1. Introduction

1.1 The British Medical Association (BMA) welcomes the opportunity to respond to the Department of Health’s consultation on direct payments for healthcare.

1.2 The BMA is an independent trade union and voluntary professional association, which represents doctors and medical students from all branches of medicine all over the UK. We have a membership of over 143,000 worldwide. We promote the medical and allied sciences, seek to maintain the honour and interests of the medical profession and promote the achievement of high quality healthcare.

1.3 This response provides comments on the aspects of the consultation proposals on which we have specific concerns and or suggestions. Many of these comments apply equally to the other two forms of personal health budget, namely notional budgets and real budgets held by a third party.

1.4 The BMA welcome the government’s commitment to undertake a comprehensive and robust pilot programme on personal health budgets before developing its policy in this area further. As the Department of Health is already aware, while the BMA will certainly look at the findings of the pilot, we have a number of overarching concerns about personal health budgets being introduced into the NHS in general, which are amplified in relation to direct payments. Whilst this may not be the Government’s intention, we believe that the introduction of personal health budgets has the potential to undermine some of the fundamental principles of the NHS and their very existence appears at odds with the workings of the system. We understand that there is an argument that where personal health budgets enable individuals to better meet their health needs (which will be different to the health needs of others) equity could said to be promoted. However personal health budgets could introduce another mechanism by which NHS patients could potentially receive different levels of care, raising significant equity concerns. The policy also seems to further establish the idea of healthcare simply as a commodity, which the BMA does not believe is in patients' best interest.

1.5 It is also clear that personal health budgets will add a new layer of bureaucracy and administrative burden upon PCTs. Providing budget holders with the required level of information, advice and support will be an additional call on the time and resources of NHS and its staff, as will the arrangements that will need to be in place to continually monitor and review patients’ use of budgets. In light of this, the benefits to patients both in terms of clinical outcomes and improved wellbeing would have to be considerable to justify personal health budgets being rolled out more widely in the future.

1.6 The imbalance perceived by individual patients who are heavily reliant on the health service, but who feel they have little or no control over their care and treatment is a very real issue. Personal health budgets do not pose the only solution to this problem however, and there are alternative approaches that could be adopted that would not lead to such a fundamental shift in the way in which NHS care is delivered. We have provided an additional commentary on these overarching concerns where not covered by our comments on the specific consultation proposals at section 18 of our response.

2. Persons eligible for a direct payment

2.1 The proposal is ‘for direct payments to be available to anyone who might benefit from them, if they are
located in a pilot PCT and they meet the criteria set out in the pilot proposal.’¹ For most people however, we consider that either accessing NHS care in the traditional way, or possibly one of the other personal health budget options, would be more appropriate than a direct payment. Whilst the regulations do allow a PCT to refuse a patient a direct payment if they are not deemed capable of managing one, the underlying principle of direct payments being ‘available to anyone’ implies that a direct payment is generally the preferable option, unless it can be proved otherwise. We think that the opposite should be the case.

2.2 Whilst we understand why the Department of Health is not being prescriptive about for whom personal health budgets would be most appropriate, it would still be wise for PCTs to be aware of the fact that the social care individual budget pilots found that different patient groups benefited more from individual budgets than others; for example older people participating in the pilots were less likely than others to report higher aspirations and reported lower psychological well-being.²

2.3 We support the proposal that the accompanying guidance on direct payments will provide advice to PCTs as to how to decide whether a patient is capable of managing a direct payment. This will need to involve considerations of mental capacity and meet the requirements of anti-discrimination legislation. There will also need to be guidance to resolve disputes that may arise in regards to decisions on eligibility.

2.4 The BMA does not believe that it would be viable for the NHS to offer all patients an automatic right to a personal health budget or direct payment in the future. Indeed, the Department of Health appears to hold similar views having stated that it does ‘…not believe a personal health budget would be right for everyone, or that universal personal health budgets would make sense for the wider NHS³’. However the recently-launched Department of Health consultation, ‘NHS Constitution: a consultation on new patient rights’, seeks views on a potential future patient entitlement/right to be offered a personal health budget, which appears to be accelerating the process towards roll-out of personal health budgets across the NHS. We will be responding to this consultation in due course.

