

Individual Budgets and irrational exuberance

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This paper considers the concept of Individual Budgets (IBs) – the key mechanism identified by the Government in England to advance its ‘personalisation agenda’ for reforming the provision of social care services for disabled, elderly and ill people. It is a sceptical paper, not because IBs are viewed as a ‘bad thing’: far from it, for it is undeniable that for some people they have proved to be transformative. It is sceptical for a number of reasons, and these appear as subheadings to provide structure to what follows. In sum, however, the concerns centre on the limitations of the idea: the conceptual naivety underpinning much of the discussion, and the potential harm that could be caused if IBs become the main vehicle by which the state discharges its social care support obligations.

IBs are not an isolated initiative – ‘cash entitlements’ in lieu of traditional services are being trialled in many areas.¹ In community care, they are also being examined in relation to community care equipment services (as the ‘retail solution’²); in education as Personal Skills Accounts; in employment as Access to Work schemes and they are now to be piloted in the NHS.³

What are IBs

Critical analysis of IBs is hampered by the absence of an agreed definition as to what exactly one is: a lack of clarity that extends to associated terms such as ‘self-directed support’, ‘self assessment’ and indeed ‘personalisation’ – which like ‘community care’ is admirably ambiguous.

¹ In this respect, see Moullin, S (2008) *Getting up close and personal*: Public Finance July 18 2008 pp 24-26.

² Care Services Improvement Partnership (CSIP) (2007) *Transforming Community Equipment and Wheelchair Services programme, Community Equipment – a vision for the future*.

³ Lord Darzi (2008) *High Quality Care For All – NHS Next Stage Review Final Report*. London: Department of Health, p4.

The Government chooses to define IBs in terms of what they promise, rather than what they are. Its Care Services Improvement Partnership (CSIP) website⁴ poses the question ‘What is an individual budget?’ and then answers it as follows:

The main idea behind individual budgets is to put the person who is supported, or given services, in control of deciding what support or services they get.

For the purposes of this paper, a number of concepts associated with IBs are analysed, and these include:

1. Self assessment: the idea that an individual controls the assessment of their needs for social care support. This is sometimes referred to as ‘self directed support’ (SDS) – though it is acknowledged that there is in fact neither ‘conceptual nor an ideological consensus upon SDS’.⁵
2. Resource allocation: a computation mechanism (generally termed a ‘resource allocation system’ (RAS)) converts the self assessment into a sum of money. The individual is informed of the value and of their entitlement to this sum – their ‘IB’.⁶
3. Service flexibility: the individual has considerable freedom to use their IB to purchase services that they consider best meets their social care needs. In exercising this choice, they may (if they chose) have the assistance of independent support personnel – sometimes referred to as brokers.
4. Mixed funding streams: the resources to be allocated in theory include, not just the funds that the individual is entitled to under the community care legislation but also funding relating to community equipment, Access to Work, independent living funds, disabled facilities grants and the Supporting People programme.⁷ It appears that this aspect of the programme has encountered considerable difficulties⁸ and it is not further considered in this paper.

⁴ At <http://individualbudgets.csip.org.uk/dynamic/dohpage5.jsp> inspected 22 June 2008: CSIP is a Government funded agency that has a lead role in promoting IBs: accessed 28/07/08 .

⁵ Henwood, M. & Hudson, B (2007) *Here to Stay? Self-directed support: Aspiration and Implementation A review for the Department of Health*. Towcester: Melanie Henwood Associates, para 2.53.

⁶ Hatton, C. Waters, J. Duffy, S. Senker, J. Crosby, N. Poll, C. Tyson, A , O’Brien, J & Towell, D (2008) *A report on in Control’s Second Phase: Evaluation and learning 2005 – 2007*. London: in Control Publications, p33.

⁷ Department of Health (2006) *Our health, our care, our say: a new direction for community services*, Cm 6737, 2006, para 4.39.

⁸ Described as ‘incredibly challenging’, (Community Care (2008) *Personalisation pilots face a cultural ethos challenge* 8 May 2008 p9) and Glasby, J and Duffy, S (2007) suggest that ‘there is a real risk that the complexity of integrating money from bodies governed by very different legal and accountability

Imprecise as the new language of budgets is, there are three varieties that need to be distinguished, namely IBs, Personal Budgets and Direct Payments. Although IBs and Personal Budgets have come to be used interchangeably, the difference appears to be that in its original conception an IB included funding from a number of streams (point 4 above) whereas a Personal Budget describes the community care element (ie funds derived from the Department of Health). A Direct Payment can be distinguished from a Personal Budget in that a Personal Budget need not be taken as a money payment by the individual, but is capable of being managed notionally (ie by social services or a broker) - and so, for instance, used to obtain local authority services (which in general is not a possible use of a Direct Payment), although Government enthusiasm for such 'virtual' budgets of this variety (especially where the individual is not objectively 'in control') appears to be waning.

For simplicity, this paper uses the prevalent term 'IBs' although in certain situations what is being described might more aptly be referred to as a Personal Budget.

At this stage the Government does not envisage that the implementation of the programme will require any change to the law or additional expenditure – it is to operate within the 'existing funding envelope'.⁹

Background

Few people would deny that there are major problems with the delivery and quality of state funded social care in England. All too often help is only available to those whose need is most acute¹⁰ and the services are delivered with insufficient regard to issues of dignity or personal autonomy. The administration system has major problems, with generally low staff morale (and all the side effects that entails) and it spends an extraordinary £3 billion (16% of its entire resources) on the assessment and care planning process.

Many commentators believe that the necessary changes will not happen without extra resources¹¹ - possibly of the order of the investment made in the

mechanisms is simply not worth the effort.' *Our Health, Our Care, Our Say – what could the NHS learn from individual budgets and direct payments?* Birmingham: University of Birmingham, p.3.

⁹ Department of Health (2005) *Independence, Well-being and Choice*, p40.

¹⁰ There has been a marked decline in numbers of households receiving social care support - for example between March 2003 to March 2006 the number of older people using services has dropped from 867,000 people 840,000 - at a time when the population aged 75 and over increased by nearly 3%- see Commission for Social Care Inspection (CSCI) (2008) *The state of social care in England 2006-07. Part one: The picture of social care: data and trends* p18.

¹¹ See for example, John Carvel (2005) *Social services hindered by lack of cash* Guardian 1.12.05 quoting David Behan, when chief executive of the CSCI.

