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Who cares: who pays?

A report on personalisation in social care prepared for UNISON

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March 2010***

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Foreword

Personalisation in social care is a development affecting UNISON members across the UK – as members of the social care workforce, members of the public, family members, carers and service users.

UNISON fully supports the principles of personalisation. Everyone should have as much independence and control over their own care and support as is right for them.

But we fear that the current funding gap in social care means that this policy could over-promise and under-deliver.

This report, commissioned by UNISON from Professor Land and Professor Himmelweit, offers a timely social and economic analysis of the tension between personalisation policies and an ongoing drive by governments for cost containment in social care provision.

The report highlights the false economies and shifting political sands that underlie some of the policy making around personalisation. And it also makes the case for a sea change in how society values predominantly women's work in social care – both paid and unpaid.

I am confident that this report will make an invaluable contribution to the debate as well as offering up some practical alternatives from other countries' experiences. In particular it is heartening to see that where the political will is there, more personalised care and support can be delivered without casualising the workforce, undermining the rights of care workers, or over-burdening service users and their families.

Dave Prentis
UNISON general secretary

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Introduction

“The task of carers is not prized by society, despite it being the most dignified of all”

(A carer quoted in Green Paper, Shaping the Future of Care Together, 2009 p11)

Social care is in the news again. There is widespread recognition that the current system of social care provision is unsustainable. As in other areas of health and welfare services, a concern to increase choice while securing value for money, has led to a view, shared by government and opposition alike, that ‘personalisation’ will solve many of the problems of the current system of social care and render it sustainable. This report examines this argument.

The current sense of urgency driving social care up the policy agenda in the UK and many other countries is fuelled in part by what is often described as a demographic ‘time bomb’. On the one hand an ageing population will increase the need for and cost of social care. On the other, we will have relatively fewer working age adults and this will reduce the capacity of families to care, as well as shrink the traditional sources of labour on which the social care workforce has depended. In addition there is increasing dissatisfaction with:

- the current allocation of the costs of social care between those needing care, their families and the state
- the rising costs of social care and particularly of residential care, as labour costs increase
- the distribution of public funds for social care, which is not only inadequate but appears to be distributed unfairly between and within local authorities in different parts of the country
- the quality of care available across the whole social care sector, raising important issues about the pay and conditions of the social care workforce
- the lack of coordination between

social care and health care made worse by a distinction between the two which often seems arbitrary; with costs passing from health to social care and on to the individuals needing care, their carers and their families

- increasing pressures on informal carers, who are now more likely to be trying to combine caring with paid employment while being expected to carry more responsibility as funding fails to reach all but the most frail or disabled.

These are not new issues. Many of the challenges facing us today are woven into the history of care services for adults needing care because of illness, disability or the frailties of old age. Demographic forecasts have always been an important part of the context within which these services have developed. Cost-containment has never ceased to be an important policy goal. In the current gloomy economic climate and faced with imminent cuts in public expenditure at both local and central government levels, the public funds available for social care are likely to be restricted and the costs of care will fall more heavily on those who need these services and those who care for them. This, as we argue in this report, coincides with the necessity to increase expenditure on care just to maintain current standards and address current levels of need.

Social care services have been on the margins of the welfare state for a long time, not least because of ambivalence among the public and the policy makers about how formal and informal care should be combined. In comparison with health

care, which remains free at the point of use and provided on the basis of needs through a national system funded from general taxation, the commitment to social care as a public service is much weaker. Social care services remain means-tested services, the responsibility of local authorities, provided primarily when the family does not. Concerns that the availability of publicly funded care services or payments for care would undermine incentives for families to provide care have shaped policy, although the extent of informal care (by women in particular) has always dwarfed that provided in the formal sector. Perhaps because of an assumption that it should ideally be provided 'free' by a female family member, care and the care workforce have always been under-valued.

However, there have been some important changes, particularly in the past 20 years:

- with rising costs of care and increasing employment rates among women, including older women, the distribution of these costs (in both time and money) both between the generations, and between men and women, and the role of the state in determining this distribution have become increasingly contentious issues
- the boundaries between health care and social care have been redefined and drawn ever more tightly, changing the resources available for social care, increasing demands on the social care workforce and raising expectations of individual and family responsibility
- resources from the social security budget in the form of cash benefits in recognition of the costs of disability, chronic illness and frailty have been expanded on the one hand, but some have been transferred to local authority budgets to become means-tested on the other
- an increasing proportion of first residential care and then domiciliary services are provided through the market by private contractors
- devolution within the UK has resulted

in social care policies developing differently in some respects in the four countries which make up the UK. For example, all have introduced direct payments but only local authorities in England offer personal budgets. The key differences are discussed in the report.

There have been also shifts in influence on policy on social care:

- people with physical disabilities, mental illness or special learning needs are no longer confined in large institutions and now expect to live fully in the community. They have become more visible and vocal in the policy debates
- the role of informal family carers, who - if female - are now far more likely to be in paid employment than their mothers were, can no longer be taken for granted. Older men are more likely to be carers in their later years than their fathers were. Increasing recognition of the scale of the care family and friends provide has also given them a stronger voice
- there has been a purposeful shift in influence on the development of formal social care policies towards those who use the services, and to a lesser extent their informal carers, and away from those who directly provide them.

Nevertheless, although the implications are rarely explicitly acknowledged, there has been a constant theme running throughout debates on social care policy, both past and present, which concerns the very nature of care. Good care depends on the quality of the relationship between the giver and receiver of care. This is so whether care is provided within the family, by a friend or volunteer, or by a member of the paid workforce.

Relationships based on trust take time to build and sustain. Managing the tension between a relationship based on contract

and one based on affect is difficult whether it takes place in the public or the private sector. The success or failure of any social care policy must ultimately rest on the acknowledgment that unlike in many other parts of the modern economy, there is an irreducible time component to good care. This is true whether that care is provided 'free' by informal carers or by waged workers paid by the state, by private sector care providers or directly by those needing care or their families. In an economy in which nearly everything else can be produced faster than ever before, this means that the opportunity costs of providing the time that good care requires rises. A society that wants its older and disabled people well looked after needs to devote the necessary resources to it, and the opportunity costs of those resources inevitably rise. This too needs to be acknowledged.

However the rising opportunity cost of the time that care takes is a result of society becoming richer not poorer. Claims that as a society we can no longer afford the costs of care are nonsensical. If these costs could be afforded in the past, when GDP and standards of living were lower, they can be afforded now. We may have to devote a larger proportion of current resources to them, but those resources themselves are far larger, so that to do so still leaves everyone with more disposable income. The decision about what proportion of overall national resources to devote to funding care is a political one, and one that reflects the importance a country puts on the well-being of its most vulnerable citizens. To say that providing good care is no longer affordable is not only absurd, it fails to confront that political truth.

The development of care services: a historical perspective

The current debate about personalisation can be understood more fully when it is placed in a historical context. This shows that some of the dilemmas and problems confronting policy makers, practitioners, care workers and families today are longstanding. For example, the boundaries between health and social care services have always been contentious, not least because in the UK responsibilities for funding and delivering them have always been different. Minimising the use of residential care has been a policy objective throughout the post-war years. History also shows that when local authorities provided domiciliary services directly in the form of the home-help service it was popular among those who used the service and most home helps were sensitive to the needs and wishes of their clients. 'One size fits all' is not an accurate description of the domiciliary care service before it was privatised. The relationship between the person needing care and the person providing it is a key determinant of high quality, safe care and today it is important to understand under what conditions personalisation fosters and sustains good relationships.

Post-war developments

In 1948 the responsibility to provide residential care for those needing it was given to the new local authority health and welfare departments. In the decades following the second world war, the majority of elderly residents continued to be poor and disproportionately those who had never married or had no (or no surviving) children (Townsend 1962).

Local authorities at that time had no statutory duty to develop domiciliary services to help disabled, chronically ill or older people in their own homes.

During the second world war when, to the surprise of the policy makers, the conscription of single women left large numbers of chronically sick and frail elderly people needing support at home, local authorities were encouraged to develop services to help them. They continued to do so after the war and in 1967 there were over 62,000 home helps in England and Wales visiting nearly a quarter of a million households (Hunt, 1970 p3). These services were means-tested and also allocated disproportionately to those who had no children, daughters or daughters-in-law in particular, either living nearby or with them (Hunt 1970, Land and Parker, 1977). It was very clear that the state only stepped in when family failed.

The 1970s: a changing relationship between domiciliary and residential care

The Seebohm review of social services in 1968 led to a major shake-up of social care administration, with social services departments created from the former children's and health and welfare departments in 1971 (Parker, 1990). Although domiciliary services were nearly left out of the review, they now became a statutory service included in the new social services departments for the first time. In order to meet the unmet needs of current recipients of the home-help service and to provide a service to those eligible but not receiving it, it was estimated that the size of the service would need to be doubled or trebled (Hunt, 1970 p25).

Domiciliary care was seen as preferable to residential care, not only because it was less stigmatising but also because the running costs of residential homes were set to increase, as many of the

unmarried women who accounted for the majority (two thirds) of their staff would soon be retiring (Williams, 1967). Except in the smallest homes owned and run by a married couple, the residential care sector would have to adjust to the higher costs of increased staff turnover, part-time employment and shift working of non-residential staff who, like home helps, wanted working hours which fitted in with their family responsibilities. As Parker later wrote: "The residential home can no longer rely on the availability of single women; squeezed out of the housing market by their status and ready to dedicate a lifetime's work to the care of others" (Parker, 1988, p7). This historical comparison is of interest today when, from the point of view of the residential care provider or the person needing a live-in carer, migrant workers (see Canganio et al 2009, Gordolan and Lalani, 2009) replicate some of these cost-saving 'virtues' of the single woman in the past. Similarly, migrant workers may not always be so available.

The pay of home helps was low, because, as now, little value was placed on the skills required for care work. Not only was it women's work but it was work done everyday in the home and therefore the skills and experience required to be a good home help were taken for granted. Many of the home-help organisers thought that the service was neglected in comparison with other services and that it had "...a status lower than is commensurate with the duties it undertakes" (Hunt, 1970 p352). The Williams committee, reporting in 1967, took a similar view of employment conditions in the residential care sector: "Unfortunately there has not been in the community as a whole a general recognition of the importance of the work, nor of the knowledge and skill required to do it well. Too many people have assumed that this is the kind of work that can be done by any reasonably kind person" (Williams, 1967).

Care in the community

The economic and political context in which social care policies developed changed substantially in the following decades. Following the economic crises of 1974 and 1976, capital spending on local authority residential homes was stopped and hospital development cut back. Community care, including residential care (see DHSS, *The Way Forward*, 1977), was seen not only as a way of keeping people out of expensive hospital beds but also of returning them more quickly from long-stay hospitals and geriatric wards. The average length of stay in geriatric wards fell by half between 1975 and 1985 (Parker 1990b, p20).

The home-help service did not keep pace with the growing numbers of people aged over 75 years (Parker, 1988) and home-help organisers tended to spread their home helps across as many clients as possible, with the very old or housebound or those living alone most likely to receive help. The service remained very popular with clients, and effective in providing them with the practical help they needed (Sinclair and Williams, 1990, p167). In particular the home help service was:

- a 'lifeline' for their clients with severe disabilities who believed they could not stay in the community without their help
- valued by carers looking after confused elderly relatives by relieving them of some of the physical work of caring, providing general support and company and enabling them to get out
- there was also evidence that receipt of the service improved the mental health of carers looking after relatives with dementia. Male carers particularly appreciated home helps, perhaps because they belonged to a generation of men who, compared with men today, were less involved in domestic matters. The involvement of a home help reduced the likelihood of

the person for whom they were caring being admitted to residential care.

Criticisms of the service (ibid p168) included that:

- there were large inequalities in levels of provision between local authorities
- the service was spread too thinly
- there was a lack of flexibility in the tasks the home help would do
- insufficient attention was paid to rehabilitation and encouraging clients to do things for themselves
- contact and co-ordination with other services was lacking.

These are familiar criticisms and addressing them has continued to be a challenge for all concerned. Collaboration in general between health and social care in the community was difficult, requiring work across geographical boundaries some of which, since the 1974 reorganisation of the NHS, did not coincide. As Derek Wanless, reflecting on the 1970s, wrote: "Attempts to improve the coherence of health services were arguably at the price of creating further barriers, gaps and overlaps with local authority social services" (Wanless 2006, p12).

Co-ordination between services also involved negotiations with different professional groups not made easier by tight budgets in competition for ever scarcer resources. Where costs could be shifted from one budget to another they were, usually to the detriment of social care services.

The road to the market

The cuts in expenditure on public social services in the 1970s were further entrenched by the Conservative government in the 1980s. There was a commitment to roll back the state and encourage community care, meaning care by family and friends, together with the voluntary sector and the wider community.

However, a change in the board-and-lodgings rules within the means-tested social assistance system unintentionally fuelled an explosion of the private residential and nursing home care sector, undermining the intended reduction in elderly people relying on residential care (Parker, 1990b Land, 1988). Because central government picked up the bill, local authorities had a strong incentive to place older people or younger disabled people needing care in a voluntary or private residential care home, rather than either placing them in one of their own homes or offering them domiciliary services.

The availability of affordable residential care meant for the first time older people could choose not to rely on limited domiciliary services, although a number of research studies suggested that often the choice was made by their families rather than the older person themselves. Residential care places increased from 39,000 to 93,000 with the annual cost to the DHSS rising from £10 million in 1980 to £1 billion in 1989 (Parker, 1990b). Between a quarter and two thirds of older patients discharged from hospital went straight into residential care (Parker, 1990a. p20) with health authorities also taking the opportunity to close long-stay hospitals, particularly for people with learning disabilities, knowing that by transferring patients to private and voluntary care homes the social security system would pay their fees (Glennister and Korman et al, 1989). By the end of the decade two thirds of these residential care places were found in the private sector.

Meanwhile, consistent with the preference for care in the community and the savings that entailed, the home-help service was re-designated the 'home-care' service and the scope of what it did was expanded although it was to reach fewer people. The nationally negotiated job description for home carers stated that in addition to domestic tasks their duties included: "...physical tasks approximating to home care (including dressing, washing and feeding clients), and social duties (including talking with clients, helping clients maintain contact with family, friends and community, assisting with shopping and recreation), aimed at creating a supportive, homely, atmosphere where clients can achieve maximum independence." (Sinclair and Williams 1990, p164)

This job description and its more holistic aim bear a close resemblance to those the disability movement and others have been campaigning for today.

However in many local authorities, the opportunity to expand the home care service in the direction envisaged was not taken for the following reasons:

- the organisational structures within most local authorities, which were needed to effect such a change, were lacking
- the remaining difficulties of joint planning and co-ordination between health and social services, already mentioned, had not been overcome
- there was little room made for participative planning involving what would now be called user groups or stakeholders
- more resources were not forthcoming and home-care organisers had little opportunity to influence the allocation of existing resources
- the new home-care service involved the concentration of services on fewer people, so it became less popular and had less political influence than if it

had been more widely available and appreciated.

