

The impact of personal budgets on social care providers: perspectives from the Individual Budget pilots.

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Abstract

The individual budget (IB) pilots, and the subsequent announcement to roll-out their principles to every social care user in England, have the potential to transform the nature of the market for care services as well as the relationships between key stakeholders within it. Commissioning will increasingly be driven through user-controlled budgets, and providers expected to deliver a wider range of personalised services with less reliance on block contracts. What will this mean for providers, and what can they and local authority commissioners do to prepare for these changes? This paper presents the results of semi-structured interviews with a sample of 16 managers of social care providers, and seven commissioning managers, from the IB pilots undertaken in 2007-08. The paper explores the early impact of IBs on providers' client bases, on services being delivered, on their workforces, and on administrative aspects of managing IB payments. The study finds that providers were positive about the principles of IBs and the opportunities of better-quality services that IBs can bring about.

However, participants highlighted a number of obstacles to their effectiveness, and reported a range of potentially adverse administrative and workforce consequences of IBs.

Keywords:

Consumerism, social care market, homecare, service provision, organisation and delivery of care.

Introduction

Individual budgets (IBs) were first proposed in the Cabinet Office's *Improving the Life Chances of Disabled People* report in 2005, which outlined a pilot project that would build on the experience of direct payments and *in Control*¹ to enable greater user choice and flexibility in social care (Cabinet Office, 2005). The IB concept gained further clarity and emphasis through first the Green Paper *Independence, Well-being and Choice* (DH, 2005) and then the White Paper *Our Health, Our Care, Our Say* (DH, 2006). Like direct payments, IBs would aim to bring choice and control to the service user by allocating to them a budget from which they could purchase their own care. However the IB pilots would go further, including new approaches to assessment, resource allocation and mechanisms through which budgets are managed. Further still, the pilots would actively encourage IB users to purchase care beyond the limited range of services offered by councils, and ensure that IBs could be used more flexibly than direct payments. New support brokers would assist users in thinking creatively about what services would meet their needs, and in accessing information to help implement their plans (Cabinet Office, 2005; DH, 2005; DH, 2006).

Pilot projects were subsequently set up in 13 local authorities in England and operated between April 2006 and December 2007, and the Department of Health commissioned a full and rigorous evaluation (including an assessment of the impact of IBs on service providers). The Government has now announced the roll-out of the key principles of IBs for "everyone eligible for publicly funded adult social care support" (DH, 2007; p3), investing £520m over three years in system change and expecting "significant progress" by 2011 (DH, 2007; p5). The impetus behind this policy is such that – if successful – no social care service user or provider will be untouched by IBs (or 'personal budgets', as they have

¹ *in Control* is a social enterprise, established in 2003 in learning disability services, which formed the blueprint for many of the principles used in the Individual Budget pilots.

become known) in the future, and stakeholders in social care markets will need to prepare for changes to come. To explore the early implementation process this paper reports the experiences and expectations of providers and commissioners from the IB pilots who were well placed to observe the emerging market implications of personal budgets. The paper begins with an outline of the context in which the IB pilots were introduced before presenting the results under a series of key themes. A discussion of the implications of these findings precedes concluding remarks.

The market for social care: domestic and international context

In England, the market share of the independent sector in the provision of social care has swelled ever since a 'mixed economy' was heavily promoted through the NHS and Community Care Act 1990. In 1993 just five percent of publicly funded homecare was provided by private and voluntary organisations, but this now stands at 78 percent (UKHCA, 2008), as the role of council in-house services has shrunk. The local authority function has become one of 'commissioner' on behalf of service users: an estimated 80 percent of all homecare provider services are purchased directly through councils (UKHCA, 2008). This purchasing power has been further strengthened through greater use of block contracts that offer guaranteed service levels to providers in return for greater savings on unit costs.

