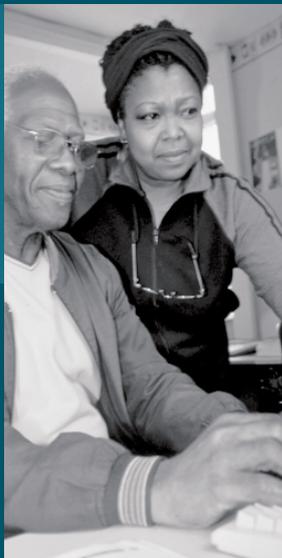


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# Direct Payments and Older People





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# DIRECT PAYMENTS AND OLDER PEOPLE

Teresa Poole

*King's* Fund

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# The Direct Payments option

Direct payments offer older people the option of receiving a cash payment in lieu of community-based social services so that they can choose, manage and pay for their own social care. They were introduced in 1997 for adults of working age, and in 2000 were extended to people aged 65 and over. Since April 2003, local councils have had a duty to make Direct Payments 'where individuals consent to and are able to manage them, with or without assistance'.

Direct Payments can currently be used to pay for personal assistants, or to purchase goods or services – although not from the local authority. The money can be used to pay for care from close relatives and friends who do not live in the same household, and this is a common choice. In exceptional circumstances, Direct Payments can be used to pay a relative who does live with the care recipient, but only if the local council agrees that this is the only satisfactory way of meeting the care needs. Separately, Direct Payments can also be paid to carers after a Carer's Assessment and the money used to buy in carers' services that have been assessed as being needed by the carer.

At their best, Direct Payments offer choice, control and flexibility for the older person receiving social care. In 2004, a survey for the Commission for Social Care Inspection (Commission for Social Care Inspection 2005b) found that 73 per cent of all respondents aged 15+ agreed that 'the person needing the social care and help should receive money from the government/council which they use to choose which care services they receive'. Women were more likely than men to think this (76 per cent versus 69 per cent respectively) and people who either received social care themselves, or knew people who did so, were more likely to agree (79 per cent).

## Take-up rates

This apparent endorsement of the principle of Direct Payments is in stark contrast to the extremely low take-up in practice. Table 1 (see overleaf) demonstrates that, although there has been a rise in the number of older people opting for Direct Payments, overall take-up remains extremely low. At 31 March 2004, using the year-end figures, only 0.5 per cent of all those aged 65+ receiving community-based care were in receipt of Direct Payments, compared with 3.3 per cent of those aged 18–64.

In the most recent figures for 2004/5 (NHS Health and Social Care Information Centre 2005), the number of clients aged 65+ receiving Direct Payments over the year 2003/4 has been revised down to 4,000, with a corresponding figure of 7,000 for 2004/5, confirming the continuing low take-up. It was still the case that fewer than 1 per cent of people over 65 receiving social care were getting Direct Payments.

**TABLE 1: NUMBER OF CLIENTS RECEIVING DIRECT PAYMENTS IN ENGLAND**

Over the year	Aged 65+	At year end	Aged 65–74	Aged 75+
2003/4	6,000	On 31 March 2004	1,200	2,000
2002/3	2,700	On 31 March 2003	700	800
2001/2	900	On 31 March 2002	300	400
2000/1	500	On 31 March 2001	200	180

Source: Department of Health 2005a  
Note: All figures are rounded.

It can be argued that Attendance Allowance, which is paid without means-testing to those over 65 who qualify, is also a form of Direct Payment, with no restrictions on how the money is spent. As of February 2005, this benefit was received by around 1.14 million people in England, at a cost of about £3 billion in 2004/5.