As a result, despite the pressure on them to do so, local authority home-care services did not expand to provide a more intensive service for those with the greatest needs in order to support them longer in the community. But nor did a market of private-sector providers spontaneously develop in the way in which board-and-lodging payments had created a market for residential care. In theory, it should have done so; based on the Exceptional Circumstances Allowance (ECA) introduced in the mid-sixties for supplementary benefit claimants who were paying for domestic help provided either by a local authority or a private arrangement. Most private arrangements would have involved the claimant becoming the employer, as few agencies existed at this time. The payment covered the wages paid (provided these were 'reasonable') plus the employer's national insurance contribution. In rare cases the ECA could be used to pay for permanent live-in help.¹ The ECA was never available to pay for domestic help provided by relatives, although it could be used to pay expenses incurred by them (for example, for travel). Perhaps more people would have claimed if they had known about the allowance; its availability was not publicised by the campaign groups representing older people or people with disabilities.

¹ They could receive a maximum of twice the ordinary scale rate for non-householders in 1980 - up to £34 weekly. It was assumed they lived rent-free and only half the allowance received was needed to cover their maintenance (DHSS, 1980 p47)

From 1980, the payment was limited to those paying for private domestic help, but a formal market in domestic help and care barely existed. At most only 16,000 annually claimed this ECA. Roy Parker estimated that there were no more than 300 commercial agencies operating in the mid-1980s, employing at most 4,000 mainly part-time staff and assisting up to 60,000 households. This represented 7% of households who privately employed domestic help (Parker, 1990, p321)². Writing in 1990, reflecting on the previous decade, he concluded: "... the prevailing character of private domestic help sector was (and is) not such that the availability of a subsidy would serve to stimulate either its growth or its transformation into a number of formally organized enterprises. This amongst other things makes it exceedingly difficult for local authorities to consider providing all or part of their home-help service by purchase from the private sector." (Parker, 1990a, p325). After 1993, local authorities had no choice but to do so.

From providers to managers of care: a challenge for local authority social services

Determined to put an end to the costly and 'perverse' incentives in favour of using residential care, the government transferred the budget for residential care from the central social security budget to local authorities. The budget was only ring-fenced initially. It thus ended the system whereby older people could enter residential care funded by the state with only a means-test, but without any assessment of their need to do so or whether their needs could be met by cheaper domiciliary care.

In order to sustain and develop the private sector in residential care and push domiciliary care into the formal market, local authorities now had to spend 80% of their social care budget in the private and voluntary sectors. At the beginning of the 1990s local authorities' own home-help/care services were providing over 90% of the publicly funded domiciliary care hours. By 2008 in England this had fallen to a little over a quarter.

This move to impose private and voluntary sector provision was justified by the belief, held by the Conservative government of the day and the subsequent New Labour government, that provision for a market is the best way of ensuring good quality and value for money. Public provision, according to this view, because it is not subject to competition in the market tends to be inefficient and poor value for money. If those who purchase services have a choice of providers they will choose those that produce the best quality for the money that they spend. The most efficient providers will therefore win custom and expand. Less efficient providers will have to improve the quality of what they provide or reduce their costs if they are to survive. Through such processes of adjustment, overall efficiency will improve, raising quality and/or cutting costs.

² Roy Parker, using the 1986 Family Expenditure Survey figures had estimated that over a million retired households (16%) purchased domestic help. This included 350,000 dependent on state pensions and 735,000 of those with additional sources of income (Parker, 1990a, p317). At this time there were 123,000 home helps in England and Wales assisting 475,000 elderly people (three quarters aged 75 or more) (ibid, p318). Including Scotland, the number was about 600,000 (ibid, p322).

These were the changes that paved the way for the later introduction of 'personalisation' and direct payments. The first step on this road was for local authorities to become managers rather than being providers of social services. As a result they were responsible for co-ordinating the market where necessary and – through exercising choice on behalf of their clients – for safeguarding standards and ensuring value for money. Every person in need of social care would have a case manager to assess their needs and arrange the necessary combination of services.

The move to community care was also fuelled by a determination on the part of central government to keep both older people and younger people with chronic illness or disability out of expensive residential or hospital care. As a result

the boundaries between health care and what has now become social care were drawn ever tighter. In 1995, an estimated 610,000 people in the UK received home-care services and 530,000 were visited by community nursing services (Royal Commission on Long Term Care, 1999, p9). This compares with 1980 when in the UK, district nurses were visiting over a million households, three times as many as visited by home helps (Social Trends, 1980). Home carers now did on a means-tested basis what district nurses did without charge as part of the NHS in the past, and gradually domestic work effectively dropped off their job description. "Home care won't clean...it's not allowed" (Home care recipient Commission of the Social Care Inspectorate (CSCI) 2006, p36).

Current developments

The shift from residential to domiciliary care

The Royal Commission on Long Term Care proposed in 1999 that 'personal care', that is care which involves touching the body, should be provided free on a similar basis to health care. This was introduced in Scotland and the Welsh Assembly is also committed to introducing free personal care, should it have the resources to do so. In England, personal care continues to be means-tested, whether provided in residential or domiciliary services. Local authority social care budgets have not kept pace with costs. Indeed local authorities in England have had to make 3% annual efficiency savings for each of the past few years and are expected to do until at least 2011 (Letter from the Department of Health to Association of Directors of Adult Social Services and Local Government Association leaders, Sept 2009). As a result, in most local authorities, only those with the most severe or critical needs now receive this means-tested support, and its reach may become even more restricted.

The policy, adopted in the early 1990s, of targeting the home-care service at the most dependent people, means that those receiving home care funded by local authorities are now far more likely to have complex needs and higher levels of dependency than in the past. In England and Wales between 1990 and 2005, although the total number of contact hours increased substantially, from an average of 3 to over 10 hours per week per household (the threshold for defining 'intensive care'), the numbers of households receiving such care fell in the same period by a quarter, to 395,000 (Commission of the Social Care Inspectorate (CSCI), 2007, p.20). The numbers have continued to fall (CSCI, 2009) and those with straightforward and modest needs are now very unlikely to receive services arranged by their local authority.

The announcement that, from October 2010, personal care in England would be free for the most dependent people living in their own homes irrespective of means, is consistent with the policy of keeping people in the community as long as possible. "The key aim of the policy... is to enable, support and encourage more people to avoid or delay entering residential care" (Personal Care at Home bill, explanatory notes, para 23, 25 November 2009). It is estimated that about 280,000 older people in England would qualify and get on average 6.5 hours of free personal care a week (Impact assessment of Personal Care at Home bill p16, 25 November 25). Those living in residential homes will not qualify and neither will those with an informal carer who is receiving support, such as a direct payment or a service under section 2 of the Carers and Disabled Children act 2000.

In other words, while consistent with what most people say they want, free personal care is also a cost -containment measure. From the end of 2012, local authorities will be expected to spend no more than 40% of their adult social care budget on residential care compared with the current average of 46%. This compares with 62% in 2002-03 (CSCI, 2009). This reduction is expected to offset some of the cost to local authorities of introducing such free personal care (estimated to be £250 million in a full year) (Pre-budget report 2009). In total the introduction of free personal home care will add £670 million to the national social care budget. This may be met in part by restricting or removing older people's eligibility for the non-means-tested, non-contributory Disability Living Allowance or Attendance Allowance. Transferring resources from the social security budget to social care budgets with more restrictive eligibility rules, as discussed above, is also not a new policy.

Changing demands on residential and domiciliary carers

Keeping very dependent people in their own homes as long as possible may not always be cheaper than supporting them in residential care, unless the domiciliary services provided are far from adequate (Lewis, 1998; Wanless, 2005). It is clear that the residents of care homes are now older, more dependent and more likely to be suffering from dementia, as 40% did in 2007 (CSCI, 2009). This puts greater demands on staff, making appropriate training even more important, especially with respect to medication, and raises costs. It has increased the rate of turnover of residents which can cause cash-flow problems for the owners. An increased number of bedridden people has also placed new demands on domiciliary care. In 2007, a fifth of home care hours were for overnight/ live-in care or 24-hour care. Sixteen per cent of care hours were outside 'normal' hours (CSCI, 2009, p36). Those who need assistance getting in and out of bed do not want to be helped to bed in the early evening or to stay in bed until the late morning. Some need to get up in time to go to work. The demand on home carers to be 'flexible' in their working patterns has increased and may not fit easily with the demands of their own families. Young migrant workers without family responsibilities are very attractive to home-care agencies in this respect.

The time spent on each visit has also declined, reducing the home carers' ability to respond sensitively to their clients' needs. There is little time for talk. Too often carers are given a prescribed list of tasks to be done and recorded. This inevitably reduces motivation. Ever shorter visits and their inappropriate or unreliable timing have become a source of much discontent for both givers and receivers of care (CSCI, 2006).

A comparison in this respect with the situation of home helps in 1970, when a study was conducted in England and Wales by the government social survey, is instructive (Hunt 1970). Then just over a quarter of the people visited by home helps were housebound and less than 2% were bedridden. Personal care was not in their job description; their work consisted mainly of domestic tasks. At this time district nurses, although belonging to the NHS, were employed by local authorities, and were, as we have seen, undertaking what are now described as basic personal-care tasks such as bathing, managing incontinence and giving routine medication.¹ Both home helps and district nurses were expected to be concerned with the well-being of their clients.

On average home helps visited four clients a week, spending between four and five hours a week with each of them. Three quarters of the recipients had only one or two visits a week and would have liked more visits rather than longer ones. The home helps on the other hand would have liked to have spent longer with their clients. Only a quarter had visits lasting less than one-and-a-half hours. Nearly half began their visits between 9 and 10 am. Nine out of ten recipients reported that they were content with the timing of the visits and were satisfied overall with the service they were receiving.

¹ In 1969-70 district nurses visited 562,000 elderly people in their homes in England and Wales. This compares with 376,000 elderly people visited by home helps (Social Trends 1970).

There was time to talk. “The great majority of all types of recipients enjoyed having a cup of tea and a chat with their home helps and indignantly denied that time was wasted by home helps in this way.” (Hunt, 1970, p18). Most referred to their home help as a friend and indeed many home helps reported doing more than they were paid to do (ibid). The Hunt (1970) study illustrates that the essential nature of care has not changed. Good care takes place within a relationship based on trust and familiarity and this takes time to develop and sustain.

The state of the current ‘market’ in social care

The contrast with current conditions is some indication of where cost-cutting leads providers competing in a market, when what is being provided is not a standard economic good but the personal service of care. Another indication is the state of the market in the social care sector. By 2008 there were nearly 5,000 home care agencies in England, 84% in the private and voluntary sector. This is more than double the number in 2000 when such agencies had to be registered for the first time. Local authorities purchase 80% of the care they provide and one in six agencies relies entirely on local authority income (CSCI, 2009). There is evidence that some agencies are uncertain about their capacity to manage individual clients, although others enjoy the contact with them. When clients stop paying suddenly because they are in hospital or have died it may be weeks before outstanding accounts are settled. For small agencies the impact on their cash flow may be hard to manage (UK Home Care Association, interview). Most agencies have less than 50 clients on their books and a minority have more than 100 (CSCI, 2009). The market is far from stable: “...the home sector is a fragile one, still reliant on small private providers and in a

prolonged state of flux” (CSCI, 2006, p29). For every two registrations of new private sector providers, one ceases (CSCI, 2009). It is significant that in countries such as France where home care agencies have been widely used for much longer, the market is characterised by a small number of large agencies, mainly in the not-for-profit sector

The labour market is not stable either. In England the domination by providers in the private sector has led to major recruitment and retention problems, with vacancy rates across the sector nearly double the average for all types of industrial, commercial and public sector employees (Skills for Care, 2008, p70). Turnover rates for all care staff are high overall at 22%, but highest for care workers in the private sector at 25% compared with 15% in the voluntary sector (idem).

The increased need for training and staff development

One way to retain workers would be to provide a good career structure and staff development. But about a quarter of private sector providers of both home care and residential care do not even meet minimum standards concerning staff development and training compared with less than a fifth of providers in the local authority and voluntary sector (CSCI 2009, Appendix B). Many do not even have information about the qualifications of their staff (Skills for Care 2008, p11). The proportion of staff with higher qualifications is much smaller in the largely private social care sector than the almost entirely public health care sector, suggesting the latter has a much clearer career structure and well supported paths to move up through it (see Table 1 below).

*Table 1
Highest level of qualification held by main occupation 2007*

SOC2000 occupation groupings	Nursing auxiliaries and Assistants %	Care assistants and home carers %
NVQ 4 and above	27.9	11.5
NVQ level 3	22.7	20.2
Trade apprenticeships	1.9	2.1
NVQ level 2	18.1	32.5
Below NVQ	14.5	12.1
Other qualification	7.8	12.9
No qualification	7.1	8.8

Source CSCI 2009, p 112 Table 8.7 based on Labour Force Survey

Of course, private-sector providers will not invest in training staff where there is high turnover. The logic of the market would suggest that social-care staff should invest in their own training. However, they will not do so while pay levels fail to reflect qualifications attained. In 2007 acquiring an NVQ level 3 qualification improved wages by 20p/hour over a level 2 qualification, and an NVQ level 4 made no further difference (ibid p 83).

Since good-quality care depends on the development of a sustained relationship between carer and care recipient, high staff turnover is significant problem. Workers cannot be retained without a career structure based on training for individual career development. This requires public investment in training because, as we have seen, individual employers do not have the incentive to provide training, nor individual workers the resources to fund their own training.

Training needs to be worthwhile for both for employers and workers. There are now government funds available for training. In England these are set to increase as part of the latest social care workforce strategy including the new social care apprenticeship scheme (Department of Health, 2009). The social care development grant, which is increasing to £192 million this year, also includes funds for staff training. However, the existing Department of Health grants – the

HR development strategy grant and the national training strategy grant available across the whole social care sector – were under-spent in 2006-7 (Skills for Care 2008, p11). Although councils spent two thirds of their allocation on their own workforce and the rest was spent on the independent sector, the HR development strategy grant was under-spent by nearly £10 million and the national training strategy grant by £29 million. Perhaps this is because even funded training requires both a commitment to reward trained junior staff and the time of senior staff to supervise or mentor them, both of which competitive pressures undermine. Inadequate staff supervision is still a significant and worrying weakness in both the residential and home care sector (Care Quality Commission 2009, p 16). It is in the very nature of care, that while a trained worker should provide better care, training does not greatly reduce the number of staff needed. If the quality of care provided does not affect how much a private sector provider is paid, there is little incentive to employ more expensive trained workers, let alone to train them.

Economic theory and the logic of the market

These problems with the private sector provision of care are not wholly unexpected. Many, as we shall see, also apply to 'personalisation', which just takes the logic of privatisation one step further. Privatisation was an agenda founded in mainstream neoclassical economic theory (LeGrand 2007). It was based on the idea that ensuring there were competing providers and giving purchasers choice would improve the quality of services and value for money. By putting purchasing power directly in the hands of the care recipient, personalisation takes this idea to its logical conclusion. Neither privatisation nor personalisation promote choice just for its own sake, or because the purchasers of care services, local authorities and care recipients respectively, always want it. Rather choice is necessary to the operation of a competitive market. What is sought is the market's process of disciplining providers to reduce costs, so that only the most efficient survived.

However, that same economic theory points out that for a market to achieve these goals depends on certain conditions:

- that purchasers are able to assess the quality of what they are/would be purchasing, and have sufficient information to compare the prices which alternative suppliers would charge
- that the costs of operating in the market, in particular acquiring such information and acting upon it are negligible
- that any other transaction costs are not high enough to impede entry and exit for suppliers and purchasers switching between them
- that the market is competitive, i.e. that individual suppliers and purchasers are insufficiently powerful to influence the market on their own
- that the interests of purchasers

and the ultimate consumers exactly coincide.