These trends may have come at a price to service quality, and may have contributed to increasingly standardised and de-personalised care (Knapp *et al*, 2001; Jones *et al* 2007). To offer choice to those who are not satisfied with council-commissioned care, direct payments have been an option since 1996 for some groups of people using services. However, despite government efforts to expand their coverage just £2.50 in every £100 of social care spending is through direct payments (CSCI, 2009) and most is used to recruit care workers directly as personal assistants (PAs), rather than through a formal provider organisation (Davey *et al*, 2006). Providers have remained unmoved by direct payments: a recent study of 32 social homecare providers concluded that, for most, direct payments had failed to impact on their business (Baxter *et al*, 2008). Even innovative schemes aimed at furthering the scope of user-held budgets, such as *in Control*, have resulted in "cautious" reactions from most providers (Poll *et al*, 2006; p81).

Evidence from other jurisdictions inevitably reflects unique organisational and funding contexts, and inference from these should be cautious. Often user-held

budgets have been introduced with broader objectives in mind, such as using them to stimulate independent sector provision where the market is weak, dominated by direct state provision or cost containment (Arksey & Kemp, 2008; Ajzenstadt and Rosenheck, 2000). Nevertheless, in the Netherlands, despite a proportionately far larger 'Personal Budgets' system than in the UK, the market has not responded significantly: in some areas providers do not even allow budget holders to purchase their services because of the associated administrative difficulties (Kremer, 2006). Elsewhere, the German and Austrian *Pflegegeld* allowances have had little impact on care delivered through the formal service sector, though in Flanders some private agencies have developed temping agencies for PAs (Waterplas & Samoy, 2005; SCIE, 2007). Further afield, qualitative interviews with budget holders in Queensland found that the providers did not improve service flexibility or responsiveness and that "high transaction costs to agencies... have resulted in steady cuts in the level of service delivery" (Spall *et al*, 2005; p62). The notable exception to these lacklustre provider responses is found in the years following the reforms to Japan's long-term care insurance system: but here providers of care to older people attempted to deliver *too many* new services, perhaps reflecting the influence of provider-employed case managers, which were subsequently not taken-up and operated at a loss. (Campbell & Ikegami, 2003; Ikegami, 2008).

However in England, the IB pilots potentially mark a new era in commissioning care that may fundamentally reshape the social care market. From one purchaser (the local authority) buying relatively homogenised units of a limited range of services (hours of homecare, sessions of daycare etc); to many individual consumers buying bespoke units of an unlimited range of personalised services. In essence, a more mixed economy of commissioning may surface, to complement the mixed economy of provision introduced in the 1990s. These reforms have the potential to transform the "power relationship" between service users, social services and providers (CSCI, 2006; p11). However, the focus on individualised purchasing runs the risk of losing a collective pressure to increase quality through reforming existing services (Burton and Kagan., 2006; Newman *et al.*, 2008). There have been successive discussions of the potential market effects of IBs (CSCI, 2006; Walker, 2007; OPM, 2007; Cole, 2008; Sawyer, 2008), however, there remains little formal evidence. This paper presents the first systematic collection of provider and commissioning manager experiences from the IB pilots.

Method and sample

As part of the national evaluation of the IB pilots (Glendinning *et al*, 2008), interviews were conducted with a sample of 16 social care providers spread across four pilot sites; and with commissioning managers in each of seven pilot sites. These areas were selected to give a spread of key characteristics, both in terms of authority type and the scope of their pilot. Further details are provided in Glendinning *et al*, 2008. The provider sample was purposively selected (Miles and Huberman, 1994), with local IB leads being asked to supply lists of social care providers that were most intensively involved in delivering services funded through IBs (to ensure that the providers interviewed had the most experience and exposure to the pilot). The final provider sample was selected to include a spread of characteristics, shown in Table 1. Note that care home providers were excluded as their residents were rarely offered IBs. Ethical permissions for the study were received from the University of Kent; the National Research Ethics Service; the local authorities involved in the pilot and the study was endorsed by the Association of Directors of Social Services.

Table 1: Characteristics of the provider sample.

