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Dealing with drift: Comparing social care reform in the four nations of the UK

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Abstract

Reform of social care for older and disabled people has become a pressing political issue, given demographic change and shifting public expectations. In the UK, social insurance for long-term care wasn't included in the post-war welfare state and remains unfinished business. Drawing on semi-structured interviews with policy stakeholders and analysis of policy documents, the concept of policy drift is used here to explain the incomplete and variable progress on social care funding reform in England, Scotland, Wales and Northern Ireland. Each nation has jurisdiction over its own care system and each has taken a different path towards introducing a form of risk pooling for social care. Of the factors which are known to create policy drift (e.g., veto players, complexity, agenda overload), Scotland has the least of these and England the most. This is consistent with the reform trajectories in which Scotland has gone furthest on care funding reform, introducing free personal care in 2002, whereas England has lagged behind the others and is only now introducing reform. The article contributes to the drift literature by exposing its comparative element: polities define their progress or justify their delays in reference to their neighbours.

KEYWORDS
devolution, policy drift, policy learning, policy reform, social care

1 | INTRODUCTION

Long-term care for older and disabled people has become a pressing political issue, given demographic change and shifting public expectations (Glasby et al., 2021; Rocco, 2017; Safuta, 2021). In the UK, social insurance for long-term care was narrow and means-tested in the post-war welfare state and there have been repeated efforts to address this. In 1998, the government established a Royal Commission on Long Term Care for the Elderly (the Sutherland Commission) which concluded:

> 'Long-term care is a risk that is best covered by some kind of risk pooling—to rely on income or savings, as most people effectively have to do now, is not efficient or fair due to the nature of the risk and the size of the sums required' (Sutherland, 1999, p. xviii).

Twenty years on most parts of the UK do not yet have risk pooling for long-term care, after a series of attempted reforms have been abandoned or delayed. Despite a succession of commissions, white papers and system reforms, the sense of unfinished business endures. This article considers reform of care funding over 20 years in the four nations of the UK to explain the slow and incomplete process of moving towards risk pooling.

Social care—the term for long-term care in the UK—developed over the twentieth century to address the social and economic risks facing people with long-term care needs (frail older people, working-age disabled people and people experiencing mental distress). However, unlike the National Health Service (NHS), state social care has always been a means-tested service, and for several decades the majority of provision has been by the private or not-for-profit sector (Hudson, 2020). People who meet a needs threshold for care then have their financial assets reviewed and if they fall above the means-test threshold they must pay some or all of their care costs. As a result some people have to pay large amounts for care, whereas others pay nothing—an inequity that does not occur for other welfare goods such as health and education.

A succession of Prime Ministers and party manifestoes have included a commitment to address the long-term funding of social care (Powell & Hall, 2020). Whilst government inaction on social issues is not unusual (McConnell & 't Hart, 2019), a feature here is the frequency with which governments themselves say *something must be done*. Given this context, we use the article to characterise social care funding reform as an example of 'policy drift' (Béland et al., 2016; Hacker, 2004). Located within the broader historical institutionalism literature on continuity and change (Béland & Powell, 2016), policy drift offers an explanation of why reform is delayed or incomplete even when there is widespread agreement that reform is needed and/or there has been a significant change in the 'social risks' that it was originally designed to solve (Béland et al., 2016; Hacker, 2004). In a US-dominated literature, exemplars of policy drift have included delayed pension reform and the slow passage of universal healthcare coverage (Hacker, 2004; Rocco, 2017).

Here we use policy drift to explain the incomplete process of care funding reform in the UK. To do this we disaggregate the four nations of the UK (England, Scotland, Wales and Northern Ireland). Each has jurisdiction over its own care system and has taken different steps towards introducing a form of risk pooling. By focusing on care reform in the four nations, the article makes three contributions. First, it draws on interviews and document analysis to offer a unique comparative account of social care funding reform in the UK's four nations. Second, it uses the policy drift literature to separate out the factors which explain why some of the nations have gone further than others. Third, it advances the policy drift literature by highlighting the extent to which drift is a comparative concept, bringing in from the federalism literature the importance of yardstick comparison (Benz, 2012). Polities define their progress or justify inaction in relation to what comparable neighbours are doing. Whilst our focus is on the UK, we see the findings as having broader relevance, highlighting how nations and provinces look to near neighbours not only for policy learning about policies undertaken but also to justify inaction and delay.

2 | POLICY DRIFT

There is an extensive literature on why and how policy changes, and the factors that encourage stability or volatility. Béland and Powell review this literature, highlighting the need for attention to the dependent variable question: the

'how much, what type and why of change' (2016, p. 129). However, there is much less attention to policy inaction, and to different types of inaction (McConnell & 't Hart, 2019). Policy drift is one type of inaction, in which a formal policy remains the same despite becoming less effective due to 'the rise of new or newly intensified social risks with which existing programs are poorly equipped to grapple' (Hacker, 2004, p. 246). For cases to be classed as drift, it is broadly agreed in the literature that the lack of change must be deliberate (Béland et al., 2016; Gildiner, 2007; Hacker et al., 2015; Shpaizman, 2017). As Hacker puts it, '[drift is] a result not of failures of foresight or perception, but of deliberate efforts by political actors to prevent the recalibration of social programs' (2004, p. 246). Béland et al. further develop the concept of drift by arguing that it requires that potential reform solutions are available but not adopted: 'Drift…is not simply a result of a dearth of policy ideas, but the consequence of a drive to maintain the legislative status quo' (2016, p. 204).

