Title: Do Cash-For-Care Schemes Increase Care Users' Experience of Empowerment? A Systematic Review

Short running title: Cash-For-Care Schemes and Empowerment

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CRediT authorship contribution statement: Eva Pattyn: Conceptualization, Methodology, Literature search, Data analysis, Writing – original draft. Paul Gemmel: Conceptualization, Supervision, Writing – review & editing. Sophie Vandepitte: Literature search, Writing – review & editing. Jeroen Trybou: Conceptualization, Supervision, Writing – review & editing

Conflict of Interest: Eva Pattyn, Prof Dr. Paul Gemmel, Dr. Sophie Vandepitte, and Prof Dr. Jeroen Trybou declare that they had no support from any organization for the submitted article; no financial relationships with any organization that might have an interest in the submitted work; and no other relationships or activities that could appear to have influenced the submitted work

Funding: This study was funded by BOF.STG.2018.0026.01

Data availability statement: A detailed overview of the search string per database and the coding sheet can be found in the Electronic Supplementary Material. The data used and analyzed during the current study are available from the corresponding author on reasonable request.

Abstract

Background

In cash-for-care schemes care users are granted a budget or given a voucher to purchase care services, under the assumption that this will enable them to become engaged and empowered customers, leading to more person-centered care. However, opponents of such schemes argue that the responsibility of organizing care is thereby shifted from governments to care users, thus reducing care users' experience of empowerment. The tension between these opposing discourses supposes that other factors affect care users' experience of empowerment.

Objective

This systematic review explores the experiences of empowerment and person-centered care of budget holders in cash-for-care schemes and the antecedents that can affect this experience.

Method

We screened seven databases up to October 10, 2022. To be included, articles needed to be peer-reviewed, written in English or French, and contain empirical evidence of the experience of empowerment of budget holders in the form of qualitative or quantitative data.

Results

The initial search identified 10,966 records of which 90 articles were retained for inclusion. The results show that several contextual and personal characteristics determine whether cash-for-care schemes increase empowerment. The identified contextual factors are establishing a culture of change, supportive financial climate, flexible regulatory framework, and access to support and information. The identified personal characteristics refer to the financial, social, and personal resources of the care user.

Conclusion

This review confirms that multiple factors can affect care users' experience of empowerment. However, active cooperation and communication between care user and care provider are essential if policy makers wish to increase care users' experience of empowerment.

Keywords: long-term care, cash-for-care scheme, empowerment, person-centeredness

Key points

- Policy makers should consider establishing a culture of change, supportive financial climate, flexible regulatory framework, and access to support and information when implementing cash-for-care schemes.
- The experience of empowerment is a complex process as contextual factors and personal characteristics also affect each other.
- More quantitative research on the experience of empowerment is needed.

1. Introduction

Internationally, policy makers strive for a shift towards deinstitutionalization to implement a more client-centered approach. In the past, care providers in disability care, elderly care, mental health care, and social care have determined how care and support services (e.g., home care, respite care, personal assistance, rehabilitation services, etc.) were provided with no or limited control on the part of its users. To adopt a user-centered approach, services need to be more flexible in order to meet people's needs in a manner that matches their preferences and life goals [1, 2]. To stimulate the implementation of a person-centered care system, several high income countries have nationally or regionally experimented with a payment system that shifts the focus from care providers to care users (e.g., Cash and Counseling, Direct Payment scheme, Individual Budgets pilot project, National Disability Insurance Scheme, etc.). This has been referred to as the cash-for-care schemes approach. In it, a government grants a cash budget or voucher to care users instead of directly funding care providers or care organizations [3, 4]. Using this budget, care users may be in a position to better address their care and support needs and to decide who will be providing their care [5, 6].

If care users are allowed to choose their own care arrangement, proponents of the strategy hold that users will become empowered customers rather than passive recipients [5, 7]. Instead of having to accept predetermined care services, care users can weigh providers against each other and choose care services that match their needs, preferences, and life goals [8, 9]. However, opponents argue that cash-for-care schemes are mainly a way to reduce costs and a means to shift responsibility for the care system away from government and towards care users [10]. Since care users become responsible for purchasing care services, they need information on available services; they thus become more vulnerable to service gaps, accountability issues, low quality care, and abuse [11, 12].

This tension between the discourses of the proponents and opponents of such schemes is rooted in the supposition that giving care users purchasing power does not automatically lead to an experience of empowerment. The responsibility of managing a budget can lead to a decreased level of empowerment, and such responsibilities can outweigh the benefits of the scheme [13]. Empowerment is also a multidimensional concept, used in different contexts and in different populations. Several conceptualizations of empowerment therefore exist in the literature. These will be discussed in the next section [14, 15].

Two reviews have investigated the outcomes of cash-for-care schemes and have reported on choice and control as one of these outcomes. These reviews give a brief overview of the effects reported by care users-budget holders, including quality of life, participation in the community, and health improvement. These reviews do not investigate empowerment as a concept of its own, nor do they investigate the way care users-budget holders define empowerment. Lastly, these reviews do not seek factors that could have an impact on the feeling of choice and control [16, 17]. Additionally, two reviews investigated the meaning of choice for care users and the barriers and facilitators to making informed choices [18, 19]. FitzGerald Murphy and Kelly [18] investigate the evidence for choice in cash-for-care schemes, but only in Australia, the UK and USA. They do not define their inclusion criteria concerning participants or choice outcomes and they include only qualitative evidence from qualitative studies, literature reviews and policy papers. Arksey and Kemp [19] also investigate the evidence for choice in cash-for-care schemes. They used no geographic restrictions but excluded care users-budget holders with mental health problems as well as people with learning difficulties. Their review sought evidence for the choices that care users can make, the barriers to choice, the facilitators of choice, and the outcomes of choice. Although choice making is an important aspect of empowerment, empowerment also includes aspects of control, self-efficacy, and competence, which were not the focus of their review [20]. Additionally, Arksey and Kemp [19] do not seek personal characteristics that might affect choice [21]. The aim of this review is thus to explore which contextual and personal antecedents can affect levels of empowerment while also investigating how care users of disability care, elderly care, mental health care, and social care experience empowerment in cash-for-care schemes.

2. Theoretical Framework

Empowerment is a complex, multilevel, multidimensional concept, that has been studied in various contexts and populations. In general, empowerment expresses a process of enablement that leads to a shift in the balance of power, increased mastery, and self-determination in a person’s life [14, 22-24]. For this review, we used the conceptualization of psychological empowerment, which describes empowerment as belonging to the subjective feelings of a person and links it with intrinsic task motivation [25-28], which in turn manifests as four cognitions: meaning, competence, self-determination, and impact. Spreitzer [29] was the first to propose a scale to measure the concept of psychological empowerment; in this scale, the experience of empowerment is measured on a continuum. The four cognitions contribute to the measurement of empowerment, so excluding one cognition from the measurement will not eliminate the empowerment-construct, but will only reduce the level of experienced empowerment [29].

Spreitzer [21, 29] also determined the antecedents of psychological empowerment, which comprehend both personal and contextual/environmental factors. Personal factors include age, gender, education, and ethnicity. Contextual factors include in the context of the work environment, for example, sociopolitical support, a participative unit climate, and access to information [21, 27, 30]. Since these contextual factors are defined in a working environment, we explored the concept of *patient empowerment* to determine contextual factors in a care context. Castro and colleagues [20] undertook a conceptual analysis to determine the antecedents of patient empowerment and to differentiate patient empowerment from patient participation and patient-centered care. This conceptual analysis concluded that patient participation facilitated a patient-centered approach, while patient-centered care is a precondition to patient empowerment. The experience of empowerment thus depends on the involvement of the care user in the decision-making process and the adaptation of care to their personal needs and preferences. In this context, care providers can have an impact on the level of empowerment that a care user can experience [2, 20, 31]. Finally, since Castro and colleagues [20] determined self-determination as an attribute of patient empowerment, we used the conceptualization of Spreitzer [21, 29] to define the attributes of empowerment.

3. Method

This review follows the guidelines of the PRISMA-statement for reporting systematic reviews and meta-analyses [32].

3.1. Search Strategy

The search string consisted of two parts: synonyms of cash-for-care schemes (e.g., direct payments) and synonyms defining empowerment and its antecedents (e.g., autonomy). We employed the conceptual analysis of Castro and colleagues [20] to determine possible antecedents of empowerment in cash-for-care schemes, and thus included person-centered care, user engagement and participation, and the competence of the care network in the search string.

Seven databases (CINAHL, Ebscohost Business Source Complete, Embase, ProQuest Social Science Premium Collection, PubMed, Scopus, and Web of Science) were searched up to October 10, 2022. A detailed overview of the search string used for each database can be found in the Electronic Supplementary Material.