3. Appropriate use of direct payment/personal health budget funding

3.1 At page 9 the consultation document sets out that ‘direct payments could be used in flexible, innovative ways to meet agreed health outcomes; they would not need to be spent on traditional NHS services. They could be spent on any services, as long as they are legal and appropriate for government to fund, and agreed in a care plan as meeting the patient’s health needs.’

3.2 We understand this to apply to all three personal health budget options and not just direct payments. There are inherent risks and implications arising from individuals being given greater choice and control over their care. First and foremost, there is a need to safeguard the use of NHS resources particularly in the impending tightened financial context. Whilst a level of flexibility for patients with personal budgets is evidently important, we have concerns over the potential for the funding to be used to pay for inappropriate and/or non-evidence based services or treatments, particularly where these services/treatments are not ordinarily available on the NHS (this includes alternative and complementary therapies and non-NICE approved treatments). Such use of personal budget funding could be considered a waste of NHS resources and may call into question the validity of personal budgets in the eyes of commissioners, whose role is to balance the population’s health needs with the finite resources

⁴ Available at http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_108012
that society is prepared to make available via general taxation. Serious consideration should be given as to whether funds should only be allowed to be used for services and treatments that GPs are currently able to refer to or prescribe.

3.3 The existence of personal health budgets will compromise equity within the NHS by creating a system that funds particular treatments/care for those patients holding a personal budget, but not for those who do not. The consultation suggests that the accompanying guidance will refer to other, existing policies that direct payments will not supersede, for example NICE guidance and ‘top up’ arrangements whereby patients would not be able to ‘top up’ a direct payment from their own resources. We would suggest that this is included in the regulations.

3.4 There is also the question of NHS resources being used to fund interventions more traditionally associated with social care. For example, an arthritis patient may prefer to put their budget towards a stair lift instead of expensive drugs as such an acquisition may provide a tangible benefit to their quality of life. Other examples given in the consultation document include air-conditioning, respite care and transport costs which are not generally associated with health care expenditure. Although the BMA broadly supports the development of flexible approaches to commissioning, at present, there is not enough financial resource for commissioners to spend on health needs and so there is unlikely to be funding available in order to invest in non-health or preventative interventions. Even where such interventions have the potential to result in future cost savings, commissioners have to achieve financial balance on a yearly basis, which presents an immediate disincentive for such investments.

3.5 We are pleased to see that personal health budgets are to exclude primary medical services and emergency or urgent care. We seek clarification as to whether this also excludes services provided by GP practices with a Special Interest and acute care services. We understand that mental health needs are an important part of the pilot programme although there needs to be consideration as to whether there are some psychiatric services that should be excluded from the pilot programme. In the NHS Confederation’s publication *Shaping personal health budgets: a view from the top* providers running secure facilities for people with acute mental illness were clear that such services should be excluded.

3.6 Patients for whom personal health budgets may be more appropriate (such as those with long term conditions) are potentially more likely to have conditions that are under active research. It is important that the establishment of care provided through personal health budgets continues to enable teaching and research.

3.7 Personal health budgets could motivate the NHS to produce more effective patient information. Yet as PCTs will be in a position to provide information to budget holders on providers they may attempt to influence the uptake of certain services through referral management schemes or other similar initiatives. We seek clarification on what will happen if some patients are forced to use referral management schemes whilst others are able to direct themselves away from such schemes. This may impact on the local health economy. Specialised services with small numbers of patients may only need to lose a few of their service users to other providers before they are no longer viable. It is also not clear how expensive but limited services will be managed. Will there be a limitation based on the cost of the service? These are also practical considerations that should be part of the guidance and the evaluation.

4. Nominated person to manage a direct payment on behalf of someone with capacity to consent

4.1 We are pleased to see that the regulations will include the requirement for the nominated person to undergo a CRB check under the Safeguarding Vulnerable Groups Act 2006. We seek clarification as to

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whether the safeguards will be similar to those included in the Power of Attorney process.

4.2 We think that there needs to be clear and regulated supervision of any nominee to prevent capital acquisition via their patient. There also needs to be safeguards in place to ensure that the nominee does not spend the budget on things that indirectly benefit them rather than the patient. For example, if the nominee was a service owner or provider manager, there should be restrictions on using the budget to subsidise the service’s running costs.

5. Representative to manage a direct payment on behalf of someone who lacks capacity to consent

5.1 At page 15 the consultation document proposes that the regulations would set out that ‘Representatives usually, but not always would be: court-appointed deputies, as set out in the Mental Capacity Act section 19(1); donees of lasting powers of attorney made by the person now lacking capacity; or parents or guardians acting on their child’s behalf.’

