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Individual Patient Budgets: Background and Frequently Asked Questions

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Following Lord Darzi's pledge to pilot direct payments and individual budgets in health care, this paper provides a brief background to the concept and principles of these ways of working, before focusing in more detail on some frequently asked questions. The paper is intended to help inform forthcoming pilots, and was initially commissioned by NHS West Midlands as part of their *Investing for Health* strategy.

Background

Since 1997, disabled people in the UK assessed as being eligible for adult social care services have been able to opt to receive 'direct payments' (a cash sum in lieu of a directly provided service). Described by disabled academics and activists as holding out "the potential for the most fundamental reorganisation of welfare for half a century" (Oliver and Sapey, 1999: 175), the 1996 Community Care (Direct Payments) Act represented the culmination of a longstanding campaign by disabled people and their allies to give people using social care services access to direct funds with which to purchase and design their own support. While direct payments can be used to purchase services from a voluntary or private sector agency, many people choose to use the money to employ their own personal assistants (PAs), essentially becoming their own care managers. Initially discretionary, direct payments were soon extended to other user groups (including older people, carers, younger disabled people and people with parental responsibility for a disabled child), became a key performance indicator and were made mandatory (for people who meet the criteria and want to receive a direct payment).

Originally pioneered by disabled people in the US, this way of working was introduced to the UK in the 1980s by disabled people's organisations, promoted by disabled people during the early 1990s, and introduced only after sustained lobbying by disabled people (see Glasby and Littlechild, 2002 for an overview). Subsequently, it has been disabled people who have been most active in providing support to direct payment recipients and in campaigning for further extensions and greater take-up of the policy. Almost more than any other current policy, this is a concept developed, implemented and rolled out by disabled people themselves, and this alone makes it worthy of further consideration. Moreover, the move towards greater self-directed support and individualised funding is an international phenomenon – with many developed countries experimenting with similar forms of what the US calls 'consumer-directed care' or 'cash and counseling' (see, for example, Alakeson, 2007; Robbins, 2006; Glasby and Littlechild, 2002; Halloran, 1998 etc).

To date, all the available evidence suggests that direct payments lead to greater user satisfaction, greater continuity of care, fewer unmet needs and a more cost-effective use of scarce pubic resources (see Bornat and Leece, 2006; Glasby and Littlechild, 2002; Hasler *et al.*, 1999; SCIE, 2005 for further discussion). Essentially, it seems as though direct payment recipients have more of a vested interest than the local authority in ensuring that each pound available is spent as effectively as possible and in designing support that enables them to have greater choice and control over their own lives. While take-up is inconsistent and low compared to the number of people who receive directly provided services, any remaining barriers seem to be the result of the way in which direct payments have been operationalised rather than of the concept itself. Where direct payments have been taken up enthusiastically, the biggest successes have often come where there is a user-led Centre for Independent Living to provide advice and peer support for people thinking about such an option and starting to test out whether it is for them.

In spite of many positives, a key limitation of direct payments is that such a liberating way of working has often been bolted on to traditional and unresponsive systems. While direct payments can transform the way in which people design and receive support, therefore, they have not yet changed the way in which people access services, the way they are assessed, the prevailing culture or the way in which the bulk of the social care budget is spent. In contrast, individual budgets seem to offer all of the advantages of direct payments, whilst also starting to transform the system as a whole.

Set up in 2003 by the Department of Health, several local authorities and Mencap (a national voluntary organisation for people with learning difficulties), in Control is a national social enterprise which has developed and is rolling out a new system of social care (often called self-directed support). In order to re-engineer adult social care, in Control stresses the importance of seven key steps (see Box 1). At its most simple, however, ***an individual budget is essentially about being clear with people from day one how much is available to spend on meeting their needs, and ensuring that the person and those close to them have as much control as they want over how this money is spent on their behalf***. As in Control often says, this amounts to little more than "sensible delegation" (personal communication), and can free up the time of trained social workers to focus in more detail on those who need most help to plan their support.

Since 2003, individual budgets have been tested with around 6,000 people. While further evaluation is underway, the initial evidence is very promising. Not only are individual budgets delivering their primary purpose of giving people more power and control over their own support, they also seem to be leading to overall improvements in well-being and to greater efficiency. In particular, early pilot work with 60 people in six local authorities demonstrated (see Poll *et al.*, 2006 for all findings quoted below):

- Improved satisfaction levels for people who use services (satisfaction with support went from 48% to 100%).
- Improved efficiency (cost savings ranged from 12% to over 30%).
- Increasing use of community and personalised support (for example, use of residential care reduced by 100%).

