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Choice, Competition and Care: Developments in English social care and the impacts on providers and older users of home care services

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Abstract

This paper critically examines recent changes in markets for home (domiciliary) care services in England. During the 1990s, the introduction of competition between private (for-profit and charitable) organisations and local authority providers of long-term care services aimed to create a 'mixed economy' of supply. More recently, care markets have undergone further reforms through the introduction of direct payments and personal budgets. Underpinned by discourses of user choice, these mechanisms aim to offer older people increased control over the public resources for their care, thereby introducing further competitive pressures within local care markets.

The paper presents early evidence of these changes on:

- The commissioning and contracting of home care services by local authorities and individual older people.
- The experiences and outcomes for individual older people using home care services.

Drawing on evidence from two recent empirical studies, the paper describes how the new emphasis on choice and competition is being operationalized within six local care markets.

There are suggestions of small increases in user agency and in opportunities for older people to receive more personalised home care, in which the quality of care-giving relationships can also be optimised. However, the paper also presents early evidence of increases in risk and costs associated with the expansion of competition and choice, both for organisations providing home care services and for individual older service users.

Introduction

This paper draws on evidence from two recent studies into the impacts of recent changes in markets for home (domiciliary) care services in England. During the 1990s quasi-markets were introduced into home care services, involving competition between private (for profit and charitable) organisations and traditional local authority (public) providers of services. Since the turn of the century, both the nature and reach of competitive pressures in the home care sector have been further transformed through the introduction of cash direct payments and personal budgets (PBs). Underpinned by discourses of user choice, these recent reforms aim to shift responsibility and command over the financial resources for purchasing services towards individual service users, thus creating a 'mixed economy' of purchasing to complement the earlier 'mixed economy' of supply.

The paper examines the early impacts of these changes:

- On local authorities' commissioning and contracting practices, and the extent to which these have increased opportunities for older people to receive flexible, responsive and good quality home care services.
- On older people's behaviour as informed and empowered consumers exercising choice over the public resources available to fund their home care.
- On the outcomes for older service users, particularly their receipt of home care that is responsive to individual needs and preferences and that optimises opportunities to create the relationships between the givers and receivers of care that are widely argued (Jochimsen 2003; Himmelweit 2007; Lewis and West 2013) to be at the heart of good quality care.

The paper argues that significant measures have been introduced that aim to make home care provision more responsive to the preferences and priorities of users. However, there is only modest evidence that these have led to increases in older people acting as empowered and informed consumers, able to make demands on providers for home care that meets individual needs and preferences. The overall thrust of recent reforms has been to extend and intensify competition, both between formal home care provider organisations and between these and less formal sources of care. However, early evidence suggests that this increased competition has also increased both risk and costs, financial and non-material, at organisational and individual levels.

The next section of the paper outlines the policy background leading to the introduction of personal budgets in England and the consumerist discourse underpinning these changes. The following section briefly summarises the data and methods employed in the two studies on which the paper draws. The fourth section presents the studies' findings on the commissioning and contracting practices of local authorities and their potential impacts on providers of home care services. The fifth section presents findings concerning the experiences and outcomes for older people using personal budgets to fund home care. The final section suggests some tentative conclusions.

Policy background

User choice and the mixed economy of care

Until 1993, English local authorities were both funders and providers of domiciliary, residential and day care services for older people. Major reforms in 1993 assigned to local authorities lead responsibility for assessing needs and funding social care services and introduced competition between public, private and voluntary service providers. Quality, efficiency and

innovation in publicly-funded services were to be stimulated through competition between providers (Le Grand 1991; Lewis and Glennerster 1996; Means *et al.* 2002). Social workers became 'care managers', responsible for conducting individual assessments and purchasing care from those providers with whom the local authority had contracts (Means *et al.* 2003). Market and consumer choices were therefore effectively exercised by care managers on behalf of service users (Baxter *et al.* 2011). These reforms were largely successful in stimulating a mixed economy in the supply of home care services. In 1992, the private sector supplied only two per cent of all domiciliary care (home help) contact hours; by 2013 this had increased to 89 per cent (Humphries 2013).

