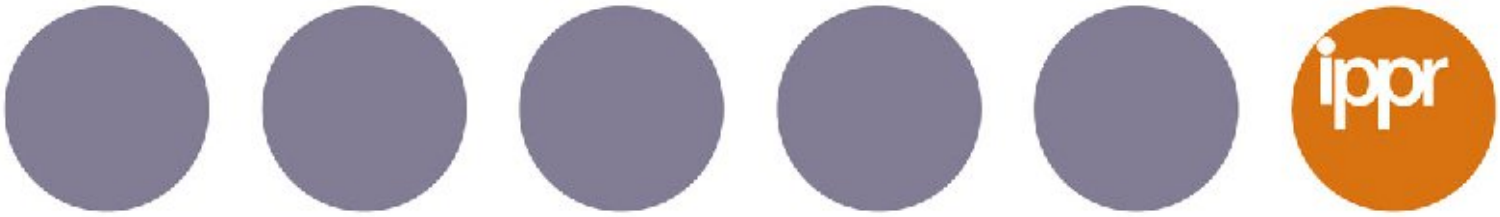


A Mature Policy on Choice

Jennifer Rankin

NOVEMBER 2005

institute for public policy research
30–32 Southampton Street, London, WC2E 7RA
tel: +44 (0)20 7470 6100
fax: +44 (0)20 7470 6111
info@ippr.org • www.ippr.org
registered charity 800065

Institute for Public Policy Research
30-32 Southampton Street
London WC2E 7RA
Tel: 020 7470 6100
Fax: 020 7470 6111
www.ippr.org
Registered Charity No. 800065

The Institute for Public Policy Research (ippr) is the UK's leading progressive think tank and was established in 1988. Its role is to bridge the political divide between the social democratic and liberal traditions, the intellectual divide between academia and the policy making establishment and the cultural divide between government and civil society. It is first and foremost a research institute, aiming to provide innovative and credible policy solutions. Its work, the questions its research poses, and the methods it uses are driven by the belief that the journey to a good society is one that places social justice, democratic participation, economic and environmental sustainability at its core.

This paper was first published November 2005

Contents

Acknowledgements

The Institute for Public Policy Research (ippr) would like to thank Bevan Brittan LLP for their generous support of this project. Particular thanks are due to John Chapman, Jean Sapeta, David Worskett and Neil Carmichael.

We are grateful to all the participants who took part in a seminar on older people's health and choices in September 2004, especially our three seminar speakers, Professor Ian Philp, the Department of Health, Paul Maltby, the Prime Minister's Strategy Unit and Professor Martin Knapp, the London School of Economics (LSE). The author would also like to thank Vanessa Davey at the Personal Social Services Research Unit, LSE and Jessica Allen and Peter Robinson at ippr.

Any errors, omissions or views expressed are the responsibility of the author alone.

About the author

Jennifer Rankin is a Research Fellow at the ippr. She has written and co-written a number of papers, including *Meeting Complex Needs: the Future of Social Care* and *Mental Health in the Mainstream*.

Jennifer Rankin
ippr
30-32 Southampton Street
London WC2E 7RA

t: 020 7470 0016
e: j.rankin@ippr.org

Summary

Choice and older people

We are experiencing what has been described as “a revolution in longevity”. People are living longer, healthier lives and the signs are that this positive trend is set to continue. However, these demographic changes have not been accompanied by a corresponding shift in the way society thinks about ageing. This report argues that a progressive agenda for choice could make a significant difference to the lives of older people and help contribute to a new understanding of ageing, which emphasises citizenship and quality of life.

There are many ways of giving people more choice and we have tried to differentiate between different types of choice. Firstly, we can think about choice in the context of everyday decisions, the ability to have control over day to day life. This embraces both consumer and non consumer choices. Further to this, there are life choices, for example making major decisions about housing, education and work. A progressive agenda for choice is concerned with improving public services and empowering individuals. However, choice is not the only way to give people more control. ‘Voice’, where people express their views through complaints procedures, public involvement forums and democratic institutions is also critical.

Supporting individual choice

This report explores the Government’s proposals for individual budgets. Individual budgets are an umbrella term, which cover 3 ways of delivering services for all older people eligible for social care or other support. Under the Government’s proposals, an individual would have control over the resources the state has allocated to meet their needs, like a bank account. Resources can be taken as a combination of cash (a direct payment); services brokered by an advisor; or council commissioned services (the current default). Individual budgets will be piloted to bring together resources from social care, housing support and other funding streams.

The ippr are supportive of the Government’s proposals to extend individual budgets. Individual budgets present an opportunity to create services that respond to people’s needs more effectively and in a more user friendly way than the current options on direct payments.

However, the introduction of individual budgets alone will not guarantee that older people’s opportunities to have choice and be in control are maximised. To date, there have been substantial variations in local authority implementation of direct payments. Getting into the mindset of responding to expressed preferences requires a cultural shift amongst providers and commissioners. This suggests central and local government need to focus on promoting cultural change in some local authorities.

At the time of writing, the Government are in the process of designing and implementing pilots of individual budgets. The pilots will help to shed light on some areas of uncertainty, including the cost of individual budgets. At present, there is no robust evidence available that would lead to the conclusion that individual budgets on a large scale will be cheaper, more expensive or cost the same compared to existing provision.

The Government should consider introducing a statutory duty on local authorities to provide assistance to use individual budgets (although using the broker could be optional for service users). In developing a brokerage service, it will be important to avoid an overly rigid approach. Other health professionals, including GPs, will continue to play a role in brokering information and advice about health.

It is important to remember that individual budgets exist in the wider context of health and social care reform. Another important area is choice over housing and care arrangements. In the UK, there are

three options on care and housing: home care, residential or nursing care and living in an Extra Care home, which combines the independence of living in an individual home with access to a care team who are part of the Extra Care site. However, while the principle of choice is enshrined in policy, it does not always work in practice. For instance, a move into residential care is often not an active choice.

It is generally considered that the Extra Care model will become more significant in the future, as the need for institutional care becomes increasingly questioned. There is some evidence to suggest that Extra Care may lead to better health and quality of life outcomes for older people and that this kind of provision is more expensive than residential care. This suggests that if the Government wants to guarantee greater choice for older people that supports better quality of life, it will require some difficult decisions about spending priorities.

Promoting collective health

Exploring prevention and health promotion is helpful in order to re-balance the focus on individual choice. Policymakers need a broad understanding of prevention that takes into account the prevention of social problems, such as isolation and poor mental health, as well as physical health problems. This approach underlines the fact that preventative care is a shared enterprise that lies at the interface between health, social care and other public services. The agenda for older people's health and wellbeing demands a more strategic approach and more joint commissioning between health and social care.

There are many encouraging signs that prevention is moving up the health agenda for older people. The Government have aspirations to reverse the balance of services and focus on community wellbeing, rather than those in acute need. However there is still a long way to go before all older people are fully engaged in their health. One helpful step forward would be greater clarity about the scope and role of preventative services.

The principles of choice and voice also have an important role to play in developing preventative services for older people. Health and social care commissioners and providers should explore how to create services based on the preferences of the local older population. Choice may be useful in helping to develop personalised, niche services, for example services for people with specific dietary needs or at particular risk of social exclusion. There needs to be further consideration of the mechanisms used to promote choice in low level preventative services as part of a wider strategy for older people's health and wellbeing.

A fair settlement for older people

There is a need for greater openness and transparency about the resources which are available to older people. The ageing population and growing demand for services makes it even more necessary to plan ahead for the rise in demand. There needs to be greater clarity and certainty about how the Government will achieve an ambitious agenda for older people. This entails revisiting the question of the resources available for long-term care and social care and involving the public in determining priorities.

1. Introduction

The revolution in longevity puts choice high up the agenda (Kirkwood 2001).

When Mrs Ward turned 65, she received some unwelcome news. She is disabled and had been receiving support services from her local authority but, at her age she was no longer classified as an 'adult', but as an 'older person'. This meant she could now attend the day centre for older people, but was no longer entitled to go on group holidays with other disabled people. She's *meant to be adapting to the lifestyle of an older person* was the response of her care manager (Clark et al 2004).

This incident is symptomatic of a wider problem in the way society thinks about and treats older people[1]. Too often, it is presumed that older people cannot or do not want to make choices. However, this view is increasingly being challenged by policymakers, gerontologists and above all by older people themselves. Older people reject both the deficit model of ageing, which frames old age as an illness with no cure, and the heroic model, where success in old age is only possible through competing with younger people (JRF 2004). Instead, a more nuanced account of ageing is helping to shape some new directions in public policy relating to older people.