The Direct Payments Development Fund was announced by the Department of Health in 2002 with the goal of promoting take-up. Since then, the fund has disbursed £9 million in grants to voluntary organisations to create and build on support schemes for Direct Payments. The Green Paper on Adult Social Care (Department of Health 2005b) proposes the wider use of Direct Payments, as well as the piloting of ‘individual budgets’. An individual budget would be allocated on the basis of a person’s need, and held by the local authority. The ‘client’ would then be able to choose the services they wished to receive. According to the Green Paper, individual budgets could be introduced for people with a disability by 2012, subject to the success of the pilot schemes and the availability of new resources to initiate change. It is envisaged that within the individual budget system, the elderly person will be able to choose a mixture of cash payments, an amount of services resource, or a mixture of both. In all these cases, the individual will be able to choose the services which they feel best meet their needs. Those services can then either be arranged by the user, brokered by an adviser or commissioned by the local authority. Thus, in future, Direct Payments are likely to become one element within a spectrum of service delivery mechanisms designed to give elderly people greater control over what social services they receive.

The use of Direct Payments is already included as a performance indicator for the assessment of local authorities. The performance bands range from fewer than 15 recipients of Direct Payments per 100,000 population, to more than 150 per 100,000 population (for all adults aged 18+). There is considerable variation across councils. Only one council (Sunderland) in 2004/5 achieved the fifth (top) band, while 18 managed the fourth band, a big increase from just two the previous year (Commission for Social Care Inspection 2005a). If the top band were to be reached by all councils in England, approximately 60,000 (Scourfield 2005) adults would now be receiving Direct Payments compared with 14,200 (all ages, 18+) who were receiving Direct Payments on 31 March 2004. That would equate to around 6 per cent of all adults receiving community-based care, compared with the actual 31 March 2004 figures of 3.3 per cent (aged 18–64) and 0.5 per cent (aged 65+).

## What Direct Payments money is used for

The majority of Direct Payments money is, in practice, used to pay for personal assistants. Among one small sample (Ungerson 2004) in England, there was a wide variety of care 'solutions' and relationships under the system. Some care-users had recruited paid carers through word-of-mouth, while others had used newspaper advertisements and Job Centres; some used a single paid care-giver, others organised a shift-system of several paid carers to provide anything up to 24/7 cover.

In Hampshire, the Direct Payments support worker for older people estimated informally that around 80 per cent of the personal assistants employed through Direct Payments were people who were already known by the older person. Many of these carers had previously been providing some form of informal help. The Direct Payments system had therefore shifted these carers in status from informal to quasi-formal or 'paid informal'. Thus the system is already breaking down the distinctions between formal and informal carers. Interestingly, the Hampshire support worker estimated that more than half of the personal assistants had previous experience working as a formal carer, but could earn more being paid through Direct Payments.

Direct payments can improve the overall status of family caregivers. One study (Ungerson 2004) commented that 'by allowing for the payment of relatives who previously have been 'classic' unpaid and formally unrecognised informal carers, [these schemes] actually provide a means whereby the work of care-givers is recognised and recompensed, such that they become more and more like care-workers'. This can be the case without any change in behaviour in terms of the way care is provided.

Increased choice can have unexpected consequences. In one such example, from Essex County Council, the take-up of Direct Payments received a significant boost because many older people wanted to exercise the choice to retain existing care workers who had previously been supplied directly by the council. A decision by Essex to move towards block provision of services from April 2005 had meant that many older people were told they would have to switch to new carers from the new block provider. This, combined with a new unified Direct Payments rate, prompted the number of older people opting for Direct Payments to jump from 299 to 387 in just two months as people opted to switch to taking cash in order to retain existing carers.

The willingness of personal carers to take on a wider range of duties than traditional formal carers fits well with the concerns of older people. A formal carer might help an older person to get ready to go out but it would not be their job to take them out, even if the older person was too scared to go out alone. A personal carer is likely to be more flexible. One study (Clark *et al* 1998) indicated clearly that help with housework, gardening, laundry, and home maintenance and repairs, both enhanced quality of life for older people and helped them maintain their independence. It found that keeping a well-maintained house was central to many older people's sense of well-being and of being part of society, as well as to their confidence about coping at home. The relationships older people developed with home carers were also often as important as the practical assistance and could make it easier for them to accept help.