3.2. Eligibility Criteria

To be eligible, studies (i) had to be peer-reviewed, (ii) had to be written in English or French, (iii) had to contain qualitative or quantitative empirical evidence about (factors influencing) the experience of empowerment in cash-for-care schemes, and (iv) had to report data from the viewpoint of care users-budget holders themselves or their representatives. Articles evaluating cash-for-care schemes were included where they reported data on the experience of empowerment of the care users-budget holders, or data on the antecedents of empowerment. No restriction on year of publication was made and no geographical limitations were used. No restrictions were made on type of care user, so the category of care users-budget holders could include people with physical or intellectual disabilities, older people, people with mental health problems, and proxy respondents of the care user. Cash-for-care schemes were defined as care models whereby care users are granted a budget to pay for community-based care and support services (e.g., home care, respite care, personal assistance, or informal care) and are in charge of the organization of their care. Studies reporting on programs that strive to reduce poverty (for example, the Bolsa Família program in Brazil), to ameliorate educational options by enhancing access to private schools (for example, school vouchers in the USA), or to enhance compliance by giving cash to program participants (for example, unconditional cash transfers in Uganda) were excluded, as they fell outside the scope of the review.

3.3. Quality Appraisal

The quality of the included articles was appraised with the revised Mixed Methods Appraisal Tool (MMAT). The MMAT can be used to appraise studies with qualitative, quantitative, or mixed method designs. This is done by comparing studies against each other, so no cut-off scores are provided [33].

3.4. Data Extraction and Data Analysis

The findings, discussion, and conclusion sections of all the articles were imported into NVivo (Version R1) for further analysis. First, the imported sections were coded through familiarization with the data. Codes described the degree to which care users experienced empowerment and the personal or contextual factors affecting this experience. After the coding process, a coding sheet was developed and codes were grouped into themes using an iterative process [34]. These emergent themes were then matched with the conceptualization of Spreitzer [21, 29] to determine similarities and discrepancies, leading to the development of a map, describing the four cognitions of psychological empowerment and all the identified contextual and personal antecedents that affect the experience of empowerment from the viewpoint of care users. The coding sheet can be found in the Electronic Supplementary Material.

The results of this review are reported in a descriptive way, as most of the studies used a qualitative approach and report on the subjective experiences of budget holders concerning empowerment and the antecedents that affect their experience of empowerment. The results are categorized following the four cognitions of psychological empowerment and the contextual and personal antecedents that are identified in the literature. The four cognitions of empowerment are meaning (M), competence (C), impact (I), and self-determination (SD). The contextual factors are an inclusive mindset (CoC), size of the budget and governmental austerity measures (FC), presence or absence of eligibility criteria and flexibility of rules and legislation (L&P) and finally access to information and support (I&S). The personal factors are sociodemographic characteristics such as age (A), ethnicity (E), and size (N) and financial resources of the network (FR).

4. Results

4.1. Study Retrieval

The initial search resulted in 10,966 records with 7292 records remaining after duplicates were removed. One reviewer screened the titles of these 7292 records, leading to the inclusion of 552 records. Two reviewers screened these 552 abstracts independently of each other. Discrepancies that occurred during the inclusion process, were discussed by the reviewers until a consensus was reached. Having read the full-texts of the remaining records, 77 articles were included; another reviewer was consulted in doubtful cases. Reasons for excluding papers at the full-text reading included the study exploring the experiences of the wrong population (for example, care givers), the budget scheme not being the main focus of the study, there being no data on the level or experience of empowerment, respondents being asked about a hypothetical situation, there being no empirical data, the study existing only as a conference abstract, the article being a duplicate, and the article not being available in English or French. The reference lists of these 77 included articles were screened for other eligible articles, which led to the inclusion of thirteen new articles. A flow diagram of the research process is presented in Figure 1.

Insert Figure 1 about here

Information on the characteristics of each study can be found in Table 1. All but nine studies took place in the UK (53%) [35-82], Australia (21%) [83-101], or the USA (16%) [102-115]. Of these nine other studies, two took place in Germany [116, 117], one in Austria [118], one in Norway [119], and two in Canada [120, 121]; two studies compared the experiences of budget holders in England and Norway [122, 123], and one article compared the experiences of budget holders in five European countries (Austria, France, Italy, the Netherlands, and England) [124]. Three-quarters of the articles (74%) employed a qualitative approach by performing a case study or conducting focus groups, semi-structured interviews, or narrative interviews. Fourteen articles used a mixed method approach [38, 60, 63, 74, 75, 79, 83, 85, 88, 96, 99, 112, 114, 119], while nine had a quantitative approach with data collected through surveys or questionnaires [42, 44, 65, 82, 102, 106, 108, 110, 113]. Table 2 shows the quality of each study as appraised using MMAT. Overall, the quality of the qualitative evidence ranged from moderate to good. The evidence of the quantitative and mixed method studies ranged from low to good.

Insert Table 1 and 2 about here

The studies included in the review explore the experiences of different types of care users-budget holders (people with disabilities, people with mental health problems, older people, or proxies for others), since each cash-for-care scheme may have had different eligibility criteria concerning which care users can apply for a budget.

4.2. Empowerment in Cash-for-Care Schemes

The next subsection discusses the results of all studies on the experience of empowerment, using the four cognitions defined by Spreitzer [29]. Following that, we report the results of the quantitative designs (including the components of the mixed method studies) regarding empowerment levels. Lastly, we discuss the contextual antecedents and personal antecedents that were found in the literature, with reference to both qualitative and quantitative data. Figure 2 presents the number of papers by publication year and Table 3 presents a heat map of the themes discussed by publication year. A map of the themes discussed in each article can be found in the Electronic Supplementary Material.

Insert Figure 2 and Table 3 about here

Table 4 presents a heat map of the themes and subthemes regarding the attributes of empowerment by number of publications.

Insert Table 4 about here

4.2.1. Meaning

One article [100] discussed the importance and meaning attributed by care users to having a budget and being able to choose their care options. Care users described the importance of having a choice and the feeling of being empowered [100].

4.2.2. Competence

The majority of the articles (87%) discussed feelings of competence and incompetence; care users have to feel competent if they are to manage the budget allocated to them and need to be able to make informed choices if they are to feel empowered. If care users cannot manage the responsibilities and tasks of managing a budget, they will feel neither empowered nor in control

[35, 40, 43, 49, 51, 54, 57, 59, 61, 62, 71, 72, 78, 83-86, 88, 97, 100-103, 111, 115, 116]. Moreover, some care users deliberatively choose not to use a cash-for-care scheme, as they expect it to be too difficult to manage or feel overwhelmed by the responsibilities of managing a budget [35, 41, 50, 51, 57, 60, 63, 68, 71, 76, 81, 101, 114, 117]. However, this feeling can change over time: almost one quarter of the articles (23%) reported increased feelings of empowerment as care users became more competent and confident over time, learning to manage their responsibilities as budget holders [35, 38, 39, 42-44, 50, 52, 59, 61-63, 84, 85, 91, 96, 105, 111, 116, 117, 121]

4.2.3. Self-determination

All but one [47] of the articles discussed the feeling of self-determination, or the lack thereof, in care users . These studies indicate that cash-for-care schemes can be a mechanism for enhancing self-determination if certain contextual conditions are in place-for example access to information and support [35, 41, 48, 51, 54, 59, 60, 81, 117]. When these conditions are met, care users are able to choose their care provider, weigh alternatives against each other, and select services that match their needs and preferences. However, the first important choice for care users is to decide whether they want to manage the budget themselves. If a cash-for-care scheme is imposed on care users, they will not feel empowered [36, 57, 58, 64, 69, 78, 105, 119].

4.2.4. Impact

Two-thirds of the articles discussed the impact on the care system and feelings of ownership that care users can have-for example, the control that care users have in determining the delivery of their care and support, and the care relationship they have with care providers. Several cash-for-care schemes allow care users to control how and when the care is provided and how relationships with a care provider or personal assistant are fulfilled; for example, whether the care provider is treated like family or a more distantly [40, 41, 43, 46, 48, 55, 56, 58, 59, 66-68, 72-74, 83, 96, 105, 111, 120-124]. However, half the articles (52%) reported that care users experienced a lack of control. The reasons for this experience of disempowerment, for example, include feeling responsible for acting as a rational consumer and allocating the budget properly [35, 45, 46, 50, 60, 66, 70, 72, 123], feeling difficulties doing things that other people can do without a problem despite the budget (such as taking a train, maintaining a relationship, or having a job) [49, 56, 78, 85, 87, 92, 104, 120], or having the feeling that the budget is not their own money but more of a gift that must be used in the right way [50, 64, 67, 70, 86, 100, 103, 104, 117].