Over the same period, organizations of working age disabled people campaigned for support in the form of cash payments rather than services in kind, so they could employ their own care workers (personal assistants - PAs) (Morris 2006). Legislation allowing local authorities to make cash direct payments was introduced in 1997 for working age disabled people and, from 2000, for older people (aged 65 and older), parents of disabled children, carers and disabled young people (Glasby and Littlechild 2006).

However, relatively few people chose direct payments and take-up was highly variable between older and younger disabled people and between localities. Research identified a range of factors affecting the willingness of older people to engage with local care markets as individual purchasers, including a lack of brokerage and support services; anxieties about managing direct payments; shortages of people willing to be employed as PAs; and professional resistance by care managers anxious about threats to traditional social work practice and/or increased risk (Ellis 2007; Fernández *et al.* 2007). Despite intensive policy pressures, by 2009 still only 3.6 percent of older people receiving publicly-funded care had this in the form of direct payments (Care Quality Commission 2010). Therefore, for most older

people home care services continued to be procured by local authorities using large block or cost-and-volume contracts, often based on geographical zones, with home care provider agencies. Such contracts optimised technical efficiency by minimising transaction costs for local authority purchasers. They also guaranteed work and income to provider agencies, enabling them to build and maintain staff capacity in particular localities and thereby minimise travel time and costs. However, large block contracts offered few incentives to providers to improve the quality of care. Nor did they provide appropriate incentives to provide services characterised by flexibility and responsiveness to individual user choice (Wilberforce *et al.* 2012).

From around 2000, a new choice-based consumerist discourse began to shape social care policy. This aimed to promote user control, intensifying earlier trajectories of squeezing provider and professional interests:

By putting users at the heart of services, enabling them to become participants in the design and delivery, services will be more effective by mobilizing millions of people as the co-producers of the public goods they value.

(Leadbeater 2004: 19-20)

This discourse led to increased pressures to devolve agency and command over public resources for care to individual service users themselves. It was also alleged to involve transfers of risk, from the state to the private sector and to older service users themselves, as well as raising concerns about equity and about the capacity of both local authorities and

private sector service providers to deliver on ambitious policy goals (Needham 2007). The evidence presented in this paper sheds light on these concerns.

Leading the implementation of this new approach was a social enterprise organization *In Control*, that initially supported learning disabled adults to take a bigger role in planning their own support arrangements through personal budgets (PBs). Whereas direct payments had up till now generally been used to employ personal assistants (PAs) to provide personal and domestic care, *In Control* encouraged much greater flexibility in how PBs were used, including paying friends and relatives or purchasing mainstream services such as art classes or gym membership rather than attending special day centres (Duffy 2004).

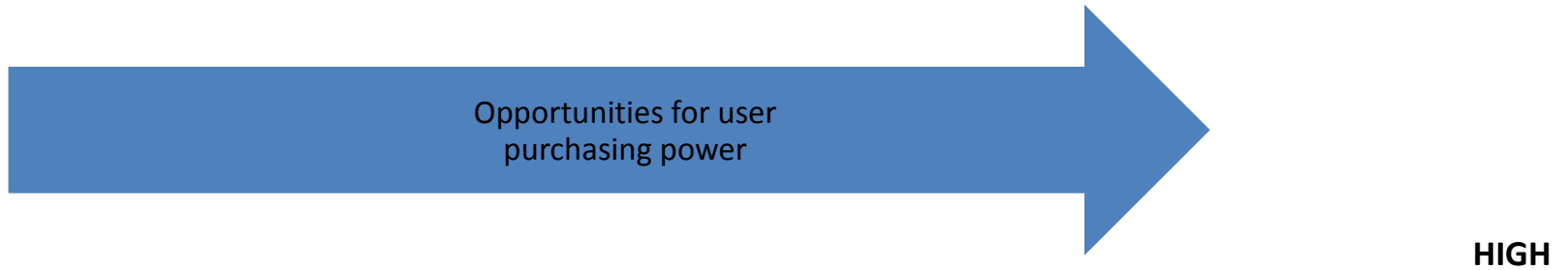
Building on *In Control's* experience, and despite equivocal evidence from rigorous evaluation of pilot schemes (Glendinning *et al.* 2008; Moran *et al.* 2012), from 2009 all English local authorities were required to offer PBs to all adults eligible for publicly-funded community-based (ie non-residential) social care (Department of Health 2008).

