

## **Do Individual Budgets Work and at What Price?**

**Karen Jones, Ann Netten, José-Luis Fernández, Martin Knapp, David Challis, Caroline Glendinning, Sally Jacobs, Jill Manthorpe, Nicola Moran, Martin Stevens and Mark Wilberforce**

### **Abstract**

Currently, the implementation of individual or personal budgets (IBs) is central to the drive towards personalisation in reshaping the delivery of social care for adults in England. The main premise is to allow more choice in the organisation of the allocated resource and purchasing of support among people eligible for publicly funded social care. The implementation of individual budgets was piloted within 13 local authorities during 2005-07 and the Department of Health commissioned an independent evaluation of these pilots. There were two main objectives of the evaluation. Firstly, to identify whether the approach improved outcomes for people by giving them greater control over the type of support they accessed and over the way that support was organised and delivered. Secondly, the evaluation explored whether IBs cost more or less than conventional arrangements, and how the costs compared across different service user groups. Overall, holding an IB was associated with better social care outcomes, including higher perceived levels of control, but not with overall psychological well-being in all user groups. Very little difference was found between the costs of IBs and a comparison group receiving conventional social care support. The average weekly cost of an IB was £280, compared to £300 for people receiving conventional social care. Overall, IBs appeared cost-effective for social care outcomes – i.e. they produced better outcomes for the costs incurred, compared with standard care – but not for psychological well-being. IBs were cost effective for mental health service users and physically disabled people with respect to both social care and psychological well-being outcomes. For people with learning disabilities, IBs were cost-effective with respect only to social care. For older people, there was no difference in social care outcomes, but standard care arrangements remained slightly more cost-effective, and people receiving these reported higher levels of psychological well-being.

### **Introduction**

Individual budgets (IBs) have been seen as a vehicle for increasing choice and control over how support needs are met among people eligible for publicly funded social care. They were first announced in the Cabinet Office Strategy Unit report *Improving the Life Chances of Disabled People* (Cabinet Office, 2005) and subsequently formed a key proposal in the White Paper *Our Health, Our Care, Our Say* (Department of Health, 2006). While giving control to people eligible for publicly funded social care is not a new concept (earlier such initiatives include Direct

Payments and *In Control*<sup>1</sup>), individual budgets were devised as a means of overcoming a number of obstacles associated with previous initiatives. In addition, IBs were intended to reduce the multiple assessments and lack of flexibility experienced by disabled people who were eligible for help from a number of relatively similar programmes and funding streams. In July 2005 the Department of Health invited local councils with responsibilities for adult social services to pilot individual budgets. Thirteen local authorities volunteered and the pilot projects ran from November 2005 to December 2007.

The IB pilots had the following objectives:

In previous initiatives, local authority social workers or care managers maintained a central role in the assessment process. In contrast, IB pilots were encouraged to develop ways to allow service users to have more control over the assessment of their needs.

Sites were to test the feasibility of integrating resources from several funding streams into a single IB. In addition to adult social care, additional funding streams were to include resources from Access to Work (AtW); the Independent Living Fund (ILF); Supporting People (SP); Disabled Facilities Grants (DFG); and local Integrated Community Equipment Services.

Individuals were to be informed of the level of resource available to them before starting to plan how they wished their support needs to be met. Sites were encouraged to build on tools developed by 'In Control', particularly the Resource Allocation System (RAS). The system assessed individual's level of need across a series of domains which were scored to provide a total number of points which were assigned monetary value.

Flexibility was also encouraged in the deployment of the IB and sites were able to test the possibility of offering different deployment options. As well as offering Direct (cash) Payments, other deployment options included care manager-held 'virtual' budgets, provider-managed accounts; and payments to third party individuals and trusts.

With the aim of widening the options for support planning, the pilot sites were encouraged to allow IB holders a choice about who they would like to be involved in the process. They were able to develop their own support plans that identified their desired outcomes or opt for friends and/or family, the local authority care manager, support broker or service provider to take the lead or provide assistance. IB holders were encouraged to develop support plans that identified their desired outcomes.