4.2.5. Level of Empowerment

Seven articles measured empowerment in a quantitative way (including mixed method studies), but the authors used different measurement scales, including an adaption of existing scales, the Personal Independence Profile (PIP), and the Adult Social Care Outcome Toolkit (ASCOT) [42, 65, 82, 96, 102, 106, 110]. Only five articles measured the difference in empowerment scores between budget holders and care users receiving conventional services. Empowerment scores were significantly higher in the group of budget holders than in the group of care users receiving conventional services [42, 65, 96, 106, 110]. Moreover, these significant results persisted in the regression analyses that controlled for confounders [65, 96, 106].

The other articles measured the difference in empowerment between budget holder age groups [102] and between different types of cash-for-care schemes [82]. Benjamin & Matthias [102] found that budget holders under 65 feel more empowered than those 65 or older. However, this difference is mainly due to the answers of budget holders who are 75 years and older. Budget holders between 65 and 74 years report similar empowerment scores to those who are under 65. Woolham and colleagues [82] found that budget holders who managed the budget themselves reported having more control over their daily life than those for whom the budget is managed by a third party.

4.3. Antecedents of Empowerment in Cash-for-Care Schemes: Contextual Factors

In general, implementation and promotion determined the flexibility of the scheme, the awareness of this option among care users, and its accessibility to various groups of care users. Moreover, four contextual factors emerged from the data: culture of change, financial climate, legislation and procedures, and access to information and support. Table 5 presents a heat map of the themes and subthemes regarding the contextual factors by number of publications.

Insert Table 5 about here

4.3.1. Culture of change (CoC)

The majority of the articles (86%) discuss ‘culture of change’ as an antecedent. This refers to the necessary change in societal ideas and attitudes and in the care network towards, on the one hand, disability, mental health, and old age and, on the other hand, towards care roles and the provision of care. It encompasses the move from a deficit-based, paternalistic, excluding attitude to a focus on the strengths and needs of the care user, cooperation of stakeholders across different care domains, and the inclusion of the individual and his or her family in society.

However, two-thirds of the articles report on barriers and restrictive views imposed by society and the care network which affect the empowerment of budget holders. Some of these articles (43%) describe how society and the care network tend to impose the views of normal, nondisabled bodies on care users, which leads to deeply rooted assumptions about the capabilities and skills of care users and to the exclusion of care users from life domains. For example, assumptions about the capacity (skills, emotional resources, and resilience) of older people to become a budget holder or to manage a budget [41, 53, 63, 70, 77, 80, 102, 112, 114], assumptions about the capacity of people with intellectual disabilities to have a job [49, 61, 87, 92, 107], or failing taking into account the transportation needs that people with disabilities have if they are to participate in society [49, 104, 120, 121]. Moreover, one-third of the articles (37%) mention that informal and professional caregivers can restrict access to cash-for-care schemes or take over decision-making processes based on such ideas of the care user's incapability and need for protection. These negative attitudes lead to a reduction in the feeling of empowerment on the part of the care user [41, 44, 47-50, 53, 54, 57, 61-64, 66, 70, 74-77, 80, 81, 87, 90-92, 100, 102, 104, 107, 114-116, 121].

Additionally, almost half of the articles (48%) discuss the lack of a holistic focus from care providers. The care user and his or her needs, strengths, abilities, and family context should be taken into account when determining how the budget will be spent. However, in some schemes, the informal caregiver becomes the focal point of attention instead of the care user. Since the informal caregiver is using and directing the budget, professional caregivers can become sensitive to the needs of and demands on the informal caregiver, discussing the care arrangements solely with the informal caregiver and thus ignoring the needs of the actual beneficiary of the budget, the care user [41, 42, 103, 116, 119]. Another important remark is that care users' needs have to be assessed in the context of their family life, since family members often support the care user. Thus, professional caregivers should neither make assumptions about the role informal caregivers have to play in these care arrangements [71, 81, 104], nor should the supporting role of the informal caregiver be minimalized [40, 48, 53, 60, 62, 69, 71, 74, 81, 91, 93, 104].

Lastly, a culture of change can also imply, as reported in almost one-fifth of the articles (19%), some pressure on care users but also, as reported in 38% of the articles, some pressure on care providers, since both are required to adapt to this new system of organizing care. In these schemes, care users have to behave as consumers, which can lead to feelings of disempowerment. In contrast, care providers need to adopt to their new role as equal partners or enabler of decision making. Some articles (22%) therefore advise making specific training available to care providers to help them develop the skills necessary for supporting care users in their new role as consumers. To conclude, coproducing a care arrangement involves cooperation and partnership with the care user, a holistic focus, and a family-centered approach.

4.3.2. Financial climate (FC)

Three-quarters of the articles discuss the financial climate of the care system; this refers to the quantity of financial resources directed towards the care system and the decisions made regarding these resources. Less than 10% of the articles report that the budget allotted to the care users is sufficiently large to cover all care needs and needed services [42, 43, 63, 65, 71, 83, 84, 89]. Conversely, almost three-quarters (73%) report on budgetary issues linked with budget cuts or increases in costs for the care user, reductions in available care services, and delayed payments of the budgets allotted to care users.

Almost 60% of the articles (59%) mention budget cuts made by the government or increases in costs for the care user, leading to waiting lists to procure a budget [84, 91, 97, 104] and to limited budgets allotted to care users (54%). These allotted budget amounts are too small to cover all the care needs of the budget holders (41%) or make it hard for budget holders to pay their care workers properly. Proper payment should include sick leave, pensions, and other benefits [45, 46, 54, 55, 60, 75, 97, 109, 117, 120, 122-124]. However, some articles (9%) found evidence opposing this where, despite having a limited budget, some users have managed to use it efficiently to cover all their needs [38, 43, 57, 65, 71, 86, 87, 91]. An example of this is the pooling of budgets in order to be able to fund all needed services [71, 86, 87].

Another issue discussed in half of the articles is the lack of available services. In times of financial austerity, care providers are less inclined to expand their supply and can even raise their prices, leaving care users with a limited amount of options or leading to a relative reduction in the available budget of budget holders. Finally, less than 10% of the articles (7%) reported on problems with the timeliness of payment of the budget. When budgets are not allotted in time, care users are unable to pay their personal assistants on time or have to make out-of-pocket purchases of goods and services [59, 103, 114, 115, 117, 122]. To conclude, policy makers should not use cash-for-care schemes as cost-controlling device, but should grant budgets that are sufficient to meet care users' needs and thus stimulate the development of a care market.

4.3.3. Legislation and procedures (L&P)

Three-quarters of the articles discussed the impact of legislation and procedures, since these determine who is eligible to apply, which administrative responsibilities budget holders have, and how flexible the budget can be used. Less than half of the articles (43%) reported that scheme policies allow for great flexibility. This refers to situations where policymakers do not use eligibility criteria to restrict access, do not make use of regulations on how to use the budget, but do keep the processes of application, assessment, procurement, and review as simple and efficient as possible.

However, two-thirds of the articles discuss the bureaucracy involved in some schemes; this can imply, on the one hand, bureaucratic processes of assessment, review, procurement, and approval, or placing high administrative demands on the care user. On the other hand, it can also imply eligibility restrictions on the type of budget holder or on how the budget can be used such as which services and materials can be bought, who can be hired as a caregiver, and financial rules concerning the management of the budget.

Some articles (16%) discuss financial rules that may apply. These can be categorized in three different categories. The first category is restrictions on payments made to care workers. This means that the government determines the payment they receive, the benefits that can be offered to them, and the taxes that they pay [86, 103, 104, 115, 122]. The second category consists of restrictions on ‘time banking’, which determines whether care users can save up unused hours of care and combine them for a bigger purchase, such as an afternoon out. The ability to saving up hours is especially beneficial for care users with fluctuating needs who may need a lot of care during a relapse, but only a few hours of care during a good period when their condition is under control [35, 54, 70, 73]. The third category of restrictions affects allocation of the budget. In some schemes, budgets are granted through an intermediary instead of directly to the care user, which whom care users must discuss their proposed use of the budget [47, 64, 81, 91, 114].

Finally, care users-budget holders indicate that the ability to hire family or friends as care providers significantly determines the flexibility of the budget [45, 54, 59, 60, 86, 91, 97, 103, 114, 123, 124]. This is particularly important for people with intellectual disabilities, since they prefer a caregiver with whom they are familiar with and who knows them well. In the study of Harry and colleagues [107], interviewees reported that young people with intellectual disabilities refused the support provided by conventional care services, and took up cash-for-care schemes after transitioning to adult care services. By permitting family members and friends to be hired as care providers, care could be provided by someone known to the care user, which was easier for them to accept. To conclude, care users should be able to use their budget flexibly by allowing them to hire family members and to save unspent funds for bigger purchases.

4.3.4. Access to information and support (I&S)

The majority of the articles (87%) discussed the availability and accessibility of information and support systems, and more than half (57%) reported that some care users had enough information to be able to manage the budget and make decisions about their care. However, almost three-quarters of the articles (72%) indicated that a lack of information and support arose from a lack of clarity, consistency and transparency in information or support provided, or from a lack of necessary information and support concerning the implications of managing a budget and being an employer.