'Personal budget' describes the public resources allocated to an individual to fund their domiciliary and/or community-based support. PBs can be taken as a cash direct payment, held and managed by the older person in a designated bank account and used to employ a PA; purchase home care directly from a provider agency; pay relatives or friends for giving help; or buy mainstream services such as taxis or ready-made meals. PBs can also be held by the local authority on behalf of the individual and used to pay for council-commissioned services. This is by far the most common option for older people; 80 per cent of older people have their budget managed in this way and used to fund home care services (Baxter *et al.* 2013; Rabiee *et al.* 2013). A third option is for the budget to be held and managed by a third party – an

individual such as a carer or an organisation that also provides accountancy, recruitment and payroll services. This third party option includes the budget being held by a service provider such as a home care agency and used as and when the older person needs it; this is sometimes called an Individual Service Fund (ISF). By March 2012, just over half of all adults potentially eligible for PBs had one in place (ADASS 2012).

These different deployment options offer varying levels of opportunity for older people to behave as active 'consumers' of home care services, using PBs to exercise agency within local care markets in order to influence the content, timing and manner in which their home care is delivered. These variations are represented diagrammatically below: at one end of the continuum are council-managed PBs, where the local authority acts as a proxy purchaser on behalf of the older person; at the other end is the direct payment option where an individual older person manages the resources allocated for her/his care and uses these to engage directly with local markets of formal or informal care providers (Figure 1).

Figure 1: Personal budget deployment options



Council managed personal budget	Individual service fund	User held	Direct payment	
Council contract framework agreement with home care provider; council purchases care for individual older person from contracted provider	Council contracts with provider; provider negotiates detailed arrangements with older person within overall budget	Older person uses direct payment to purchase home care directly from provider agency	Older person uses direct payment to:	
			Employ friend/acquaintance	Employ personal assistant not previously known

These options suggest a range of potential impacts on local home care provider markets. They include new opportunities for small providers wishing to attract business from PB-holders and therefore not dependent on large local authority contracts nor requiring the expertise and infrastructure to bid for large contracts, to enter the market. New providers also suggest increased competition, both between formal home care service provider organisations and between these and individually employed PAs, for the business of older people looking to spend their PBs. Increased competition should, in theory, lead to improvements in service quality and responsiveness, reinforced by greater ease with which individual PB-holding purchasers can exit from arrangements with providers they are dissatisfied with (Baxter *et al.* 2011). On the other hand, the fact that the majority of older people currently opt for the local authority to manage their PB and purchase council-commissioned services suggests the continued presence of large, monopsony purchasers. This presence may constrain the scope of potential developments in local care markets. It also raises the question of how far increased opportunities to engage in market-related choice behaviours are desired by, or available to, the majority of older people whose care remains subject to proxy purchasing by local authorities.

The implications of these developments for local home care markets and for the experiences and outcomes for older users of home care services were the subject of two research projects.

The research studies

Two recent studies examined the implementation and outcomes of new opportunities created by PBs for older people to have greater command over the public funding allocated for their care and greater control over the care delivered through that funding. Both studies included interviews with local authority staff responsible for commissioning and contracting home care

services and with older people receiving home care funded through PBs. Together, the data from the two studies covered the full range of possible PB deployment options and provide preliminary evidence on their impacts, including the outcomes for local care markets and the experiences of older home care service users.

