Free choice in publicly organised and funded social services

Background report for the Economic Policy Council

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Introduction

Free choice in social services was introduced in Finland in the 1990s by local voucher pilots in elderly care and day care services. Internationally, and most particularly in Western welfare states, free choice started to gather momentum in the 1990s. It has gradually become an important political aim in social and health services also in the Nordic countries, where the legacy of publicly funded and produced services has been strong. Although the institutional change towards a mixed model of service provision has been incremental, it has been more or less constant and has taken many different forms (Streeck & Thelen 2005). In Finland, the Sipilä government's proposal for social and health care reform is one of the largest ever introduced in an advanced welfare state; it aims to implement free choice to cover the entire system of health and social care services.

Internationally, free choice is much more typical in health care than it is in publicly funded social services. Therefore, there is more research and other evidence on choice in health care compared to social services. The implementation of free choice models in social and health care is deeply context bound, however. Presumably, the outcomes of these models vary between different countries and policy areas. This report provides some important information on free choice models and their implementation in the field of social services. This knowledge is needed in the current political situation in Finland, since free choice is a major part of the proposed social and health care reform. It is important to stress that the effects of free choice systems in social services are not very well known (THL 2016a; 2016b).

This report aims to fulfil two purposes. The first part presents a systematic review of existing research and 'grey' literature about the outcomes of choice systems in social care services in Europe and the USA over the past 20 years. The aim of the review is to reveal how the introduction of choice systems in social services affects services, service users, costs, cost-effectiveness, and other potentially important aspects. The most important finding is that robust and generalisable evidence about the outcomes of choice are scarce. I will present some reasons for the lack of evidence and research in this area. The second part (published separately in Finnish) provides a unique analysis of the preferences and incentives of the CEOs or managing directors of the largest for-profit social and health care companies in Finland. The qualitative study consists of eight thematic interviews collected in the autumn of 2018. The findings reveal that private health and social service providers have diverse approaches towards free choice, especially in terms of the implementation of free choice models. This most likely derives from the different market roles

and positions of the firms. Nevertheless, many similarities were found. The private firms have definitely entered the publicly funded markets of Finnish social and health care with the intention of staying.

This report is structured as follows. First, I present the political aims and theoretical assumptions of free choice in publicly funded services. Secondly, I present some of the different choice models introduced in the field of social care in terms of what models are chosen and how they vary in different services and countries. Thirdly, I present and evaluate the results of our literature review.

Theoretical assumptions and policy aims of publicly funded free choice

According to quasi-market theory, choice is a demand-side tool to increase competition in the publicly funded social and health care market (Le Grand 2007). Daniels and Trebilcock (2005) describe the voucher as a tool that aims at improving efficiency in the delivery of services by creating competition on the supply-side and choice on the demand-side. Although we know from research that people do not always make rational choices (e.g. Meinow, Parker, & Thorslund 2011), the theoretical foundation for increasing choice in public services is based on the idea of citizens acting as active consumers (Rostgaard 2006; Clarke 2007). By making choices, exiting certain services, and choosing better providers, citizen-consumers shape the market and force providers to compete against each other and produce better quality services. As Gingrich (2011) shows in her study on varying publicly governed markets, different kinds of market models and choice models have been introduced in social and health care, and the dynamics and power relations vary from model to model. To sum up the theoretical discussions, publicly governed markets based on choice can either empower or disempower citizens as consumers. Theoretically, choice can also be approached from a non-market perspective. By offering more choice and empowering citizens, people can feel more in control and thus happier, and consequently take more responsibility for their own lives.

It is interesting to see that free choice reforms have been promoted by the left and the right (e.g. Kremer 2006), but the arguments for the reforms differ (Gingrich 2011). Gingrich (2011) argues that publicly funded markets vary depending on the political forces in power and the type of choice models introduced. In Finland, for example, a centre-right government implemented voucher legislation in 2009, aiming to increase choice for the customer and patient, improve the availability of services, and increase cooperation between municipalities' social and health services and private service providers (Act on the Voucher 2009).

The international argument for the pro-choice stance in social and health care services has followed two main lines: firstly, choice is a way to empower the service user, and secondly, choice cuts costs or makes the system more durable fiscally. Based on the literature on free choice, the most important aims set for choice models are the following: empowering users; personalising services; increasing the responsibility of users; ensuring high quality services; maintaining independence when ageing or otherwise being in need of help and services; avoiding costly institutionalisation (cash for care systems); saving costs; creating care jobs; reconciling work and family life; and increasing the share of women in the labour market (Mikkola 2003; Lundsgaard 2005; 2006; Department of Health 2005; Timonen et al. 2006; Rodrigues 2014; Whellams 2016).

Already in the 1970s, the disability movement in the USA was demanding the right to choose the services and aid needed by the means of a personal budget and respective choice mechanisms (Gingrich 2011, 177). Political debate at that time centred very much on rights and increasing choice; cost savings were not on the agenda. Later in the 1980s and 1990s, reforms based on free choice were justified by the aim of saving costs in public services (e.g. Kremer 2006; Karsio & Anttonen 2013; Meagher & Szebehely 2013; Burau et al. 2016). Choice policies in publicly funded health and social services also became attached to the promotion of competition in the evolving social and health care market to enhance quality and efficiency and contain costs (Arksey & Kemp 2008; Da Roit & Le Bihan 2010). Some scholars have described the overall choice shift as a process of transforming the citizen into an active rational choice-maker – a citizen-consumer – instead of being a passive welfare recipient (e.g. Clarke 2007).

Free choice models in social services

What can be chosen

The implementation of free choice in social and health care services may point to different kinds of choices. In his seminal study, *The Other Invisible Hand: Delivering Public Services through Choice and Competition*, Le Grand (2009, 39–40) defines five different kinds of choices a service user can make in the context of public services. Firstly, the user can choose the service provider (where). This is perhaps the most typical form of choice. All the voucher models and other similar models usually include this aspect of choice. Secondly, the user can choose the professional (who). This is seldom possible in voucher models, but this type of choice is made possible in cash for care and direct payment systems – naturally with the condition that markets can provide such a service or the user has the option to employ, for example, a personal assistant. Thirdly, the user can choose

the service (what). In elderly care, for example, this could mean a choice between home care, residential care, and/or a personal carer. Different forms of personal budget and cash for care systems might enable this kind of choice. Fourthly, the user can choose the time of the service (when). Fifthly, there is the choice of how the service is provided face to face, and today digital methods are increasingly being used (how).

