Does anyone care about fairness in adult social care?

Viewpoint
Informing debate

September 2008

This *Viewpoint* reviews some of the key proposals in adult social care of the last ten years from an equity perspective. It uses the analysis to argue that we can develop practical policies that are informed by clearly stated equity principles which serve to ensure that the most disadvantaged groups of people are treated more fairly.

Key points

- All parties with a stake in adult social care, including the main political parties, say that they are in favour of fair funding arrangements. The problem is that everybody has been saying this for many years, and we are still stuck with a system that everyone agrees is unfair.
- Looking forward, any new system will need to be equitable, and seen to be equitable.
- The task of identifying the most equitable funding system is not straightforward. Equity can be defined in different ways, and there are genuine differences in beliefs about the fairness of any given reform proposal.
- These difficulties cannot be used as an excuse for inaction. A difficult task is not an impossible one. We need a framework that will allow us to judge the merits of different proposals, and translate equity principles into policies that work on the ground.
- We also need a framework for practical reasons. Funding is shared between the state and individuals, and individuals need to know what the state is willing to provide so that they can make their own financial plans. The state's policies need to be seen to be equitable, otherwise they will not survive and we will quickly return to the current unacceptable situation.
- More detailed discussions should take explicit account of the consequences for key groups of people, notably the lowest-paid care staff, the poorest older people who need care, and the poorest carers.

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Where are we now?

There are a number of fundamental problems with our adult social care services, and the Government recognises the scale of the problem. In *The Case For Change*, published in May 2008, the Government stated that it wanted:

> … an affordable, fair and sustainable way of delivering and funding a first class care and support system in the future.
> (Department of Health, 2008, p14)

This echoed the views expressed in *Putting People First* in December 2007:

> We agree that there is a need to explore options for the long term funding of the care and support system, to ensure that it is fair, sustainable and unambiguous about the respective responsibilities of the state, family and individual.
> (HM Government, 2008, page 1)

These statements are consistent with the Government's stated desire since it came to power in 1997 to make public services more equitable. Every Budget report is studded with references to fairness. [1]

On the face of it, then, the task is straightforward. We want to make sure that any future adult social care system is fair. It should be possible to draw on principles and practical solutions that the Government has used in other policy areas, which should ensure that any proposals are politically acceptable. Unfortunately there are three problems here. First, there are genuine differences of opinion about the equity principles that should be applied. The long-term care debate at the turn of the century provides a stark illustration of this point. Second, it remains difficult to identify what equity principles the Government thinks should be applied – policies across the public services point in different directions. Third, discussions of equity tend to become entangled with other (proper) political debates, particularly over the sustainability of different funding options. It would be wonderful if we could design a new social care system, starting with equity principles, and hold on to them as we introduce other important policy considerations such as efficiency. But this isn't possible, not least because equity does not exist in isolation. It has to be balanced against efficiency, and against the freedoms that citizens need to pursue their own lives in the ways they want.

This *Viewpoint* starts with a brief outline of the policy debate, using it to draw out the key equity questions that need to be addressed. Then the two main conceptual frameworks that underpin equity debates are set out. The next section returns to the debate over funding long-term care for older people around the turn of the century. The reasons that debate ran into the sand contain important lessons for the current deliberations over adult social care. The final sections seek to clarify the nature of the decisions that need to be made. The models outlined in the Wanless review of social care in 2006 (Wanless, 2006) are used as practical vehicles for sketching out the equity implications of different practical solutions. Any future government is likely to find itself choosing between the models, or some close variant of them, and in doing so will be choosing between equity frameworks.

Background to the debate

Social care is currently a 'residual' service, and does not provide comprehensive cover to the whole population. As a result, there is a need to balance the financial and non-financial contributions made by the state and by private individuals and their families. The practical challenge is to distribute the available money in a fair way, bearing in mind that some people are able to pay for services and others are not.

In recent times, social care funding has tended to be targeted at people with the greatest needs and who cannot organise or pay for services themselves. This policy, while intuitively attractive, has created problems. Targeting, which involves means testing, has proved to be both complicated and inequitable (Thompson and Mathew, 2004). The complications arise from the mix of funding and provision, which includes social services provided at a charge (or means tested), state benefits which people can use to buy services for themselves, and other services which people are expected to pay for from their own incomes (whether or not they are in receipt of benefits). Many people who need social care also need NHS care, and the fact that this is generally provided free at the point of receipt, and is relatively easy to access, has provided a marked contrast with social services.

