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Editorial

Direct payment is a healthy option

In the UK, current health care policy is focused on increasing choice and control for people who use services, and on developing more effective support for people with long-term conditions. As part of these agendas, there is talk of 'personalisation', of the 'expert patient' (who is able to use their knowledge of their condition to support others) and of 'contestability' (creating more of a genuine market in health care). In both primary and acute care, there are also new systems that help government spending on health care to get closer to individual patients (under 'payment by results', the funding follows the patient as they go into hospital; under 'practice-based commissioning', local groups of General Practitioners will be able to commission new services locally).

Yet for all this talk, these policy goals are not new and are often already being pursued in other areas of the public sector. A good example of this is in social care, where 'direct payments' have long enabled disabled and older people to receive cash equivalents in lieu of directly provided services (sometimes also known as personal budgets or as a form of consumer-directed care in other countries) [1–6]. Often, direct payment recipients will use this funding to design their own support arrangements and hire their own staff—becoming a service commissioner rather than a passive recipient of statutory welfare. Introduced under 1996 legislation, direct payments have since been shown to lead to higher service user satisfaction, greater continuity of care, fewer unmet needs and a more creative use of resources which is able to invest the same level of funding in new and more imaginative ways. As a result of this, direct payments are now a central feature of government policy—they are now mandatory, increasing direct payments is a key government target, and direct payments feature prominently in a recent Green Paper on the future of adult social care.

In spite of this, direct payments can only be used in lieu of social care services, and cannot be used to purchase health care. This has recently been reiterated by the government, who seem to be promoting direct payments and encouraging health and social care partnerships on the one hand, while at the same time preventing people from using their direct payments to create integrated packages of health and social care. This is in spite of evidence that suggests that direct payment recipients do indeed use their funds to purchase some forms of health care (and, indeed, would like official support and guidance so that they could do this in a more open and transparent way).

If policy were to change, there is undoubtedly a group of people with both health and social care needs that could benefit from the choice and control that direct payments offer. This has already been highlighted in a previous article in the *International Journal of Integrated Care* (17 June 2003), with Dennis Kodner providing a cogent argument in favour of making links between the integrated models of care which form the focus of this Journal with the lessons from 'consumer-directed care' projects around the world [5]. However, what UK policy makers have been slow to realise is that direct payments could also help to meet some core NHS targets as well (for people who have only health care needs). If the current focus is on choice, control, contestability, long-term conditions and expert patients, then this is exactly what direct payments mean in a social care context. In future, what would the UK health care system be like if a pregnant woman could choose to have her baby in hospital, in a midwife-led unit, at home or could opt to have the cash equivalent to hire an independent midwife to give her a birth of her choosing? What would happen if someone with a mental health problem could refuse to go on a waiting list for a non-existent NHS counsellor, but could receive a cash equivalent to see an independent practitioner? More radically, what would happen if an obese person with heart problems was funded to join a gym, or if someone with chronic respiratory problems could choose to use some of their available funds to insulate their house and repair broken windows?

In all these scenarios, there would need to be careful piloting and appropriate support to help people think through their options and plan their care (and again the direct payments example offers important lessons about the role of peer support and of disabled people-led centres for independent living in providing such support). In the early days, professional concerns about the new system might mean that resources would need to be made available via an individual budget (either real or notional) to be spent on meeting assessed needs, rather than via a more generic allowance that could be spent more flexibly. However, such

an approach would effectively change the emphasis in the UK health care system, putting patients genuinely at the centre of services and giving them the power to vote with their feet (and with their wallets) if they did not feel that the services on offer were meeting their needs appropriately. For providers, this would also mean a dramatic departure from the traditional monopoly that the NHS has enjoyed—henceforth all providers would have to ask themselves what it is about their service that would make them the number one choice for service users empowered by direct access to resources: low waiting lists, continuity of personnel, well trained workers, responsiveness, promoting independence?

Perhaps one of the hall marks of genuine partnership working between health and social care is the ability to learn from each other and to explore what our different perspectives can contribute to better services. In direct payments, personal budgets and consumer-directed care, we might have a genuinely new way of working that could really enrich current health care and current health and social care partnerships.

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References

1. Glasby J, Littlechild R. Social work and direct payments. Bristol: Policy Press; 2002.
2. Leese J, Bornat J, editors. Developments in direct payments. Bristol: Policy Press; 2006.
3. Lewis S. Direct payments: frequently asked questions. London: Social Care Institute for Excellence; 2005. Available from: URL:www.scie.org.uk.
4. Lundsgard J. Consumer direction and choice in long-term care for older persons. OECD Health Working Papers. Paris: OECD; 2005.
5. Kodner D. Consumer-directed services: lessons and implications for integrated systems of care. International Journal of Integrated Care [serial online] 2003 Jun 17; 3. Available from: URL:www.ijic.org.
6. Tilly J, Wiener M, Cuellar AE. Consumer-directed home and community services programmes in five countries: policy issues for older people and government. Washington: Urban Institute; 2000.