Applying market logic to care

These conditions may apply to a greater or lesser extent in the market for many goods, but care is not a standard good. The very nature of care as a personal service that involves the development of a relationship between care giver and care recipient means that these conditions do not automatically hold in the market for care, and even special efforts made to create them may not be successful.

First, the quality of care is hard to assess and monitor. Care is a quintessentially 'soft' product whose essential characteristics are not easily measured. It is possible to monitor the attainment of certain physical tasks, such as, whether a client has been bathed or taken their medicine. Market-driven provision, in its drive for efficiency, will tend to meet these measurable outputs and economise on the less tangible aspects of good care. But these are of the very essence of good care, which in nearly all cases needs to include the development of a warm relationship between care provider and recipient. Such things are hard to monitor and necessarily tend to fall by the wayside in the pursuit of market-led 'efficiency' (Gilbert, 2002; Stone, 2000).

Second, this means that there are considerable costs to acquiring information about the quality of care. Providers in the private sector fail in their duty to shareholders if they do not take every opportunity to reduce costs. One way to do this is to lower costs in ways that do not show up in current monitoring procedures. Unless all aspects of quality can be monitored, the logic of the market leads to quality reduction in those aspects of quality that cannot. But these, as

we have seen, may constitute the very essence of good care. Providing better information to those who make purchasing decisions about the measurable aspects of care quality may only exacerbate this tendency for those aspects of care that cannot so easily be monitored.

Similarly, information about prices in the absence of reliable information about quality, can lead to a pursuit of 'value for money' that becomes a race to the bottom in terms of quality. Monitoring standards need to be continually changed in an attempt to prevent this; not only is this process expensive, it will always run behind existing practice seeking for further ways to reduce costs - that, after all, is the argument for private provision being efficient.

Third, there are also considerable costs in acting on the information that another supplier is providing a better service. In care, continuity of provision is important, especially in residential care, where shifting from an unsatisfactory provider may mean a disorienting and even fatal change in both home environment and familiar carers. Not surprisingly, such changes are rarely made willingly. In such circumstances the transactions cost of change are too high to make market information useful. Even with home helps, continuity is important in developing a warm and trusting relationship. As the Hunt report showed, where that was possible in the past, home helps tended to work for the same clients for a long period. Two-fifths of home help recipients (three-fifths in London) had had the same home help for at least a year (Hunt, 1970).

For consumer choice to promote high quality, consumers have to be able to change poor-quality providers for higher-quality ones. Carers learn how to care for particular people (Waerness, 1987). This tacit knowledge takes time to acquire and cannot instantly be replaced by a carer offering better value for money.

Fourth, there is evidence that if markets are to be sustainable, larger providers will become more dominant across all sectors of the care market. This is already the case in the residential and nursing-care sectors which, as already discussed, have had much longer to develop than the domiciliary care sector. Large providers such as the Swiss company USI Group are consolidating their portfolio of nursing and residential care homes. As the Commission of the Social Care Inspectorate (CSCI) noted "A care market of fewer, larger providers presents a challenge to, or in some cases removes, the power councils have as the major purchaser in local residential care markets. This has largely positive implications for the market...but largely negative ones for choice" (CSCI, 2005, p.80) Evidence from France and other countries with a more established market in domiciliary care suggests that greater concentration is likely to occur as this market develops in England too.

The commission noted that this might explain why the fees paid by councils in many areas had increased sharply in recent years. Meanwhile more elderly people who want to live in a local and or smaller home have less choice, because in order to take advantage of economies of scale large providers tend to run larger homes (ibid. p.184). It also means that those requiring specialist provision, for example, those with special disabilities needs or dementia, will have increasing difficulty in finding a home which suits them. These same trends were observed in the US private market in the 1980s (Walker, 1995).

Finally, choice is in practice always constrained by rules and the interpretations of needs by others. For example, a person qualifying for local authority support can insist on being supported at home, but cannot choose to go into residential care sooner than their social worker decides it is

necessary, because that would cost the local authority more, unless they were owner occupiers. While many studies demonstrate that most older people want to live at home as long as possible, the consultation exercise conducted by the Department of Health in preparation for the white paper on health and social care revealed some who would prefer residential care to living in increasing isolation and apprehension in their own homes, even if they could still 'manage' on their own (Department of Health, 2006). Residential care should remain available as a positive choice. Further, purchasers who are not direct consumers do not necessarily have the care recipients' direct experience of the quality of care being received. This is particularly problematic if the care recipient has difficulty articulating their needs, as some older people or people with learning disabilities may have. The more dependent they are before entering residential care, the more likely their capacity to choose is reduced.

There are therefore a number of reasons why a market for care does not reliably guarantee choice, and in so far as it brings about value for money, savings may be at the expense of the essential characteristics of good care. Regulation too may produce perverse incentives. In other words, there are inherent reasons why even regulated market provision is likely to deliver poor quality care. Gordon Brown recognised this when he questioned the desirability of treating health care provision as a commodity to be left to the market: "The many market failures in health care, if taken individually, challenge the adequacy of markets to provide efficient market solutions" (Brown, 2004, p25). The same applies to social care.

The labour market and the cost of care

Economic theory can also help make sense of current tendencies in the labour market in which there is an increasing shortage of care workers. The most appealing solution to the shortage of care workers might be to raise their productivity. Such a process could raise the pay and conditions of care workers at the same time as reducing the amount that adult care would cost. Public spending could be reduced or could be used to finance improved quality. However, it is hard to raise the productivity of care, because the need to develop a relationship with clients sets a limit on how many people can be cared for at the same time, or how many home-care visits can be made in a day, without reducing the quality of care provided. After a certain point, and that point has certainly been reached when home visits can be as short as 15 minutes, spreading care over more people becomes synonymous with reducing quality. In care, as in education, the measure of high productivity, a high client-to-carer ratio, is specifically taken as an index of low quality.

The care workforce does, however, need to be paid wages comparable with those in other occupations if recruitment and retention problems are not to overwhelm the sector. For a given wage level, total wage costs are inversely related to productivity. So, the wage bill will rise faster in social care than in industries where productivity can rise and wage costs per unit produced consequently fall. This is not caused by inefficiency in care provision, nor by rising standards or increasing numbers of people needing care, but is inherent in the relational nature of care. The current shortage of workers is a direct result of funding not keeping up with that reality.

If funding is sufficient, labour market

processes can be successful in providing jobs and allocating suitable people to those jobs in a sustainable way, providing the following conditions hold:

- employers reward high-quality work, by providing opportunities for advancement
- employers can impose contracts that ensure that they can recoup the costs of training, and/or workers or individuals have the incentive and means to pay for their own training
- the labour market is competitive i.e. individual employers do not dominate a local labour market and workers have a range of potential employers who meet their needs in terms of hours, allocation and skill requirements
- workers' motivation is simply determined by the pay that they receive (perhaps raised or lowered to compensate for particularly unpleasant or pleasant work) rather than doing a good job; market processes may be inefficient if they crowd out other intrinsic motivations .

Again these conditions are problematic in the case of care. As we have seen, there is little gain to acquiring training in care and little career structure. Employers are reluctant to train workers they cannot retain. Private-sector employers, in particular, won't pay to train workers in skills that they can take from one employer to another. Although some employers put clauses in contracts requiring repayment of training costs if employees leave within a year, it is not clear if these requirements are enforceable (Baxter et al, 2008).

Few care workers therefore, in contrast to nurses or social workers, have access to employer funds to pay for their training or public funds, especially if they are over 25 years of age. (Given that only a minority of care workers enter employment in social care in their twenties the age limit is important. Only Scotland has raised the age limit from 25 to 50 years in the new social care traineeship scheme). The

logic of the market is that workers need to pay for their own training, and recoup the cost in higher wages. But this is unrealistic given the low wages that carer workers earn, and the limited opportunities that training brings to earn more.

Wages tend to be low and opportunities for advancement are limited because workers lack mobility. Many care workers are women with their own family responsibilities that limit their hours of work and the distance they can go to find it. At the same time, local authorities have tended to place social contracts for care on a locality basis, further limiting the choice of employers for such workers (ibid).

Finally, a care worker's motivation can be the key to the quality of work she does. Given the impossibility of monitoring the quality of all aspects of good care, the most reliable source of quality is for carers to have an intrinsic motivation to provide good care. As Hunt found in 1970, few care workers see the rewards that they get from their work as purely monetary. In the right circumstances, as we have seen, motivation can arise out of professional pride, notions of public service and/or emotional connection. These may be more difficult to harness for the private-for-profit sector than the not-for-profit and public sectors, with whose missions of public or charitable service, rather than maximising the profits of shareholders might more easily identify.

However, even in these sectors, where there is too much pressure on workers or they feel controlled in such a way that they cannot use their own professional judgement, intrinsic motivation can easily be crowded out. This can also happen through too hierarchical an extrinsic reward structure, particularly one which appears to restrict rather than enhance the autonomy of carers (Ungerson, 2004; Stone, 2000). For example, home carers' ability to respond sensitively to

their clients' needs has been diminished through being given a prescribed list of tasks to be done and recorded and through reductions in some cases to as little as 15 minutes, in the time they can spend with a client (the care package). When home care was in the public sector, carers were never well paid but they could take pride in their work and most enjoyed a good relationship with their clients, knowing that what they did for them was needed and valued. As we have seen, turnover rates were low and many did far more than they were paid to do (Hunt, 1968; Sinclair et al, 1990; Social Services Inspectorate, 2002).

Knijin (2000) found a similar picture of reduced motivation among home carers in the Netherlands, following increasing dependence on the private-for-profit sector. In pursuit of cost savings, by destroying the job satisfaction and generous professionalism of a group of workers that came from developing relationships with their clients, turnover rates may have increased, thus undermining those savings as well as the quality of care. Again Gordon Brown recognised this problem for the health service: "...even if that task of regulation could be practically accomplished, public provision is likely to achieve more at less cost to efficiency and without putting at risks the gains from the ethic of public service where, at its best, dedicated public servants put duty, obligation and service before profit or personal cost" (ibid, p 26).

Government responses

The current personalisation agenda is based on recognition of some of these problems; in particular a recognition of the distortions that arise from the interests and knowledge of a local authority, as a purchaser of care, being different from those of the care recipient. It is recognised that using the expertise of the care recipients themselves in planning and purchasing their own care, could lead to better targeted expenditure, meeting needs better at lower cost. The growing demand over the past 15 years for direct payments in place of services has in part been fuelled by the failure of both local authorities and the private sector to rise fully to the challenges of the reforms of the early 1990s and deliver a home-care service that fits people's needs, expectations and their understanding of the meaning of good care. The current reforms look likely to address some of these concerns, but may exacerbate others.

However, the need for reform also stems from governments' continued treatment of social care as an under-funded residual service. In recognition of this, the latest green paper (2009) on social care in England explores alternative methods of funding including various insurance schemes. However, whether these will be sufficient to provide adequate funding remains to be seen, since the possibility of using general taxation to fully fund a basic social care system for all has already been ruled out "...because it places a heavy burden on people of working age" (green paper, 2009, p18).

Personalisation

Direct payments are payments from public funds to people with care needs in order that they can purchase their own care services on the market, either from private or voluntary sector providers, or by employing their own personal assistants directly. They immediately overcome the problem that the purchaser

and the consumer of care services could have divergent experience and interests by making sure they are the same person. In the UK means-tested direct payments were first introduced in 1997, partly in response to the demands of the independent living movement and the disability movement for people with disabilities to be enabled to arrange and purchase the services they needed for themselves, rather than relying on what their local authority was willing and able to provide or commission.

Challenging the idea that the need for assistance in daily life renders a disabled person 'dependent', the disability movement argued that:

"independence is achieved by having choice and control over the assistance they require; and that this choice and control is essential to enabling people who need support to access their human and civil rights"
(Morris in Glendinning and Kemp, 2006, p 237).

While supportive of direct payments, Morris challenges the view that the notion of 'choice' necessarily undermines the development of public services, even though it is consistent with the New Labour government's emphasis on consumers rather than citizens. To Morris not only choice but also control is necessary to achieve self-determination:

"...it is not an impairment in itself which restricts what someone can do but the lack of choice and control over the required assistance. This is not about consumerism, or the application of market forces to undermine public services; instead it is about fundamental rights to self-determination that, if denied, prevent certain groups of people from being fully part of society"
(Morris, p245).

Direct payments are only for purchasing services on the market and cannot be used to obtain a local authority service. It is now recognised that this might not suit all people needing care. In England an alternative to taking a direct payment is a personal budget that allows the person needing care to choose for themselves which services to use and who will provide them. However, the personal budget leaves all or part of the responsibility to commission those services with the local authority. In theory therefore, a personal budget would be a better choice for those who do not want the responsibility of managing a direct payment, particularly if this involves becoming an employer of a personal assistant. However, the real choice of using a service provided directly by the local authority may no longer exist. In England, many local authorities have outsourced all their home-care services, for example.

An individual budget is more flexible in theory than a personal budget because it combines resources from different funding streams including local authority social care. The other components could come from the Independent Living Fund, integrated community equipment services, disabled facilities grants, supporting people for housing-related support and access to work. The individual-budget holder can get some support in commissioning the services they want but may have to pay for this support

The IBSEN study, which evaluated individual budgets as they were piloted in 13 local authorities in 2006-07, found that the majority of recipients of individual budgets took them in the form of a direct payment (Glendinning et al, 2008 p57). In addition many used the money to employ a personal assistant. This is not surprising because:

- older people are much less likely than younger people to be eligible

for support from these other funding sources

- managing different funding streams can be complicated and time consuming if expenditure from each one has to be accounted for separately. In practice, for administrative and legal reasons, they cannot always be amalgamated to pay for a single service because there are restrictions on the use to which certain benefits can be put
- some forms of provision may not be viable at all. For example, local authorities and voluntary organisations may no longer be able to provide day centres if numbers making use of them fall (Sense, 2008, Glendinning et al, 2008)
- in theory direct-payment or individual-budget holders might provide a market for an enterprising provider of day-centre services, but there are very few commercially run day centres. The history of market generation in this area is poor, not only in the UK (see above) but also in other countries. The barrier to entry of the minimum number of clients to make provision viable may simply be insurmountable, given low profit margins in many areas. In the case of childcare, in many areas provision needed start-up grants to make it viable and even then there was considerable churn when start-up grants ran out
- by devolving budgets to individual service users who have much less market power than a local authority, the potential for cost savings is reduced (Glendinning et al, 2008 p206).

Direct payments, personal budgets and individual budgets all form part of a government agenda to introduce personalisation in social-care services. Along with a rejection of “one-size-fits-all” policies for public services more generally, this agenda is based on the

belief that many previous problems in social care can be overcome by enabling people to engage more actively in the construction of the care services that they need. However there is continuity in its approach too, in that another of the UK governments' objectives in introducing direct payments has been to extend the market in care services. Thus the government asserted in relation to England, without evidence, in the green paper *Independence, Wellbeing and Choice: our vision for the future of social care for adults in England*, published in 2005:

“the ability of people to ‘buy’ elements of their care or support packages will stimulate the social care market to provide the services people actually want, and help shift resources away from services which do not meet needs and expectations” (p35).

It remains to be seen whether the opportunity to take up direct payments will be enough to create a sustainable market that provides the personal assistants and the specific services that these payment holders will require. The minimum number of clients required to make services viable provides a barrier to entry which low profit margins may not be able to overcome. Evidence from the UK and abroad discussed later in this report suggests that this might be the case.