5.2 It is natural for adolescents and young adults to disagree with their parents or guardians from time to time. There is a potential for disagreements in regards to their preferred health care and use of their personal health budget. Arrangements and guidance will need to be in place for how to sensitively work through such situations.

6. Patients with fluctuating capacity to consent

6.1 At page 15 the consultation document proposes that ‘When someone loses the capacity to consent, we intend that a representative would be required to receive direct payments on their behalf’. The same restrictions and safeguards should be in place in these situations to make sure that the personal health budget is not spent on things that indirectly benefit the budget holder instead of the patient and to prevent capital acquisition via the patient.

7. Care plans

7.1 At page 9 the consultation document proposes that ‘before receiving a direct payment, the individual would have to agree a care plan with their care co-ordinator. This would set out the desired health outcomes, how they would be met (the services to be purchased) and the resources available (the budget).’ The Care Plans should also be reviewed to make sure that they adequately take into account the risks for deterioration.

7.2 We are pleased to see that a care plan will form the basis of the arrangements for personal health budgets and should be agreed before a PCT gives a direct payment. However we believe that additional funding and resources will be needed to properly implement these care planning proposals. The guidance will also need to include information on how to manage disputes that may arise between the care co-ordinator, the patient and/or their carer.

8. Employment

8.1 At page 19 the consultation states that ‘In some circumstances, people will wish to use their direct payment to employ staff. PCTs should support them to do so, while ensuring that there are proportionate safeguards in place. (This issue is not so relevant to other models of personal health budget, where recipients would not employ staff directly.)’

8.2 Whilst we do not envisage doctors being employed by direct payment holders, we are aware of the concerns of other unions who represent health care professionals who might be employed by direct
payment holders and fully support their position(s).

8.3 The regulations propose to ‘prohibit people from employing members of their family who live in the same house, except in exceptional circumstances and with the agreement of the PCT.’ It is possible that direct payments might be used to employ carers or other non-NHS employees. We can see that there may be situations where patients’ would like to employ family members as they often perform a significant caring role. In principle we would support this as long as governance processes and systems are strong.

9. Under-spend

9.1 Section 3.6 of the consultation document on ‘frequency of payments’ sets out that the accompanying Department of Health guidance would ‘advise PCTs to allow spare money to be ‘banked’ for use when a need arises, so long as the outcomes agreed in the care plan are met.’ However, we would recommend that under-spend is retained by the NHS. Personal health budgets and direct payments should not encourage patients to spend up to the budget limit regardless as this undermines the principle that access to NHS services is based on clinical need. Funding should not be unused in individual accounts when it could benefit other parts of the health economy. This is similar to the arrangements around practice based commissioning, whereby any savings made are re-invested back into patient care as a whole, rather than specifically into the service/areas where those savings were made.

9.2 We are also concerned that allowing patients to have money ‘banked’ may encourage patients to save money for a rainy day rather than spend what they need on their care. The care planning review process and monitoring of spending will be important here.

10. The risks involved in health care versus social care

10.1 We welcome the explicit recognition in the consultation document (Section 4 - Conditions that patients or payees would be required to meet) that there are far greater risks involved in health care than social care. For example, there will be fewer deviations from standard courses of treatment in health that will be suitably effective both in terms of clinical outcomes and cost. The consultation (and pilot) proposals are based almost entirely on the experience of social care however, with an underlying assumption that this provides the beginning of the evidence base for introducing personal budgets to health care. This makes it particularly important for there to be adequate piloting and evaluation before personal health budgets are rolled out further.

11. Budget setting

11.1 We have serious concerns over budget setting for direct payments and other forms of personal health budgets. Ensuring that the initial payment level for personal health budgets is appropriate will be essential. The evaluation of the Department of Health’s individual budgets pilot programme within social care called for ‘… national debate on the principles and processes for allocating resources, with particular attention to issues of transparency and fairness.’ We would support this recommendation being taken forward in respect of the personal health budgets pilots.

11.2 The Department has provided PCTs with very little in the way of guidelines on how to go about setting budgets. Although this is because the overriding emphasis within the pilot scheme is that it should not
be prescriptive, we believe that resulting lack of uniformity across the pilot sites will make evaluation on the basis of cost-effectiveness difficult. If an inappropriate budget is set this may also cause problems with increasing the chances of either over or under-spend with the subsequent implications for the budget holder, commissioner and relationships with the NHS staff supporting the patient’s use of the personal health budget.