Study 1: Managed personal budgets

This study focused on the choice and control available to older people whose PBs were held and managed by the local authority, or by a service provider as an ISF. It was conducted in three English local authorities that were known to be pro-active in facilitating personalised home care services for people using council-managed PBs; had large proportions of older people within their populations; and had large proportions of people using managed PBs. One authority covered a large rural county, one was an ethnically diverse London borough and the third covered a metropolitan area of north-west England.

Data collection took place between August 2011 and October 2012. This comprised interviews with senior managers from each authority about commissioning, contracting and market development activities; focus groups with front-line staff to explore their experiences of supporting older people with managed PBs to make choices and thereby shape demands on home care providers; interviews with managers of home care agencies about their experiences of providing support to people using managed PBs; and interviews with 18 older people (without dementia) using managed PBs, who were recruited from the home care agencies. The latter interviews explored the older people's perceptions of the choices available to them over who provided their care, the timing and content of the home care they received; their opportunities to shape the delivery of care to their individual routines and preferences; and their satisfaction with the care they received. All interviews and focus groups were digitally

recorded and transcribed; data were analysed using the Framework approach (Ritchie and Spencer 1994).

Study 2: Direct payments

This study focused on the choices made by older people who had recently opted to take their PB as a direct payment; the reasons for the specific deployment option chosen; and the outcomes of these choices. The study took place in three London local authorities: all had larger numbers of home care agencies and therefore relatively competitive markets; and large (absolute and relative) numbers of older people taking their PBs as direct payments.

Interviews were conducted with commissioning managers and social workers with knowledge of personal budget processes in each authority about procedures for assessing and allocating PBs and the local care market. The authorities also identified people aged 60 and older who had been allocated a PB in the form of a direct payment for the first time in the past year and had the necessary cognitive capacity to be interviewed (or relatives willing to be interviewed as proxies). Purposive sampling within this frame aimed to recruit equal numbers of older people who used their direct payment PB to purchase care from an agency; hire a previously unknown person to work as a PA; or employ an acquaintance or relative as a PA.

Twenty-four older people were interviewed between March and May 2013. Interviews covered their decision to opt for the direct payment form of PB; the choices of agency or PA; negotiation of care tasks; and their satisfaction with the care received. Most interviewees were very frail and a significant proportion of interviews took place with proxy respondents; the latter were all either co-resident or close relatives and therefore familiar with the older person's preferences (Lee *et al.* 2004).

All interviews were digitally audio-recorded with permission from interviewees, transcribed verbatim and analysed with MAXQDA software using the Framework approach (Ritchie and Lewis 2003).

Changes in local authority commissioning and contracting practices

As existing block contracts with home care provider organisations began to expire, local authorities in both studies were replacing these with framework agreements. Framework agreements set prices and quality standards but do not guarantee providers any volume of work or income. The six study authorities were at different stages in moving from block contracts; for example, in one authority (Study 2) around half the home care agencies still had block contracts and were therefore guaranteed work and income until these expired (within a year).

Senior commissioning managers and front-line staff argued that framework agreements allowed them to procure individual or personalised care services from home care service providers for older people with council-managed PBs. Framework agreements were praised by care managers as they offered greater flexibility; as proxy purchasers, they were not required to purchase from providers that had been guaranteed (and expected funding for) specified numbers of clients or hours. Framework agreements were also not restricted to specific geographic zones, thus enabling care managers to purchase care from a wider range of agencies and offer older people greater choice between potential home care service providers. Framework agreements were widely believed by local authorities to increase competition and drive up quality, in contrast to block contracts.

“It’s probably generated an element of competitiveness, [...] they [providers] have to be constantly proving themselves and proving their worth and being prepared to sign up to what our requirements are.”