If anything the complications have increased in recent years, with the introduction of schemes such as winter fuel payments and free TV licences. People may receive money or benefits in kind from several different sources. The inequity arises from variations in the application of rules, particularly over means testing, and the fact that there has been limited co-ordination across the various services and funding streams. People with similar needs may receive different services, or different benefits, or both.

In addition, important structural problems have become more obvious in the last few years. Local authorities have had few resources to commit to prevention and rehabilitation; that is, to delaying or avoiding the need for intensive support. As prevention and rehabilitation have moved up the social care (and NHS) policy agenda, the problem has come into sharp focus.

Looking forward, any new system will need to be equitable, and be seen to be equitable. Perceived inequities underlie much of the anger and frustration aimed at the current arrangements. The overall objective, from the point of view of any government, must be to ensure that the resources available for social care services are seen to be distributed fairly. This immediately raises some major questions. Can a residual system be designed to achieve fair funding arrangements? How broadly should we cast our net: should we focus on actions of governments, or on the totality of resources committed by governments, individuals and families? If the latter, we need a clear government contract on what the 'offer' is.

While money always matters, we need to be sensitive to a wider objective – the need to encourage caring relationships. Many of the arguments about caring are separate from questions of fairness and are discussed in a companion *Viewpoint* (Beresford, 2008). But the separation is not complete. Held (2006) argues that it is important to identify ways in which an ethic of care – concerned with the proper basis of the social relationships between people – can be reconciled with notions of justice and equality. Her argument is that an ethic of care is a prerequisite for any theory of justice, because justice is of little consequence unless there is the possibility of a society where people care for one another. Whether or not one accepts this argument, she is surely right when she points out that the situation inside many families has been unjust over long periods. Caring has often been distributed very unequally, most obviously in typically being undertaken by women rather than men. As we consider the distribution of funding between the Government and citizens, we should also consider whether any given proposal is likely to encourage or discourage fairness in the distribution of caring responsibilities.

Equity – two traditions

There are two main traditions that have been used in discussions of welfare policies in recent years. Both set out to identify universal principles which can be used as a basis for organising societies. The first is utilitarianism, which rests on the idea that any given action should be judged on the basis of its contribution to the overall utility of a population. It has proved difficult to develop a usable definition of utility within utilitarianism, but it is easy enough to appreciate the value of the central idea. If one adds together individuals' utilities, or preferences, for a course of action then it is justified if the total benefits that accrue to a population are increased, and if not then it is not. (In Jeremy Bentham's phrase it is the doctrine that 'Each [is] to count for one, and none for more than one'.)

The weaknesses of utilitarianism have been debated over a long period. One problem is that it is difficult to make inter-personal comparisons. The NHS has been successful in providing comprehensive health care, but it remains difficult to decide between any two treatments that benefit different groups of patients in different ways. (Or rather, it is possible to do this but decisions to withhold funding for particular treatments are often controversial.) Another problem is that utilitarianism does not offer us a route map for thinking about the ways in which utility is distributed: the focus is on maximising utility rather than on the details of the ways in which it is distributed across a society. This said, utilitarianism is important because it requires policy-makers to consider the trade-offs involved in any decisions they make – who wins, who loses and whether there are superior alternatives available.

The second tradition centres on the work of John Rawls. He developed a framework which offers both a distributive principle – in his case equality of opportunity – and arguments over what should be distributed fairly. He was particularly interested in the distribution of what he called 'primary goods', which include income and wealth, liberty and self-respect. His Difference Principle essentially states that the ways in which any new resources are distributed across a society are justified if the distribution helps to improve the circumstances of the least well-off person in that society. Rawls states that:

> The intuitive idea is that the social order is not to establish and secure the more attractive prospects of those better off unless doing so is to the advantage of those less fortunate.
>
> (Rawls, 1999, p 65)

The distribution should, further, be consistent with a just savings principle and fair equality of opportunity (*op cit*, p266). In the context of this essay, the just savings principle essentially deals with obligations to future generations, and might include developing an affordable social care system for people who will need it in the future. Fair equality of opportunity expresses the concept that access to key resources should be assessed on the basis of merit or need, and irrespective of income or geography. Note that these two ideas might have different policy implications. One leads us to ensure that the least well-off people receive the services and support they need in the long run, while the other focuses attention on equitable access at a particular point in time (such as the period of the next Comprehensive Spending Review).