The concept of drift has been applied to a range of welfare fields including pensions, health and long-term care (Béland et al., 2016; Gildiner, 2007; Hacker, 2004; Rocco, 2017). These are areas where 'new social risks' have emerged, particularly through contemporary patterns of work, family and longevity (Bonoli, 2007). Studying policy drift is difficult given that it is a study of inaction (McConnell & 't Hart, 2019). Rocco and Thurston (2014) highlight the need to move 'from metaphors to measures', that is, to identify ways to categorise and explain drift. There are several factors in the policy literature which are known to make policy reform difficult, which Cairney et al. (2016) summarise as ambiguity, overload, silos and complexity. Shpaizman, looking at drift in reform of prescription drug coverage, identifies a similar set of issues inhibiting policy change: 'uncertain policy outcomes', 'feedback effects that make changes politically risky', and 'policy-makers' limited attention span or crowded agenda capacity' (2017, p. 699). Writing about long-term care, Rocco (2017) argues that policies are most likely to drift if: (1) reform is expensive; (2) there is no built-in mechanism to reauthorise the policy (e.g., an inflationary uplift); (3) there are many veto players blocking change; (4) if the political system is polarised.

Given overlaps in these lists of variables, we can synthesise the factors into six categories which increase the likelihood of policy drift:

1. Cost: drift is more likely if reform is expensive.
2. Automaticity: drift is more likely if the original policy does not provide any built-in reauthorisation points.
3. Veto players: drift is more likely with more veto players and veto points.
4. Partisan polarisation: drift is more likely if it is a divisive party political issue.
5. Uncertain outcomes/complexity: drift is more likely if there is not a clear set of policy proposals with predictable outcomes.
6. Agenda capacity: drift is more likely if policy-makers do not prioritise the issue over other demands on their time.

These six factors can be considered when explaining drift in empirical cases. Due to the ambiguous nature of defining policy and whether it has changed, we follow Hacker in focusing on authoritative policy change, that is, a change in legislation or formal guidance. We acknowledge that, even after such a change, drift can continue at the street-level (McConnell & 't Hart, 2019).

3 | RESEARCH DESIGN AND METHODS

To explore care funding in the UK we disaggregate reform in the four nations of the UK. McConnell and 't Hart, in their article on policy inaction note the importance of 'comparative case designs to track differences in the presence/absence, timing and thrust of public policy responses in different jurisdictions' (2019, p. 657). Comparing England, Scotland, Wales and Northern Ireland provides an opportunity to understand how and why the nations have taken different paths on care funding reform. Prior to devolution, all four of the nations had social care systems that derived from the National Assistance Act 1948. Since the UK legislated to devolve powers to Scotland, Wales

and Northern Ireland in 1997–1998, increasing differences have developed between the four in their policy and legislative environments (Gray & Birrell, 2013). There are of course limitations to suggesting that this four-nation comparison provides a 'natural experiment'. England is far larger than the other three nations and has had no devolution settlement, continuing to be governed by the UK government at Westminster. Nonetheless, following Keating et al. we argue that there are enough similarities between the four to allow 'a controlled comparison within a single state' (2009, p. 54), and to provide insights into the conditions which exacerbate or correct drift.

The focus on drift forms part of a wider study by the authors comparing the four care regimes that have emerged in the UK, funded by the Economic and Social Research Council (ES/P009255/1). For this we undertook 65 semi-structured interviews with national policy stakeholders in the four nations from 2019 to 2021. Ethical approval was provided by the University of Birmingham (ERN_18-). Interviews were conducted by telephone by one of the authors, audio recorded and professionally transcribed. We agreed with interviewees that their contributions would be anonymised, and indicated only with a descriptor of the job role (e.g., Welsh civil servant).

Interviewees were purposively selected to cover the key policy stakeholder interests across the care system (politicians, civil servants, local government, care providers, NHS, third sector). We worked with a not-for-profit project partner in each part of the UK to identify policy contacts. We aimed for 20 interviews per nation and recruited 22 people in England, 17 in Wales, 13 in Scotland and 13 in Northern Ireland. The COVID-19 pandemic from March 2021 constrained our ability to obtain our target number of interviews. Nonetheless, we covered almost all of the key stakeholder groups in the four nations (as shown in Table 1) and through supplementing the interviews with document analysis were able to get a wide range of perspectives on care funding reform. Documents were identified through asking interviewees to nominate influential social care policy documents from the last 20 years. From the interviewee recommendations we developed a corpus of 31 documents from across the four nations (see Table A1 in the Appendix), including government consultation documents, commissions and strategies.