Characteristic	Categories	N
Organisation type	For profit	8
	Not for profit	7
	In-house	1
Primary user group served	Older people	9
	Physical disability / sensory impairment	2
	Learning disability	3
	Mental health	2
Services provided*	Personal care	12
	Day services	5
	Supported living	10
	Advocacy and support	5
	Personal Assistant recruitment	4
Provider size	Small (up to 500 hours service per week)	4
	Medium (501-1500)	4
	Large (1501+)	6
	Don't know	2
Individual Budget holders	None	3
	1-5	5
	6-20	6
	21+	2
Providers with prior experience of direct payments		9
Providers with		5

privately-funded clients		
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* *more than one response possible per provider.*

A single interviewer (MW) conducted all interviews face-to-face using a semi-structured schedule, supplemented with a brief structured questionnaire collecting standard information about the 16 providers in our sample. Interviews with provider managers (hereafter 'providers') were with the most senior manager in the organisation with operational responsibility for delivering care in that pilot authority. Interviews with providers were conducted in December 2007 - January 2008 (the very end of the pilot phase, to allow the greatest possible exposure to the pilots) and with commissioning managers (hereafter 'commissioners') during summer 2007. Interviews were recorded with permission and transcribed and coded within MAXqda into a series of themes both developed *a priori* and then expanded during the process (DiCicco-Bloom & Crabtree, 2006). Provider and commissioner interviews were coded separately, but used a set of common themes where responses could be drawn together in analysis. In the final stage the researcher summarised responses within each theme before drawing conclusions.

Findings: the impact of IBs on providers

First reactions

The providers interviewed were universally positive about the principles of IBs, and in particular about the potential to improve the quality of service users' lives. Most common were positive remarks about how important choice, control and empowerment were to the organisation, but several providers spoke in more fervent terms about IBs being "heaven sent"; that the office was "buzzing"; and that "at last people are going to get what they want". Some spoke about their disappointment that traditional local authority commissioning had taken their services a long way from the flexibility that IBs were intending to create and that direct payments were an unsuccessful "one size fits all" attempt at personalisation.

Providers inevitably had many questions about IBs and generally found that the IB pilot local authorities, whilst being good on the principles of IBs, were poor on explaining detail. Most felt that there was a lack of clarity on important decisions that needed to be taken before providers could properly engage with the new system. These issues included the mechanisms by which payments for services purchased with IBs would be made; auditing and accounting; and the appropriate

or legitimate use of IBs. One provider remarked that implementation appeared to have been rushed, and that the local authority was building “a house on the foundations of sand” by not having the appropriate infrastructure in place. There were also concerns about how IBs would be implemented for service users that lacked capacity to make decisions and the safety of other vulnerable adults that may be at risk of abuse (see Manthorpe *et al*, 2008). Commissioners likewise stated that providers were generally positive towards the IB concept, but that the overall response was less enthusiastic than that reported above. The level of engagement amongst providers seemed to improve as the pilot progressed, with one commissioner reporting that any reticence at the beginning of the pilot had waned by the end.

The impact of IBs on the client-base

A key question was whether IBs would mean fewer people would choose traditional providers. Three potentially negative effects could occur:

- Homecare providers would experience a loss of business as service users opted for PA-delivered care;
- Day service providers would lose business because of the general perception that day centres are unpopular;
- In-house providers would be too expensive to be popular amongst IB holders.

Five of the 12 providers that offered homecare had already experienced individuals leaving their service to employ a PA instead. When this occurred it caused frustration, because the provider had usually provided training, support and Criminal Record Bureau (CRB) checks for the care worker and this investment was then lost to them. Another provider thought that it was impossible to compete with PAs who lacked the costs of overheads and training that an agency must cover.

However, providers did not anticipate that these losses would significantly impact on their overall business: one provider with a large number of IB holders as customers thought that the loss would, at most, cost them five percent of their customer base. Moreover, where existing agency customers used their IB to employ a PA, this had enabled some providers to generate new business by offering PA recruitment, payroll and reference checking services. This could work well for them, providers commonly reported, because they had expertise in the recruitment and payroll administration of care staff; the marginal costs of

expanding this would be relatively low; and the provider could also offer a covering option for holidays and sickness. One provider's entire business was now dominated by this function (having developed first from providing support to direct payment users).