Rawls' theory has been very influential in the course of the last 30 years, and has been the subject of much debate. For example Sen (1992) has taken issue with the choice of primary goods, arguing that we should focus instead on the fair distribution of 'basic capabilities'. In the context of poverty, for example, income is important but is not sufficient by itself to ensure that people can be active members of a society. We should take a wider view of the strategies that we should adopt to reduce social inequalities. He also argues that Rawls does not offer a way of valuing – ranking, counting – primary goods, and that different approaches to valuation may lead to different policy implications. Sen has sought to develop robust ways of valuing primary goods. Rawls also only touches on equity within the family context (pp 447-8). Writers on the ethics of care and leading feminist writers (Kymlicka, 2004; Okin, 1989) have pointed out that none of the older philosophical traditions deals properly with justice within families. All of this said, Rawls' ideas are the starting point for many of the serious commentators on poverty, gender and other sources of inequality.

What should we be trying to equalise?

We would not need to worry about equity if we were all similar in important respects. But we aren't. We differ in our personal circumstances, including our age, gender and disabilities. We also differ in the environments we find ourselves in. Some inherit wealth, are born in areas with high life expectancy and live in communities that offer opportunities to express themselves. Others have none of these advantages. It is important to stress that we are not seeking to achieve perfectly equal incomes, or outcomes, across society. The aim is to identify policies for fair services and funding which, given the differences between us, are bound to vary from person to person. The question is, then, what level of advantage or disadvantage is acceptable in any society that we might actually want to live in?

We need to decide what we want to equalise, and rules for ensuring that the distribution is fair. For the sake of clarity, I take the view that the principal task is to ensure fair utilisation of adult social care services. A fair funding system is an important means to this end.

Given the current complicated picture of social care services and funding, it is not immediately obvious what we want to equalise. Is it incomes? Or outcomes? Or access to services? Each of these might be a legitimate goal. For example, we may want to maximise the wellbeing of everyone in our society, as far as resources allow. Alternatively, we may wish to ensure that social care services can be accessed equally, irrespective of people's incomes. This highlights an important point. In debates about adult social care, commentators – quite naturally – stress the importance of one or other of these goals. But in practice we have to achieve a balance between them. And to do this, we need a framework for considering priorities and trade-offs systematically.

The Royal Commission on long-term care – a cautionary tale

On coming to power in 1997, the Labour Government set up a Royal Commission to review long-term care. Then, as now, the problems centred on fragmented services, overly complicated financing arrangements, and the widespread belief that the system was both inefficient and unfair [2]. The Royal Commission, which reported in 1999, was committed to finding a fairer way of financing and providing services. The concluding section of its report *With Respect to Old Age* states that:

> This report … is about a better and fairer split between costs met by the individual and the state.
>
> (Royal Commission, 1999, Chapter 10, para 10.30)

Statements about the nature of the 'better and fairer split' occur throughout the report. The Royal Commission argued for financing of both nursing and personal care from general taxation, on the basis that general taxation is the most progressive method for raising money. Subsequently the Scottish Assembly took the same view (Community Care and Health (Scotland) Act 2002). If the state financed most long-term care, then better-off people would generally contribute more, through their taxes, than worse-off people. In the last chapter of their report the commissioners stated that:

> We argue that long-term care should continue to be funded from general taxation. Existing taxes that pay for public services are redistributive. ... The better off will contribute more for benefits which will be realised only if they are in need.
>
> (Royal Commission, 1999. Chapter 10, paras 28-29)

It is important to recall that there were many issues where all sides agreed, and that the Government has moved to resolve some of the issues that had generated political controversy in the preceding years. In particular, the Government accepted the Royal Commission recommendation that all nursing care should be free, wherever it was provided. The Government also agreed with the Royal Commission that people on higher incomes should continue to pay the 'hotel' costs of long-term care, often the largest single component of the costs faced by private individuals. And it agreed with the Royal Commission that there were unacceptably large geographical variations in charging for social services.