Documents and interview transcripts were imported into NVIVO for analysis. We approached the analysis through the lens of critical realism, which rejects a positivistic understanding of causation (Bergene, 2007). The goal of case study comparison for critical realists is to examine the causal relations at play in explaining phenomena (in this case 'drift') in a number of strategically chosen cases, rather than expecting regularities to appear in every possible case. Data was initially coded against criteria for our broader study of care in the four nations. We

TABLE 1 Interviewees

Role	England	Scotland	Wales	Northern Ireland	Total
Elected politician	2	1	2	-	5
Civil servant in care-relevant department (incl. one former civil servant)	2	1	1	2	6
Local government representative	1	1	1	N/A	3
NHS	2	1	2	1	6
Provider representative	2	3	1	1	7
Regulatory/oversight body (including Older People's Commissioner's office in NI and Wales)	1	1	2	1	5
Carers' organisation	2	2	2	2	8
Director of Adult Social Services	2	-	1	1	4
Care commissioner	2	1	1	1	5
Social worker	1	-	1	1	3
Care provider	5	2	3	3	13
Total	22	13	17	13	65

independently read and coded a preliminary set of interviews and documents, highlighting and annotating key passages relating to care policy, institutions and outcomes. We met together to discuss and compare these texts through a consensus coding approach (Gibbert & Ruigrok, 2010), and continued to meet and discuss sample sections as we coded the rest of the data. Through the analysis we found that a recurring pattern in the documents and interviews was the phenomena of delay and reversal in relation to funding reform, despite widespread agreement on the need for action. Once we defined this phenomenon of interest, we undertook a second phase of coding around the six categories of drift identified in the literature (those listed in the previous section).

Below we structure the findings section according to the six categories. We then go on to discuss an additional theme which emerged inductively from the data, relating to drift as a relative phenomenon, linking it to the concept of 'yardstick competition' in the federalism literature (Benz, 2012). We utilise illustrative quotes from interviews and documents below to illuminate key aspects of the findings.

4 | FINDINGS

It is evident that in all four nations social care reform is recognised as a pressing issue. Each new set of policy proposals highlights the failings of the past and the urgency of the challenge. The 2017 *Power to People* report on reforming social care in Northern Ireland states:

> The challenges are great and arguably the solutions have been resisted for some decades. We believe that there is now no choice but to be radical. A mixture of incremental adjustments is no longer sufficient to keep an unsustainable system working (Kelly & Kennedy, 2017, p. 6).

Documents from the other nations refer to the same sense that reform is urgent. In Wales, the *Sustainable Social Services* white paper (Welsh Assembly Government, 2011) calls for a shift from retrenchment to renewal in order to meet rising demand. Scotland's *Changing Lives* report notes: 'Increasing demand, greater complexity and rising expectations mean that the current situation is not sustainable' (Scottish Executive, 2006, p. 8). In England, the 2010 white paper on *Building the National Care Service*, states: 'The current care and support system is no longer sufficient. It cannot meet our needs, nor match our aspirations. If left unchanged, it would not cope with the extra demand in years to come' (HM Government, 2010, p. 2).

To address drift, and move social care funding to a more sustainable footing, documents from all four nations highlight the need to realign the responsibilities between individual and state. Two main options for funding reform are set out in the documents. The first is to bring social care into alignment with how the NHS is funded. A version of this option was the majority recommendation of the Sutherland Report (1999), proposing 'free personal care', covering help with tasks of daily living such as washing and meals. The second option, proposed by the 2011 Dilnot Commission was to continue with private payments for care (for those with assets above the means-test threshold), but to cap the individual contribution (Dilnot, 2011).

Both of these versions of funding reform have had some success with policy-makers. The Sutherland proposal was adopted in Scotland for over 65s in 2002. People who pass a needs assessment are entitled to free personal care (although this is narrowly defined and councils can still charge people for other parts of care including food, transport and equipment) (Bell, 2018). Accommodation costs in care homes remain subject to a means test (set at £28,750 in 2021–2022). Free personal care was extended to working-age disabled people in 2019. These funding reforms sit alongside a broader set of care reforms in Scotland which include a legislative commitment to self-directed support in 2013 and the structural integration of health and social care from 2014 (Pearson et al., 2018). Although this has been an active reform phase for social care within Scotland, Pearson et al. (2018) question whether the attention to structural integration of health and care since 2014 has displaced attention on other reforms (see also Pearson & Watson, 2018).

The Sutherland proposal was rejected by the rest of the UK as unaffordable (Brindle, 2009). The UK government waited a further decade and then in 2010 set up the Dilnot Commission to look into long-term care funding in England. The Commission's proposal of a cap on private care spending, described as 'social insurance with an excess' (Sturrock & Tallack, 2022), was passed into law in the Care Act 2014. However the cap was never implemented, being first delayed and then abandoned due to concerns about the costs it would impose on local government (Glasby et al., 2021). It took until autumn 2021 for the government to announce that it would phase in a version of the cap from 2023, with a plan that no one will need to pay more than £86,000 for personal care. The means-test threshold will also be lifted from £23,250, so that a tapered state contribution comes in when assets fall below £100,000 (DHSC, 2021a).