(Care manager, Study 1)

This view was particularly marked in one local authority (Study 1) which had over 40 home care service providers on its framework agreement. Another authority (Study 2) had only four providers on its framework agreement but aimed to stimulate competition by replacing these every three years.

However, these more flexible, purchasing arrangements also introduced new risks and additional costs. To complement framework agreements, local authorities in Study 1 had introduced new ‘broker’ roles - local authority staff acting as market intermediaries between the front line care managers who assessed the care needs and PB levels of individual older people and the home care service providers. Brokers sent out the basic details about potential clients and their support needs to all framework providers asking if they were able to provide their specified levels of care. Details of providers that responded were then given to care managers, who would ask the older person to select their preferred provider. However, both local authority care managers and home care provider agency managers were concerned that brokers knew little about individual older people and their needs; they worked through emails and paper and did not meet service users. This generated a lot of *‘to-ing and fro-ing’* between local authority staff and home care service providers to ensure that older people’s preferences could be met. Indeed, in one authority (Study 1), the brokerage system was reported to create such delays that local authority care managers by-passed brokers and contacted home care agencies directly, only asking brokers to finalise arrangements once these had been agreed

informally with the agency. Agency managers also reported preferring to negotiate directly with care managers about new clients. For example, they reported having offers to take new clients who lived close to existing clients turned down by brokers who were unaware of their geographical proximity, thus preventing the more efficient geographical clustering of visits.

Because they provided no guarantee of work or income, framework agreements also introduced new risks for home care service providers and for the stability of the local markets. Thus several authorities across the two studies had initially placed only relatively few home care providers on their framework agreements in order to ensure a reasonable amount of work to each, thereby safeguarding their financial viability, market stability and home care service capacity across the authority as a whole. However this had the effect of reducing choice for older people. Even in a large rural authority with over 40 home care service providers on its framework agreement (Study 1), local authority care managers thought there was still insufficient choice of home care provider; often only one provider was able to provide the care advertised by the council brokers. Care managers in other authorities reported that it remained very difficult to meet specialised needs (for example for carers from specific ethnic or cultural backgrounds) through framework agreements.

The tensions between competition, market stability and choice were also recognised by the managers of home care service providers. On the one hand, framework agreements allowed them to select clients from any geographical area and also turn down new referrals - options that were not available under the former block contracts if they were below their contracted minimum volume. This gave them greater control over their staffing and workloads. On the other hand, provider managers were aware of the risk of having more agencies on a framework agreement. The increased competition risked increasing pressures to accept all

the clients they were offered; this could in turn reduce opportunities to group clients geographically, with consequences for maintaining efficiency by employing local care staff and reducing travelling time.

Providing home care to older people with local authority managed PBs under framework agreements was not the only source of business available to home care providers. Older people taking their PBs in the form of a cash direct payment could also use this to purchase services from home care providers. One local authority (Study 2) had recognised this as an opportunity to help protect local home care service providers against the potential instability introduced by framework agreements. It had negotiated an agreement that local providers would charge direct payment holders the same (lower) rates for their home care services that they charged council-managed PB holders, thus sustaining demand for home care providers' services. In contrast, however, another authority (also Study 2) expected local home care service providers to compete for, and generate additional income from, the higher charges that direct payment holders (as well as those funding their own care privately) were expected to pay. Initially home care providers in both these authorities expressed anxiety that increased numbers of older people using direct payments to purchase home care directly from agencies could increase agencies' exposure to late payment and debts, although this new risk had so far not materialised.