In 2005, the Government published *Opportunity Age*, a White Paper on managing demographic change and a Green Paper on social care, *Independence, Wellbeing and Choice* (DWP 2005, DH 2005a).[2] These documents set out an ambitious agenda for improving older people's services and quality of life. They look to a future where all older people can be independent, have equal opportunities to work and to participate in society, unhindered by age discrimination. Both documents are informed by the concept of "active ageing", described by the WHO as "the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age" (WHO 2002).

Choice is an important element of this strategy and has occupied a central place in the public policy debate in recent years. The Government has made several bold claims for choice. It has been presented as the route to social justice and better public services. In contrast, critics have argued choice could worsen existing inequalities and is a distraction to improving public services. Specifically in the NHS critics see choice as a threat due to the presumed expansion of private sector provision. Much of the debate has been focused on one particular dimension of choice, namely individual choice as a lever to enable competition between providers. But there should be more to choice policy than facilitating contestability. Progressives should also be concerned with choice as a way to enable individuals to be in control and have more input into the design and delivery of the public services they receive.

In this report, ippr will present a progressive account of choice.[3] A progressive account of choice starts with the individual, rather than the mechanics of public service improvement. Under this account, choice is valuable where it helps to achieve more personalised public services and is a lever for empowering people and improving services. There are many ways of giving people more choice and therefore it is useful to differentiate between different types of choice. Part 2 will discuss how choice can be classified in different ways, such as individual daily decisions, which include consumer and non consumer choices and life choices, major decisions about housing, education and work. However, any policy to extend choice will require support to be made available so that everyone can benefit and not just those who understand the system. Making choice work in practice requires more accessible information, enhanced capacity and the empowerment of 'choosers'.

---

[1] This report discusses older people as aged over 65 unless otherwise stated. It is focused on England, although may be relevant to the other devolved nations

[2] *Independence, Wellbeing and Choice* (DH 2005a) applies to adults of all ages. In 2005, the Strategy Unit also published *Improving the Life Chances of Disabled People*, which deals with promoting independent living and citizenship for disabled adults of working age.

[3] See also Farrington Douglas J and Allen J (2005) *Equitable Choices*: ippr

A progressive account of choice also recognises that choice has limits. Choice is not always appropriate and may conflict with the collective good. For example, in the context of limited resources, unlimited choice for individuals limits the resources available for everyone. Also, choice is not a panacea for all social problems; choice will not lead to a fairer society, although in some forms it can lead to better outcomes and / or improved services for some people.

Finally, it is important to acknowledge that choices are not made in a social vacuum, but are influenced by wider socio-economic and cultural conditions. An example which is central to this report is how older people can be supported to remain in their own homes.[4] On the one hand deciding where to live is a simple matter of individual choice. However, this decision will be heavily determined by wider social factors, such as a person's health status, availability of domiciliary care and / or informal care and exposure to health promotion activities.

For this reason, this report will also consider a preventative agenda in relation to older people. Addressing the theme of prevention will help to contextualise the role of choice in delivering improved outcomes for older people. While many older people are in regular contact with health services, these may be peripheral to their ongoing strategies towards maintaining wellbeing. Older people themselves are concerned with a broad agenda for maintaining health and wellbeing, which encompasses physical and mental health, getting out and about and maintaining social networks (Godfrey et al 2004).

Other factors such as poverty and social exclusion are also critical factors in influencing people's health. Levels of pensioner poverty remain high: in 2003-4 one in five pensioners lived in relative poverty (Paxton and Pearce 2005). If we want to make a real impact on preventing illness and tackling health inequalities, we also need to think about a more serious commitment to eradicating pensioner poverty. Socially excluded people are less likely to take part in civic activities and more likely to doubt their ability to change things (SEU 2004, Dean 2004). This suggests the importance of finding new ways to reach people. But also, it acts as a reminder that while choice over health and care services is important, it may be less meaningful in the context of limited life choices and opportunities.

This report is divided into four sections. First, it provides a brief overview of the future drivers that will affect the availability of care for older people. Secondly, it explores the concept of choice and what this means for older people, in relation to three areas: the NHS, social care and choice of housing and long-term care arrangements. Thirdly, it looks at what a preventative agenda means for older people. Finally, it draws together some conclusions and implications for policymakers.

2. Future drivers

Like other developed countries, the UK has an ageing population. This means not only that people are living longer, but also that there are fewer young people as a proportion of the population. By 2051, people over 65 are likely to account for over a quarter of the population (DWP 2005). If we are going to consider how services may develop for older people, it is necessary to understand the scale and nature of the demand. This section draws on data that ippr commissioned from CASS Business School (Rickaysen 2005) and the Personal Social Services Research Unit at London School of Economics, which projects key trends to 2020-2 (Malley et al 2005).

There is considerable uncertainty about the implications of an ageing population. One area of ongoing debate is whether the future population will live longer healthier lives, or longer lives with more time spent in poor health and disability. There are three theses on the future health expectancy of the population, which are set out in Box A.

Box A Health Expectancy – three theses
(Rickaysen 2005).

Compression of morbidity
This is the most optimistic thesis and proposes an increase in life expectancy combined with a postponement of disability / ill health to later years. The overall result is a reduction in the proportion of time spent in disability.
Expansion of morbidity
This is the most pessimistic thesis and suggests that people will live longer lives and experience more time in disability.
Combination
The third hypothesis is a combination of the previous two. It suggest there could be an expansion in the time spent in good health as well as the time spent in disability

The data produced by CASS does not unequivocally support any of these hypotheses. Much depends on the definitions of illness and disability that are used (Rickaysen 2005). If disability is defined broadly as 'any disability' the data is consistent with the third trend; as life expectancy increases, there will be a small increase in the levels of low to moderate disability. However, if disability is defined as 'severe disability', the projections support the compression of morbidity thesis, where time spent in severe disability will reduce.[5]

The critical distinction between severe and minor disability is also a key theme of the Treasury's Wanless Review (Wanless 2002). The Wanless Review set out to assess the resources required to ensure that the NHS can provide a publicly funded, comprehensive high quality service available on the basis of clinical need. The Review suggests there will be a fall in serious ill health, but an increase in minor health problems. It anticipates that the future generation of older people will be healthier in 2022 than the older people of 2002 (Wanless 2002). Of course, there remains a degree of uncertainty about all projections. The size and health status of the older population will be determined by which model of progress the next fifteen years most closely resembles: i.e. whether public health achievements are characterised by slow uptake, solid progress, or whether they match the fully engaged scenario set out in the Wanless Review (Wanless 2002) (see Box B).

[5] Severely disabled life expectancy is defined as "being unable to carry out some of the six 'Activities of Daily Living'". These are bathing, dressing, going to the toilet, transferring (to and from a bed or chair), continence or feeding.

Box B: The health of the nation in 2022 – the Wanless scenarios (Wanless 2002)

The Wanless Report set out three scenarios to describe possible changes in the health needs and demands of the population, technological developments and medical advance, the use of the workforce and productivity.

Slow Uptake – There is no change in the level of public engagement: life expectancy rises by the lowest amount in all three scenarios and the health status of the population is constant or deteriorates. The health service is relatively unresponsive with low rates of technology and low productivity.

Solid Progress – People become more engaged in relation to their health: life expectancy rises considerably, health status improves and people have confidence in the primary care system and use it more appropriately. The health service is responsive with high rates of technology uptake and a more efficient use of resources.

Fully Engaged – Levels of public engagement in relation to their health are high: life expectancy increases beyond current forecasts, health status improves dramatically and people are confident in the health system and demand high quality care. The health service is responsive with high rates of technology uptake, particularly in relation to disease prevention. Use of resources is more efficient.

Although the population of future older people is predicted to remain healthier for longer, the overall demand for services is likely to rise. A smaller proportion of the population over 65 will require intensive support both in the home and within institutional care. Data commissioned from the LSE shows that between 2002 and 2022, the number of disabled older people will increase by 40% and residential care and nursing home places will increase by 40%. Under this scenario, long-term care expenditure should increase as a proportion of GDP from 1.5% to 1.8% (Malley et al 2005). [6] Meeting the needs of those requiring intensive support will remain critical. The small increases in moderate levels of disability and ill health underlines the continuing importance of engaging people in their own health to prevent existing disabilities and health conditions from becoming worse.

