

Personal Health Budgets: A critical analysis of the NHS vision

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Abstract

Personal Health Budgets (PHBs) could prove to be a radical policy initiative for the National Health Service (NHS) in the UK because they represent changes to the way services are organized and delivered that, if extended, potentially challenge existing funding, commissioning and delivery of health care service arrangements.

This paper aims to provide a critical analysis of the NHS vision for PHBs and a discussion of potential risks and negative effects should a wider roll-out of PHBs take place.

To do this the paper explores ways in which PHBs are claimed to offer choice and control through the combination of documentary analysis of policy documents and guidelines and semi-structured interviews conducted with PHBs specialists. The vision for PHBs emerging from these sources is discussed against the critical literature available on the topic.

The paper suggests that for the promises of PHBs (choice and control) to be delivered, the concomitant radical shift in the way services are financed, commissioned and delivered may lead to the further privatisation of NHS services and the individualisation of care interventions.

Keywords: Personal health budgets, personalised care, choice

Introduction

Personal Health Budgets (PHBs) are a new approach to service delivery in the UK National Health Service (NHS). They can be defined as follows:

A Personal Health Budget is an amount of money to support the identified healthcare and wellbeing needs of an individual, which is planned and agreed between the individual, or their representative, and the local clinical commissioning group (CCG). It isn't new money, but a different way of spending health funding to meet the needs of an individual.

(<https://www.england.nhs.uk/personal-health-budgets/what-are-personal-health-budgets-phbs/>)

Unpacking this definition, and complementing it with the requirements set by NHS England for PHBs (*Ibidem.*), their key features emerge together with the process that links them together: following an assessment of needs and outcomes for an individual, a support plan is developed by the individual and their CCG (or NHS team) on the basis of an indicative budget. This provides an indication of how much money is available in order for the assessed needs to be met. Minor adjustments of the budget are allowed provided they are justified by the support plan and, once the CCG (or NHS team) approves the plan, its overall cost becomes the PHB of the individual. People can then choose between direct and indirect management of a PHB. In the first case they will receive their PHB as a direct payment while in the second one a third party or the CCG will manage the budget. This last option is usually referred to as notional budget. A mix of these three options is also possible.

PHBs were first introduced in health care in England in 2014 – following a three year pilot programme which ended in 2012 – and they represent a key component of the NHS England personalised care model.

Personalisation is today a major driving principle of health care policy in England and the NHS commitment to personalisation in terms of choice, self-direction and the use of ‘budgets’ somehow mirrors that of social care policy in the country just over ten years ago. At that time, the third sector organisation ‘In Control’ had introduced a new model of service delivery known as self-directed-support (Hatton *et al.*, 2008). In Control’s work influenced government policy in social care, and the slogan of ‘choice and control’ originally coined by disability movements in the 1980s (Oliver, 1996) was incorporated into the then government ‘personalisation agenda’ (HM Government, 2007).

However, though arguably research on personalisation and personal budgets (PBs) in social care is now extensive and varied, that on personalised care and PHBs within the NHS is currently quite limited (Gadsby, 2013; Gadsby *et al.*, 2013). Most of the evidence regarding PHBs comes from two independent evaluations commissioned by the NHS (Forder *et al.*, 2012; Jones *et al.*, 2017). The recommendation in support of a wider roll out of PHBs beyond the pilot was based on these studies’ conclusion that PHBs were cost-effective – given certain assumptions – and that their use was associated with significant improvements in care related quality of life and psychological wellbeing for budget holders. I will argue below that partisan interpretations of these evaluations’ results have supported the wider roll out of PHBs and that the warnings of critical scholars regarding the risks PHBs might pose for NHS services have been overlooked or ignored. These risks include how PHBs might contribute to furthering the individualisation of health care practices and the privatisation of health care services.

This article contributes to research on PHBs by investigating the NHS vision for PHBs against more critical literature on the topic. In particular, it will focus on the way in which assumptions about PHBs have turned into a powerful narrative and how such narrative risks to overshadow potentially contested changes of current funding, commissioning and delivery arrangements of NHS services.

Methods

This study is based upon critical analysis of policy documents and guidelines on PHBs together with interviews conducted with experts on PHBs. The analysis and discussion draw on the work of other scholars who have considered the rationale behind PHBs and the evidence so far produced in their support.

Searching for ‘personal health budgets’ on the NHS England homepage reveals a series of links providing information and guidance about PHBs (<https://www.england.nhs.uk/?s=personal+health+budgets>). The first link leads to a webpage detailing all the different areas in which PHBs have been applied (<https://www.england.nhs.uk/personal-health-budgets/>) and, through this, to a ‘questions and answers’ section addressing various matters on PHBs (<https://www.england.nhs.uk/personal-health-budgets/what-are-personal-health-budgets-phbs/frequently-asked-questions-about-phbs/>). These links, together with key documents identified via these links and references to PHBs from more generic policy documents setting out the NHS vision for *personalised care*¹ were used as data for my analysis. The focus was restricted to include only documents published after 2014 (the year of the introduction of PHBs in the NHS as a ‘right to have’) and containing information about the plans for expansion of PHBs within the NHS. The focus of the analysis was concerned with understanding the vision of the NHS with regard to PHBs.

¹ The main documents setting out the NHS vision for personalised care are: the *Five Year Forward View (5YFV)* (2014), the *Next Steps on the Five Year Forward View (Next Steps)* (2017), the *NHS Long Term Plan* (NHS, 2019a) and the last government’s *Mandate to the NHS* (DHSC, 2018b).

This vision was then further explored through semi-structured interviews conducted with experts from both NHS England and Clinical Commissioning Groups (CCGs). A request was made to the Personalised Care Group at NHS England to interview PHB experts in both strategic and delivery roles. These experts provided details of PHB lead managers within CCGs. The Personalised Care Group is the team which, within NHS England, is in charge of embedding personalised care into NHS policy and processes while CCGs are bodies responsible for the translation and delivery of personalised care into local areas. Seven people were invited to participate. Six accepted and were interviewed: four experts from NHS England and two managers from CCGs. One person accepted but subsequently withdrew from the study. Four interviews were carried out in person while two were completed by telephone.