Different models of choice

Over the last 20 years, roughly three systems of choice have been introduced in social services in Western welfare states: firstly, there is the choice of how to spend a personal budget granted by public authorities; secondly, there is the choice between a cash benefit and an in-kind service; and thirdly, there is the choice of provider. These definitions are simplifications of the national and local systems and practices used in various countries. For example, the Finnish voucher model first offers the customer a choice between in-kind services and a voucher; if the voucher is chosen, only then is the customer given a choice of provider. In England, the customer can choose between receiving cash for care as a direct payment or as a managed personal budget.

Firstly, the system of a personal budget, which offers the customer a budget to use for purchasing purposeful aid and services, is the most extensively studied and used choice model. The budget can be given to customers who can then use the money the way they want, or it can be managed by a case manager who, together with the customer, makes decisions about the aid and services needed. Secondly, in some countries customers are entitled to choose between a cash benefit and an in-kind service. This arrangement exists in Germany, the Netherlands, and the USA (OECD 2013). Thirdly, there is the choice of provider or the voucher model. Although the choice of provider model exists in many countries, it is the least used and studied model of choice. In social services, it is used at least in Portugal, Spain, Japan, the USA, Finland, Sweden, and Denmark (OECD 2013; Meagher & Szebehely 2013; Kuusinen-James 2016). The choice of provider is typically limited to choosing from a list of service providers competing for customers, as in the Finnish voucher model.

Research has very much focused on personal budget choice models – such as the English personal budget and direct payment systems, the Dutch personal budget system, the Cash and Counseling pilots under Medicaid in the USA, the Swedish choice of provider model, and the central European model of long-term care – where the choice between informal and formal care is made possible. These choice models dominate the literature evaluated in this research report; there is a clear

emphasis on the English personal budget and direct payment system and the US cash for care system.

English personal budget and direct payment

The English choice system has a 20-year history. It has developed through different kinds of pilots promoting choice and the personalisation of services for service users. In 1996, local authorities were permitted to offer cash payments called 'direct payments' to people with disabilities. In 2003, local councils were required to offer direct payments to all people eligible for social services. Cash payments made it possible for social service users to employ personal assistants. In 2001, the 'In Control' approach was introduced for people with learning disabilities. In Control was developed on top of direct payments, and it was described as 'self-directed' support. Building on these experiences and systems, individual budget pilots were implemented between 2005 and 2007 in social care and between 2009 and 2012 in personal health budget pilots (Forder et al. 2012, Gadsby 2013).

In 2018, both the personal care budget and personal health budget were in use in England. The personal care budget is aimed at people in need of social care, and the personal health budget is intended for people in need of health services. In addition, an integrated personal budget combining health and social care budgets was also in use. The personal care budget is means-tested and needs-assessed, and the local market prices for care affect the level of the budget. The personal care budget may be used in three ways. Firstly, the user can manage a direct payment. The local council pays the service user a cash payment, and the user is responsible for using it independently for the needs agreed in a care plan. Secondly, the local council can manage the budget for the user. The council arranges the care and services, but they are based on the user's wishes and an agreed care plan. This is the mostly commonly used practice. Thirdly, the budget can be managed by a third party, such as a private service provider (ageuk.org.uk). The same rules apply for the personal health budget (England.nhs.uk).

Swedish provider choice

The Swedish customer choice system introduced in 2009 resembles a voucher system. The core idea is that local authorities can choose to adopt a system of choice for any social service. After a needs assessment, eligible service users can choose from a list of authorised public or private

service providers. Many Swedish municipalities have implemented the system in home care for the elderly and lately also in residential care services (Erlandsson et al. 2013). The Swedish system differs from the Finnish voucher system, because the customers can choose either a public or a private provider. In the Finnish voucher model, initially introduced in 2009, only private providers could be chosen (Karsio & Van Aerschot 2017). The same principle of choice will be part of the proposed social and health care reform in Finland.

US Cash and Counseling

The 'Cash and Counseling' scheme was piloted in the USA in three states – Arkansas, New Jersey, and Florida – between 1998 and 2002. In the 2010s, most states offer some kind of consumer direction within Medicaid programmes. The idea of the original pilots was to expand options and increase freedom of choice in home and community-based long-term care. Some states introduced the model also for people with serious mental health problems. The pilots offered 'flexible' vouchers for users, and in the 2010s the form used has been either direct cash payments or a budget that is managed by a third party.

Dutch personal budget

The Dutch personal budget was introduced in 1996. Until 2012, it was one of the least regulated and most generous personal budget/cash models for the care system. Originally, a budget was granted to different user groups, such as people with a disability, chronic illness, psychiatric problems, or age-related impairments. The costs and the number of users rose rapidly during the 2000s, which finally resulted in the system being cut back. In 2012, many restrictions were introduced and the use of the budget was reduced; since 2014, only people who would otherwise have to move into a long-term care home have been eligible to apply for a budget. The Dutch personal budget can be offered as a direct payment or paid directly to a service provider (van Ginneken et al. 2012; Gadsby 2013).

Methods of the literature review

I conducted a thorough systematic literature review that included essential electronic databases. In addition, I contacted leading researchers in the field (see the acknowledgements). The electronic database searches resulted in outcomes ranging from a few hundred to thousands of hits. By narrowing down the search phrases and excluding irrelevant publications, I chose 150

potentially relevant items, which included research reports, peer-reviewed books, and scientific articles. I selected 30 publications from the 150 for the final analysis. The databases used were Andor (Tampere University Library database combining dozens of databases), Academic Search Premier (Ebsco), Applied Social Sciences Index and Abstracts (ProQuest), Business Source Elite (Ebsco), Google Scholar, Medline (PubMed), OECDiLibrary, Social Sciences Citation Index (Web of Science), Scopus (Elsevier), and Social Services Abstracts (ProQuest).

The results of the database search are presented in Table 1. The table includes the following information: reference, the purpose of the study, methods and data, main results, country studied, and the choice system studied. The results are summarised in the following chapter.

Results

Table 1. Review of the results.