When care users are allowed flexibility, they need support to make decisions about their care and to manage their responsibilities as a budget holder. Leaving them without the required information or support leads to poor decision making and inefficient use of the budget. Care users-budget holders are concerned with four aspects of information: the independent nature of information and support, its timeliness, the option of a try-out phase, and special attention on minority groups. One-third of the articles emphasis the importance of the independence of information and support sources such as peer or informal caregiver groups. A quarter of the articles emphasize that information and support should be given in time and be ongoing. A small minority of the articles (8%) emphasize the value of a try-out phase in which the care user can become familiar in the responsibilities involved in managing a budget [54, 57, 61, 62, 66, 87, 98]. Lastly, special attention should be given to minority groups who have problems accessing the right information or support, due to language difficulties, inaccessible formats, and mistrust of the care system. It is therefore important to offer support through trusted people and to offer information in diverse formats [37, 51, 54, 57, 83, 91, 99, 100, 118]. For example, providing information only through internet sources, will disadvantage care users who do not have the skills needed to access such sources [37, 62, 84, 99]. Additionally, if this information is only provided in one language, some ethnic groups may not have access to this information [37, 51, 57, 91, 99]. To conclude, care users will need information and support to navigate the care system and to be able to manage their budget.

4.4. Antecedents of Empowerment in Cash-for-Care Schemes: Personal Characteristics

Table 6 presents a heat map of the themes and subthemes regarding the personal factors by number of publications.

Insert Table 6 about here

Personal characteristics refer to the financial, social, and personal resources of a care user that facilitate the use of a cash-for-care scheme and taking on the role of budget holder. Age as a personal resource was discussed in almost a quarter of the articles (23%). Some studies found that older budget holders were less empowered, lacked control or did not want to take control over their budget [41, 70, 73, 82, 84, 96, 102], while Mitchell and colleagues [62] found that younger adults reported that they had problems with self-directing their care and thus feeling less empowered. Moreover, contextual factors affect the level of self-determination that older budget holders have. Some articles report that smaller budgets are granted to older people than to younger adults, leading to a smaller range of care options [42, 53, 63].

One in five articles discussed ethnicity, generally in relation to the ability of care users of various ethnicities to access the cash-for-care scheme and the needed information and support [37, 44, 51, 57, 85, 99, 121]. However, once ethnic care users-budget holders began to manage their budget, they could control who provided their care and thus purchase person-centered care adapted to their cultural norms [44, 51, 63, 70, 106, 111].

An important resource, discussed in two-thirds of the articles, is the financial and human resources of care users. Although care users may sometimes be unable to manage their budget due to their disability or condition, they can still feel empowered when the care network supports them in managing the budget. A good care network can provide the necessary skills, abilities, and, in some cases, financial resources, when the budget is limited. The financial resources of the network or the budget holder are of primary importance when budgets are limited and do not cover all care needs. This can allow care gaps to be filled through making out-of-pocket expenditure on the part of either the care user or his or her network. To conclude, evidence relating to age and ethnicity is mixed, but the literature shows the importance of social and financial resources in enabling care users to manage the budget.

4.5. Empowerment and Person-Centered Care

In general, when care users are able to choose their care services, their choices are based on their needs and preferences. The results of the studies examined here report that cash-for-care schemes enable person-centered care and afford the opportunity to live a normal life in the community. For example, by being able to choose who provides care services and when and where these are provided, care services are built around the daily routine of the care user, and not around the daily routine of the care provider. As a consequence, care users may be able to search for a job, go to work, and enjoy hobbies [42, 45, 52, 53, 66, 72, 73, 89, 92, 120, 121].

Another effect of being able to choose care services is family-centered care. Family members can take a break from each other, and informal caregivers can be relieved of some of their care tasks through the opportunity to work in partnership with a professional care provider who they trust. This can alter the roles between, for example, parents and children, with some care users being able to go to university or to prepare to live independently of their family [35, 38, 40, 43, 48, 52, 57, 59, 60, 79, 86, 89, 91, 103-105, 112, 119].

5. Discussion

5.1. Level of Empowerment

The evidence base on the effect of cash-for-care schemes on feelings of empowerment among care users is mainly qualitative. Using the concept of psychological empowerment, our review analyzed the literature and found evidence for the four cognitions of empowerment namely, meaning, competence, self-determination, and impact. However, only one article described the meaning that managing a budget has for budget holders, while the majority of articles discussed the cognitions of competence, impact, and self-determination. In light of this evidence, we propose some recommendations for future research.

On one hand, the primary aim of the majority of qualitative studies was to evaluate the cash-for-care scheme they investigated; they thus also reported on other effects (for example, quality of life). Only six articles had the sole aim of exploring the experience of power and control or the meaning of power and control to budget holders [50, 55, 56, 70, 80, 124]. From these six articles, only one study used a theoretical framework to develop their interview guide and analyze the findings of their research [56]. On the other hand, are the concepts of choice and control, which are used interchangeably in the evidence base. For example, the titles of the articles of Hamilton and colleagues [50], Rabiee & Glendinning [70], and Williams & Porter [80], mention choice and control as equivalent. This is not uncommon, since Castro and colleagues [20] remarked in their concept analysis that self-determination theory is an underlying theory of empowerment. However, it does make it difficult to distinguish empowerment of the decision making process and the concept of ‘choice’. We therefore recommend that future qualitative research should focus on a clear conceptualization of empowerment using existing frameworks. This should also allow to obtain a clearer focus on the antecedents of empowerment in cash-for-care schemes.

Quantitative evidence on the level of empowerment that care users experience in cash-for-care schemes is scarce. Only seven articles measured empowerment in a quantitative way, of which three used a scale that measures the impact of social care interventions on quality of life (ASCOT) [65, 82, 96, 102, 106, 110]. Since these three articles also reported results on the individual items of the scale, we decided to include these results in the review [65, 82, 96]. However, this also shows the need for more quantitative evidence with validated measurement scales of empowerment. Since our review provides evidence that it is important for care users to feel capable of managing the budget, this should be taken into account when measuring the feelings of empowerment of budget holders. It can therefore be of value to use the psychological empowerment scale to determine the level of empowerment of care users and to investigate the antecedents of empowerment.

5.2. Antecedents of Empowerment

Cash-for-care schemes can enhance care users' experience of empowerment. However, contextual and personal factors affect the experience of empowerment and should thus be taken into account when implementing such schemes. Policy makers should be aware of these contextual factors, and should take into account the importance of four contextual factors: establishing a culture of change, supportive financial climate, flexible regulatory framework and access to support and information. If policymakers implement a cash-for care scheme, they should be aware of the importance of installing a mindset of cooperation and collaboration with care users, of providing budgets that are sufficiently large to cover all care needs, of allowing flexibility in the use of the budget, and of fostering accessibility of support and information.

Personal factors included age, ethnicity, financial resources, and the care network of the budget holder. Since the evidence base contains mostly qualitative evidence, it is difficult to capture how these personal factors affect the experience of empowerment and of person-centered care. For example, evidence on the influence of socioeconomic status, gender, or living situation are not clear. Future research should therefore use quantitative methods to explore the effects of these personal factors on the experience of empowerment and person-centered care.

Additionally, personal and contextual factors also affect each other. For example, older people receive smaller budgets than younger adults [53, 63]. If budgets are limited, the financial resources of the network can enhance the feeling of self-determination of budget holders, because care gaps are met with out-of-pocket spending [87]. These interactions show the complexity of determining what affects feelings of empowerment, so future research should pay attention to these linkages of contextual and personal factors.

5.3. Limitations

First of all, the titles of the articles were screened by just one reviewer, who however deliberately passed all doubtful cases onto the abstract screening phase, so these could be discussed with the second reviewer. Second, the ASCOT-measure was included, although this scale was not designed to measure empowerment. However, the articles using the ASCOT reported on the individual results of the item that asks about existing needs of control over daily life, or the satisfaction that care users have with their say in their care. Since this definition is also used in the qualitative evidence, we decided to include this measure in the results. Third, the evidence base has a mainly qualitative design, and we included studies that examined the effects of cash-for-care schemes in different care user populations. However, since all care users received the same type of intervention, it is interesting to note that they report in a similar way on the antecedents that affect their experience of empowerment. Although these conclusions cannot be generalized to the whole population, it can direct policy makers towards the most important aspects to be considered when implementing cash-for-care schemes. Fourth, this review explored the experience of empowerment in several types of cash-for-care schemes in different countries, which casts some doubt over the comparability of their outcomes. However, the experience of empowerment and the antecedents affecting this experience show no salient differences in the different types of cash-for-care schemes or between European countries, Australia, the USA, and Canada. Finally, due to the lack of quantitative evidence, this review could not report on the level of empowerment of care users in cash-for-care schemes. It is therefore important that future research targets this research gap in the literature.

