Domiciliary Care Providers in the Independent Sector

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1 Introduction

Domiciliary care for older people has changed significantly over the past two decades. Eligibility criteria have been tightened, intensity of support has increased, user charges have spread and patterns of support across the week have been extended. A more recent but no less important shift has been the changing balance of provision between the public, private and voluntary sectors. For example, the independent sectors' share of the publicly-funded home care market had reached 51% of all domiciliary care provision in England by 1999 (Department of Health, 2000). For the first time ever, the proportion of domiciliary care that English authorities purchase has exceeded the proportion that they provide in-house (Laing & Buisson, 2000).

Furthermore, the latest national statistics on domiciliary care services show that the average number of contact hours is considerably higher for the independent sector (8.1 hours) than for in-house (5.2 hours) (Department of Health, 2000). This reflects the tendency for local authorities to contract out responsibility for more intensive packages to independent sector organisations.

Who are these independent sector providers? What are their main characteristics? What are their market experiences and how do they respond to changes in the context of care, especially in relation to local authority commissioning? What is the nature of providers' relationships with purchasers? What were the motivations for entering the domiciliary care market? What are the working conditions and qualifications of staff? Finally, what expectations do providers have for the future?

These questions prompted and structured a major survey of independent sector domiciliary care providers in 1999. The study was conducted as part of the Mixed Economy of Care Research Programme, which is a long-running joint endeavour by the Personal Social Services Research Unit, London School of Economics, and the Nuffield Institute for Health, University of Leeds. It follows on from a similar study by the same group in 1995. Although we can make comparisons in general terms between the two studies, the samples do not comprise exactly the same providers due to the considerable movement on and off local authority lists. We focus on comparisons between 1995 and 1999 in another paper (Ware et al., 2001).

In this paper we summarise the descriptive findings from the 1999 domiciliary care study. Detailed analyses of these data are presented in four papers, marked with an asterisk in the references at the end of this report.

AIMS OF THE DOMICILIARY CARE PROVIDERS STUDY

- to describe the main features of independent sector provider organisations, such as their legal status, funding sources, length of time in business, number of hours provided and client groups served;
- to examine the nature of provider motivations and their past and future plans;
- to describe how local authorities employ incentives and constraints in order to manage the supply side of social care markets; and
- to examine the general effects on providers of the development of the mixed economy.

2 Sample selection

The data used in this report were gathered using a two-stage sampling process. The sample of local authorities was first selected in 1995, to be representative of the national picture at that time in respect of political control, total social services expenditure per head of population, and percentage of social services expenditure going to independent sector services. In 1995 we had a sample of eight local authorities; in 1999 this had increased to eleven because three new unitary authorities had been established in these eight areas. These eleven comprised two London boroughs, three shire counties, three metropolitan districts and three new unitary authorities.

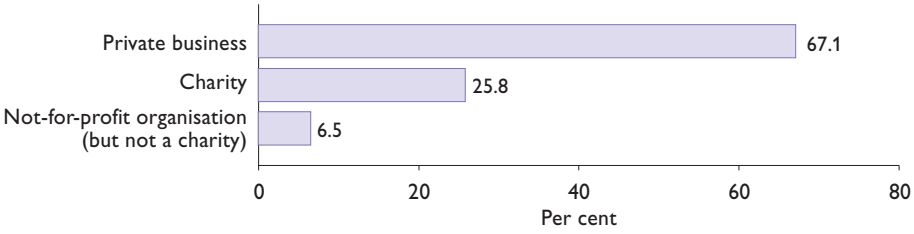
At the second stage, we asked each local authority social services department to identify all providers from whom they had purchased home care services. Postal questionnaires were sent to each provider on current local authority lists. A total of 408 survey forms were sent out. The response rate to the total number of questionnaires sent out was 57%; the response from the current working lists was 62%.

Subsequently, 20% of those on the working lists for each of the authorities were selected for interview. Our interview sample is not exactly a sub-sample of the postal survey sample since seventeen interviewees did not complete a postal questionnaire. We also identified ten providers who were no longer in the domiciliary care business and who were willing to discuss their reasons for leaving the market. The statistical findings in this paper are based on 155 completed postal surveys and 56 interview schedules.

3 Provider characteristics

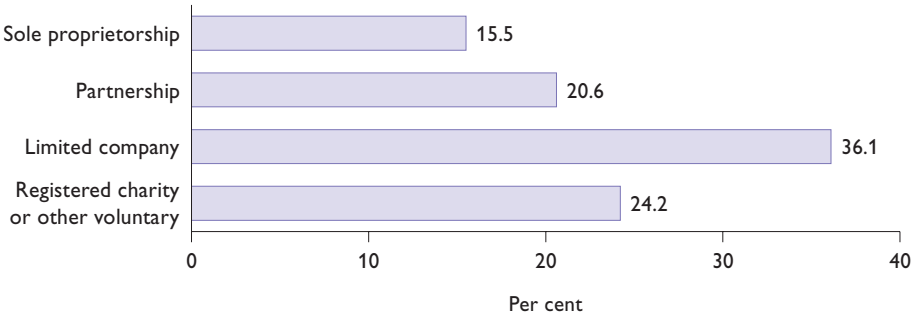
The provider characteristics examined were legal structure, organisational size, ownership, geographical coverage and time in business. Our sample differed from the 1995 study in having slightly smaller proportions of sole proprietors, partnerships and charities, and a greater proportion of limited companies. In 1999, two-thirds of providers were private businesses and 26% charities (figure 1).

Figure 1: Sector of ownership (n = 154, missing = 1)



There was a range of legal forms: 36% of organisations were limited companies and 24% were registered charities and other voluntary organisations (figure 2). Similarly, the study by Laing & Buisson (2000) found that 41% of independent sector providers in their sample were sole traders or partnerships, another 41% were limited companies, and only 18% were voluntary sector organisations.

Figure 2: Legal structure (n = 155)



Two out of five organisations were part of a larger business or organisation. Thirty respondents (19%) were part of a residential or nursing home business and the average number of beds per home was 28. There was also a slightly smaller proportion of organisations that were part of a residential or nursing home business.

According to Laing & Buisson (2000), by 1997 47% of independent sector organisations had been in business for less than four years, 27% between four and ten years, and 32% had been in domiciliary care business for more than ten years. In our study we found that one provider had joined the market within the past year, 13 (8%) in the past two years, and 64% since implementation of the community care changes in 1993 (table 1).

Table 1: Time in business (n = 144, missing = 11)

Year of start-up	Years in service	Count	% of 155
1999	Less than 1	1	0.6
1997-1998	1-2	13	8.4
1993-1996	3-6	85	54.8
1989-1992	7-10	17	11.0
Before 1988	More than 10	28	18.1
Missing		11	7.1

Almost half the sample worked over a comparatively small area within their own local authority, but half (76 organisations) were operating in more than one authority. However, this latter figure may overestimate the number of respondents that directly work in other authorities since about twenty organisations in our sample were part of larger organisations that operated across a wider area: the individual provider (branch) may have only worked in one local authority.