The interviews explored with participants the NHS vision for PHBs, focusing in particular on the changes required for the vision to be implemented. Three overarching research questions were asked: 1) What are the main changes PHBs demand at a service level?; 2) What is the scale of such changes?; 3) What could be the effects of a wider roll out of PHBs?

In line with these research questions, the interview topic guide focused on the role of PHBs within NHS policy and practice; the changes PHBs demand at a service level; and the scale of the implementation process of PHBs, including strategies and targets. Questions about positive and negative aspects of PHBs, relevant examples and similarities/differences between PHBs and Personal Budgets (PBs) were also included.

All interviews were scheduled to last a maximum of one hour. The shortest interview lasted 52 minutes while the longest 60 minutes. With the consent of the participants, all interviews were recorded.

Interviews were transcribed and thematic analysis applied to the transcripts. The topic guide was also used as the analytical framework for coding which was carried out using *Nvivo*.

The main findings emerging from my study were then compared and discussed against the work of critical scholars on PHBs. PHBs in the NHS are a fairly new policy and there is currently limited research literature on the topic. *Google Scholar* was used to identify relevant texts and hand searching of reference lists was also employed to select key studies. Most of the critical studies relied on experiences from other fields and countries – such as, respectively, social care (Slasberg *et al.*, 2015) and the US (Scott-Samuel, 2015) – or on the critical analysis of existing evidence (Slasberg *et al.*, 2013) to highlight potential risks and negative effects, as PHBs are mainstreamed in the NHS and current funding, commissioning and delivery arrangements of health care services might change. There appears to be currently limited research evidence about this topic.

Findings

These are organised in three main sections: first, an outline of the current scenario and the NHS vision for PHBs as it emerged from policy documents and guidelines; second, a description of key findings from interviews and, third, an analysis that, drawing on the work of critical scholars, discusses findings in terms of the potential effects of a wider roll-out of PHBs for NHS services and implications for policy and practice.

The NHS Vision

In accordance with the NHS *Five Year Forward View* (2014), the *Next Steps on the Five Year Forward View* (2017) and the *NHS Mandate 2018/2019*, the focus of the wider agenda to which PHBs belong is on prevention and public health initiatives aimed at supporting users of NHS services to take an active role in their health and wellbeing. A strong emphasis on self-care is indeed at the heart of the many policy initiatives which fall under the umbrella of *Personalised Care*. Choice and control over a budget are just one way of encouraging NHS users to take an

active role in their care. *Patient activation, social prescribing, shared decision making and community capacity building* are other measures and programmes which are intended for the same purposes (NHS, 2014; NHS, 2017; DHSC, 2018b).

One factor which distinguishes PHBs from other initiatives is their target population. The Comprehensive Personalised Care Model (<https://www.england.nhs.uk/wp-content/uploads/2019/02/comprehensive-model-of-personalised-care.pdf>) shows how, out of the whole NHS population, PHBs (and integrated budgets) are deemed relevant for just the 5% of the population, comprising people with the most complex needs, including long-term health conditions and disabilities.

It is for this 5% of the NHS population that choice and control over a budget become relevant. To briefly summarise NHS policy and guidelines on PHBs, personalisation is claimed to allow users of health and social care services to have more choice and control over the way their needs are met and PHBs represent a key mechanism for personalisation (DHSC, 2018a). It is suggested that people are empowered to become more confident in managing their own health and wellbeing and that they are able to influence, through their choices, the development of more appropriate and tailored support solutions compared to those of traditional NHS services (NHS, 2019b). Finally, for those individuals with both health and social care needs, PHBs also mean the possibility of joining together their resources into an integrated budget, so needs can be met in a seamless and integrated way (DHSC, 2018a).

This logic is not dissimilar from that which underpinned the introduction of personalisation through PBs in adult social care. Here, personalisation was defined in terms of self-direction and choice through PBs and Direct Payments (Hatton *et al.*, 2008). These concepts informed social care policy in the same way as they are now influencing NHS policy. Arguably, the model of self-directed-support promoted in social care by 'In Control' (Duffy, 2006) and later endorsed, in many of its aspects, within government policy (HM Government, 2007) is similar in respect of how it links support and care planning to 'indicative budgets' (or upfront allocations) in the NHS. Moreover, the claim that PBs would deliver better and more efficient care together with greater empowerment (Hatton *et al.*, 2008; Leadbeater *et al.*, 2008) resonates with today's commitment from the NHS to expand PHBs as a means for personalised care.

This commitment is declared in the *NHS Long Term Plan* (NHS, 2019a), a key component of which are PHBs. Since March 2019, PHBs have become a *default option* for NHS Continuing Healthcare (CHC)² users. Action 12 of the *Universal Personalised Care* document requires steps to 'ensure all people receiving home-based NHS CHC have this provided as a PHB by default by 2019/2020' (NHS, 2019b, p.43). Adults eligible for NHS Continuing Healthcare (CHC) and children receiving continuing care packages have also been the first groups of users for whom the 'right to have' a PHB was introduced, in 2014. This means that, irrespective of where they live, since 2014, people with CHC arrangements have been able to request a PHB from their local CCG. For some other user groups, instead, the right to request a PHB depends on where they live and on whether there are plans to expand the use of PHBs by their local CCG. Accordingly, they may be available to people with mental health problems, learning disabilities, autism, people using end of life care, wheelchair services and, more recently, women using maternity services (NHS England, 2017). Also, as part of the Integrated Personal Commissioning (IPC) Programme launched in 2015, integrated budgets for people with a range of long-term conditions and disabilities and high level of needs across health and social care have been piloted and, following a recent consultation (DHSC, 2018a), work is underway to introduce new 'rights to have' for new groups of people with ongoing health needs.

² Adults with long-term complex health needs might be eligible for NHS CHC. Eligibility for NHS CHC depends on the complexity, intensity and unpredictability of certain health needs. If eligible for CHC, both the social care and health elements of a person's package of support will solely be funded by the NHS: '*free social care arranged and funded solely by the NHS*' (<https://www.nhs.uk/conditions/social-care-and-support/nhs-continuing-care/>).