6. Conclusion

This review explored the experience of cash-for-care schemes and the antecedents affecting this experience. Exploring the evidence yielded four contextual factors which should be taken into account by policymakers namely culture of change, level of the budget, flexibility and complexity of rules and legislation, and access to information and support. Additionally, personal factors influence the experience of empowerment, and contextual and personal factors also affect each other. Of these personal factors, the network of the care user has an important role in experiencing empowerment and in mitigating the effect of less favorable contextual factors. However, the evidence base for the experience of empowerment of care users in cash-for-care schemes has two main gaps. First, more quantitative research is required to measure the level of empowerment of care users and to explore how these antecedents of empowerment affect the experience of empowerment and of person-centered care. Second, qualitative research should be based on a theoretical framework so as to define the concept of empowerment.

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FIGURE 1

PRISMA flow diagram of the inclusion process

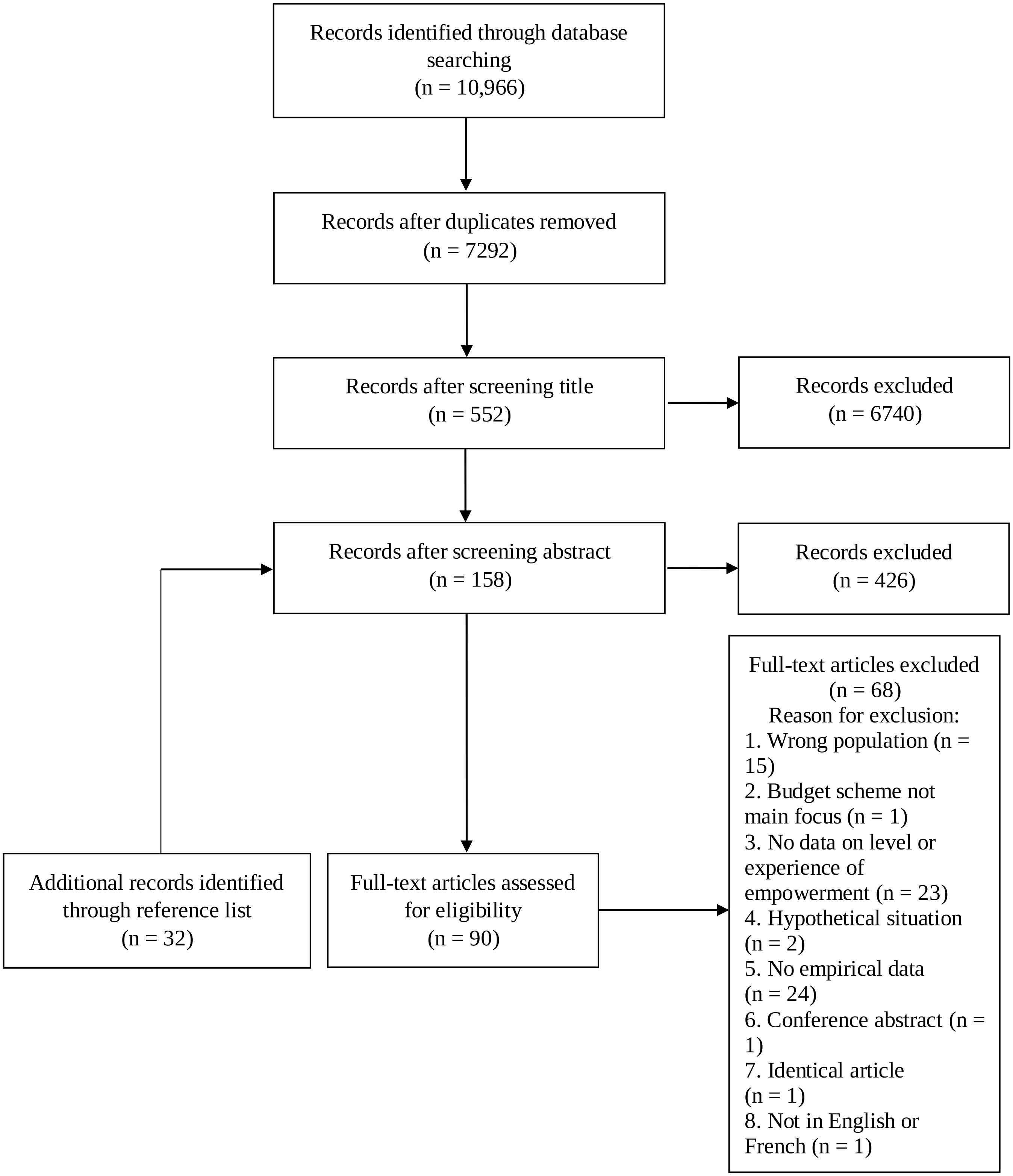

TABLE 1
Study Characteristics of the included studies

Cash and Counseling

Article	Publication year	Method	Territory	Scheme	Type of care user/budget holder
San Antonio et al. [111]	2007	Qualitative	USA	Cash and Counseling	People with disabilities Older people Proxies
Schore et al. [114]	2007	Mixed method	USA	Cash and Counseling	People with disabilities Older people Proxies
Shen et al. [113]	2008	Quantitative	USA	Cash and Counseling	People with mental health problems
San Antonio et al. [112]	2009	Mixed method	USA	Cash and Counseling	People with disabilities Older people Proxies
Harry et al. [107]	2017	Qualitative	USA	Cash and Counseling	Parents or guardians of adult children with intellectual disabilities
Harry et al. [108]	2017	Quantitative	USA	Cash and Counseling	Young adults with disabilities Proxies

TABLE 1 (continued)

Direct Payment scheme (DP)

Article	Publication year	Method	Territory	Scheme	Type of care user/budget holder
Glendinning et al. [45]	2000	Qualitative	England	DP	People with disabilities Proxies
Glendinning et al. [46]	2000	Qualitative	England	DP	People with disabilities
Leece [55]	2000	Qualitative	England	DP	People with disabilities Older people
Maglajlic et al. [57]	2000	Qualitative	England	DP	People with learning difficulties People with mental health problems People with physical disabilities Proxies
Pearson [67]	2000	Qualitative	England and Scotland	DP	People with disabilities
Stainton and Boyce [76]	2004	Qualitative	Wales	DP	People with disabilities Parents of children with disabilities
Spandler and Vick [75]	2006	Mixed method	England	DP	People with mental health problems
Blyth and Gardner [38]	2007	Mixed method	England	DP	Parents of children with disabilities
Leece [54]	2010	Qualitative	England	DP	People with disabilities
Leece and Peace [56]	2010	Qualitative	England	DP	People with disabilities Older people

TABLE 1 (continued)

Direct Payment scheme (DP) (continued)					
Article	Publication year	Method	Territory	Scheme	Type of care user/budget holder
Arksey and Baxter [35]	2012	Qualitative	England	DP	Young people and adults with disabilities Older people
Griffiths and Ainsworth [48]	2014	Qualitative	England	DP	People with mental health problems Proxies
Laybourne et al. [53]	2016	Qualitative	England	DP	Proxies of people with dementia
McGuigan et al. [59]	2016	Qualitative	Northern Ireland	DP	People with disabilities People with mental health problems Proxies
O'Rourke [66]	2016	Qualitative	England	DP	Older people
McNeill and Wilson [60]	2017	Mixed method	Northern Ireland	DP	Parents of children with disabilities
Williams et al. [81]	2017	Qualitative	United Kingdom	DP	People with intellectual disabilities Proxies
Rodrigues [72]	2019	Qualitative	England	DP	Older people Proxies
Damant et al. [41]	2020	Qualitative	England	DP	Older people Proxies
Davey [42]	2021	Quantitative	England	DP	Older people Proxies
Porter et al. [68]	2022	Qualitative	England, Wales and Scotland	DP	People with physical and/or sensory disabilities Parents of children with developmental and learning disabilities

TABLE 1 (continued)

Individual Budgets (IB) pilot project and Individual Recovery Budgets (IRB)

Article	Publication year	Method	Territory	Scheme	Type of care user/budget holder
Daly et al. [40]	2008	Qualitative	England	IB	Young people and adults with physical disabilities Young people and adults with learning disabilities Young people and adults with mental health problems
Coyle [39]	2011	Qualitative	England	IRB	People with mental health problems
Stevens et al. [77]	2011	Qualitative	England	IB	People with disabilities People with mental health problems Older people Proxies
Netten et al. [65]	2012	Quantitative	England	IB	People with disabilities People with mental health problems Older people
Moran et al. [63]	2013	Mixed method	England	IB	Older people Proxies
Rabiee et al. [71]	2014	Qualitative	England	IB	People with disabilities People with mental health problems Older people Proxies

TABLE 1 (continued)

Pre-NDIS Individualized Funding (IF) and National Disability Insurance Scheme (NDIS)