The range of services that will be purchased with Direct Payments money is supposed to expand if the system develops in line with its original philosophy whereby more

imaginative methods are used to meet an assessed need. Rather than Direct Payments being bolted onto the back of the existing range of services, older people are now able to choose more individual ways of meeting their assessed needs. Anecdotal examples are legion, such as the man who wanted to be taken fishing rather than to the local day care centre, and the women whose sense of well-being was most improved by asking their personal assistants to do the ironing.

A study (Glendinning *et al* 2000) of disabled people receiving Direct Payments found that they were purchasing assistance which crossed the conventional boundaries between social services and health services, including physiotherapy, chiropody, management of incontinence. They purchased this help from their personal assistants because statutory services were not available, had been withdrawn, or because they were able to retain greater independence and control. The overall result may be to reduce the relative demand for formal care. If these wider choices are allowed, then the challenge will be to allocate a rigorous Direct Payments personal budget according to assessed need which is not simply based on a list of traditional services which are supposed to meet those needs, but which the older person may in practice decide not to purchase.

There is considerable evidence that many of those who have opted for Direct Payments have found it a positive change. One recent study (Clark *et al* 2004) found that older people on Direct Payments reported feeling happier, more motivated and had an improved quality of life compared with before. There was a positive impact upon their social, emotional and physical health. Direct payments promoted independence, quality of life and social inclusion.

## **Barriers to take-up**

Looking ahead 20 years raises the question of what proportion of older people might eventually opt for Direct Payments. For the number to increase, some of the barriers that appear to exist to take-up will need to be addressed. Support services have been shown to be crucial in enabling older people to opt for Direct Payments, given the difficulties of managing the financial and administrative aspects of the system, in particular the bureaucratic and security side of employing personal assistants or other staff. Preliminary analysis from one study (Pearson *et al* 2004) showed that support schemes encouraged take-up by 80 per cent.

A number of studies (Clark *et al* 2004, Commission for Social Care Inspection 2004, Hasler and Stewart 2004) into existing barriers have come to very similar conclusions. Among the main problems are the lack of clear information for older people; poor awareness of Direct Payments among social services staff and their reluctance to promote this option; lack of support to help the older person with the administration of employing a care worker; concerns about obtaining criminal record checks and reliable references for personal assistants; and inconsistencies in local practice. In particular, many potential users have been unaware of their right to request a Criminal Records Bureau (CRB) check from their local authority, and when they are the check involves complex registration procedures and often takes three months (Department of Health 2005c). The government is now taking forward a programme of work to improve protection in response to the recommendations of the Bichard Inquiry (2004), including the development of a registration scheme covering those working with vulnerable adults (Department of Health 2005b). The Safeguarding

Vulnerable Groups Bill, published March 2006, provides for a new central vetting process built on the Criminal Records Bureau (CRB). For the first time, individuals, parents and families, including Direct Payment recipients employing nannies, music teachers, care workers, personal tutors will be able to make an instant online check of their barred status.

In discussions, many practitioners also mention that social services are often only called in at a time of crisis when the older person is least likely to be able to manage Direct Payments. Once direct services have been arranged, the question of Direct Payments is not revisited when the client's circumstances improve. The strict social care eligibility rules, both in terms of the needs assessment and means-testing, also mean that those who currently qualify for state-funded social care may be less likely to have had much recent experience of being an employer, and may be particularly daunted by taking on such a role without considerable support. Even for those with relevant workplace experience, taking on such responsibilities when ill and frail can appear challenging.