This paper draws on the full report of the evaluation (Glendinning et al., 2008) to explore whether individual budgets worked and at what price.

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<sup>1</sup> In Control is an umbrella organisation campaigning for people with learning difficulties to control and direct their own support ([www.in-control.org.uk](http://www.in-control.org.uk)).

## Methods

A randomised control trial (RCT) was used to randomly allocate eligible service users to either the intervention (IB) group, or the comparison group who would receive conventional services. Twelve of the 13 pilot sites used a simple web-based tool to randomise potential IB users. The 13th site planned to offer IBs to people making major transitions in their service arrangements, so randomisation was not considered appropriate in this site. Each of the 12 randomising sites agreed a target number of potential users who were willing to be randomised to enter the trial. Sites' target numbers were calculated according to the scope and anticipated scale of the pilot in their area. The size of each user group to be recruited to the study was calculated in order to yield adequate statistical power for the subsequent analysis. It was planned to recruit 1,336 service users to the study; this was expected to yield a final 'achieved' sample (after drop-out) of 1,000 people.

For each service user, data were gathered following the steps below:

- Structured baseline data was collected by local authority staff about the circumstances and current support arrangements (including costs) of members of both groups.
- Members of the IB group were offered an IB, whilst members of the comparison group received standard social care services (which could include Direct Payments (DPs)).
- For the IB group, information was obtained from local authorities on the content and costs of the support plans that had been agreed. The information requested included:
  - The total level of resource in terms of social service expenditure; recurrent annual, one-off payments and contributions from other funding streams; funding for support planning and support brokerage and the proportion of the budget the individual was expected to contribute through user charges, if this was included.
  - The formal organisation of the budget in terms of deployment options.
  - The budget per year and the activities included in the support plan that the budget was to be spent on. Information about funding for the following activities was asked for: personal assistance; home care (through registered external agency); home care (from in-house services); telecare equipment; other equipment; other one-off purchases; leisure activities; transport; accommodation; planned short breaks; payment in lieu of services; DP support; payroll support; child care; health and dental services; meal services and all other services that were reported on the support plan record.

- Service users in both the IB and comparison groups were asked to participate in an interview six months after randomisation, using a structured interview schedule to collect information about service receipt, self-perceived health and functional abilities, plus a number of standardised outcome measures, including the General Health Questionnaire (GHQ-12; Goldberg, 1992) to reflect psychological well-being and a single quality of life question using a seven-point scale (Bowling, 1995). The Adult Social Care Outcome Toolkit (ASCOT) was used which has been designed to measure and monitor outcomes that are addressed by social care interventions (Netten et al., 2006). The measure is applicable across all user groups and has seven domains ranging from basic areas of need such as personal care and food and nutrition to more aspirational domains such as social participation and involvement and control over daily life. When summing responses to an overall outcome 'score' they were weighted to reflect the relative importance of each domain and level of need, drawing on previous work on population preferences (Burge et al., 2006). Satisfaction and quality of care measures were based on indicators used in previous national surveys of service user experiences (Jones et al., 2007; Malley et al., 2006).

Multivariate statistical analyses were used to explore relationships between outcomes and the characteristics of IB budget holders and members of the comparison group at the point of assessment (baseline). We also explored the variability in cost-effectiveness through the estimation of net benefit regressions (Glendinning et al., 2008).

### ***Cost estimation***

Cost estimation is rarely straightforward but there were particular challenges in the evaluation of IBs. In our estimates we wanted to ensure as far as possible that costs were comprehensive and compared like-with-like. Information about service use supplied by individuals and their proxies in the comparison group at six months provided us with the overall pattern of resource use. In order to compare like with like it was important to collect unit costs in the same areas as these would best reflect what IB holders would be able to purchase with their budgets. Local authorities provided unit costs of mainstream services to facilitate estimates of the cost of social care services. Each unit cost supplied by the local authorities was multiplied by the appropriate frequency of use and summed to produce an overall social care cost for each member of the comparison group. The same procedure using the national unit costs (Curtis, 2007) was followed to obtain an overall health care expenditure for each member in both the IB and comparison groups. As previously mentioned, for the IB group we drew on the support plan records. The IB total cost was estimated by summing the total funding of services and support identified on the support plan record.