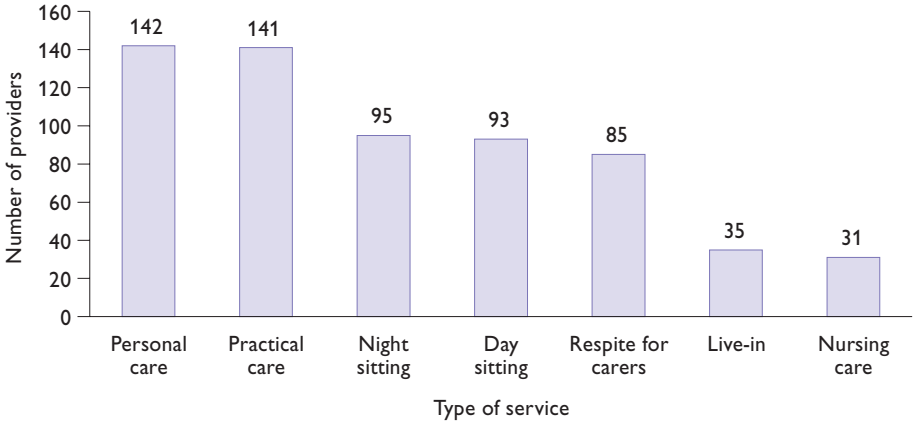
The most distant client in our interview sample was 60 minutes travelling time away from the office base, but generally clients were fairly close.

4 Local market and demand for services

In the postal questionnaire we asked about the provider's current business focus and the proportion of their clients with particular dependencies, the types of services currently provided, the number of clients and the number of hours of service provided in the sample local authority and other local authority areas.

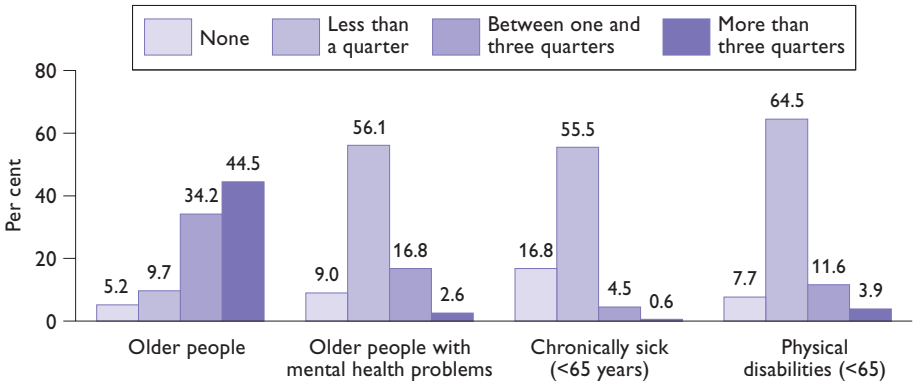
Almost all of the sample provided personal care and practical care, and more than half offered night sitting, day sitting and respite for carers. Less commonly provided were live-in services and nursing care (figure 3). The nature of domiciliary care continues to develop, with a greater emphasis in England on personal care and less on practical tasks (Laing & Buisson, 2000).

Figure 3: Services currently provided



Although our focus was on agencies providing care for older people, local authority lists sometimes included organisations providing services to a wider age group. In fact, only 6% of providers had no client aged under 65. Nearly half of the sample (44.5%) reported that more than three-quarters of their clients were older people (figure 4). For the other three client groups, over half of our survey

Figure 4: Proportion of all your clients made up of the following groups (n = 155)

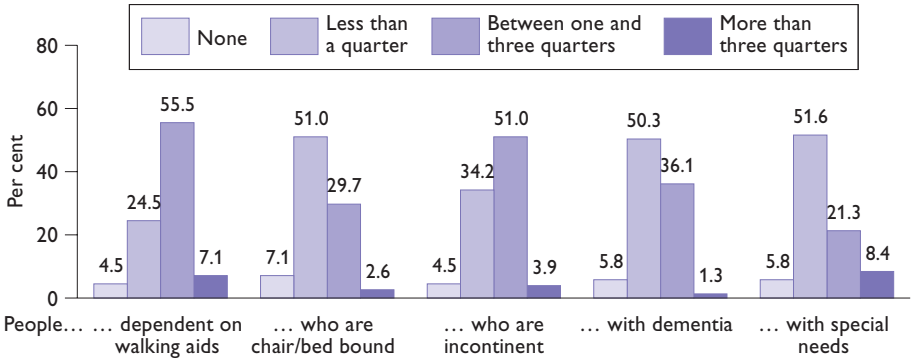


sample said that these groups represented less than a quarter of their clients.

Specialised services (e.g. sensory impairment, learning disabilities and mental health problems) were provided to less than a quarter of clients.

We also asked about client dependency in aggregate. Few providers had large proportions of clients with high dependency levels (figure 5).

Figure 5: Proportion of all your current clients with particular dependency characteristics (n = 155)



Providers were also asked about their the relevance of clients' professional or religious backgrounds and their funding sources. Only 9% of interviewees currently provided for people with particular professional, ethnic or religious characteristics. Forty-three per cent of those interviewed did not aim their services at people with a particular funding source. Of those 30 providers (out of 56) who did, four had more than 75% private payers and 26 had more than 75% public payers.

We asked respondents how big their business was in terms of hours of service. Many providers operate on a small scale. Although there has been an increase since our 1995 study in the proportion of agencies providing more than 500 hours a week, there are still over a quarter which provide 250 hours or less per week. This underlines the continuing small scale of many providers operations. UKHCA findings indicate that 85% of their members surveyed in 1998 provided fewer than 5000 hours per month (Hardy, 1998). These findings are consistent with Laing & Buisson's study (2000) which showed that the average organisation in England provided 763 hours per week, equivalent to 3300 hours of domiciliary care per month.

As would be expected, our question about the number of clients served by agencies generated very similar patterns to the question about the number of hours (table 2). In our 1995 survey, 46% of our sample provided services for 50 clients or fewer in the sample authority. As table 2 shows, around 43% of the sample served this number of clients in 1999.

In order to examine providers' advertising behaviours, we asked the interview sample about the proportion of their turnover spent on advertising and whether that proportion had changed since 1993, or since they started in the business. Six interviewees (out of 56) could not tell us the proportion of turnover spent in this

Table 2: Number of clients per agency for whom services provided in the last week in this local authority (n = 155)

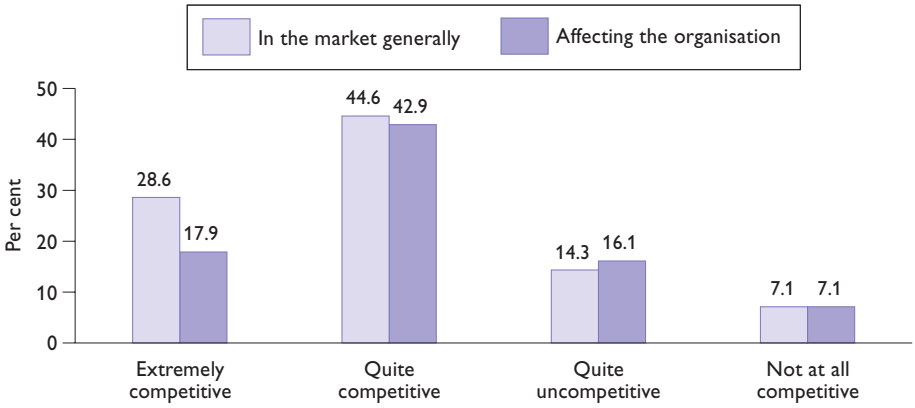
Number of clients	Count	% of 155
0	6	3.9
1-20	33	21.3
21- 50	27	17.4
51-100	33	21.3
101-500	51	32.9
More than 500	3	1.9

way, 21 did not formally advertise, 23 spent less than 5% of their turnover on advertising, and two spent between 5% and 10%. Thirteen (23%) said that they advertised more in 1999 than in 1993 or when they started in business and twenty-four (43%) said that they advertised the same or less.