One research paper (Riddell *et al* 2005), which was looking primarily at Direct Payments for disabled people rather than older people, also found some resistance among local authorities and public sector unions. The former sometimes argued that Direct Payments undermined other services and threatened public sector jobs. There was considerable regional variation in take-up, and it was noticeable that the top 10 local authorities in terms of Direct Payment users all had support schemes in place. One analysis (Pearson 2004) showed that local political control was an important factor, with 70 per cent of the top 10 authorities with highest clusters of Direct Payments users being Conservative-led. A review of the government's policy on promoting choice (Rankin 2005) concluded that 'getting into the mindset of responding to expressed preferences requires a cultural shift amongst providers and commissioners. This suggests central and local government need to focus on promoting cultural change in some local authorities'.

An extensive study of barriers to implementation (Hasler and Stewart 2004) found that Direct Payments worked best where a supportive local authority infrastructure was combined with an understanding of the principles of independent living and 'a commitment to partnership with users'. Similarly, a separate study (Rankin 2005) concluded that where Direct Payments have taken off, it has been through a combination of social work enthusiasm, voluntary sector advocacy and local government ambition. Local authorities who had been supportive of Direct Payments for disabled adults of working age tended to be at the forefront of developing Direct Payments for older people (Fernandez J-L *et al* forthcoming). There was also some evidence to suggest a negative correlation between low take-up of Direct Payments and high levels of in-house provision. Those councils which were more resistant to outsourcing services were also less likely to be encouraging Direct Payments.

# Other countries' experiences

Some European countries have operated Direct Payment systems for older people for considerably longer than has been the case in England, and it is useful to look at the take-up rates that have been achieved. A study for the Office for Economic Co-operation and Development (OECD) (Lundsgaard 2005) provided the figures shown in Table 2, below. These schemes vary considerably, especially in terms of the extent to which the older person has a right to opt for Direct Payments or an individualised budget, but almost all permit the employment of co-habiting relatives.

In Austria, all public support for home care is through a system of Direct Payments. Compared to the UK system, this would be equivalent to all social care support being

**TABLE 2: TAKE-UP OF DIRECT PAYMENTS AND PERSONAL BUDGETS, INCLUDING PAYMENTS FOR INFORMAL CARE**

Country	Type of programme	Employment of relatives?	Percentage of 65+ population in receipt of social care who have direct payments or a personal budget
Austria	Cash allowance	Yes	100
Germany	Option of a cash allowance or care-in-kind or a combination of the two	Yes	80 (including those who choose a care package that combines cash and services)
Luxembourg	Option of a cash allowance to cover first 7hrs/week of care	Yes	91 (including those who choose a care package that combines cash and services)
Sweden	Cash payment; minimum need of 17hrs/week	Yes	1
Netherlands	Personal budget – since April 2003 available to all those qualifying for long-term home-based care	Yes (but not in same home)	7
Norway	Personal budget for care assistants when local authority considers this a better option than formal agency care	Yes	2
United States	Medicaid pay for a specified number of hours of a user-hired personal assistant	Yes (but not spouses)	18

Source: Based on Lundsgaard 2005

channelled through an Attendance Allowance type social security benefit. In Germany, an older person has the choice between services in kind and the cash allowance for care. In 1995, when long-term care insurance was introduced, 84 per cent of all older people receiving support chose cash only. Since then there has been a gradual shift towards services and combinations of cash and services so that in 2001, 73 per cent of people receiving support opted for cash only. Under the German regulations, the older person is obliged to acquire sufficient care, but there are no explicit restrictions on how the cash is spent. As one might expect, those with the greatest dependency have been less likely to opt to take cash-only Direct Payments. The data indicates how the proportion of older people who choose to take the cash-only option decreases for higher levels of care needs: lowest needs (82 per cent opt for cash-only); middle needs (77 per cent), highest needs (64 per cent) (Lundsgaard 2005).