The outcome data and costs data were analysed separately, comparing the IB and comparison groups. We combined these data for the purposes of the cost-effectiveness evaluation which followed standard practice in health and social care economics (Drummond et al., 2005). We also conducted statistical analyses to explore how costs, outcomes and cost-effectiveness varied between and within user groups. For each user group we computed the incremental cost-effectiveness ratio (ICER) - the difference in cost between the IB and comparison groups divided by the difference in an outcome measure between the groups (Glendinning et al., 2008).

### ***Estimation method***

Drawing on previous theoretical research on sources of cost variation among social care service users (Forder, 2008; Fernández et al., 2007; Darton et al., 2006; Kavanagh and Knapp, 2002; Knapp, 1984), the statistical models controlled for a number of demographic, socio-economic and dependency related factors. In order to maximise the degrees of freedom, given the relatively limited number of cases available, only those predictors showing a statistically significant effect were included in the final models.

Levels of costs were modelled using generalised linear model (GLM) estimation methods. The analysis imposed a log link function and a Gamma distribution for the error term, in order to account for the skewed distribution of the cost indicator. Robust standard errors were used to account for the likely presence of heteroscedasticity. Following Schaffer (1997) and Little and Rubin (1987) missing values were replaced using multiple imputation procedures, hence allowing the analysis to account for the stochastic nature of the imputed values. The multiple imputation process was implemented using the ICE command, in STATA version 9.

## **Results**

### ***Sample***

A total of 959 people using social care services took part in the 6-month outcome interviews: 53 per cent (510) and 47 per cent (449) in the comparison and IB groups respectively. Table 1 shows the spread of the sample across primary user groups. Mental health service users constituted only one in seven of the sample but this still represented a greater proportion than in the population of social care services users as a whole and only marginally less than the research quota set for mental health (16 per cent).

**Table 1: Distribution of the sample between primary user groups**

	<i>Count</i>	<i>Percentage of total sample</i>
Physical disability	327	34
Older people	263	27
Learning disability	235	25
Mental health (working age adults)	131	14
<b>Total</b>	<b>956</b>	<b>100</b>

Table 2 combines information on age, gender and ethnicity. People with learning disabilities were the youngest, on average, of the working age groups. Women constituted the majority of older people and disabled people. Eight per cent of the sample was from black and minority ethnic (BME) groups, with proportionately more amongst people with physical and learning disabilities. Across the sample as a whole, Asian, Black and 'Other' ethnic groups amounted to approximately two per cent each, with people of 'mixed' ethnic groups accounting for a further one per cent.

**Table 2: Characteristics by age, gender and ethnicity of the sample**

	<i>Mean age (years)</i>	<i>Per cent female</i>	<i>Per cent BME</i>
Physical disability	55	63	10
Older people	82	66	5
Learning disability	35	42	11
Mental health	49	46	5
<b>Total</b>	<b>57</b>	<b>56</b>	<b>8</b>

Nearly two fifths (39 per cent) of service users in the sample lived alone. Of the 587 service users who lived with someone, 511 (87 per cent) reported that a co-resident household member was also their carer. Eighty per cent of service users lived in a private household, 9 per cent in a sheltered/extra care setting and just 14 (1.5 per cent) in a care home. For 90 people (9.4 per cent of the sample), information about their household/living situation was missing. Data collected on users' capacity to perform activities of daily living (ADLs) at baseline showed that approximately three-

quarters of the sample needed regular help with shopping and housework and two-thirds needed help with cooking. A small minority of service users required assistance with eating and drinking, and a little over a quarter needed regular help with toileting and washing their face/hands. Any differences between the two groups did not reach statistical significance.

### ***Support planning***

Pilot local authorities supplied 285 support plan records with the total IB amount indicated. The average annual gross cost of an IB was about £11,450 (median £6,610; standard deviation £15,810; minimum £72; maximum £165,000)<sup>2</sup>. On average approximately £11,760 was for annual recurrent funding (n=278; median £6,580; standard deviation £16,860)<sup>3</sup> and £1,260 for one-off payments (n=46; median £675; standard deviation £1,500). The average gross value of IBs for people with learning disabilities was significantly higher (mean £18,610; p<.001) and included a higher amount of recurrent funding (mean £18,470; p< 0.01) when compared with the other three user groups.