One of the main reasons for this change in providers' advertising behaviour is that word of mouth is relied upon to generate business. Overall, the majority of providers from this category see advertising as a waste of resources. The majority of those who do advertise reported using Yellow Pages, local newspapers, doctors' surgeries and local hospitals.

We asked our interview sample how they perceived the degree of competition in their local market and whether it had changed since 1993. As figure 6 shows, 73% of interviewees described the market in general as 'quite' or 'extremely competitive', but fewer (61%) reported that the competition directly affecting their organisations was as high. This suggests that some providers felt themselves to be insulated from competitive pressures. Interviewees indicated that this may have been because of the type of contract that they had or because of particularly good relationships with care managers.

Figure 6: Degree of competition in the home care market generally, and the competition which directly affects your organisation (n = 56)



From our interviews it emerged that providers who reported that the market was quite un-competitive or not at all competitive in terms of both directly experienced and perceived overall competition were mainly providing quite specialised types of service and were those with a good reputation.

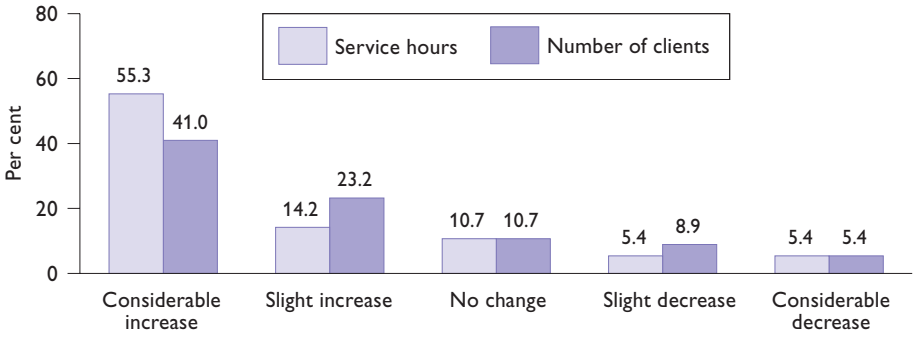
Just over half of our interview sample thought that there was now more competition since 1993 or when they first started in business. For many providers the competition has increased due to large companies moving into the home care market. When asked about competition, some interviewees said that the domiciliary care market was not about 'competition', it was about getting qualified and suitable staff. A big problem for providers was that they were often competing for the same staff.

In order to see whether there had been any change regarding the types of clients and the amount of services provided we asked the interview sample to report how they perceived changes in their local market since 1993 or when they started in business.

A clear majority of interviewees reported increases (generally 'considerable increases') in the hours that local authorities wanted to purchase and clients they wished to have supported (figure 7). We asked our postal sample what changes to client and staff numbers there had been over the past year. Although the majority reported growth on both counts, 25% reported a fall in client numbers and 17% a decrease in staff numbers.

More than half the sample of providers said that new clients applying for services

Figure 7: Changes in the number of service hours and the number of clients funded by the local authority (n = 56)



were more dependent than previous or current clients. These findings are in line with the national figures, which show that the number of households receiving home care has decreased by 5%, but at the same time the number of contact hours provided by the independent sector has gone up by 3% (Laing & Buisson, 2000). Also, 38% of organisations reported an increase in the proportion of privately-funded clients seeking home care support. Frequently, interviewees said they were in favour of taking on more private payers simply because it reduced their business risk and meant less paperwork in comparison with local authority clients.

With regard to changes in the proportion of clients where respondents would be the only supplier, 29% of the sample reported an increase. This could suggest that local authorities are reducing the way they use independent agencies to work alongside care assistants with the same clients.

5 Prices

Two of the main elements of the commissioning process are decisions over pricing structures and the types of contracts to be employed. For the purpose of this study the price was defined as the cost to the local authority of the case it buys from independent sector providers in social care markets. The postal questionnaire sought information on the range of prices that organisations charged for domiciliary care tasks. We were interested to identify differences between geographical areas, between organisational types, between private and publicly funded clients and for clients with different needs.

In general, independent sector providers find themselves under considerable financial pressure because local authorities are offering price increases that do not match the rate of cost inflation (Laing & Buisson, 1999). However, there is evidence that the prices paid by some local authorities are increasing. Laing & Buisson (1999) found that the cost of an average weekday daytime personal care hour to an English authority was £6.89 in 1997.

Unsurprisingly, there has been an increase in prices for home care services since our 1995 study. In our 1999 survey we found that average prices were very similar across types of providers, with the exception of charities which had higher mean prices and a wider distribution. Prices were significantly higher in our six London and southern sample authorities than in our five northern authorities, both for practical care and personal care (table 3). Personal care was defined as washing and dressing clients while practical care includes shopping and cleaning. In a separate paper we have examined these inter-authority differences in detail (see Forder et al., 2001).

Table 3: Hourly daytime prices for personal and practical care for local authority funded clients (£) (n = 155)

Region	Time of care	Practical care			Personal care		
		Mean	Minimum	Maximum	Mean	Minimum	Maximum
London and the South	Weekday	8.08	5.00	13.60	8.41	5.00	13.60
	Weekend	9.51	5.20	18.75	9.83	5.00	18.75
The North	Weekday	7.11	4.50	15.00	7.21	4.98	15.00
	Weekend	7.79	4.50	15.00	7.90	5.60	15.00

In order to see if different types of organisation tend to charge at different rates we compared the prices for sole proprietors, partnerships, limited companies and charities/voluntary organisations (table 4). As in 1995, charities appear to charge higher amounts. Differences in clientele or other factors might in part explain these variations. In the charity category the range in prices is also much wider than for other types of organisation, perhaps because there are different ranges of funding alternatives. There are differences within the charity sector according to whether charities are also limited companies. Across charities and voluntary organisations as a whole there is a wide range in prices (£6-£15) but among those organisations which are both registered charities and limited companies there is

less variability (£6-£13.60) — although this range of prices is still wider than for other types of organisation (table 5).