Wales had been planning to follow England down the route of a care cap around the time of the Care Act 2014, however those plans were put on hold once England failed to implement the cap (Boyce, 2017). In place of that wide-ranging reform, Wales introduced a maximum weekly charge for home care (currently £100). The means-test threshold for free care in Wales was set at £50,000 for residential settings. These changes were designed to be short-term fixes ahead of a longer-term settlement. The Welsh Government has commissioned modelling of hypothecated taxes including for social care although there have been no specific proposals as yet (LE Wales, 2020).

Progress on funding reform in Northern Ireland, has been hampered by the broader lack of governmental activity following repeated suspensions of the executive in the period since 1998 (including suspensions for long periods such as 2002–2007 and 2017–2020). Northern Ireland also has the added complexity of structural integration of health and social care which is further advanced than in other parts of the UK. Mainly due to this integration with health (which is not means-tested) there is currently no charge for home care, although there is a means-test for residential care which is set at £23,250. Somewhat ironically given moves to widen risk pooling elsewhere in the UK, Northern Ireland's *Power to People* (2017) report proposed a move *away from* free home care for those with assets above the means-test threshold: 'By giving free domiciliary [i.e., home] care to people who could afford to contribute simply means you have less available for those who can't or to invest in new services' (Kelly & Kennedy, 2017, p. 65). The suspension of the Executive from 2017–2020 meant no progress on implementing these proposals, although in 2022 the newly-installed Executive launched a consultation on *Power to People* (Department of Health, 2022).

Overall, Scotland has gone furthest on risk-pooling, introducing free personal care, initially for over 65s and now for all adults with a disability. This covers support for a range of functional care tasks, although people are still asked to contribute to other things, such as use of day services and respite provision. The Feeley report into reform of Scotland's care services was critical of the impact that charging was having on people with assessed care needs and recommended that all charges for home care should be removed (Feeley, 2021). Wales has made some changes, raising the means-test threshold and introducing a maximum weekly charge for home-based services but abandoning plans for an overall spending cap. England proposed a care cap and a more generous means-test than elsewhere in the UK in its 2014 Care Act, but the reforms were not implemented and are only now being revived. Northern Ireland has made no progress on care funding reform as yet, although currently offers free home care as part of the unified health and care service. We summarise the current arrangements in Table 2.

Twenty five years after the Sutherland Report recommended risk-pooling for social care across the whole UK, we can see that the timing and extent of progress towards this in the four nations varies. The factors distilled from the literature as explaining drift were: cost; automaticity; veto players; partisan polarisation; uncertain outcomes/complexity; agenda overload. We coded our data against these variables and found the following:

4.1 | Cost of updating policy

In England, interviewees frequently discussed the perceived affordability problem of social care funding reform. They related the abandonment of the Care Act 2014's funding cap to the wider crisis in public spending since 2010 and to the vulnerability of local government expenditure:

TABLE 2 Summary of adult social care funding arrangements in the four nations (as of July 2022)

	England	Scotland	Wales	Northern Ireland
Home care	Means tested. No state support if assets are above £23,250 (not including value of the home)	Personal care is provided free. Other aspects (e.g., meals, assistance aids) are means-tested (threshold is £29,750)	Means tested and subject to a maximum weekly charge of £100 if assets are above £24,000 (not including value of the home)	Personal care is provided free. Other aspects may be means-tested for the under 75 s (threshold is £23,250)
Residential care	Means tested. No state support if assets are above £23,250 (including value of the home)	Personal care is provided free. Food and accommodation costs are means tested (threshold is £29,750)	Means tested. No state support if assets are above £50,000 (including value of the home)	Means tested. No state support if assets are above £23,250 (including value of the home)

> *The reality is, trying to institute the biggest change to the legal framework in this sector in 70 years, at the time it was facing the biggest squeeze in funding in pretty much the same period, meant that a lot of the intention of the Care Act hasn't universally come to fruition yet.* (*England, former civil servant*).

Cuts to social care spending have been much larger in England than elsewhere (Atkins et al., 2021). Interviewees in Scotland and Wales noted that they had not been affected as badly by austerity:

> *Social care cutbacks have even more ferocious in England than they have been here in Wales.* (*Wales, Assembly member*).

> *Local government in Scotland has not sustained anywhere near the scale of cuts that some councils have had to deal with in England.* (*Scotland, Third sector provider representative*).

Interviewees also noted that England has a much bigger population and many more self-funders than any other jurisdiction meaning that the rebalance from private to public funding here would be much more expensive than elsewhere—with estimates around £7–10 billion (BBC, 2021). Although the bill for putting social care onto a sustainable footing in the other nations is still substantial—at around £0.66 billion in Scotland (Audit Scotland, 2021)—the issue of affordability was raised much more by English interviewees than by interviewees in the smaller nations.

4.2 | Automaticity

This criteria refers to the extent to which policies include automatic renewal mechanisms such as inflationary uplifts which limit drift. There is no automatic process for reforming care funding in any of the four countries. Where change has happened—for example, the increase in the means-test threshold in Wales—it has required new primary or secondary legislation. However, there is a form of automaticity in Northern Ireland since its social care spending is incorporated into the much more generous and regularly updated NHS budget. This has helped to keep care spending in Northern Ireland higher than elsewhere in the UK (Atkins et al., 2021). However this automaticity only applies to spending uplifts. Proposals to change the balance between public and private funding—as set out in *Power to People*—remain unachieved.