### ***Funding streams***

One of the most challenging aspects of the IB pilots was the requirement to integrate or align other funding streams along with resources from adult social care. Despite considerable efforts by the pilot sites, little progress was made with this because of continuing legal or administrative restrictions which local sites found difficult to circumvent. 282 (99 per cent) of the support plans contained information on the levels of social care resources included in IBs (mean £9,980; median £6,320; standard deviation £13,910)<sup>4</sup>. Of the remaining streams, more people (31; 11 per cent) received money from local authority-managed Supporting People funds (SP) in their IBs than any other funding stream, although the value of the funding received from the Independent Living Fund (ILF) was highest (mean £15,640; median £16,420, standard deviation £7,820). Only one budget included funding from Access to Work (AtW). Although possible in principle, no IBs included funding from the Disabled Facilities Grant (DFG).

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<sup>2</sup> Seven IBs contained only one-off payments. If we exclude the budgets containing only one-off payments, the average annual value of individual budgets is £11,600 (median £6,800).

<sup>3</sup> The recurrent annual funding included in the budget is slightly higher than the overall average because of the seven budgets that contain only one-off payments.

<sup>4</sup> Three people were not receiving recurrent local authority social care funding. One person was privately funding their services, one person was only receiving funding from the ICES and the third person was only receiving funding from the ILF.

A key objective of the evaluation was to identify whether the approach improved outcomes for people with IBs by giving them greater control over the types of support they accessed and over the way that support was organised and delivered.

Table 3 shows the measures of quality of life, well-being and social care outcomes at six months for all those randomised to the IB group and to the comparison group. Overall current levels of met need measured by the ASCOT score appear slightly higher among people in the IB group. However, at this global level there were no statistically significant differences.

**Table 3: Quality of life, well-being and social care outcome states**

	<i>IB group</i>	<i>Comparison group</i>
<b>Quality of life</b>	N=504	N=439
So good, it could not be better	3%	3%
Very good	15%	18%
Good	27%	28%
Alright	38%	31%
Bad	8%	9%
Very bad	7%	7%
So bad, it could not be worse	2%	5%
<b>GHQ-12</b>	N=448	N=380
Mean score <sup>1</sup> (sd)	13.83 (6.74)	13.80 (6.85)
Percentage <sup>2</sup> scoring 4+	36%	33%
<b>ASCOT<sup>3</sup></b>	N=457	N=385
Social care outcome state (sd)	3.55 (0.79)	3.48 (0.89)

**Notes:**

<sup>1</sup> GHQ item scoring 0-3, higher GHQ scores indicate poorer outcomes.

<sup>2</sup> Using GHQ 12 item scoring 0-1. Psychological distress is identified when the score of 4 or more (Goldberg, 1992).

<sup>3</sup> Higher scores indicate lower levels of need.

In order to analyse the results for specific groups of service users, we converted the quality of life question into a score for the purposes of comparison, with higher scores reflecting better levels of quality of life. There were two significant differences. Self-reported quality of life for people with a mental health problem was significantly higher for those in the IB group than for those in the comparison group ( $p < 0.05$ ). For older people, those in the IB group reported significantly lower well-

being on the GHQ-12 than the comparison group ( $p < 0.05$ ). In other instances, the lack of significant effects may well be due to the low number of observations.

### ***Social care outcome state domains***

When we examined individual social care domains there was just one statistically significant difference; people in the IB group were more likely to report that they felt in control of their daily lives (48 per cent,  $p < 0.05$ ) compared with those in the comparison group (41 per cent). We examined whether there was any evidence of differences between user groups in terms of these domains of outcome. The results suggested that people with learning disabilities in the IB group were more likely than those in the comparison group to feel they had control over their daily lives (46 per cent reporting they felt in control of their lives compared with 35 per cent in the comparison group;  $p = 0.054$ ). Once those who had refused the IB were excluded, this difference grew, with 47 per cent reporting no needs and 9 per cent reporting high needs ( $p < 0.05$ ).