Table 4: Hourly daytime prices for practical and personal care for local authority funded clients by legal structure (£) (n = 155)

Legal structure	Practical care			Personal care		
	Mean	Minimum	Maximum	Mean	Minimum	Maximum
Sole proprietor	7.17	5.00	9.32	7.37	5.00	9.32
Partnership	7.39	5.20	10.00	7.57	5.40	10.00
Limited company	7.20	4.98	10.72	7.39	4.98	10.72
Charity/voluntary organisation	8.72	4.50	15.00	8.94	6.00	15.00

Table 5: Hourly daytime prices for personal care for local authority funded clients by type of charity (£)

Provider is …	Mean	Minimum	Maximum
Registered charity only	8.00	6.00	12.75
Registered charity and limited company	9.97	6.00	13.60
Charity/voluntary organisations (all)	8.94	6.00	15.00

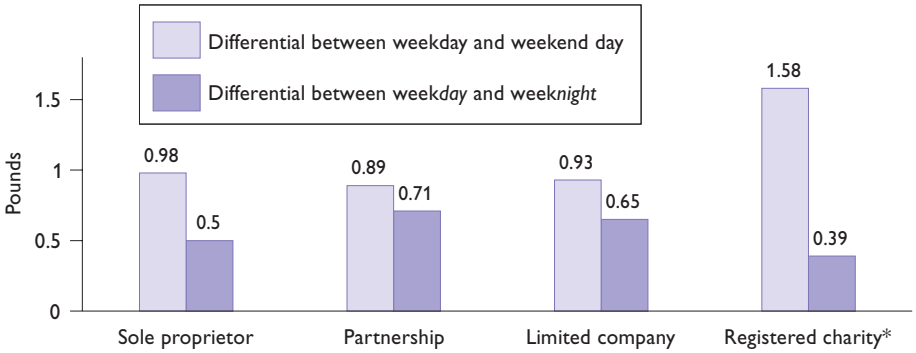
We sought to establish the difference in prices between daytime, night-time, and weekend care for local authority funded clients (table 6). We analysed these price differentials by legal structure of organisation and found that registered charities had greater price differentials than sole proprietors, partnerships or limited companies. There was also a significantly greater difference between weekday and weekend daytime prices than between weekday and weeknight prices (figure 8) and greater variation in prices in London and the South than there was in the North (table 7).

We sought the same information about hourly charges for privately funded rather than local authority funded clients. The range of prices and the average charge were generally lower for privately funded clients than for publicly funded clients

Table 6: Hourly prices for personal care for local authority funded clients at different times of the day/week (£) (n = 155)

Region	Time of care	Mean	Minimum	Maximum
London and the South	Day weekday	8.41	5.00	13.60
	Night weekday	9.46	6.19	15.75
	Day weekend	9.83	5.00	18.75
	Night weekend	10.42	7.50	18.75
The North	Day weekday	7.21	4.98	15.00
	Night weekday	7.37	5.27	12.00
	Day weekend	7.90	5.60	15.00
	Night weekend	7.98	5.60	14.00

Figure 8: Price differential (£) between mean daytime weekday/weekend and mean weekday/weeknight personal care for local authority funded clients — by legal structure



* This category included registered charities that were also limited companies.

Table 7: Price differential (£) for personal care by region (local authority funded clients)

Region	Price differential between mean weekday and weekend day	Price differential between mean week*day* and week*night*
London and the South	1.42	1.05
The North	0.69	0.16

Table 8: Hourly daytime prices for practical and personal care for privately funded clients (£)

Region		Practical care			Personal care		
	Time of care	Mean	Minimum	Maximum	Mean	Minimum	Maximum
London and the South	Weekday	7.35	3.90	12.75	7.97	5.00	12.75
	Weekend	8.80	5.20	18.75	9.25	5.50	18.75
The North	Weekday	6.58	4.00	11.00	6.67	4.25	11.00
	Weekend	7.30	4.50	11.00	7.39	4.50	11.00

Table 9: Hourly daytime prices for practical and personal care for privately funded clients by legal structure (£)

	Practical care			Personal care		
Legal structure	Mean	Minimum	Maximum	Mean	Minimum	Maximum
Sole proprietor	6.93	5.00	9.28	7.18	5.00	9.28
Partnership	7.02	5.20	9.95	7.28	5.27	9.95
Limited company	6.84	4.00	10.72	7.11	4.25	10.72
Charity/voluntary organisation	7.20	4.50	12.75	7.94	5.25	12.75

(tables 3 and 8). A similar pattern was also seen regarding legal structure (tables 4 and 9).

In the charity sector there was a marked difference between privately and publicly funded clients and there was a greater range of prices for publicly funded clients (table 10).

Table 10: Hourly daytime prices for charities and voluntary organisations (£)

	Mean	Minimum	Maximum
Publicly funded prices	8.94	6.00	15.00
Privately funded prices	7.94	5.25	12.75

We wanted to find out whether agencies set their hourly charges to reflect particular client needs. For a large majority of the sample (72%) the charges did not reflect level of need or the type of clientele. However, some 29% of providers reported that their prices for publicly funded clients vary according to client group (e.g. older people, physical disability, learning disability, and mental health problems).

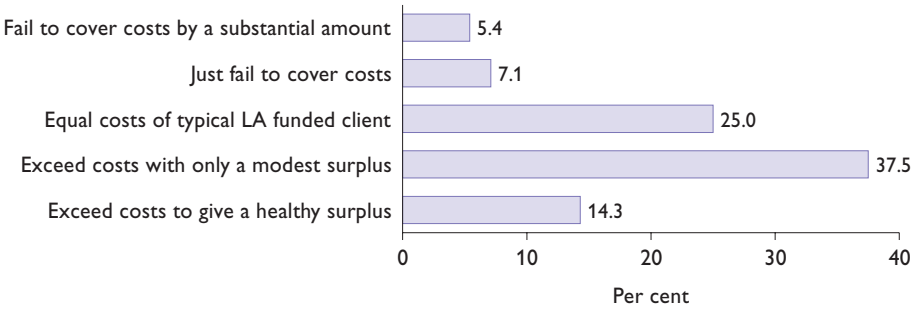
Travel costs were included in hourly charges for the majority of providers, although for privately-funded clients there was more likelihood that travel costs would be added according to the client situation. Some 70% of organisations had their travel costs included in the price of service for the publicly-funded clients whereas for private payers, 55% of providers included travel costs in their prices.

We asked our interview sample some more detailed questions about pricing, including how prices were set, how well they covered costs and how they reacted to competition. For a third of the sample, prices were set on an annual basis, while 45% of providers reported setting the prices every three years. Whether set annually or otherwise, prices were said to be set principally by local authorities in a third of cases (32%), by the provider in half of cases, and jointly for only 9 per cent of our sample. Interestingly, however, in our larger postal survey only 8 per cent of providers thought of themselves as having the most influence over the final contract price. For 57% of our survey sample the local authority had the most influence over the final contract price. Nearly a third (28%) of providers reported

that the prices are usually set through a process of negotiation between providers and purchasers. These findings show that local authorities are having more influence in price setting than in 1995 when 32% said that the local authority had the most influence on prices.

We also asked our interview sample whether the prices for the local authority funded clients adequately covered their costs. Thirty eight per cent of agencies reported being able to cover their costs with only a modest surplus while a quarter of providers said that the prices equal their costs (figure 9). Provider mark-up rates were influenced by the type of contract used, service characteristics and provider motivation (as discussed in the following sections).

Figure 9: Relationship of prices to costs of local authority funded clients



Twenty per cent had responded to local authority pricing policies by reducing their costs. Of these, 36% had done so by reducing their profit or surplus and 11% had seriously considered exiting the care market.

