

FORUM ARTICLE

Asset-based approaches, older people and social care: an analysis and critique

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ABSTRACT

Asset-based thinking is increasingly prevalent in health policy and is to be found also in discourses on social care. This article explores and critiques the applicability of asset-based approaches to social care for older people, using Carol Bacchi's analytical framework to consider developments in the UK especially. The problem construction, assumptions and suggested solutions underpinning an asset-based approach are considered in turn. The paper draws two major conclusions. The first is that, while it has potential application to the field, the key assumptions and objectives of the asset-based approach do not hold well for social care and therefore adopting the approach carries risks. The paper concludes, secondly, that an asset-based approach is 'over-promised' in the sense of being insufficiently theorised and lacking empirical evidence. A number of suggestions are made for greater critical interrogation, improved empirical evidence and closer scrutiny of the policy 'solutions' associated with assets-related thinking.

KEY WORDS - asset-based approaches to health; social care; older people, social policy, gender and social care.

Introduction

There is a growing trend towards an asset-based approach in health policy, in the UK and elsewhere. The approach focuses attention on maximising personal and social network resources for the purpose of promoting health and well-being (Foot and Hopkins 2010). Asset-based thinking is making inroads into the policy environment on social care also, especially in a context of a virtual transformation of UK social care, with growing numbers of older people having to fund their own care and cutbacks in the public system of social care leading to mounting unmet need (Vlachantoni *et al.* 2015). The King's Fund (a major UK social and health care policy think tank) has identified three key strategic challenges facing UK adult social care policy: i) offering more for less, in the sense of responding to greater need in a context of an ageing population and fewer resources; ii) making a different offer, in terms especially of changing, and even lowering, the public's expectations of the state; and iii) long-term reform which will involve significantly rethinking the current adult social care model in the UK (Humphries *et al.* 2016).

Against this backdrop an asset-based approach has been emerging as a potential new script for social care (Glasby *et al.* 2013: 17). The *Care Act 2014* - one of the most significant pieces of English legislation in social care for many years - is underpinned in key respects by an asset-based approach, especially in its orientation to prevention and/or delaying care needs. Developments in Scotland and Wales also reflect similar orientations. The *Community Empowerment (Scotland) Act 2015*, for example, formalises Community Planning Partnerships. These are now required in every Scottish local authority and must plan and deliver local outcomes and engage and involve communities at all stages.

This paper critically interrogates what we see as in some ways an explicit turn but is probably closer to a tacit drift towards an asset-based approach to social care for older people in the UK. As used here social care refers to the network of policy and services associated with providing home-based and institutional care for frail adults who need it. The UK is, we

suggest, an insightful case study in its own right but also because developments there resonate with trends and pressures in other systems. Austerity policies are well underway, especially in England, with the last five years seeing cuts in the central government allocation to local authorities of the order of 37% in real terms (Humphries *et al.* 2016). Like elsewhere, the country is also facing major challenges associated with the supply of informal care to older people with disabilities and health needs (Pickard 2015). Moreover, the challenges faced by the UK in undertaking major reorganisation of social care services – which continue to be local authority run in the midst of a strong discourse of integrated health and social care – are to be found across countries.

Conceptual approach and method

When critically interrogating any approach, it is vital to focus on the theoretical and conceptual foundations. We employ Carol Bacchi's (2009) analytic framework for this review. Bacchi's framework is especially good at interrogating the problem representation in policy and/or practice and is therefore well-suited to the analysis of such a normative and complex domain as social care. The main questions which we employ from Bacchi's approach are as follows: (1) What is the problem represented to be? (2) What presuppositions or assumptions underpin the representation of the 'problem'? (3) What is left unproblematised in this problem representation? (4) What effects are (likely to be) produced by this representation of the 'problem'?