NHS over the last five years¹² – even before one considers the rapidly escalating core costs¹³ consequent upon our aging population. The political response to the dilemma could mirror that adopted for the NHS: namely major investment. This response is unattractive, ideologically (for ‘New Right’ reasons considered below) and for reasons of simple political perception: that social care – and in particular the care of the elderly – is not high on voters’ lists of concerns (unlike, for example, NHS waiting lists). Such a political calculation points therefore, not to an ‘NHS’ type solution, but to a social security solution – of converting the right to social care into a right to a fixed non-discretionary (monetary) entitlement. If the individual’s care cannot be met by this payment, then s/he will need to ‘top up’ – either from their own resources, or from social or charitable networks.

Viewed from this perspective IBs have great merit. They appear to require no additional expenditure on social care (indeed they promise ‘savings’); they have the potential to dismantle the remaining apparatus of public provision and also to return primary responsibility for social care back to disabled people and their families. To this enticing cocktail, can be added the passionate espousal of IBs by leading members of the disability rights movement.

IBs as a Governmental policy initiative

In January 2005 the *Improving the Life Chances of Disabled People* Final Report¹⁴ emphasised the importance of ‘personalising’ social care responses for disabled people, and to this end recommended that:

different sources of funding [eg - community care resources; housing adaptations; independent living; advocacy; and employment and education support¹⁵] should be brought together in the form of individual budgets – while giving individuals the choice whether to take these budgets as cash or as services. The overall aim would be to enable existing resources to be allocated and services delivered in ways that personalise responses to need, and give disabled people choice over how their needs are met.

Two months later the Government announced its intention to develop a programme to test the introduction of “‘individual budgets’” for adults with a disability or with an assessed need for social care support’.¹⁶ It is important to note that the *Improving the Life Chances* Report stressed that individuals

¹² Wanless, D (2006) *Securing Good Care for Older People: Taking a long-term view* London, Kings Fund.

¹³ Estimated to double in the next 20 years – see McCrone, P, Dhanasiri, S, Patel, A, Knapp, M, and Lawton-Smith, S. (2008) *Paying the Price: The Cost of Mental Health Care in England to 2026*: London, King’s Fund

¹⁴ Prime Minister’s Strategy Unit (2005) *Improving the Life Chances of Disabled People*, p93.

¹⁵ Ibid, p92.

¹⁶ Department of Health, footnote 9 above, p11.

should have the choice 'to take these budgets as cash or as services'¹⁷ and also that its recommendations were directed at disabled people (and not necessarily at older people or people suffering ill-health *per se*¹⁸).

In 2006, in its Community Services White Paper¹⁹, the Government outlined its programme to offer individuals IBs so that they could:

... choose to take this money out either in the form of a direct payment in cash, as provision of services, or as a mixture of both cash and services, up to the value of their total budget. This will offer the individual much more flexibility to choose services which are more tailored to their specific needs.

It will be seen that the White Paper envisaged the direct payment of cash as central to the IB programme – although of late the Government is suggesting that this is no longer the case. The White Paper was followed by an announcement²⁰ that IBs would be piloted in a number of local authority areas (the pilots running for between 18 months and two years²¹) which if successful would be followed by national implementation in 2009/10. In December 2007, well before the independent research results on the pilots were to hand, a Department of Health led concordat *Putting People First: A shared vision and commitment to the transformation of Adult Social Care* was signed by a range of Governmental and non-governmental bodies, committing councils, by 2011 to the goal of ensuring that 'everyone eligible for publicly funded adult social care support has personal budgets other than in circumstances where people require emergency access to provision' (p.3).

Legislative framework

IBs are at best a policy initiative – or perhaps more aptly at this stage merely the 'terminology of modernisation'.²² They are not referred to in any community care legislation and (as noted above) although the White Paper talked of the radical changes they may require, it did not do so in terms of changing the law. Implicitly it suggested that the initiative can be accommodated within the existing legal envelope. What little is clear about IBs however is that whatever they are, they must operate within the law, and this means that, in so far as they engage a local authority's community care obligations, it must ensure that:

¹⁷ Prime Minister's Strategy Unit, footnote 14 above, p93.

¹⁸ Ibid p22 footnote 2.

¹⁹ Department of Health, footnote 7 above, paras 4.32 et seq.

²⁰ LAC (2006)8 *Adults' Personal Social Services (PSS) Allocation 2006-07: Individual Budget Pilot Projects*.

²¹ Department of Health, footnote 7 above, para 4.33.

²² Personal communication with Department of Health.

- The person is assessed under s47 NHS & Community Care Act 1990;
- the assessment complies with binding policy guidance and directions;
- qualifying carers are offered a Carers Assessment;
- the identified needs are compared to the relevant eligibility criteria;
- all 'eligible needs', are met by service provision or by direct payments;
- 'financial resources' are not used as a reason for not meeting an eligible need;
- that the financial contribution the individual may need to make is assessed according to the relevant charging regimes and that the assessment for this, must follow the decision on the individual's support needs;
- services /support must meet minimum human rights standards – most importantly, the 'dignity' standard.

It follows that local authorities cannot, for example, operate cost ceilings on care packages; cannot offer cash payments that conflict with the Direct Payments regulations and cannot insist on a person having a Direct Payment. The IB pilot sites do not operate in a kind of Free Trade Area or other zone immune from domestic law.

Given this state of affairs it is troubling how little regard has been paid, in publications concerning the programme, to the law and binding guidance that regulates this area. The impression is conveyed that somehow IBs operate in an entirely different realm to existing community care arrangements; that a Government policy announcement somehow trumps the law. The Department of Health and the linked 'In Control'²³ web sites are essentially silent on this question, whereas the IB website suggests that compliance with community care obligations is *passé* – observing that in the pilots, local authorities adopted a 'a wide variety of approaches to the assessment of needs':²⁴

A more conservative approach involves care managers leading the assessment process in consultation with users; other approaches are almost entirely dependent on self-assessment questionnaires.