	Purpose of the study	Methods and data	Results	Country	Choice system
Brown et al. 2007	To examine: 1. The effects of the cash for care scheme for the participating beneficiaries and the beneficiaries' paid and unpaid caregivers; 2. The cost effects for Medicaid. Pilots in three US states.	Evaluation study. Multiple data sources. Experimental design. 1. A telephone survey. Baseline interviews and a follow-up nine months after enrolment. The sample size was 1,739 adults (59.6% proxy) in Arkansas, 1,465 adults (49.7% proxy) in New Jersey, and 1,547 adults (64.5% proxy) and 859 children in Florida. Response rate: min. 81.4%; max. 88.7%. Overall n=6,583. Multivariate logistic regression models. 2. The states provided administrative data on allowance amounts, start dates, reassessments, disenrolments, and the uses of the allowance at eight months after enrolment. Multivariate regression analysis.	The programme increased the consumers' likelihood of receiving the care to which they were entitled. Across all ages, the control and flexibility offered by the programme greatly increased the consumers' satisfaction with the help they received and their overall quality of life. Many unpaid caregivers were paid under the programme. Only 5–10% of eligible users enrolled in the programme. Some 20–50% disenrolled in the first year. Two years after the enrolment, costs were 5–12% higher in the programme compared to the traditional system.	USA (New Jersey, Arkansas, Florida)	Cash for care scheme: Cash and Counseling

Carlson et al. 2007	To determine how Cash and Counseling changes the way that consumers with disabilities meet their personal care needs and, in turn, how this affects their well-being.	Experimental design. Regression analysis. Telephone interviews conducted 9 months after random assignment. The sample size was 1,739 adults (59.6% proxy) in Arkansas, 1,465 adults (49.7% proxy), in New Jersey, and 1,547 adults (64.5% proxy) and 859 children in Florida. Response rate: min. 81.4%; max. 88.7%. Overall n=6,583.	Users of the Cash and Counseling scheme were more likely to receive paid-for care, had greater satisfaction with their care, and had fewer unmet needs than the control group members in every state and age group, excluding the elderly in Florida (because so few participants actually received the cash benefit). Cash and Counseling substantially improved the lives of Medicaid beneficiaries of all ages when consumers actually received the allowance.	USA (New Jersey, Arkansas, Florida)	Cash for care scheme: Cash and Counseling
Castle 2009	To determine whether consumers use quality measures at their disposal, and to investigate whether they can interpret the quality information.	Mail survey data. A sample of 8,000 family members with elders living in one of 200 randomly selected nursing homes. Response rate: 59%. Multivariate analyses (ordered logistic regression models).	Some 31% of the consumers used the Internet in choosing a nursing home, and 12% recalled using the service. Comprehension index scores were high. The understanding of the quality measures provided was good.	USA	The Nursing Home Compare report, which provides information online on quality measures for almost every nursing home in the USA

Dale & Brown 2006	To test the effects of the cash for care scheme (Cash and Counseling) on the costs of Medicaid services.	Experimental design. Outcome measures were constructed from Medicaid claims data for the first 12 months after enrolment for the full sample, and for 24 months after enrolment for a cohort of early enrolees for whom 2 full years of data were available. The sample size was 1,739 adults (59.6% proxy) in Arkansas, 1,465 adults (49.7% proxy) in New Jersey, and 1,547 adults (64.5% proxy) and 859 children in Florida. Response rate: min. 81.4%; max. 88.7%. Overall n=6,583. The Medicaid claim data was used as a data source for the analysis.	Medicaid costs were generally higher under Cash and Counseling because those in the traditional system did not get the services to which they were entitled. Additionally, other, less common reasons were found. During the first year, the total Medicaid costs were generally higher for the treatment group than for the control group, with treatment-control cost differences ranging from 1% (statistically insignificant) for the elderly in Florida to 17% for the elderly in Arkansas. In the second year, the costs were even higher (with the exception of Arkansas).	USA (Arkansas, New Jersey, Florida)	Cash for care scheme (Cash and Counseling)
Eichler & Pfau-Effinger 2009	To explain the persistence of family care despite the new consumer choice options.	1. Survey data on the care of elderly people in Germany. Reviews several earlier survey studies to answer the research question. 2. Interview data from family members involved in care, n=33.	1. Elderly people and their families oriented their behaviour towards traditional care values in which the first priority is given to mutual support between spouses and the generations. 2. Elderly people on the one hand and care agencies on the other	Germany	Long-term care insurance that enables elderly people to choose between cash for care and services in-kind

			have substantially different definitions of good quality care. Elderly people have continued to favour familial care over in-kind services. From the beginning of the introduction of the long-term care insurance in 1996 until 2006, the share of people receiving services in-kind increased only from 9% to 13% (Lundsgaard 2005).		
Eklund & Markström 2015	To evaluate the free choice reform in mental health services (outcomes of implementing choice in day care centre services).	All eligible service users from one city were included (n=78): 41 of them participated in a 3-year time-series sub-study with four follow-ups; 60 of them participated in a 15-month follow-up study; and 78 of them completed a questionnaire. The study started before the introduction of the choice system. Wilcoxon's test (two comparisons) or Friedman's test (multiple comparisons) was used to calculate changes over time, and Spearman correlations were employed to analyse associations between variables. The Mann–Whitney *U* test and the Chi-squared test were	Some 56% knew about the choice reform, and 15% had used the option to change service provider (half of them because their former service provider had been closed down). In the follow-up study, six participants considered the reform to be a positive change. There were no changes in the participants' perceived empowerment, the size of the social network, or engagement in activities. Satisfaction with the services decreased.	Sweden	Free choice of provider in mental health services

		employed to test group differences, mainly for the dropout analysis.			
Foged & Houlberg 2015	To examine the indirect economic effects of free choice in home care for older people. How does the private market share of publicly funded service provision affect municipal costs?	The data for 2008–2013 include all 98 Danish municipalities. The data are organised as a panel data set, observing 98 municipalities each year over six years. The analysis is based on fixed effects (FE) models/change impact analysis (IA).	During the study period, the share of older people choosing private services rose 15% for practical help and 4% for personal care. By 2013, almost 50% of older people received privately produced practical help, but only 7% received personal care. The results show that a rise of 5% in the private service provision share increased the costs of municipal practical help services by 1.1%. There was no correlation in personal care services.	Denmark	Free choice in home care services for the elderly
Forder et al. 2012	To explore the patients' outcomes, experiences, and service use, and to examine the costs of the personal health budget in England under the NHS.	The evaluation had a mixed design, using both qualitative and quantitative methods. A randomised controlled trial was used to analyse the experiences of the service users. The study included approximately 6,000 individuals divided into six different user groups based on their medical condition.	The use of personal health budgets was associated with a significant improvement in the care-related quality of life (ASCOT) and psychological well-being (GHQ–12) of patients (at 90% confidence). Personal budgets with a higher value showed a significant positive impact compared to budgets with a lower value. Personal health budgets did not appear to have an impact on health	England	Personal health budget (including health services, which include aspects of social care and support)