### ***Variations in outcome***

Some of the lack of impact reported above may reflect the fact that not all the IB group were actually receiving their new IB-funded support arrangements by the time of the six-month outcome interview; the effect of proxy informants; and the combined impacts of these on the effective sample size. We used multivariate analyses to explore these and the impact of other potential influences on outcomes. These influences included measures of baseline needs and other characteristics, as well as some operational measures such as the level of support received (as indicated by the cost of the support package). The analysis is reported in detail in Glendinning et al., (2008). Here we summarise the key outcome findings.

Not surprisingly, all outcomes were significantly associated with aspects of physical and mental health impairments at baseline. Evidence of cognitive impairment at baseline reduced the reported social care outcome states overall and the sense of control over daily life significantly. Some of the effects of disabilities in relation to activities of daily living were interactive or non-linear. For example, among the 42 per cent least 'able' individuals (people scoring below 23 on the ADL scale), higher levels of ability were associated with lower levels of psychological well-being as measured by GHQ. For more 'able' people (as rated on the ADL indicator), greater ability to carry out the activities of daily living was associated with better psychological well-being. Greater ability to undertake ADL tasks was associated with better social care outcomes, although once all other factors were allowed for, the ability to transfer from and to bed and chairs was associated with poorer outcomes. When other factors were not included in the model, and particularly when a dummy variable identifying the learning disability user group was omitted, the effect of ability to perform ADL tasks was significant for all indicators of ability.

Differences between user groups may reflect differences in the severity or type of disability, although they may also reflect differences in perception and attitudes towards the outcome questions themselves. People in the learning disability group reported better outcomes on all indicators and people with mental health problems reported lower well-being and social care outcome states. Younger adults with physical disabilities reported higher levels of control over daily life. In addition, people in the learning and physical disability groups reported higher levels of control over daily life.

Whether or not people were receiving an IB, age was also found to be important in similar ways, although the exact relationship depended on the measure of outcome. Older people reported better quality of life, social care outcome and control. However, among individuals aged up to 48 years greater age was associated with lower psychological well-being, but beyond this age the association was reversed and older people reported better psychological wellbeing. This U-shaped effect of age on wellbeing has been identified in studies of general populations (Blanchflower and Oswald, 2004).

People in full-time or part-time employment reported higher quality of life and better social care outcome states. Those in education also reported better quality of life. The only other contextual characteristic associated with outcome was that people living with their partner reported lower levels of control.

Turning to formal support, higher levels of funded support (as measured by weekly expenditure) led to improvements in most outcomes, whether through IBs or conventional services. For both quality of life and social care outcomes the marginal effect was reduced as the intensity of provision increased. In contrast, levels of service expenditure were not found to increase the feeling of control over daily living among individuals.

Once these factors were allowed for, those in the IB group did report better social care outcome states and control over daily life. The size of the effect on the overall ASCOT score, however, was no longer significant at the 10 per cent level if we did not control for the fact that some IB users did not have a support plan in place by the time of the interview and in particular for the fact that in some cases user proxies were involved in answering the outcome questions. In other words, and perhaps not surprisingly, IBs were associated with better ASCOT scores only among IB users whose support plan had been implemented by the time of the interview. Sense of control was less influenced by whether the plan was in place but it was important to allow for the impact of proxy responses.

## Costs and cost effectiveness

A key question to be answered by the evaluation of the IB pilots concerned cost-neutrality: was it possible to introduce IBs and so to improve choice and control without increasing the overall cost to the care system? This led us to ask whether IBs cost more or less than conventional arrangements, and how the costs compared across different service user groups. When drawing comparisons with people receiving standard care packages we focussed on recurrent expenditure and used weekly costs, drawing on the content of the support plan records to ensure that as far as possible we were comparing like with like<sup>5</sup>.