These statistics make clear the financial challenges that the ageing population poses to society. However, it is important that potential costs do not become the driving force behind policy on older people. Policymakers need to ensure an adequate and equitable settlement for older people's health and care needs in the present, before a significant rise in the numbers of older people takes place.

[6] These projections are made under the base case, which is the least optimistic scenario provided, where age specific disability rates remain constant. The LSE produced two other scenarios where age specific rates fall in line with increases in life expectancy. For further details see Malley et al 2005.

3. Choice

Put simply, choice is the power to make decisions. However, as the introduction discussed, this simple concept and its implications for individual empowerment appear to have been lost in the heat of the debate on choice and the market. But choice should be about more than creating markets and can be classified in different ways. Firstly, we can think about choice in the context of everyday decisions, the ability to have control over day to day life. This embraces both consumer and non consumer choices. For instance, the National Consumer Council Policy Commission on Public Services have differentiated between economic choice, where users asserts their choices with financial payment for selected services and non economic choice, where users make choices that are not immediately followed by financial payment, but are nevertheless real choices, such as choice of treatment or choice of appointment (Policy Commission 2004). Further to this, we can think about life choices, making major decisions about housing, education and work. A different but related form of empowerment is 'voice', where service users express their views through complaints forums, public involvement forums and democratic institutions.

It is interesting to observe that choice in the NHS has evolved in a very different way to choice in social care. In the health service, choice policy has evolved from the top-down, although admittedly this policy was motivated by the perception that the health service needed to be more responsive to consumers. In 2001, choice in the NHS was emphasised in the Labour Party Manifesto, but it gave little indication as to what the purpose of choice was (Labour Party 2001). Since then, choice has developed in two ways: choice of hospital provider and greater convenience for patients, such as greater choice over appointment times. By December 2005, all patients will be able to choose between four or five different providers for elective care, this will be increased to an unlimited number of providers by 2008.

In contrast, in social care choice was pioneered by disabled service users who were dissatisfied with the 'provider knows best' approach to their care provision and campaigned for direct payments in the 1980s. The idea of choice was more closely related to empowerment and being in control, rather than introducing contestability (Barnes et al 1999). Under the NHS and Community Care Act 1990, choice became an explicit goal for community care policy. Still, in many cases there remains a noticeable gap between the policy goals and the day to day experience of service users.

Choice in the NHS

There are many conflicting views as to whether people actually want choice in the NHS. The Government has argued that people do want choice, which has been countered by the response that people just want a good local service. It has also been argued that patients prefer to trust in medical expertise when faced with difficult decisions about their care (Schwartz 2004). The 'good local service' argument is frequently made in relation to older people. It is true that older people are more likely than younger age groups to think that choice is unnecessary: out of all those people who told a Mori survey that choice is unnecessary (23% of respondents), the highest proportion were those aged over 75. However, in this survey, 62% of respondents of all ages agreed that they would like to make a choice of hospital, although they would like advice and information to help them with their decision (Mori 2004). Research by *Which* found contradictory attitudes to choice. On one hand, people wanted more personal services that were more responsive to their needs. On the other hand, the public were reluctant to make choices in healthcare and older people in particular were more likely to be 'choice averse'. In general, many found it hard to imagine how choice might work, as the concept of choice was at odds with their experience of the NHS. There was a low awareness of many of the Government's proposals to extend choice (Which 2005). However, older people are prepared to take up choice if it has a demonstrable outcome, e.g. faster access to treatment. In a poll by Help the Aged, four out of five people would travel in order to get faster treatment (Help the Aged 2003). This suggests that the test for policymakers is to make choice in the NHS more practical with demonstrated improvement in outcomes, including those that are important to users.

Choice has been an alien concept to the UK health system. One international study rated the UK to be the worst among six countries at involving patients in decisions about healthcare (Schoen et al 2004). Under the current system, well-off, well-educated patients have become better at negotiating more and better services for themselves. This raises the considerable risk that extending choice in the NHS might widen inequalities of access by only benefiting those patients who are already more health literate, better able to communicate their preferences and move between providers (Farrington Douglas and Allen 2005).

To enable everyone to benefit from choice in the NHS, ippr has recommended strengthening support systems in a number of ways. These include better targeting of advice, support and advocacy at disadvantaged groups; providing a wider range of information on hospitals, including practical information on hospital facilities and transport links. It is also important to improve peer support mechanisms, by linking people with community and patient support groups (Farrington Douglas and Allen 2005). Elsewhere, it has been argued that further testing of the use of economic consumerism (e.g. choice of provider) is necessary in order to develop better technical criteria for its use so that it does not conflict with the public interest (Policy Commission 2005).

Choice in social care

In social care, the case for choice has been more immediately obvious. Since the NHS and Community Care Act 1990, the object of community care policy has been to provide greater choice and control for service users and to improve value for money, by targeting resources on those with the greatest level of need (Netten et al 2005). The focus on choice has resulted in emphasis on supporting people to live in their own homes, a life choice that many older people want to make (Wanless Review Team 2005). As such, the Government has a Public Service Agreement (PSA) target to increase the proportion of older people supported to live in their own home.[7]

There is increasing interest in how greater user choice might transform arrangements for domiciliary care and help people to remain independent in their own homes. In general, users of social services are enthusiastic about more choice in domiciliary care services and the general public are supportive of the idea that older people should have more choice and control over home care. In a poll by Mori, choice in homecare for older people was seen as one of the most important areas among various public services, where choice mattered and could contribute to improvements (Audit Commission 2004a). However, it is worth noting that the public's enthusiasm for choice is diminished if it costs more. In a poll of the general public, less than half (43%) thought that they would be prepared to pay more for older people to have more choice in domiciliary services (although this was relatively high compared to willingness to pay for other choices) (Audit Commission 2004a). Clearly, we need to strike a balance between the choices of the individual and wider collective desire to have affordable public services.

The current focus for extending choice is through direct payments and individual budgets (see box C). Although the arrangements for direct payments have been in place for almost a decade, it was not until 2000 that older people were entitled to receive them. To date, the take up of direct payments has been low, especially among older people. In 2004, only 6300 older people were recipients of direct payments although over 1 million receive services from local authority social service department (DWP 2005). [8]

[7] The PSA target is to improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible, by:
- increasing the proportion of older people being supported to live in their own home by 1% annually in 2007 and 2008; and
-increasing, by 2008, the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care.

[8] However between 2002- 4 there was a significant rise in uptake of direct payments.

Box C

Direct payments: A direct payment is a cash payment to an individual in lieu of local authority social services. Individuals often use this money to employ a personal assistant. Direct payments were introduced for adults of working age by the 1996 Community Care (Direct Payments) Act and extended to adults over 65 in 2000.

Individual budgets: Individual budgets are an umbrella term, which cover 3 different ways of delivering services for all older people eligible for social care or other support. Under the Government's proposals for individual budgets, an individual would have control over the resources the state has allocated to meet their needs, like a bank account. Resources can be taken as a combination of cash (a direct payment); services brokered by an advisor; or council commissioned services (the current default). Individual budgets will be piloted to bring together resources from social care, housing support and other funding streams (DWP 2005).

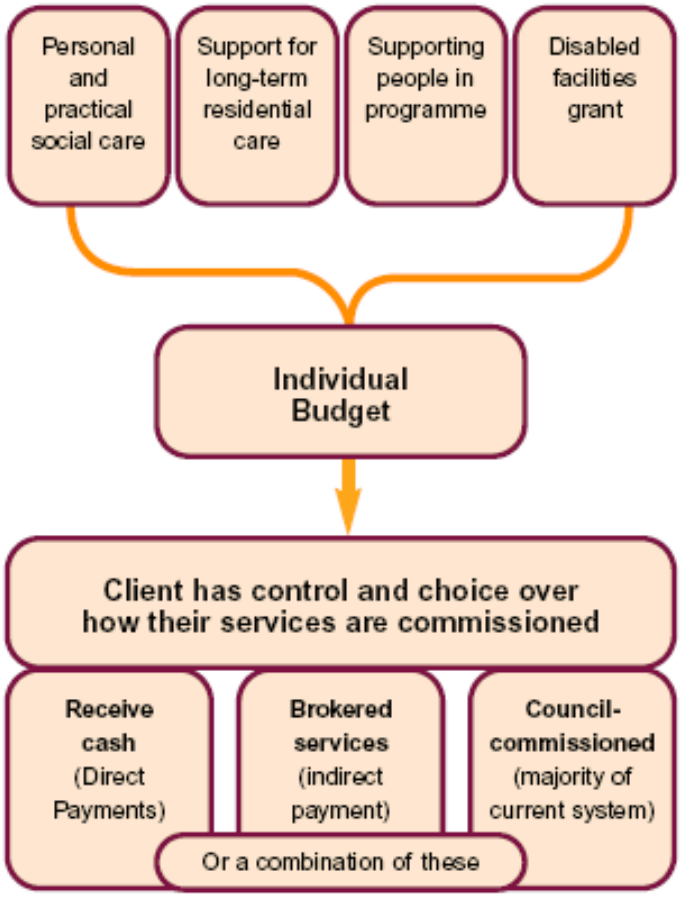
The reason for this low take-up is not because direct payments do not work in practice for older people. Older users of direct payments have reported improvements in satisfaction with services, quality of life and a greater sense of freedom (Clark et al 2004). Other research has suggested that older people will be attracted to the idea of direct payments if they are offered appropriate information and support (Hasler 2003). However, it is important to acknowledge that the response to the Department of Health consultation on the social care Green Paper showed lower levels of support for direct payments among older people and associated organisations compared to other users of social services (DH 2005c).