²³ In Control is a social enterprise organisation, of which it appears that the Department of Health is a partner body: see www.in-control.org.uk/

²⁴ *Individual Budgets Evaluation: A Summary of Early Findings June 2007* p8 Individual Budgets Evaluation Network at www.ibsen.org.uk/metadot/index.pl?id=2191&isa=Category&op=show accessed 28.07.08

The impression that the community care statutory regime is merely optional is also to be found in a 2007 Department of Health paper²⁵ which observes that in many pilots sites 'self assessment and the Resource Allocation System' did not replace social work involvement or a community care assessment, so there was an element of duplication. Given that Parliament has laid down a mandatory regime for the provision of community care services, the implication in this comment is surprising – namely, that somehow self assessment and a RAS can substitute for a community care assessment.

A particularly troubling dimension to this question concerns the extent to which a RAS determined resource entitlement can trump an individual's community care entitlement. The simple answer, of course, is that it cannot – policy (speculative or otherwise) cannot negate a legal right. There is some evidence, however, that this truism has been overlooked in the IB pilot areas. Henwood and Hudson, for example, refer to the perception that one benefit of the RAS is the greater certainty a person has as to their entitlement: that (citing a local authority respondent)²⁶ 'what the RAS says you get is what you get'. In some areas this appeared to translate as a fixed 'non-negotiable' allocation – for which there was an upper limit of £50,000 pa – illustrated by the following comment:

When the person from Department of Health said that the RAS wasn't fixed and if support needs were higher, increases need to be negotiated there was general amazement around the room from people who had been told by local authorities that under the RAS that was all the person could have.²⁷

The proponents of IBs, promote, on occasions, a false dichotomy – essentially that that the failings of the existing community care regime means that IBs are a good thing. Lapses of logic of this type are all the more painful when they pray in aid the law. A good example is the following extract from the 2008 Demos report, which seeks to highlight the benefits of IBs over direct payments:

Under a direct payment a person can take their care budget as a single payment so they can employ staff to support them. For many this is a major step forward compared with traditional services. Yet direct payments, in practice, have come with their own downsides, largely because of the myriad rules and regulations imposed by central government and local authorities.²⁸

²⁵ Department of Health (2007) *Older People's Services and Individual Budgets Good Practice - Examples and Ideas* May 2007: a paper written by Angela Nicholls for the Department of Health and the Care Services Improvement Partnership (CSIP) at p13.

²⁶ Henwood & Hudson, footnote 5 above, para 3.46.

²⁷ Private correspondence (2008) Major UK Charity.

²⁸ Leadbeater, C. Bartlett, J and Gallagher, N (2008) *Making it Personal* London: Demos, p30-31.

The argument is fallacious since (a) a person does not have to use their direct payment to employ staff; and (b) IBs are subject to exactly the same constraints, since (absent a change in the law) any payment made to a service user from a social services budget as an IB is (at law) a Direct Payment. A similar criticism can be levelled at the comment in a CSIP 2007 publication that:

With Direct Payments, some people felt that there had been an overemphasis on checking whether people were using their money for the 'correct' purposes. ... the emphasis on outcomes with Individual Budgets allows for a simpler approach to the monitoring and review process.²⁹

Likewise, the following quotation used by Henwood and Hudson to illustrate the shortcomings in what they refer to as 'traditional standard' Direct Payments arrangements:

Individual Budgets give you more freedoms and that's a really good thing. Why pay somebody to come in and do the support if your family member is living there with you and you can save on travel costs?³⁰

'Traditional' direct payments already allow payments to family members, and if they did not, then IBs couldn't do either, because – at the risk of repetition³¹ - in this context an IB is (at law) a Direct Payment.

The morality of the 'New Right'

The policy and research material contains a perplexing mix of dogmas, of which the approach of the New Right would appear to be the dominant discourse: privatisation, commoditisation and individualism tinged with a form of moral communitarianism. Mark Drakeford (1999) suggests that this approach is underpinned by the perception that 'primary responsibility for care of this sort should lie not with the state at all, but with families and charitable provision'.³² Conceptualising social care support in this way leads into the language of obligations: of individual and family responsibilities. It leads to criticism of those whose approach envisages collective solutions and who believe in the left side of the social contract – that the state exists to provide for frail and vulnerable people. It leads to the conversion of 'rights'

²⁹ Nicholls, footnote 25 above.

³⁰ Henwood & Hudson, footnote 5 above, para 2.10.

³¹ These are not isolated misconceptions – see for example, Henwood & Hudson, footnote 5 above, at para 2.12 concerning the flexibility of 'SDS' as compared to current arrangements which is illustrated by the quote ' ... For example if Joe X wants to go to a football match he could say to a neighbour 'I'll buy your ticket if you come with me'.

³² Drakeford. M (1999) *Social Policy and Privatisation*: London, Longman, p .103

into 'purchases' and as one less than enthusiastic IB service user complained, to the loss of her 'choice' to keep her existing local authority care service.³³

The focus on individual and family responsibility for social care provision is evidenced in much of the IB literature: which Ferguson describes as the process of 'reponsibilization'.³⁴ Hatton *et al* (2008) refer to the 'moral foundations of social care'³⁵ and provide an extended list of the responsibilities of 'citizenship' including duties 'to decide on the best use of the resources available'³⁶; 'to be in control of planning, selecting and managing their supports'; 'to explain their decisions, reflect on what they are learning from their experience of support and share what they have found with others.'³⁷ In this context, Beresford and Jones (2008), whilst stressing the potential for the personalisation agenda, have warned that 'it carries the dangers of just passing on to disabled people the requirement and responsibility to be the restrictors of their own ambitions'³⁸ and ultimately that disabled people might end up being blamed and held to account 'for how they fail to manage their lives and aspirations with the little money that is made available':³⁹ in essence, the transfer of risk to the individual.⁴⁰

The New Right emphasis on individual responsibility for social care and its concomitant espousal of what might be termed moral communitarianism results in carers being drawn into the discourse of 'duties'. This sleight is illustrated in the Hatton *et al* (2008) report which suggests that service users have duties 'to contribute to mobilizing the support they require'⁴¹ and 'to engage available capacities outside the social care system'⁴²: this would appear to be shorthand for 'carers' and in most cases this means 'family'. It is perhaps ironic that just as the 'liable relative' rule is abolished⁴³ we are witnessing a programme that seeks to resurrect another Poor Law relic – the liable family rule.

The 2007 *Putting People First* concordat agreeing to the rollout of personal budgets by 2011 occurred before the publication of any independent research on the impact of the programme on carers. This paper is unable to explore these implications in any detail – but clearly they are likely to profound – and

³³ Cohen, (2008) *Letter to Community Care* 24 January 2008 p12.