But there were also some sharp differences of opinion. There were two dissenting members of the Commission, Joel Joffe and David Lipsey, and in setting out the reasons why they could not support free personal care at the point of delivery, they stated that:

> To make personal care free for all who are assessed as needing it would make matters worse. In essence it would transfer initially at least £1.1 billion rising to at least £6 billion in 2051 from the private to the public purse. ... It would transfer income and wealth to the better-off members of society and their heirs, at the expense of those most in need.
>
> (Royal Commission, 1999, Note of Dissent, Chapter 1, paras 3 and 4)

In its formal response to the Commission in 2000 the Government stated that:

> … a fairer and lasting balance between tax-payers and individuals must be found for the funding of long-term care … to ensure that people's health care is provided squarely in line with NHS principles and they are not forced to sell their homes as soon as they enter residential care.
>
> (Department of Health, 2000)

On the face of it, these comments looked like the start of a serious debate about matters of principle, including the choice of equity principles that should be used. But in practice the result was a nightmare, with the two sides becoming deadlocked. That deadlock is one reason why the funding system is largely unchanged almost ten years later.

In retrospect we can see that there were faults on both sides. Two general lessons stand out. The first is that we cannot afford another disagreement about basic principles. We must agree to make the best of whatever framework is adopted. The second lesson is that it is essential to set out equity arguments clearly. The Government failed to specify the judgements that (it believed) should be used to work out the split between state and individual financing in long-term care – even though it had recognised that this was needed. Indeed, as the earlier quotes show, the Government is still saying that this type of judgement is needed, but seems to be no nearer making it. Unfortunately, the Royal commission also failed to spell out its position. Rather, it simply asserted that an NHS-style solution should be adopted for funding all personal care.

It was possible to work out that the majority of the commissioners attached the highest priority to fair access to care, and in order to achieve this recommended a move to a more universal system of funding and provision. They believed that their proposals were affordable over the longer term, so that there was no conflict in practice between fair access (today) and ensuring that people received the services they needed in the future. But the reader had to piece together the arguments from different parts of the report.

We can also use the long-term care debate to identify the concepts of fairness that underpinned the debate in more detail: this may stand us in good stead today. The differing views on funding personal care, which was one of the areas that generated most debate at the time, offer one clue. The Royal Commission report contrasted free treatment of cancer and heart disease within the NHS with the financial costs that can be incurred by people with Alzheimer's disease. It stated that:

> … the distinction between the way care is offered for different diseases has no justification. The situation must be put right. The proposal to exempt personal care costs from means testing would do that. ... The principle of equal care for equal needs would be properly recognised for the first time.
>
> (Royal Commission, 1999, Chapter 6, paras 34-5)

In contrast, the Government worried that:

> Making personal care free for everyone carries a very substantial cost, both now and in the future. … It does not help the least well off. We have not followed this recommendation because we believe our alternative proposals to improve standards of care and fair access to services will generate more important benefits of health and independence for all older people, now and in the future.
>
> (Department of Health, 2000, para 2.6)

This introduces additional concepts of fairness. The quote from the Commission suggests a concern with fairness of rules that discriminate on the basis of the type of treatment or service that is needed, and also on the basis of ability to pay. The Government was, in contrast, concerned with longer-term affordability – arguably echoing Rawls' Just Savings concept.

One view of the disagreement about affordability is that the two sides made different value judgements about affordability, without appealing to any particular equity principle. As Wittenburg and colleagues have shown, there is still considerable uncertainty about the costs of long-term care in 20 or 30 years' time (Wittenburg *et al*, 2004). The available data cannot be used to determine who is right. So, a political judgement sat at the heart of the long-term care debate – and will do so for adult social care now.

More generally, we can detect four concepts of fairness in play in the long-term care debate. These include concerns with fairness in the application of rules in means testing and other contexts, fair access to care (irrespective of ability to pay), fairness in the approach to services and funding of conditions which are (primarily) health or social care problems, and fair funding arrangements, which would rest on a fair distribution of responsibilities between government and citizens. The two sides used different concepts of fairness, and it is no surprise that they reached an impasse.

Before we move on, the discussion of the role of informal carers should be noted, as it highlights a fifth fairness argument. At the time of the long-term care debate the Government paid scant attention to them, although it has since published a carers' strategy. The Royal Commission and a range of voluntary organisations devoted considerable effort to consideration of questions about the principles and practice of informal caring. This said, it was unclear what view the Royal Commission and other commentators took on the way that informal carers' rights should be incorporated into wider judgements about a fair settlement in long-term care. Neither side rose to the challenges posed by the need to encourage a fair distribution of caring responsibilities.