The transition to framework agreements was accompanied by some devolution of responsibilities to home care providers for devising detailed care plans with older people with local authority managed PBs and for initiating reviews of these plans as needs and preferences changed. Some home care providers also reported having greater freedom to negotiate directly with clients exactly how their managed PB would be used; they were allowed by their

respective councils to adjust the details of care plans in agreement with clients, without seeking permission from the authority. However, significant restrictions on this flexibility were also reported. Some authorities imposed blanket prohibitions on the use of PBs for house cleaning or any tasks other than personal care. Only a few home care agencies reported their clients were able to save PB-funded time, for example if a routine visit was cancelled, and 'bank' this for later use. Both providers and older people reported that local authorities 'clawed back' any unused time on the grounds that the funding was not needed. Moreover it was rare for providers to be given PBs to manage on behalf of older people as ISFs; instead they invoiced the local authority retrospectively for care they had provided.

"The local authorities are still going to want to hold the purse strings, so ISFs, yes it still can work and I think it can work in a fantastic way, but as I say unless the local authorities are prepared to let go of that funding and trust the ... service provider ... [...] money's so tight now."

(Home care provider manager Study 1)

Indeed, only one of the six study authorities (Study 2) had established ISF arrangements, with four local home care providers who managed PBs on behalf of older clients; this arrangement had been set up for people who took their budget as a cash direct payment and used it to buy home care from provider agencies. Here direct payment users chose one of the four providers and the local authority transferred the direct payment to the provider, which was then responsible for managing it. The stated aims were to relieve older people of the responsibility of managing a direct payment and to increase opportunities to devise care plans directly with the agency.

Across the six councils, some measures had been introduced to support older people who opted to take their PB as a cash direct payment and engage directly with their local home care markets – both formal and informal - as individual ‘consumers’. In one authority, council brokers would negotiate between individual direct payment holders and home care providers over the timing and content of home care services. In a second council, these functions were carried out by a third sector, user-led organisation commissioned specifically to support direct payment holders. Two authorities offered pre-paid cards linked to a bank account held by the local authority; direct payment holders were issued with the card and used it to pay home care providers for the services provided. In one local authority a third sector organisation had recently been commissioned to recruit a pool of people wishing to work as PAs; this organisation helped direct payment holders to identify and hire a PA.

The experiences of older people – ‘consumers’ of home care?

Combining evidence from the two studies enabled a comparison of the experiences of older people who had chosen different options for deploying their PBs and who were therefore engaging with local home care markets with different levels of opportunity to exercise choice as ‘consumers’ of home care services. What were the outcomes of the various deployment options, in terms of receiving services that were flexible and responsive to changes in circumstances and preferences? In particular, were those deployment options that offered more extensive user control reflected in accounts of more individualised and responsive home care?

Older people whose PBs were managed by the local authority all reported having little choice over which agency provided their care. This was consistent with the caution of local authorities in not allowing too many home care providers onto the new framework

agreements; usually only one provider was able to respond to brokers' advertisements.

However, this lack of choice was not a concern; older people either thought they lacked the information and skills to make choices between providers or had felt too unwell at the time to be able to absorb the necessary information and take responsibility for evaluating alternatives.

Much more important were variations in opportunities to develop relationships with regular care workers. Older people with local authority-managed PBs reported being visited by the same small team of care workers and they valued this. A few interviewees reported having been able to change particular care workers they did not get on with, while older people from minority ethnic communities reported their cultural and religious preferences were respected by care workers. Thus, even within the constraints of local authority managed PBs, older people reported being able to develop relationships with their small team of care workers. This enabled older people sometimes to ask for additional small tasks to be carried out 'off the care plan'; sometimes care workers themselves offered to undertake these (for example, collecting shopping on the way to a home visit).

Nevertheless, older people with local authority-managed PBs still wanted more flexibility over how the time funded through their PB was used and the tasks that made up their day-to-day care – for example, being able to shorten several routine visits and 'bank' the saved time for a longer visit or outing at a later date. Others would have liked a few unallocated hours each month to use flexibly.

Those older people who had opted to take their PB as a cash direct payment did so often because of previous unsatisfactory experiences with local authority-commissioned home care. They reported earlier difficulties in getting the services they wanted or providers to accept

them as clients, lack of continuity or delays in receiving care. With the direct payment option, they reported significant improvements in satisfaction, with greater flexibility and control over their care schedules, improvements in care workers' punctuality and greater responsiveness to changing preferences. Those who used direct payments to employ a PA also reported greater flexibility over the timing and range of tasks undertaken.