Above all, however, individual budgets appear to provide a particularly effective way of empowering people who use social care. As Table 1 demonstrates, a massive proportion of people in the early pilots were able to achieve the changes that they wanted to achieve in their lives over the course of one year.

Box 1: Seven key steps to self-directed support

Step 1 - Using in Control's resource allocation system (RAS), everyone is told their financial allocation - their individual budget - and they decide what level of control they wish to take over their budget.

Step 2 - People plan how they will use their individual budget to get the help that is best for them; if they need help to plan, then advocates, brokers or others can support them.

Step 3 - The local authority helps people to create good support plans, checks they are safe and makes sure that people have any necessary representation.

Step 4 - People control their individual budget to the extent they want (there are currently six distinct degrees of control: ranging from direct payments at one extreme to local authority control at the other).

Step 5 - People can use their individual budget flexibly (including for statutory services). Indeed, the only real restriction imposed is that the budget cannot be used on something illegal (as long as people are meeting their eligible needs).

Step 6 - People can use their individual budget to achieve the outcomes that are important to them in the context of their whole life and their role and contribution within the wider community.

Step 7 - The authority continues to check people are okay, shares what is being learned and can change things if people are not achieving the outcomes they need to achieve.

Table 1: Impact of individual budgets

Desired change	% Achieved
Where I live	76%
Who I live with	81%
What I do with my time	69%
Who supports me	89%

Source: Poll *et al* (2006)

Faced with such early achievements, the English Government has taken up the concept of individual budgets with enthusiasm and is now rolling it out nationally. However, what is most remarkable about both direct payments and individual budgets (for present purposes) is the extent to which they mirror key policy goals in the UK National Health Service (NHS), yet (until recently) have been actively resisted in a health care setting.

In 2008, the NHS in England is facing a series of challenges as it tries to deliver the vision set out in a government White Paper, *Our Health, Our Care, Our Say* (Department of Health, 2006):

- Faced with demographic pressures and rising public expectations, health services are increasingly being asked to deliver an individualised and person-centred approach which fits services around the needs of the individual rather than the other way round.
- Following high profile financial difficulties (and faced with a much tighter financial settlement over the next three years), health services are having to concentrate on managing rising demand within cash-limited budgets.
- Tasked with promoting public health and well-being, health services are increasingly being asked to work in a way that encourages people to take control of their own health and to develop a preventative approach.
- While services will continue to be publicly funded, there is growing emphasis on opening up health care provision so that future services will be provided by a range of services across the public, private, voluntary and community sectors.

While many of these are new challenges to the NHS, they are longstanding issues in social care (which has often learned the hard way about what works and what does not work when tackling such issues). In all cases, these challenges are increasingly ones to which social care has looked towards direct payments and individual budgets as potential solutions.

Despite the current emphasis on inter-agency partnerships between health and social care, both direct payments and individual budgets are being actively promoted in social care at the same time (until recently) as they were being actively ruled out in health care (Department of Health, 2006: 85). At best this seems idiosyncratic; at worst it seems actively counter-productive. In response, a momentum for change has started to develop in recent months, with calls for the introduction of direct payments and/or individual budgets in areas of health care coming from a previous Health Secretary (Milburn, 2007), from a previous health policy adviser to Tony Blair (Harding, 2005; Le Grand, 2007), from the Opposition (Conservative Party, 2007) and from prominent think tanks (Alakeson, 2007; Leadbeater *et al*., 2008). More recently, this idea has also received support from the current UK Prime Minister (Brown, 2008) and from the Darzi Review. At the same time, additional impetus has come from concepts such as the 'year of care' model being explored by the NHS Diabetes Support Team, by a landmark NHS Ombudsman case (2003) and by thinking undertaken by the national in Control initiative to explore the different funding streams that could be integrated into current (social care) individual budgets (Waters and Duffy, 2007). Work by in Control and the Integrated Care Network (*Staying in Control*) is also exploring potential connections between direct payments/individual budgets and integrated care, while similar issues have previously been raised both in research (Glendinning *et al*., 2000a, 2000b) and in policy debate (Glasby and Hasler, 2004; Glasby and Duffy, 2007).