Despite this, it seems highly likely that many more older people could benefit from having greater choice and control over the services they receive. (This does not imply a direct payment is always the best vehicle for delivering choice). Currently, older people who use social services report a mismatch between what services provide and what they prioritise as a need (Godfrey et al 2004). Direct payments and their equivalents could fulfil unmet needs, because they allow people to tailor services to factors that influence their quality of life. Choice can help address the aspects of services that are difficult to quantify by managers and policymakers, but valued by individuals, such as personal relationships between an older person and a carer (Luundsgaard 2005). In this sense, they represent a more effective use of resources than providers' attempts to second guess people's experiences and perceived needs.

The demand for direct payments models is set to grow in the future. The current generation of middle aged people expect to be able to have the kind of choice and flexibility that direct payments bring. A poll by Mori for the Commission for Social Care Inspection showed that three quarters of people in their 50s endorsed the concept of direct payments (CSCI 2004). Qualitative research with people in this age bracket shows that people expect a broader range of services than those that are currently on offer (Levenson et al 2005).

The Government wants to see a substantial expansion of choice for older people, through individual budgets. In 2005, they set out proposals for individual budgets, with the expectation that older people should be "active consumers" rather than "passive recipients" of care (DWP 2005). Significantly, under the individual budgets schema people can choose not to choose, i.e. people retain the right to use local authority services. Individual budgets are a more user friendly version of direct payments. It appears that the 'hiring and firing' model of direct payments holds less appeal for older people than to adults of working age (Glasby and Littlechild 2002). One pilot study of different options for choice in older people's services in Portsmouth in 1999 showed that a mid-way option of brokered services was more popular than direct control through direct payments or council commissioned services. Out of 31 users, 7 chose a direct payment, 20 negotiated services with support of a carer and 4 chose to continue receiving traditional services (Clark and Spaffard 2001).

Figure 1 Individual Budgets



Source: DWP 2005

However, the introduction of individual budgets alone will not guarantee that older people's opportunities to have choice and be in control are maximised. To date, there have been substantial variations in local authority implementation of direct payments. Where direct payments have taken off, it has been through a combination of social work enthusiasm, voluntary sector advocacy and local government ambition. Local authorities who were supportive of direct payments for disabled adults of working age have also been at the forefront of developing direct payments for older people (Fernandez et al 2005). However, in many authorities direct payments are under-promoted and unknown to those who might benefit from them, despite the statutory duty which requires local authorities to offer all 'suitable' users a direct payment (Carr 2004). Assumptions about the restricted lifestyle of an older person may also mean that direct payments are less actively promoted for older people. Some social workers regard direct payments as an abrogation of their duty of care towards clients, although there is also evidence that workers can and do change their minds when they see direct payments work in practice (Stainton 2002). As well as attitudinal barriers, there are wider institutional barriers. There is some evidence to suggest a negative correlation between low take-up of direct payments and high levels of in-house provision (Fernandez at al 2005). This suggests that those authorities most resistant to developing direct payments were also least responsive to the changes introduced by the NHS and Community Care Act 1990, such as greater diversity of provision and a more developed commissioning role for local authorities. This legacy suggests that the commitment to develop individual budgets may also vary according to a local authority's enthusiasm to promote choice and control for older people.

At the time of writing, the Government are in the process of designing and implementing pilots of individual budgets. As various stakeholders have stressed, it will be important to learn from them about how individual budgets can best be supported. The pilots may also shed some light on a number of uncertainties.

The first area of uncertainty relates to the cost of individual budgets. The Government anticipates that changes in social care policy should be delivered on a cost-neutral basis (DH 2005a). Experience in other countries of equivalent policies shows that direct payments have some potential for cost savings. For example, in Germany people preferred to choose the cash benefit, despite the fact it was lower in value than the value of the in-house provision (Wanless Review Team 2005). However, some experts are less confident about the prospect of substantial savings and it has also been suggested that individual budgets may prove to be a more expensive option.[9] The experience of implementing NICE guidance has shown that the most cost-effective options are not necessarily the cheapest (Audit Commission 2005c).

One reason why individual budgets may be no cheaper or possibly more expensive is the need for brokerage and support services if they are to work effectively. It has been shown that direct payments schemes are most likely to be successful when there is an adequately resourced support system in place (Hasler 2003). The Government's consultation on the social care Green Paper showed that older people in particular wished to see increased provision of assistance to help access direct payments (DH 2005c). Although there is no statutory requirement to provide this support, it seems advisable to have a brokerage and support system in place if people are to take up individual budgets with confidence and to the maximum effect. There is no robust evidence available that would lead to the conclusion that individual budgets on a large scale will be cheaper, more expensive or cost the same compared to existing provision.

If costs rise or fall below current levels, this raises further questions. If they are cheaper: who will reap the cost savings? Will they be re-directed into social care? If they are more expensive, will the political commitment to individual budgets be sustained? On the basis of improved outcomes for older people, the grounds for political support are strong. This uncertainty about costs must be considered in relation to the future funding of social care.

Another unresolved question is where individual budgets sit on the historic dividing line between health and social care. At present, only people who are eligible for help from social services are entitled to receive direct payments. However, many users have health and social needs and would not easily differentiate between them; a bath is a bath, whether it is delivered by the NHS or social services (Glasby and Littlechild 2004). Moreover, as nursing care develops, the boundaries between 'nursing care' and personal 'social care are likely to become even more blurred (Brooks et al 2002). Legally, direct payments are only available for social care needs.[10] However, in practice direct payments have been used for some aspects of health care. In one study of disabled people in the UK, direct payments were used to purchase a range of services that would traditionally be defined as healthcare, such as physiotherapy, injections, footcare and alternative therapies while in hospital. These services were either unavailable, had been withdrawn or the individual felt they could control them better by having them delivered by a personal assistant. In this study, it was reported to be rare for health services to reimburse social care for these costs (Glendinning et al 2000). This suggests there is a strong case for the NHS to reimburse social care costs where direct payments are used for

[9] This reflected the discussion at an ippr 'Chatham House' seminar on older people's health in September 2005. At this seminar, various views were expressed, including that individual budgets would be a more expensive option, a cost neutral option and cheaper than existing provision.

[10] In 2005 a statement by the Department of Health clarified that individual direct payments for health cannot be used under the Health & Social Care Act 2001: "*direct payments made under the […] Act […] relate only to certain local authority social services. This means that where an individual has an identified heath need which falls to the NHS, that part of any "care" package cannot be delivered as a direct payment within the meaning of the legislation*". http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/DirectPayments/DirectPaymentsArticle/fs/en?CONTENT_ID=4104420&chk=GQsPsD

healthcare. The Government needs to ensure greater clarity about the funding arrangements for health and social care so that resources are aligned to support the best outcomes.

At the time of writing, the Government is planning a White Paper on the future of care outside hospitals, which will encompass reforms to the social care and primary care system. This White Paper presents a welcome opportunity to join up health and social care and promote public health, along the lines of the Wanless 'fully engaged scenario'. It is important these wider goals are not lost amidst ongoing reconfiguration of PCTs.

Finally, it is important to remember that individual budgets exist in the wider context of health and social care reform. Some have raised the prospect that focusing on individual budgets may lead to the development of a 'two tier service', where there are innovative services for people with the confidence and opportunity to choose and unimaginative mass produced services for those who cannot or will not (CSCI 2005). The principles of responsiveness to individual need and personal control should be core values for all aspects of care services and also need to be applied to different types of housing and residential care.