		Cost effectiveness was assessed by estimating whether the personal health budgets group experienced greater benefits than the control group, who received conventional service delivery. The groups were compared 12 months after recruitment.	status per se over the 12-month follow-up period. There were no statistically significant differences between the costs for budget users and traditional service users. Personal health budgets were cost-effective when measured by care-related quality of life (ASCOT), but no significant difference was found when measured by health-related quality of life. Budgets were cost-effective for people using mental health services and continuing health care services.		
Foster et al. 2005	To determine who participated in the Cash and Counseling choice system, and why those eligible agreed/declined to participate.	Questionnaire: 1,538 respondents in Arkanas, 4,669 respondents in Florida, and 2,685 respondents in New Jersey.	During the intake period of 24 months, participants represented 6.3–16% of those eligible. The participation levels were fairly low. It was less likely for people to participate during the intake if they were 1) not using traditional services, 2) had lower costs in traditional services (under $300/month), or 3) were in the last two years of their life. The four most common reasons for agreeing to participate were 1) having greater control over the	USA (New Jersey, Arkansas, Florida)	Cash for care scheme (Cash and Counseling)

			hiring of caregivers, 2) paying family members or friends, 3) choosing the time of care giving, and 4) receiving better care. The main reason for declining was satisfaction with current services.		
Glendinning et al. 2008	To evaluate the outcomes of individual budget (IB) pilots. The report evaluates 13 local IB pilots.	A multi-method design. A randomised controlled trial examined the costs, outcomes, and cost-effectiveness of IBs compared to conventional methods of service delivery. A longitudinal design using pre- and post-intervention data. The sample included 959 people: 510 in the treatment group and 449 in the control group. The sample included four groups: physically disabled people (34%); older people (28%); people with learning disabilities (25%); and people using mental health services (14%). Service users were interviewed six months after being allocated to the treatment/control group. Some 130 in-depth interviews were conducted with lead	As a whole, the IB group was significantly more likely to report feelings of control in daily life, and satisfaction with the support accessed and the manner it was delivered. Younger disabled people and mental health service users were more likely to report a higher quality of life. No effect was found for older people. Over the full sample, the IB was cost-neutral. Regarding cost-effectiveness, for the full sample of people some evidence was found that IBs produce higher overall social care outcomes given the costs incurred, but no advantage in relation to psychological well-being. For older people, the standard arrangement was more cost-effective. It is doubtful that these results can be generalised to any other system.	England	Individual budget programme for mental health service users and disabled and elderly people

		officers and other staff responsible for the implementation of the pilots; front-line staff and first-tier managers; and representatives of users and carer organisations.	The average annual gross value of an IB was found to be about £11,450.		
Harry et al. 2016	To determine what the long-term effects of the Cash and Counseling model are for people with disabilities requiring long-term care.	Participatory action research; qualitative content analysis. Interviews were conducted with 17 adults enrolled for at least five years on a Cash and Counseling-based programme.	Main findings: 1) The programme's flexibility allowed for adaptations to meet the participants' changing needs over time. 2) The programme attendants helped connect participants with the community in multiple ways.	USA	Cash and Counseling (participant-directed home- and community-based services, HCBS)
Harry et al. 2017	To evaluate the effectiveness of the Cash and Counseling model of self-directed budgets for young adults with long-term care disabilities.	A randomised control trial with a 9-month follow-up. Bivariate and multivariate logistic regression. The study included 456 participants (207 in the treatment group and 249 in the control group). The participants were aged 18 to 30.	The treatment group members had significantly greater odds of being very satisfied with the following: life, when care was received, the care arrangement, transportation, help around the house and community, personal care, and getting along with paid attendants. They had significantly lower odds of having unmet needs in terms of transportation, medication, and routine health care at home.	USA	Cash and Counseling (young disabled people)

Hatton & Waters 2011	To evaluate personal budget outcomes for users.	1. A survey for personal budget users (n=1,114) and the carers of personal budget users (n=950). 2. A total of 163 participants answered the open-ended questions about the personal budget process.	1. The majority of the personal budget users reported positive experiences about the impacts of using the personal budget. The same applied to carers but to a lesser extent. A small minority of personal budget users and carers reported negative impacts. 2. A clear majority of the comments written by the participants were negative. The validity and clarity of the results of this study are questionable, because of the unclear description of the methodology and results. Still, it is topical study in this area.	England	Personal budget and direct payments
Ibsos MORI 2012	To determine how service users actually choose services and/or their reasons for not exercising choice.	Telephone interviews (n=2,573): 14% were asked about the choice of school for their children; 13% about choosing social services; 37% about choosing a hospital; and 13% about choosing a general practitioner (GP).	Results regarding social care: The five most important factors in selecting a service: professional recommendation, quality of service, no other choice, reputation, and location. The study found that the biggest barrier to choice is having no alternative. Other barriers included the following: it was either difficult or expensive to choose differently, there was no real alternative, the	England	Choice of school for children, social services, hospital, and GP.

			user was unaware of the alternatives, or the decision was made for them by a professional. The study shows that how users choose/do not choose and their reasons for choosing/not choosing differ in health, school, and social care services.		
Juntunen 2010	To outline the experiences and outcomes of the Dutch personal budget.	Qualitative design (11 interviews with experts and budget users).	There is no scientific research on the effects of the personal budget on the economy. Advantages: Macro level: emergence of unique, creative forms of care; innovation in healthcare institutions; lower rates for personal budgets than for care in kind; attracting particular segments of the labour market; and the emergence of administrative and intermediary agencies. Client level: having freedom of choice and being in control; the client comes first with a personal budget; and family members can take care of one another. Disadvantages:	The Netherlands	Personal budget