4.3 | Partisan polarisation

English interviewees discussed the political polarisation in the UK Parliament and the responses to social care funding reform proposals by both major political parties. Social care has been seen as a damaging election issue in two Westminster elections: the so-called 'Death Tax' campaign at the 2010 election (against Labour proposals to fund social care through inheritance tax) and the 2017 'dementia tax' campaign (against Conservative proposals which were seen as unfair to people with long-term conditions such as dementia) (Powell & Hall, 2020). The issue is not so much that the parties have different visions for social care, rather that they prefer the short-term political gains of critiquing their opponent's plans over the longer-term gains of a consensual cross-party approach to care reform. As one interviewee put it:

> *What tends to happen here in England is the [opposition] party thinks the other party's just being stupid and they obviously have the answer to this, and they'll solve it, and then they get into government and go, "Oh, god, it's really quite hard, isn't it?"* (*England, former civil servant*).

In Northern Ireland party polarisation (between the unionists (orange) and the republicans (green)) was given as one of the explanations for lack of attention to social care reform:

> *I mean even after the experience of a decade or two of devolution, the green and orange question still dominates the majority of their policy capacity* (*NI, Civil servant*).

In contrast, in Wales and Scotland, party polarisation was not felt to be a barrier to reform. In Wales, interviewees pointed out the absence of polarisation and the lack of opposition faced by the Labour administration, and indeed decried the fact that Labour have not taken the advantage to press on with more extensive reform:

> *It's a shame Labour haven't capitalised on the fact they've had so much influence. They could have been so much more radical, they didn't really have an opposition.* (*Wales, Third sector provider representative*).

In Scotland, discussions about reform were felt to be more inclusive and co-productive, without any clear partisan splits on the care agenda:

> *The reform programme…it's been a lot about the co-production approach, been a lot of discussion around about… it's trying to gain consensus on what the challenges are in Scotland.* (*Scotland, Local government representative*).

Partisan polarisation then was reported as more of an issue in Northern Ireland and England than in the other jurisdictions.

4.4 | Veto players

English interviewees saw the internal dynamics of the Westminster government as contributing to drift on funding reform, in particular the strong veto of the Treasury (the finance ministry). The role of the Treasury as a blocking force within Whitehall has been highlighted in other work on reform delays (Richardson, 2018). The 'silo working' of different departments was also seen as to blame for the sense of drift. This seems to have contributed to the abandonment of the Care Act cap after 2014. As one interviewee put it:

> *The Department of Health was happily engaging with the sector and building on many years' worth of development through the Law Commission work to come up with a long-term statutory framework. But the reality was the Treasury conversation about money was quite far detached from that.* (*England, former civil servant*).

A current civil servant at DHSC similarly reported a sense that the Treasury were keen to minimise the scope of care reform:

> *Basically what [the Treasury] do is they say, is there a legal requirement to provide this? Are we going to get sued if we don't provide this?* (*England, civil servant*).

Financial veto players were not raised in the Scottish interviews. This may be due to the Scottish Government's directorate structure, which is not as firmly siloed as departments at Westminster, such that the finance team are not seen as veto players in the same way (Ferguson, 2019).

Scottish interviewees from outside government reported a collaborative and inclusive culture in Scottish policy making rather perceiving a series of veto points:

> *The ministers, they hear us. We have no problem telling them what we think about stuff. And usually they have no problem hearing it. It's kind of quite a collegiate atmosphere.* (*Scotland, Third sector provider representative*).

In the Welsh interviewees there was little mention of internal or external blockers to reform. As in Scotland, Welsh interviewees were keen to emphasise the open and consensual nature of discussion:

> *I think Welsh government has always very much been on that kind of open access, making sure we bring in a broad house of different organisations, voices, listening to them.* (*Wales, civil servant*).

In Northern Ireland, the veto players were not specific to social care but rather to the difficult experiences of power-sharing and the failure to sustain a governing coalition between the opposing blocs: '*It really is amazing that parts of the UK can go a thousand days plus without government*' (*NI, civil servant*).

4.5 | Uncertain outcomes

Part of the reason for drift has been the difficulty of clarifying which reforms to implement given the complexity of the social care market and the risks of destabilising an already fragmented sector. The care spending cap, for example, risks undermining the self-funder subsidy which many care providers see as keeping them afloat (County Councils Network, 2022). The title of a think tank report—'15 options for funding social care' (Oung et al., 2019)—highlights the vast range of options available. One interviewee reflected:

> *I think social care, for about the last 40 years has been put in a box that's, "Too complicated, too expensive, too difficult. Let's just muddle through, let's just play around with the capital that you're allowed to keep before we start charging you for stuff."* (*Wales, Assembly member*).