Choice in housing and care

The vast majority of people want to remain in their own homes in old age. However, people can and do revise their preferences on moving into residential care (Wanless Review Team 2005). In the UK, there are three options on care and housing. In 2004 around 700,000 people received home care, 440,000 people were in registered nursing care and there were between 30-35,000 Extra Care Homes for sale. The Extra Care model enables older people to live in an individual home, with access to an on-site care team. It is generally considered that the Extra Care model will become more significant in the future, as the need for institutional care becomes increasingly questioned (Best 2003). However, for those with complex care needs, such as dementia, residential care will continue to play a role in the foreseeable future (Laing 2005). There is a continuing need to ensure quality and adequacy of provision, and to ensure that people are supported in making decisions and have a good range of options to choose from.

Although the principle of choice is enshrined in policy, it does not always work in practice. Frequently, moving into residential care is not an active choice, but results from a combination of pressures, such as the onset of a crisis and the propensity of medical professionals to see residential care as the logical next step for older people (Stilwell and Kerslake 2004). Many older people may feel they lack alternatives. One small scale study found that as many as two thirds of older people who had recently entered residential care could have benefited from Extra Care (Stilwell and Kerslake 2004). Overall, an individual's ability to choose a care home appears to be undermined by confusion about entitlements, the absence of clear information and an insufficient range of options in the market. The funding system for long term care lacks transparency and many people regard it as unfair (Robinson and Banks 2005). Despite some improvements in recent years (such as the guarantee of free nursing care) the system remains confusing. The Government rejected the Royal Commission on Long Term Care's central recommendation that personal care should be free and there remains an inequitable and uncertain distinction between free nursing care and charged personal care. This means that a cancer patient receives free treatment, because they are deemed to have health needs, whereas a person with Alzheimer's is required to pay for their care (subject to a means test), because they are deemed to have social care needs (Brooks et al 2002).

In general, there is an absence of good information sources about care homes (OFT 2005). There is also some evidence to suggest that older people have been rushed into decisions on residential care in order to meet Government targets on delayed discharge (CSCI 2004). More fundamentally, it appears that older people have a limited ability to influence quality of care and insufficient income to purchase what they require. Due to block purchasing and a preference for in house services, older people are rarely given much choice of care home (Knapp et al 2005). This is despite the existence of the legal right to choose a residential or nursing home subject to suitability, availability and cost. A major

inquiry by the King's Fund found that older people had very limited choices and had a narrower range of options than younger disabled people over their care arrangements. In particular, people from black and minority ethnic communities had difficulty finding care homes that were sensitive to religious, cultural and social needs. The Inquiry also highlighted the continuing problem that a significant number of care homes were not meeting expected basic standards (Robinson and Banks 2005).

A related problem is the under-provision of Extra Care. It is likely that Extra Care will be an increasingly desirable choice for older people with moderate to high care needs. Research for the Extra Care charitable trust has suggested that Extra Care Homes result in healthier outcomes in comparison to traditional forms of care. The data suggests that people living in Extra Care have an average mobility improvement of more than 35%, a 20% improvement in daily living functions, 10% increase in sensory ability and 25% reduction in medication use. The Extra Care environment can also lead to improvements in mental wellbeing and perceived health status (Extra Care 2005). However, Extra Care is more expensive than residential care (Wanless Review Team 2005). In view of these benefits, it appears that current levels of provision are too low and will need to be expanded to allow older people this choice. The King's Fund Inquiry into care services has recommended an expansion of different kinds of housing, such as Extra Care. To address insufficient market capacity the Inquiry recommended that the Government should make available funds for capital investment in Extra Care and new care homes (Robinson and Banks 2005)[11].

Voice

In addition to extending choice to older people, it is important to ensure that older people are involved in the design and delivery of services. 'Voice' is a related form of service user empowerment, which ranges from complaint and redress procedures to user involvement in shaping public services. Various accounts have emphasised the importance of service user voice and it has been argued that user involvement must be heard at the point at which services are commissioned, regulated, inspected and monitored and not just at the point of supply (Policy Commission 2004).

Local communities should take a lead on ensuring participation of older people, as well as helping to develop a collective understanding of the standards society wants to promote for older people. The ADSS has recommended that local government should develop local indicators to measure older people's quality of life. These indicators should be recognisable, easily understood and owned by the whole community (ADSS and LGA 2003). Further to this, the Government has stated they will develop new incentives for local authorities to involve older people in local decision-making (DWP 2005). In developing these measures to improve civic engagement, there is a need to ensure that all policies are inclusive of all older people. This requires thinking about ways to reach hard to reach groups, involving older people's advocates and using multiple formats and languages.

Conclusion

There remains a gap between official policy and people's day to day experiences of using services and making choices. Direct payments have yet to realise their full potential for older people and many older people have an inadequate level of choice and control over their housing and care arrangements. In the NHS, there is some uncertainty about how choice will benefit people.

Ensuring greater choice and control over domiciliary care arrangements and housing arrangements can lead to better outcomes for older people and a greater sense of satisfaction and control. These types of choices help to support independent living and as such deserve to be widely supported. Involving older people in the design and delivery of services and in setting priorities for local services through local government will help to ensure that older people's preferences are heard and acted upon by policymakers.

[11] Between 2005-7 the Government made available £60 million additional resources for Extra Care housing (DH 2005c).

However, the evidence on the cost of extending choice is uncertain. For example, individual budgets have been billed as an option, which will either be cost-neutral or will lead to cost savings. However, there is no clear evidence on the costs of introducing greater choice on this scale or the costs of an effective brokerage service to enable people to take up choice to maximum effect. Secondly, enabling people to have greater choice over different housing options may also lead to cost pressures. The opportunity to choose Extra Care housing rather than residential care emphasises that there may be a conflict between the best outcomes and cheapest outcomes. Extra Care can lead to better outcomes than residential care, but these benefits are obtained at a higher cost. If the Government wants to guarantee greater choice for older people that supports better quality of life, this is likely to require making some difficult decisions about spending priorities.

4. Prevention

Everyone agrees with the old adage that prevention is better than cure. But in the context of health and social care policy, it has not been easy to put this simple idea into practice. With pressing demands on services, policymakers and local managers have found it difficult to divert limited resources to preventative interventions. This is partly because the potential benefits can be difficult to demonstrate and also because the national debate has focused overwhelmingly on hospitals and acute services (Harrabin et al 2003). In 2005, the Government stated an intention to shift the balance of services towards prevention in order to prevent or deter the need for more costly support (DH 2005a). However, it is not yet clear exactly what is meant by prevention or how far a preventative agenda will fulfil policy goals related to wellbeing.

Exploring prevention is helpful in order to re-balance the focus on individual choice. The White Paper on public health emphasises the role of individual choices, in that people want to make choices on their own health (DH 2004b). This helps to emphasise that choice is about more than one off episodes of care, but needs to be placed in the framework of broader lifestyle decisions. However, it is also important that the slogan of choice doesn't dominate our understanding of public health. Health status is determined by socio-economic factors and many of the choices older people want to make, whether it is deciding to do more exercise or choosing to stay in their own home, will be determined by the wider social environment and provision of services.

As this chapter discusses, policymakers need a broad understanding of prevention that takes into account the prevention of social problems, such as isolation and poor mental health, as well as physical health problems. This approach underlines the fact that preventative care is a shared enterprise that lies at the interface between health, social care and other public services.

Understanding prevention

Currently, most resources are focused on older people with the highest levels of needs. One of the results of the community care reforms in the 1990s was the shift of resources towards people with high levels of need, which is widely acknowledged has had the consequence of removing low level support (SEU 2004). On the one hand, this may represent a better use of resources on those most in need. On the other hand many people at high risk who could benefit from services are not receiving them (Wanless Review Team 2005). There is also some evidence that the targeting of services is poor and has excluded people with mental health problems and people from certain ethnic minority backgrounds (Knapp et al 2005).

The development of a preventative approach to older people's health and wellbeing should start with what older people value and an understanding about the changes that ageing brings. As the Older People's Steering Group at the Joseph Rowntree Foundation have written "old age is a constant (and at times quite rapid and radical) negotiation between losses, gains and quality of life" (JRF 2004). People's health and wellbeing can be threatened by the experience of retirement, bereavement and the onset of long term health problems. In general, people are motivated to preserve their independence. Surveys have shown that people's greatest fears of old age (apart from poor health) are loneliness, lack of money and having to depend on others (Mori 2005).