The paper rests on a body of evidence accumulated through a review of the relevant literature. The review focused on literature published between 2005 and 2015, with earlier documents included if they had particular significance or saliency. International academic databases were sourced through Oxford SOLO (the Bodleian Library's search portal) as a primary resource. Targeted website searches and independent, free text internet searches were

also conducted. Both academic and grey literatures were accessed. For the purposes of the research, the ‘grey’ literature comprised: discussion papers; green papers; white papers; working papers; government enquiries and reviews; ‘think-tank’ reviews; policy statements, documents, reports, and guidance. As well as primary searches, secondary searches were conducted using such methods as citation searches, i.e., tracking articles which had cited a key article, snowball searching and reference harvesting, i.e., scanning the reference lists of all relevant literature. Documents were selected for their relevance to the UK context of social care policy and provision for older people. Non-UK literature was selected if it added value to the quality of the review and/or described innovative models of interest. The search identified 82 relevant key documents. Of these, 18 focused on asset-based approaches to older people and social care and it is these, most of which refer to England, which form the main basis for the discussion that follows. They included various types of document: policy statements, research reports, academic literature. A thematic analysis was undertaken using the four questions from the Bacchi framework.

What is the problem represented to be and what is the solution?

An orientation to positive health and well-being is one of the founding principles of the asset-based approach. Its claim to uniqueness derives from two grounds. The first is its orientation to, on the one hand, identifying, and on the other, releasing or nurturing the factors leading to and enabling wellbeing. Second, the approach differentiates itself by its claim to be an alternative to a deficit approach which it sees as focusing on the causes and treatment of illness and disease and over-focusing on problems, needs and deficiencies (Foot and Hopkins 2010). This ‘positive’ emphasis is traceable directly to the roots of the approach in Antonovsky’s (1979) work on salutogenesis. A medical sociologist, Antonovsky theorised health from a perspective which emphasised the promotion of health, the prevention of illness,

and the encouragement of those resources which facilitate resilience. Antonovsky's model of salutogenesis, originally based on research on female survivors of concentration camps, identified two key sets of such 'assets': sense of coherence and generalised resistance resources. The former mainly refers to cognitive abilities, skills and orientations such as the extent to which a person finds their situation comprehensible, meaningful and manageable, while generalised resistance resources refer to a person's ability to use and reuse the resources available to them for an intended purpose.

The literature on asset-based approaches has broadened the original salutogenesis work in several respects. First, it has elaborated the nature of health-inducing resources. The resources of both individuals and communities have received attention, with particular emphasis on the latter. The kinds of resources highlighted are those that encourage face-to-face community networks, citizen participation and civic power (Foot and Hopkins 2010). This general line of thinking has significant overlaps with the concept of social capital (Knapp *et al.* 2013) – the idea that attributes of social life, such as networks and a sense of mutual obligation, can be mobilised for individual and collective wellbeing and success (Daly and Silver 2008). Agency and place are two further elements highlighted as characteristics of an asset-based approach. Agency tends to be viewed from the perspective of self-directed change. Terms like 'personalisation' and 'co-production' – which have been important levers of reform in the UK – are close neighbours (National Colloquium 2012; Needham 2011). The emphasis on place is taken forward by one of the original iterations of the approach – asset-based community development (ABCD) – which rests centrally on place-based partnership working and asset mining (Kretzmann and McKnight 1993). The latter is taken forward through the methodology of asset mapping (Kretzmann and McKnight 1993). It has been described as “a process of building an inventory of the strengths and gifts of the people who make up a community prior to intervening” (Morgan and Ziglio 2007: 4). Hopkins and

Rippon (2015: 4) offer some examples of how it is operationalised: reframing goals and outcomes; reprioritising assets (over deficits); mapping and describing assets; mobilising assets through ‘new relationships, new approaches to leadership, systemic action across organisational boundaries’; and the co-production of outcomes by professionals and local community members.

When the approach is examined through Bacchi’s first lens, the main problem representation in regard to social care for older people seems to be the lack of mobilisation of the individual’s or community’s resource set for the purpose especially of preventing, delaying, deferring or avoiding the need to use formal social care and support. This can be broken down further in terms of what is being problematised: the gap between demand and supply, and identifying and meeting the assumed preference for informal care of those who need care. The approach is strong on both counts. In regard to the gap between demand and supply, it focuses especially on the supply side, aiming to galvanise informal resources for care – through mapping and activating community or local assets (Foot and Hopkins 2010). But it also attempts to be ‘people-centred’ and therefore fits well with the rhetoric of choice and control that has been dominant in both policy and public discourse in the UK for some 20 years (Duffy 2007; Duffy *et al.* 2010). The asset-based approach appeals also in having potential application to reducing social isolation and loneliness among older people which has been highlighted as a major problem (Nygqvist *et al.* 2013). Asset-based projects with older people which have so far been reported in the literature include: supporting volunteering by older people in order to reduce loneliness and isolation; developing befriending schemes by and/or for older people; introducing health champions at local level; and developing innovative social network promotion schemes, such as the Men in Sheds project and the Social Connectedness Grants (Buck and Gregory 2013; Foot and Hopkins 2010; Glasby *et al.* 2013; Hopkins and Rippon 2015; McLean and McNeice 2012; Miller and Whitehead 2015).