The idea behind personalisation is more in keeping with the notion of the ‘active citizen’, it assumes that those needing care will be empowered to ‘co-produce’ the support they need. In other words they have become partners with those who provide support and services. “Self-directed services work because they mobilise a democratic intelligence; the ideas, know how and energy of thousands of people to devise solutions rather than relying on a few policy makers” (idem). This chimes with

the emphasis on individual responsibility and active citizenship found in so many policy documents in recent years. These descriptions of those in need of and using publicly funded services and support in future are contrasted with previous older generations who ‘passively’ accepted what the state offered them.

This perspective however fails to recognise that the meaning of ‘independence’ changes over time as people get older and more aware of their ‘interdependence’ (Audit Commission, 2004). Many older people who have been active, contributing citizens for all their adult lives, not least in bringing up the next generation of citizens and workers, now feel it is the turn of the younger generation to provide the support they now need because of growing frailty. As a woman in her eighties living in residential home explained to researchers in an earlier study:

“The best thing is the lack of responsibility. People don’t understand, you see. I nursed through two world wars, the general strike, the flu epidemic so I think I’m justified in wanting a little respite.”
(cited in Sinclair 1988, p265)

This is not to say that older people, even if they do not wish to organise their own care, do not wish to be listened to and treated with dignity and respect.

Personalisation is described by the Department of Health as meaning that “every person who receives support, whether provided by statutory services or funded by themselves, will have the choice and control over the shape of that support in all care settings” (“Expert guide to personalisation”, *Community Care*, 13 July 2009). This approach therefore underpins not only the use of direct payments, but also individual or personal budgets, user-led services and self-directed support.

Further, “self-assessment will also be a cornerstone of personalisation. Giving service users the opportunity to assess their own care and support needs and decide how their individual budgets are spent are central parts of the agenda” (idem). Although self-assessment is currently widely viewed as “a misleading term” according to the Commission of the Social Care Inspectorate, (CSCI, 2009, p139) entailing intensive support from care managers, it marks a different way of thinking from that behind the shift that occurred in 1993 when assessment of the need for social care and other services was placed firmly in the hands of social workers. Self assessment means that social workers are now required to behave more like brokers than managers of care.

The most successful use of direct payments occurs when the person receiving them has a condition which is stable over long periods. With the Health and Social Care Act 2008 extending the availability of these payments to people lacking the capacity to consent, not all service users will be capable of determining what they want and some will not have the autonomy they might wish for. Social workers have to assess the risk of a direct payment user misusing their budget or being abused. In addition, for any direct payment user the need for a different arrangement may occur when their health deteriorates and they are least able to make new arrangements. Older people are more likely than some younger people with physical disabilities to experience reducing capacities over time. This reduction can sometimes happen suddenly and unexpectedly as a result of a fall for example. They need a system which can re-assess their needs very promptly. Local authorities retain a duty of care for those they support and are therefore responsible for making alternative arrangements when they are interrupted or break down, or needs suddenly change. This responsibility is

not always made clear to direct payment recipients.

Restraining public expenditure

Even the keenest advocates of personalisation recognise that in the face of a government’s determination to limit growth in, or cut, public expenditure, choices may be too restricted to achieve their aims (Morris, p248). The level of funding remains an issue with direct payments and other ways of extending choice, such as personal and individual budgets. However, it is clear that making spending more cost-effective is part of the motivation behind personalisation.

In introducing direct payments, the UK government was influenced by evidence presented to it in the mid-1990s that direct payments were not only what disabled people wanted but they were more cost-effective (see Yeandle and Steill, 2007). Personalisation will be more cost-effective because “...people who participate in creating solutions that meet their needs make public money work harder and help deliver public policy goals” (Leadbeater et al, 2008, p81). Indeed, there is evidence that many direct payment recipients use the money frugally and imaginatively. They may even spend less than they have been given and often less than the local authority would have done if they had provided the home care themselves (interview, Scotland). There is also evidence from Scotland that some local authorities have clawed back any underspend even when recipients have been keeping it for emergencies (Scottish Personal Assistant Employer’s Network, 2009, p1).

The government announced in autumn 2009 that by 2011 every English local authority would have a user-led organisation directly contributing to the development of personal budgets and, amongst other things, supporting personal budget and direct payment

holders and their carers. ('Personalisation; councils given benchmarks on progress', *Community Care*, 10 Sept 2009). This is a welcome development, for in the early years in England there were no additional funds to develop personalisation in general or support direct payment holders in particular by providing on-going support for them in their new role as employers. Indeed initially there was an expectation that the switch to direct payments would lead to reductions in local authority expenditure because local authorities would cut back on the infrastructure which had supported the direct employment and training of home carers. Responsibilities for good employment practices and their costs were passed to direct payment holders, providing a source of saving to all local authorities.

In 2006 the Audit Commission commissioned research in 11 local authorities to establish under what conditions, if any, direct payments saved local authorities money. The key variables identified were:

- the hourly rate on which the direct payment was based
- the number of direct payments in payment
- the costs of training local authority social services staff and the time they subsequently spent on providing advice and guidance to direct payment holders.

There were very large variations between local authorities, with one paying direct payment at half the local authority hourly rate and another at 50% more. Lower rates, which were more common than the same or higher rates, were explained on the grounds that "direct payment customers are purchasing from a different segment of the market (for example, friends, families and neighbours)" (Frontier Economics, 2006, p59).

It is clear from this research that in order to make savings local authorities are under

considerable pressure to base the amount paid on a lower rate than they would pay for in-house or agency home carers. A study by Janet Leece conducted a little later than the NAO study cited above, found that personal assistants were typically paid £5.16 an hour compared with £6.14 an hour for home-care staff. When unpaid overtime was taken into account one personal assistant in her study was being paid less than £3 an hour (Mickel, 2009).

There were also very large variations in the amount spent on managing direct payments, ranging from £200 to £1,800 per direct payment holder. There was some discussion in the Audit Commission report of the need to train social workers in their new role of offering help to direct payment holders, and to reduce their resistance to introducing direct payments, especially to older people. However, there was no consideration given to the support that a personal assistant might need in the form of advice or training.

Pressure on local authorities to increase the uptake of direct payments is also becoming greater. In 2006 only 7% of recipients of social care were direct payment holders. By 2011, the Care Quality Commission will be measuring local authorities' performance against a target of having 30% of service users on a personal budget.

The extent to which direct payments are 'cost-effective' therefore depends on what basis the comparisons with publicly provided services are made. If the basis is too narrow, the potential for and efficacy of direct payments in containing the costs of social care will be exaggerated and the transaction costs, which fall on the direct payment holder themselves and their carers, including their personal assistants (discussed below) are at best minimised and at worst ignored. So far in many authorities in England, but less

so in Scotland and Northern Ireland, these transaction costs have been largely overlooked. As direct payments are rolled out more widely, the willingness of holders and their personal assistants to absorb these costs can be expected to fall. Those who have chosen to be the early movers into this system are likely to be those most dissatisfied with previous provision and/or those with particular ideas as to how to use their payments differently. These are likely to be those for whom the transaction costs of direct payments are least; those who are most willing to absorb those costs; and those who have relatives and friends to help them manage their payments.

Problems with cost containment

Payments for care have been seen as a way of restraining the growing costs of long-term care. This is for two reasons: not providing unnecessary services and spending less on those that are purchased, in practice achievable only by employing less well remunerated staff. While the first is wholly desirable, the savings may be one-off. Once budgets are spent more efficiently to meet needs, further savings will not be forthcoming, but the pressure to restrain costs through rising unit costs will not diminish. Saving on wage costs may result in poorer quality care if it is simply a way of shifting the cost of high quality care from the local authority to the care worker through underpayment. Again this may also just be a one-off saving. Opening up the labour market to carers who had not previously taken employment will expand the available pool of labour and thus may restrain the need to raise wages, which would otherwise be unavoidable. However, once this new pool of labour is absorbed, and especially if personal assistants develop some form of organisation to represent their claims and needs, the same pressures on costs will re-emerge. So while direct payments

might provide one-off savings they do not provide any long-term restraint on the rising costs of care.

Further they may add to costs. This is for three reasons. The transaction costs of the myriad of small contracts that the relationships between direct payment holders and their personal assistants entails are inevitably more costly than block contracts with a few providers. These costs may be shifted to the direct payment holders but they are real costs, so unless holders are compensated for these, this is just a way of making care recipients manage on less. These transaction costs and the consequent diseconomies of scale are large, especially if conditions are to be regulated to meet at least minimum standards and security checks are to be properly carried out. This may be one reason why the voluntary registration of home-care workers has been postponed to 2011, and the registration of personal assistants is still to be discussed and consulted upon.

Other increased costs through the loss of economies of scale may be even more serious, such as those associated with providing training and back-up cover for emergencies. It is not surprising if direct payment holders are not prepared to pay for training their personal assistants if they are not funded to do so and are given no support with finding replacement carers while training takes place (see Table 3 below). These provisions can be made collectively even when employment contracts are individual; however, the ethos of individual choice that lies behind personalisation may work against that. Second, those who do not want to employ personal assistants but wish to spend their payments purchasing care from a provider may find costs rising as providers lose the advantages of economies of scale. Already some providers are talking about dropping out of the market or having to raise charges if they cannot rely

on the number of clients in a given area that a local authority contract would have provided (Yeandle et al, 2006, interview with UK Homecare Association).

Finally some forms of provisions may not be viable at all. For example, local authorities and voluntary organisations may no longer be able to provide day centres if numbers making use of them fall (Sense, 2008). In Northumberland for example in the teeth of a strong local campaign by unions and service users, the council decided to close seven day care centres citing under-use linked to the introduction of personal budgets. The move to personal budgets has also been cited by Norfolk County Council and many others as reason to close day centres – despite strong opposition from the people who use them. In theory direct payment holders might provide a market for an enterprising provider of day centre services, but there are very few commercially run day centres. The history of market generation in this area is poor, not only in the UK (see above) but also in other countries. The barrier to entry of the minimum number of clients to make provision viable may be just insurmountable, given low profit margins in many areas. In the case of childcare, in many areas provision needed start-up grants to make it viable and even then there was considerable churn when start-up grants ran out.

The very process of trying to restrain spending also has deleterious effects. As has been seen in recent years, restricted spending tends to get concentrated on meeting measurable targets, making the notion of self-assessment highly problematic. Pressure to meet measurable targets inevitably has a tendency to squeeze out other aims, including the willingness to trust workers to provide a service governed by professional norms and individual experience. But these are of the essence

of good care. Such pressures also tend to crowd out spending on the ‘extras’ such as training and lead, as argued above, to the passing on of ‘invisible’ costs to individual care recipients or their carers.

From the point view of the government, the cost of cash payments is much easier to contain than the cost of services, especially those in the public sector where there is an organised and vocal workforce. Not letting cash payments rise in line with costs when those in receipt of them are isolated care recipients, many of them employing their previous informal carers, is a relatively easy way to restrain spending. In Germany in 2001, three-quarters of domiciliary care users took the option of a cash payment even though it was worth half the value of services in kind (Glendinning and Kemp, 2006, p 236). Many used it to pay an informal carer. There is now evidence that more are changing back to opt for the service not least because the cash payment has not been increased since it was introduced (Glendinning and Moran, 2009).

To counteract such easy ways to reduce costs at the expense of care recipients themselves it is important that assessment of their needs and their costing is carried out by a different body than the one that will pay the costs. It is also important that needs assessment is done on a ‘carer-blind’ basis (disregarding the presence of an informal carer). This is not mentioned in the green paper. The proposed limitation on the provision of free personal care to those without a carer in receipt of local authority support is disappointing.

The role of informal carers

Some more recent changes in the UK government’s policy towards informal carers need to be seen in this light. As well as introducing measures to enable them to combine paid employment with caring, such as in 2006 extending to informal

carers the right to request to work flexibly, it now allows direct payments to be used to employ them, including in exceptional circumstances, co-resident relatives. Although the IBSEN study conducted in 2006-07 reported resistance in some local authorities towards using direct payments to pay relatives, this marks a major shift in policy towards recognising and paying for care provided within the family (Ungerson, 2004). England, in particular, had been out of step with the rest of Europe in refusing to use public money to pay relatives for childcare or the care of frail or disabled adults throughout the whole of the last century. This rapid policy change is not only a response to the significant numbers of direct payment recipients who choose to employ their informal carers, even if an alternative is available, and of informal carers who wish to be able to combine employment with caring, but also a realisation that if pressure on budgets is not to become intolerable, policy makers need to consider how best to sustain informal care.

“The sheer size of informal care provision within families and local communities make it essential for all countries to consider how support for informal care can best be targeted and if alternatives such as non-financial support give more value for money for the persons receiving and giving care.” (Lundsgaard, 2005, p39)

Sweden has extensive formal adult care services and the state is regarded as the provider of first rather than last resort. Nevertheless, even there it has been estimated that the volume of unpaid informal care is twice as large as the volume of formal care (*idem*).

There is evidence that paying informal carers is cost-effective. First they typically do a great deal more than they are paid to do. This has long been acknowledged

elsewhere in Europe. For example, in Norway family carers were employed (and had the same employment rights) as part of the municipal home help service in the 1970s and were regarded as very good value for money. Family carers (and other personal assistants) can still be employed by the municipalities in Norway. Second, the NAO (2006) noted that it was easier to pay family and other informal carers a lower rate. The IBSEN study estimated that when carers were involved either directly with a payment or benefiting indirectly from the services provided for the individual budget holder, “the average value of funding through individual budgets for the service users whose carers took part in the study was £270 (median £170) compared with the costs of conventional service packages of £390 (median £350) in the comparison group” (Glendinning et al 2009, p58). This is based on small figures so must be treated with caution. Nevertheless they are indicative of the difference a carer can make.

While families and friends are often keen to provide some informal care, it is important that the demands made on informal carers are not excessive. There is growing evidence that without support, carers’ health suffers (Lundsgaard, 2005). A review of the evidence for the Wanless committee concluded that: “Those groups most likely to suffer ill-health as a result of their caring responsibilities receive least support, whereas those who are particularly at risk of a negative impact from long hours of care, that is those who care for the longest periods, are least likely to be able to access health care when needed” (Wanless, 2006, Annex 11, p38). The health of 72% of carers over the age of 50 is adversely affected compared with 40% of younger carers” (*ibid*, p37). Adequate support for informal carers can be regarded as a preventative health, and therefore budgetary, measure. In the UK, carers have recently won the right to respite care funded by primary

care trusts (although the system does not always mesh well with local authority social care because of the long standing and continuing problems of co-ordination between health and social care discussed above) (Glendinning et al, 2009, chapter 14).

Finally, economic activity rates of older women have increased in Britain to over 70% compared with 56% in 1971 (Population Trends, Sept 2009). The cohorts of women entering their fifties since 2007 are those who benefited from the post-war expansion of first, educational and subsequently employment, opportunities for women. Their experience and expectations of employment are very different from those of their mothers and it is government policy to increase these participation rates still further to 80% as well as to raise the pension age. At the same time their

parents are surviving longer into old age so government employment and social policies must take seriously that many are combining employment with (often substantial) caring responsibilities. They may also be providing essential child care for their grandchildren. Currently 40% of mothers in paid employment rely at least in part on informal (most commonly grandmothers) childcare. In these circumstances, denying direct payment holders the opportunity to employ a relative if this is what all concerned consider the most appropriate choice, makes little sense. Moreover the formal services needed to replace some of this informal care do not exist in many areas. This is no doubt one of the main reasons for excluding carers, in contrast to lone mothers, from the obligation to prepare for and to take up, paid employment in the current welfare to work reforms.