In terms of numbers, the *Universal Personalised Care* document (NHS, 2019b) reports that 32,000 people across the UK have a PHB, as opposed to just over 1,200 in 2012, and the commitment is to reach 40,000 by March 2019 (NHS, 2017), 100,000 by 2020/21 (DHSC, 2018b) and 200,000 by 2023/24 (NHS, 2019b).

Key Findings from the Interviews

PHBs and Changes

We have seen how the NHS vision emerging from policy documents and guidelines has emphasised the power of PHBs to lead to better self-care, more tailored support solutions and better integration between health and social care. The paper will now present key findings emerging from interviews with PHB experts. These enable a deeper understanding of what changes PHBs might imply at a services level and what could be the consequences of such changes.

The shift towards self-management and self-care was highlighted clearly in the interviews:

... it's a thread really that runs through everything that comes out of the NHS now [...] That's all about taking care of yourself and your health... and that's the shift. [...] So, all that self-management, self-care stuff... I think that the language has changed slightly around our responsibility.

(NHS England Expert 1)

However, within this agenda, PHBs were described as covering a double role. On the one hand, they were referred to as the “*purest version of personalised care*” (NHS England Expert 2) or “*the ultimate in handing over of power and control to an individual*” (NHS England Expert 4). On the other hand, their remit was described as going beyond the strict number of people using them. PHBs, in this sense, were described as a mechanism to introduce new care models within the NHS.

So, the way that we think about it is that PHBs are a good top-down way of changing and introducing personalised care [...]. What you've got is two different ways of approaching it. So, one is PHBs which are for a smaller group of people but which are a very pure and very accelerated way of making change, and then you've got the bottom-up approach which is for a much bigger number of people. It's a lot less pure [...] So, if you do it from both directions that's what leads to change.

(NHS England Expert 2)

PHBs can therefore be seen to represent a further step in the expansion of treatments which, within the NHS, are provided based on the model of ‘money following the patient’ which were previously introduced in order to create an internal market in the NHS (Timmins, 2005). What is specific about PHBs is the application of a demand-side strategy through a shift from population-based commissioning – based upon estimations of annual demand for services and on fixed-value contracts with providers – to individual commissioning based on cost-per-case contracts and linking funding to activity. The ‘unpicking’ of block contracts emerged from interviews as necessary for a full roll-out of PHBs. If this was achieved, it would represent a major change in the way services are commissioned within the NHS. From the interviews, however, unpicking block contracts was perceived to be not just necessary but also the biggest challenge to the expansion of PHBs: freeing up money from block contracts was extremely difficult and – despite the efforts of NHS England and CCGs in this direction – block contracts continued to underpin the provision of the majority of NHS services.

The problem with a community contract is that it's just one block of money that goes to the provider, and it's very hard to take individual personal money out of that, so [...] it's very hard for me to take £2,000 out for one individual and give it to them as a PHB. This is one of the biggest challenges.

(CCG Manager 1)

The fact that PHBs are a 'right to have' in CHC is indicative: CHC funding sits outside the NHS financial remit from which the majority of NHS services are funded. This means it is much easier for CHC packages to be provided in the form of PHBs, because the commissioning model for CHC services is not based around block contracts. For all other services though, unpicking block contracts remained a big challenge:

... no one is doing that yet, so in many places they are double funding for PHBs...

(CCG Manager 2)

An example which was repeated several times during interviews was that of integrated budgets offered as part of IPC programmes. IPC is based on a model of integration at the individual level but, at least in the geographical areas in which interviews were conducted, this was achieved so far through 'doubled' funding, rather than through the use of available resources from existing block contracts.

No one has managed to take money out of the existing contracts yet. So that's the biggest hurdle they need to overcome. So, yes, it's good to do a lot of testing [...] but we need to work out how do we make it sustainable in the long term as well, which is a big challenge...

(CCG Manager 1)

This suggests that – despite claims that PHBs do not require new money – the pilot sites where PHBs have so far been implemented did have a significant amount of new money. This allowed managers to get round the difficulties they would otherwise have had of finding ways to de-commission providers to release the money needed for PHBs. Beyond the injection of new money, however, PHBs have proven to be difficult to implement. Nevertheless, NHS England and CCGs remain committed to explore ways for unpicking block contracts. Reducing the size of some contracts is one way; and the embedding of PHBs into new contracts is another. The extract below from one interviewee describes the way this could be done but also potential reasons why this model might not work:

... I went to a PHB masterclass from NHS England, that was for children's services, they had a big block community contract and they managed to change the commissioning of that contract. So, 80% of it was provided in block, so 80%, whatever happened, that was paid to the provider, 20% of it was paid on a cost and volume basis, and so of that 20%... if the body was a million pounds, every year we would give them £800,000 regardless, and then £200,000 is set aside based upon the activities in the contract, so, if for example twenty PHBs go through that service and they cost £50,000, that £50,000 will come out of that 200,000. That is based upon what actually happened in the service, and you can take some of that money out. It's really hard to do though [...] from a provider point of view, there is no real incentive for them, really getting involved in PHBs and promoting them...

(CCG Manager 1)

Other difficulties, relating to cost per case commissioning models also emerged, including the problem of unreliable resource allocation systems (RAS) which aim to link needs to an amount of money; local markets which do not necessarily respond to the needs and wants of PHB holders and – related to this last point – the uncontrolled expansion of non-conventional and non-NHS providers, including some, for instance, providing new treatments such as aromatherapy, homeopathy, yoga or tai chi for which there is no clear clinical evidence of benefit and which are not 'approved' by the National Institute for Clinical Evidence (NICE).

These difficulties, however, were mainly treated as barriers yet to be overcome rather than risks to NHS services.