In total, 268 support plan records contained all the information about the funding allocated to different services/activities. Table 4 shows that the differences between the total costs of support received by the comparison group and those offered an IB were small and not statistically significant: the average value of funding within IBs across all user groups was £279 per week compared with £296 in the comparison group.

**Table 4: Social care costs**

	<i>N</i>	<i>Average weekly cost</i>
<b>Overall</b>		
IB group	268	£279
Comparison Group	250	£296
<b>Learning disability</b>		
IB group	70	£359
Comparison Group	63	£390
<b>Mental Health</b>		
IB group	35	£149
Comparison Group	33	£152
<b>Older people</b>		
IB group	73	£228
Comparison Group	66	£227
<b>Physical disability</b>		
IB group	90	£310
Comparison Group	88	£334

<sup>5</sup> It is difficult to reach firm conclusions as we cannot be sure whether hidden costs have been included in the expenditure for IBs. Moreover, we are costing social care for the comparison group using self-reported data and therefore there is always a possibility of reporting error. People in the IB sample who only received a visit from their local authority social worker/care manager were omitted from the analysis.

When we explored the breakdown of costs by type of support, we found that the weekly cost of home care in the comparison group was significantly higher (mean £70;  $p < 0.001$ ) compared with the IB group (mean £37). However, the weekly expenditure on personal assistants, whose role may have extended outside the home, in the IB group was significantly higher (mean £100;  $p < 0.001$ ) compared with the comparison group (mean £52).

### ***Predictors and sources of cost variation***

We estimated an expenditure function in order to control for the effect on the estimate of average cost difference of potential differences in baseline characteristics of users in the comparison and IB groups; and to investigate in greater detail the nature of the interactions between needs, costs, outcomes, and some indicators of care processes.

The analysis is reported in detail in Glendinning et al., (2008). Overall the results indicated that the allocation of resources were related to a wide range of needs-related factors, including physical disability, mental health problems, informal support and broader socio-economic characteristics.

As we would expect, ability in activities of daily living was found to be negatively associated with the cost of the support package. A variable indicating that the care manager perceived the service user as having some degree of cognitive impairment such as dementia was associated with higher costs. Interestingly, this effect was found over and above the indirect effect of cognitive impairment on costs through its impact on ADL problems. The fact that service users who were in employment received significantly fewer resources is likely to be related to lower average severity of mental or physical health problems among people able to maintain a working routine.

Other things being equal, mental health service users appeared to have received lower levels of support. This finding could be explained by the fact that much support for mental health service users is funded and provided by the NHS, which was outside the range of support accounted for in the expenditure explored in this analysis. However, overall health care expenditure in this group was no higher than for other user groups.

Interestingly, even when the degree of dependency was controlled for through the ADL indicator in the regression equation, the age of the service user was significantly related to the cost of the support package. Older service users tended

to receive significantly lower levels of resources. Ethnicity also appeared to be associated with levels of resources<sup>6</sup>.

Overall, the level of social care resources was not dependent on whether the service user received practical help from an informal carer. However, after controlling for the other effects, the cost of the support package was affected in part by whether individuals were supported by carers who lived in the same household.

Of central importance to the evaluation was the impact of IBs on resource use. No statistically significant difference was found, although the direction of effect on the IB indicator suggested that, once confounding factors were accounted for, IB holders tended to use slightly fewer resources than people in the comparison group. The fact that the analysis could not identify significant interaction effects between the receipt of IBs and baseline characteristics of service users suggested that the allocation of resources for comparison and IB cases was broadly comparable. However, differences in the relationship between needs and support costs were explored further through individual utilisation functions for the IB and comparison groups, as reported below.

Two indicators were included in the model in order to adjust for the fact that some people in the IB group did not have a support plan fully in place by the time of the six-month interview, and for the fact that approximately 10 per cent of those offered IBs declined them and opted instead to receive a standard care package. People who declined an IB received on average significantly higher levels of resources, which is explained by the fact that, in most such cases, individuals turned down IBs precisely in order to avoid a reduction in the support package they received.

We looked for evidence of differences in expenditure levels between current and newly referred service users. After controlling for individual characteristics, the analysis suggested that newly referred cases received significantly higher levels of resources, equivalent to approximately £80 per week of extra support ( $p < .05$ ).