Personalisation on the ground: direct payment holders and their personal assistants

“Across government there are examples of policies accidentally placing workers at risk in vulnerable employment, for example through the introduction of direct payments without sufficient support for social care service users to undertake their responsibilities as employers.”

(TUC Commission on Vulnerable Employment, 2009, p35)

Personal assistants, those employed directly by direct payments, are some of the most isolated workers in the UK. If personalisation is successful in its aims, their number is set to grow. It is therefore important to consider the employment relationship in which they and direct payment holders engage to see what implications this has for:

- the conditions of employment of personal assistants
- their working relationship with their employers
- any problem that direct payment holders have in being employers
- the boundaries of employer responsibility.

Conditions of employment: some problems for personal assistants

Many personal assistants are traversing the boundary between the informal and formal care sectors. On one hand, many work very short hours. A study for Skills for Care by IFF, was based on the experience of over 500 direct payment

users and personal assistants drawn from 16 local authorities in England in 2007, found nearly two-fifths were working under eight hours a week (IFF and Skills for Care, 2008). Of those working very short hours, half were continuing to work alongside a job in the formal social care sector. Altogether, a quarter of all personal assistants were combining this work with another job in this sector. On the other hand, resident personal assistants may find themselves on-call 24 hours. This group includes significant numbers of migrant workers, who will be discussed in more detail below.

Evidence from the TUC's Commission on Vulnerable Employment (2008), the Low Pay Commission, 2009, reports from Citizens' Advice Bureaux and various research studies of care workers in general and personal assistants in particular (Leece 2008, Skills for Care and IFF, 2008) including migrant workers (Cangiano et al, 2009), shows that personal assistants may be vulnerable in a number of ways, through:

- having an unclear employment status

because of working very short hours, living-in or being wrongly defined as self-employed. All may result in loss of pay, benefits and other employment rights

- lacking job security or guarantee of work
- the level of direct payment or individual budget being insufficient to meet the needs of the care receiver
- ignorance of, and lack of clarity about, their rights. This ignorance is shared by their employer in the absence of a contract
- lack of knowledge about, or access to, advice and support if the relationship becomes difficult
- lack of training opportunities, including health and safety matters
- agency workers being open to exploitation, although the UK government's recent signing up to the EU directive on agency workers may offer some protection.

In theory all direct payment holders should be given sufficient money to pay their personal assistant at least the minimum wage. However, in its latest report the Low Pay Commission recorded evidence that local authority payments to providers of social care in general had not kept pace with increases in minimum wages and other costs, thus adding to the pressure to keep down wages. The commission recommended that local authority commissioning policies should reflect the actual costs of care (Low Pay Commission, 2009, para 3.38). Inadequate funding of direct payments in the context of lack of clarity concerning the inclusion of tax and the payment of national insurance contributions, holiday and sick pay, the costs of emergency cover (for example if the personal assistant falls sick) and the rights of a personal assistant to paid maternity or sick leave, leaves personal assistants particularly vulnerable to exploitation. Further, wage rates for overnight or live-in support where

the application of minimum wage rates is not straightforward could be contentious and - in the case of migrant domestic-care workers - a cause of considerable anxiety (Gordolan and Lalani, 2009).

Some direct payment holders avoid some of the responsibilities of being an employer by employing personal assistants for a small number of hours, so that they fall below the national insurance level (eight hours in the UK). This is possible if the direct payment holder has a low level of need or is prepared to pay several personal assistants each for very short hours. The Personal Social Services Research Unit (PSSRU) research on direct payments found evidence of this practice, particularly among older people (Davey et al, 2007, p62). The advantage of not paying national insurance contributions is that the personal assistant can then be paid a higher hourly rate, but it may have deleterious effects on their entitlements to benefits in the future, particularly pension entitlements. Other personal assistants may define themselves as 'self-employed' (or find themselves so defined) without fully understanding the negative consequences in relation to tax and social insurance and their employment rights (see Gordolan and Lalani, 2009 and TUC Commission on Vulnerable Employment, 2009)

The views and interests of some personal assistants can conflict in other ways with those of their employer. In particular the Skills for Care study showed that there were differences in views concerning the importance of a written contract of employment, taking up references or a CRB check (a third of employers in the study had not done so) and the advantages of being included in the voluntary registration of social care workers. The view that there was no need for a formal contract was more common among direct payment recipients than among their personal assistants, although

there were some assistants who did not want to formalise a relationship based on friendship either: "The man I have no contract with I am friends with him as well as being a carer for him so therefore a contract would get in the way" (IFF and Skills for Care, 2008 p63).

The lack of a contract, however, could in practice be a problem for assistants. They need clarity about their pay and employment rights and also to reduce the possibility of conflict when working alongside other informal carers or members of the family who have different views about the tasks they could be expected to do (Gordolan and Lalani 2009, Scottish Personal Assistance Employers Network, 2009). When differences cannot readily be resolved, personal assistants need access to professional support which is often not forthcoming. A personal assistant's need for access to training cannot easily be met within an informal relationship, particularly in the absence of funds. Relationships which become abusive are particularly difficult to handle, especially when the personal assistant is a migrant care worker, isolated from family and friends who could give them advice and support (Gordolan and Lalani, 2009).

A significant proportion of personal assistants have already been caring for the direct payment holder either as an informal carer (a third) or employed by an agency (a fifth). As well as those receiving direct payments, an estimated 145,000 older people were employing and funding their own personal care in 2006 (PSSRU, 2006 p46). In that sense the employer/employee relationship between someone needing care and their personal assistant is not a completely new one. What is new is that it is being funded by the state.

Working relationships

There have been a number of research studies on the experience of direct

payment/individual budget holders who are employing personal assistants. The Skills for Care study is one of the largest to be published so far. Like all studies so far, its sample is of early movers into the personalisation system, so is likely to over-represent those who were dissatisfied with their previous care. But in this study, like in all previous, smaller studies, the majority of the personal assistants and their employers were found to be very satisfied with the arrangements for a number of different reasons. It is therefore worth quoting some of the findings at length. Many direct payment holders reported that they had time to develop a relationship with their personal assistant, who would be reliable and flexible in their work, and many contrasted this with previous experiences with care workers arranged by the local authority (although often provided by private-sector care providers) who were under much greater time pressure:

"My carers are marvellous, more like a friend than doing a job, more like a friend or neighbour attitude. My cleaner does extra jobs that were not done before. The personal assistants do certain tasks that they would not do in regular hours."
(Quoted in IFF and Skills for Care, 2008 p44)

"It means I get the same people all of the time and I can build up more of a trusting relationship rather than not know who is coming through the door."
(Quoted in IFF and Skills for Care, 2008, p44)

"The advantages were that we weren't waiting for a home help who wasn't coming - for a start. (Or who) when they came, said: 'I can't stop, because I've got somebody to go to'." (Yeandle and Steill, 2007, p127)

"There's a very big difference between

somebody who is with you five hours a day and somebody who is with you 20 minutes or something like that.”
(Idem)

Many personal assistants also found the relationship with their employers more rewarding than their previous experiences in the social care sector:

“It’s good fun and the hours are suitable. The agency I was working for beforehand wanted me to do extra hours and I couldn’t as I have disabled children.”
(Quoted in IFF and Skills for Care, 2008, p79)

“Employed as a personal assistant I had only one person to please; employed in a care home I had lots of people to keep happy.”
(L Tidder, 2006, p141)

There were advantages to direct payment holders in being able to set limits on what they needed to ask family carers to do because someone else was available, and in being able to value at least some of the help given by family carers by being able to pay for it. Payment reduced their sense of dependency on a family carer and acknowledged the value of the task. The ability to reciprocate reduced their sense of dependence:

“It has stopped me having to rely on my Mum and Dad. I can ask my personal assistant to do things I would not like asking my parents to do.”
(Quoted in IFF and Skills for Care, p44)

“It makes me happier that someone is now getting paid to do the jobs, like showering me. I think it is good that someone should get paid to do it.”
(Quoted in IFF and Skills for Care, 2008 p44)

On the other hand, it was clear that setting

limits on what the personal assistant could be expected to do within a relationship defined as ‘friendship’ was complicated. As Ungerson (2004) found in her research this was often mentioned, especially if the carer was living in; because carers felt responsible they often then did more than they were paid to do:

“I can form more of a personal relationship with my carer where I would not feel daunted by asking about personal matters because I have got to know them in a more personal way. I can now ask my personal assistant to assist me with anything, and would not feel embarrassed to do so.”
(Skills for Care and IFF p43)

“You become quite close to them because they trust you and you trust them. I would say you almost become like friends really, on the whole I think you don’t want to let them down.”
(Quoted in Yeandle and Steill 2007 p130)

However this carer found that although she was doing more and more for her client, the agency wouldn’t pay any extra.

“Say you fell ill or your children were ill. If they (personal assistant) are your friend then they will help you even if it is not their time to be at work.”
(Direct payment user quoted by Leece , 2008)

“But if you’ve got a cold here you can’t let Gemma down, you don’t want to come you don’t want to give her a cold but what alternative have you got.”
(Personal assistant quoted by Leece, 2008)

“[The personal assistant] gives more friendship time in care than paid care time which is wonderful for me obviously because to be selfish I couldn’t manage without him but I’m

not sure it is good for him.”
(Direct payments user quoted in Leece, 2006, p196)

This is in contrast to a home care worker who was able to place limits on friendship.

“I’m not her friend friend. I’m her friend but only so far.”
(Quoted in Leece, 2006, p198)

While some personal assistants did not miss working with colleagues and enjoyed the freedom of not being answerable to a manager, there were others who found the job emotionally draining. Working with very vulnerable people can be extremely demanding:

“What I hate the most about the job is having to sit and watch someone in agony 24 hours a day, 7 days a week because even though I can’t feel the pain, believe it or not mentally it is just as bad.”
(Personal assistant quoted in Leece, 2008)

Had she been working as part of an local authority home care department or one of the better home care providers described, for example, in Yeandle et al’s study of local domiciliary care markets (Yeandle et al, 2006), she would have had colleagues to talk to and a manager who could advise and support her. Moreover, more demanding clients can be shared with other workers and individual home carers have a mix of clients, some with very complex and others with simpler needs.

Some personal assistants who had given up work with a home-care agency in order to become a personal assistant found that not only was the pay not as good as it seemed at first, but that they had underestimated the importance of support from colleagues. Crossroads, a homecare provider in the voluntary sector, for example, is concerned that the

lack of professional support for personal assistants may add to the sector’s difficulties in improving overall recruitment and retention rates. Some personal assistants request to be allowed to return to their previous employer (Baxter et al, 2008). Providers do not welcome their workers being ‘poached’ or tempted away by (seemingly) higher wages, even if some eventually want to return, for it destabilises their workforce. Attempts to reduce this by adding penalty clauses in their contracts have little effect because they are difficult to enforce.

Problems for direct payment holders employing personal assistants

More personal assistants than direct payment recipients saw their relationship as a straightforward employer/employee relationship. This is not surprising. After all many direct payment recipients had chosen someone already known to them or someone whose recommendation they could trust. They felt they already knew enough about their personal assistant’s background. In practice, this could cause problems.

Like the personal assistants themselves, a majority of those employing personal assistants reported that overall they were satisfied with the arrangements. However two in five direct payment holders in the Skills for Care and IFF study expressed some dissatisfaction, particularly with their role as an employer. These concerned:

- difficulties in finding personal assistants
- formalities involved in establishing and maintaining the employment relationship
- the burden of managing a payroll
- concern about the management and resolution of disputes
- uncertainties about how to handle matters when the relationship broke down

- practical worries about cover in emergencies or change of circumstances
- financial concern about the levels of pay that could be afforded out of direct payments
- how to pay for holidays and other entitlements.

Direct payment holders have the option of using an agency to find or provide a personal assistant, so some of these difficulties could be reduced or avoided. In addition to assistance finding a personal assistant they are likely to get a replacement assistant more quickly in an emergency. However, agencies charge an administration fee of 10% to 15% of the holder's budget. This reduces the amount out of which the personal assistant's wages are paid.

The paperwork involved in setting up and maintaining the formal requirements of being an employer can be very burdensome. Even those with previous experience of handling accounts do not necessarily want to continue doing so into their eighties. The IBSEN study (Glendinning et al 2009) found some carers had given up work in order to manage the budget of a relative who was a direct payment or personal budget holder. On the other hand other studies have found some enterprising - and younger - direct payment holders, having learned the ropes, were providing a service to other direct payment or personal budget holders (see section 3 in Leece and Bornat, 2006).

These financial concerns are but one aspect of the problems of self-assessment discussed earlier. In general there is a lack of clarity about how levels of direct payments are determined, and a belief that the points system (or resource allocation system – RAS) for particular levels of disability, or for older people, does not translate into

a fair formula that reflects the needs of different groups and the costs of meeting those needs appropriately. This view has been expressed, not only by direct payment holders themselves, but also organisations, such as Age Concern, those concerned with disability rights and, in particular, organisations representing people with specific disabilities, such as Sense, which works for and with adults and children who are deaf and blind.

The boundaries of employer responsibility: policy and practice across the UK

The difficulties arising from the employment relationship between givers and receivers of care described above are common to all payment for care schemes. There are, however, interesting practices and policies within the UK, which can reduce the vulnerability of personal assistants to poor working practices at the same time as protecting the quality of care given. These experiences show that it is possible to balance better the interests of both the direct payment holder and the personal assistant, thereby increasing the sustainability of the personalisation project. Conversely there is clear evidence that lack of effective oversight and regulation can lead to exploitation of either or both parties as well as showing that 'cost-effectiveness' is achieved at the expense of personal assistants and the quality of care they can provide.

As Table 2 below shows, the introduction of direct payments in the rest of the UK has been far more cautious than in England, in part perhaps because of a greater ideological resistance to the marketisation of social care (Pearson, 2006), as well as a wish to develop policies independently of England. Other forms of personalisation are also far less developed in general in other parts

of the UK, with Scotland developing a very different set of policies around the provision of free personal care and Wales not yet prepared to introduce personal budgets. England is the only country in the UK to have introduced personal budgets.

*Table 2
Distribution of recipients of direct payments across the UK in Spring 2008*

Country	2002-03	2008
England	7,882	55,900
Scotland	292	2,500
Wales	185	2,000
Northern Ireland	49	1,100

Source: Pearson, 2006 p38 and Cangiano, 2009 p14

Scotland has considerably more autonomy than the rest of the UK over the development of local social care policies. The demise of public sector direct provision of care is not envisaged there, as it seems to be in England. In addition in Scotland the voluntary and local authority sectors still provide most domiciliary and residential care services (Scottish Care Commission 2008). UNISON is more involved in the development of policies and practice through its partnership with the Scottish Personal Assistance Employers Network (SPAEN). In contrast, the focus in England has been more on involving 'users' and less on including personal assistants and other social care workers who provide the hands-on care. Indeed, paid hands-on care workers are conspicuous by their absence in many of the English policy discussions about structures and systems for supporting the development of direct payments, personal budgets and individual budgets

In Northern Ireland, there are few private home care agencies although, when residential care is included, the private sector now accounts for most social care provision. The Department of Health, Social Services and Public Safety combines health and social care responsibilities which reduces some of the competition over budgets and shifting boundaries between health and social care. The trusts provide some basic training for personal assistants concerning lifting and the use of equipment such as hoists. The administration is keen to improve access to training (Department of Health, Social Services and Public Safety, 2007).