The RAS could be taken as an exemplar. Talking about RAS, NHS England Expert 1 said:

We've learnt from social care that the areas that did the RAS in the IB pilots are probably on version 625 of their RAS, and some of them just abandoned them because it was so complex. [...] what we said right from the very beginning was 'you don't have to have a RAS', what you have to be able to do is to understand what you would normally spend on the service, so if you assess me and I need... I don't know... six sessions of physio, and some bath equipment and a ramp for my front door... you need to understand how much that would normally cost...

(NHS England Expert 1)

Personalising the cost of services into allocations to single individuals, however, is problematic both at a technical and structural level. CCG managers provided examples of the complexities of 'costing' budgets and of the solutions different CCGs have adopted. These range from using average costs of different kinds of care packages within a certain CCG area – with margins of error of a few thousand pounds a week per package – to engaging in quite complex and uncertain calculations with the aim of turning different services' costs into single package monetary values. The excerpt below illustrates this last case:

One of the tricky things is that... how do you calculate the size of someone's budget? ... it's quite difficult, and within the rehab service we looked at different ways [...]. If someone is referred to the rehab service, they get an assessment from the nurse, and they have 14 different types of packages of care they provide for people, so anything from mobility and transfers, communication therapy and... 14 different types of support they provide and each of those are tiered in complexities from 1 to 3. So, what we've tried to do is to look at each of those packages, associating a budget value to what's assessed in someone. [...] so what I looked at is for a package of care, say mobility and transfers, I sat down with the team and said so... for that, how many hours do you spend with the patient? So, if it's mobility and transfers tier 1, they might say we spend 5 hours with the patient face to face... so for the 5 hours face to face, how much time do you spend in preparation, travel time, non-face to face hours, ... so we got a total number of hours for that specific package and I looked at what professionals are involved in that care, so if it's a band 8 physio involved in that care for 5 hours, I then work out what is the hourly rate of the band 8 physio to the NHS, and then times that by the average number of hours in the package, if that makes sense... it gives you a monetary value. [...] it's not completely robust but it's the best way we could find to get to a budget for each of these packages.

(CCG Manager 1)

'Technical' difficulties, however, are not the only problem. The unpicking of block contracts may affect the stability of existing NHS services and its underpinning value as a universal public service. Another extract from one interview clearly describes this issue. The example of physiotherapy is used to highlight what moving from block contracts to PHBs would imply:

... we are working really hard with CCGs to understand how we can do without destabilising current services, but you know [...] ... to actually give someone a budget for physio would mean you have to start to unpick that block contract and individualise some of those services, so that's actually incredibly difficult to do, because what you have to understand enough about I think is what you need to hold on to, because everyone has a right to have a physio appointment within, for example, a physio rehab gym for people with a stroke. So, at what point have you put so much money out of your block contract that you make your rehab gym not viable? And I guess that's the thing that people are really struggling with, it's how possible is that to do, when actually some of these stuffs like the rehab gym needs to be there but it's actually quite expensive and requires everyone to pay into that... if you see

what I mean... it's a community resource that everybody uses, so actually by slicing off, you know, your £200 a week here and there for physio and pulling that out of the block contract... at what point do you jeopardise that free at the point of delivery and available to everyone? And it's a universal service... so it's really key that people understand the whole of how the NHS works and the whole universality and stuff...

(NHS England Expert 4)

The risk of jeopardising the universal and public value of NHS services in the name of individuals' right to control a budget, however, did not generally lead interviewees to question the use of demand-side strategies for the provision of NHS services. The extract above represents in fact one of the very few instances of scepticism from interviewees.

PHBs and Scale

The objective of reaching, with PHBs, the 5% of NHS patients might seem quite small, as the target, reported earlier, of 200,000 PHB users by 2023/24. To achieve such targets, however, NHS England is pressuring CCGs to 'sign up' more and more people to IPC and PHB programmes and it is also supporting them through incentives and dedicated resources.

... now it has to be a priority because everyone has been managed around how many PHB numbers we do have, what we are doing with them etcetera [...] And so, each quarter we report back to NHS England on how many PHBs we have, what areas are they for, what are our challenges etcetera... and then they're pretty good, people like XXX come and provide training to individual areas [...]. That team [the Personalised Care Group] has been set up specifically to provide local support to each area.

(CCG Manager 1)

'Notional' budgets³ are key in enabling targets to be achieved. At present, only a small percentage of those with a 'right to have' a PHB have chosen to directly manage their budget. This has resulted in an increase of notional budgets. The claim of NHS England that notional budgets would still offer more choice and control was explored in interviews. Some responses confirmed this claim:

I would say the difference [between notional budgets and traditional service delivery] would be the person knowing how much money is available... making sure that everybody has been provided with information about all the different types of PHBs [...] they have to have the choice, they have to choose to take a notional budget, they have to make sure that's what they want to do by knowing how much money [...] the idea of notional is that it does mainstream personalisation and that way of thinking within service provision, and then the step further is when you need the structural changes and the DP etcetera... but why not getting everybody thinking about personalisation?

(CCG Manager 1)

Other responses introduced elements of doubt:

I think there is a danger that people start calling things notional budgets that are not, so they just set it up... so they could set up an agency and say this is a notional budget. Even though they haven't had that conversation with the person to say – how would you like to manage? Is it really this agency that you want? And so that's kind of my worry about doing this at this speed.... [...] because people say they're doing personalisation and this term is banded around a lot... so we do person-centred planning but actually we don't when you

³ Notional budgets represent one of the three management options for a PHB: managing the money as a direct payment, a third-party budget or a notional budget. In this last case, the CCG is responsible for managing the budget and the money is hence retained within the NHS.

look at it. Just because we've asked the person how they are for instance, so how are you... well let's go... let's tick the plan...

(CCG Manager 2)

The prospect that PHBs would bring just cosmetic changes to NHS services, without actually changing the experiences of NHS patients was raised. Nevertheless, 'success stories' about PHBs were also mentioned to counteract scepticism. One such, mentioned twice, was of a woman using her budget to buy a dog – who would help her at home and keep her company at night thus allowing her to keep living in her house and, as a by-product of that, to save money to the NHS. Other examples of positive stories can be found on the NHS England website (<https://www.england.nhs.uk/personal-health-budgets/phbs-in-action/patient-stories/>). These stories have a strong appeal and they tend to showcase the success of PHBs without showing, however, how the key features the NHS requires PHBs to have are preserved and respected.