			Macro level: increased demand for care as a result of personal budgets; monetisation of voluntary care; and income-related contributions. Client level: more administrative expenses; the client can become an employer; there are fewer rules regarding the quality of care; care institutions may be able to identify a deterioration in the situation of a client sooner; and a healthcare institution offers more continuity of care. Providers: more administrative expenses and higher implementation costs for providers; differences in implementation practices; mismanagement of the personal budget by the client; misuse of personal budgets by administrative and intermediary agencies; and no clear guideline regarding rates.		
Kuusinen-James 2016	To reveal how freedom of choice and consumerism are constructed in the interaction between older	Case study (Lahti) survey for the users (n=44), interviews with the users (n=19), survey for the service providers (n=21), focus group interview with the service providers (n=3), focus group	The findings show that elderly care service voucher users appreciate the opportunity to continue with the same service provider. In addition, they stress the importance of the option to buy	Lahti, Finland	Voucher model for home care services for older people

	people using vouchers and care managers.	interview with the care managers (n=5), and policy documents concerning the introduction of the voucher.	additional services from the same provider, which is not currently possible for municipal home care clients. Elderly people found the freedom of choice too narrow, however, because it is limited to just the choice of service provider. A substantial improvement in the quality or efficiency of the services should not be expected because service users do not compare, complain, or change their service provider.		
Larsen et al. 2015	To report people's experiences of outcomes from using personal budgets in relation to social care needs arising from severe mental health problems.	Semi-structured in-depth interviews (n=47) with people receiving a personal budget from three English local authorities. Thematic framework analysis.	Personal budgets can enable people to achieve outcomes that are relevant to them in the context of their lives, particularly through enhancing their well-being and social participation. Some of the participants needed extra support to benefit from the personal budget.	England	Personal budget for mental health services
Leece & Leece 2006	To determine if there is a difference in the income levels of people using direct payments and traditional services.	A sample of 480 individuals (80 receiving direct payments, 400 receiving traditional services), who received a financial assessment by the local	No statistical differences were found in the income levels. This suggests that the income levels of individuals do not affect receiving or choosing direct payments and	England (a single local authority)	Direct payment for disabled people

		authority between 2002 and 2005. Multivariate analysis.	thus receiving the opportunity to choose one's own services.		
Linnosmaa et al. 2012	To determine how the use of vouchers in elderly care services affects the well-being and quality of life of the services' users.	Experimental design. A survey based on the ASCOT measure of well-being. Control group n=21; treatment group n=25.	The quality of life of voucher users improved more compared to those using traditional services.	Helsinki, Finland	Voucher for elderly care services
Moberg, Blomqvist, & Winblad 2016	To reveal what kind of information about quality is offered and available to elderly home care customers.	Case study of Swedish home care services for the elderly. The data consist of information from 223 service providers in 10 municipalities. The analysis is based on written and web-based information made available for elderly people who have been assessed as eligible for home care services. Content analysis.	Three out of ten municipalities offered web-based tools for comparing providers. The information was poor and lacking in important quality dimensions. This indicates a lack of real user power, since it is virtually impossible for users to make informed choices without relevant information. It also makes it less likely that the general quality level of home services will increase as a result of user choice.	Sweden	Free choice of provider in home care for the elderly
Moran et al. 2013	To determine what the impacts and outcomes of the individual budget (IB) pilot in 2005–2007 were for older people.	Structured interviews (n=263) with those who took part in a randomised controlled trial. Follow-up interviews six months after randomising the participants into two groups: treatment group n=142; control group n=121.	Older people spent their IBs predominantly on personal care, with few resources left for social or leisure activities. Half of the IB users (53%) used the budget for conventional services such as home care services, 41% used the budget for a personal assistant, and only	England	Individual budget for older people

			15% used the budget for leisure activities. IB users had higher levels of psychological ill health, lower levels of well-being, and worse self-perceived health than older people in receipt of conventional services. The potential advantages were increased choice and control, continuity of care worker, and the ability to reward family members. Anxiety was also reported about the responsibilities of organising one's own care.		
Netten et al. 2012	To determine the effects of the individual budget pilots and the variation of effects between different user groups.	Randomised controlled trial. The sample included 959 people: 510 in the treatment group and 449 in the control group. Multivariate analyses with a six-month follow-up.	A key finding was the greater sense of control expressed by members of the IB group, which was not dependent on the plan being in place, or the level of resources allocated to the individual (excluding older people).	England	Personal budget
Rabiee et al. 2016	To explore the benefits of personalisation in terms of creating opportunities for greater choice and control for older people using managed personal budgets to fund home care support.	Interview data were collected from three English local councils: 19 council support practitioners and 15 home care agency managers were interviewed.	The managed personal budget is one of the forms of using the English personal budget. In a managed personal budget, a public council or a third party (service producer or a broker) is responsible for the use and targeting of the budget together	England (three councils)	Elderly care services

			with the service user (compared to the direct payment, which is a cash payment). The study suggests that new commissioning and brokerage arrangements have the potential to give older people using managed personal budgets greater choice and control over their support. The low levels of older people's personal budgets, council restrictions on what personal budgets can be spent on, and limited opportunities for time banking all imposed constraints on social care practice that, in turn, limited opportunities for empowering service users to exercise choice and control.		
Rodrigues & Glendinning 2015	To determine how the emphasis on choice and competition is being operationalised within six local care markets, and to outline the experiences and outcomes of individual older people using home care services through	Includes two studies about 1) managed personal budgets and 2) direct payments. Both studies included interviews with local authority staff responsible for commissioning and contracting home care services, and with older people receiving home care funded through PBs (no specific details	Direct payments and personal budgets offer more personalised care, but older people are reluctant or have difficulties in taking on the role of consumer. The study also concludes that the shift from block contracts to framework agreements presents an increased risk for home care providers.	England	Direct payment and personal budget for home care for the elderly