As Table 3 below shows, practice with respect to costs covered by a direct payment varies across the UK, as well as within England. The uncertainty about what personal assistants are entitled to is reduced in Northern Ireland by providing a payroll service to all direct payment holders, including drawing up a contract. The trusts also pay for and arrange employers' indemnity insurance and CRB checks. In addition every new direct payment holder is introduced to an existing one and/or to an appropriate user group. The Centre for Independent Living, which is independent of government, also plays an important part in the development of policy and practice as well as being a source of information for direct payment holders. Personal budgets have not yet been introduced in Northern Ireland. The use of informal carers is widespread but if an agency is wanted the local trust will approach them directly. Direct payment recipients may require an extra payment to meet an unanticipated need; only in Northern Ireland are these extra payments always available either on an ad hoc or periodic basis. In contrast a quarter of Scottish and a fifth of English local authorities never make payments of this kind (Davey et al PSSRU, 2007, p63).

Table 3
Items included in the direct payments hourly rate of local authorities/trusts in the UK by country

Country	No of LAs/ Trusts	Tax	NI	Hol pay	Sick pay	Contingency funds	Start-up costs	Support costs	other
		%	%	%	%	%	%	%	%
England	110	88	96	86	78	46	19	25	24
N.Ireland	3	100	100	100	67	0	0	0	0
Scotland	8	50	100	100	75	75	13	13	25
Wales	3	67	67	67	67	1	0	0	0

Source: Davey et al PSSRU, 2007, p63

Experience and lessons from Europe and elsewhere

Cost containment in other countries

Cost containment is a key driver of social care policies across many industrialised countries because in the light of demographic, social and political trends and rising unit costs for care, significantly increased budgets look unavoidable. It has been estimated on the basis of a study of 19 OECD countries in 2000 that even countries currently spending between 2.5% and 3% of GDP on social care provision that this percentage will have to double by 2050 just to maintain current service standards - let alone improve current standards or extend availability to more of those needing care (OECD, 2005, p39). Expenditure on social care for adults in the UK, at 1% of GDP, was close to the average for the countries studied (ibid. p26 Figure 1.1). In many OECD countries, including the UK, there is widespread dissatisfaction with current standards and with only those with the highest levels of need receiving care services. Better quality care and reaching all those with significant needs would require higher staffing levels and training standards (OECD health project, 2005, p13) which would add further to costs.

Large variations across countries in public expenditure on care do not reflect demographic or social structures in a simple way. In other words they are not driven entirely by the growing numbers of old (and very old) people or people with disabilities, compared with those of working age. They also reflect;

- political choices about where and how to draw the line between public and private responsibility
- the level of women's employment affecting, in one direction, the amount

of time people in employment can devote to the care of others and, in the opposite direction, the financial resources families and governments have available to spend on care. By taking up paid employment, women on the one hand become taxpayers in their own right as well as contributors to social insurance systems, but on the other hand their availability to provide care for their families is reduced

- the extent to which it is possible to combine care with paid employment. This varies between countries. Comparative studies show that the economic activity rates of older women are positively correlated with the level of provision of formal care services
- explicit government strategies to alter the division between men and women of the responsibility for the care of younger and older generations. These have developed unevenly, with Scandinavian countries recognising the need for such strategies earlier and more fully
- the poor image of care work. The cost of care services is too often presented as a 'burden' and employment in this sector poorly paid, menial and monotonous (European Foundation for the Improvement of Living and Working Conditions, 2006). The power of this image depends in turn on the rights associated with citizenship and understanding of intergenerational solidarity.

The form of public support for social care has also been changing across Europe as well as in other industrialised countries. In some countries, particularly in southern Europe, formal care services are under-

developed and state provision of social care services is widely regarded as a last resort. Cash payments have been seen as a way of sustaining family responsibilities for care. In other countries, such as Germany and even in some municipalities in Sweden, existing provision of publicly funded services is being curtailed or replaced by cash paid to those needing care and systems of direct payments have been developed. While there is a common aim to increase 'choice' and 'flexibility' in long-term care services, one of the key objectives of these policies has also been to curb the growing costs to the public purse of social care

The place of care workers in the labour market

In some European countries the problems involved in becoming an employer are avoided or at least reduced, because the direct payment holder is not the employer. Instead the chosen personal assistant becomes an employee of the municipal authority as in the case of Finland and Norway. They enjoy the same benefits as other municipal employees and can join their pension scheme.

In Norway direct payment recipients can now choose a voluntary organisation representing people with disabilities (ALABO) to become their chosen personal assistant's employer. Those needing care have none of the responsibilities of being an employer. In the Netherlands, from the outset of the scheme in the 1990s, the national Social Insurance Board became the personal assistant's employer. Direct payment holders can still make this arrangement but with the growth of home-care agencies, direct payment holders have the choice of either paying an agency to provide a personal assistant or arranging for their chosen personal assistant to be employed by an agency (Glendinning and Moran, 2009). In France, as will be discussed in more

detail below, the use of non-profit home care agencies is the most common arrangement. Here, 55% of direct payment recipients who need home care pay a carer employed by such an agency and a further third use an agency to recruit a care worker and in many cases get help with the administrative responsibilities of being an employer (Martin and Le Bilan, 2007, p46). This means that nine out of ten direct payment recipients have access to assistance with recruitment and finding a temporary or permanent replacement when their needs change.

In some countries there are organisations which assist mainly with recruitment. Some provide training as well. One example, operating across Europe is the international Caritas federation based in Freiberg, Germany. Caritas provides some training in social care and acts as a recruitment agency in a number of Eastern European countries, offering a placement service for those seeking domestic care workers, not only in Germany but also in Italy and Austria, where there is no regulation over the use of direct payments. In Vienna Caritas may also act as an employer of a personal assistant including a relative, but its main activities are focussed on helping those needing a personal assistant to find one and vice versa. In Romania the national Caritas also provides training - not only for those who are planning to migrate to become care workers but also on-the-job training for care workers it employs itself (European Foundation for the Improvement of Living and Working Conditions, 2006, p30 and p47).

In other countries, notably those of southern Europe, there is growing evidence that many personal assistants and migrant domestic workers are operating on the fringes of the labour market where little is done to protect their rights and needs or increase the visibility of these workers. Recent experience in

Italy, where formal social care services are undeveloped, especially in the south, and direct payments have been widely used for 20 years, is instructive. There, there is no oversight of the 'companion payment' introduced in the 1980s for disabled and older people needing constant care, which is funded from general taxation and is not means-tested. In 2003 well over a million people were receiving it. Immigrants are often employed, many as live-in carers where, even if they are legal, they can be paid below the minimum wage and can be instantly dismissed. When in 2002 there was an amnesty for undocumented migrants, there were 340,000 applications for regularising a foreign domestic worker. It was estimated that half of home helps and domestic workers were migrants (Theobald et al, 2007). While some arrangements work well and last over several years, the tensions arising from this relationship, especially for live-in carers, can lead to exploitation (Ungerson, 2007).

Experience in the US also shows that little or no regulation may result in the state funded expansion of a 'grey economy' of care and domestic workers with heavy dependence on immigrant workers. Following the welfare-to-work reforms starting in the late 1990s, such as the introduction of temporary assistance for needy families, which requires labour force participation as a condition of income support, lone mothers have provided another vulnerable source of such workers (Gilbert, 2002 Keigher, 2007).

Expanding the boundaries of the formal labour market

In contrast to ignoring a growing grey market, national employment policies in France have been based on the objective of expanding the boundaries of the formal labour market. Since 1990 there have been tax incentives in the form of paying the employer's pension contribution

for those paying their informal carer or domestic helper the minimum wage and paid holidays. These measures legalised previously informal jobs and by 1996 over three-quarters of a million households, compared with half a million in 1990, were employing a domestic worker on a formal basis. However these jobs often remained casual and vulnerable (Martin and Le Bihan, p 41, 2007).

In 1997 a form of direct payment, the *Prestation Specifique Dependence* (PSD) was introduced on a means-tested basis to those over the age of 60 living at home or in residential care and assessed on a national dependency scale as being very dependent. The responsibility for agreeing a care package, in consultation with the older person and their family, rested with the local authority. It could be used to employ a relative (except a spouse) or a home carer either recruited from, or directly employed by, a home-care agency. If the agency was non-profit making they could be entitled to social security and tax exemptions. Nearly 70% of the hours paid for out of the PSD scheme were accounted for by personal assistants recruited through the agencies, which might also deal with the administrative arrangements concerning recruitment and the payment of the worker (ibid, p43). The exclusion of those with moderate assessed needs and income, together with recovery of the cost from the old person's estate (this had always been the case for *Aide Sociale*, the local means-tested assistance scheme), meant the scheme was not very popular and fell short of expectations. It was also criticised because it created new unskilled and casual jobs and the personal assistants experienced problems arising from lack of ongoing support similar to those experienced by personal assistants in England (described above).

In 2002 the PSD was replaced by the *Allocation Personnalisée a L'Autonomie*

(APA), which included those who were less dependent, abolished recovery from inheritance and guaranteed access to the same services across the country - care plans that gave rights to a specified amount of money according to level of dependency. This was guaranteed by the state which made good any shortfall in the resources of individual local authorities, who were responsible for implementing the negotiated care plans. At the same time a co-payment element was introduced whereby above a certain income threshold the older person contributed to the funding of the care plan in proportion to his or her income. Initially it was funded from the social insurance system together with an agreed proportion of funds from local authorities.

The introduction of the APA was a success, rapidly increasing the numbers of claimants. However, with a shift to the right among local and central government, cuts were made in the spring of 2003, reducing the proportion of recipients exempt from making any contribution from 67% to 36% (ibid, p45). The heat wave of the summer of 2003, in which 15,000 elderly people died in hospitals, residential homes or in their own homes, resulted in a rethink. The government and administrative authorities were blamed for their lack of preparation for such an event. The minister of health was not re-elected and, among other measures, the government guaranteed funding for APA for frail older people. In particular, a new fund was established based on an increased employers' contribution of 0.3% of their payroll balanced by a 0.1% increase on the Contribution Sociale Generalisee paid by employees and the abolition of a one-day public holiday. However, there is no social partnership (gestion paritaire) between the government and the trade unions and other professional organisations; unlike in other parts of the social security system where trade unions have equal membership of

the boards managing the particular social security fund and developing policy. The management of this negotiated bargain between employers and wage earners therefore may not be as firmly based as in other branches of the contributory social security system as a whole (Martin and Le Bilan, p54).

Nevertheless, overall Martin and Le Bilan concluded: "with the APA, the French cash-for-care system is no longer an assistance policy, reserved for the poorest and more dependent, but a more universal scheme, open to all people in need of support because of their dependency" (op.cit p54). It is an interesting illustration of what can be achieved when the welfare of the older generation is taken seriously, albeit as the result of a disaster. Solidarity between the generations has more salience in France. Good quality collective child-care services have been taken seriously for decades, not only to facilitate the employment of mothers, but also because children as citizens are entitled to such care in their own right.

In this context, the training and professional development of care workers was taken seriously. In 1996 a two-tiered approval system for agencies had been introduced. Approval granted by the Regional Prefet meant that agencies providing care services for older or disabled people (or childminding services) have to conform to certain standards of funding and staffing at either a 'basic' or 'quality' level. There was also a national diploma for home helps but only a small proportion held it (9% in 1999). In 2002, a national qualification was introduced arising "from the political desire to raise the quality and qualification of this work, alongside the implementation of the APA" (ibid, p47). It requires nearly twice as much time as the previous diploma: 500 hours of theoretical learning, 560 hours of practical training and 17 hours of personal tuition, and can be taken on a full-time or

part-time basis. In her recent comparative study of care workers, Ungerson found that a large number of agency-employed social-care workers in France hold this diploma as well as being trained in health and safety matters (Ungerson, 2006). The downside of these reforms are that agency workers have a number of clients and often feel rushed and under pressure to limit their care to a fixed set of tasks. They could not always practice the holistic approach they had been taught, although they did work with the same clients over a period of time.

Agency workers in France have regulated and scheduled hours. There is no long-hours culture and the EU Working Time Directive is taken seriously. By establishing maximum hours of work it has not only been possible to reduce the opportunities to exploit agency workers but it can also be used to limit 'on-call' duties. In France, care workers must be remunerated for the hours during which they are on call including during the night, these hours, called "heures de presence responsable", must be paid at a rate not less than two-thirds of the standard wage (Gordolan and Lalani, 2009 p24).

Building on common interests and the role of trade unions

Support for establishing and maintaining good employment practices is to the benefit of both the direct payment holder and the personal assistant, since the quality of care delivered depends on good relationships and care workers' motivation. However, some direct payment holders and a smaller number of personal assistants, as already discussed, worry that more formal contracts will interfere with the very relationship that they wish to establish. This tension - which Knijn and others have called the different logics or rationalities of care which come into play when care is brought into the workplace (Knijn 2004) - cannot be wished away.

However the parties concerned can be helped to manage it.

There have been some very interesting attempts to create organisations which involve both personal assistants and those using direct payments to employ them. One is the success in Los Angeles county of the SEIU, a nationwide union in the US, which in 1999 represented 1.4 million low and moderately paid workers in building services, health care and public services. At the time it was devoting 40% of its resources to organising new workers such as home-care workers, who were doing very similar work to home carers in the UK.

The union wanted to follow care work into community-based settings where the workforce had doubled between 1990 and 2000. In doing so, it had to overcome:

- the lack of a common workplace
- the absence of a clear chain of employment responsibilities between home-care providers, those using their care and the county, state and federal government
- the existence of a third party in the employment relationship, namely frail older people and those with disabilities, who wanted to control how personal care work is organised in their homes, for all the reasons described above.

Based on their common interests, the union managed to create a long-term alliance between care workers and those to whom they provide care, which had as its purpose to secure and maintain security for both parties.

SEIU's first attempt to gain union recognition to represent home-based care workers was to argue that LA county was their shared employer because it was the source of 90% of the money which paid their wages and its representatives determined the number of hours and

rates of pay. The courts rejected these arguments on the grounds that LA county was only administering a state programme¹.

After strenuous lobbying the union won the right to enrol members and collect dues on a voluntary basis. On this basis, they developed services such as a registry of home-care workers to assist recruitment and increase the public profile of home carers. They subsequently won the right to become a public authority which could act as an 'employer of record' for home-care workers, although those employing care workers in their own homes retained the right to hire, fire and supervise their assistant, thus removing some of the concerns of the disability activists. This organisation could then bargain on behalf of both care workers and the care recipients. They fought a common campaign for more public funds to have the costs of employing a personal assistant recognised as well as for higher wage rates. "Key to the success at both state and local levels was the mobilisation of workers and consumers (direct payment recipients) and the emergence of one voice that linked worker and consumer issues and identified solutions that enhanced the position of both within the in-house supportive services system" (Walsh, 2001, p 232). Thus, though the union gave up some rights to defend individual home carers, they won the right to represent home carers collectively. As a result, access to training as well as to better pay has improved.

¹ A case concerning a personal assistant, which UNISON took in South Lanarkshire in very different circumstances involving sexual abuse, attempted to prove the local authority was the employer but it too was lost (see Pearson, 2006).

Issues arising

Family support

In common with experience in other countries, it is younger and physically disabled adults who have been the most interested in and willing to manage their own care (Lundsgaard, 2005, p32). Given their active participation in advocating this policy, it is not surprising that in the UK they were the first in 1997 to receive direct payments. The scheme was subsequently extended to older people and then to carers, to parents of disabled children and to 16 and 17 year olds with disabilities. They are no longer confined to those with long-term needs.