Looking forward

Any government that addresses adult social care policy seriously will need to decide on the equity principles that should be used. Two broad approaches are possible. One is to develop an appropriate equity framework and then work out the implications for other important objectives such as efficiency, the other is to identify a small number of plausible policy solutions and investigate the equity implications of each one. This section sketches out the first approach, and the next section the second.

The main steps along the route could involve:

1. deciding on the scope of a review;
2. deciding what is to be distributed fairly;
3. identifying equity principles that should underpin that distribution; and
4. identifying key trade-offs and how to deal with them.

Any serious government will adopt a broad approach to the problem, not least because the state offers many benefits and concessions that lie outside the social care system and yet contribute to wellbeing. The list includes free bus passes, free TV licences and winter fuel allowances, as well as benefits (particularly Attendance Allowance and Disability Living Allowance) and benefits in kind such as NHS care. These are all set within the overall design of the tax system: it is the tax system that offers the opportunity to distribute or redistribute resources from one group of citizens to another. There is currently much rhetoric about transforming public services, including social care. It seems reasonable to hold the Government to account on these statements, and to expect the same vision and ambition that we saw in the 1940s.

The second step is to decide on what is to be distributed. A full consideration of this issue is beyond the scope of this paper, but as noted earlier we can assume here that the highest priority should be assigned to fair utilisation of social care. This does not mean that other fairness criteria do not matter – far from it – but we cannot make any progress unless we identify priorities.

The third step is to decide on the distributional principle that should drive decision making. As the discussion so far has suggested, there are a number of possible approaches, and proper debates to be had. But in practice the key decision probably lies between two options. One is a recognisably Rawlsian position, which is to give priority to the least well-off people who need social care, ensuring that they have the resources that they need over time. The other is to promote equality, which could be done along broadly utilitarian lines. If we are principally concerned with the utilisation of services, we will look for ways of maximising that utilisation. This might lead us to judge that we need to pay attention to people on middling incomes, as well as to people on the lowest incomes, because those on middling incomes cannot afford to pay for services they need out of their own pockets. (Note that it is possible to arrive at a similar position within a Rawlsian framework, if you attach a high weight to equality of opportunity, as he did, and a low weight to issues such as affordability over time. You don't have to be a utilitarian to take a broad societal view.)

The final step would be to review any practical proposal and seek to iron out or minimise conflicts between objectives. We cannot, in the real world, work to achieve a single equity objective at the expense of all others. For example, we cannot design a social care system that we (really) can't afford in the name of fair utilisation of services. Balances will need to be struck that are affordable by government and citizens, and create acceptable boundaries between NHS and social care, and so on.

Towards practical options

We need to root the discussion of principles in practical policy-making. The review of social care by Sir Derek Wanless and his team (2006) is helpful here. The team reviewed all plausible funding options against a range of criteria including fairness. The Wanless team identified the three most promising options, noting that there was no single 'absolute winner', and invited the Government to choose between them. The aim here is to highlight the different equity considerations underpinning them.

The three main funding options were means testing, partnership and personal care. Taking means testing first, the means testing process would determine an individual's eligibility for help, and a properly implemented fair charging regime would determine the charges for service. The report observes (p 264) that means tested systems should perform well on fairness tests, because resources are targeted at those most in need. The Wanless team found that the current means testing arrangements tend to favour the least well off at the expense of people on modest incomes who 'fail' the means test and have to pay for services. In the context of this essay, the important general point is that means testing is based on the belief that resources should be targeted on the least well off, a Rawls-type position.

The Wanless team, in line with many other commentators, found that an element of universal entitlement to services helps to ensure a more equitable distribution of outcomes. These arguments are partly technical and partly to do with the politics of universal provision. The argument about the NHS – and to a lesser extent the education system – is that universal provision leads everyone to be interested in the scope and quality of the services on offer. The more confident and articulate among us will use services, and can act as advocates on behalf of everyone.

It may be that the current Government has been attracted to means testing because it genuinely believes that targeting resources at the least well-off people in society is more important than other equity considerations. The irony appears to be that a policy-maker using Rawls' ideas might actually plump for a more universal funding system, because it offers a better way of ensuring that the least well-off people receive the services they need, and that these services are of reasonable quality. So we should reject means testing, at least in anything resembling its current form.