### **Cost Effectiveness analysis**

In considering the policy of personalisation – in this case as operationalised through IBs – decision makers are primarily interested in effectiveness: does the policy work in terms of improving user choice and control, quality of life, and met needs? Closely following behind is a second question: is it cost-effective? That is, does the policy achieve its aims (in terms of user outcomes) at a cost that is worth paying?

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<sup>6</sup> The demographic pattern of the population across England and the focus on different user groups by different pilot authorities mean that older and non-white groups are more heavily clustered in some localities than others. It is not possible to say whether the effects are associated with local authority policies or other individual factors.

The cost-effectiveness evaluation within IBSEN examined the mean differences in outcomes over the six-month follow-up period between people randomly allocated to the IB group and those allocated to the comparison group, and compared them with the mean difference in costs between IB and comparison groups. A ratio of cost difference to outcome difference is computed – the so-called incremental cost-effectiveness ratio (or ICER) – for each outcome in turn. We concentrate here on two outcomes: the total ASCOT score and the GHQ-12 score (using the 0-1 coding of responses).

For the full sample (all user groups combined), the IB group was slightly less costly than the comparison group (so the difference in cost was negative); the score on ASCOT was slightly higher for the IB group (so the difference was positive); and the score on the GHQ was slightly lower (indicating better psychological well-being) for the IB group (so the difference was negative). On average across all user groups combined, IBs looked to be cost-effective, although the mean value was small and not statistically significant from zero. When we looked at the mean ICER using the GHQ measure, however, there was a different story. The cost difference was of course the same (IB had slightly lower costs) but the outcome measure favoured the comparison group: the difference was very small but negative, suggesting that the comparison group had very slightly better psychological well-being.

For *people with learning disabilities*, there was a cost-effectiveness advantage in terms of social care outcomes but only really when we excluded people without support plans in place from the analysis. In other words, the *potential* was there to achieve cost-effectiveness, but implementation delays in the pilot sites meant that we did not observe this during the evaluation period. When looking at the psychological well-being outcome, standard care arrangements looked slightly more cost-effective than IBs.

Cost-effectiveness evidence in support of IBs was strongest for *mental health service users*, on both the outcome measures examined here. For *older people*, there was no sign of a cost-effectiveness advantage for either IBs or standard support arrangements using the social care outcomes measure. Using the GHQ outcome measure, standard arrangements looked marginally more cost-effective. There appeared to be a small cost-effectiveness advantage for IBs over standard support arrangements for younger physically disabled people using either of the outcome measures.

## **Discussion**

While the evaluation provided an opportunity to explore the impact of having an IB on the overall care package and outcomes for people in need of social care, there were limitations that need to be acknowledged when interpreting the findings. Both

the Department of Health expectations and the evaluation design required the pilot sites to offer IBs to target numbers of people within a timescale that was challenging. As a consequence, the numbers who actually experienced an IB before the six month outcome interview were limited: some people declined an IB, and for many others there were delays in implementation, with the result that less than half (45 per cent) of those who accepted an IB actually had a support plan in place at six months.

The challenging implementation timescale also contributed to widespread early reliance on established deployment options for IBs which differed little from previous arrangements, such as Direct Payments and care-managed 'virtual budgets'. As mentioned above, one of the most challenging aspects of the IB pilots was the requirement to integrate or align other funding streams along with resources from adult social care. This was largely unsuccessful because of legal or administrative restrictions and may have restricted the extent to which IB holders experienced increased choice, control and flexibility.

### ***IB deployment mechanisms and support planning***

Despite these challenges, clear differences between service user groups in terms of levels, deployment, management and patterns of expenditure was found. It could be argued that to some extent these differences reflected the policies of the pilot authorities rather than the characteristics of the user groups themselves. Compared with other user groups, older people seemed less likely to use their budgets for leisure and in other innovative ways, possibly reflecting the lower level of budget received and the fact that they were less likely to manage their IBs for themselves through direct payments. Allocated resources for people with learning disabilities were highest and appeared to provide most scope for a wide range of uses, although this group still spent most on mainstream services. Unsurprisingly, given the success of direct payments with this group, younger physically disabled adults appeared most likely to have personal control over their budget.