However “many of the success stories in using personal budgets featured new patterns of support often developed with the help of exceptional caring families and of visionary and committed staff” (CSCI, 2009, 130). As the parent of a deaf-blind child said: “I think the government is exploiting vulnerable parents and calling it empowering. It is actually exhausting” (Sense, 2008, p 17). In practice, in these cases the transaction costs of setting and monitoring care packages are being taken up by families and friends rather than the local authority. It is unlikely that these levels of family support will be available for the newer groups of direct payment and personal budget holders.

The employment of relatives

Direct payments were slow to develop even in England, compared with other European countries, where similar forms of cash-for-care schemes were introduced in the 1990s. This may in part be because they, like individual budgets, were initially only available to pay relatives in very restricted circumstances, since relatives were expected to provide care services unpaid. So the restriction was partly imposed to save the government the dead-weight cost of paying someone for a service they would anyway provide for free (not recognising that this was the not

a real saving but simply a transfer of that cost from the government to the carer). The restriction was also imposed from a fear that, despite evidence to the contrary from other countries, paying relatives would undercut the basis on which family care was provided and lead to its decline. The final reason for imposing, until very recently, the restriction on employing relatives was that, unlike in other European countries, one of the UK government's initial aims in the development of direct payments was to stimulate a market of domiciliary care services.

Few other European countries have imposed such restrictions on the employment of close or co-resident relatives and those that still do, often only restrict the employment of spouses. (Lundsgaard, 2005; Glendinning and Moran, 2009). However, the elaborate restrictions in England (see Ungerson, 2004) on employing relatives using direct payments and individual budgets are now being reduced because in many circumstances relatives are the only people available. Research on local domiciliary care markets has shown that they are not (yet) well prepared to meet the needs of individual direct payment holders (Baxter et al, 2008; Yeandle et al, 2006). In rural areas and small towns the ‘market’ barely exists. That this is still a problem in many countries where direct payments were introduced much earlier and home-care agencies are larger than in the UK, suggests that alternatives to the market will continue to be necessary even in a more ‘mature’ home care market (Glendinning and Moran, 2009). It is also clear that those wanting to employ a personal assistant are uncertain about how to find one in the marketplace. Indeed they do not know how to locate the market (ibid). Although as already discussed the employment of carers in Italy and Austria is largely unregulated, the organisation Caritas plays an important part in putting care workers and those

needing care in touch with each other.

The restrictions on employing relatives have also been relaxed because, in line with the emphasis on personalisation, direct payment recipients' choice to employ who they want has come to supersede the aim of developing a market in social services. Many (nearly half in the largest study so far conducted of direct payment recipients discussed above) choose to pay a relative or friend, not least because they want someone they know and can trust (IFF, Skills for Care, 2008). This is their choice and is not surprising as experience from other countries shows:

“... in a very direct way, the option to have a relative or friend as carer (and vice versa to provide care for a relative or friend) can be seen as a central element of choice and flexibility in long

term care-provided that both parties consent”.

(Lundesgard,2005, p4)

Older people

The government wants direct payments to be used more widely, so local authorities approached by those needing domiciliary care are now required to offer a direct payment before offering to arrange a service. As Table 4 below shows, the result has been a substantial increase in the numbers taking up direct payments, particularly among older people, although this is still only 2% of the 650,000 older people eligible for direct payments. In autumn 2009 the target for the numbers of people on personal budgets in 2011 was set at 30%. It remains to be seen how many of these will be direct payment holders.

Table 4: Adults and older people receiving direct payments in England 2001- 07

Administrative category	2001	2007
Adults 18-64	4, 274	16,140
Older people 65+	537	13,184
Carers (for carers services)	21	7,728
Adults 18-64 with learning disabilities	353	6,587
Adults 18-64 with mental health issues	61	2,086
Adults 18-64 with sensory impairment	100	1,126
HIV/AIDS	n/a	197
Drug and alcohol abuse	n/a	41
Total	5,346	47,088

Skills for Care annual workforce report 2008 p 23

Personalisation, whether it takes the form of a direct payment, personal budget or individual budget, poses challenges for social service departments in general, and social workers in particular. The tasks involved in implementing personalisation involve assessment, planning, putting plans in place and ongoing management. Although self-assessment is an important part of the process, some groups needing care require a considerable amount of help. Older people are more likely to need more support than other groups (Glendinning et al, 2008, p238) so the demand on local authorities is likely to increase.

Because older people are more recent recipients of direct payments, their experiences have yet to be fully represented in many studies so far published. In any case, the studies which have been published to date include mainly those who have actively chosen direct payments. There is some evidence from the pilot studies that older people are more reluctant to have an individual budget, especially if it entails becoming an employer, and doing so increases their level of anxiety (Glendinning et al, 2009; Yeandle and Steill 2007). This result is consistent with findings from comparative research studies, not only in Europe but in the US and Canada.

The dependence of the social-care system on migrant workers

The success of personalisation depends on the availability of suitable carers. While some are content to employ a member of their family and that relative is happy to care on that basis, this is not an option for everyone. So far the labour market in social care has not worked well. Constrained by government funding and care recipients' own income, wages in the social care sector are among the lowest in the country with little career structure for

staff. There are high turnover rates and continual vacancies. The employment of personal assistants may help with the latter, through bringing some informal carers, previously out of the labour market, into employment. However this 'informalisation' of care-sector employment, as we have seen, is likely to exacerbate its problems of low wages, training opportunities and absent career structure. This makes care work an unattractive occupation and dependent on recruiting those whose choice of employment is heavily constrained. In the past, as discussed above, single women were drawn into residential care work because it provided them with a roof over their heads. Today migrant workers choose care work for similar reasons or because fewer jobs are open to them, especially if they are combining work with studying.

This is not an inevitable result of the introduction of personalisation. Ungerson found two major variants in the rules and regulatory framework which significantly determined the outcomes of cash-for-care schemes. One was whether or not the payment of relatives was permitted. The other was the regulatory framework for enforcing the social rights of care workers (Ungerson, 2004, p210). Ungerson and other researchers have found that where regulation is weak there is likely to be heavy reliance on migrant labour, often undocumented.

In some parts of England, the expansion of the social-care workforce both in the residential and domiciliary care sectors, is already heavily dependent on migrants, as Table 5 shows.

Table 5 Percentage of the social-care workforce born outside the UK by country and region 2007

Country	% social-care workforce born outside UK
England	19
London	68
South east	25
Most English regions	11-15
Northern Ireland	13
Scotland	2
Wales	4
United Kingdom	16 = 105,000 people

Source: Skills for Care 2008 based on the labour force survey

This is not a recent phenomenon. Migrant workers made a significant contribution to the development of the post-war British welfare state and to its health and welfare services in particular from the outset. Since the turn of this century they have been making a growing contribution to the social-care workforce. By 2008 nearly one in five social care workers were foreign born, compared with 8% in 1998. In addition, between 2003 and 2008, half the additional 155,000 workers who joined the social care workforce in England were foreign born.

Not surprisingly, recent migrant care workers, those that arrived in the past 10 years, have some different characteristics from longer established migrant or UK-

born care workers. In particular recent migrants tend to be younger, with the majority aged between 20 and 34 years; 43% of earlier migrants are aged between 50 and 64 years. Many are engaged in education, and of those working part-time 50% are doing so to undertake training, 75% for qualifications in the health or social care sector. Otherwise migrant workers are less likely to be working part-time, only 25% compared with 50% of the UK-born social care workforce. Recent migrants are less likely to be employed in the public sector (5%) than either long established migrants (18%) or UK-born care workers (23%). They are also more likely to be men; men are nearly a third of recently arrived migrant care workers, but only 13% of UK-born care workers.

Table 6 Distribution of foreign-born social care workers by immigration status 2007-08

Status	Percent
UK national	28
EU national	20
Indefinite leave to remain	14
Spouse	7
Student visa	9
Other visa category	2
Work permit holder	19
TOTAL	100

Source: COMPAS 2009 table 4.6 based on LFS data

In some parts of England, the expansion of the social-care workforce, both in the residential and domiciliary care sectors, has become heavily dependent on migrants. Overall, the regional distribution of foreign-born care workers is similar to the distribution of the whole of the migrant population in the UK. However there are distinct distributional patterns between regions and within the social-care sector. Whereas Indians and Eastern Europeans are evenly spread across the regions, Africans and Caribbean people are more likely to be found in London, reflecting in part earlier flows of migrants. Social-care workers from Zimbabwe and the Philippines also reflect the distribution of residential care establishments and are therefore found disproportionately in the south east and south of England.

The government does not address the issue of migrant workers in the latest Department of Health's paper *Working to Put People First: The strategy for the adult social care workforce in England*, (DH 2009(b)). The document only discusses the need for a more diverse workforce, arising from earlier migrations.

The shift to a points-based immigration system for those outside the EEA, poses challenges for the social-care sector. Social care is defined as low-skilled work and therefore the recruitment from overseas of only senior social-care workers with relevant qualifications and experience will be allowed. In addition such migrant workers must be paid an annual salary of at least £24,000. Providers are concerned that the government may well have underestimated the effect of the changed immigration rules on social care providers' ability to recruit and retain the existing senior staff they still need (Canganio et al 2009) New migrant workers from outside the EEA face additional problems for they have no access to publicly funded education, including even language courses, for the

first three years and no recourse to public funds if they lose their job or a contract is terminated. They cannot get indefinite leave to remain until they have been in the UK for five years. This means they must rely entirely on their employers to give them even basic training opportunities. Those who employ domestic care workers are very unlikely to give them such opportunities either because they do not have the resources or because they are unwilling to give them the necessary time off (Gordon and Lalani, 2009). Perhaps the government is hoping that the recruitment subsidy for employers to take on 50,000 traineeships, together with plans to extend apprenticeships in social care to include personal assistant roles, will compensate for the loss to the sector of new immigrant care workers due to the points-based migration system.

All this raises questions about the ways in which in this growing international labour market in care is spread across regions and nations and who bears the cost of such a system. By the UK taking only skilled workers it may fail to remedy shortages at more junior levels in the care sector. It will also unfairly benefit from training provided in other countries, while at the same time undermining efforts to produce a career structure within the sector, necessary to recruit and retain UK-born care workers.

Policy recommendations

It is clear that personalisation has brought benefits to many who have taken up the opportunity to use direct payments, personal and individual budgets. It has also brought benefits, in terms of employment opportunities and working relationships, to many personal assistants. However, most experience so far is of those who have chosen to be early movers into this new system, who are more likely to be dissatisfied with the old system, and therefore more inclined to appreciate the benefits of the new.

If this system is to be rolled out more generally in a sustainable way there are some important issues that need to be resolved.

The issue of choice

Personalisation is designed, among other benefits, to enhance care recipients' choice of how they are cared for. Recent legislation recognises that not everyone may wish to exercise that choice by buying their own care services.

Burden of responsibility

Personal and individual budgets have been designed for those who wish to continue using social services at least in part, in particular those who do not want the responsibility of being an employer. However, this does not remove the responsibility of management of a budget and making decisions that some people, particularly older people may not want. It is important that the introduction of personal budgets and individual budgets is managed sensitively so that those who prefer to be provided with an established package of well-run services continue to be able to do so and do not have to take on what may be seen as a burden of choice.

Threat to day centres

There is also the question of support for collective provision. By others exercising

the choice of taking cash instead of a service, those who would prefer to use collectively provided care services such as a day centre will find such provision closing. As discussed above, this is already happening, and affects not only public-sector but also voluntary- sector provision. A recent study of 269 users of care services in four local authorities conducted by Demos with the Centre for Disability Research at Lancaster University, found that nearly a third would spend their money on a day centre if they had a personal budget (reported in *Community Care*).

Limitations of individual payments

Individual pots of money are not easily used to fund such centres - or other community- based services (or even safe pavements). It is significant that at the same time as demanding direct payments the disability movement also campaigned successfully for public provision and regulation to make public buildings and amenities, as well as transport systems, accessible to people with disabilities. Direct payments cannot meet such systemic needs of older people or those with disabilities.

Increased cost of services

If many people take up direct payments, some services directly provided or financed by local authorities may no longer be commercially viable on current funding. It needs to be recognised that the introduction of personalisation means that such services may become more expensive to run. It is important that collective services that rely on economies of scale, such as day-care centres, continue to be available (and indeed are expanded and improved). Such collective forms of care bring benefits, including social contact that it is difficult or impossible for individuals to produce through spending individual budgets on their own. A specific budget needs to be set aside to provide them. Otherwise the

effect of personalisation will be to restrict the choices of those who wish to make use of such services, which are vital to overcoming the isolation in which many old people and some younger people with disabilities live.

Reducing the appeal of day centres

There is also concern that through certain types of users being more inclined to take up direct payments than others, centre users will become much less mixed and therefore the experience of using them less enriching. The effect of 'care in the community' of keeping all but the most severely disabled out of residential homes, was to make them much less cheerful places and to increase their unit costs substantially to cope with greater average needs and higher turnover rates (through increased death rates). If the same happens to collective forms of care in the community, fewer people will want to use them and local authorities are unlikely to continue to fund them. These cuts will achieve savings on the social care budget and may release a valuable site for sale but at the expense of those who have lost higher quality collective provision. They will be left even more isolated.

Negative impact on carers

Lack of available services can also have a negative impact on carers. "Cash payments alone, without appropriate services which they can be used to purchase, also risk institutionalising low paid or unpaid informal carers and trapping relatives in enforced dependency on the person they are caring for" (Glendinning and Bell 2008, p9).

The level of individual budgets and direct payments

There is no evidence that self-assessment of needs works in practice as a way of setting levels of direct payments. It would be surprising if it did, given a concern with fairness in the allocations of limited funds. The level of funding to individuals must eventually be down to government or local authorities. In practice complaints have been more about an inflexible system in which the budgets allocated for specific needs do not take account of the costs in meeting them arising from particular disabilities, or significantly disadvantage older people.

To some extent this is inevitable in such a system, since to have to account for every item for which funds are needed goes against the spirit of direct payments. However there are some principles that should be included in any system.

Avoiding the post-code lottery

The assessment of which needs are to be covered should be done on a national basis, so that there is no 'post-code lottery' determining which needs are allowed for, even if there may have to be local assessment of how much it costs to meet those needs (for example transport costs are quite different in rural and urban areas). This is the practice in many other countries. The process is likely to be more transparent when eligibility does not involve a means test and is either insurance-based or funded from general taxation. Compared with many other countries, the English system is particularly disjointed and heavily dependent upon the extensive use of means-testing of income and assets (Glendinning and Bell 2008). The proposed introduction in England of free personal care at home, already available in Scotland, is a welcome change in theory. In practice, however, if it is restricted to those with most severe needs, it amounts to little more than the

provision of continuing care services which once would have been provided free within the NHS. Even worse, it may involve cuts in other parts of social care budgets.

Support for ‘care brokers’

Personalisation brings into being a new role - that of a ‘care broker’ to support an individual budget or direct payment holder in choosing and commissioning the services they require. In many countries this is a separate role from the assessment of individual eligibility and the translation of that into an individual’s budget. Such a separation of roles follows from the logic of privatisation. The IBSEN study found that while local authorities were heavily involved in assessment, some local authorities used external independent brokers because they attached considerable importance to keeping the brokerage function separate from assessment. Comparative research suggests that this is a view which informs the delivery of social care policies elsewhere. However, it is important to recognise that both assessment of needs and helping people find the services that suit them best require considerable skills and experience. Whether based inside or external to the local authority, the staff undertaking these tasks need adequate support, training and pay. The development of systems of brokerage, and the difficulties of ensuring high-quality provision while making them truly independent, show that there are real limits to personalisation and self-assessment in practice.