Key Principles

The work of in Control (who developed and rolled out the concept of individual budgets and of self-directed support) is underpinned by seven key principles (see Box 2)

Box 2: Seven key principles of self-directed support

- *The right to independent living*: if someone has an impairment which means they need help to fulfil their needs as a citizen, then they should get the help they need.
- *Right to an individual budget*: if someone needs on-going paid help as part of their life they should be able to decide how the money that pays for that help is used.
- *Right to self-determination*: if someone needs help to make decisions, then decision-making should be made as close to the person as possible, reflecting the person's own interests and preferences.
- *Right to accessibility*: the system of rules within which people have to work must be clear and open in order to maximize the ability of people to take control of their own support.
- *Right to flexible funding*: when someone is using their individual budget they should be free to spend their funds in the way that makes best sense to them, without unnecessary restrictions.
- *Accountability principle*: the person and the government both have a responsibility to each other to explain their decisions and to share what they have learnt.
- *Capacity principle*: people, their families and communities must not be assumed to be incapable of managing their own support, learning skills and making a contribution.

When exploring the concept of individual patient budgets, there is a tendency to focus on the individual budget per se, rather than on the underlying principles and key features of self-directed support more generally. However, the individual budget is only a means to an end (albeit a potentially powerful one) of active citizenship for all, and there is a danger that pilots in health care adopt the rhetoric of individual budgets without fully engaging with the underlying implications/ethos of this way of working.

Against this background, the remainder of this paper provides brief responses to a series of frequently asked questions raised by local PCTs exploring this way of working.

Issues	Responses
Can we actually give money away?	Understanding and signing up to the key underlying principles of individual budgets is more important than the technicalities of implementation – without the former, there is no point exploring the latter. However, the key feature of an individual budget is that the person knows up front how much is available to spend on their needs and can then make choices about how this money is spent on their behalf – while money can change hands, it doesn't necessarily need to (and many people might not want to control the money direct, but have someone else to manage it with/for them). More generally, this is a legally complex area – but there have been a series of test cases (and an NHS Ombudsman ruling) which have demonstrated ways in which PCTs can make payments (and indeed some areas are doing this already in practice). Prominent models include working with the local authority to make payments or establishing a user-controlled trust (both essentially a way of making payments indirectly via a third party). Also possible is the notion of a budget-holding lead professional (e.g. a community matron with an individual budget to spend with a person with long-term conditions to keep them out of hospital) – albeit that this is something of a diluted model. The key is the will to work in this way in the first place.
What additional services are there really to buy?	In some areas, there are already a range of different providers (e.g. maternity services, counselling services). Developing greater plurality of provision is also a key task for the NHS, and individual budgets could assist with this broader process. However, the real test will be the extent to which they lead to people designing support that does not look like traditional 'services' at all (for example, a person with respiratory problems installing double glazing, someone with obesity going to a gym, a person recovering from psychosis attending an adult education course etc).
Do we need ethical approval?	This may need checking in detail, but in principle this is about a new mechanism to meeting needs that the NHS has always tried to meet. The key is remaining focused on outcomes (see below for further discussion), not on the details of the support/processes that the person chooses to use to meet these outcomes.
When might individual budgets start in the health process?	This depends on the nature of the pilot – a long-term conditions pilot could begin at referral to a community matron, a mental health pilot could begin during planning for hospital discharge, a maternity pilot could begin at first assessment etc. Tactically, it may work best if the front-line worker can make a simple referral through to the person/service that then introduces the concept of an individual budget. Without this, there is a risk that pilots will fail because the concept is not introduced in a balanced way at first contact with services. Whatever happens, it is crucial that the person has access to support to test out new ideas, build their confidence and reflect on learning. In social care, access to peer support has been particularly important – and there may be clear links with the expert patient programme in health care.
What would success look like? (e.g. money/outcomes/quality of life/patient satisfaction)	This would depend on being clear on the need to be met and remaining focused on this, allowing maximum discretion with regards to how the person goes about meeting this need. Success would therefore vary by pilot/service area. Thus, a long-term conditions pilot might focus on the extent to which people at risk of hospital admission remain living independently in the community, while a mental health recovery budget could be measured on the extent to which it helps people reintegrate into work and society. The key is that the need in question is one which it is appropriate for the state to be meeting, but that the person has maximum flexibility to go about meeting this need in a way that makes sense to them.
How would we manage inequalities?	While some people fear that individual budgets could increase inequity, others argue that the current system is already inequitable. Indeed, this way of working could actually increase equity by tailoring support more fully to individual need and by making options only currently available to those funding their own care available to all. There also seems to be scope to increase equity by freeing up workers to focus on those who most need support (rather than on trying to work in the same way with everyone, irrespective of whether they need this level of intervention). Pilots could also be targeted on specific groups or communities (e.g. a maternity pilot based in a Sure Start centre).