Turning to the five day service providers interviewed, only one had concerns about the viability of their service and this was attributed to the tightening of Fair Access to Care Services eligibility criteria in their local authority, not to the IB pilot *per se*. This was in contrast to the views of commissioners in two of the IB pilot sites that were already in advanced preparation for rolling out IBs to all adult social care service users at the time of the interviews. Both were anticipating a sharp contraction in demand for day care services. One day service provider had nevertheless used the IB pilot to its advantage by diversifying and starting to provide home care in addition to the day centre. This provider had wanted to develop a linked home care service earlier but had been unable to as it could never meet the low unit costs demanded by local authority contracts. However, it believed that IB holders would be prepared to pay a little more for its service because of their organisation's reputation for quality.

With regard to in-house services, commissioners commonly noted that these could not continue as present because of their high unit costs. One commented that the IB pilot projects themselves had highlighted how 'hideously expensive' in-house services were; another anticipated that demand for in-house services would fall away 'because it costs three times more to get in-house so why on earth would [IB holders] want to [use them]?'. Yet another commissioner intended to switch the local in-house home care service to a more specialized reablement service in the future. The provider sample only included one in-house service which was unable to confidently predict what would happen to client numbers with the expansion of IBs.

Providers and commissioners also gave examples of how IBs appeared to have stimulated new service developments. In one area, a local authority-funded drama group was being closed down but the provider felt that IB holders would want to continue using it - and use their budgets to fund it - and so decided to continue running it themselves. In another, a provider had fostered close links with the local Learning and Skills Council to develop an educationally-focused service involving local colleges. One commissioner reported a new culturally-sensitive care service being developed in response to the demands of IB holders in their area, and another reported that one provider had started to establish links

with telecare and meals-on-wheels organisations, with a view to sub-contracting parts of potential IB packages to these partner organisations.

Did IBs change the existing services being delivered?

Providers reported that for many of their customers there was no real change resulting from the IB pilots. A number of IB users chose to simply continue with their existing care packages and in these cases the process was purely an administrative exercise of changing where the invoice was sent. Several providers argued that this was most common amongst older people who were unlikely to ask, or take-up, new types of care during the pilot. Compounding this was a commonly reported concern that the levels of IBs allocated to older people were insufficient for them to purchase anything beyond basic personal care, and that it was hard to be creative when the IB was only sufficient to meet functional needs like dressing and bathing. For one provider this amounted to the offer of a “false choice”, and for another it proved frustrating that service users were having expectations raised by the promotion of IBs but then dashed due to the level of funding.

Despite this overall assessment, managers reported several examples of existing service users using their IBs to purchase new types of care, mostly from homecare providers. Those most commonly cited included cleaning and domestic assistance; gardening; transport and shopping. Homecare providers also reported that the practice of banking hours was now more common, whereby users received fewer hours of support over the course of several weeks in order to “save-up” for a special activity. Examples included enabling a care worker to take them Christmas shopping, or for daytrips, and in another example it allowed a care worker to assist a visually impaired person with baking. There were also reports of more frequent demands for short-notice care, with users asking for more or less support the same day, and also for care at specific times (especially “peak” hours around lunchtime). Some providers and commissioners reported that IBs had led to an improvement in the quality of care, through small, subtle changes such as giving care at a pace that suited the service user whereas the care worker had had to rush previously to other clients.

Where demands such as these were new to the organisation, providers had to decide whether they could meet them. Some providers thought responding more flexibly would be rewarding for care workers. However, others wanted to protect their care workers from becoming “glorified home helps”. The following examples from two different providers illustrate this difference in thinking:

We've got a guy whose main companion is his dog, but he can't get out and walk the dog. So he's assessed to having four half hour calls a day so we go in and walk his dog for him ... who are we to argue if that's what he wants, it's his choice, isn't it? [Provider 1]

I still wouldn't provide a different service. I mean, at the end of the day this is about the care ... obviously there will be things that you would have to explain [to IB holders], 'I'm really sorry ... if you want your loft cleared out, well then you're going to have to get somebody that can do that task'. I'm not going to change my goalposts. [Provider 2]

Both providers and commissioners in some pilot sites acknowledged that recent changes in local authority commissioning practices had enabled many of these perceived "new" arrangements to have become commonplace even without IBs: care workers supporting people on daytrips, supermarket shopping, swimming and cleaning services were nothing exceptional to them.