	direct payment and a personal budget (PB).	about the number of interviews conducted).			
Socialstyresen 2015	To evaluate the outcomes of the free choice system in Swedish municipalities.	Two datasets were used. 1. The data are based on a survey sent to all municipalities in Sweden who had received state funding for investigating the introduction of the free choice model (n=259). The response rate was 61% (176 municipalities) in 2011–2014. The survey was collected annually between 2011 and 2014. 2. For the comparison of customer satisfaction in the municipalities with and without the free choice system, data from 12,465 elderly service users from 30 municipalities were selected from national secondary survey data on user satisfaction.	Only a tenth of the users refrained from choosing the provider. The most common choice was the municipality's own provider (56%), while just over a third (34%) chose a private provider. Changing one's decision was rare, which suggests that most users do not choose a new provider when dissatisfied. Most users are able to make their own choice of provider. The most crucial factors in the selection are recommendations from relatives, close relatives, friends, and acquaintances. The information provided in connection with the selection of providers was described by users and relatives as being too similar and difficult to understand. A comparison of customer satisfaction shows that older people with less than 25 hours of home care per month were more satisfied in municipalities that introduced free choice systems compared to municipalities that did not. For the elderly with more than	Sweden	Free choice of provider in social care services (mainly elderly care, but marginally in services for the disabled)

			25 hours of home care per month, there was no difference in customer satisfaction between the municipalities.		
Stefansson et al. 2018	To determine how much freedom home care clients have to choose their services. To investigate the association between the effectiveness of home care services and freedom of choice.	A structured postal survey conducted among regular home care clients (n=2,096) aged 65 or older in three towns in Finland. Freedom of choice was studied based on the clients' subjective experiences. The effectiveness of the services was evaluated by means of changes in social care-related quality of life. Regression analyses were used to test associations. The study does not focus on publicly funded choice models, but on freedom of choice among home care clients in general.	Some 62% of home care recipients reported having some choice regarding their services. Choosing meals and the visiting times of the care worker were associated with better effectiveness. There was a significant positive association between freedom of choice and the effectiveness of public home care services.	Finland (three municipalities)	Home care for older people
Van den Berg & Hassink 2008	To determine how the amount of the personal budget affects service prices.	A postal survey to 3,000 people with a cash benefit: 609 respondents with a cash benefit returned the completed survey (response rate 18.4%), of which 404 respondents were clients receiving the cash benefit for nursing and caring (66.3%).	The higher the personal budget, the higher the costs (a 1% rise in personal budget led to a 0.3% rise in the price of services). The interpretation is that the budget user has no incentive to negotiate a lower price for the care service,	The Netherlands	Personal budget

			because they have no right to keep the unused part of the budget.		
Williams et al. 2017	To outline professionals' views and experiences of personalisation in residential care, as well as their thoughts on the potential contribution of direct payments in promoting personalisation.	Interviews (n=54) conducted with 34 local council project leaders, social workers, etc. and 20 care home owners and managers in 12 local sites.	Doubts were voiced about whether direct payments were an appropriate mechanism to achieve the aim of personalisation. This was seen as particularly pertinent in relation to residents with very high care needs and a limited capacity to exercise choice and control. Interviewees also identified a number of risks and challenges to implementation, including financial risks to care homes. The findings from these interviews suggest that the contribution of direct payments to personalising residential care may be more modest than expected.	England (12 local councils)	Direct payment for older people in residential care
Woolham & Benton 2013	To determine the costs and benefits of a personal budget (PB).	Comparative design. Data were collected from a random sample of service users who received 'traditional' services and compared with data obtained from a cohort of people who had agreed to try a PB. Data from both groups were obtained by a self-completion postal questionnaire.	The costs for personal budget users were higher in all user groups than the costs for traditional services users. The personal budgets are more expensive, but benefit the users more. Younger PB users benefit more than older PB users.	England (a single council)	Elderly care, mental health services, support for learning and physical disabilities

			The study did not evaluate cost-effectiveness.		
Woolham et al. 2017	To determine the outcomes for older direct payment users and those receiving care via a managed personal budget.	A postal questionnaire in three English councils. The study included 1,341 budget users aged 75+ living in ordinary community settings. The response rate was 27.1% (339 respondents). Three validated scales measured the outcomes: EQ-5D-3L (health status), the Sheldon–Cohen Perceived Stress Scale, and the Adult Social Care Outcomes Toolkit (social care-related quality of life).	Direct payment users appreciated the control conferred by budget ownership, but in practice, it did not translate into improved living arrangements for many. The study found no statistically significant difference in outcomes between direct payment and managed personal budget users.	England (three councils)	Direct payment and personal budget for older people receiving social care

Findings and discussion

I focus here on three perspectives: 1) what the outcomes of choice are for the service users, 2) how and why service users make choices, and 3) how choice affects the costs and cost-effectiveness of services. The main finding of the review is that the most robust evidence on choice comes from the English individual budget, personal budget, and direct payment systems, and from the US Cash and Counseling programme. Some relevant studies have been conducted in Sweden, Denmark, and Finland, but they are not methodologically as strong as the studies from England and the USA. In addition to the literature reviewed in the table above, I will refer to other review studies from the field of social services and free choice. These review studies were not included in the literature review since they are not original studies, but they are in some respects relevant to this report.

Outcomes of choice for service users

The main finding of the review from the customer's perspective is that having a personal budget, cash for care benefit, or more choice over services increases the users' satisfaction, sense of control, and feelings of empowerment (e.g. Brown et al. 2007; Glendinning et al. 2008; Hatton & Waters 2011; Forder et al. 2012; Harry et al. 2017). Sometimes service users need extra help to achieve the benefits of choice (Larsen et al. 2015; Rabiee et al. 2016). However, specific case studies reveal some negative outcomes of the introduction of choice. In Sweden, the choice of provider did not improve the service users' quality of life or increase satisfaction with mental health services (Eklund & Markström 2015). The benefits of choice and control over one's own services vary between different user groups. Many studies show that younger and disabled people are more likely to benefit from choice compared to older people (Glendinning 2008; Netten et al. 2012). Some studies suggest that for older people, choice and a personal budget increase stress and might become a burden instead of an empowering factor (Glendinning et al. 2008; Wells et al. 2018). Based on a review study, Lundsgaard (2005; 2006) argues that elderly people feel less dependent and more satisfied when they can choose the person providing the care (the who) and the timing of the care provided (the when). A study based on 263 structured interviews with an experimental design and follow-up interviews after six months found that older individual budget users had higher levels of psychological ill health, lower levels of well-being, and worse self-perceived health compared to older people in receipt of conventional services (Moran et al. 2013).