³⁴ Ferguson I (2007) *Increasing User Choice or Privatizing Risk? The Antinomies of Personalization*, *British Journal of Social Work*; vol 37: 387 – 403.

³⁵ Hatton et al, footnote 6 above, p127.

³⁶ Hatton et al, footnote 6 above, p 124.

³⁷ Hatton et al, footnote 6 above.

³⁸ Beresford, P and Jones, R (2008) *Fair Shares Society* Guardian 23rd January 2008, p3.

³⁹ *Ibid.*

⁴⁰ Ferguson, see footnote 34 above.

⁴¹ Hatton et al, footnote 6 above.

⁴² Hatton et al, footnote 6 above, p 124.

⁴³ Health and Social Care Act 2008, s147.

quite probably negative, especially if (as is envisaged) they become the primary broking service providers.⁴⁴

Allied to its espousal of the individual as consumer, the personalisation agenda additionally seeks to challenge the state's paternalistic⁴⁵ role as a commissioner and as a provider of services. It is in this respect that the rhetoric of cultural change becomes almost evangelical⁴⁶ with troubling comments about the existing 'institutionalised professional culture in tension with the new paradigm' having to be 'unlearned'.⁴⁷ This 'unabashed quasi-religious enthusiasm'⁴⁸ for the personalisation agenda can be seen as problematic, for three specific reasons.

Firstly it can be a mask to foil those who seek to analyse the substance of the programmes' claims: as one respondent is cited as saying of a presentation on the subject '10 out of 10 for campaigning zeal but a very low score for addressing the wicked issues which were over simplified'.⁴⁹

Secondly, its use of jargon – often revolutionary jargon – can obscure some of the programmes many positive traits. For example, a statement such as 'the paradigm-changing implications of the SDS model and of the need for cultural transformation'⁵⁰ conveys little of value, as at first sight does the assertion that '[a]t the heart of the new paradigm lie three key ideas: user control, choice of service and flexibility of support'.⁵¹ On one level one could validly retort that 'choice' and 'flexibility' were core elements of the community care reforms proposed in the Griffith's Report of 1988⁵² – but then again, 'user control' is in fact a relatively new idea and has great value and is capable of standing as a maxim on its own.

Finally the repetition of the need for cultural change – of 'professionals opting for 'service-led' decision-making'⁵³ - suggests that the solution to the problem of providing decent and cost effective social care is rooted primarily in the inappropriate ideological outlook of social workers and disabled people rather than acknowledging the complexity of the problem and in particular the complexity of the market place for social care services. Such a simplistic

⁴⁴ In this regard, see Clements, L (2007 - unpublished) *Individual Budgets and Carers* at www.lukeclements.co.uk/page1/page1.html accessed 28.07.08, and see also Moullin, S (2008) *Hidden Heroes* Guardian June 4th 2008.

⁴⁵ See for example, Henwood & Hudson, footnote 5 above, p ii.

⁴⁶ What Henwood & Hudson, footnote 5 above, refer to (at para 2.22) as ideological 'evangelism'.

⁴⁷ Henwood & Hudson, footnote 5 above, para 2.31.

⁴⁸ See for instance Henwood, M (2008) *Self-directed support: grounds for optimism in Community Care* 15 May 2008 pp 34 – 35 at 35.

⁴⁹ Henwood & Hudson, footnote 5 above, para 4.5.

⁵⁰ Henwood & Hudson, footnote 5 above, para 2.19.

⁵¹ Henwood, M. & Hudson, B (2007) *The road ahead* Community Care 15 November 2007 p23.

⁵² Griffiths, R. (1988) *Community Care: An Agenda for Action. A Report to the Secretary of State for Social Services*, London: HMSO.

⁵³ Hatton et al, footnote 6 above, p69.

approach fails to get to grips with the reality of a profound supply side imbalance – and its causes.

It is often said that the IB programme is not about systems change, but about cultural change.⁵⁴ If this is the case, it should also be acknowledged that it was the FACS systems that this Government put into place that reinforced the culture that is now deemed in need of change, and that this fierce system of micromanagement not only ‘did things to disabled people’, it also ‘did things’ to the professionals that had the misfortune to operate it: FACS is big on budgets, big on ‘gate-keeping’ and silent on independent living and ‘dignity’.⁵⁵

Conceptual naivety

The repeated use of revolutionary jargon has the danger, as noted above, of diverting attention from the ‘wicked issues’: the complexities of the social care system that cannot be resolved simply by sending front line social work staff to re-indoctrination (or re-employment) centres. The literature so far published on the personalisation agenda display a degree of naivety when addressing a number of these difficult questions, of which the following are illustrative:

- What is meant by ‘equity’?
- What is meant by ‘user choice’?
- What does ‘self-assessment’ connote?

The conceptualisation of ‘equity’

The literature makes frequent reference to ‘equity’ and ‘inequity’: in general terms, inequity is associated with the existing system and greater ‘equity’ associated with the new programme. A CSIP report (2007)⁵⁶ for example observes that ‘under the traditional approach, when budgets become tight, individuals receive less – and this is often the source of ... inequities’. Henwood & Hudson 2007⁵⁷ cite a respondent’s comment that due to the complexities of the marketplace ‘learning disability provision is more costly than it is for older persons’ provision and equity isn’t the same in some

⁵⁴ See for example. Hatton et al, footnote 6 above, p69.

⁵⁵ Save only that it does state (almost as a curiosity) that ‘Many service users value their autonomy and dignity, and their ability to make informed and independent choices, very highly’ FACS Practice Guidance at Q3.5 A.

⁵⁶ Nicholls, footnote 25 above, para 58.

⁵⁷ Henwood & Hudson, footnote 5 above, para 3.39.

respects'. Hatton *et al* 2008⁵⁸ observe (in relation to the payment of brokers) that people who have no family or friends to rely on would in consequence be 'treated less equitably than others' and (in relation to a discussion on the virtues of the RAS allocation system) that it:⁵⁹

identifies an objective level of need. This level of need is then used to determine how much money an individual should receive in their Personal Budget. This has an immediate benefit in terms of equity because it enables people with the same level of need to receive the same level of funding.