What presuppositions or assumptions underpin the representation of the ‘problem’?

It is important to see the asset-based approach as relatively complex, resting on several sets of assumptions.

One assumption is that health is an entity to be developed, a situation or condition that can be altered, positively, by a particular perspective and set of resources. Even if one accepted this as true, it is hard to see a single or simple application to social care. What is it in or about the need for care or social care that is to be developed or nurtured? Is it the capacity and own resources for self-care? Or the capacity to give care to others? Or, indeed, the capacity to access and utilise services in a way that contributes to one’s care? And what is the ideal end point from a policy or collective perspective - Is it to shift social care – in timing and/or location – or to change the volume of care needed?

Regardless of the answers, the asset-based approach seems forced to tie itself into a position such as that of ‘successful ageing’. This makes it an approach with only partial application in that its main orientation is to people in the ‘third age’, i.e., functioning ‘younger older’ people. There is a question, then, of whether – oriented to embodied wellbeing and illness prevention – the approach has any application to those already in situations of poor health or disability. People who are either ill, disabled or older than this who, because of cognitive and/or physical impairment are inherently reliant upon others for their everyday care and survival, are pushed to the margins. In this and other ways, there are ‘ablest’ undertones in the approach.

An overarching claim underpinning an asset-based approach is the idea of ‘empowering’ people. There are a number of underlying assumptions here. A first is that people need empowering and by implication that existing service models are disempowering. Second, there is an assumption that informal resources are empowering and, by implication,

that to be in receipt of formal state support is to be ‘disempowered’. The evidence does not support either of these assumptions (Westwood and Daly 2016; de São José *et al.* 2016). In a social care context it is not at all clear what type of services are empowering, either for people needing care or those giving it. We know that older people in general prefer to be cared for in their own homes but whether or not this translates into better quality of care or empowerment is not clear. This opens up the whole question of what constitutes good quality care for older people and the very nature of social care itself.

Furthermore, we are of the view that there is a selective bias in the approach about the particular assets that are of most relevance. Authors vary but generally the asset-based literature highlights the following types of resources above others: communities, social networks, connectedness, resilience, and psychosocial health (Hopkins and Rippon 2015). There is a striking specificity here. For one, these resources are primarily relational and/or psychosocial, deriving from one’s personal resources and social capabilities and local and other connections and connectedness. There is nothing wrong with this *per se* but it is notable that any theorisation of material resources – and inequalities arising from them - is downgraded. Some authors exclude them, others include them; but the approach as a whole tends to pursue its discussions outside of the money economy. A further assumption is that resources have not already been harvested or that there are potential new resources that can be activated. This is the kind of claim that should be tested rather than assumed. And it is pertinent to point out that in a UK context moves towards individual budgets and personalisation reforms in social care have been found to have led to a reduction, rather than an increase, in community resources (Needham 2013). This in turn connects to a debate about the role of more traditional community development and social work practices versus building community capacity in neoliberal contexts (Gray 2011).

What is left unproblematised in the ‘problem’ representation?

There are grounds to suggest that the asset-based approach is at root individualist, despite its apparent focus on communities and social connectedness. The whole approach is tipped towards mental wellbeing and coping abilities in the sense of resilience and positive adaptation (Foot and Hopkins 2010). Of Antonovsky’s two constituent elements of salutogenesis, the first - the sense of coherence - is found mainly within individuals. The second (general ‘resistance resources’ such as material resources, knowledge, identity, intelligence, coping strategies and cultural resources) is a mixture of elements of individuals and their environments, but from a health perspective they are primarily resources to be amassed and utilised by individuals.