Integrated budgets were also problematic. Responding to a question about how a PHB would support integration, NHS England Expert 1 replied:

I think a PHB can help in the short term because you can actually make some quick wins if you do an integrated personal budget. So if you integrate around the level of the individual you haven't had to have all the really difficult conversation about pulling structures, pulling teams, collocating teams, and all of that structural stuff that takes forever... [...] so you do it around the person so that all the systems and processes are staying but you just join them up for when you talk to the individual... and so you could do some really good quick wins. [...] But I think from a long-term perspective you couldn't... this is my view [...] I would have thought that it's not a long-term sustainable solution to continue with two separate processes that then just meet at the individual, so at some point we are going to have to start merging... otherwise you double fund everything...

(NHS England Expert 1)

The extract above suggests the possibility that cosmetic rather than structural changes might again be at work. However, in the case of integrated budgets, these have been supported through dedicated resources. As mentioned already, integrated budgets have been so far piloted through double funding. This suggests that the intention to introduce a shift towards demand-side funding of NHS services is real. Given this scenario, the changes PHBs might bring about within NHS services might be more than cosmetic, in the sense that they might reconfigure the funding and commissioning of NHS services on the basis of ideological assumptions which have so far proven to be problematic in their application. This will be discussed further in the next section.

Discussion

The rest of this paper will critically discuss the findings presented above. In particular, the promises PHBs are trusted to deliver will be discussed against the potential risks and negative effects they might imply for the NHS. The discussion will intentionally focus more on risks and negative effects than opportunities and positive outcomes, drawing on the work of critical scholars to question the rationale behind PHBs and further exploring the implications of PHBs for the rest of NHS services. This last aspect has not received much attention, neither in the context of the evaluation studies (Forder *et al.*, 2012; Jones *et al.*, 2017) nor, to date, in the academic debate around PHBs. Within the discussion, an aim will be to highlight the need for debate about the changes PHBs might bring to the way NHS services are funded, commissioned and delivered and on the effects such changes might imply for the future of free and universal health care in the UK. The nature of this work is exploratory and both the small scale of the project and the purposive nature of the sampling of the interviewees are limitations to the study. Despite these, however, some suggestions for future research and some implications for policy and practice could be drawn from this work.

Comparison of Findings with the Work of Critical Scholars

We have seen how the commitment to introduce PHBs within the NHS is based on the premises that PHBs would allow individuals to be the best judges of their own health and wellbeing, the best compass for services in the market and the best integrators of their own care. We have also seen how such commitment is translating into practice through the combination of new commissioning mechanisms: the notion of ‘money following the patient’, the unpicking of block contracts and the development of new resource allocation systems. None of these mechanisms has proven to be free from controversial implementation processes. Nevertheless, such mechanisms continue to be promoted and trialled in the NHS. The changes PHBs are trusted to deliver rely then on a radical shift in the way NHS services are financed, commissioned and delivered. A few instances of scepticism were observed; such as the interviewee who questioned the possibility of further expanding PHBs without destabilising the universality of current healthcare arrangements, or another who expressed the view that PHBs might be more about cosmetic than structural change. Overall, though, interviewed managers and experts seemed more inclined to suggest that PHBs represent the purest version of choice and control and, as such, the best tool to introduce personalised care within the NHS.

The contention of this paper is that assumptions more than empirical evidence underpin this claim. The works of scholars critical of the rationales behind PBs and PHBs can help the understanding of these assumptions.

A central assumption is that knowing and controlling a pot of money allows users of care services to exercise choice and control (Slasberg *et al.*, 2015). Not only is this a very limited notion of choice and control – one which undermines social and civic rights in favour of ‘market’ rights (Daly, 2012) – but, it has also been argued that this notion subverts the original, emancipatory values of disability activism: choice is reconfigured to be less about day-to-day decisions regarding how to live one’s own life and more about shopping around and selecting support services. As Ferguson (2012) has argued, this exercise of choice through consumer power has been very powerful in translating a neo-liberal ideology around choice into public services. The mechanism of resource allocation systems capable of linking needs to a tariff provided the basis for upfront allocations. RAS systems, however, regardless of the different ways in which they have been tried in practice, have proved to be very poor predictors of what resources are required to meet people’s needs (Series & Clements, 2013) and – a few years after their launch – they have largely been abandoned in social care (Slasberg *et al.*, 2013). Nevertheless, RAS might be successful in respect of introducing an overtly resource-led culture in healthcare, where models which ensure spending is within a cash limit get greater support than models based on clinically defined need and which demand a stronger role for commissioners in planning around unmet needs, and a stronger focus on care planning (Slasberg & Beresford, 2015). In this respect, the critique offered by Slasberg *et al.* (2013) of the first PHBs evaluation report highlights how, on a closer reading of its results, having an upfront allocation did not seem to bear much relation with improved outcomes among PHB holders. However, the attempts to make upfront allocations, RAS and the ‘unpicking of block contracts’ work – as we have seen in the findings from the interviews – lead in the opposite direction, suggesting that the risk of introducing a resource-led-culture in the NHS is actually a possibility.

A second assumption is the ability of individuals to make choices as rational agents and, as such, to increase their agency and to inform the responses of a market, or quasi-market, of services capable to adapt to the different needs and wants of its users. This is an example of how rational choice theories (Le Grand, 2009) have been applied to the idea of PHBs. The traditional failures of such theories in the context of public services – represented by market externalities, information failures, behavioural failure and rising inequalities – have been discussed at length by researchers (Glennerster, 2009; 2013). Some references to these ‘failures’ have also emerged from interviews reported in this paper which suggested that NHS markets may both be unable to respond to basic individuals’ choices whilst also offering

choices of treatments such as reflexology or aromatherapy, the effectiveness of which is challenged by other NHS organisations, such as NICE, whose guidance around treatments healthcare professionals are expected to follow. Nevertheless, the trust in budgets, explored in the interviews, still appeared to prevail over practical difficulties and setbacks.