The second option is free personal care. This has features in common with the Royal Commission's recommendations. Individuals are not charged for community-based personal care services, or for the personal care element of institutional care: the state pays for them. (The costs of accommodation – so-called hotel costs – are still means-tested.) This model has some of the characteristics of the NHS, as services are financed through general taxation and are free at the point of receipt. We can therefore say that this model emphasises equity of both financing and of access to care, and may also protect the interests of the least well-off people who need social care. The consultation Caring Choices (Caring Choices, 2008) concluded that this was the most favoured option.

The partnership model is based on public financing of a guaranteed minimum level of care, with any additional care being funded through matched contributions from the individual and the state. A key idea is that the guaranteed minimum ensures that people with significant needs receive the care they need, even if they cannot afford to contribute financially themselves. Additionally, the matching of state and individual contributions above the minimum guarantee helps to smooth – make fairer – the costs faced by people across society, in the sense that there is a reasonably close relationship between ability to pay and payments made for social care. This proposal helps to avoid the 'cliff effect' in the current means tested system where people on the lowest incomes have all care costs paid, but those on moderate incomes may face substantial private charges for care.

A key point about both of these options – over and above them both being preferable to means testing – is that they offer alternative strategies for sharing out government and personal contributions across all groups of people who need social care. As a result they place different weights on different equity objectives. The following table offers an illustrative rank ordering of equity objectives. These are offered to stimulate discussion: it is quite possible to argue with the rankings, but the rankings presented are less important than the idea that it is possible and necessary to arrive at such a ranking. For example, justice within families has been placed last in each column. The Wanless team might argue that this underplays the different effects that funding models are likely to have on the behaviour of informal carers, as they explicitly considered scenarios which involved promoting a more caring society.

Both the free personal care and partnership models focus attention on the overall distribution of social care resources. It is not helpful to take the arguments much further, because fairness will depend on major decisions about the scale and nature of funding. We can say, though, that any more detailed discussions should take explicit account of the consequences for key groups of people, notably the lowest-paid care staff, the poorest older people who need care, and the poorest carers. This is important because parallel experience in the NHS alerts us to the fact that free care at the point of delivery does not offer any overt mechanisms to encourage just caring within families (or indeed within communities). Arguably, these most disadvantaged groups need the most robust policy attention.

Figure 1: Illustrative rank ordering of equity objectives for two policy options

Free personal care	Partnership
1 Equity of utilisation of services	1 Equity of financing across society
2 Equity of financing across society	2 Equity of utilisation of services
3 Targeting the least well-off people who need care	3 Equity of outcomes
4 Equity of outcomes	4 Targeting the least well-off people who need care
5 Justice within families	5 Justice within families

Conclusion

This *Viewpoint* has sought to show that it is perfectly possible to think clearly about equity principles, and to think through the implications of applying those principles in adult social care.

We need an equitable system of adult social care for practical reasons. If citizens do not know what the state will and will not provide, then they cannot make informed decisions about payment for their own care. This argument goes wider than social care, because of the long-term care element of care – informed decision-making includes judgements about incomes, savings, pensions and the use of assets. If a new care system is not fair, and not seen to be fair, then it will not survive. It will, one suspects, be tinkered with and soon we will be back where we are now, with a ragbag of funding streams.

It is clear that, in the list of decisions needed to identify an equity framework – scope, what is to be distributed fairly, principles to inform distribution, reviewing trade-offs – the biggest decisions are about scope. That is, decisions about the overall resources that should be committed to social care, and the balance between state and personal contributions, will have very substantial effects on all of the following decisions. The Government has at different times hinted that it will continue with residual services and will 'transform' social care so that it is more universal in nature. Transformation won't be possible unless decisions are made about scope, and the repeated promises to spell out equity principles are finally fulfilled. Equally, decisions need to be made about what kind of society we wish to see in future and how well we treat our older citizens, particularly those who are least well off.

Notes

[1] Government almost always uses the term fairness, but academic commentators tend to use the terms equity and equality. Fairness is usually taken to be a broader term, but the distinction is not important in the context of this paper – the task is to define whatever terms we choose to use.
[2] A fuller version of the arguments in this section can be found in Keen *et al.* (2007).

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