‘Carer-blind’ assessments

Assessments should be ‘carer-blind’ – they should not take account of whether there is an existing family carer, so that those who have previously relied on such carers should have the same opportunities to choose their form of care as those who have not. This both ensures that family carers have a choice as to whether to continue in that role, or to alter the terms on which they carry it out, and allows

direct payment recipients the choice as to whether to use their direct payments to pay them. The interests of family carers may not always coincide with those of the person needing care. Indeed the IBSEN study found that this is one of the reasons some local authorities are reluctant to use direct payments or individual budgets to pay relatives. It is disappointing that it is proposed that the assessment for free personal home care in England will take account of any local- authority-funded support in cash or kind to their carers, especially as ‘intimate care’ is excluded from such support (Personal Home Care bill 2009). This may encourage the long standing practice of restricting publicly subsidised care to those without carers.

Adequate funding

Funding should be adequate to allow direct-payment holders to cover all associated employment costs, including replacement care during a personal assistant’s sickness or leave, training costs and tax and national insurance, as well as pay appropriate to qualifications and experience.

Levels of support should be continually reviewed since needs change; in particular older people’s needs tend to increase; all direct payment holders should have the right to a review of the level of their direct payments whenever requested and interim support provided in the meantime.

The relationship between direct payment holders and their personal assistants

Employment protection legislation has grown up over the years because individually generated contracts can be exploitive – in both directions. Some of the benefits claimed for being a direct-payment holder sound like those of a 19th-century factory owner, able to hire and fire at will, secure complete working time flexibility and avoid health and safety

risk assessments which other employers have to adopt. It is important that the freedom that direct payments allow does not recreate old problems in this respect, particularly since the quality of care is so dependent on sustaining good working relationships.

Help payment holders become good employers

Direct-payment holders need guidance about the responsibilities and reasonable demands of employers. It may be worth considering whether it would be better for the local authority to remain the employer, as is the case in some countries with longer experience of the use of direct payments. At the very least direct-payment holders should be given the choice of having the local authority as the employer. This might also make direct payments more attractive to those who do not want the responsibility of being an employer. Failing that, better advice needs to be given to direct-payment holders, in a form that is seen as helpful rather than controlling, about what to expect from personal assistants and the rights and possibilities of being an employer. For example, a range of standard contracts could be produced, which local authorities should endorse as the basis of the employment packages that they are willing to fund.

Training for personal assistants

Personal assistants need guidance about their role and responsibilities too. An induction course for personal assistants outlining their legal responsibilities, health and safety issues and ways of negotiating work practices with employers could be provided by local authorities. Such a course could also provide information about further training and encouragement to personal assistants to see the benefits to them and their employers of taking further training.

When things go wrong

We cannot assume that the best is always generalised. While not wishing to lose the benefits in terms of good personal relationships that existing informal working arrangements between direct payment holders and personal assistants often provide, these do not always work. More needs to be done for these cases. It is not acceptable to have created a large class of employment effectively exempt from good employment practices, either legally or through neglect. Further, it is reasonable to require some regulation of the way in which taxpayers money is spent on employing others. This is accepted in the case of childcare where tax credits can only be used to employ registered childminders; while registration of personal assistants may not be the solution here, some protection of both sides for cases where things go wrong is necessary.

Isolation and mutual learning from experience

The setting up of local care associations involving both personal assistants and their employers, building on their shared interest in providing good quality care and working conditions, should be encouraged and financially supported by local authorities. These could provide some of the benefits that accrue to larger employers, by for example sharing the costs of training, covering absence through illness or family emergencies, while at the same time protecting personal assistants' working conditions. Such an association could also help overcome one of the main problems of personalisation, the isolation and lack of experience of both direct payment holders and their personal assistants. This is not just a social problem; it also affects the quality of care since there is less learning from others' experience. The requirement that all English local authorities should have a user group to support direct payment

and personal budget holders in place by 2011 could provide an opportunity for the inclusion of representatives of personal assistants and other social care workers. This could be along the lines of UNISON's partnership working with the Scottish Personal Assistance Employers Network (SPAEN).

Sustaining the care workforce

In order to create a sustainable workforce delivering good quality care, it will be necessary to bring in new sources of labour without undermining the conditions of the current workforce. Traditionally care workers have been some of the least well remunerated sections of the workforce. Recruitment problems have meant new sources of more disadvantaged labour continually needed bringing in, whether it was unmarried women to staff residential care homes in the immediate post-war period, immigration from various parts of the world, or now - the government hopes - unpaid carers and unemployed young people on apprenticeship schemes.

These new workforces need organising to ensure that they share in the rights that other workers have in the UK. This is not only to ensure that they help develop a sustainable care workforce in the UK, but also so that the conditions of the existing workforce are not undermined, worsening current retention and recruitment problems. Some of these issues are outlined below.

Immigration laws threaten workers' rights

It is important that immigration regulations do not create a pool of less protected workers, either through illegality, or through not being offered the rights of other workers, for example to training. To build a sustainable workforce requires all workers have the same opportunities for training and progression; currently greater restrictions on the rights of recent

immigrants mean that this is not case (Gordon and Lalani, 2009).

Agencies exploiting migrant workers

Homecare agencies and the more general employment agencies provide little or no support and some exploit the vulnerability and isolation of migrant workers (ibid). Any measures taken to make their regulation more effective would be of general benefit to the workforce as a whole. The Care Quality Commission in its first report stated that 30% of agencies provide no or inadequate supervision of staff (CQC, 2009).

More flexible working for carers

Various measures to help carers combine employment with caring responsibilities are important too. Although being a personal assistant can be a convenient job for people with their own informal caring responsibilities, no-one should have to become a personal assistant through lack of alternative employment. The right to request flexible working has already been extended to cover many of those caring for adults (indeed it would be better if that right covered workers without caring responsibilities too). Forms of leave for carers, paralleling those for parents, should also be developed. Overall, the ending of the UK's opt-out of the EU Working Time Directive would be an important step towards weakening the 'long-hours culture' which limits and undermines so many caring activities.

Make social care a desirable career

The new apprenticeships in social care for young people will only be effective if a career structure exists. It is also important that the young people who take them up do so because they see social care as a desirable career, not just because they cannot find anything else to do. The selection process for these

apprenticeships should inform candidates of the real nature of care work. Well motivated, trained young people could provide a much needed boost to the social-care workforce, but without any intrinsic motivation the care they provide could be of poor quality. Care is too important to be treated just as a job of last resort.

Equal opportunities for older women

It would also be good to try to expand the diversity of entrants into social care through apprenticeships, for example, by encouraging young men to enter the profession. At the same time, it is important that those on whom the care labour force has always depended, such as women whose children have grown up and now have more alternative opportunities for employment, remain encouraged into social care by having equal opportunities to train. Governments should give some thought to providing apprenticeships that are open to re-entrants to the labour force in addition to these for young people, and removing the age qualification on them in the meantime, as has already happened in Scotland.

Training and career structure

Ultimately as a country we cannot rely on always finding new untapped sources of labour for the social care workforce. To train and expand the existing workforce it is important that a proper career structure for work in social care is created.

This needs to encompass those personal assistants who wish to make a career in social care too. Good employers look after the development needs and career prospects of their staff, and direct payment holders as employers cannot be exempt from that responsibility. However, they need to be given support in doing so. Not only are earmarked funds required, that cannot be spent in

other ways; training courses need to be provided and systems need to be set up to cover personal assistants' absences. All this should be the responsibility of the local authority, but funded by government as a national concern with creating a sustainable workforce. Contracts with care providers should be dependent on their showing that their own employment practices make a contribution to creating such a workforce, by ensuring that their workers are given and take up training opportunities; otherwise as we have seen, employers have little incentive to do so.

Training by itself is not enough to create a career structure. Trained workers need to be given greater responsibilities and paid more as a result. That social-care providers do so should be requirement of their contracts, and direct payment holders could be encouraged, for example through the organisations suggested above, to enable personal assistants to mentor each other and share work experiences (in some case, this might also help break down the isolation of the care recipients). All this needs careful thought, but cannot be ignored. Much more needs to be done to support personal assistants, otherwise the short-term boost to the social-care workforce that personal assistants have provided will be lost.

Carers learn to care for particular people and some direct-payment holders are only concerned with training them to meet their own needs. However, it is in the interests of society as a whole to improve the skills of the care workforce to improve the quality of care more generally. The need for support and training for personal assistants is beginning to be mentioned in the latest policy documents. However, for reasons discussed above, the issue of training is not just one of funding. Current structures to access funds are failing for the reasons discussed above.

There is a role for unions to access some

of these funds in order to support and develop the skills of personal assistants. In Finland older care workers are being encouraged to provide training, mentoring and information to newer entrants to the social care workforce. "Retaining the experience and expertise of older social care workers is an essential element of maintaining high quality standards in care provision" (European Foundation for the Improvement of Living and Working Conditions 2006, p29). With a large number of older care workers in the public sector coming up for retirement (many of them members of UNISON), there is a wealth of experience which could be used to develop the human capital of the next generation of social care workers, including personal assistants of all ages. They could be an important resource for the new apprenticeship schemes. In the child-care sector, the National Child Minders' Association is funded with public money to train its members.

The skills involved in care work must be more fully recognized and valued. The ILO defines care workers as those who provide routine personal care, such as bathing, dressing, or grooming, to the elderly, convalescent or disabled persons in their own homes or in independent residential care facilities. There is now a medical dimension which was not present in the job description negotiated 20 years ago (see p 7 above) and forbidden 50 years ago. Their tasks now include:

- maintaining records of client care, condition, progress, or problems, reporting and discussing observations with supervisor, or referring concerns to appropriate nursing, medical or social service workers
- helping clients to move in and out of beds, wheelchairs or vehicles, and with bathing, toilet, dressing and grooming
- providing patients and families with emotional support and instruction in areas such as caring for infants,

preparing healthy meals, living independently or adapting to disability or illness

- changing bed linen, washing and ironing patients' laundry, and cleaning patients' quarters
- entertaining, conversing with, or reading aloud to patients to keep them mentally healthy and alert
- planning, purchasing, preparing, or serving meals to patients or other family members, according to prescribed diets
- ensuring that persons take prescribed medication at the right times and assisting them with their medication if required.

(ILO Draft ISCO-08 Group Definitions: Occupations in health. Updating the International Standard Definition of Occupation, 27 April 2009. Cited in Gordolan and Lalani, 2009, p9)

Now that social care has expanded to include some aspects of health care, the boundaries between health and social care are becoming more blurred. If these boundaries are not to become barriers to the detriment of both givers and receivers of care, it is even more vital that health and social care workers work closely and possibly train together. Again there are interesting parallels with childcare where, over the last 10 years, far greater attention has been paid to developing some joint training and qualifications, as well as working across the education and care boundaries. These developments have occurred because the state rather than the market has both initiated and developed them.

Trade unions

The development of personalisation and the expansion of the social care workforce provide some new challenges for trade unions. The extent to which migrant workers and personal assistants are kept on the margins of the social-care workforce by weak regulation, poor pay

and conditions and lack of opportunities to progress could have a deleterious impact on the core social-care workforce, as well as on these groups themselves. This in turn risks reducing the quality of care provided across the whole sector and therefore rebounds on those needing care.

Immigrant workers, personal assistants and those on new apprenticeships will have to be organised too, if they are not to undermine conditions achieved by unions for their members. However the very conditions that make these new types of workers potential new recruits to social-care workforce make them harder to organise. But not to do so risks worsening not only their conditions of employment, but also those of the more organised public sector work force. Unions therefore need to:

- challenge restrictions on migrant workers to ensure that once in the UK they have the same access to education, training and employment opportunities as the existing workforce
- support the development of effective regulation of the employment agencies who recruit care workers from overseas. For example, the proposal that they be included in the remit of the Gangmasters Licensing Authority (Kalaayan, 2009)
- set up programmes specifically to recruit personal assistants and address their concerns
- get involved in setting up the new traineeships and apprenticeships, influencing their content as far as possible, and making clear the benefits of union membership and protection
- set up a comprehensive advice and support service for personal assistants. This might be one way in which some of the many recently retired, highly experienced home-care workers might become involved. A helpline for personal assistants and domestic-care workers such as the

one which Counsel and Care provides and operates for older people, their families and unpaid carers could be part of this service. In contrast to nannies and au pairs, those caring for adults may have few opportunities to leave the home of those they are caring for if they are living in. If they are also recent migrants they may be very isolated indeed

- find ways of supporting personal assistants by collectively negotiating contracts, terms and conditions.

Unions could also step in to help create institutional forms that are missing in this market way of organising care. For example, they could, like in LA county, make common cause with care recipients; in the UK they could help set up the sort of joint organisation talked about in the 'Isolation and mutual learning from experience' section, above. Unions could themselves, if local authorities fail to do so, draft model employment contracts for personal assistants. Many direct-payment holders are keen to have some of transaction costs of being an employer taken off their hands. Unions could help do this and in so doing protect the interests of personal assistants as well. They could also be active advocates or even providers of better training facilities.

Funding

As argued throughout this report, none of the benefits of personalisation will be achieved if funding is insufficient. Two-fold government reasoning in support of personalisation, that it can deliver services people actually want and reduce costs, suggests that this is a serious concern. There is little prospect in the UK of raising extra funds for social care out of general taxation.

This will be unsustainable in the long run. As argued earlier, the costs of care services rise faster than those of other sectors, so funding has to rise faster than

inflation. Even if there were a constant proportion of the population needing care, funding would have to rise in line with GDP. That would be the case even if the proportion of the population needing care remained constant, the proportion of care provided by unpaid carers remained the same and wages did not need to rise to sustain the care workforce. None of these conditions hold in practice, which means care will have to take a rising share of GDP. This should not be a problem, since rising costs of care result from tax payers getting richer rather than poorer, and would still leave them better off. However, it appears that no political party at the moment is willing to admit that reality and argue that higher taxes will be needed to pay for a social care system that reaches all. There is an argument to be had therefore with all of them.

One worry is that personalisation is a way to push that inconvenient truth on to care recipients themselves, since it will be easier for local authorities (and indirectly the government) to fail to raise direct payments and individual budgets in line with rising wages than to cut services directly. The assessment of the level of such payments and budgets is already recognised to be problematic. To ensure that payments keep up with costs, an independent auditing commission should be set up to monitor their levels to ensure that if payments do not rise as fast as costs, the implications of this political choice are known. Putting pressure on government to set up such a commission, or even directly setting up a shadow commission to operate in this way, is another potential role for the unions.

The decades-old split between health and social care budgets at local and national level has seriously distorted social care policies as budget holders have tried to shift costs from health to social care. It cannot be assumed that markets will develop unaided or indeed will develop at

all in some parts of the country. Ensuring good care provision will require sustained attention and help to direct payment and individual budget holders when the market does not provide. It would be unwise to assume that this will be possible without any public services or without doing more to support paid as well as unpaid carers. To succeed in providing good quality social care to all who need it, adult care provision will have to change from being the poor relation of the NHS. Above all, care - and those who give it whether paid or unpaid - will have to be more highly valued.

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