The proliferation of policy documentation on care funding reform over the last 20 years indicates that the need to do *something* is clearly understood. The range of options under consideration is consistent with the requirement in the policy drift literature that reform proposals be available (Béland et al., 2016, p. 204). However the challenges of agreeing on what to do in a complex sector continues to be an issue.

This complexity was felt to be particularly an issue in England, given the much larger population:

> *If you look at what they can do in Scotland and Wales…then you see the difference of how much easier it is to reconfigure the system in those particular areas, because of the scale of them. When you start talking about it in relation to the scale in England, it is much more difficult.* (*England, Private sector provider representative*).

A Scottish interviewee made the same point: '*I think there is a sense in Scotland that because there's five million rather than 55 million [people], we can afford to be a bit more agile*' (*Scotland, NHS*).

4.6 | Agenda capacity

In all four nations, agenda capacity for social care requires the prioritisation of care over other issues. Pressures on agenda capacity were reported as an issue in England, Northern Ireland and Wales, for different reasons. In England, the high turnover of staff and ministers at the Department of Health and Social Care (DHSC) in the last decade was seen as limiting the capacity for sustained attention to the issues. In relation to the abandonment of the 2014 care cap, an English interviewee noted:

> *A lot of people left the DHSC…So, I think there was quite a lot of turnover in the people who were helping shape delivery who hadn't necessarily had the benefit of understanding how the model had evolved and what it was trying to achieve, and therefore who didn't always approach implementation in a way that was helpful for the model.* (*England, former civil servant*).

Political attention on the Brexit negotiations has been hugely important in pushing other issues off the policy agenda at Westminster—with ramifications for Northern Ireland due to the border implications with the Republic of Ireland. One of our interviewees noted the ways in which party politics in Northern Ireland had been affected by the political turbulence at Westminster over Brexit, and the role of the DUP (Democratic Unionist Party) in supporting a Conservative minority government from 2017 to 2019:

> *The reality is that because Westminster has been obsessed with Brexit and also because of the complications of the DUP's role in supporting a minority government, we've not [had new social care legislation].* (*NI, civil servant*).

In Wales, it was the attention given to institution building over the period which was seen as a limiting factor in agenda capacity for care reform. Welsh devolution in 1998 was less extensive than Scottish devolution, and much of the last 20 years has been spent in expanding the devolution settlement to bring it closer to the Scottish model.

> *One of the things I would say…the institutional capability that we have to deliver policy…isn't enough.* (*Wales, Third sector provider representative*).

The relative recency of Wales' legislative and tax raising powers was a particular feature:

> *We're still in the very early phases of utilising our tax raising powers because there's only about three new taxes.* (*Wales, Assembly Member*).

> *I think that we've really suffered from the fact that there's that inexperience, in terms of legislation and policy making.* (*Wales, Carers organisation*).

Whilst some of these issues have been demanding attention, it is important to emphasise that deprioritising social care over other issues is also a choice. Scotland—which has had its own constitutional preoccupations (particularly over independence) (Gallagher, 2019) and has also experienced the system shock of Brexit—has nonetheless been an active legislator on social care (Pearson et al., 2018). What is paradoxical about the Scottish case is that its *overactivity* on care legislation may have contributed to a form of drift at the frontline, although our data did not look at implementation (Pearson et al., 2018; see also Needham & Hall, forthcoming).

In summary therefore we found all of the six drift factors evident in some of the nations. In Table 3 we map the extent of formal policy change onto these variables in the four cases. The Table shows that England has the highest number of drift factors and Scotland had the least, which fits with the earlier finding that Scotland introduced the earliest and most extensive funding reform in the UK and England is only now introducing reform, 20 years on. Under first the Labour Party and then the SNP, Scotland has developed an activist legislative agenda (Housden, 2014). Cairney et al. (2016) argue that a small executive in Scotland has led to reliance on external policy expertise, with strong professional and personal networks between interest groups and public bodies, minimising veto players.

Wales has had some of these favourable conditions, but devolution has been a more gradual process than in Scotland and much of the policy capacity in Wales since 1998 has been spent on constitutional reform (Drakeford, 2005; Harvey, 2020). Primary legislative and tax raising powers remain relatively new. In Northern Ireland, the periodic and lengthy suspensions of the Executive have been a serious barrier to reform, although the integration with health has provided a degree of automaticity to increase care spending. In England, the prevalence of veto players, the bitter partisan polarisation on reform proposals, the distraction of Brexit and the ongoing effects of austerity have meant that care funding reform has taken much longer.

A factor which emerged from our data but was not in the drift literature, was the extent to which the four nations explained advancement or delay on care funding reform in relation to what the other nations were doing. There was an asymmetry to this, with England being positioned as the 'first mover', whilst not itself looking to learn from the other nations. In Wales and Northern Ireland, policy drift in England has been a drag on reform. As our interviewee from Welsh local government put it:

> *The conversation keeps coming back to: well, shall we see what England's doing? And until we resolve that bit of it, I think that's the big stumbling block.* (*Wales, Local government representative*).

Similarly, one of our Northern Irish interviewees suggested that a lack of progress on the mainland had contributed to delays in addressing care funding:

> *We do this thing here in Northern Ireland – and we don't just do it on care, we do it with a lot of things – wait and see what happens over there.* (*NI, Regulatory/oversight body*).