Issues	Responses
How would we manage requests to top up an individual budget?	This is a common query, but one that is relatively simple to answer. First of all, the question is not entirely fair, as many people currently 'top-up' by opting out of the NHS and 'going private'. Essentially, individual budgets are a way of nationalising and greatly expanding such choices and opportunities via a publicly funded and supported system. Secondly, the topping up issue does not really arise if there is a menu-based approach (albeit that this is a reduced form of choice). Third, the practice could simply not be permitted (as is the situation at present in the UK with elective surgery), with the accounting/review process acting as a monitoring device to ensure that the prohibition was not infringed.
What if consumers want to use alternative therapies that have no proven benefit?	The key is being clear about the outcome to be achieved. As long as the person can argue (credibly) that the way they want to spend their individual budget will help to meet this desired outcome, then they should have maximum flexibility. While the state has a key role in not making an individual budget if it is not achieving desired outcomes, this should not be unnecessarily restrictive and should be conducted in a learning manner.
How would governance and risk be managed? Who is responsible?	Planning how to use an individual budget is a crucial part of the process, and this should include an explicit consideration of risk and the contingencies that will be put in place. Ultimately, some would argue that it is the person's risk – and ultimately up to them about the risks they want to take. However, individual budgets are not a panacea, and do not change the fact that some health care decisions are very difficult to make – while individual budgets make these decisions more explicit and transparent, they do not change the underlying issues that would arise with a directly provided service. While the state has an important duty of care, some people who use services experience the current approach to risk as very disempowering. In their eyes, risk is a legitimate issue to discuss, but the result can be that someone in authority has ultimate power to make decisions about their lives with which they disagree. While this can sometimes be justified, some would argue that the current system is too risk averse and that taking considered risks is part and parcel of choice and control. With individual budgets, risk shifts from being an issue primarily for direct services to a situation in which risks are shared between the individual and the state.
What process would need to be in place to withdraw an individual budget?	The state retains the duty to ensure that people's needs are met, so should be clear in advance about the steps it will take if budgets aren't being spent in a way that enables needs to be met. However, this should not be overly punitive and should permit maximum creativity, innovation and learning.
Would we need to use evidence based interventions/therapies?	This could be part of checking that a person's support plan is meeting their needs, but should not be overly restrictive – in principle, there is scope for people to devise new ways of meeting health needs, and the system needs to be open to this. Effectively, this could be a form of learning by doing and reflecting together (a form of *practice-based evidence*, rather than just traditional *evidence-based practice*).
What form of contract management would there need to be in place? What approval would there need to be for new organisations? Do we need contracts with all providers (e.g. families/neighbours)? How would compliance to contacts be managed?	'Contract management' would be minimal (in its traditional sense). Instead the person and their worker agree the need to be met, the person (with support) designs a support plan, and the worker checks that this is an okay way of meeting needs. In one sense this is an informal 'contract' between the state and the individual, but one which operates by setting out the need that it is legitimate for the state to be meeting and the way in which the person is going to try to go about doing this. More generally, the role for strategic commissioners is to help to ensure that a wide range of different types of support is available for individuals to purchase (i.e. developing the market). Where a user-controlled trust is in place, there needs to be a brief agreement as to what the trust is going to achieve on the person's behalf and setting out accountability arrangements etc. If a PCT was seeking to develop its local market, it would simply do this in the normal way. However, it would still be up to the person (with appropriate support) as to how they spend their budget and who, if anyone, they contract with. More generally, the advent of individual budgets could aid the shift to more outcomes-based contracting.