The literature contains no discussion as to how in this context, 'equity' is to be conceptualized – or indeed from whose perspective it is to be assessed. Equity for a local authority commissioner may be inequity for the service user: a standardised 'entitlement allocation' may appear equitable to the administrator, but be anything but for service users and their carers. It is not that one would seek an extended discussion on the relative merits of Rawls or Sen & Nussbaum or Dworkin or Roemer, but given that so much emphasis is given to the greater 'equity' of IB arrangements, the absence of any discussion on this key issue is troubling. The general tenor of the literature, however, is that equity is envisaged in New Right monetarist terms – that its assessment is essentially a financial accounting exercise. Such an approach would appear to be unsatisfactory, in terms of outcomes, for many community care service users where equity should presumably be measured in terms of the quality and effectiveness of the support that is provided and whether it achieves the desired outcomes of the individuals, rather than its cost. This is particularly so in an area where the market is distorted by supply side deficits and the availability of services is often dependent upon a high degree of 'chance'.

The reality of, and the value of choice

Choice is expressed as one of the three key ideas 'at the heart' of the social care personalisation agenda.⁶⁰ It is very much a New Right mantra and was billed as central to the previous 'big idea' – community care – where the 1990 reforms were to:⁶¹ 'give people a greater individual say in how they live their lives and the services they need to help them to do so'. Choice has received an obligatory five star mention in every succeeding policy document.

⁵⁸ Hatton *et al*, footnote 6 above, p70.

⁵⁹ Hatton *et al*, footnote 6 above, p33.

⁶⁰ Henwood, M. & Hudson, footnote 50 above p23.

⁶¹ Secretaries of State for Health, Social Security, Wales and Scotland, *Caring for People: community care in the next decade and beyond*, Cm 849, HMSO, 1989, para 1.8.

As with 'equity' the IB literature contains no discussion as to how in this context, 'choice' is conceptualized; why it is deemed to be a principle of the first order and whether it is *per se* always a 'good thing'. As Wistow⁶² has observed, choice as an outcome, in the community care context, is a flawed concept: the reasons he gives, include:

First, some users of social care services do not voluntarily choose to access them. Second, the very conditions that give rise to the need for services may militate against choice (for example, frailty, confusion, mental health problems, personal and family crisis, or the 'breakdown of caring relationships'). Third, decisions about access to social care are generally rare lifetime events and we have little previous experience to guide or inform our choice. Finally, the concept of choice is inherently flawed if there are too few options.

An analysis of the value of 'choice' is necessary for the additional reason that the existence of power relations within the realities of the social care environment mean that the choices made by one group (eg men and/or the articulate) may limit those of another.⁶³ If, for example, half the service users in a care facility opt for an alternative service, it may mean that the remainder cannot choose to use it, as it has ceased to be economic.⁶⁴ Carers are a very significant 'group' in this dynamic: what weight is to be accorded to their right to 'choose' if service user choice is pre-eminent?

Choice would appear to be self evidently a 'good thing' for those disabled people who have the ability, the will and the energy to exercise it. It should however be remembered that the community care client group is not necessarily dominated by this group – in terms of expenditure over 60% of the community care budget is spent on services for older people, who generally access services as a result of a crisis – and at a time when their ability to make 'informed choices' about care support arrangements may not be great.⁶⁵

An informed analysis would also question why choice has been prioritised over the right to a 'decent support service': or (put in the alternative) whether 'choice' generally leads to a 'more decent service'. Putting aside how one measures such a thing, self funding service users are already 'in control' of their care arrangements and the evidence suggests that they 'have a poor

⁶² Wistow, G (2002) *Social Care's Wider Role* Community Care 26 Sept 2002, p34-36.

⁶³ See for example, Lewis, J. and Giullari, S. *The adult worker model family, gender equality and care: the search for new policy principles and the possibilities and problems of a capabilities approach* in *Economy and Society*, Volume 34 Issue 1 2005 76 – 104 and Clements, L. *Winners and Losers: Social Exclusion and the impact of the Human Rights Act* in *Human Rights Act: A Success Story?* (L Clements & P Thomas – eds) *Journal of Law and Society*, Spring 2005 pp 34 – 51.

⁶⁴ See in this respect comments of Des Kelly, Executive Director of the National Care Forum cited in Cole A (2008) *Will care become a commodity?* *Guardian*, 6 February 2008 p 13.

⁶⁵ 61% on older people and 21% on adults aged 18 to 64 with learning disabilities: CSCI footnote 10 above, Part one: p17.

quality experience' compared to those who do qualify for traditional local authority support.⁶⁶

In the current social care market, choice is all too often determined by the extent of an individual's resources. It is a legitimate question to ask "why the personalisation agenda will increase the availability of choices in this 'minimum wage' market place, when there is to be no new funding and when the increased (independent sector directed) funding that accompanied the community care reforms so evidently failed?"⁶⁷

What does 'self-assessment' connote?

The discussions concerning the assessment process and the idea of 'self-assessment' are one of the most troubling examples of the conceptual naivety underpinning the personalisation agenda. An early example is the Department of Health's 2005 statement that:⁶⁸

For too long social work has been perceived as a gatekeeper or rationer of services We want to create a different environment, which reinforces the core social work values of supporting individuals to take control of their own lives, and to make the choices which matter to them.

Whilst the Government might dislike the idea of social workers being 'perceived' in this way, there is absolutely no doubt that this is one of their core functions. Social care resources (like all public resources) are scarce and access to them must be regulated by a state agent. Lipsky, in his seminal analysis of the rationing process, referred to these agents as 'street-level bureaucrats' and observed that:⁶⁹

Street-level bureaucrats have discretion because the nature of service provision calls for human judgment that cannot be programmed and for which machines cannot substitute ... It is the nature of what we call human services that the unique aspects of people and their situations will be apprehended by public service workers and translated into courses of action responsive to each case within (more or less broad) limits imposed by their agencies

Individuals cannot 'self assess' their entitlement to social services resources, anymore than they can choose the value of their children's state educational support. Notwithstanding this truism, the literature suggests that the

⁶⁶ Ibid.

⁶⁷ See Clements, L and Thompson, P. (2007) *Community Care & the Law*: London, Legal Action at para I.24.

⁶⁸ Department of Health, footnote 9 above, p10.