Does the very high take-up of Direct Payments in Germany demonstrate what could be achieved in England? It is striking that the cash option is very popular, even though it is usually worth roughly half the value put on the services in kind. However, unlike in England, the recipient can use the Direct Payments money to reward what would otherwise be informal care, including paying a spouse/relatives in the same household. Respite care is also included in the benefit package. The Direct Payments option is also popular in Luxembourg, where a cash allowance is available to cover the first seven hours of home care a week, and where it is also permitted to pay relatives.

One study (Wiener *et al* 2003) of the German take-up of Direct Payments reported evidence that consumers elected to receive cash because they preferred to receive care from family and friends rather than strangers (87 per cent). Cash beneficiaries relied on relatively little informal care-giving aside from family. In a local survey, only 16 per cent of beneficiaries reported any informal assistance outside of family and neighbours. Only 11 per cent of beneficiaries who chose the full cash benefit purchased any professional services at all. The low level of the cash payment can itself be a problem for anyone who wants to use the Direct Payments money for formal care as the older person cannot afford the market rates (Leece 2004). Thus, in Germany, it would seem that most of the Direct Payments cash remains within the wider family. The wider context is rather different from that in England because, under German law, children are obliged to support their parents in old age, to the extent that their own resources are sufficient (Karlsson *et al* 2004). Cash payments are particularly attractive because any cash that family members (or other informal carers) receive for providing care is not taxed as income and is not counted against eligibility for other state benefits. In contrast, in England payments to carers (including family members) out of Direct Payments money are taxable and incur National Insurance contributions. In countries such as Austria and Italy, where the payments are entirely unregulated, the additional income also tends to flow into the household as a whole, rather than ending up in the pocket of the carer (Ungerson 2004).

A review (Ungerson 2004) of 'cash for care' systems in five countries (Austria, France, Italy, the Netherlands and the UK) looked at both the level of regulation/non-regulation and whether or not relatives could be paid with the money. Regulation covers care delivery (standards, qualifications, etc) and care work (tax environment, employment rights, etc). The author concluded that in the Netherlands, where regulation is high and relatives can be paid, a 'fully commodified' form of informal care had emerged, meaning that cash was now being attached to what was formerly unpaid informal care. In Austria and Italy, where

regulation is low, 'a mix of informal and formal care-givers/workers has emerged with many international migrant workers'. It concluded that no scheme had a simple outcome or advantage.

In the Netherlands, the personal budget scheme has expanded rapidly, in part because it enables older people to bypass waiting lists for some services (Glendinning *et al* 2004). The money can be used to buy any of the interventions available under the social care insurance scheme, including home nursing, from informal or formal sources. The study found that older people expressed satisfaction with their increased choice and control, but there were complaints from users about the administrative burden and lack of support.

# The scope for future take-up

The question of the likely future demand for Direct Payments in England, and the type of services that will be purchased by those who opt for Direct Payments, is one that will depend on the future shape of the system. It will also be affected by workforce issues. Scourfield (2005) points out: 'If we assume (and this might be seen as conservatively by some) that in the next five years, demand for Direct Payments rises to 10 per cent of those eligible for services, then this translates to roughly 150,000 people. This in turn suggests that tens of thousands of personal assistants would be needed. If Direct Payments really do take off in the way that many envisage, then in the next decade this could see the demand for this kind of worker rise to the order of hundreds of thousands. It is important to understand this in the context of ongoing recruitment and retention problems in the wider home care sector.' Two relevant factors will be the popularity of employing non-cohabiting relatives and friends, and whether Direct Payments will ever be extended to cohabiting spouses and relatives.