Issues	Responses
What is/are the legal issue/s?	Part of the impact of individual budgets in social care is that they are designed to produce potentially revolutionary changes in people's lives, but in a way that is fully in keeping with current legal and policy frameworks. Although it is slightly more complicated in health care, the same appears to be the case here too – with the right level of commitment and understanding, then this way of working seems equally feasible.
What level of checks would need to be undertaken on suppliers such as neighbours/family members etc?	In one sense, none – it would be up to the person (with appropriate support) to decide how to spend their budget. The test of whether arrangements are working in practice is the extent to which the budget is helping to meet agreed needs – not on what processes are put in place to do this. If a person wishes to carry out a check (e.g. a CRB check) then they should be supported/enabled to do so – but the choice is ultimately that of the person concerned.
How to link individual budgets to the 7 challenges within *Investing for Health*?	This is a broader question – but one of the reasons why individual budgets are being considered in health care is that the NHS currently faces a series of challenges and must do's (well articulated in *Investing for Health*). In social care, direct payments/individual budgets seem to offer a very positive way of meeting such challenges – hence a desire to explore a potential extension to some forms of health care.
How to minimize bureaucracy and authorisation of individual budgets?	The main lesson from social care is that the simpler this can be, the better – the one clear cut way of destroying the impact of individual budgets is to audit or to regulate all the creativity and power out of this way of working. The role of the state is to assess initial needs, facilitate access to support (if needed), check that the support plan seems a good way of going about meeting needs, then checking out the results and sharing learning. Anything more than this runs the risk of being too restrictive.
What is authorised within individual budgets? Is it anything legal?	It is the need/outcome that is agreed by the individual and the state. The state then has a role in checking that the support plan seems a good way of meeting these needs/achieving these outcomes. However, the person can then spend the money on anything that is legal.
How can we reassure patients that they will still be entitled to support if policy changes in the future?	The state retains a responsibility for ensuring that people's needs are met. If policy changes in the future, then the NHS will still have to find a way of meeting people's needs. However, this would be the same with a directly provided service or with any form of pilot project.
What organisations are there in place to provide support (if necessary)?	In social care, particularly effective results have been achieved by Centres for Independent Living (organisations of disabled people offering practical assistance and peer support). However, local authorities are currently developing six different types of support/approach (ranging from having a care manager support you/control the money on your behalf through to receiving the full amount as a direct payment – see www.in-control.org.uk for further details). In health care, there would be scope to tap in to such support locally and/or to train appropriate NHS staff (e.g. CPNs in a mental health pilot).
What accreditation needs to be in place for suppliers of services?	In one sense, none – as explained above, the focus is on the outcome to be met, not on how the person goes about achieving this outcome. If the person wants to access formal services that fulfil the usual accreditation/quality requirements, they should have the information to do this (but equally they may choose another way of meeting their needs).
What resource requirements are needed to be put in place to support this in health, and do they need to be different to social care?	In the longer-term, the absence of meaningful unit costs and outcome measures in community health care makes this more complex than in social care. In the short-term, however, a piloted approach would be a helpful way of overcoming this (and indeed of helping to develop more meaningful community metrics/tariffs). For example, a pilot that focused on expensive out-of-area placements would be able to work with individuals where we already know the 'individual budget' attached to the person (and indeed where we know that outcomes can sometimes be poor). Such a pilot could therefore take the same amount of money and use it differently to explore the potential impact. Similarly, a maternity pilot could develop approximate costs for a simple hospital birth, a midwife-led unit, a home birth and the cost of an independent midwife (if these do not exist already).

Issues	Responses
What success stories are there?	There are lots of success stories in social care (see www.in-control.org.uk). Until recently, it was harder to find health care examples due to what was perceived as a more hostile policy context. Now that this has changed, individual budget pilot sites and other areas are starting to talk more openly about local work that was going on anyway to explore such options. One request from participants in a recent CSIP workshop on this topic was for the greater availability of such success stories – and this could be a key role for the SHA.
What is the national and international evidence?	There is very positive national evidence with regards to social care, and emerging examples of good practice at the health and social care interface. Summarising the international evidence is difficult due to different contexts and different boundaries between health care, social care and social security. However, a recent review of US examples has been very positive about the opportunities that individual budgets could offer the NHS (Alakeson, 2007).
What are the barriers to the development of individual budgets?	Although there are many practicalities to work through, these seem capable of being resolved if there is sufficient commitment and if lessons from social care can be taken on board. The biggest barrier (and probably also the biggest potential advantage) is undoubtedly cultural – working in this way calls for a very different value base and a very different relationship between the state and the individual, which can often feel counter-cultural to current welfare professionals. Essentially, this involves moving away from a situation where the person is a passive recipient of state services (a professional gift model) towards an approach based on active citizenship. It is this battle for 'hearts and minds' (at all levels of the NHS) that is arguably crucial.
How do we maximise shared approaches to commissioning?	This involves a very different approach to commissioning – instead of purchasing bulk services and offering people access to pre-paid packages, individual budgets involve the individual becoming their own commissioner. However, there is scope for individuals to come together to pool their budgets (and support organisations or even the co-operative movement may have a key role here). In many ways, this is a very sophisticated question – but the current debate seems to imply that there is a choice between large-scale, block purchased care and individual support. In reality, this seems a false contrast - many people, when asked, want to do some things by themselves and some things in groups, and individual budgets could be used to do both (e.g. friends with mental health problems pooling their direct payments to hire an artist to lead an art class, rather than going to a day centre to do art and craft there; friends with learning difficulties sharing a house and pooling budgets to fund support).
Patients and families say that they want to be able to spend their individual budgets flexibly – how can we ensure common sense approaches in the pilots so that scrutiny is fit for purpose?	As previous answers suggest, the key is to focus on the needs that the budget should be meeting. Provided it is legal, the budget can then be spent flexibly. The pilots will need strong leadership so that the old system does not reassert itself by imposing excessive monitoring requirements.
How do we inform/involve the population we work with to better manage expectation and understanding?	The main issue is NHS leaders and front-line staff in pilot sites understanding and committing to this way of working. Beyond this, forward-thinking social services departments, existing support organisations and disabled people's organisations have a key role to play – as to do current individual budget recipients (whose testimony is usually the most powerful of all). The key, however, is to keep individual budgets as simple as possible (as the concept is often poorly understood and poorly explained).