“And she is very, very flexible actually. She is very good. She will do things which are perhaps not entirely in her remit... but don't tell anybody that 'cause it might get her into trouble [laughter]”.

(Older person Study 2)

This flexibility included being able to adapt daily routines to changing needs or schedules. Underpinning such flexibility were extensive informal arrangements between direct payment users and PAs which included clear notions of reciprocity. These were evident when agreeing care schedules – where overtime or early visits were ‘repaid’ later by shorter shifts – and included symbolic exchanges of ‘gifts’ or social support, for example, when older people gave advice on non-care related issues to a foreign-born PA. It appeared therefore, that greater command over care-related resources offered increased scope for the relational dimensions of care-giving to develop between older people and their care workers. Those employing PAs often reported developing deep, reciprocal relationships with their carers. Even those using their direct payments to purchase care from formal service provider organisations reported developing and sustaining close relationships with individual care workers; a few even reported moving to a different provider in order to keep a particular carer if the latter moved employer.

“Yeah, that’s important because you need to feel comfortable with the person that comes into your home.”

(Older person Study 2)

However, the benefits of this enhanced agency had costs in terms of increased uncertainty and responsibility. Recruiting a PA not previously known to an older person caused considerable anxiety; this issue was so salient that some of these older people had used their direct payment PB to purchase care from a formal service provider. Conversely (and similar to those older people with local authority managed PBs), those who used direct payments to purchase care from an agency reported less freedom to choose the identity of their carers, but this was offset by reduced anxiety and stress.

“I just sort of thought, oh well if I go with this agency [name omitted due to confidentiality], the manager there [name omitted due to confidentiality] is pretty accommodating with finding the right sort of people.”

(Older person Study 2)

To reduce this uncertainty, acquiring information on a potential home care provider or PA employee was paramount. Recommendations came from friends, neighbours employing carers or support agencies. Uncertainties and risks remained even after PAs had been recruited, as older people still had to find temporary cover for holidays or illness. Here existing relationships with PAs were valuable, as the latter could suggest acquaintances who might be willing to act as temporary replacements. Even so, some older people who had optimised their consumer choice by employing PAs still felt that an agency would be able to offer better backup in these situations or provide them with added reassurance about the identity and

competences of the PA. Finally, agencies were considered better able to handle the responsibilities of employing PAs:

“Yeah, ‘cause they know they’re going to be able to handle the paperwork. Like now we are getting too old to do this sort of thing, you know really, I am. I was never an office worker and I could see straight away the problems that may arise with insurance and holidays and bookings and all that, you’d be on your own. “

(Older person Study 2)

Discussion and conclusions

Drawing on two relatively small scale, in-depth studies, this paper has reported recent changes in England aimed at increasing choice and competition in home care services – whether provided by formal service providers or individually employed PAs - so that care can be better tailored to individual preferences and needs. These changes have been underpinned by consumerist discourses and have utilised market-related mechanisms as levers for change. Specifically, they have aimed to increase competition by placing greater agency in the hands of individual older people needing care.

However, many older people appear to be reluctant to or have difficulty taking on the role of active consumers. Thus local authorities have retained a major role as large scale purchasers of home care services, albeit with changes to the contractual basis for this role that are intended to increase competition. The shift from block contracts to framework agreements involves only minimal devolution of purchasing power to users of home care services or relaxation of tight service specifications in the form of agreed care plans. However the move does entail increased risks for home care provider agencies, who are exposed to greater

competition and wider market uncertainty. Attempts to mitigate these risks include limiting numbers of providers on local framework agreements – but this in turn reduces the range of services and choices available to older people with local authority managed-PBs. Other opportunities for increasing flexibility and choice for those with local authority managed PBs, such as ISFs and time banking, were not widely available among the six authorities at the time of the studies reported here. Further research is needed into the longer-term sustainability of local home care markets, under the dual pressures of increased competition and risk.