It seems vitally important to interrogate what the asset-based approach has to say about power at a more systemic level. There are several possible lines of analysis here - the power of the medical profession, for example, or the power structure in existing medical and social services or, more generally, the distribution of power in society and how it is manifest in health and related inequalities. There is a case to be made that asset-based approaches have the potential to change the status quo (although whether they actively seek to do so or not is open to question). However, the narrative seems to be of coexistence rather than of radical change. Foot and Hopkins (2010: 12) point out that the approach seeks not to replace investment in services but to achieve a better balance between service delivery and community building. Hopkins and Rippon (2015: 19) underline the argument for asset-based approaches as complementing efficient treatment and good care.

Viewed through the lens of inequality more broadly and of inadequate or unequal health in society, the asset-based approach has relatively little to say. As Friedli (2013: 133) notes, the approach is based on the idea that the psychological attributes of individuals can be extrapolated to explain what is happening to health at a population level. Her critique is that

the approach insufficiently engages with the unequal distribution of health in society and the role of inequality and unequal access to power as part of that inequality. We might even say that it could potentially exacerbate inequality in that well-off people are likely to have more of all the resources highlighted, and are less likely to be vulnerable to shortages and inadequacies in public services. Agency (particularly in relation to ‘successful ageing’) is itself socioeconomically (as well as functionally) contingent, especially for people with ill health and disabilities (Ellis *et al.* 1999).

And then there is the matter of social care as a relational phenomenon and an exigency for some people rather than others. In its community-focused discourse, the approach treats the needs of older people as a problematic ‘other’ rather than offering a framework for how our society might benefit from rethinking and reorganisation (Tronto 1994). The asset-based approach, therefore, risks silencing more radical critiques of the place of care in society. This is consequential. Think especially of the matter of compensation and support for those who provide care. The privatisation of gendered care has long been critiqued for the inequalities and disadvantages it creates for ‘informal carers’, who are most likely to be women. A number of authors have argued that ‘informal carers’ are not only entitled to compensation but to care in their own right. Eva Feder Kittay (1999) has advanced the notion of *doulia*, i.e., the principle that those who provide care are less able to care for themselves and therefore are entitled to care from others and especially the state. There is nothing in the asset-based approach about carers’ rights and indeed its thrust is to rely on a relatively unproblematised notion of voluntarism which includes greater informal provision of care.

What effects are produced by the representation of the ‘problem’?

While it usefully turns a critical lens on existing models of care and support for older people, the approach risks taking forward a flawed analysis of existing provision. When applied to

social care, the implication is that existing services de-emphasise the importance of promoting independence, choice and control among older people. In essence, co-opting salutogenesis to the context of social care assumes that people with social care needs are constructed through a deficit-based lens which does not take their strengths (personal, social, economic capital) into account. Even a cursory examination of policy shows these assumptions to be incorrect. The community care model in the UK for the past 50 years has been predicated on the understanding that formal state services and resources would only step in once the informal supply of social care (from family, friends and community including the voluntary sector) has been depleted. Community care assessments have always been based on initially identifying what informal support is already available, then identifying any gaps in that informal social support, and, in turn, identifying when and where the state needs to step in. This is not a deficit-based approach. It is, rather, an asset-based approach, which recognises, first, that people's assets and resources need to be taken into account for the purposes of entitlement and access to services and other public resources; secondly, that the nature and level of people's resources vary; and thirdly, that there is an asset sufficiency threshold determining wellbeing outside of the public services. Such an asset sufficiency threshold is executed by the long-standing practice of means-testing of economic assets.

Asset-mapping, therefore, may not be so different from current social and community care assessments which always take into account what an older person can already do for themselves and what assistance is available through informal supports. The receipt of social care tends to be assessed by consideration of the resources available for such daily needs as bathing and dressing and levels of physical and cognitive disability, and involves the dynamic interaction of multiple factors "including an individual's demographic and socio-economic characteristics, and the extent to which individuals can use technologies in their home environment to compensate for disabilities" (Vlachantoni *et al.* 2015: 324).

Furthermore, the asset-based approach contributes little to the critical interrogation of how the structure and operation of paid work and its relationship to unpaid work may have to change in order to reflect and respond to the growing care-related exigencies in society. In addition, to the extent that the approach leads to a lack of investment in paid care work, which is predominantly women's work, it might incentivise the state to push care work out of the regulated, paid public sector and (back) into the unregulated, unpaid, private sphere. Certainly in a UK context, the assumption that there exists a supply of untapped informal and voluntary support is counterfactual given the evidence to suggest a forthcoming shortage of unpaid care (Pickard 2015). Furthermore, the approach fails to take into account the risks attached to promoting an unqualified, unregulated, unpaid volunteer care and support workforce engaging with vulnerable older people. In particular, there is a need to consider the safeguarding implications with regard to the increased risk of 'elder abuse' which is most commonly perpetrated by informal providers of care and support. Finally, there is a danger that the approach approximates a form of asset stripping among vulnerable populations.