The impact of IBs on the provider workforce

There were several examples given by providers of workers leaving to become a PA to an IB holder. Despite this, most providers and commissioners did not expect IBs to have a substantial impact on their workforce in the long-term. Their greatest concern – looking beyond the pilot project - was that meeting an increased demand for short-notice and unplanned care would require a considerable change in the organisation of staffing, and that IB user expectations of what a provider can deliver may be too great. The common view amongst providers was that it was important to have a clear understanding with service users from the outset about both what the user required, but also what the provider was able to meet. One provider explained that they had had no serious problems meeting expectations of IB holders 'because they were told [what's reasonable to expect] from day one'.

Because working for an IB user was expected to involve greater flexibility and less rigid adherence to a strictly specified care plan, both providers and commissioners noted that care workers would encounter new, unanticipated risks. Whilst local authorities had developed strategies for managing risks at the point at which the IB support plan was signed off (see Glendinning *et al*, 2008), providers thought that they would also need to educate their staff on risk-

management as new flexibilities in care were demanded day-to-day by IB holders.

The administrative consequences and costs of IBs

Thirteen of the providers interviewed had experiences of the transaction and administration costs and consequences of IBs. Two of the remaining three did not have local authority contracts against which to contrast the IB system. For the most part concerns were about the costs of individual invoicing and chasing non-payment. Four providers already had experience of IB clients refusing to pay bills. Strategies varied in how to deal with the problem: one provider had chased payment until it was finally received; two had accepted the loss; and the last had agreed with the client to provide reduced hours in the future to recoup the money. One provider expressed distaste with the thought of potentially having to pursue older people for payment. However providers expressed different views as to how severe the problem would be in the longer term, with one saying that “if you run a shop, you accept that three to five percent of your products get nicked, so you just build that in”. Most agreed that non-payment would be rare and mostly resolvable, though one provider anticipated that their service costs would have to rise to compensate.

Invoicing individual IB holders, in comparison to sending a single invoice to the local authority under a block contract, was expected by most providers to require new investments in back office staff and upgrading IT systems. One provider explained that they had just recruited a Finance Director specifically to lead this task as the local authority had already announced that they were rolling-out IBs to all users. Another explained that they had visited another leading provider that specialised in IB-style care and noted that they had three times *more* back office staff than their own organisation, despite having three times *fewer* clients. One commissioner also anticipated that the “administration costs will be terrible”, but mostly commissioners were focused on solutions to the problems. In particular two were interested in implementing payment cards based on a model trialed in Kent whereby an individual’s IB would be loaded onto a swipe card that could automatically transfer payment to providers without any paperwork (Kent County Council, 2008).

Another common concern amongst providers was the cost of developing new flexible and person-centered service packages, for low levels of support in particular. One provider expected that the costs of setting these up, calculating charges and administering them were disproportionate to the income they would

generate. One commissioner reported an instance where a provider had spent time developing a new “Pick ‘n’ Mix” service – whereby IB holders could piece together a package of care from a menu of services – but lamented that no-one had taken this up. Some providers expected that IB holders would be more likely than others to request changes to their support arrangements during the year and more generally anticipated spending more time in discussion with service users resolving problems and adapting services. Though undoubtedly better for service users, providers noted this would require additional management resources.

Discussion

It is important to bear in mind the limitations of the evidence presented here. Although our interviews with service provider managers were conducted towards the end of the pilot period, this was still early in a transformation process introduced as being “the future of social care” (DH, 2005). In common with any pilot evaluation early experiences may not always be representative of longer-term outcomes (though the commissioners and providers also had a greater-than-average experience of other self-directed budget policies, such as direct payments and *in Control*). A further caveat is that the sample size of providers was small and it is unlikely that we captured the full range of views on a number of issues in the interview schedule. Interviews with commissioners will more likely have captured the (perceived) experiences of a wider range of providers (and for the most part the views of commissioners and providers tended to coincide, even if there were differences of emphasis on some topics). A final note of caution is that there may be ‘motivated misreporting’ (Groves *et al*, 2004), whereby providers might have been tempted to overstate some of the expected costs of change in the expectation that this study might influence policy.