In the medium term, the emergence of the proposed individual budgets will be key to the take-up of Direct Payments. Individual budgets may well prove more attractive to some eligible older people as they will offer the degree of choice that Direct Payments already provide, but with the option of using a broker or asking the local authority to make the arrangements. Thus it is to be hoped that older people will in future benefit not only from choosing the components of a care package, but also from gaining choice about the degree of support that is preferred. (Rankin 2005) quotes one pilot study of different options for choice in older people's services in Portsmouth in 1999 showed that a mid-way option of brokered services was more popular than direct control through Direct Payments or council commissioned services. Out of 31 users, 7 chose a Direct Payment, 20 negotiated services with support of a carer and 4 chose to continue receiving traditional services. The challenge will be to calculate transparent charges for the complete range of services and support which are currently provided by local authorities. If individual budgets are seen as the umbrella term for a spectrum of alternatives which range from Direct Payments to fully-facilitated services, then on a 20-year horizon it is likely that everyone will fall within the individual budget system. It would then be a political decision whether the cost to the state of a person opting for Direct Payments is less than the cost of services in kind (as in Germany), or equal to it.

Various other factors are also likely to drive the take-up of Direct Payments. The population of 18–64 adults who are physically impaired, among whom Direct Payments already have a higher prevalence, will themselves age. It is difficult to imagine someone who has been using Direct Payments for many years suddenly deciding to abandon the system just because they have reached the age of 65. Secondly, the independent baby-boomer generation, whose preference for control and choice is a constant theme when planning ahead for the ageing population, might be assumed to provide prime candidates for Direct Payments.

As mentioned, achieving the current top band for the Direct Payments performance indicator across the board would mean 6 per cent of all those receiving any community-based care opting for Direct Payments. In one 1993 study (Zarb and Oliver 1993) of adult disabled people who were looking ahead to old age, more than 20 per cent intended to recruit personal assistants in the foreseeable future, and a similar number felt that they might use personal assistants depending on what changes (if any) they experienced in their circumstances. However, overall there does not appear to be rigorous, up-to-date, information or research which would point to the likely future uptake of Direct Payments by older people. In any case, uptake will in part depend on the quality of services offered via the local authority. The question may itself be out of date because its answer is likely to depend on the final format of an individual budget system. In that sense, the results of the national evaluation of the individualised budget pilots announced by government should provide important evidence as to the likely future success of consumer-directed schemes in England.

The projected increase over the next 20 years in the number of old people with dementia raises the question of how competent a person needs to be to opt for Direct Payments. The adult social care Green Paper (Department of Health 2005b) proposes that Direct Payments are extended to those who do not have the capacity to consent by allowing carers to take on the Direct Payment. The Alzheimer's Society (Alzheimer's Society 2005) is supportive of this idea, but points out that many carers feel their workload and stress levels are already too high to cope with taking on Direct Payments, so people with dementia and their carers must be given specialist support if they do choose to use Direct Payments. It would not, however, support the adoption of targets to increase the numbers of people with dementia and carers using Direct Payments, 'as this may lead to undue pressure to take on an unwanted system of care provision'. It adds that the provision of choice of Direct Payments for people with dementia should be monitored. The Society believes that individualised budgets 'present an interesting opportunity for people to have more control of the services they are receiving, while avoiding some of the perceived negative aspects of Direct Payments'.

# Impact on funding

The funding implications of Direct Payments for older people will depend on the cost-effectiveness of the system. One study (Zarb and Nadash 1994), dating back to 1994, with disabled adults (almost all under 65 years old) compared the costs of support financed by direct or indirect payments with the cost of direct service provision. Administrative costs and other overheads associated with both the payments and services options were included. The findings indicated that support arrangements financed by direct/indirect payments were, on average, between 30 per cent and 40 per cent cheaper than equivalent service-based support. Part of this difference was related to the fact that hourly rates for direct/indirect (Independent Living Fund) payments were usually lower than payments from local authorities. But the main factor accounting for the difference was the administrative overheads involved. The Direct Payments hourly rates have been increased in recent years, which would erode the cost benefits, and the author now estimates that 20 per cent – 25 per cent might be an updated figure. (It is difficult sometimes to compare like with like as personal assistants hired directly by users do not always receive paid pensions and sickness benefits, etc.)