TABLE 3 Factors explaining policy drift on care funding reform in the four nations

	Least drift		Most drift	
Presence of drift factors	**Scotland**	**Wales**	**Northern Ireland**	**England**
Cuts in spending				×
Lack of automaticity	×	×		×
Internal and/or external veto players			×	×
Partisan polarisation			×	×
Uncertain outcomes/complexity	×	×	×	×
Lack of policy capacity	×	×	×	×

The English interviewees did not make reference to the rest of the UK. When asked about the other nations, comparisons were felt to be unhelpful due to the differential scales:

> *Certainly, the other three nations, if I was to go English snobbery, are in effect large local authorities in comparison to England, aren't they? Rather than England's scale with its multiple different regional markets.* (*England, former civil servant*).

In Scotland, interviewees were keen to demonstrate or even exaggerate separateness:

> *I think Scotland likes to think they do things differently. I think there's a kind of, bit of self-mythologising about it, if you like…I am moaning about all the policy deficiencies in Scotland, but thank god I do not work in England and Wales, it would have driven me mad by now* (*Scotland, Third sector representative*).

It was felt by so that Scotland was taking over as 'first mover', shaping developments in the rest of the UK rather than vice versa:

> *I think a lot of nations are looking to learn from Scotland. We have a lot of approaches from the other nations to look to learn and see what we've done in different areas. As I said, recently a delegation from the Welsh Government came up…One of the areas that they wanted to discuss with us was around free personal care and the pros and cons around that.* (*Scotland, Local government representative*).

These patterns highlight the performative and comparative elements of policy drift: just as in policy transfer more broadly, there is a tendency for patterns to develop in which nations position themselves as the lenders and borrowers (Dolowitz & Marsh, 2000). Of the people we spoke to, Wales and Northern Ireland interviewees talked of being held back by delays in England; Scottish interviewees were keen to claim to be setting an agenda for other nations to follow; English interviewees were not interested in the other UK nations.

5 | DISCUSSION AND CONCLUSION

In the article we have drawn attention to the variable and incomplete process of reforming care funding in the four nations of the UK. The article makes three contributions to the social policy literature. First, we draw on interviews and document analysis to offer an account of social care reform in the four nations of the UK, which has been neglected as an area of comparative analysis. We highlight how the balance between individual and state liability for care costs now differs across the four nations. Scotland has risk pooling for personal care, although narrowly defined to exclude many of the categories often associated with care. Wales has limited the liability for home care through a maximum weekly charge and increased the means-test threshold for residential care so that more people are eligible for public funding. England has repeatedly delayed reform, although is now planning to phase in a care cap (passed into legislation in 2014 and again in 2022) which will limit private liability for care expenditure. Northern Ireland has state-funded home care through its integration into the health system since the 1970s, but across the period since devolution in 1998 has failed to achieve other proposed reforms.

Second, we bring in the policy drift literature to explain why care reform has been slow and variable. Béland et al. (2016, p. 215) describe policy drift as 'a major theoretical innovation in the field of policy research and particularly for the analysis of social policy stability and change'. Here we have used the concept of drift to explain and compare the progress on care funding reform in the four nations of the UK. From this we can see that England has the highest number of 'drift factors'. The UK (and therefore England) has a majoritarian system which maximises veto players and party polarisation whereas the new institutions in Wales, Scotland and Northern Ireland were

designed to encourage power sharing or coalition governments. Progress on care funding reform has been most extensive in Scotland, with the fewest drift factors, whereas Wales and Northern Ireland have struggled with agenda capacity in particular. In Northern Ireland the ongoing political instability of the regime has meant that power sharing has not operated as planned. In Wales, the limited devolution settlement in 1998 has ensured that much of the last 20 years has been spent on building and expanding Wales' institutional separateness from England, putting Wales behind Scotland in terms of experience in legislative matters.

Third, we develop the concept of drift as a relative and performative concept. The three smaller nations in our study looked to each other to emphasise their progress or justify their inaction. The interviewees in Scotland were keen to position their nation as an innovator, acting as a first mover and inspiring change in the other nations. Interviewees from Northern Ireland and Wales explained their relative lack of progress on care funding reform by reference to the repeated delays in England. We see this as a contribution to the literature on policy transfer, particularly given that it fits the pattern that (within the UK) the smaller nations tend to be more receptive than England to policy learning (Asare & Studlar, 2009; Keating et al., 2012). However policy transfer tends to be about actions taken rather than *inaction* (Brown & Stark, 2022) and to assume a fairly stable pattern of lenders and borrows (Dolowitz & Marsh, 2000). A be explanation for our findings can be found in the 'yardstick competition' concept from the federalism literature (Benz, 2012; Benz & Fürst, 2002; Revelli, 2006). In this literature, provinces compare their performance with other provinces (which may be through formal league table type approaches or informal benchmarking) and seek to improve their performance relative to others. Here, some jockeying for position and discursive claims to be the policy hegemon is part of a dynamic rather than static process of policy learning (Benz, 2012). However, again this literature tends to focus on action rather than the use of yardsticks to justify inaction. By suggesting that yardstick comparison has a role to play in relation to policy drift, our findings begin a new line of inquiry into when inaction by others is either a stimulus to change (as in Scotland in our case) or a justification for delay (as in Wales and Northern Ireland).