Issues	Responses
In what areas should we be looking to pilot?	Key areas seem to include: areas where people's health and social care needs are so intertwined that making individual budgets for one and not the other is counter-productive; areas of health care where choice and control are essential to the quality of the service; areas where genuine alternatives exist; and current areas of health and social care where individual budgets could simplify and resolve existing controversies. Practical examples could therefore include: recovery budgets for people with mental health problems; hospital admission avoidance for people with long-term conditions; expensive out-of-area placements; services for people with learning difficulties; continuing health care; maternity services; counselling services; physiotherapy etc. In the longer-term, there could also be scope to link this way of working to current attempts to promote more healthy lifestyles.
What do we mean by individual patient budgets? Is this the right name/title?	In social care, terms have changed/proved ambiguous/been used imprecisely – the lesson here is the importance of keeping this simple and using terms consistently.
How do we manage/inform/involve health care professionals?	This is an issue to do with broader change management rather than individual budgets per se. However, this battle for 'hearts and minds' is arguably crucial.
How do we learn from consumers?	In social care, the individual and the state both commit to sharing what they have learnt. Nationally, in Control has made significant progress in developing such a learning community, and their support/advice/experience would be crucial here.
How do we manage quality and safety?	See previous questions about risk, contracts and monitoring.
What organisations/other sectors can we learn from?	This way of working was developed in social care and there are many good practice examples (plus a much longer track record of exploring such issues). Nationally, in Control has been at the forefront of this way of working and has developed numerous (and freely available) practical tools, case studies and lessons. in Control's 'Staying in Control' project is currently seeking NHS membership to work on precisely these issues.
How can we take complexity out of the process?	By understanding it really well ourselves and by staying true to the key values and principles set out by in Control (a short paper on in Control's ethical principles is available via www.in-control.org.uk). Individual budgets are nothing more complicated than being clear with the person from the outset how much is available to spend on meeting their needs, then allowing them maximum control over how this money is spent/how much control they would like over it. Anything else is unnecessarily complicated and restrictive.
Budgets are means tested in social care and not in health - will this make the population think both will be means tested?	Only if it's poorly explained – see above for questions about complexity/keeping it simple.
How will we ensure equal allocation of money/budgets to ensure there is not another form of postcode lottery	Many would argue that a 'postcode lottery' already exists so that this is no different – on the contrary, it makes such a situation less likely because it gives a clearer and more transparent sense of entitlement. Initially, however, a series of pilots such as those proposed in *Investing for Health* would enable us to explore these issues in more detail on a small scale before considering future lessons/changes. In the longer-term, some sort of national resource allocation system might be possible.

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HSMC has been one of the leading UK centres for research, personal and organisational development in health care for over thirty years. Commissioning of healthcare and provision of healthcare outside hospitals have become specific areas of expertise in recent years, underpinned by a continuing commitment to issues of quality improvement and public and patient engagement. This reputation has also started to extend to adult social care, with a growing track record in inter-agency commissioning and provision of health and social care services. HSMC has also developed a national reputation for both organisational and leadership development across all health settings. For further information visit: **www.hsmc.bham.ac.uk**