Other studies show that choice benefits all age groups. In their study based on a randomised controlled trial and data from over 6,500 telephone interviews with follow-up interviews after nine months that across all ages, Brown et al. (2007) show the control and flexibility offered by the Cash and Counseling programme increased consumers' satisfaction with the help they received and their overall quality of life. The results about the outcomes of choice for older people are mixed and most likely dependent on the background of the social and health service system. Despite the partly conflicting results, the majority of the studies with a large dataset and experimental design show the benefits of personal budgets and cash for care benefits for most service users in systems with means-tested social services (Brown et al. 2007; Carlson et al. 2007; Glendinning et al. 2008; Netten et al. 2012).

As already noted, personal budget and cash for care systems are better studied compared to systems based on a voucher or provider choice. Voucher systems and provider choice models exist in the Nordic countries, and surprisingly only a couple studies examining the outcomes for the customer were found. One small-scale case study based on an experimental design from Helsinki, Finland, found that in elderly care services, the voucher users' quality of life improved more compared to those using traditional services. The study is based on a survey with only 46 participants, so the results are not generalizable. (Linnosmaa et at. 2012.) A Swedish case study evaluating the outcomes of implementing a choice of provider in mental health services in a single city found that choice did not improve service users' lives in any respect, and the satisfaction with the services decreased. The study included all eligible service users (n=78) in the city in question, and four follow-up interviews were conducted during a three-year study. (Eklund & Markström 2015.)

Most of the review studies analysed for this report but not included in the final results table conclude that choice – whether in the form of a personal budget, cash for care, or a voucher – often increases user satisfaction and offers a greater sense of having control over life (Lundsgaard 2005; 2006; Arksey & Kemp 2008; Colombo et al. 2011; Morse 2011; OECD 2013; Ottman, Allen, & Feldman 2013; Leinonen 2014). More importantly for this report, these reviews report limited evidence, gaps in evidence, and a lack of robust research about the impact of choice in social services (Arksey & Kemp 2008; Health Foundation 2010; OECD 2013; Manthorpe 2015). User satisfaction and user experiences are important areas of research, but more evidence is needed about the effectiveness and effects of choice models for customers.

How and why service users make choices

The outcomes of choice are dependent on the context of the choice model, but they are also connected to the reasons and the ways in which people choose. I did not find studies investigating how the outcomes of choice are related to the ways people choose and their reasons for choosing, but many robust studies were found on people's reasons for choosing and the ways they choose. The first relevant question in this context is whether people choose when given the opportunity. The results are again mixed, but there are some studies aiming to explain the reasons behind the differences. Based on a mixed methods study with survey and qualitative interview data, Eichler and Pfau-Effinger (2009) found that German elderly care service users have continued to choose family care and cash for care over in-kind services, even when given the option. Conversely, elderly care service users in the Netherlands have chosen in-kind services over cash for care (Nadash et al. 2011). In their qualitative study, Nadash et al. (2011) found that elderly people's preferences between cash or in-kind services varies from country to country. The aforementioned study features interviews with key persons in Austria, England, France, Germany, and the Netherlands.

Foster et al.'s (2015) study, which is based on questionnaire data (n=8,892) sought to discover who participated in the Cash and Counseling cash for care scheme in three US states in the USA, and to explicate the reasons for non-participation. The intake period for the programme was 24 months. During the period, only 6.3% to 16% of the eligible service users participated in the programme; i.e. the participation levels were quite low. People were less likely to participate in the cash for care scheme if they were not eligible for the traditional services before the programme started, were receiving low levels of services, or were in the last two years of their life. When from the service users were asked their reasons for not participating, the main reason was satisfaction with current services (Foster et al. 2015).

A different result is found in Sweden. A study by the Swedish National Board of Health and Welfare (2015) based on national survey data from over 12,000 elderly people found that elderly people in Sweden use their right to choose provider extensively. Only 10% of the service users did not want to choose. Of the 90% who made an active choice, 54% chose a public provider and 36% chose a private provider. The report also reveals that elderly people make choices based on recommendations from relatives, friends, and acquaintances. The information available to compare the providers was nevertheless inadequate and too difficult to use. A case study on the

quality of information provided by the public sector in Sweden supports this result (Moberg et al. 2016). Moberg et al. (2016) show that the information is poor and lacking in important quality dimensions.

As with the outcomes of choice for the service users, older people as choice makers differ from other groups. Older people more often choose public services, prefer somebody else to manage their budget, or prefer not to choose at all compared to other user groups (Foster et al. 2005; Socialstyrelsen 2015; Rabiee et al. 2016). Older people may feel they receive more personalised care, but with increased risks and costs (Rodrigues & Glendinning 2015).

Some studies argue that service users experience difficulties in making informed choices (Morse 2011; Brennan et al. 2012). Service users might be unaware of the possibility of choice (Eklund & Markström 2015), or they may not be aware of the terms of choice (Wells et al. 2018). In some cases the information about the quality of services is insufficient (Moberg et al. 2016). Some studies argue that different social groups have different resources for making informed choices, and they are therefore in an unequal position (Brennan et al. 2012). The amount of personal budget or direct payment has been an obstacle to making actual choices in some cases (Rabiee et al. 2016). Surprisingly, this is rarely studied.

Costs and cost-effectiveness

As reported above, a few solid and robust studies show that giving people the opportunity to choose and affect the services they receive can have a positive effect on their lives, but with some restrictions, especially concerning older service users. However, the research evidence about the costs and cost-effectiveness of free choice models is weak. I will report here the most reliable and relevant studies from the perspective of costs and cost-effectiveness.

In England, Glendinning et al. (2008) conducted a cost and cost–benefit analysis of individual budgets. The study evaluated an individual pilot programme for different care groups; it was based on a randomised controlled trial with 959 participants, and it included pre- and post-programme interviews. The researchers found that the over the full sample, the individual budget was cost-neutral. Regarding cost-effectiveness, the study found positive outcomes for younger adults, but no evidence of benefit for older individuals. A single city case study from England shows that the personal budget increased costs compared to the use of traditional services (Woolham & Benton 2013). The study did not evaluate cost-effectiveness. Another study from

England based on a randomised controlled trial about the experiences of over 6,000 participants examined the costs and cost-effectiveness of personal health budgets that include some elderly care and mental health services. Personal health budgets were cost-effective when measured by care-related quality of life, but no significant difference was found when measured by health-related quality of life. The budgets were cost-effective for people using mental health services and people using continuing health care services, but not for people using social services. (Forder et al. 2012.)