Some local authorities have made their own assessments. The London Borough of Richmond upon Thames, in a March 2005 report (London Borough of Richmond upon Thames 2005), considered the financial implications of its Direct Payments scheme (for recipients of all ages). The average hourly rate for the agency home care providers at that time used by the council was £12.21 an hour (not including council administrative costs) compared with the Direct Payment average hourly cost of £10.14 (including the support service). Overall, Direct Payments were estimated to reduce costs by around 17 per cent of the direct service costs. The report pointed out that the agency home care fees were set to rise to £12.95 an hour, which would raise the overall savings from Direct Payments to an estimated 23 per cent. Councils sometimes assume that the cost of the support services will make Direct Payments uneconomic, and this can be true in the early days when the take-up is too low to achieve the necessary economies of scale. However, to great extent, the cost-effectiveness of any scheme can be controlled by setting accordingly the hourly rates that are paid under the Direct Payments regime, although this will also affect how attractive the scheme is to users.

Like many aspects of community-based care, however, there are big variations around the country in the way councils operate their Direct Payments scheme. One unusual example is Hampshire where in 2005 the net rate paid under Direct Payments was £8.17 an hour, with the care-user taking full responsibility for arranging all necessary care. Unusually, no means-testing was carried out on those choosing this option, as the rate paid was not expected to cover the full cost of obtaining and arranging care. Care obtained through an agency would typically cost the local authority £13–£14 an hour, but only a small proportion of this amount might actually be paid to the carer. Thus an older person taking

**TABLE 3: AVERAGE GROSS WEEKLY EXPENDITURE PER OLDER PERSON FOR DIRECT PAYMENTS AND COMPARATIVE SERVICES IN ENGLAND AT 31 MARCH 2004**

<b>Expenditure</b>	<b>Direct payments</b>	<b>Home care</b>	<b>Day care</b>	<b>Meals</b>
Average	£130.00	£95.00	£57.00	£16.20
Median	£131.00	£97.00	£63.00	£16.50
Quartile 25%	£83.00	£81.00	£43.00	£10.60
Quartile 75%	£182.00	£121.00	£93.00	£23.00
Minimum	£0	£46.00	£13.00	£0.10
Maximum	£942.00	£200.00	£722.00	£925.10

Source: Based on 2003/4 PAF indicators from the Department of Health

Direct Payments and paying around £7 an hour was offering an attractive rate to prospective carers.

The average amount that is paid out to older people in Direct Payments can be seen in Table 3, above, which also includes comparisons with other social services for older people. The figures demonstrate how recipients with wide-ranging levels of needs are receiving Direct Payments. They also indicate that Direct Payments can be cost effective.

# Conclusions

Recent government policy in England has favoured the promotion of Direct Payments as part of a renewed emphasis on personal choice and control. In that context, it is interesting to consider the debate in Japan over cash payments when that country's new long-term care funding system was being decided, as many of the issues are just as relevant in England. A review of the debate (Campbell and Ikegami 2003) in Japan found the following arguments were put forward in favour of cash payments. They:

- have the potential to save money, if they are set at a lower level than the cost of services, as in Germany
- maximise consumer choice
- recognise and reward the role of family carers, particularly daughters-in-law who traditionally provided care
- avoid poor care from paid strangers.

The arguments put forward against cash payments were backed by Japan's feminists.

- For consumers to have a genuine choice, the number of formal service providers would have to expand rapidly. But cash allowances would inhibit demand for formal services, and therefore depress the market and reduce the diversity of provision for those who want to buy in outside help.
- Cash payments alone would not change existing care-giving patterns, because these are inherently oppressive, especially for daughters-in-law.
- Formal care-giving by trained people is better than care by family members who may, for instance, keep older people in bed all day because it is less trouble. Day care is more enriching than staying at home all day.
- The system could end up costing more because everyone would apply for cash, while only those who really wanted services would ask for them.

In the end, Japan decided not to introduce cash payments, and services are offered only under the current long-term care system.