⁶⁹ Michael Lipsky, *Street-Level Bureaucracy*, Russell Sage Foundation, 1980.

assessment process is essentially simple; that human judgment can be dispensed with and that machines (in the form of a RAS) can substitute. By way of example, Leadbeater *et al* (2008)⁷⁰ state that 'the self-assessment is checked and quickly translated into a resource allocation: a sum of money': Browning (2007)⁷¹ states that 'people start with a self-assessment, albeit with help where necessary. The resources they are entitled to are then determined at the beginning of the process through a resource allocation system (RAS)'.

States' cannot (and do not) give their citizens blank cheques. To retain confidence in the allocation process they empower intermediaries (eg social workers) to make these discretionary judgments. There remains however the problem that these quasi-professionals might prove to be excessively generous in their decision making and to guard against this eventuality, the state makes them:⁷²

... more accountable by reducing their discretion and constraining their alternatives. [by writing] manuals to cover contingencies. [and auditing] performance of workers to provide retrospective sanctions in anticipation of which it is hoped future behaviour will be modified.

It is out of this imperative that we have the assessment process, Fair Access to Care Services (FACS), the Single Assessment Process (SAP) and so on. Whilst few would deny that the current assessment regime has achieved absurd levels of micro-management⁷³ the basic requirement for discretionary decision makers, guidance manuals and audit trails is – in a Western democracy – as inevitable as death and taxation.

Henwood & Hudson (2007)⁷⁴ acknowledge the incongruity between 'self assessment' and the requirement of 'balancing the budget' and pose the question 'how does self-assessment fit with FACS?': a question that has not as yet been answered. Although Henwood has observed⁷⁵ that:

it would be very regrettable if gatekeeping remained paramount because eligibility criteria are so tight. We mustn't raise people's expectations and then say personalisation doesn't apply because they don't qualify.

⁷⁰ Leadbeater *et al*, see footnote 28 above, p23.

⁷¹ Browning, D (2007) *Evaluation of the Self-Directed Support Network: A Review of Progress up to 31st March 2007: 3rd Draft: 31st May 2007*. London: Care Services Improvement Partnership (CSIP), p1 at http://icn.csip.org.uk/_library/Resources/Personalisation/Personalisation_advice/Evaluation_of_Self_Directed_Support_draft_3_David_Browning_May_07.pdf accessed 28/07/08.

⁷² *Ibid*.

⁷³ See for example, Clements and Thompson, footnote 67 above, para 3.5.

⁷⁴ Henwood & Hudson, footnote 5 above, para 3.33 and see also para 3.29.

⁷⁵ Cited in Ivory, M (2008) *Time's up for gatekeeping* Community Care 12 June 2008 p27.

Resource Allocation Schemes (RASs)

A core element of the IB programme is a computation mechanism (generally termed a 'resource allocation system' (RAS)) that converts the individual's self assessment into a fixed sum. The proponents of the IB programme consider it vital that individuals are notified of the value and of their entitlement to this sum.

The process for developing a RAS has been discussed in a number of reports⁷⁶ and most prominently by an organisation 'In Control'⁷⁷ of which it appears, the Department of Health is a partner body. In general a RAS reduces the needs of a community care service user to a 'points score', and then assigns a value to each 'point' conditioned by the local social care market. At its simplest, the individual's score is multiplied by the value of the 'point' to provide their IB: a process that could be described as the ultimate end of commoditisation – having commoditised social care, the RAS now commoditises individual need: or 'objective need'.⁷⁸

The law however is framed in terms of an entitlement to have care needs met – not in terms of an entitlement to a financial payment (that may or may not 'meet need'). The direct payment legislation too is framed in terms of a right to a payment that secures the provision of the assessed service needs.⁷⁹

The proponents of the RAS either believe (a) (contrary to Lipsky's assertion) that machines can substitute for the function of service provision; or (b) that service provision can cease to be an individual process. In either case they accept that there will be losers, but consider their loss is a price worth paying for the (purported) efficiency savings.

Cost reductions

In most formulations, the RAS computation incorporates a cost abatement 'multiplier' that reduces the value of the IB: this factor, which is entirely arbitrary, is justified as encouraging 'cost-efficiency and [to] protect against overspending'⁸⁰ or 'value for money improvements'⁸¹ or providing 'headroom ... to avoid overspending'⁸², or to avoid inducing 'dependency'⁸³ (a curious

⁷⁶ Browning, footnote 71 above.

⁷⁷ See www.in-control.org.uk/

⁷⁸ Hatton et al, footnote 6 above, p33.

⁷⁹ The Community Care, Services for Carers and Children's Services (Direct Payments) (England) Regulations 2003 SI 762 regulation 4(3) and see the Community Care (Direct Payments) Act 1996; accounting and financial management guidelines. Chartered Institute of Public Finance and Accountancy (1998).

⁸⁰ Browning, footnote 71 above, p 15.
accessed 28/07/08.

⁸¹ In Control (2008) *Creating a Resource Allocation System (RAS4)*.

⁸² Browning, footnote 71 above, para 58.

argument – in that the begs the question as to what would be the effect of an under-allocation of resources?). The literature then reports that IBs have resulted in cost savings to authorities of between 9% and 45%⁸⁴ (ie broadly equivalent to the cost abatement multiplier). It is not surprising therefore that a number of commentators have suggested that the IB model is ‘essentially about cost reduction’⁸⁵: that the policy ‘gives way, when scratched, to hidden rationing and restrictions’.⁸⁶

The overall losers appear to be people ‘with higher and more complex needs’⁸⁷ – which the ‘In Control’ organisation suggests is ‘not necessarily a bad thing’.⁸⁸ The problem has been exacerbated by some RAS allocation schemes imposing a maximum payment band of £50,000.⁸⁹ Whilst this of course is unlawful – in that eligible community care needs must be met regardless of resources – many service users and their carers will be unaware of this fact and simply accept it as the limit of their legal entitlement. The difficulty for people with high care needs is that the social care market is distorted through supply side imbalances for certain groups - for example learning disabled adults with challenging behaviour or people with profound sensory impairments. In such a situation, the cost of a care package may change radically from one day to another – and be determined by the highly specific needs of the individual and by ‘chance’. The fact that there is no ‘objective’ cost for such care packages severely undermines the concept of RAS’s – but paradoxically the literature frequently interprets this as a ‘problem’ of the ‘marketplace’⁹⁰ rather than the RAS.⁹¹ Accordingly Hatton *et al* express disappointment that ‘two individuals who have similar needs might have services costing £3,000 or £30,000’⁹², whilst then acknowledging that these differences could ‘represent costs in real services in particular markets’⁹³. It is one thing to use a computer to simulate reality, but quite another thing to criticise reality when it fails to live up to a computer’s prediction: particularly when the simulation enables those on the highest

⁸³ Brindle, D (2008) *We must be wary of cost-cutting* Society Guardian 6th February 2008 at p5

⁸⁴ Leadbeater et al, see footnote 28 above, that suggests between 10% and 15% (p37)- rising to 45% or the most expensive services (p3); Hatton et al, footnote 6 above, p S. Senker, J. Crosby, N. Poll, C. Tyson, A, O’Brien, J & Towell, D (2008) *A report on in Control’s Second Phase: Evaluation and learning 2005 – 2007*. London: in Control Publications suggests 9% (p47) and 15% (p48).