A final assumption is in relation to the power of PHBs to deliver integration. PHBs and integrated budgets are trusted to promote integration at the level of the individual. This is an alternative approach to integrated care focused at a system level (Exworthy *et al.*, 2017) where other kind of arrangements – such as for instance joint commissioning and joint funding – underpin the idea of integration. The risk, in the individual level approach, is that of transferring the responsibility to ‘integrate’ services onto service users while avoiding structural and ideological challenges to integration, such as the fact that the NHS is a free and universal service while social care is means tested. Again, we have seen this risk emerging in the findings from the interviews.

Doubts about the NHS vision and its assumptions around PHBs have emerged. Nevertheless, it is on these assumptions that the PHBs model continues to be promoted, regardless of evidence that, in practice, this has so far produced only small gains and has unveiled difficulties and controversial mechanisms. Moreover, problems and difficulties – as highlighted earlier – tend to be turned into barriers that have yet to be overcome rather than being addressed as potential risks for the future of NHS services. The ‘unpicking of block contract’ is a clear example of this.

Comparison with the introduction of PBs in social care may also be useful, because arguably, it highlights some of the consequences of promoting a model based on assumptions and little evidence that could act as a warning for NHS services.

Parallels with Social Care

Despite some differences⁴, it could be argued that there are close similarities between what happened in social care during and after the pilot study of PBs (Glendinning *et al.*, 2008) and current developments within the NHS.

As part of the personalisation agenda in social care, between 2005 and 2007, PBs were implemented in 13 pilot sites in the UK and an independent evaluation of the pilots was commissioned by the government. The aim was to test whether individual budgets would offer better care compared to conventional solutions and, if so, what model would work better for different groups of users (Glendinning *et al.*, 2008). The work of In Control, the charity which had already supported local authorities to pilot self-directed-support models, helped to create the climate for this large-scale trial of PHBs (Woolham *et al.*, 2015), which later became known as the IBSEN report. However, without even waiting for the results of the trial to be published, the Government announced its intention to extend personal budgets with the publication of *Putting People First* (HM Government, 2007) and the allocation of £500 million of funding to support local authorities to introduce, among other things, self-directed-support. Some misleading interpretation of the IBSEN report (Woolham *et al.*, *op cit.*) together with the use of powerful personal stories ‘framed in human, flesh-and-blood terms’ (Beresford, 2014) helped to ‘sell’ PBs in social care after 2008, in spite of the evidence-based policy commitment of the then government (*Ibid*). In 2014, with the publication of the *Care Act* (DH, 2014), all local authorities in the country have been required to provide a PB to all adults with eligible needs. This means that PBs are nowadays the default option for everyone accessing social care services.

⁴ The main differences between PBs and PHBs are the following: PHBs do not allow top-ups from users; PHBs need to satisfy the two tests of added value and cost effectiveness; no contribution can be requested to PHB holders; the NHS clearly indicates what are the services for which PHBs cannot be used.

Three observations can be made at this point. First, the evidence about the success of PBs in delivering choice, control and better quality care was far from conclusive at the time of the introduction of PBs in social care and, even today, such evidence is mixed and often questioned (Glasby & Littlechild, 2016). For example, evidence about the success of personal budgets in delivering better care outcomes for older people, by far the largest group of adult social care users, is weak (Woolham *et al.*, 2015). For PHBs, the scenario is not too different. On the one hand, the evidence for their expansion is again to be found in research commissioned by the Department of Health, confirming the position of Williams & Dickinson (2016) who contend that much of the personalisation evidence is produced mainly by those in favour of the concept. On the other hand, partisan interpretations of the findings from the evaluation took place (Slasberg *et al.*, 2013) and the cherry picking of some of the findings over others, together with the use of powerful personal stories, have also helped to make the case for PHBs. Support for a wider roll out of PHBs (beyond the pilot) was based on two independent evaluations, previously referred to (Forder *et al.*, 2012; Jones *et al.*, 2017). These were commissioned by the NHS and their findings were that PHBs were cost-effective – given certain assumptions – and that their use was associated with significant improvements in care related quality of life and psychological wellbeing for budget holders. However, other findings from these same studies received less attention. For example, on other outcomes indicators – such as health status and health related quality of life, having a PHB appeared to have no impact or, as highlighted strongly in the second report (2017), certain conditions were necessary for positive outcomes to be achieved for PHBs. Among these were: capability and willingness of the budget holders to receive a PHB; presence of a diverse providers' market; and ability of commissioners to create a fertile environment for PHBs, including assuming some financial risks in order to release further the benefits of PHBs.

A second observation concerns the development of PBs and PHBs once implemented as a 'default option'. The increase of notional budgets in health recalls the increase of council managed budgets in social care (Beresford, 2014), which we have seen some authors interpreting as the sign of a resource-led culture where budgets are allocated based on resource-led assessments, without necessarily leading to greater choice and control for users of care services (Slasberg & Beresford, 2015). Who guarantees then, similarly, that PHBs are not just a way to set a limit on the resources available to users and patients of NHS services, rather than a mechanism for choice and control? The developments around the use of notional budgets which emerged from the interviews lend support to this claim.

Finally, there is the question of how PBs and PHBs are used. The employment of Personal Assistants (PAs) is often portrayed in the context of powerful case stories as evidence for the success of PBs: people are allowed to continue living in their home with the flexible support from PAs of their choice (Slasberg, 2018). However, evidence shows that only 29% of Direct Payment (DP) recipients employed their own PAs (Skills for Care, 2018), and DP recipients are anyway far from being the majority of community care users (NAO, 2016). Slasberg also suggests that if the success of PBs is to be measured by the use of PAs to support independent living, there is not much that the PBs strategy would add, for PA users, to what the Direct Payment Act (1996) had already made possible. Applying this argument to the case of PHBs within the NHS raises doubts as to whether a massive transformation of NHS services' commissioning, such as in the case of the 'unpicking of block contracts' for NHS specialist services, is needed. Could there be other measures allowing NHS users to stay in control of their life and treatments?