The most commonly cited ways of reducing costs were reducing wages and/or staff benefits and streamlining the administration and staffing. Those who failed to cover costs often cross-subsidised from other services of the organisation or topped up clients' fees with external sources or from their own surplus.

We asked providers what they would do hypothetically if prices were reduced by 10% (i.e. about 70-80p per hour). There were a number of reactions:

- 27% of providers would try to recruit more private payers;
- 23% would adjust the total number of hours provided;
- 16% would close down;
- 13% would decrease quality levels, staff pay, training;
- 9% would increase the cross subsidy from other sources
- 9% would not respond, and take a cut in surplus.

We also sought reactions to two other hypothetical situations. If their nearest competitor were to reduce standard prices by 10%, few providers would respond by reducing their own prices. Our results indicate that 80% of our interview sample said that they would not reduce their standard prices while only 4% were prepared to respond to market competition by reducing their standard prices.

Second, we asked about their responses to a local authority guarantee to buy one third of the hours they currently provide. Some 43% of providers were not in favour of lower prices in order to secure a contract with the local authority. Only five agencies said that they would offer a 5% discount and three agencies would offer a 10%, 15% and 20% discount respectively.

6 Contracts

We asked about the types of contracts (defined in the box below) that providers have with their local authority and their preferred type of contract.

TYPES OF CONTRACTS — DEFINITIONS

- **Block** — payment for a pre-determined number of hours or clients whether taken up or not
- **Call-off** — price per hour specified in advance; paid when service is provided
- **Spot** — price agreed and paid when service is provided
- **Cost & volume** — guaranteed block purchase of hours plus negotiable option to purchase further hours of service
- **Grant** — general payment not linked to particular client or amount of service

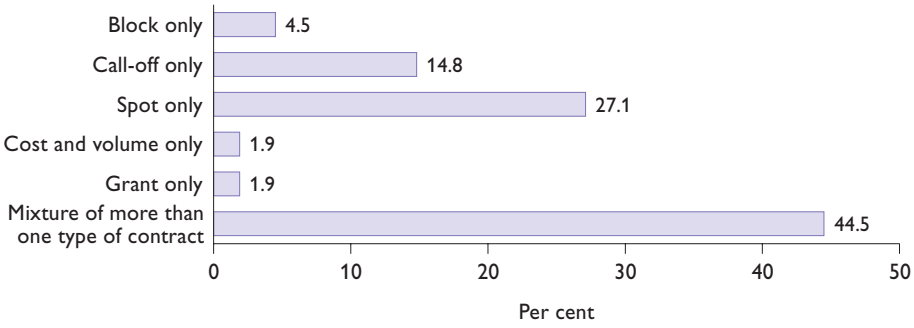
In the course of analysing the data it became clear that many respondents considered the terms 'spot' and 'call-off' interchangeable. An important feature of call-off or spot contracts is that there is no guarantee of purchase in advance whereas with block, grant or cost and volume arrangements there is some commitment to purchase a certain amount of work or number of hours. The difference between spot and call-off contracts is that for spot purchasing the price is negotiated on an individual basis at the time the service is delivered, whereas for call-off purchasing the price tariff is already negotiated and agreed, often on an annual basis, before the service is delivered. Respondents used the term spot where in fact call-off would have been the more accurate description, using the above definitions. This is evidenced by the fact that only around 5% of providers indicated that the hourly charge was negotiable on an individual basis. Confusion arises because the terms 'block' and 'spot' are popularly used as a shorthand to signify whether hours are guaranteed in advance or not.

Our previous study in 1995 indicated that there was a heavy reliance on call-off or spot purchasing, such that three-quarters of the interview sample only had these sorts of contracts with purchasers. Only 12% of providers had some combination including block contracts and 6% had cost and volume contracts. Such prevalence of spot and call-off contracts was perceived to be the most significant potential source of instability (Hardy et. al, 1996).

We wanted to know whether agencies generally had just one sort of contract or had negotiated a mixture of different sorts. In the 1995 study, 76% of our sample only had spot or call-off contracts. In 1999 about half of the postal survey respondents had just one type of contract. One provider indicated that they had all five types of contract (figure 10). Of the 78 agencies that had only one sort of contract a large majority (42% of all agencies) had spot or call-off contracts.

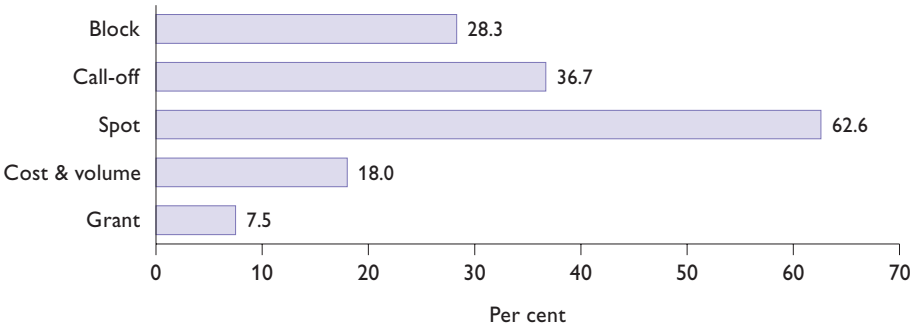
With regard to organisations with a combination of different contracts, in 1995 only 6% of providers had a variety of contracts while in 1999 some 45% did. The

Figure 10: Types of contract with the local authority (n = 147, missing = 8)



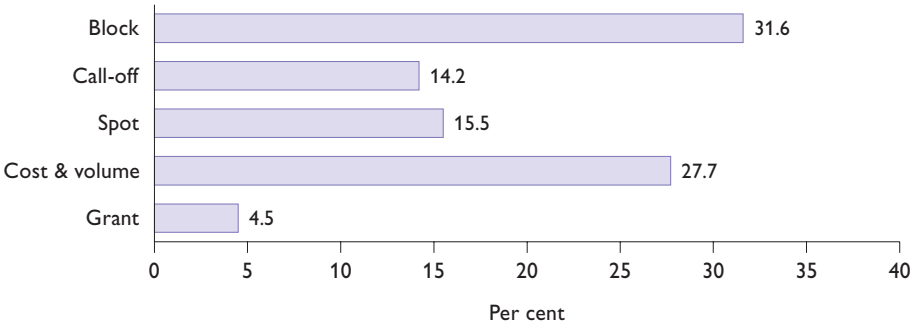
most commonly mentioned was a spot contract, followed by a call-off contract (figure 11). Private sector providers were less likely to have block and cost & volume contracts.

Figure 11: Types of contract with the local authority — proportion of providers using each contract type (n = 147, missing = 8)



Although there was no clear preference for any particular type of contract, almost two thirds of the survey sample said they would prefer grant, block, or cost & volume contracts, which give guaranteed hours and therefore provide some security (figure 12).

