Evidence-based policy or policy-based evidence?

When challenged (at the consultation meeting at the Ermine Road day centre on 6 January) on the lack of evidence supporting Haringey's plans to rationalise its adult social care services, interim head of social care Beverley Tarka invoked the authority of Gerald Pilkington, from whom Haringey council officials appear to have received the gospel of 'homecare reablement'.

Gerald Pilkington is an accountant and management consultant who led the Department of Health's Care Service Efficiency Delivery (CSED) programme up to 2011. This programme promoted homecare reablement as a means of meeting 'efficiency targets' in the public sector set by the businessman and Conservative Party advisor, Sir Peter Gershon in his report, *Releasing Resources to the Front Line*. (Gershon 2004, DH 2007a, 2007b) According to his website, as well as preaching the virtues of reablement around the country and the world, Pilkington is 'supporting 152 English local authorities to achieve their efficiency targets within adult social care'. (Pilkington, G) He modestly declares that 'working with services and academic research teams he has built the most comprehensive body of evidence on homecare reablement within the UK, having written much of the work himself.'

Pilkington describes a method which is the antithesis of 'evidence-based policy' – his approach is more accurately characterised as the pursuit of 'policy-based evidence': *first* decide the policy, *then* find the evidence to support it. He refers to a body of evidence that has been 'written' and 'built' largely by himself, in the sense that evidence is 'produced' by a witness in a court of law, and presented by an advocate who tries to make the most persuasive case on behalf of a client. 'Evidence' of this sort is selected to advance an established conviction, in a way similar to that of a propagandist who presents selected facts in the pursuit of a political argument or polemic. By contrast, scientific evidence is the outcome of a process of disinterested inquiry or experimentation. It begins from a 'null hypothesis' – the default position that there is no relationship between two phenomena (say, a policy intervention and a particular outcome). If the investigation shows this hypothesis to be false, then it is possible to claim a positive result – evidence which may legitimately inform the development of policy.

In the various versions of the major study which Pilkington presents as 'evidence' supporting his policy, he and his colleagues declare that its 'overall aim' is 'to provide robust research evidence on the immediate and longer-term benefits of homecare reablement'. (DH 2009a, DH 2009b) In other words, the study began from the presumption that homecare reablement is beneficial and sought to produce 'robust research evidence' in support of this presumption. It can be safely assumed that evidence which might cast doubt on the presumption of benefit was not likely to receive much attention. Indeed even evidence which was not considered 'robust' in its support for the dogma of reablement is likely to have been neglected.

Two early 'interim reports' of the Pilkington study can be found on the CSED website (DH 2009a, 2009b); a final version was published in the form of a 'working paper' by the Social Policy Research Unit at the University of York in November 2010. (Glendinning 2010) This

‘prospective longitudinal study’ presents detailed evaluations of reablement programmes in five English local authorities over a 12 month period. Given the uncritical way in which this study is now being used to promote the policy of reablement as means of rationalising services in many local authorities (including Haringey) it is worth drawing attention to some of the reservations and caveats expressed by the authors themselves, particularly in the final version.

The authors acknowledge that the study was funded by the Department of Health, which is greatly concerned about problems of hospital discharge and readmission, because of inadequacies in social care services – and is committed to the policy of homecare reablement as a means of tackling these problems. The close institutional and financial relationship between the Department of Health and the team engaged in this project raises serious questions about the independence of this sort of academic research. The authors also acknowledge that the study has not been submitted to independent review and has not been published in a peer-reviewed journal, the usual standard for academic research. The study was not randomised, there were issues of selection bias and of attrition of subjects as many patients dropped out of follow-up.

Despite claims that this study demonstrates the cost-effectiveness of reablement, the authors themselves are notably circumspect. Though they noted short term gains, they conceded that the ‘reduction in care costs was entirely offset by the initial cost of the reablement intervention’. Matters were further complicated if longer-term health costs were also taken into consideration:

‘Taking total health, social care and reablement costs together, there was no statistical difference in costs of all services used by the reablement group and the comparison group over the 12 month study period’. (Glendinning 2010:vii)

The key question for Haringey concerns the extension of the reablement model from patients suffering from limited physical disabilities to a wider population of adults eligible for social care services, including those with learning disabilities and other complex needs. Reablement programmes in two of the five local authorities in this study explicitly excluded people with learning disabilities; the rest admitted to restricting services informally to those considered capable of ‘achieving small improvements’ (which may well have excluded people with severe learning disabilities). None even mentioned autism (which generally accounts for 40-50% of the population of adults with learning disabilities). In their concluding comments, the authors noted ‘political pressures’ from some councils to move from a service targeted on selected patients (following hospital discharge, acute illness, fall or fracture) to provide a universal, inclusive service for anybody referred for adult social care services. But staff expressed reservations about the benefits of the programme for people with dementia, mental health or more complex problems:

‘People with chronic, complex or progressive health problems affecting their ability to carry out self-care and domestic tasks were considered far less likely to show major benefits from reablement interventions.’ (Glendinning, C *et al* 2010: 134)

On the last page of their report the authors recommend that ‘a return to more targeted services may be appropriate’ – exactly the opposite of the policy now being pursued in Haringey. (Glendinning 2010: 134)

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