Conclusions and Implications

This paper has argued that the promises of choice and control PHBs are trusted to deliver rely on a radical shift in the way NHS services could be financed and delivered in future. The target, reported earlier, of 200,000 PHBs by 2023/24 is tiny in comparison with the numbers treated by the NHS. They do, though, appear to represent a significant shift within the NHS commissioning model. This shift becomes even more significant if the speed at which it has been – and still is

being – introduced is considered. In a time span of less than 10 years, PHBs moved from being considered a tool that would never apply to NHS services to being a growing reality (Glasby, 2009). As highlighted above, the CHC example is instructive. Introduced as a ‘right to have’ in 2014, since March 2019 PHBs have become a *default option* for NHS Continuing Healthcare (CHC) users. And work is also underway to extend the ‘right to have’ for PHBs, reaching the 5% of the NHS population made of people with the most complex needs and making high use of high cost specialist services.

The relevance of PHBs in the wider NHS agenda is, then, related less to the number of people who will benefit from them and more to the kind of changes they might imply in terms of support provision for an increasing number of people with complex needs and long-term conditions who depend on high cost NHS services. The introduction of a different commissioning model for this specific user group, however, represents a major change in terms of how NHS services could be funded, commissioned and delivered in future. And this change could be read as a further and covert process of privatisation of NHS services. In particular, the shift towards personal responsibility for self-management and self-care, the idea of dividing government tax revenues into single user entitlements and the attempt to free up money from contracts, which individuals can then spend freely among NHS and non-NHS providers suggest that a further step in the individualisation of care and in the privatisation of the NHS could be underway.

Given this scenario, it is possible to argue that the potential of PHBs to deliver choice and control is limited, but the likelihood that PHBs could be mainstreamed without being accompanied by a more personalised care system is credible. The experience of social care and PBs should act as a warning here as well as the worries of some critics (Scott-Samuel, 2015; Slasberg & Beresford, 2015; Alakeson *et al.*, 2016; Williams & Dickinson, 2016) which point to the risks PHBs might imply in terms of de-personalisation of care interventions in the context of resource-led systems of care, rising individualisation within public institutions and, finally, privatisation of a public healthcare system.

What is at stake, in this scenario, is the stability of a universal public healthcare system based on the principle of redistribution of resources and benefits for all (Williams & Dickinson, 2016). Some scholars push this reasoning further in claiming that PHBs would lead to the creation of a health insurance-based market on the US style, with only very limited cover for the very poor (Scott-Samuel, 2015).

Even if this last scenario was a distant possibility, the privileging of individuals’ right to choice through the control of a budget might act as the ‘trojan horse’ threat to a free and universal NHS. This is why a reflection on PHBs continues to be needed, their development deserves attention and further research is required in this area.

Some implications for policy and practice could be drawn from this paper. The mantra of choice and control is so powerful, and so widespread within both health and social care, that it is now very difficult, both at a policy and practice level, to challenge such concepts or to substitute them with others. Consumerist and individualistic notions of choice in the context of marketized healthcare services have been so powerful in subverting the original, emancipatory meaning of ‘choice and control’ as originally conceived by disability movements that there is currently little space for investigating and testing alternative frameworks. However, reflecting on some of the risks which the current model of choice and control might imply for the sustainability of NHS services could help to question some of the assumptions around choice and also to consider alternative meanings of the concept if not, possibly, even alternative concepts to inform a universal healthcare system. More research would be needed to examine what seem to be controversial and contestable mechanisms of PHBs, including the development of new resource allocation systems and the unpicking of block contracts. These represent in fact the core of the shift in the way NHS services are financed, commissioned and delivered under PHBs and which may lead to a further step in the privatisation of NHS services and the individualisation of care interventions.

References

Alakeson, V., Boardman, J., Boland, B., Crimlisk, H., Harrison, C., Iliffe, S. & Patterson, J. (2016) 'Debating personal health budgets', *BJPsych Bulletin*, **40**(1), pp. 34-37.

Audit Commission (AC) (2012) *Making Personal Health Budgets Sustainable: Practical Suggestions on How to Manage Financial Risk*, Audit Commission.

Bennett, S. (2014) *Getting Serious about Personalisation in the NHS*, London: Think Local, Act Personal, accessed 4 July 2018 online at: <https://www.england.nhs.uk/wp-content/uploads/2014/09/tlap-getting-serious.pdf>.

Beresford, P. (2014) *Personalisation*, Bristol: Policy Press.

Daly, G. (2012) 'Citizenship, choice and care: An examination of the promotion of choice in the provision of adult social care', *Research, Policy and Planning*, **29**(3), pp. 179-189.

Department of Health (2014) *Care and Support Statutory Guidance, Issued Under the Care Act 2014*, London: DH.

Department of Health and Social Care (DHSC) (2015) *The NHS Constitution for England*, accessed 19 April 2019 online at: <https://www.gov.uk/government/publications/the-nhs-constitution-for-england>.

Department of Health and Social Care (DHSC) (2016) *NHS Choice Framework*, accessed 19 April 2019 online at: <https://www.gov.uk/government/publications/the-nhs-choice-framework>.

Department of Health and Social Care (DHSC) (2018a) A consultation on extending legal rights to have for personal health budgets and integrated personal budgets, accessed 30 March 2019 at: <https://consultations.dh.gov.uk/commissioning-integration-and-transformation/extending-rights-to-personalised-budgets/>.

Department of Health and Social Care (DHSC) (2018b) *The Government's Mandate to NHS England for 2018-19*, accessed 30 March 2019 online at: <https://www.gov.uk/government/publications/nhs-mandate-2018-to-2019>.

Duffy, S. (2006) *Keys to Citizenship: A Guide to Getting Good Support for People with Learning Disabilities*, Birkenhead: Paradigm Ltd.

Exworthy, M., Powell, M. & Glasby, J. (2017) 'The governance of integrated health and social care in England since 2010: Great expectations not met once again?', *Health Policy*, **121**(11), pp. 1124-1130.

Ferguson, I. (2012) 'Personalisation, social justice and social work: A reply to Simon Duffy', *Journal of Social Work Practice*, **26**(1), pp. 55-73.