Figure 12: Preferred type of contract (n = 147, missing = 8)



Compared to our 1995 study, there seems to be less of a preference for block contracting among independent domiciliary care providers. In 1995, more than 60% selected a block contract as their preferred type of contract, whilst in 1999 only 32% of providers said that block contracts were their preferred type. One of the main reasons is that since our last study, local authorities' contracting arrangements have developed considerably, and there are now more different types of contracts with a certain amount of guaranteed hours. Furthermore, our 1999 sample had a greater proportion of for-profit providers which were more dependent on spot contracts than voluntary sector providers. Laing and Buisson (1999) reported that over a third of voluntary providers said that more than 80% of local authority funded domiciliary care was purchased under block contracts. The second most popular contract type was cost & volume, with 28% selecting this type as their preferred contract.

7 Relationships with the local authority

The nature of purchaser-provider relationships plays an important role in the quality and delivery of domiciliary care. We were interested in how dependent providers are on authority funding, in the providers' perceptions of risk, and the degree of contact and flow of information between providers and the local authority. A detailed analysis of these issues is presented in a separate paper focusing on purchaser-provider relationships (Hardy et al., 2001).

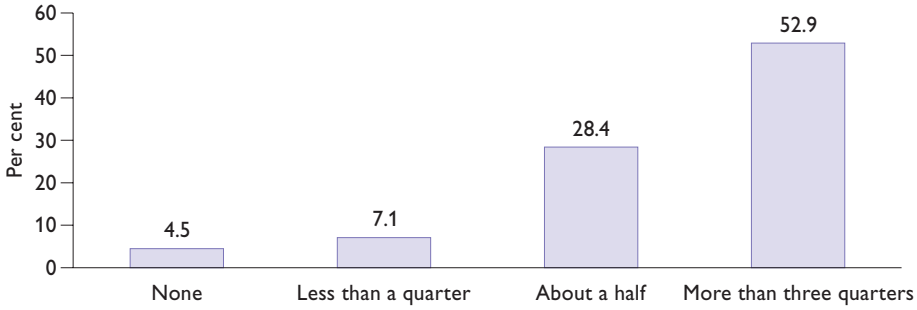
A large majority of providers were registered with their local authority as home care providers. Despite there being no statutory registration requirement, nearly 85% of providers had undergone a registration process of some sort. Providers indicated that if they were not on the list of the accredited agencies it was unlikely that the local authority would contract with them. According to one interviewee:

> Accreditation means that the local authority are happy with what you do and they are willing to use you because they have seen your records and how you operate. A registration process should carry more weight. A registration process would mean agencies have to be registered if the local authority is going to use you. At the moment the system is that you do not need to be registered because there is no registration process. Companies can start up without being accredited — they can come in at quite cheap prices — and can take on work if the accredited companies can't take on the work.

There was clearly still a considerable dependence on local authority funding (figure 13), but this dependence may be decreasing. The most recent study of UKHCA members by the Nuffield Institute (see Hardy, 1998) suggested that 70% of members were dependent on the local authority for 80% or more of their income, whereas figure 23 suggests only a little over half depended on local authorities to that extent. The figures published in the Laing and Buisson (2000) survey indicate that 70% of independent sector income came from local authorities compared to 76% in 1997.

Frequently, providers expressed their concerns with having a large proportion of local authority funded clients. Many organisations were in favour of a more even split between private and public payers.

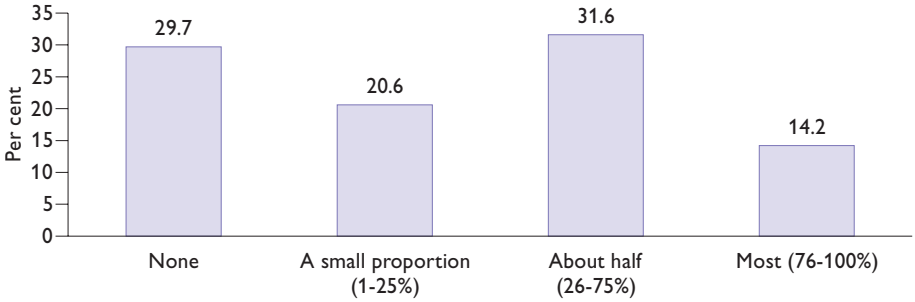
Figure 13: Proportion of clients who have local authority funding (n = 144, missing = 11)



Agencies have frequently argued in the past that they are less willing to provide short visits. Our survey addressed this issue with two questions: What is the shortest chargeable visit you provide? What is the shortest chargeable visit you have been asked by local authorities to provide? Local authorities are twice as likely (54%) to ask for short visits of this nature than agencies are prepared to provide them (27%). However we also asked our postal survey sample whether they charged more for shorter visits and just over a quarter said that they did. Some 40 per cent reported the same charges for short visits of half an hour or less.

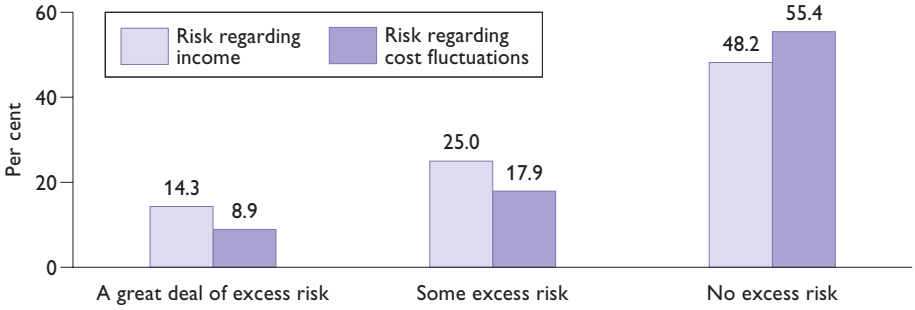
In our postal questionnaire we asked about the number of all their clients receiving visits of 30 minutes and less. As figure 14 shows, there is a wide range in the proportions of clients who receive such visits. We found that nearly 30% of providers do not provide short visits at all whilst around 14% provide short visits to most of their clients. Overall, nearly half of the providers in the sample were providing short visits to half of their clients.

Figure 14: Proportion of all your clients who receive visits of 30 minutes or less



Providers were asked about their perceived business risks in the relationship with the local authority. Their responses indicated that about one third of respondents felt that there was some 'excess' risk (figure 15). The perception of risk associated with revenue for the coming year (e.g. the number of referrals and local authority prices) was greater than risks concerning the costs of the service (e.g. challenging clients, changes in labour market conditions or local authority policy changes).

Figure 15: Perceived risk regarding income in the coming year and regarding fluctuations in costs in the coming year (n = 54, missing = 2)



Pertinent to the question of risk is information about providers' perceptions of the intentions of local authority purchasing staff. We asked what contact there was with such staff either individually or through purchasing forums and whether they were satisfied with this contact. Although half of the sample had frequent contact and a little over half (57%) were satisfied with the contact they had; nearly 20% were unsatisfied.