While clearly there were examples of innovative ways of using IBs that were highly valued by a few IB users, it seemed that these were relatively rarely reported in our sample. Most people made use of mainstream services and/or PAs, now quite common among direct payment users. However, there was evidence from semi-structured interviews conducted with a subsample of people in the IB group around two months after they had been offered an IB that people were taking advantage of the flexibility of budgets to reflect their personal preferences. We might expect, as confidence and experience grow, both among individuals themselves and those supporting them in planning, that more innovative approaches to care and support will increasingly be used.

Although an important aim of IBs was to integrate resources from a variety of funding streams, in our sample there was limited evidence of the use of non-social service

funding streams and some indications that pre-existing funding sources were not being drawn into IBs. It did appear that SP (from local authorities) funding was being used more as a consequence of IBs but, possibly due to implementation problems discussed elsewhere in this paper, there was limited use of ILF and virtually no integration of AtW funding.

### ***Sources of cost variation***

As with all new initiatives, it is important to have a clear understanding of the determinants of cost variation and whether IBs are cost-saving, cost neutral or more expensive in the short-term and long-term. While overall, there was not a significant difference between total costs of support received by the comparison group and those offered an IB, the multivariate analysis suggested that allocation of services responded to a wide range of need-related factors. Consistent with previous research (e.g. Wanless, 2006; Pickard et al., 2000), the multivariate analysis suggested that the allocation of resources was associated with levels of physical and cognitive impairments and socio-demographics factors, such as age, whether the principal carer was living in the same household; whether the service user was white.

Although the higher level of resources for IBs associated with new cases, once disability characteristics and needs were allowed for, hints of preferential treatment for people newly referred to social care, or this could reflect the particularly acute needs that can prompt a crisis referral to social care.

### ***Impact of IBs on outcomes***

A key finding was that of higher levels of control expressed by members of the IB group, which was of particular relevance given the objectives of IBs. Given our caveats about expected effects (in view of the short follow-up duration, the delays in putting support plans in place and so on), this particular finding must be an important one. While in most instances not statistically significant (which is not surprising, given the limited level of actual implementation), the direction of effects in other domains of social care outcomes was also generally encouraging.

A very important message for rolling out IBs for older people was that they may make a negative impact on psychological well-being, at least in the short term and in the ways these new arrangements were introduced and implemented during the pilot. The results suggested that while lower levels of well-being or higher anxiety levels might be slightly more prevalent among those older people able to respond in the interview, higher levels of anxiety also appeared to have been systematically attributed to more vulnerable older people whose experiences of IBs were reported by their proxy respondents. We cannot distinguish whether this was due to the concerns of more vulnerable older people, less able to respond on their own behalf,

or of their relatives (the most frequent proxy). This finding may be partly a cohort effect, but clearly has implications for the pursuit of a 'personalisation' policy built on IBs or something like them.

### ***Are the outcome gains worth the cost of achieving them?***

The findings are (cautiously) encouraging for the introduction of IBs. This was particularly the case for people with mental health problems, and probably also for younger physically disabled people. When we look at the results for people with learning disabilities, IBs appeared to be more cost effective once we take into account that a number of people in the sample had been randomised to the IB group but not actually had a support plan set up by the time of the follow-up interview. As far as older people are concerned however, there was no evidence of cost-effectiveness from the pilots.

### **Summary**

In summary, IBs appeared to be cost-neutral at least in terms of the level of care and support packages. However other costs not in the scope of this analysis may need to be taken into account, including the costs of helping IB holders to plan their support; the costs of managing an IB on a day to day basis; and the possible loss of economies of scale as individual commissioning of services replaces the bulk purchase of local authority contracts. Whether IBs remain cost neutral or whether there are cost savings or they become more expensive in the long term remains an open question as many factors will have an impact. Nevertheless, the outcome and cost effectiveness findings suggest that IBs have the potential to be beneficial and encouraging for some user groups.

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