Conclusion

This piece has undertaken a review of the asset-based approach, on the grounds that it is becoming more popular and that a review helps to spotlight key issues associated with social care for older people as a policy and societal exigency.

It is clear that the asset-based approach plays host to interesting ideas and conversations. None of these is especially new but they serve to highlight important issues in a context where care for frail older people is an increasing challenge. The approach brings needed focus on how different resources contribute to health and suggests that the under-use or lacking availability of a range of personal and social resources are crucial to ill-health and poor

capacity to deal with it. While developed in the context of public health, asset-based thinking has some purchase in regard to social care. It can help focus attention on prevention and delaying recourse to care, suggesting that there are assets for social care (care capital) that may act in a preventive fashion. It can also help to address the challenge of isolation and loneliness among older people. However, three particular problems or weaknesses in this way of thinking and its application to social care for older people have been highlighted in this review.

The first is that the approach has limited application to social care if viewed and understood as a present time issue. That is, it has little remedy for immediate issues associated with care need and rising demand for social care, especially in the context of limited supply and pressures on private care-related resources. While the need for social care can be curtailed among certain sectors of the population, there are limits to this and when it exists or manifests itself there has to be a response of some kind in the here and now. Second, the approach lacks meaningful engagement with macro issues such as the need to reorganise our societies so that we can better meet the growing need for care. Whether this involves change towards a more care-oriented society with necessary reform around the prioritisation of and balance between paid and unpaid work or reforms addressing inequalities (including those that are gender-based), there is a sense that the asset-based approach accepts the status quo – and also power imbalances – and consists of a set of prescriptions that are in essence located at the individual and community levels. Thirdly, we suggest that the critique of existing provision and the claim that what is being offered is an alternative approach are both under-developed and over-promised. That is, it could be argued that the existing system of governing access to care services in the UK already utilises an asset approach. What are means tests other than tests of assets, including personal and family capacity assets? Furthermore, an asset-based approach

in our view risks entrenching binary discursive and conceptual divides between formal service provision and informal support and care of and with older people.

We suggest that insufficient theorising and a lack of empirical evidence risk an over-reliance on an unproven approach which may mask the retreat of the state and the public authorities from responsibilities associated with the care of older people. A programme of further research and critical engagement is needed. This should critically interrogate the assumptions about increasing reliance on local communities without evidence to confirm that such resources exist and consider the gendered and other inequality-related consequences of asset-based approaches. Such a programme should address theoretical and empirical questions, along the following lines:

- How might asset-based approaches be theoretically and conceptually understood in the context of care for frail older people (as an exigency and in terms of institutional and other responses)?
- Do (older) people have untapped resources (assets) in their personal networks which can be mobilised in preventative ways or as alternatives to formal social care provision? What are the gendered, class and age-related implications of such tapping such resources where they exist? What are the (direct and indirect) cost implications and by whom are the costs borne and met?
- Do communities hold potentially new resources which can be mobilised by or for older people in preventative ways and/or as alternatives to formal social care provision? What are the inequality- and power-related implications of those supposedly untapped resources? What are the (direct and indirect) cost implications and how are these costs distributed?
- Do informal community-based interventions – as alternatives to formal state-funded services - actually serve to prevent or delay the need for formal state intervention in

relation to older people? And with what implications, taking into account informal care costs, care quality, and carer burden?

In conclusion, until more, and better, evidence is obtained, the asset-based approach should be treated with caution, and there should be considerable concern about the promise claimed for it in current policy discourse. There needs to be far greater critical interrogation of asset-based approaches, and closer scrutiny of policy ‘solutions’ which derive from them. Failure to do so may lead to policy strategies which are unrealistic in their assessment of the volume of untapped resources that exist and can be mobilised for social care. The result could be older people being without the necessary resources to support them in later life, either informal ‘assets’ or formal support previously provided by a now-retreating state.

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