11.3 Particular consideration should be given to how the budgets will correspond, if at all, with existing practice based commissioning (PBC) budgets and the PBC budget setting process. We would point out that the experience from PBC is that the process of setting an accurate and fair budget at practice level is extremely difficult; this will be considerably more difficult at individual patient/group level. We are also aware of the impact that errors in coding procedures can have on budgeting and financial planning.

11.4 A transparent pricing system already exists in secondary care, through the national tariff, however such a system does not exist for the majority of primary, community and mental health care. We understand from the Operating Framework for the NHS in England 2010-11 that as a first step to introducing Payment by Results to mental health services, a new currency for adult mental health services will be available in 2010/11. The Operating Framework also states that a currency for community services is in development with the aim to have currencies for specific community services by 2011/12. This will pose problems for the budget setting process. Presumably PCTs will need to attach specific pricing to activities undertaken in community and mental health care in order that the use of the budget can be transparently measured and costed. Needless to say, this will be a complicated and time-consuming task. It will also inevitably result in different PCTs pricing care differently, meaning that patients will ‘pay’ more for care in one area than they would in another.

11.5 The proposals for the regulations in section 5 requires ‘that if a direct payment runs out within the time period it was intended for, the care plan should be reviewed.’ We agree that the care plan should be reviewed, but also suggest that there should be a review of the budget setting process that was followed to establish whether the original budget set was inadequate. It is proposed that the accompanying guidance will recommend that ‘if the agreed care cannot be funded from the original sum allocated, additional resources may be required.’ Again, a closer look at the budget setting process will be needed here, as would a review of whether the decision to award a direct payment was the correct one in the first place. Of course, the PCT should continue to take responsibility for continuing to fund the necessary care for that individual whether or not this is outside of the original budget set, but where a patient significantly and consistently overspends against their allocated budget (assuming it was appropriate), this may call into question the validity of personal budgets in the eyes of commissioners. In such circumstances, there will need to be guidelines around whether patients in this position should be allowed to continue having access to a personal budget.

11.6 It may be that some patients end up with less funding, to their detriment, through use of a personal health budget than they would have if using NHS services in the traditional way, or that they have been allocated more funding than other patients with similar needs using NHS services in the traditional way. Neither scenario is fair or appropriate within a system like the NHS.

11.7 We would suggest that the regulations make provision for the budget to reviewed and re-set annually.

12. PCTs reclaiming a direct payment

12.1 We agree with the proposed regulations that would ‘allow a PCT to issue notice of its intention to reclaim, and then reclaim all or part of a direct payment, if: …an unplanned surplus develops.’ There will

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need to be careful consideration as to whether the patient was saving their budget for future services or treatment/s. Presumably this scenario would be viewed as a planned surplus and not come under the reclaiming criteria. We also support a PCT being able to reclaim all or part of the payment if ‘the person’s circumstances change so that a direct payment is no longer a viable mechanism for meeting their health needs.’ However we would add that it might not solely be due to a change in personal circumstances that renders a direct payment no longer viable, it might be that holding a direct payment (or other personal health budget) was simply not suitable or appropriate in the first place. We would recommend that the regulations therefore allow for this. The regulations should also cover the situation alluded to in the section above whereby continued overspend against the budget means that a direct payment is no longer a viable option.

13. Review and monitoring

13.1 The proposal is that the regulations will set out that PCTs should review the financial spending of a direct payment holder annually as a minimum. However, monitoring of financial spend should take place more frequently, which should also be included in the regulations. We would suggest that quarterly reviews would be appropriate. We also recognise that there may be cases where monthly checks would be useful.

13.2 It is important that during the pilot a number of related issues are reviewed such as whether service providers change their marketing strategy to directly target patients. There is the potential for unscrupulous providers to try and take advantage of budget holders.

13.3 PCTs will need to have explicit authority to require the disclosure of the details of the account that payments are made into or expenditure on a pre-paid card to review and monitor the financial spending of the personal health budget.