However, it would be helpful if there was greater clarity about how the Government understands prevention. Potentially, there are two ways of thinking about prevention: a 'medical model' of prevention and a 'social model' of prevention. The first model is concerned with preventing illness and admissions to secondary care and residential care. In contrast, a social model of prevention has broader aims, such as preventing isolation, social exclusion and promoting quality of life.

Yet while there is a relatively firm consensus on the importance of preventing ill health, there is less agreement on 'social prevention'. This can be seen in the debate around low level services. Low level services are defined as help with housework and home maintenance. The value that policymakers

attach to these services depends upon how prevention is understood. If a 'medical' definition of prevention is used, i.e. preventing the need for acute services, then the cost effectiveness of low level services is unclear, it is not certain that low level services reduce the need for downstream care (Wanless Review Team 2005). However, if we define prevention as preventing isolation and promoting quality of life the case for low level services is more persuasive. These services are widely valued by older people who see 'that little bit of help' as central to their confidence and general wellbeing (Clark et al 1998).

The different approaches to low level services can be seen in different government policy documents. The DWP observes "we believe that, in principle, there is a case for refocusing resources on preventative low level care over the long term… however, we need to understand the costs and benefits of a preventative approach more clearly" (DWP 2005). In contrast, the Social Exclusion Unit notes that "our consultation [on excluded older people] has shown overwhelmingly the importance that low level preventative services can have in improving the quality of life for excluded older people, and in preventing the need for high cost intensive care services" (SEU 2005a).

Policy developments in prevention

There has been a strong emphasis on preventing ill health among older people. Under the National Service Framework (NSF) for older people, there has been progress in preventing falls, promoting uptake of flu vaccinations and extending screening programmes (DH 2004). Initiatives such as the Healthy Communities Collaboratives (HCCs) also highlight the value of a preventative approach. The work of the HCCs show how one targeted intervention (preventing falls) can have numerous spin-off benefits, including improving quality of life and promoting 'full engagement' in their health among older people. Other outcomes from this programme include an impact on reducing age discrimination, increasing physical activity and reducing depression and isolation (National Primary Care Development 2005). However, there is still some way to go in fully realising a preventative approach for all older people. As the Government acknowledges, people continue to be sent to hospital in an emergency because the right care is not available (DWP 2005).

To date, there has been less emphasis on promoting mental health. Depression is one of the most prevalent conditions in later life, estimated to affect one million older people (SEU 2005). However, there is little evidence of a broad and inclusive approach to mental health and wellbeing in later life (Seymour and Gale 2005a, Audit Commission 2004b). Part of the answer lies partly in improving formal services, such as better diagnosis and treatment in primary care. However, also significant is the role of the wider community in developing a comprehensive strategy on older people's health and wellbeing, which embraces health promotion strategies, access to transport and opportunities for education and leisure (Godfrey and Denby 2004).

A development of potential significance is the introduction of a home visiting service for older people. The Government has announced an intention to introduce a comprehensive home visiting service, which will offer older people a care, benefit, fuel and housing check up (DWP 2005). The evidence available suggests this is a welcome development. One study shows that preventative home visits to older people can reduce mortality and admission to long-term care, as home visitors were able to identify a large number of previously unmet health and social care needs (Elkan et al 2001). In Sweden a pilot of a home visiting service showed that visits of one to two hours can help people maintain independence and improve self reported health and wellbeing (Hellner et al 2005). A similar UK home visit service should result in improvements in health, access to services and uptake in unclaimed benefits, and therefore increased spending.

At the time of writing, it is unclear exactly how prevention will evolve and whether a focus on prevention will bring about more low level support. But in considering the prospects for success for any preventative measures, it is important to be aware of the continuing effects of inequality and how this might affect targeting. It is well known that there is a stark variation in health status between different groups. According to the English Longitudinal Study on Ageing, a third of manual male workers aged 50-59 report a limiting long-standing illness; whereas rates for professional men remain

much lower than this until age 75 (Marmot et al 2005). Similarly, depression has a disproportionate effect on people with low incomes: people aged 60-74 on low incomes were at greater risk of experiencing common mental health problems (Mentality 2002). This suggests the need for more targeted interventions and health promotion activity at disadvantaged groups and people with long term illnesses. The development of NHS accredited 'health trainers', from 2006 should play a role in helping deliver health promotion and healthy lifestyles for disadvantaged groups (DH 2004b).

The principle of choice may be useful in developing some low level preventative services. Introducing greater choice and flexibility could help to develop niche services that meet specific needs. Again, the work of the Healthy Communities Collaboratives suggests how 'choosing prevention' might work. For example, in one case study, an older person devised a cooking scheme for elderly widowers as an alternative to the local authority 'meals on wheels' service. The 'Have Fun, Cook for One' scheme is a weekly course to teach widowers basic cooking and shopping skills. It was set up by an older volunteer who received training and now runs the courses. As well as helping to improve people's diets, the scheme has the added advantage of developing people's social networks (Henry and Knowles 2005). This example shows how introducing greater choice and flexibility in low level services can help services to become more responsive to particular needs. There needs to be further consideration of the mechanisms used to promote choice in low level preventative services as part of a wider strategy for older people's health and wellbeing.

The policy literature emphasises the importance of taking a strategic approach to older people. There are already a number of levers available, including Local Strategic Partnerships, Link Age, Care Trusts and opportunities for pooled budgets and lead commissioning under the Health Act 1999[12]. However, in practice integration between health and social care remains patchy and integration with transport, leisure and other services even more sporadic. The Government has indicated that they prefer not to force integration between health and social care, although "doing nothing will not be an option" (DH 2005a). This suggests that there needs to be a range of alternative models for commissioners to choose from. Care trusts offer one model, but local authorities could also experiment with older people's trusts, drawing on the example of children's trusts. The agenda for older people's health and wellbeing demands a more strategic approach and more joint commissioning between health and social care. Joint commissioning should help to bring together health promotion activity, opportunities for education, leisure and social participation, which would bring positive benefits to health. More joint commissioning is made possible by the re-configuration of primary care trusts, which will be re-drawn to ensure better relationships with local authorities (DH 2005b). It is important this opportunity is not missed.

Conclusion

To enable all older people to have genuine choice and control over health and care services, any choice policy must be underpinned by a health promoting NHS and the development of joined-up local strategies on older people's health and wellbeing.

There are many encouraging signs that prevention is moving up the health agenda for older people, including the National Service Framework, development of home visits and personal trainers (DH 2004a, DH 2005b). However there is still a long way to go before all older people are fully engaged in their health. In particular older people with disabilities and those living on low incomes are more likely to experience poor physical and mental health. The Government have aspirations to reverse the balance of services and focus on community wellbeing, rather than those in acute need (DH 2005a). One helpful step forward would be greater clarity about the scope and role of preventative services. In developing future preventative services, health and social care partners should also explore how to create services based on the preferences and involvement of the local older population.

[12] The Health Act 1999 introduced new freedoms and flexibilities across health and local authorities, such as pooled budgets, lead commissioning, integrated provision and a unified management structure.

5. Conclusions and Recommendations

People are living longer healthier lives and the signs are that this positive trend is set to continue. This has rightly been described as a revolution in longevity (Kirkwood 2001). However, while society has been successful in meeting the physical demands of ageing, it has been far less successful in meeting the social consequences of ageing, such as age discrimination, social exclusion and inequality (Dean 2004). This report has argued that a progressive agenda for choice could make a significant difference to the lives of older people and help contribute to alleviating the social problems of ageing. In essence, a progressive agenda for choice is concerned with the empowerment of the individual, allowing individuals to express their preferences and ensuring that these preferences are understood and acted upon by policymakers. However, this account recognises that choice is not a panacea. If choice is going contribute to people's quality of life, there needs to be support for people to make choices, especially for disadvantaged groups.

The Government's agenda for older people strongly emphasises independence, wellbeing and choice (DH 2005a, DWP 2005). This broad framework commands general support. As such, this shifts attention to how these policies will be implemented and achieved in practice. The rest of this report offers some recommendations on this subject.

Supporting individual choice

The ippr is supportive of the Government's plans to develop individual budgets. Individual budgets are likely to lead to better outcomes for older people ranging from improved satisfaction with services to improved health and wellbeing. It is important that these improved outcomes remain the driver of policy, rather than the potential for cost savings. It will also be critical to take the time to evaluate and learn lessons from the pilots.