Article	Publication year	Method	Territory	Scheme	Type of care user/budget holder
Spall et al. [97]	2005	Qualitative	Australia	IF	People with disabilities and a proxy Parents of children with disabilities
Ottmann and Mohebbi [96]	2009	Mixed method	Australia	IF	Older people Proxies
Laragy and Ottmann [91]	2011	Qualitative	Australia	IF	Parents of children and young people with disabilities
Dew et al. [86]	2013	Qualitative	Australia	IF	Parents of children with disabilities
Ottmann et al. [95]	2014	Qualitative	Australia	IF	Parents of children or young people with disabilities Parents of children or young people with mental health problems
Howard et al. [88]	2015	Mixed method	Australia	NDIS	Parents or guardians of children with disabilities
Laragy et al. [90]	2015	Qualitative	Australia	NDIS	Adults with disabilities
Tracey et al. [99]	2018	Mixed method	Australia	NDIS	Parents of children with disabilities
Moskos and Isherwood [94]	2019	Qualitative	Australia	NDIS	People with disabilities Proxies

TABLE 1 (continued)

Pre-NDIS Individualized Funding (IF) and National Disability Insurance Scheme (NDIS) (continued)

Article	Publication year	Method	Territory	Scheme	Type of care user/budget holder
Barr et al. [83]	2021	Mixed method	Australia	NDIS	Parents of children with hearing loss
Fisher et al. [87]	2021	Qualitative	Australia	IF	People with physical and/or mental disabilities Proxies
Loadsman and Donelly [93]	2021	Qualitative	Australia	NDIS	Parents of children with disabilities
Devine et al. [85]	2022	Mixed method	Australia	NDIS	People with psychosocial disabilities Proxies
Hurley et al. [89]	2022	Qualitative	Australia	NDIS	Proxies of people with disabilities
Wilson et al. [100]	2022	Qualitative	Australia	NDIS	People with mental health problems
Yates et al. [101]	2022	Qualitative	Australia	NDIS	Women with disabilities Women with mental health problems
Lloyd et al. [92]	2023	Qualitative	Australia	NDIS	Parents of adults with intellectual disabilities

TABLE 1 (continued)

Personal Budget (PB) and Managed Personal Budget (MPB)

Article	Publication year	Method	Territory	Scheme	Type of care user/budget holder
Williams and Porter [80]	2003	Qualitative	England	PB	People with intellectual disabilities (and physical or sensory disabilities)
Rabiee and Glendinning [70]	2009	Qualitative	England	MPB	Older people
Larsen et al. [52]	2015	Qualitative	England	PB	Adults and older people with mental health problems
Hamilton et al. [50]	2016	Qualitative	England	PB	Adults and older people with mental health problems
Hamilton et al. [49]	2017	Qualitative	England	PB	Adults with intellectual disabilities (in combination with a physical or sensory disability or with mental health problems)
Irvine et al. [51]	2017	Qualitative	England	PB	Chinese adults with physical and/or sensory disabilities Chinese older people
Pozzoli [69]	2018	Qualitative	England	PB	Young people with mild or moderate learning disabilities Parents of young people with learning disabilities
Aspinal et al. [36]	2019	Qualitative	England	PB	People with physical and/or learning disabilities People with physical disabilities and mental health problems Proxies

TABLE 1 (continued)

Personal Health Budget (PHB)

Article	Publication year	Method	Territory	Scheme	Type of care user/budget holder
Davidson et al. [43]	2013	Qualitative	England	PHB	Adults and older people with disabilities Adults and older people with mental health problems
Glick et al. [47]	2022	Qualitative	England	PHB	People with disabilities Parents of children with physical and learning disabilities
Welch et al. [79]	2022	Mixed method	England	PHB	People with disabilities People with mental health problems Older people Proxies

TABLE 1 (continued)

Scottish Self-directed Support (SDS)

Article	Publication year	Method	Territory	Scheme	Type of care user/budget holder
Mitchell [61]	2015	Qualitative	Scotland	SDS	Young people with disabilities and their parents
Manji [58]	2018	Qualitative	Scotland	SDS	People with disabilities (and mental health problems)
Rummery et al. [74]	2022	Mixed method	Scotland	SDS	People with disabilities Proxies

TABLE 1 (continued)

Other Cash for Care Schemes

Article	Publication year	Method	Territory	Scheme^a	Type of care user/budget holder
Doyle [44]	1995	Quantitative	England	ILF	Adults with disabilities Older people
Mattson Prince et al.[110]	1995	Quantitative	USA	WP	People with physical disabilities
Keigher [109]	1999	Qualitative	USA	COP	Older people Proxies
Benjamin and Matthias [102]	2001	Quantitative	USA	IHSS	Adults with disabilities Older people
Askheim [119]	2003	Mixed method	Norway	BPA	People with intellectual disabilities and their parents
Hagglund et al. [106]	2004	Quantitative	USA	PAS	People with physical disabilities
Caldwell [104]	2007	Qualitative	USA	IHSS	Parents of adult children with intellectual and/or developmental disabilities
Gross et al. [105]	2012	Qualitative	USA	WP	Parents or guardians of adult children with intellectual and/or developmental disabilities
Junne and Huber [117]	2014	Qualitative	Germany	GPB	People with disabilities

TABLE 1 (continued)

Other Cash-for-Care Schemes (continued)

Article	Publication year	Method	Territory	Scheme[a]	Type of care user/budget holder
Brown et al. [103]	2018	Qualitative	USA	WP	Parents of adult children with intellectual and/or developmental disabilities
Day et al. [84]	2018	Qualitative	Australia	HCP	Older people
Junne [116]	2018	Qualitative	Germany	GPB	People with disabilities
Schmidt [118]	2018	Qualitative	Austria	PG	Older people
Stewart et al. [98]	2018	Qualitative	Australia	PIR	People with mental health problems and a proxy
Neale et al. [64]	2019	Qualitative	England	Pilot	People with mental health problems
Spaulding-Givens et al [115]	2019	Qualitative	USA	SDC	People with mental health problems Older people
Katzman et al. [120]	2020	Qualitative	Canada	SMAS	People with physical disabilities Older people Proxies
Katzman et al. [121]	2022	Qualitative	Canada	SMAS	People with physical disabilities Older people Proxies

[a] GPB = German Persönliches Budget; HCP = Home Care Package; IA = Italian Indennità di accompagnamento; PG = Austrian Pflegegeld; Pilot = 'test and learn' program; PIR = Partners in Recovery; SDC = Self-Directed Care program; SMAS = Self-Managed Attendant Services; WP = self-directed Waiver Program

TABLE 1 (continued)

More Than One Cash-for-Care Scheme

Article	Publication year	Method	Territory	Scheme[a]	Type of care user/budget holder
Ungerson [124]	2004	Qualitative	Austria, France, Italy, The Netherlands and England	PG, APA, IA, PGB & DP	Older people
Christensen [122]	2009	Qualitative	England and Norway	DP and BPA	People with physical disabilities
Baxter and Glendinning [37]	2011	Qualitative	England	DP and PB	Adults with disabilities Older people
Christensen [123]	2012	Qualitative	England and Norway	DP and BPA	People with physical disabilities
Rodrigues and Glendinning [73]	2015	Qualitative	England	DP and MPB	Older people
Mitchell et al. [62]	2017	Qualitative	England	DP and MPB	Young people with physical disabilities
Woolham et al. [82]	2017	Quantitative	England	DP and MPB	Older people
Turnpenny et al. [78]	2021	Qualitative	England	DP & PHB	Parents or guardians of children with disabilities and/or mental health problems

[a] APA = French Allocation Personnalisée à l'Autonomie; BPA = Norwegian Brukerstyrt Personlig Assistance; DP = Direct Payments; IA = Italian Indennità di accompagnamento; MPB = Managed Personal Budgets; PB = Personal Budget; PHB = Personal Health Budget; PG = Austrian Pflegegeld; PGB = Persoonsgebonden Budget;

TABLE 2
Quality Appraisal of the Included Articles

Articles using a qualitative approach

Article	Relevance qualitative approach	Data collection	Data analysis	Interpretation	Coherence of data and method
Keigher [109]	+	+/-	-	-	-
Glendinning et al. [45]	+	+	+/-	+/-	+/-
Glendinning et al. [46]	+	+/-	+/-	+	+
Leece [54]	+	-	-	+/-	-
Maglajlic et al. [57]	+	+	-	+/-	+/-
Pearson [67]	+	-	-	+/-	-
Williams and Porter [80]	+	+	+	+	+
Stainton and Boyce [76]	+	+	+	+	+
Ungerson [124]	+	+/-	+	+/-	+/-
Spall et al. [97]	+	+	+/-	+/-	+/-
Caldwell [104]	+	+	+/-	+	+/-
San Antonio et al. [111]	+	+	+/-	+/-	+/-
Daly et al. [40]	+	+	+	+/-	+/-
Christensen [122]	+	+	+/-	+	+
Rabiee and Glendinning [70]	+	+	+	+/-	+
Leece [55]	+	+	-	+/-	+/-
Leece and Peace [56]	+	+	-	+/-	+/-
Baxter and Glendinning [37]	+	+	+	+	+
Coyle [39]	+	+	+	+	+
Laragy and Ottmann [91]	+	+	+/-	+/-	+/
Stevens et al. [77]	+	+	+	+	+

