisation fails. It shows that the benefits are mixed, dependent on the circumstances and contingent on application of the principles in context.

## **Conclusion**

Documents from the Department of Health seem to be based on the proposition that providing individuated responses to personal circumstances is something new - an exciting, innovative approach, in contrast with that introduced after Griffiths:

there is now an urgent need to begin the development of a new adult care system. A personalised system which can meet the challenges described earlier and is on the side of the people needing services and their carers. While acknowledging the Community Care legislation of the 1990s was well intentioned, it has led to a system which can be over complex and too often fails to respond to people's needs and expectations. (HM Government, 2007)

Personalisation is supposed, in theory, to match services better to needs. The theoretical arguments are disputable; the empirical evidence is equivocal. Neither the theory nor the

practice offer adequate justification for developing a programme of personalisation for all of the groups, all of the time.

Nothing in the material I have reviewed suggests that personalisation simply fails; but there is no reason, either, to suppose that it is universally appropriate, as the model of “total transformation” implies. Personalisation falls short, not just in terms of the wildly exaggerated claims that are made for personalisation, but in terms of the theoretical benefits that consumerism is supposed to achieve, the extent to which it delivers tangible benefits, and its delivery of services in practice. If, as the largest evaluation suggests, services for older people and people with learning disabilities are not actually improved by personalisation, and the gains for younger people with physical disabilities are marginal, then most of the people who are supposed to benefit from personalisation gain little or nothing from it. The variation in results revealed in evaluation seems to suggest that the appropriate response would be to review which people might be able to benefit from greater decentralisation of control, under what circumstances. That is a pragmatic test, and it is not susceptible to a general theoretical answer.

## Notes

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