At the heart of any discussion about whether cash payments are good for informal carers is the question of whether older people should be allowed to use the money to pay co-habiting family members. As already demonstrated, in the countries where this is permitted, a high proportion of older people have opted to take cash rather than services. The purchase of formal services with a cash payment in such places tends to remain rather modest.

In England, the restriction on paying co-habiting relatives is likely to become more relevant given evidence (Pickard *et al* 2000) that a smaller share of older people will be living alone by 2031 than was the case in 1996, and correspondingly more still living with a spouse or partner. The OECD (Lundsgaard 2005) also points to the changing profile of informal

caregivers, in that active older people may start to take over from children and grandchildren as informal care-givers.

Relaxing the rules in England would put more money into the household, although this would also depend on any knock-on effects on state benefits that are being received. Allowing cohabiting relatives to adopt the role of a paid personal assistant might also alleviate the problem of workforce shortages. A less desirable result would occur if the cash were simply absorbed into general household budgets, and not used to buy the care needed. In this case the payment would end up subsidising existing informal care that would be provided regardless of any remuneration. Extensive informal care is being provided now in Germany, for instance, in the same way as it was before the cash option was introduced (Wiener *et al* 2003). Thus less care might then be commissioned than under the existing Direct Payments rules – though this would be a result of personal choice. State expenditure could, as a result, rise because Direct Payments would be claimed by older people who only want to be cared for by someone very close, or who are averse to receiving services through the local authority. There is little research to assist in balancing these considerable uncertainties and, at the moment, no indication that the government is planning to change the rules in England.

Overall, when considering the successful implementation of a Direct Payments system, there are a number of key issues. First, although people value being in control, this comes at a price with Direct Payments – specifically that most of the burden of administration falls on the user and their family. More support is necessary for Direct Payments to attract a wider take-up.

Second, there may be uncertainty about the quality of the services that people commission themselves. Do people opting for Direct Payments in practice trade-off improved ‘control’ against reductions in the quality of the personal care? In Germany, for example, there have been concerns about quality, so much so that informal carers are encouraged to undertake some formal training.

Third, can the use of consumer-directed care be cost saving? When the carers have previously been providing some form of informal help, Direct Payments will shift them in status from informal to quasi-formal or ‘paid informal’, and can therefore shift some funding from private to state. In the German system, despite the cash benefit being around half the value of services, around 73 per cent of people in 2001 were choosing cash-only benefits. This does suggest that people might willingly take lower cost services in exchange for greater control, assuming that the family carers are willing to take on the work. To counteract this advantage, there are undoubtedly people who would not claim state support in the absence of a cash benefit. Another rather less positive aspect is that users of Direct Payments will get a more expensive deal from formal provider agencies than the local authorities do, because social services departments can negotiate lower hourly prices for care staff by block booking.

Fourth, it is apparent that Direct Payments give people more choice over services and, as a consequence, over the outcomes they personally want to achieve. Further research is required to understand more fully how Direct Payments money is spent, but many people choose services that meet not only their personal care needs but also practical and quality of life outcomes. In England, the majority of Direct Payments money is, in practice, used to

pay for personal assistants, whose willingness to take on a wider range of duties than traditional formal carers fits well with the concerns of older people. The greater flexibility is helpful for the people involved, but it does mean that older people with personal care needs can also obtain state-funded practical/instrumental care services (for example, housework, shopping), while older people with only practical/instrumental care needs would be denied such help unless current eligibility criteria changed for them too. This appears inequitable.

In conclusion, in England there is clearly considerable scope to increase the take-up of Direct Payments by those over 65, but the introduction of individual budgets will significantly change the landscape by offering a range of options from local authority organised services through to a cash payment. This flexibility is likely to be attractive to older people. But if the Direct Payments end of individual budgets spectrum is to be encouraged, the key issues raised above will need to be addressed.

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