+ = Good; +/- = Moderate, - = Low

TABLE 2 (continued)

Articles using a qualitative approach (continued)

Article	Relevance qualitative approach	Data collection	Data analysis	Interpretation	Coherence of data and method
Arksey and Baxter [35]	+	+/-	+	+	+/-
Christensen [123]	+	+	+/-	+	+
Gross et al. [105]	+	+/-	+	+	+
Davidson et al. [43]	+	+	+/-	+/-	+/-
Dew et al. [86]	+	+	+/-	+	+/-
Griffiths and Ainsworth [48]	+	+/-	+	+/-	+/-
Junne and Huber [117]	+	+	+/-	+	+
Ottmann et al. [95]	+	+	+/-	+/-	+/-
Rabiee et al. [71]	+	+/-	+	+	+
Laragy et al. [90]	+	+/-	+/-	+/-	+/-
Larsen et al. [52]	+	+	+	+	+
Mitchell [61]	+	+	+	+	+
Rodrigues and Glendinning [73]	+	+	+/-	+/-	+/-
Hamilton et al. [50]	+	+	+	+	+
Laybourne et al. [53]	+	+	+	+/-	+/-
McGuigan et al. [59]	+	+	-	+/-	+/-
O'Rourke [66]	+	+	+	+	+
Hamilton et al. [49]	+	+	+	+	+
Harry et al. [107]	+	+/-	+	+	+
Irvine et al. [51]	+	+	+	+	+

+ = Good; +/- = Moderate, - = Low

TABLE 2 (continued)

Articles using a qualitative approach (continued)					
Article	Relevance qualitative approach	Data collection	Data analysis	Interpretation	Coherence of data and method
Mitchell et al. [62]	+	+	+	+	+
Williams et al. [81]	+	+	+	+	+
Brown et al. [103]	+	+	+	+	+
Day et al. [84]	+	+	+	+	+
Junne [116]	+	+/-	+/-	+/-	+/-
Manji [58]	+	+/-	-	+	+/-
Pozzoli [69]	+	+/-	-	+/-	+/-
Schmidt [118]	+	+/-	+/-	+	+
Stewart et al. [98]	+	+	+	+	+
Aspinal et al. [36]	+	+	+/-	+/-	+/-
Moskos and Isherwood [94]	+	+	+	+	+
Neale et al. [64]	+	+	+	+/-	+/-
Rodrigues [72]	+	+	+	+	+
Spaulding-Givens et al. [115]	+	+/-	+	+/-	+/-
Damant et al. [41]	+	+/-	+/-	+	+
Katzman et al. [120]	+	+	+	+	+
Fisher et al. [87]	+	+	+	+	+
Loadsman and Donelly [93]	+	+	+	+	+
Turnpenny et al. [78]	+	+/-	+	+	+
Glick et al. [47]	+	+	+	+	+
Hurley et al. [89]	+	+	+	+/-	+/-
	+ = Good; +/- = Moderate, - = Low				

TABLE 2 (continued)

Articles using a qualitative approach (continued)

Article	Relevance qualitative approach	Data collection	Data analysis	Interpretation	Coherence of data and method
Katzman et al. [121]	+	+/-	+	+	+/-
Porter et al. [68]	+	+	+	+/-	+/-
Wilson et al. [100]	+	+	+/-	+/-	+/-
Yates et al. [101]	+	+	+	+	+
Lloyd et al. [92]	+	+/-	+	+	+/-

+ = Good; +/- = Moderate, - = Low

TABLE 2 (continued)

Articles using a quantitative approach: randomized controlled trials

Article	Appropriate randomization	Comparable sample	Complete outcome data	Blinding	Adherence
Shen et al. [113]	+	+	+	+/-	+/-
Netten et al. [65]	+	+	+	+/	+/-
Harry et al. [108]	+	+	+	+/-	+/-

Articles using a quantitative approach: non-randomized controlled trials

Article	Representative sample	Measurement	Complete outcome data	Confounders presented	Intervention
Doyle [44]	+/-	+/-	+	-	+
Mattson Prince et al. [110]	-	+	+/-	-	-
Benjamin and Matthias [102]	+/-	+	+	+	+
Hagglund et al. [106]	+	+	+/-	+	+
Woolham et al. [82]	+	+	+/-	+	+
Davey [42]	+/-	+	+/-	+	+

+ = Good; +/- = Moderate, - = Low

TABLE 2 (continued)

Articles using a mixed method approach

Mixed method part

Article	Relevance mixed method approach	Integration of data	Data analysis	Interpretation	Data quality
Askheim [119]	+/-	-	-	-	-
Spandler and Vick [75]	+	+/-	+/-	+/-	+/-
Blyth and Gardner [38]	+/-	+/-	+	+	+
Schore et al. [114]	+	+/-	+/-	+/-	+/-
Ottmann and Mohebbi [96]	+	-	+/-	+/-	+/-
San Antonio et al. [112]	+	+	+/	+/	+
Moran et al. [63]	+	+/-	+	+	+
Howard et al. [88]	+/-	+	+	+	+/-
McNeill and Wilson [60]	+/-	+	+	+	+/-
Tracey et al. [99]	+	+/-	+/-	+/-	+/-
Barr et al. [83]	+/-	+	+	+	+/-
Devine et al. [85]	+	-	-	-	-
Rummery et al. [74]	+	-	-	-	-
Welch et al. [79]	+	+/-	-	-	+/-

+ = Good; +/- = Moderate, - = Low

TABLE 2 (continued)

Articles using a mixed method approach (continued)

Qualitative part

Article	Relevance qualitative approach	Data collection	Data analysis	Interpretation	Coherence of data and method
Askheim [119]	+	+	-	-	-
Spandler and Vick [75]	+	+	+/-	+/-	+/-
Blyth and Gardner [38]	+	+	+	+	+
Schore et al. [114]	+	+	+/-	+/-	+/-
Ottmann and Mohebbi [96]	+	-	+/-	+/-	+/-
San Antonio et al. [112]	+	+	+/-	+	+/-
Moran et al. [63]	+	+	+	+	+
Howard et al. [88]	+	+	+/-	+	+
McNeill and Wilson [60]	+	+/-	+/-	+	+/-
Tracey et al. [99]	+	+/-	+/-	+/-	+/-
Barr et al. [83]	+	-	+	+/-	+/-
Devine et al. [85]	+	+	+	+	+
Rummery et al. [74]	+	+	+	-	-
Welch et al. [79]	+	+	+	+	+

+ = Good; +/- = Moderate, - = Low

TABLE 2 (continued)

Articles using a mixed method approach (continued)

Quantitative part

Article: descriptive studies	Sampling strategy	Representative	Appropriate measurement	Low nonresponse bias	Appropriate analysis
Askheim [119]	-	-	-	-	-
Spandler and Vick [75]	+	+	-	+/-	+
Blyth and Gardner [38]	+	-	+	-	+
Howard et al. [88]	+/-	-	+	-	+
McNeill and Wilson [60]	+	-	-	-	+
Tracey et al. [99]	-	-	+	-	+
Barr et al. [83]	+	+	+/-	+/-	+
Devine et al. [85]	+	+	+	+	-
Rummery et al. [74]	+/-	-	+/-	-	-
Welch et al. [79]	+	+/-	-	-	-
Article: non-randomized study	Representative sample	Measurement	Complete outcome data	Confounders presented	Intervention
Ottmann and Mohebbi [96]	-	+/-	+/-	+/-	+
Article: randomized controlled trial	Appropriate randomization	Comparable sample	Complete outcome data	Blinding	Adherence
Schore et al. [114]	+	+	+	+/-	+/-
San Antonio et al. [112]	+	+	+	+/-	+/-
Moran et al. [63]	+	+	+	+/-	+/-
	+ = Good; +/- = Moderate, - = Low				