However at this stage, without the benefit of the pilots, there are several areas where action will be necessary to make individual budgets work. In future, central and local government leaders need to find ways to promote change in some local authority social service departments and tackle cultures that constrain the development of extending choice. Getting into the mindset of responding to expressed preferences requires a cultural shift amongst providers and commissioners. More broadly, the success of extending choice for older people is also contingent on a culture change in how society thinks about ageing and the lives of older people.

There should be further consideration as to the function of the brokers or navigator, which appear to be critical to the success of the policy. Previously, ippr has recommended creating a role for a service navigator to help provide information, case management, advocacy and support for people with complex needs (Rankin and Regan 2004). This role also has relevance for supporting people with individual budgets. Specifically for older people, service navigators or brokers could support people to use individual budgets; for example, by providing information and advice on different options and supporting people in managing individual budgets, whether they choose a direct payment, brokered support or local authority services. Good practice suggests that an appropriately resourced support service and or support workers is an essential pre-requisite of a successful scheme (Hasler 2003, Clark et al 2004). The Government should consider introducing a statutory duty on local authorities to provide assistance to use individual budgets (although using the broker could be optional for service users). In developing a brokerage service, it will be important to avoid an overly rigid approach. Other health professionals, including GPs will continue to play a role in brokering information and advice about health.

It is important that the principles of choice and independence are not exclusive to people who live in their own homes. The Government's model (see figure 1) indicates that individual budgets can incorporate people's residential care budgets. However, for people in supported housing or residential care, other changes need to take place to ensure genuine choice and control. Various experts have recommended that the Government needs to ensure a mix of different housing options;

this entails building more Extra Care homes and more retirement communities. Local authorities and regional government can use planning powers to influence care and support for older people by offering developers the right incentives (Robinson and Banks 2005). Navigators and brokers would also be important in helping people make decisions about housing.

This report has discussed some of the differences in the ways choice has evolved in the NHS and in social care. To date, choice policy in the NHS has been primarily focused on choice of acute provider, whereas in social care the rationale for choice has been rooted in the empowerment of service users. In this sense, social care, with its person-centred approach to choice has something to teach the NHS, particularly in relation to primary care. A person-centred approach to choice offers a model for how choice might develop in primary care. For example, health and social care partnerships could give greater attention to developing preventative and health promotion services that are based on people's preferences for improving health. Greater choice in this area could help to meet the needs of particular groups, for example older people with special dietary requirements, or reduced mobility.

Promoting collective health

It seems plausible that individual budgets would develop the preventative aspect of older people's services. This is because those people who received individual budgets would have greater control over what the service provided: they can choose whether they want help with the housework, or assistance to get out and about. In the past, services have been criticised for adopting a 'minimalist conception of what was appropriate', by focusing on responding to the physical demands of ageing, rather than the psychological, emotional, social and cultural demands of ageing (Godfrey el al 2004). Individual budgets are an opportunity to resolve this problem by developing bespoke services which people can match to their needs.

However this does not address the issue of preventative services for people who are not entitled to receive individual budgets. It appears there is a case to re-balance the targeting of services, if social care is to meet the ambitions of a wider agenda for social inclusion and participation, rather than simply act as a safety net for those in acute need. If this requires more informal services (i.e. voluntary care) there needs to be a more strategic approach to drawing on the resources of the community. If this requires an extension of formal services, there would need to be further investigation into how this would be paid for. In either case, there should be a re-evaluation of the relationship between social care and the NHS to ensure a fair division of costs.

Prevention and health promotion lies at the interface between health and social care. The policy literature emphasises the importance of taking a strategic approach to older people. There are already a number of levers available, however it is widely considered that many mechanisms, such as including Local Strategic Partnerships have yet to reach their potential (DH 2005c). It is important that the opportunity to strengthen joint commissioning is not lost amidst another re-organisation of the NHS.

A fair settlement

There is a need for greater openness and transparency about the resources which are available to older people. The ageing population and growing demand for services makes it even more necessary to plan ahead for the rise in demand. There needs to be greater clarity and certainty about how the Government will achieve an ambitious agenda for older people. This entails revisiting the question of the resources available for long-term care and social care and involving the public in determining priorities.

The current arrangements for long-term care are unsatisfactory and are contrary to choice and fairness. The ippr has recommended that the Government introduces free personal care in order to end the confusing and inequitable distinction between the diseases of acute healthcare and the diseases of long term care. The additional cost of free personal care would be between 0.2 - 0.45% of GDP. This is a significant sum, but is affordable and could be paid for by progressive changes to the

tax system, such as abolishing equity based Individual Savings Accounts, reducing the value of age related allowances and aligning the upper limit of National Insurance Contributions to the higher rate of income tax (Brooks et al 2002).

There also needs to be greater certainty about the availability of domiciliary care. In 2006, the Wanless Review Team at the King's Fund will publish a report on how to pay for social care and the implications for delivery and resources. This should promote understanding of the costs of social care and how they relate to the NHS. However ultimately, it rests on government and society to reach a collective decision as to what kind of social care services society wants to deliver (and pay for): whether social care is organised to prevent admission to hospital or residential care, or whether it will be organised to promote health, quality of life and well-being. The Wanless Review Team have concluded that the evidence base for prevention is insufficient and it is unclear how much resources could be targeted at lower need groups to achieve prevention benefits (Wanless Review Team 2005). However, other accounts emphasise the role of low level services in preserving older people's wellbeing (Clark et al 2004, SEU 2005a).

A mature policy on choice?

All of this has taken us far from the starting point of individual choice. However, this is to emphasise that choice needs to be placed in context of the wider outcomes society wants to achieve for older people. This paper has argued that a progressive account of choice, understood in the context of control and empowerment has a very important role to play in improving public services and quality of life for older people. A progressive account of choice helps to re-balance the debate on choice, which has been largely focused on the merits and risks of introducing greater contestability in the NHS.

It is important that empowerment and quality of life remain at heart of any policy on choice. Extending choice in any area brings no guarantee of cost savings. To maximise the potential of individual budgets there should be brokerage and support services available to all older people who are eligible to receive an individual budget. Responding to people's preference to live in their own home may require extra funding, for example to develop Extra Care, which is a more expensive arrangement than residential care.

However, ensuring any type of choice is only possible when the basic foundations to promote older people's health and wellbeing are in place. This includes promoting a new collective understanding of ageing, where age 65 no longer means people's ability to make choices is ignored.

Appendix 1

Older People's Health and Choices Seminar Thursday 8th September 2005

Attendee list

Neil Carmichael	Strategic Impact
Jane Cass	Social Care Institute for Excellence
John Chapman	Bevan Brittan
Gillian Crosby	Centre for Policy on Ageing
Neil Crowther	Disability Rights Commission
Vanessa Davey	LSE
Leonie Dawson	Chartered Society of Physiotherapy
Carolyn Denne	Commission for Social Care Inspection
Michael Dixon	NHS Alliance
Rekha Elaswarapu	Healthcare Commission
Jonathan Ellis	Help the Aged
Julian Forder	London School of Economics
Linda Henry	National Primary Care Development Team
Andrew Isaac	Sodexho Healthcare Services
Martin Knapp	London School of Economics
John Knox	British Medical Association
Paul Maltby	Prime Minister's Strategy Unit
Catriona Moore	Long Term Medical Conditions Alliance
Andy Nash	Department of Health
Luke O'Shea	Social Exclusion Unit
Jenny Owen	Commission for Social Care Inspection – Eastern Division
Mary Parkinson	National Pensioners Convention
Ian Philp	Department of Health
Jean Sapeta	Bevan Brittan
Eddie Sherwood	Sheffield Social Services
Phil Taylor	GP
Jessica Allen	ippr
John Cannings	ippr
Joe Farrington Douglas	ippr
Jennifer Rankin	ippr

