

Personal health budgets for the UK NHS: a revolution for the patient?

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About the author

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In this issue:

Personal health budgets for the UK NHS: a revolution for the patient	1
In the news	2
In the journals	2
Health awareness – dates for your diary	2
Making the headlines	4
Forthcoming events	4

2008 began as a very upbeat year for social care, with talk of radical reform, ‘transformation’, ‘personalisation’ and ‘self-directed support’. The aspiration was to increase the ‘choice and control’ of individual service users. The key vehicles to achieve this were ‘individual’ or ‘personal budgets’, which would put each service user in charge of a designated sum of money to spend on their support as they wished. The idea was not new in social care. It had its origins in the ‘direct payments’ developed by the disabled people’s movement more than 20 years earlier. The real innovation, however, was that this reform was to be extended to the NHS. One of the recommendations of Lord Darzi’s NHS review (2008), was that a pilot scheme of 5,000 such personal budgets for people with long term conditions (LTCs) should be established in the NHS.

It is not surprising that the benefits to be achieved from people being able to access their own pot of NHS money have gained widespread support as a means of increasing patient choice and control. People living with LTCs (e.g. diabetes, multiple sclerosis) have often been expected to accept narrowly prescriptive and paternalistic approaches to their care and support. As research on direct payments has long evidenced, there are real gains to be had from being able to shop around to put together your own package of support, which fits with how you want to live your life, instead of being based on professional assumptions about a particular diagnosis or set of symptoms. Such purchase of service rings particularly strong bells for mental health service users. The response to their often complex and multi-faceted needs has continued to be based on a psychiatric system over-reliant on drug

therapy, frequently unsafe and often institutionalised.

A year, however, is a very long time in politics and as we came to the end of 2008, the situation for both social care and its prized idea, personal budgets, was looking rather more downbeat. The government published the findings of the evaluation of the individual budgets programme in social care, which it funded: the Ibsen Research Programme (Glendinning et al, 2008). Significantly, the government had not waited for these findings before rolling out its personalisation policy.

Importantly, the Ibsen study highlighted that the cost savings promised for individual budgets were probably illusory. Some groups, e.g. significantly older people, the largest group of health and social care service users, did not seem to value individual budgets or feel they benefitted from them. This finding has been challenged by government and by other evidence.



The government now seems to have distanced itself from equating personalisation with self-directed support schemes.

... continued on page 3

In the news

■ Pain in childbirth 'a good thing'

Women who have epidurals may be missing out on the hidden benefits of labour pains. According to Dr Denis Walsh, Associate Professor of Midwifery at Nottingham University, pain has both psychological and physiological effects. Psychologically, pain may strengthen a mother's bond with her baby and help her to prepare for the demands of motherhood. Physiologically, pain is known to stimulate the production of endorphins, which help women adjust to the pain and establish a rhythm to childbirth. The researchers were keen to point out that we should not underestimate the pain of childbirth and that an epidural should still be made available to those who request one.

■ Obesity 'link to same sex parent'

New research from the Peninsula Medical School, UK, indicates that there is a strong link in obesity between mothers and daughters and fathers and sons, but not across genders. Obese mothers were 10 times more likely to have obese daughters and obese fathers were 6 times more likely to have obese sons but in both cases children of the opposite sex were not affected. It is thought that this link is unlikely to be genetic, as it would be unusual for obesity to be influenced along gender lines. "Behavioural sympathy" is more likely with children adopting similar lifestyles to their same sex parent. This research suggests a change may be needed in government policy, which is currently focused on children and young people in the belief that obese children become obese adults. However, 8 in 10 obese adults were not obese as children and this new research suggests that we may need to focus on ensuring that parents are good role models for their same sex children.



In the Journals

Teachable moments for health behaviour change

- 1** "Teachable moments" have been proposed as a particular event or set of circumstances which lead individuals to alter their health behaviour positively.
- 2** They have been accepted intuitively as an important focus in promoting health / wellness but empirical support is absent.
- 3** A comprehensive review was undertaken to uncover common definitions and key elements.
- 4** The "teachable moment" has been poorly developed conceptually and operationally. It is synonymous with (1) "opportunity" (81%); (2) higher than expected behaviour change, labelled retrospectively (17%); (3) a phenomenon that involved a cueing event that prompts specific cognitive and emotional responses (2%).
- 5** The concept of the "teachable moment" is under-theorised. Conceptualising it as created through interaction opens several avenues of investigation. For example, presentation of a worrisome symptom or test result provides opportunities for encouraging adoption of healthy behaviours.

Lawson PJ et al (2009) Teachable moments for health behaviour change: a concept analysis. *Patient Educ Couns* 76: 25-30.

Health Awareness - dates for your diary



[International Youth Day: 12 Aug](#)

[World Breastfeeding Week: 1-7 Aug](#)

[Gut Week: 24-30 Aug](#)

[Road Victim Month](#)

Personal health budgets for the UK NHS: a revolution for the patient?

... continued from page 1

It now talks more vaguely about personalisation as a social care approach committed to increased individualisation, choice and control, across all services, including community and residential services and regardless of whether service users are in receipt of individual budgets. The serious international economic difficulties have also cast a shadow over personal budgets, making it unlikely that there will be any additional money for the foreseeable future to compensate for current shortfalls, let alone for the increased demands envisaged from predicted demographic changes.