Forder, J., Jones, K., Glendinning, C., Caiels, J., Welch, E., Baxter, K. & Dolan, P. (2012) *Evaluation of the Personal Health Budget Pilot Programme*, PSSRU Discussion Paper; Vol. 2840(2), Canterbury: PSSRU University of Kent.

Gadsby, E.W. (2013) *Personal Budgets and Health: A Review of the Evidence*, Centre for Health Services Studies, Kent: University of Kent.

Gadsby, E.W., Segar, J., Allen, P., Checkland, K., Coleman, A., Mcdermott, I. & Peckham, S. (2013) 'Personal budgets, choice and health: A review of international evidence from 11 OECD

countries', *International Journal of Public and Private Healthcare Management and Economics*, **3**(3), pp.15-28.

Glasby, J. (2009) 'Individual budgets and the interface with healthcare', *Journal of Management & Marketing in Healthcare*, **2**(4), pp. 355-365, doi: 10.1179/mmh.2009.2.4.355.

Glasby, J. & Littlechild, R. (2016) *Direct Payments and Personal Budgets. Putting Personalisation into Practice*, Bristol: Policy Press.

Glendinning, C., Challis, D., Ferná'ndez, J-L., Jacobs, S., Jones, K., Knapp, M., Manthorpe, J., Moran, N., Netten, A., Stevens, M. & Wilberforce, M. (2008) *Evaluation of the Individual Budgets Pilot Programme: Final Report*, York: Social Policy Research Unit, University of York.

Glennerster, H. (2009) *Understanding the Finance of Welfare*, Bristol: Policy Press.

Glennerster, H. (2013) *Paying for Welfare. Towards 2000*, Abingdon, Oxon: Routledge.

Hatton, C., Waters, J., Duffy, S., Senker, J., Crosby, N., Poll, C., Tyson, A., O'Brien, J. & Towell, D. (2008) *A Report on In Control's Second Phase: Evaluation and Learning 2005–2007*, London: In Control Publications.

HM Government (2007) *Putting People First: A Shared Vision and Commitment to the Transformation of Adult Social Care*, London: HM Government.

Jones, K., Forder, J., Welch, E., Caiels, J. & Fox, D. (2017) *Personal Health Budgets: Process and Context Following the National Pilot Programme*, PSSRU Working paper; Vol 2910, Canterbury: PSSRU University of Kent.

Le Grand, J. (2009) *The Other Invisible Hand: Delivering Public Services through Choice and Competition*, Princeton University Press.

Leadbeater, C., Bartlett, J. & Gallagher, N. (2008) *Making it Personal*, London: Demos.

National Audit Office (2016) *Personal Commissioning in Adult Social Care*, London: NAO.

NHS (2014) *Five Year Forward View*, accessed 30 March 2019 online at: <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>.

NHS (2017) *Next Steps on the Five Year Forward View*, accessed 30 March 2019 online at: <https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf>.

NHS (2019a) *The NHS Long Term Plan*, accessed 24 August 2019 online at: <https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/>.

NHS (2019b) *Universal Personalised Care: Implementing the Comprehensive Model*, accessed 30 March 2019 online at: <https://www.england.nhs.uk/wp-content/uploads/2019/01/universal-personalised-care.pdf>.

NHS England (2017) *Personal Health Budgets and Integrated Personal Commissioning. National Expansion Plan*, accessed 8 July 2019 online at: https://www.england.nhs.uk/wp-content/uploads/2017/06/516_National-expansion-plan_S10.pdf.

Oliver, A. (1996) *Understanding Disability: From Theory to Practice*, Basingstoke: Palgrave MacMillan.

Scott-Samuel, A. (2015) 'Personal Health Budgets in England: Mood music or death knell for the National Health Service?', *International Journal of Health Services*, **45**(1), pp. 73-86.

Series, L. & Clements, L. (2013) 'Putting the cart before the horse: Resource allocation systems and community care', *Journal of Social Welfare and Family Law*, **35**(2), pp. 207-226.

Slasberg, C. (2018) *NHS Personal Budgets - A Failing Strategy Driven by Neo-Liberal Ideology*, accessed 30 March 2019 online at: <http://classonline.org.uk/blog/item/nhs-personal-budgets-a-failing-strategy-driven-by-neo-liberal-ideology>.

Slasberg, C. & Beresford, P. (2015) 'Building on the original strengths of direct payments to create a better future for social care', *Disability & Society*, **30**(3), pp. 479-483.

Slasberg, C. & Beresford, P. (2016) 'The eligibility question – The real source of depersonalisation?', *Disability & Society*, **31**(7), pp. 969-973.

Slasberg, C., Beresford, P., Schofield, P. & Harlow, E. (2013) 'The increasing evidence of how self-directed support is failing to deliver personal budgets and personalisation', *Research, Policy and Planning*, **30**(2), pp. 91-105.

Slasberg, C., Beresford, P. & Schofield, P. (2015) 'Further lessons from the continuing failure of the national strategy to deliver personal budgets and personalisation', *Research, Policy and Planning*, **31**(1), pp. 43-53.

Skills for Care (SFC) (2018) *The State of the Adult Social Care Sector and Workforce in England*, accessed 10 April 2019 online at: <https://www.skillsforcare.org.uk/NMDS-SC-intelligence/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-state-of-the-adult-social-care-sector-and-workforce-2018.pdf>.

Timmins N. (2005) 'Use of private health care in the NHS', *BMJ (Clinical Research Ed.)*, **331**(7525), pp. 1141–1142.

Williams, I. & Dickinson, H. (2016) 'Going it alone or playing to the crowd? A critique of individual budgets and the personalisation of Health Care in the English National Health Service', *Australian Journal of Public Administration*, **75**(2), pp. 149-158.

Woolham, J., Daly, G., Steils, N. & Ritters, K. (2015) 'The evolution of person-centred care to personalised care, personal budgets and direct payments in England: Some implications for older users of social care services', *Sociologia e Politiche Sociali*, **18**(1), pp. 145-162.

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