The evidence from the US shows that the costs were higher in the Cash and Counseling programme compared to traditional services (Dale & Brown 2006; Brown et al. 2007). Similar results were found in studies concerning the Dutch personal budget. Some descriptive and qualitative studies suggest that the use of personal budgets increased rapidly in the Netherlands, and as a result the overall costs of the care system increased along with the demand for care (Junninen 2010; van Ginneken et al. 2012). Based on a postal survey of personal budget users, Van den Berg and Hassink (2008) found that higher levels of personal budgets lead to a rise in service prices. This means that services users buy more expensive services when given the opportunity. Van den Berg and Hassink argue that this might be a result of budget users not having the right to keep any budget surplus after purchasing services. A study on the costs of the Danish choice model in elderly care revealed that the indirect costs of the system increase as service users choose private providers more often. The study showed that choosing privately produced services increased the costs of publicly funded services in elderly care services in Denmark. This might be an outcome of losing economies of scale (Foged & Houlberg 2015).

Previous review studies on the outcomes of choice in social services conclude that there are no robust studies focusing on the costs and cost-effectiveness of free choice models in social care. Leinonen (2014) found no studies on the economic outcomes of personal budgets. Colombo et al. (2011) and the OECD (2013) conclude that there is little evaluation of the impact on quality or cost-effectiveness. Manthorpe (2015) criticises studies for being small-scale or having small sample sizes, relying on studies focusing on pilots, and lacking long-term follow-ups. Finally, Morse (2011) argues there is no evidence on costs. These review studies conclude there is a lack of research on costs, a position also supported by this report.

I did not find any empirical studies investigating how free choice in social services affects employment or influences fiscal-level matters. A couple of studies have discussed these issues and

come to conclusions based on the existing literature. Lundsgaard (2005; 2006) argues that the implications of choice models on employment and fiscal sustainability are quite complex. One outcome of cash for care systems, which enable informal carers to be employed or paid cash, is the potential creation of incentive traps for informal carers. Lundsgaard also argues that cash allowances for care would be best suited to countries where unemployment benefits are less generous. Thus, the combined effect of informal care payments, taxes, unemployment benefits, and other transfer incomes would not risk creating an obstacle to the normal labour market. A policy analysis by Morel (2007) evaluated the outcomes of child and elderly care policy reforms in France, Germany, Belgium, and the Netherlands. Morel argues that the focus on free choice in all of these countries has simultaneously reinforced social stratification in terms of access to the labour market and weakened certain labour market rigidities.

It is surprising that the fiscal effects of free choice in social services are hardly evaluated at all in the studies in this field. One explanation for this lack of research might be that most of the free choice reforms have been incremental, and there are no clear examples of social service systems that have been reformed in their entirety. This might be the case with the Finnish social and health care reform.

Challenges in studying free choice in social services

One of the main findings of this review is that the international literature on the subject is focused on the outcomes of free choice for the customers, plus the customers' satisfaction with services and quality of life. In comparison, studies about the costs, cost-effectiveness, and fiscal effects of such models are seriously insufficient. One reason for this could be that it is simply easier to study the effects of change in a system for the customers. Secondly, differentiating between the effects of choice reforms and the effects of increasing private service production is challenging. The simultaneous social policy changes of increasing publicly funded choice and the general marketisation of social services and public administration are hard to separate in empirical studies. Studies about the outcomes of outsourcing and contracting out social services exist, but studies separating the effects of publicly funded free choice from outsourcing and marketisation are scarce. This is acknowledged also in the background reports published by the National Institute for Health and Welfare (THL) on the social and health service reform in Finland (Jonsson et. al. 2016; Whellams 2016). Thirdly, many choice reforms have been local and limited, making it more difficult to produce generalisable results (e.g. Mikkola 2003; Arksey & Kemp 2008). Fourthly, in

some cases, funding cutbacks have been introduced simultaneously with choice reforms, and it is difficult to separate the consequences of these two separate factors.

Even if we could use the evidence from the studies comparing the costs between private and public service provision, the results would be complicated and mixed. The studies examining the costs of private and public service provision are not comprehensive, and the quality of the evidence is weak. As Petersen and Hjelmar (2018) argue, 'the evidence in social services is much scarcer and more difficult to uncover than in technical services. There is a remarkable lack of studies thoroughly examining the effects of contracting out for service quality, and the findings in the few studies that do examine service quality are mixed.'

Summary of the results and conclusions

The main findings of this report are, firstly, that there are only a few studies evaluating the effects of free choice in social services, and those studies are from England and the USA. These two social service systems are very different from the Finnish welfare system, and therefore it is difficult to generalise the results to the Finnish case, but the studies on personal budgets could be useful in the implementation of a personal budget in Finland. The evidence found in this review shows that free choice – whether in the form of a personal budget, individual budget, direct payment, or cash for care system – increases the service users' satisfaction, sense of control over their own life, and in some cases quality of life. Nevertheless, the results vary. Older people do not benefit from the choice as much as younger and disabled people. Secondly, even though some sound evidence exists on the outcomes of choice for users, no reliable and robust studies were found on the costs and cost-effectiveness of choice models. Previous review studies have come to the same conclusion.

The choice models in social services vary significantly between countries and also within countries on many occasions. In addition, the national methods of implementing these choice models differ in terms of what is chosen and how it is chosen. For example, the studies in this review present mixed results on how service users choose between in-kind and cash benefits and how they choose between public and private services. In the case that the Finnish social and health care reform is carried out as planned, based on this review, it seems difficult to anticipate the behaviour of citizens when offered a choice of services.

From a social policy perspective, the studies investigating choice in the Nordic countries are much more relevant for the Finnish social and health care systems, since the context of introducing

choice is more similar in these studies than those focusing on the systems in the Anglo-Saxon liberal welfare states or the corporatist or conservative welfare states. This is due to the similarities of the Nordic systems. Unfortunately, research evidence about the outcomes of choice in the Nordic countries is scarce.

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