References

- ADSS/LGA (2002) *All Our Tomorrows:* Association of Directors of Social Services and Local Government Association
- Audit Commission (2004a) *Choice and Public Services:* Audit Commission
- Audit Commission (2004b) Older People – Independence and Wellbeing: Audit Commission
- Audit Commission (2005c) Managing the Financial Implications of NICE Guidance: Audit Commission
- Barnes et al (1999) *Unequal partners: user groups and community care*: Policy Press.
- Best R (2003) 'Meeting the growing demand for long term care' in *Tackling UK Poverty and Disadvantage in the Twenty First Century:* Joseph Rowntree Foundation
- Brooks R, Regan S and Robinson P (2002) A New Contract for Retirement: ippr
- Carr S (2004) Has Service User Participation Made a Difference to Social Care Services? Social Care Institute for Excellence
- Clark H, Gough H and Macfarlane A (2004) *It Pays Dividends: Direct Payments and Older People:* Joseph Rowntree Foundation and Policy Press.
- Clark H, Spafford J (2001) Piloting Choice and Control for Older People – An Evaluation: Policy Press
- Clark H, Dyer S, Horwood J (1998) The Importance of 'Low Level' Preventative Services to Older People: Joseph Rowntree Foundation
- CSCI (2005) Response to Independence, Wellbeing and Choice: Commission for Social Care Inspection
- CSCI (2004) What People Want from Social Care Services and Inspections as They Get Older: Commission for Social Care Inspection?
- Dean M (2004) Growing Older in the 21st Century: ESRC
- Department of Health (2005a) Independence, Wellbeing and Choice: DH
- Department of Health (2005b) Commissioning a Patient Led NHS: DH
- Department of Health (2005c) Responses to the consultation on adult social care in England, analysis of feedback from the Green Paper, 'Independence, Wellbeing and Choice' : DH
- Department of Health (2004a) *Better Health in Old Age:* DH
- Department of Health (2004b) *Choosing Health*: DH
- Department for Work and Pensions (2005) *Opportunity Age:* DWP
- Elkan R, Kendrick D, Dewey M, Hewitt M, Robinson J, Blair M, Williams D, Brummell K, and Egger M (2001) 'Effectiveness of Homes Based Support for Older People: Systematic Review and Meta Analysis' *British Medical Journal* 323
- Extra Care Charitable Trust (2005) http://www.extracare.org.uk/pages/aboutus/better.htm. Accessed on September 15th 2005
- Farrington Douglas, J and Allen J (2005) Equitable Choices: ippr
- Fernandez J et al (2005) Direct Payments in England: Factors Related to Variations in Local Provision: MS, accepted for publication in Journal of Social Policy 2007.
- Glasby J and Littlechild R (2002) Direct Payments and Social Work: Policy Press
- Glasby J and Littlechild R (2004) The Health and Social Care Divide and the Experiences of Older People: Policy Press
- Glendinning C , Halliwell S, Jacobs S, Rummery K, Tyrer J (2000) *Buying Independence: Using Direct Payments to Integrate Health and Social Services:* Policy Press
- Godfrey, M. , Denby, T. (2004) *Depression and Older People:* Help the Aged and Policy Press.
- Godfrey M, Townsend J and Denby T (2004) *Building a Good Life for Older People in Local Communities:* Joseph Rowntree Foundation
- Harrabin R, Coote A, Allen J (2004) *Health in the News* : The King's Fund
- Hasler F (2003) *Clarifying the Evidence on Direct Payments into Practice:* National Centre for Independent Living.
- Hellner B, Sahlen K and Stig K (2005) *Preventative Home Visits – A Strategy for Better Ageing* National Board of Health and Welfare, Sweden www.socialstyrelsen.se

- Help the Aged (2003) Fair for All, Personal to You: Choice, Responsiveness and Equity in the NHS and Social Care : The Help the Aged Response, London.
- Henry L, Knowles J (2005) Opening Doors to more Healthy Communities: The Healthy Communities Collaborative – UK, Widening Access to a Healthy Diet in Low Income Groups: National Primary Care Development Team (NPDT), Manchester NHS.
- JRF (2004) *Older People Shaping Policy and Practice:* Older People's Steering Group at the Joseph Rowntree Foundation
- Kirkwood T (2001) *The End of Age – 2001 Reith Lectures* www.bbc.co.uk/radio4/reith2001
- Knapp M, Fernandez J, Kendall J, Beecham J, Northey S, Richardson A (2005) *Developing Social Care: the Current Position* Social Care Institute for Excellence
- Labour Party (2001) *Ambitions for Britain, the Labour Party Manifesto 2001* : www.labour.org.uk
- Levenson R, Jeyasingham M and Joule N (2005) *Looking Forward to Care in Old Age*: The King's Fund
- Laing W (2005) Trends in the London Care Market: 1994-2024: The King's Fund
- Lundsgaard J (2005) Consumer Direction and Choice in Long-Term Care for Older Persons, Including Payments for Informal Care: OECD Health Working Papers No. 20, Directorate for Employment, Labour and Social Affairs
- Malley J, Wittenberg R, Comas-Herrera A, Pickard L, King D. (2005) Long-term Care Expenditure for Older People, Projections to 2022 for Great Britain, report to ippr: PSSRU Discussion paper 252: London School of Economics.
- Marmot M, Banks J, Blundell R, Lessof C, Nazroo J, (eds) (2002) Health, Wealth and Lifestyles of the Older Population in England – the 2002 English Longitudinal Study on Ageing : Institute for Fiscal Studies
- Mentality (2002) Mental Health Improvement: What Works. A Briefing for the Scottish Executive: Scottish Executive and Mentality.
- Mori (2005) *Attitudes to Growing Older* : 10th February 2005 www.mori.com/polls
- Mori (2004) *The Impact on Public Expectation:* 13th August 2004 www.mori.com/pubinfo
- National Primary Care Development Team (2005) *National Primary Care Development Team, an Introduction*: Available at http://www.npdt.org/scripts/default.asp?site_id=1
- Netten A, Darton R, Davey V, Kendall J, Knapp M, Williams J, Fernandez J, Forder J (2005) *Understanding Public Services and Markets.* PSSRU Discussion Paper 2123/2
- Office of Fair Trading (OFT) (2005) *Care Homes for Older People in the UK- a Market Study:* OFT
- Pearce N, Paxton W (2005) *Social Justice:* ippr
- Policy Commission on Public Services (2004) *Making Public Services Personal: A New Compact for Public Services:* National Consumer Council
- Rankin J, Regan S (2004) *Meeting Complex Needs: the Future of Social Care:* ippr and Turning Point
- Rickaysen B (2005) Note on CASS Projections of Trends in Healthy Life Expectancy: CASS Business School
- Robinson J and Banks P (2005) *The Business of Caring* King's Fund
- Schoen, C., Osborn, R., Huynh, P., Doty, M., Davis, K., Zapert, K. and Peugh, J. (2004) "Primary Care and Health System Performance: Adults' Experiences in Five Countries" *Health Affairs* Web Exclusive.
- Schwartz B (2004) The Paradox of Choice: Why less is More: Harper Collins.
- Seymour L and Gale E (2004) Literature and Policy Review for the Joint Inquiry into Mental Health and Wellbeing in Later Life Mentality and Age Concern
- Social Exclusion Unit (2005a) Excluded Older People Interim Report: ODPM
- Social Exclusion Unit (2005b) Multiple Exclusion and Quality of Life Amongst Excluded Older People in Disadvantaged Neighbourhoods: ODPM
- Social Exclusion Unit (2004) *The Impact of Government Policy on Social Exclusion among Older People:* ODPM
- Stainton T (2002) 'Taking Rights Structurally: Disability, Rights and Social Work Responses to Direct Payments', *British Journal of Social Work* 32, 6
- Stilwell P, Kerslake A (2004) 'What Makes Older People Choose Residential Care and are there Alternatives', *Housing, Care and Support* December 2004
- Strategy Unit (2005) Improving the Life Chances of Disabled People: HMSO

- Wanless Review Team (2005) Social Care Needs and Outcomes: The King's Fund
- Wanless D (2002) Securing our Future Health – Taking a Long Term View: HM Treasury
- Which (2005) Which Choice? : Which
- WHO (2002) *Active Ageing: A Policy Framework:* World Health Organisation

Other recent health policy titles from ippr:

Equitable Choices for Health
Author: Joe Farrington-Douglas and Jessica Allen
Price: £9.95 from Central Books
Published16 November 2005

Mental Health in the Mainstream
Author: Jennifer Rankin
Published: 13 June 2005
Price: £9.95 from Central Books

Fit for Purpose: the reform of incapacity benefit
Author: Kate Stanley with Dominic Maxwell
Published: 06 December 2004
Price: £5.95 from Central Books

Who Cares? Building the Social Care Workforce
Author: Deborah Roche and Jennifer Rankin
Published: 29 October 2004
Price: Free at www.ippr.org

Meeting Complex Needs: the future of social care
Author: Jennifer Rankin and Sue Regan
Published: 03 March 2004
Price: £9.95 from Central Books

orders to:

Central Books, 99 Wallis Road, London E9 5LN
t: 0845 458 9910, f: 0845 458 9912

friends of ippr

Public sector employees can receive all of ippr's reports and invitations to ippr events from just £49 per year by joining the *friends of ippr* scheme. Call (0207) 470 6123.