14. Purchasing information, advice and support

14.1 The consultation proposes that the regulations would ‘allow PCTs to include the cost of purchasing support services in an individual’s direct payment, if this is appropriate.’ The BMA does not have a firm view on this proposal. It could result in funds being diverted from direct patient care at a time of financial restraint. It could also result in more transparency with the costs being clearer to the patient and the evaluation team. This could therefore make questions of cost effectiveness easier to consider.

15. Treating direct payment services as NHS services

15.1 The consultation proposes that the regulations would ‘define the extent to which services provided by direct payments should be regarded as services provided by the NHS. For example, regulations could define circumstances where a PCT could fully discharge its legal obligations to a person by providing a direct payment. Conversely, the power could be used to make clear that, even though a person had received a direct payment, he or she was eligible for other health services.’ The consultation document describes this power as ‘a precautionary measure’, but that it is not intended to be used at this stage.

15.2 We are concerned that this could be used by a PCT to refuse to provide further care when a personal health budget has been spent or to significantly ration services. In this scenario a personal health budget would act as an imposed budget. We are concerned that this could go against the fundamental tenet of the NHS, namely comprehensive care based on clinical need which is free at the point of delivery. A set of principles that should be respected in the use of personal health budgets are stated in the Department
of Health’s *Personal health budgets first steps* report and include, ‘upholding NHS values’.  

16. The review of the pilot programme

16.1 We suggest that the review of the pilot programme also seeks to look at whether personal health budgets have led to improved outcomes at the same time as being cost effective. Cost effectiveness and value for money are particular concerns given the current financial situation and should be included in the review. We would wish to see the evaluation focussing on improved outcomes both from the patient’s perspective and a clinical perspective. The review should also look at the issue of appropriate use of funding, for example, if personal health budgets are used for non-traditional treatments, there is a need to measure the efficacy of these treatments both clinically and in terms of costs.

17. The future of direct payments

17.1 The Department of Health has made the commitment to ‘…only promote the further take-up of personal health budgets, and … seek parliamentary approval for more widespread use of healthcare direct payments, if the pilot programme proves their effectiveness’. We suggest therefore that the regulations include provision to adhere to this policy commitment.

18. Overarching views on personal health budgets

18.1 The BMA has a number of reservations over the introduction of personal health budgets, direct payments in particular: our concerns relate to the principles, practicalities and future implications for the NHS as a whole. Despite these concerns, the BMA does welcome the government’s commitment to undertake a comprehensive and robust pilot programme on personal health budgets before developing its policy in this area further. The piloting period is crucial for starting to try to work through some of the complexities and practicalities involved in introducing personal health budgets to the NHS. We are also pleased to see that the government has made a commitment not to automatically roll-out this policy once the pilot period is over.

18.2 However, we hope that other developments in the Department of Health – for example the consultation referred to above ‘NHS Constitution: a consultation on new patient rights’, which includes a proposal that there would be a future patient entitlement/right to be offered a personal health budget – do not supersede or override the cautious approach currently being taken by the personal health budgets team. As stated earlier in our response, the BMA does not believe that it would be viable for the NHS to offer all patients an automatic right to a personal health budget or direct payment in the future.

18.3 The very concept of personal health budgets is one that instantly seems at odds with the principles of the NHS and incompatible with the system if it is to be preserved in its current form. Although direct payments and individual budgets in social care have been well received by many, decisions around health, health options and services are very different to those in social care and more often than not, far more complex. For example, there will be fewer deviations from standard courses of treatment in health that will be suitably effective both in terms of clinical outcomes and cost.

18.4 The principles that the Department of Health established in ‘Personal health budgets: first steps’ in taking forward the pilot programme are both welcome and necessary. We understand that there is an argument that where personal health budgets enable individuals to better meet their health needs
(which will be different to the health needs of others) equity could said to be promoted. Whilst this may not be the Government’s intention however, we believe that the introduction of personal health budgets has the potential to undermine some of the fundamental principles of the NHS and their very existence appears at odd with the workings of the system. The questions listed below seek to illustrate this point:

- How can equity be maintained between patients with a budget and those without if personal health budgets can be spent on services not ordinarily available on the NHS?
- How can NHS resources be safeguarded if personal health budgets can be spent on services and treatments that are not proven to be clinically and cost effective?
- Will patients believe that they as an individual have an actual, financial entitlement to NHS services, undermining the principle that NHS resources/services are made available to patients on the basis of clinical need?
- Will an increasing emphasis on the individual through personal health budgets undermine the ability of the NHS to address the collective needs of patient populations?