Nonetheless, the findings presented here demonstrate a positive provider reaction to the principles of IBs and some positive examples of how new flexibilities and choice have the potential to lead to the development of more personalised services being delivered. Providers were excited by the prospects of moving away from the rigid care plans and task-and-time approaches to delivering homecare that was either directly forced upon them by social services contracting practice or indirectly by resource constraints. Providers also reported being broadly unthreatened by the prospect of fewer people using their services; indeed, opportunities for new business through offering a wider range of services would compensate for this. The prospect of providing more PA-management services (eg recruitment, payroll etc) may prove lucrative: in the Netherlands a

third of personal budget holders have outsourced these tasks (Kremer, 2006). This will be welcome news to local authorities charged with implementing personal budgets, since a lack of enthusiasm and a fear of change has been identified as a risk to implementation (CSCI, 2006).

Despite this, two sets of potential risks were identified in the interviews. First, IBs often resulted in little change in the services delivered by the provider. In some cases the provider was already able to offer relatively flexible, personalised care within the current contracting arrangements. Providers in Australia are similarly arguing that personalised services can be delivered without cash or voucher systems, as being considered by their Government (ACSA, 2008). However, amongst providers of services to older people more negative reasons dominated: such as IB amounts being insufficient to fund anything more than just basic personal care; and that older people were reluctant to ask for or accept new types of services.

Second, a clear majority of homecare providers who were interviewed had either direct experience of or concern about the administrative consequences of IBs, in particular the potential for higher cost burdens including those associated with investment in new IT systems; processes for invoicing and chasing non-payment; recruitment costs to replace care workers who leave to become PAs; costs of developing new service options; retraining care workers to work in new flexible ways (including how to respond to new, unanticipated risks); and possibly additional insurance premiums. A total of £520m has been given to local authorities to enable system change, yet there are no reports of providers being assisted financially to meet the challenges which face them.

It is not clear from this study what the *extent* of these costs is likely to be, nor how *severe* will be the impact on providers. Sawyer has argued that any additional costs of administering personal budgets may be partially offset by a reduction in the difficulties that home care providers currently experience in relation to local authority purchased services (Sawyer, 2008). This is an area that warrants close monitoring and further research.

The impact of personal budgets on providers of other services - day care, supported living and ultimately perhaps residential care - may be very different from that on homecare agencies. Indeed, the findings show that some commissioners felt that day services would be at risk from the different patterns of support purchased by IB holders. Although this was not a threat keenly felt by the day care service providers who were interviewed in this study, it is supported

by evidence from the wider evaluation on changes in demand and also by data from *in Control*, which suggests that users of personal budgets in learning disability services spent 28% fewer days in day centres than previously (Poll *et al*, 2006). Day centres are particularly vulnerable to the effects of lower demand because of their high fixed costs in running the service irrespective of the attendance rate and associated travel costs. This raises an important issue of equity and stability: if a day service closes because a sufficiently large number of users - empowered by greater choice - elect to leave the service, the remaining users may find their choice restricted and be forced to find alternative arrangements. In short greater choice for some may occur at the expense of lesser choice for others, perhaps particularly in rural areas (Manthorpe and Stevens 2008). Furthermore, the very individualistic nature of purchasing may lose the potential for collective impact on service quality (Burton and Kagan, 2006). These, again, are issues that merit further investigation.

Conclusion

The findings presented here suggest that providers may react positively to the principles of IBs and may seek opportunities for new ways to meet the needs of service users as a result of the flexibilities that IBs allow. However two key risk factors may emerge. First, in many instances IBs did not lead to any changes in the types of services being provided. This appeared to reflect a lack of change in user demand as much as a lack of responsiveness on the part of providers, or that current commissioning arrangements already allow the flexibility demanded. Second, there appear to be significant cost consequences for providers of the transition to IBs. Unless these are addressed, they have the potential to adversely affect providers and, subsequently, the choices and options available. These issues and risks need to be addressed by providers and commissioners alike to ensure that the transition to personal budgets does indeed result in greater choice and control for people with rights to social care support.

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