⁸⁵ Brindle, D (2008) *We must be wary of cost-cutting* Society Guardian 6th February 2008 at p5.

⁸⁶ Beresford & Jones, footnote 38 above, p, R (2008) *Fair Shares* Society Guardian 23rd January 2008, p3.

⁸⁷ Henwood & Hudson, footnote 5 above, para 3.37.

⁸⁸ In Control (2008) *Creating a Resource Allocation System (RAS4)*, p13.

⁸⁹ Private correspondence (2008) Major UK Charity and Brindle, D (2008) *We must be wary of cost-cutting* Society Guardian 6th February 2008 at p5.

⁹⁰ Henwood & Hudson, footnote 5 above, para 3.36.

⁹¹ See for example Browning, footnote 71 above, p55.

⁹² Hatton et al, footnote 6 above, p33.

⁹³ *Ibid* p34.

level of need to have their care support cut – for no other reason than the cost disturbs the purity of a graph's curve.

SDS without a RAS

The principle of SDS can function without the need for a RAS. The computation of the value of a direct payment, for example, is in general done by a relatively transparent and fair process which is tied directly to the individual's assessed need. Such criticism as there has been of the process, concerns the level of the payment⁹⁴ rather than the process of calculation. Given the practical and philosophical shortcomings of the RAS programmes – and their increasingly demanding nature in terms of input information⁹⁵ - it could be argued that dogged insistence on their pivotal role is undermining the effective development of SDS. A pilot in Coventry, for instance, has shown that the aims of SDS can be achieved without the use of a RAS – and thereby created a model that does not require the abolition of care management and all the organisational turbulence that this would cause.⁹⁶

Given that the development of the personalisation agenda does not require the deployment of RASs, it is legitimate to ask why such political investment has been made in the idea of all service users being advised, at an early stage, of the value of their IB? More specifically, what possible benefit is there for a service user in knowing the value of the IB if s/he does not want (or is simply unable – even with a broker) to direct their own support? Arguably, for many service users the benefit is not to them, but to the state. For the state, it provides almost total cost control and 'greater certainty' over 'forward planning, with a much clearer idea of the cost envelope involved'.⁹⁷ A budget allocation can be index linked and in difficult years the cost abatement multiplier can be adjusted and the risk of 'care inflation' transferred to the service user.⁹⁸

⁹⁴ See for example, the Audit Commission, *Choosing Well*, 2006, and Davey, V. (2006), *Direct Payment Rates in England*, PSSRU, Kent University, 2006 at www.pssru.ac.uk/pdf/uc/uc2006/uc2006_directpayments.pdf accessed 28/07/08.

⁹⁵ See for example Henwood and Hutton, footnote 5 above, para 3.38 and Hatton et al, footnote 6 above, p36.

⁹⁶ Reece, A (2008) *The social Care System - Beyond repair or missing vital parts?* [publication pending Journal for Integrated Care October 2008].

⁹⁷ Henwood & Hudson, footnote 5 above, para 3.46.

⁹⁸ Ferguson, see footnote 34 above.

Industrialisation

The 'mould breaking' revolutionary language promoting IBs spring from the assumption that the current system is broke⁹⁹ and that wholesale system change is required. The independent research evidence for the effectiveness of IBs – and their impact on 'all community care' service users and their carers – is slight in the extreme. The few truly independent research papers that have been published have all acknowledged their small sample sizes. On the other hand the evidence is incontrovertible, that the organisational turbulence accompanying wholesale system change in the public sector not infrequently undermines their stated ambitions. We have only to look at the NHS systems reforms of the last 10 years to understand this point.

The Government is proposing to provide every community care service user with a personal budget by 2011. An understanding of what this will entail, requires an appreciation of the scale of the task and the extent of the resources available for the task. As to scale, at present it appears there are perhaps 4,000 IB holders and about 50,000 Direct Payment recipients.¹⁰⁰ These figures should be contrasted with the 1.75 million adult social services service users¹⁰¹, and that as a proportion of total social services expenditure direct payments constituted (in 2007) 2% of community care expenditure.¹⁰²

As to resources, the Government is clear that the reforms will be achieved within the exiting 'funding envelope': that there is no commitment to additional resources. It must follow the proponents of IBs believe 'that there will be savings made in different parts of the system which allow trade-offs of higher costs elsewhere'.¹⁰³

Even if this proves to be the case it begs the question of the hump costs. There will be a transitional phase, when the existing commissioners are supporting those in traditional care packages (and those moving to IBs¹⁰⁴) whilst the new army of 'brokers' are supporting their new IB recruits. During this period there will be 'double running costs ... to resource both the old and the new services in parallel'.¹⁰⁵

⁹⁹ See Duffy, S (2007) *The Economics of self-directed support*, Journal of Integrated Care, vol 15(2): 26-37.

¹⁰⁰ As at 31 March 2007, there were 40,600 adult direct payment service users: CSCI footnote 10 above: Part one: p.17.

¹⁰¹ During 2005-06 1.75 million adults received one or more social care services from councils: CSCI footnote 10 above: Part one, p17.

¹⁰² CSCI footnote 10 above: Part one, Table 3.1.

¹⁰³ Henwood & Hudson, footnote 5 above, para 3.43.

¹⁰⁴ Hatton et al, footnote 6 above, p69 which found that 71% of the successful service users in their sample had social work support; and Browning, footnote 71 above, para 88, found that the SDS initiative was increasing the workload on care managers.

¹⁰⁵ Mansell J, Knapp M, Beadle-Brown J and Beecham J (2007) *Deinstitutionalisation and community living – outcomes and costs: report of a European Study. Volume 1*: p 9-10.