FIGURE 2

Number of Articles by Publication Year

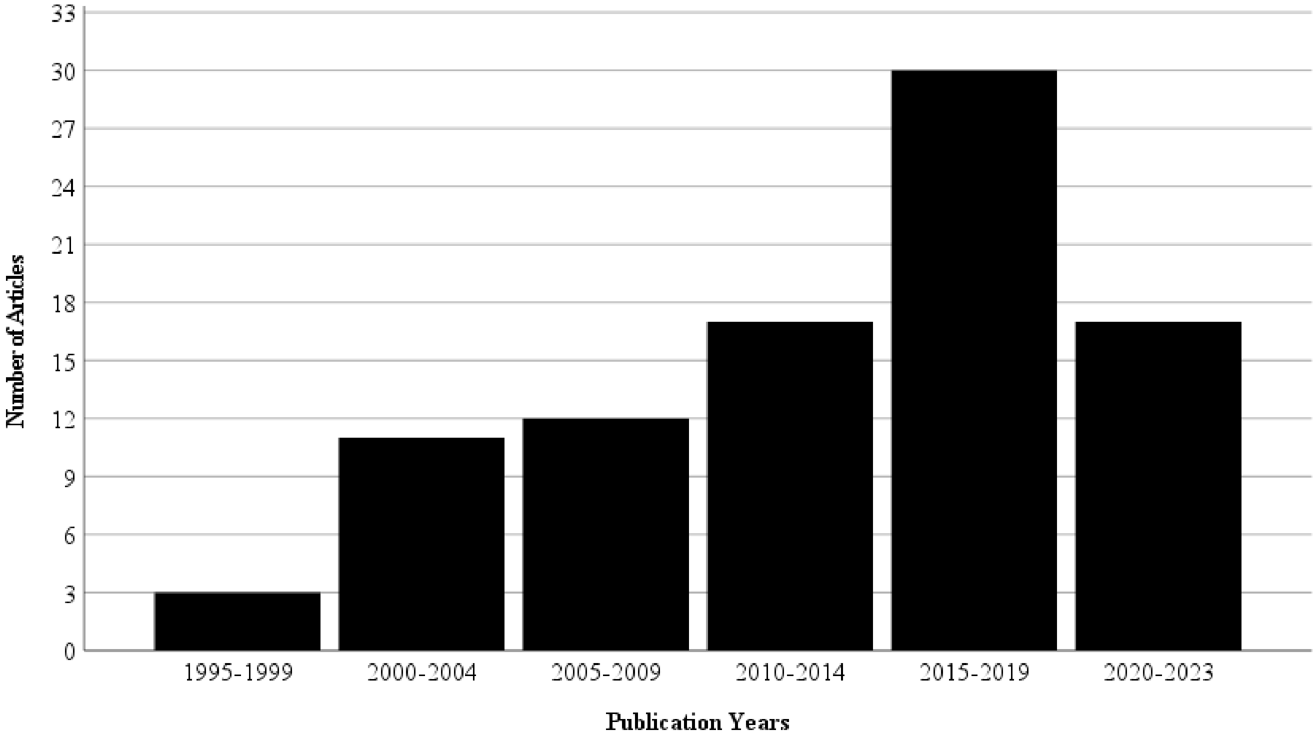

TABLE 3
Themes Discussed in Each Study

Publication years	Empowerment[a]				Contextual[b]				Personal[c]				**Total Number of Articles (%)**
	M	C	I	SD	CoC	FC	L&P	I &S	A	E	N	FR	
1995-1999	0	3	1	3	2	2	2	2	1	2	2	3	3 (3%)
2000-2004	0	10	5	11	10	8	10	8	3	4	3	2	11 (12%)
2005-2009	0	12	7	12	11	11	12	10	3	2	6	3	12 (13%)
2010-2014	0	15	14	17	15	12	15	15	5	4	8	4	17 (19%)
2015-2019	0	25	18	30	25	22	19	29	7	4	12	9	30 (33%)
2020-2023	1	13	14	16	14	14	12	14	2	3	10	7	17 (19%)

[a] M = Meaning; C = Competence; I = Impact; SD = Self-Determination

[b] CoC = Culture of Change; FC = Financial Climate; L&P = Legislation and procedures; I&S = Access to Information and Support

[c] A = Age; E = Ethnicity; N = Network; FR = Financial Resources

1-6 articles (1%-20%)	**7-12 articles (21%-40%)**	**13-18 articles (41%-60%)**	**19-24 articles (61%-80%)**	**25-30 articles (81%-100%)**

TABLE 4
Empowerment Themes by Number of Articles

Attribute	Total Number of Articles (%)	Themes	Total Number of Articles (%)	Subthemes	Total Number of Articles (%)
Self-determination	89 (99%)	Enhancing self-determination	9 (10%)		
		Imposing the scheme on the care users	8 (9%)		
Competence	78 (87%)	Feeling incompetent	65 (72%)	Responsibilities of care users	26 (29%)
				Not choosing cash-for-care schemes	14 (16%)
		Feeling competent	34 (38%)	Evolution of care user	21 (23%)
Impact	59 (66%)	Lack of impact	47 (52%)	Feeling responsible	9 (10%)
				Not having ownership	9 (10%)
				Having a restricted impact on one's life	8 (9%)
		Ownership	27 (30%)	The impact of being an employer	24 (27%)
Meaning	1 (1%)				

1-18 articles (1%-20%)	**19-36 articles (21%-40%)**	**37-54 articles (41%-60%)**	**55-72 articles (61%-80%)**	**73-90 articles (81%-100%)**

TABLE 5
Contextual Factors by Number of Articles

Attribute	Total Number of Articles (%)	Themes	Total Number of Articles (%)	Subthemes	Total Number of Articles (%)	Examples	Total Number of Articles (%)
Access to Information and Support	78 (87%)	Lack of information and support	64 (71%)				
		Enough information and support	51 (57%)				
		Value of information	47 (52%)	Independent sources of information and support	33 (37%)		
				Timeliness	22(24%)		
				Special attention to minority groups	9 (10%)		
				Try-out and evaluation	7 (8%)		

1-18 articles (1%-20%)	**19-36 articles (21%-40%)**	**37-54 articles (41%-60%)**	**55-72 articles (61%-80%)**	**73-90 articles (81%-100%)**

TABLE 5 (continued)

Attribute	Total Number of Articles (%)	Themes	Total Number of Articles (%)	Subthemes	Total Number of Articles (%)	Examples	Total Number of Articles (%)
Culture of Change	77 (86%)	Persisting paternalistic images or attitudes	60 (67%)	Lack of a holistic focus	43 (48%)	No family-oriented focus	12 (13%)
						Ambiguous attitudes towards the user of the scheme	5 (6%)
				Deficit-based and excluding view	39 (43%)	Capacity of older people	9 (10%)
						Capacity of people with intellectual disabilities	5 (6%)
						Transportation needs	4 (4%)
		Pressure on the care system	34 (38%)	Training	21 (23%)		
		Pressure on the budget holder	17 (19%)				

1-18 articles (1%-20%)	**19-36 articles (21%-40%)**	**37-54 articles (41%-60%)**	**55-72 articles (61%-80%)**	**73-90 articles (81%-100%)**

TABLE 5 (continued)

Attribute	Total Number of Articles (%)	Themes	Total Number of Articles (%)	Subthemes	Total Number of Articles (%)	Examples	Total Number of Articles (%)
Legislation and procedures	70 (78%)	Bureaucracy	61 (68%)	Financial rules	14 (16%)	Regulations towards payments	5 (6%)
						Restrictions towards the allocation of the budget	5 (6%)
						Restrictions towards time-banking	4 (4%)
				Regulations towards workforce	11 (12%)		
		Limiting bureaucracy	39 (43%)				

1-18 articles (1%-20%)	**19-36 articles (21%-40%)**	**37-54 articles (41%-60%)**	**55-72 articles (61%-80%)**	**73-90 articles (81%-100%)**

TABLE 5 (continued)

Attribute	Total Number of Articles (%)	Themes	Total Number of Articles (%)	Subthemes	Total Number of Articles (%)	Examples	Total Number of Articles (%)
Financial Climate	69 (77%)	Budgetary issues	66 (73%)	Budget cuts or raising costs	53 (59%)	Limited budgets: Not covering all care needs	37 (41%)
						Limited budgets: No proper wages	13 (14%)
						Limited budgets: Opposite findings	8 (9%)
						Waiting lists	4 (4%)
				Lack of available services	46 (51%)		
				Timeliness of payment	6 (7%)		
		Enough money in budget	8 (9%)				

1-18 articles (1%-20%)	**19-36 articles (21%-40%)**	**37-54 articles (41%-60%)**	**55-72 articles (61%-80%)**	**73-90 articles (81%-100%)**

TABLE 6
Personal Factors by Number of Articles

Attribute	Total Number of Articles (%)	Themes	Total Number of Articles (%)	
Age	21 (23%)	Older people	16 (18%)	
		Younger people	3 (3%)	
Ethnicity	19 (21%)	Access to the scheme	7 (8%)	
		Managing the budget	6 (7%)	
Network	41 (46%)			
Financial resources	27 (30%)			
1-18 articles (1%-20%)	**19-36 articles (21%-40%)**	**37-54 articles (41%-60%)**	**55-72 articles (61%-80%)**	**73-90 articles (81%-100%)**