Other concerns have also been raised: What about people with fluctuating and deteriorating conditions? How will flexibility be ensured with payments? What limits will be set to how service users can spend the money?

Much less attention, however, seems to have been paid to the broader issues of principle, values and philosophy that are raised by the extension of personal budgets to the NHS. But it is these that demand particular attention and that are also likely to tell whether this development will, ultimately, be progressive or regressive for patients and service users. Interestingly, there has been just such a discussion of another NHS development and its potential impact on traditional health service principles, i.e. the new government agreement to allow people to top-up treatments by paying for them privately while still receiving NHS care free. This has sparked intense debate and made headlines but it is difficult to see how the introduction of personal budgets raises any less fundamental questions for the NHS.

At the core of the issue are the fundamentally opposed principles underpinning the NHS and social care in England. The NHS was established and is still largely seen as a universalist service free at the point of delivery.

Social care has always, since its inception under the 1948 National Assistance Act, been a residual service to which people have no general entitlement. Instead, they are subjected to both 'needs' and financial assessment. They must fall within an ever narrowing series of 'eligibility criteria' to secure access to state support and then, through means testing, expect to be charged for it. There is little question that the ideologically opposed basis of these two services, health and social care, has been one of the major obstacles to successful integration and partnership between them.

This raises the issue of how we square the universalist principles of the NHS with a model of cash payments or allowances borrowed from a selective social care system. It is difficult to see how such personal budgets are more than a rebranded version of the health vouchers once advocated by Mrs Thatcher's ideologues as they cut NHS funding.

It would seem to make more sense to look to the NHS to find a more satisfactory system of funding for social care, than to look to social care for a more satisfactory way of delivering appropriate support. The latter seems especially important given recent reports from the Commission for Social Care Inspection (CSCI, 2008a & b). These highlight first how social care currently disadvantages two large groups of service users – 'self-funders' who, when left without guidance or support, are disproportionately likely to be institutionalised and, those with significant needs who fall outside eligibility criteria and as a result are often 'left struggling with a poor quality of life'. Second, such eligibility criteria seriously limit service users' 'choice and control' and directly oppose the goals of personalisation. Individual and personal budgets have been developed mainly as a consumerist tool reframing service users as customers.

... continued on page 4

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Personal health budgets for the UK NHS: a revolution for the patient?

... continued from page 3

They purchase services according to a 'resource allocation system' (RAS) set by the funding authority in line with existing finances. However, direct payments were intended originally as a route to democratising policy and provision, empowering people by putting them in control of the support they needed in line with the philosophy of independent living. An infrastructure of support to run direct payments schemes was to be offered to individual service users by a network of local 'centres for independent living' or user controlled organisations.

Extending personal budgets to health not only raises major problems of principle for the NHS. It also has other implications that need to be worked through. What will be included as part of people's individual health budget and what will continue to be part of their core NHS entitlement? What will stop the latter being eaten away? How will lines be drawn and who will draw them? What will happen to individual budgets in an economic downturn? The government has just rejected CSCI's recommendations for reforming existing arbitrary social care eligibility criteria. So, now that Lord Darzi

has stepped down from his ministerial role, what will happen to his vision?

I do not suggest here that all is ideal in the NHS garden, or that reforms aren't necessary to meet patient needs more appropriately. There are many failings in existing provision. It can be over-prescriptive and bureaucratic; the continuing care system is heavily restricted and difficult to access. But whether such inadequacies are best resolved through radically challenging health's underpinning principles is another matter. The real issue to address is how are the NHS and social care to combine universalist entitlement with flexible self-directed support.

Of course, some may argue that the founding principles of the NHS are already effectively a thing of the past. The erosion of NHS dentistry, routine charging for prescriptions, glasses and even hospital car parking, reflect modern realities. However, if this is to be argued, then such a hidden agenda needs to be made public, so there can be truly inclusive debate about the future of the NHS. In the meantime, the practice, politics and values of personal budgets, which originated as a truly bottom-up liberatory initiative, need to be critiqued much more carefully before they are imported wholesale into a universalist NHS which remains, for many people, one of the most cherished achievements of modern UK society.

Making the headlines

- [Last NICE word on Alzheimer's meds](#)
- [Life expectancy in England between the rich and poor widens for both men and women](#)
- ['Honest Joes' and cheaters unmasked in brain scans](#)
- [Middle-aged men twice as likely to have diabetes as women](#)
- [Darzi resigns as health minister but remains government advisor](#)
- [Data on flu deaths are potentially misleading](#)
- [GPs poor at spotting depression](#)
- [Leading academic calls for shake-up in NICE procedures](#)
- [Poorest at risk of worst diabetes](#)

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Forthcoming events

17-19 Aug 2009

Measurement, Design and Analysis Methods for Health Outcomes Research

Harvard School of Public Health, Boston, USA

9-11 Sept 2009

BPS Division of Health Psychology

Aston University, UK

23-26 Sept 2009

European Health Psychology Society

Pisa, Italy

9-11 Oct 2009

Why men die early and suffer more: 6th Biennial World Congress on Men's Health and Gender (WCMH)

Vienna, Austria