Of course the costs assumption may prove to be wrong (as it was in relation to Direct Payments¹⁰⁶). Beresford and Jones suggest that IBs could prove to be more costly, in that 'moving away from institutional services where large numbers of people are warehoused together is likely to be more intensive in terms of providing the flexible personal assistance that is required'.¹⁰⁷ Henwood and Hudson also note that the loss of local authority 'block contracts' for social care may have an adverse costs impact.¹⁰⁸

The industrialisation of IBs from a few thousand at present to over a million within three years raises questions of the highest order of concern.¹⁰⁹ In concluding, this paper can do little other than summarise, some of these. They are concerns that ought to have been tested out by research, but it seems that the concept of IBs is simply too appealing to have to undergo such an analysis.

From where will the new providers emerge? The evidence suggests that current service providers have 'a low awareness of what the changes might signal' and in fact feel destabilised by the changes.¹¹⁰ There is even a risk – possibly not too farfetched – that during the transitional period, many service providers will go into a cash flow 'meltdown', once service entitlement is converted to money and whilst service users are deciding how they will spend their (probably inadequate) IB. The experience of the 1990 community care reforms – designed to herald a vibrant new mixed economy of care – suggests that this is an unpromising area for industrialisation.

The new care opportunities may be small scale and low paid.¹¹¹ Leaving aside the employment, health and safety rights of these workers (predominantly women), there are serious questions as to whether there exists a workforce of the size required.¹¹²

The IB programme envisages a significant number of budget holders employing advisers – often referred to as brokers. The evidence suggests that there are not large numbers of qualified individuals able to take on this role¹¹³ and that few localities have user-led organisations (or the immediate potential

¹⁰⁶ Audit Commission, *Choosing Well*, 2006.

¹⁰⁷ Beresford & Jones, footnote 38 above, p3.

¹⁰⁸ Henwood & Hudson, footnote 5 above, para 3.91.

¹⁰⁹ See Hopkins, G (2008) *Visionary initiatives need visionary solutions* in *Community Care* 7 February 2008 at p28.

¹¹⁰ Henwood & Hudson, footnote 5 above, p.iv.

¹¹¹ Sense (2008) *Deafblind people and families' experiences of direct payments* London: Sense (also at www.sense.org.uk/directpayments accessed 28/07/08) which reported that hourly rate of direct payments were often insufficient to pay specialist staff with the skills to work with deafblind people

¹¹² Yeandle, S, Shipton, L and Buckner, L (2007) *Local Challenges in Meeting Demand for Domiciliary Care*: Sheffield, Sheffield Hallam University p14; and see also Sense (2008) *Deafblind people and families' experiences of direct payments* London: Sense (also at www.sense.org.uk/directpayments accessed 27/07/08). Which identified a shortage of appropriate staff to hire through direct payments.

¹¹³ Henwood & Hudson, footnote 5 above, para 3.76.

of developing one) that could facilitate development of this sector.¹¹⁴ There appears little independent research on the cost impact of a new brokerage 'profession'. It is suggested that payment may be at £20 per hour¹¹⁵ or their 'fee calculated as a percentage' of the individual's IB.¹¹⁶ Presumably, however such a costs impact evaluation must exist – since the 'authorised representative' provisions in the Disabled Persons (Services, Consultation and Representation) Act 1986 s1 (which remain on the statute book) have not been brought into force because of their cost implications.¹¹⁷ If (as is being suggested) brokers are to be licensed¹¹⁸ and subject to 'regulation and accreditation' then this too is likely to have significant cost impacts.¹¹⁹

Another factor that is uncertain is the extent to which fraud could unsettle the programme. In this context, although major fraud is unlikely to come from service users it is quite possible that third parties will seek to exploit the new regime (given that many of the service users will have insufficient information or experience to make appropriate choices and may also be exhausted, unassertive and/or lacking sufficient mental capacity). Fraud was responsible for the collapse of a not dissimilar programme, Individual Learning Accounts¹²⁰ and a Swedish IB type social care scheme also suffered from significant fraud – not by budget users but by some of the independent personal care providers.¹²¹ The potential for fraud to cause political embarrassment as well as to impact on the cost of the scheme is likely to result in the inevitable bureaucracy of financial auditors and monitors 'ensuring there are adequate audit trails'¹²² and, history suggests, that their remit will extend incrementally beyond the hoped for 'light-touch' approach.¹²³

¹¹⁴ Maynard Campbell, S with Maynard, A and Winchcombe, M (2007) *Mapping the Capacity and Potential for User-Led Organisations in England* Equal Ability and Future Inclusion Ltd para 4.12- at www.tinyurl.com/3dtvoq accessed 27/07/08.

¹¹⁵ Hatton et al, footnote 6 above, p72, and see also p64 and 70.

¹¹⁶ Leadbeater et al, see footnote 28 above, p46.

¹¹⁷ Virginia Bottomley House of Commons Hansard, written answers to questions 22nd March 1991 column 252.

¹¹⁸ Leadbeater et al, see footnote 28 above, p46.

¹¹⁹ Hatton et al, footnote 6 above, p71.

¹²⁰ Leadbeater et al, see footnote 28 above.

¹²¹ Waterplas, L and Samoy, E (2005) *L'allocation personnalisée : le cas de la Suède, du Royaume-Uni, des Pays-Bas et de la Belgique* in *Revue Française des Affaires Sociales*, 2/2005 pp. 61-101; and personal communication with the authors.

¹²² Henwood & Hudson, footnote 5 above, para 3.65.

¹²³ Leadbeater et al, see footnote 28 above.

Conclusions

This paper has sought to highlight the conceptual naivety surrounding some aspects of the IB programme and some of the pitfalls that may jeopardise its roll out over the next three years. It is not a critique of the Department of Health's personalisation agenda *per se*, but it is a criticism of the decision to 'go national' with the programme before the results of the pilots have been fully evaluated by independent research studies of significant sample size.

The Department of Health's personalisation agenda has much to recommend it, if it is implemented on a human scale. At this time, there appears every prospect that this will not occur: that lessons that might be learned from the research – as to 'what works' (or more importantly 'what doesn't work') - will not be taken on board in the wholesale industrial roll out of the programme. If this fear is realised, then it will be disabled, elderly and ill people, and their carers who will be the losers.