18.5 The recent relaxation of the guidelines around patients paying to ‘top-up’ their NHS care has already paved the way to the NHS running as a two-tier system, with the resulting potential for NHS patients to receive different levels of care depending on their ability to pay. The promotion of personal health budgets in the NHS introduces another mechanism by which NHS patients could potentially receive different levels of care.

18.6 It is clear that personal health budgets will add a new layer of bureaucracy and administrative burden upon PCTs. Providing personal health budget holders with the required level of information, advice and support will be an additional call on the time and resources of the NHS and its staff, as will the arrangements that will need to be in place to continually monitor and review patients’ use of budgets. In light of this, the benefits to patients both in terms of clinical outcomes and improved wellbeing would have to be considerable to justify personal health budgets being rolled out more widely in the future.

**Personalisation versus the wider needs of society**

18.7 Whilst in general terms we are supportive of the intended aims of the personalisation agenda, we consider the more pertinent issue to be how to create the right balance between the needs of individuals, patient populations and the wider NHS.

18.8 The imbalance perceived by individual patients who are heavily reliant on the health service, but who feel they have little or no control over their care and treatment is a very real issue. Personal health budgets do not pose the only solution to this problem however and there are alternative approaches that could be adopted that would not lead to such a fundamental shift in the way in which NHS care is delivered. A lot can be done to meet the needs of individuals within existing frameworks, for example, more effective care planning through discussions that focus on a genuine partnership between the patient, carer (if applicable) and health professionals is one way in which patients can become more empowered and involved in their care. It may be that for many patients with long term conditions, proper and meaningful implementation of care planning will be sufficient to correct the imbalance.

18.9 Over emphasis on the individual may have an adverse effect on commissioners’ ability to focus on the needs of their overall patient population(s). This will become particularly apparent over the next few years when the NHS will receive little or no increase in funding, making it ever more difficult to balance and prioritise demands on the NHS. The growing emphasis in government policy on choice and personalisation have the potential to transform the manner in which future services are shaped as the nature of individual referral decisions and associated treatment pathways impact upon the shape of the NHS. Consequently, there needs to be a balance between the individual as a ‘consumer’, choosing and using services, and as a citizen, responsibly playing a part in how services should be delivered.
Commodification of healthcare

18.10 The very concept of personal health budgets in the NHS seems to further establish the idea of healthcare simply as a commodity, which the BMA does not believe is appropriate, nor in patients’ best interests. By attaching a price tag to healthcare procedures in secondary care, the introduction of the national tariff, payment by results (PbR), has made it possible for care to be delivered by any provider, whether NHS or independent sector. Personal health budgets takes this approach one step further, by attaching a sum of money to an individual patient that they can then spend on healthcare with any provider, again, whether NHS or independent sector. This reinforces the concept of the market in the NHS in England, at a time when there is little or no evidence for its benefits and significant evidence for its adverse effects, including encouraging fragmentation, discouraging cooperation and increasing bureaucracy and transaction costs. Personal health budgets can also be seen as a further tool to stimulate patient choice and thus create a more competitive environment within which providers are fighting to attract patients in order to remain viable.

Involvement of GP commissioners and impact upon practice based commissioning

18.11 The impact that personal health budgets will have on practice based commissioning is unclear and needs to be reviewed. There may be potential for patient and GP relationships to enter difficulty if disagreements over funding and commissioning or resource allocation decisions arise. The involvement of GP commissioners in personal health budgets would require additional funding and resources to support patients and the implementation of relevant Departmental guidance and PCT systems. There would also be a need to ensure that there was no duplication of infrastructure and/or effort between GP commissioners and the work of the PCT.

Local health economy and double running costs

18.12 There is the potential for other services to be compromised. As outlined by the NHS Confederation the introduction of personal health budgets will not involve ‘closing a service and simultaneously transferring users to a parallel system.’ Budget holders will be able to leave services and choose others. This could result in trusts having to ‘continue funding the fixed costs of their existing services as well as the personal budgets of those users who have left.’ Some specialised services are small providers who may find that the movement of even a few service users affects their future viability. This has the potential to necessitate the closing of services. This could also make it more difficult to implement the Department of Health’s strategy to move services of out hospitals and into the community if there is no guarantee of patient activity. The overall result of this scenario is a reduction in choice where patients may have more control over their care but are faced with fewer provider options.