Turning to the experiences of older people, the findings reported above are consistent with earlier evidence of the reported benefits of optimising consumer agency over care provision through user-held cash direct payments (Glasby and Littlechild 2009). Comparing the accounts of older people with local authority-managed PBs against those of older people using direct payments to engage more closely with local care markets does suggest the latter may experience more freedom to shape the timing and content of daily care routines to their preferences. Significantly, the latter group may also have more opportunity to nurture the relational aspects of care, through enhanced opportunities to develop close and reciprocal relationships with directly employed PAs. This is a dimension of care that is highly valued and associated with higher quality care by end users (Kane and Kane 2001; Lewis and West 2013). However, this difference may be relative rather than absolute, as older people with local authority managed PBs also reported being able to develop relationships with home care agency-employed care workers.

Against these cautious positive conclusions, however, some major concerns arise. Both studies clearly expose the limits to consumerism and the commodification of care. Not all the older interviewees wanted greater choice or acted as empowered consumers of care. Many

did not want to take responsibility into their own hands and therefore opted for local authority-managed PBs, trading off the lack of responsibility against the lower levels of choice this allowed. Even amongst those who did opt for direct payments, choosing a home care agency or recruiting a personal assistant was daunting and filled with uncertainty, compounded by a lack of relevant information. This illustrates another dimension of wider societal shifts from state or corporate, to personal, responsibilities for managing risk, including the sense of isolation experienced by newly exposed individuals and families (Hacker 2006). Moreover, the older people taking part in both studies emphasised how important the relational aspects of care were to them. It is not clear that current consumer-driven reforms prioritise this important aspect of the quality of care (see Lewis and West 2013).

Further concerns relate to the additional costs involved in attempts to transform the purchasing of care services from large scale enterprises conducted by monopsonic local authority purchasers to more individualised purchasing arrangements - whether conducted by proxy, with local authorities purchasing care for individual older people through framework agreements, or by older direct payment holders themselves. These costs may be substantial and both financial and psychological. They include the costs of local authority brokers; the additional time and other transaction costs incurred by brokers in facilitating the matching of demand with supply within framework agreements; and the brokerage and support arrangements that enable individual purchasers to search for and purchase appropriate care. As Thaler and Sunstein (2008: 158) point out, 'the more choices you give people, the more help you need to provide'. Wider costs to local care markets and constraints on opportunities for individual choices may also be incurred over time, if some home care agencies are unable to sustain increases in business risks and competition pressures. Individual older people also reported tensions between exercising greater control over their care and the risks this

entailed; indeed, some were willing to trade off reduced agency for a reduction in risk. Given the salience to effective market functioning of good information for both buyers and sellers (Baxter *et al.* 2011) there appeared to be a particular imbalance in the ease of obtaining information about formal home care providers compared with potential PA employees. More generally, the evidence tends to support Wilberforce *et al.*'s (2012) predictions of the increased costs associated with improvements in allocative efficiency and Spicker's (2013) scepticism about the cost-effectiveness of personalisation.

The conclusions reported here may change as local authorities and home care providers gain experience in managing increased choice and its associated risks, or as more older people take their PB as a cash direct payment. These early findings nonetheless suggest that older people with local authority-managed PBs do experience some limited opportunities for flexibility and choice over the delivery of their care. Those with direct payments appeared to have greater degrees of control and choice and were better able to tailor care to their needs, even when using formal service providers. But against these gains must be set new risks and additional costs; the size and sustainability of both of these, for both organisations and individuals, warrant further investigation. Local authorities are currently experiencing an unprecedented period of austerity and restrictions on expenditure and the increased costs of managing more personalised local care markets may be difficult to sustain.

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