As far as information about local authority purchasing plans was concerned, our sample was fairly equally divided between those who did and those who did not receive such information. Some 40% of providers did not receive information while 46% reported receiving information regarding purchasing plans. Of those that did receive the information half were satisfied with it. Of those that did not receive the information about one third said it did not matter to them, but about two-thirds indicated that it did matter. Furthermore, providers believed that they

should be more involved in decision-making processes. Some providers felt that even when the information about local authorities' purchasing plans was published, they often contained insufficient detail. As one provider said:

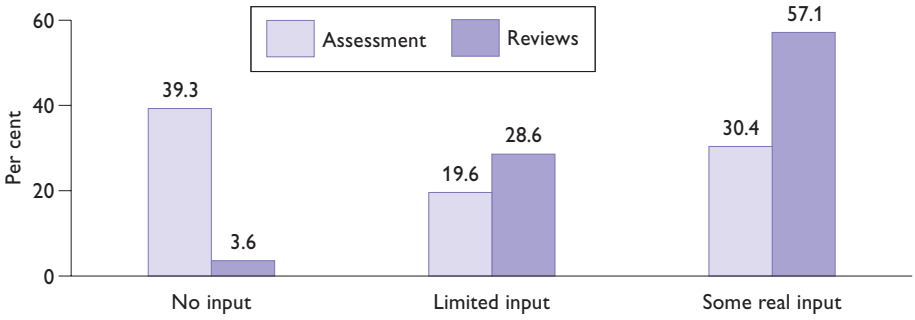
> I don't think it [the purchasing plan] is particularly thorough. They have pages and pages on how your staff should act, what they should be, what they should do in the home, etc. That's the same year in year out. And they have a little bit that says 'this year we'll be purchasing in this way.' [e.g. block contract].

Similarly, we asked whether the local authority made available to providers (and others) information on the unit costs of the in-house home help service. Most of the agencies did not receive this information. Some 80% (45) reported that they did not know the unit costs of the local authority's home care services. Indeed, nearly two-thirds (64%) of our sample believed that the local authority always or sometimes favoured their in-house service. A larger proportion (73%) felt that the local authority gave users no choice or only limited choice over the selection of provider. Little more than a quarter of providers (29%) indicated that they were satisfied with the present situation.

As far as tangible support to develop new services and service options was concerned, our sample was fairly evenly divided between those who felt that there was real support (38%) and those who experienced no support (36%).

One important aspect of provider-purchaser relationships is the amount of providers' inputs to user assessment and reviews and their ability to alter services according to need. There was a wide range of responses, from those who said that had no input to those having a genuine input (figure 16). Respondents indicated that they were slightly more satisfied with their input to reviews (59%) than they were to the initial assessment (46%). Overall, providers were satisfied with care reviews both in terms of their involvement and the way they are conducted.

Figure 16: Amount of provider input to the initial user assessment and care plan and subsequent care reviews

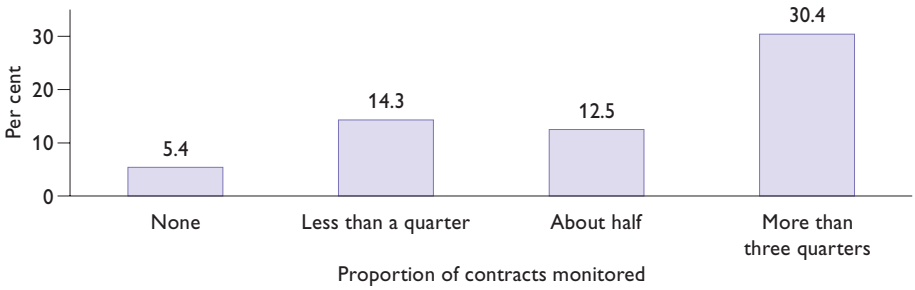


The results in figure 16 show that 39% of organisations reported no involvement while 20% reported only limited input into the initial assessment. In general, providers expressed their concerns about not being able to participate in the initial assessments and to utilise their skills and experience. As one interviewee pointed out:

> I think for me, one of the most frustrating things is that care plans are drawn up by a person who is not actually going to do the work. They are drawn up in theory and one care manager may think that it would take an hour to wash somebody for example. And then we go in and we find it takes half an hour. And I will ring up and say could we suggest a reduction in time to save money.

We asked the providers whether they were satisfied with their local authority's monitoring arrangements regarding individual contracts (figure 17). Satisfaction levels were mixed, with 36% expressing satisfaction with the level of monitoring and the current review arrangements.

Figure 17: Level of monitoring and follow-up of individual contracts by the local authority (n = 37, missing = 19)



In order to examine the trading relationship with the local authority, we asked our interview sample whether they had any difficulties regarding delayed payments and collecting client contributions and local authority fees. A significant proportion had some problems in these areas. Forty-five per cent of providers experienced problems with delayed payments. These were often perceived to be a consequence of poor management skills, but also an indication of a lack of understanding of the business pressures that many independent providers face, whether directly or as a result of late payments in general.

In terms of forward planning and contact between provider and purchasing local authority regarding new clients (e.g. last minute referrals), 63% of agencies reported no problems with late referrals.

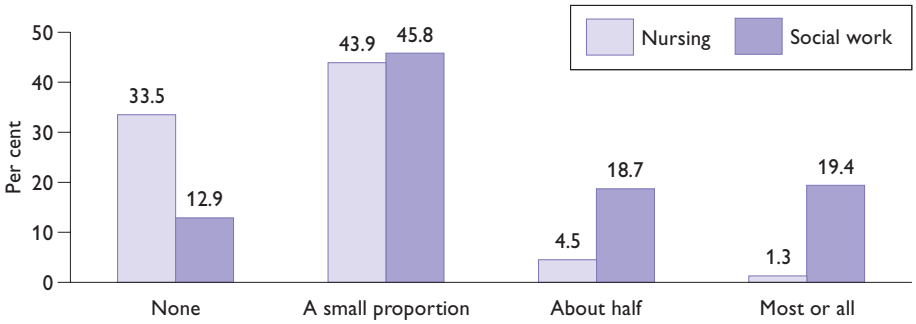
8 Service quality and staffing

Qualified care staff are a key ingredient in good quality domiciliary care. As noted earlier, there is a high level of competition among providers for qualified care workers.

Providers were asked about their levels of staffing, and what differences there have been in recruiting over time. We also collected information to provide an indication of quality such as training, supervision and qualifications. We asked whether organisations belonged to a national or local association of home care providers: 72% did. Membership has (potential) quality implications to the extent that such associations have their own frameworks of audit, regulation and quality standards.

The majority of providers employed fewer than 200 staff. Questions regarding staff qualifications (figure 18) did not stipulate types of formal qualifications and best represent managers' perceptions about staff competence.

Figure 18: Proportion of care workers with nursing or social care qualifications

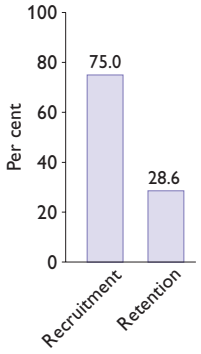


Roughly one in five respondents reported most or all of their staff having a social care qualification. A smaller percentage of our interview sample (9%) indicated that most or all of their staff had such qualifications. However, the latter figures may overestimate the number of people with qualifications if set alongside figures from the Improvement and Development Agency which suggest that only 7% of local authority domiciliary care staff have a formal qualification and that only 6% of staff are studying for qualifications (Social and Health Care Workforce Group, 1999). Our interview sample indicated that over 90% of respondents pay for unqualified staff to train for qualifications. However, it may well be that respondents did not differentiate between on-the-job induction training and qualifications. Some 75% of our interview sample did not receive any assistance from the local authority to provide training.