Our findings are located within the UK, with its distinctive variant of asymmetrical devolution (Keating et al., 2012). Future research could helpfully consider whether the elements of comparative drift are evident in more conventional federal systems. We recognise that our own research is limited by a relatively small interview sample and that most of our data was collected before or in the early waves of the COVID-19 pandemic which has had a transformative impact on health and care systems (Daly, 2020). However, whilst there has been an impetus for *Build Back Better* (the title of the UK government policy paper which announced the revival of the care cap (DHSC, 2021b)), the pandemic has also exacerbated drift factors such as fiscal pressure and agenda overload. The issues we find relating to drift and its causes are likely to remain just as pertinent as care systems recover from COVID-19 (Swinford, 2021).

The article has focused on the incomplete progress of reforming social care funding in the four nations of the UK since the devolution settlements in 1998, despite the overwhelming agreement of all key actors that change is needed. The degrees of drift differ between parts of the UK, with Scotland having made the most progress towards risk pooling for social care. At the time of writing, Scotland is currently looking to introduce further reform through a National Care Service, but with a lack of clarity on how it would be funded in the long-term (Feeley, 2021); Wales is considering various funding options as part of its own National Care Service (Welsh Government, 2021); England has plan a care cap and additional funding for health and care, although most of this will be assigned to health, reinforcing the domination of the health sector (Oung, 2021). Northern Ireland is consulting on the *Power to People* proposals, including charging for home care (Department of Health, 2022). Given two decades of attempts to reform care funding, it would be optimistic to expect that these proposals mark the end of policy drift, or the realisation of a funding settlement that protects older and disabled people from the high costs of care.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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APPENDIX

TABLE A1 Social care policy documents from the four nations, 1999–2022

Title	Year	Country	Status
With Respect to Old Age—Report of the Royal Commission on Long-Term Care (Sutherland Report)	1999	UK	Royal Commission
Securing Good Care for Older People (Wanless report)	2006	England	King's Fund (think tank)
Putting People First: a shared vision and commitment to the transformation of adult social care	2007	England	Concordat
Shaping the future of care together	2009	England	Green paper
Building the National Care Service	2010	England	White paper
A Vision for Adult Social Care: Capable Communities and Active Citizens	2010	England	'Vision' document
Fairer Care Funding: the Report of the Commission on Funding of Care and Support (Dilnot report)	2011	England	Commission
Caring for our Future: reforming care and support	2012	England	White paper
A New Settlement for Health and Social Care (Barker report)	2014	England	King's Fund (think tank)
Integration and Innovation: working together to improve health and social care for all	2021	England	White paper
People at the Heart of Care: Adult Social Care Reform white paper	2021	England	White paper
Fair Care for Older People	2001	Scotland	Proposals to inform legislation
Care 21 – The Future of Unpaid Care in Scotland	2006	Scotland	Report commissioned by Scottish Executive
Changing Lives: Report of the 21st Century Social Work review	2006	Scotland	Government commissioned report
Caring Together: the Carers' Strategy for Scotland 2010–2015	2010	Scotland	Government strategy document
Reshaping care for older people: a programme for change 2011–2021	2010	Scotland	Government strategy document
Self-Directed Support: A National Strategy for Scotland	2010	Scotland	Government strategy document
Integration of Adult Health and Social Care in Scotland: consultation on proposals	2012	Scotland	Government consultation paper
Adult Social Care Reform for Scotland: a discussion paper	2018	Scotland	Government discussion paper
Independent Review of Adult Social Care in Scotland (Feeley report)	2021	Scotland	Government commissioned review
A National Care Service for Scotland—Consultation	2021	Scotland	Government consultation document
Review of Health and Social Care in Wales	2003	Wales	Government commissioned review
Beyond Boundaries: Citizen Centred Local Services for Wales (Beecham review)	2006	Wales	Government commissioned review

TABLE A1 (Continued)

Title	Year	Country	Status
From Vision to Action: the report of the Independent Commission on Social Services in Wales	2010	Wales	Government-sponsored commission
Sustainable Social Services for Wales: A Framework for Action	2011	Wales	White paper
Connected Communities	2020	Wales	Government strategy
Rebalancing Care and Support	2021	Wales	White paper
Transforming your care: a review of Health and Social Care in Northern Ireland	2011	Northern Ireland	Government review
Prepared to Care? Modernising Adult Social Care in Northern Ireland	2015	Northern Ireland	Report, N.I. Commissioner for Older People
A Managed Change: An Agenda for Creating a Sustainable Basis for Domiciliary Care in N Ireland	2015	Northern Ireland	Health and Social Care Board report
Systems not Structures: Changing Health and Social Care (Bengoa Report)	2016	Northern Ireland	Government commissioned report
Power to People: proposals to reboot adult social care and support in N.I.	2017	Northern Ireland	Government Commissioned Report