Just over 50% of providers indicated that supervisors had either daily or weekly phone contact with care workers. However, two respondents noted that they only had face-to-face contact with their workers between six monthly and yearly. Further, the majority of organisations (70%) did not offer their staff a minimum number of hours.

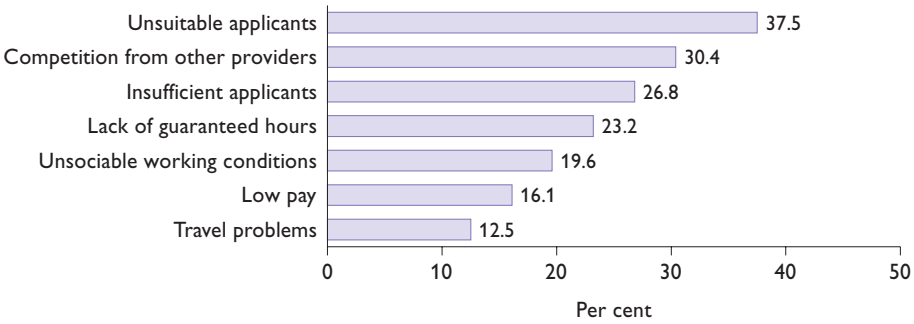
Most respondents had experienced difficulties in recruiting suitable care staff (75%) and nearly a third rejected at least half of their applicants. The findings from the UKHCA 2000 survey also showed that over three-quarters of providers had experienced difficulties in recruiting domiciliary care workers. However, respondents reported less difficulty in retaining staff once they had them in place (figure 19).

Figure 19: Proportion experiencing problems recruiting and retaining suitable care staff in the last year



Problems with the applicants themselves and the competition from other providers were more often mentioned as difficulties than conditions associated with the job *per se*, such as lack of guaranteed hours, low pay, or unsociable hours (figure 20). Competition from other providers could also include competition from a social service department's in-house service, where differentials regarding pay and conditions for staff are significant.

Figure 20: Problems of staff recruitment and retention

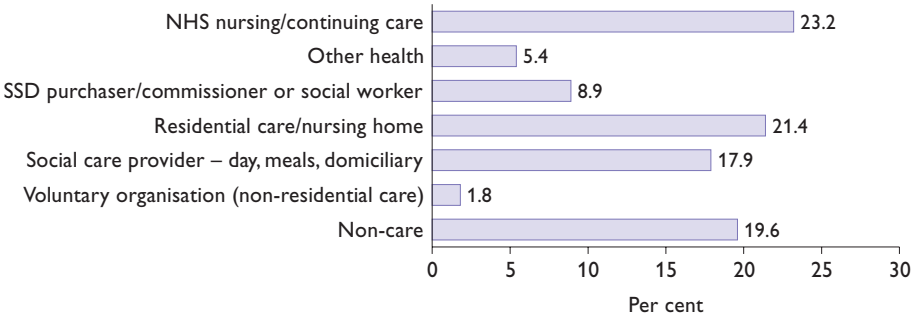


Percentages add up to more than 100% because some respondents gave more than one answer.

9 Providers' background and expressed motivations

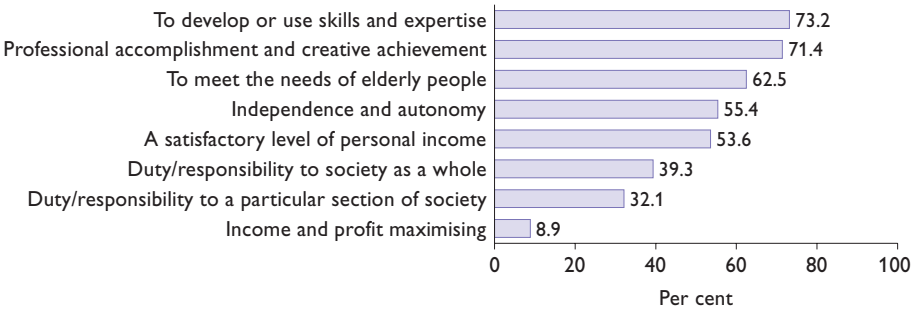
As in our earlier 1995 study, one of our research aims was to examine providers' motivations and identify the factors that influence their motives. The 1995 survey found that 75% of the interviewees had a background in the caring professions. We asked our 1999 interview sample about their previous occupation and their current motives for being in this business. As figure 21 indicates, the majority of interviewees (79%) had a background in the caring professions.

Figure 21: Interviewees' occupation before coming into this business (n = 56)



Providers were asked to select, from eight given motives, those important to them (figure 22). The majority (73%) of providers selected developing skills and expertise, followed by professional achievement (71%). Some 63% said they were motivated by meeting the needs of elderly people. Finally, only 9% of interviewees reported profit maximising as one of their main motives.

Figure 22: Current motivations for being in this business (n = 56)



Percentages add up to more than 100% because respondents chose more than one motive.

When we asked interviewees to rank their three most important motives, those selected as most important were:

- to meet the needs of older people
- professional accomplishment and creative achievement
- to develop or use skills and expertise

It is worth emphasising that 'a satisfactory level of personal income' was the most frequent third choice and that 'income and profit maximising' was the least frequently mentioned motive.

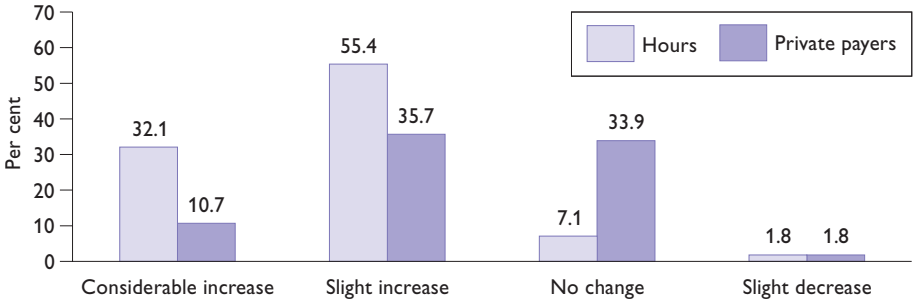
We asked interviewees whether their motives had changed since 1993. Nearly two-thirds (63%) reported no change in their motivations since then. In addition we were interested to find out whether the operational aims of their organisation reflected their personal motives. The findings show that 86% of our interview sample said that their motives correspond to the motivations behind their organisation.

Two further points concerning this evidence on expressed motivations are important. First, while we might expect providers to present themselves in a good light by playing down the significance of financial considerations, evidence from previous MEOC provider studies suggests that actual pricing behaviour is consistent with expressed motivations (Forder, 2000) Second, providers' motivations in social care need to be understood not only in terms of the more fixed factors listed above, but also as bound up with the natures of the structures for communication and feedback set in place by purchasers, and the character of their relationships with public purchasers. In another paper (Kendall et al., 2001) we explore how these linkages can be conceptualised, and show empirically how distinctive combinations exist.

10 Future plans

We asked interviewees about their business expectations, over the next 12 months, in terms of the number of hours of service and the proportion of private payers (figure 23).

Figure 23: Plans for the business over the next 12 months in terms of total number of hours and proportion of private payers (n = 55, missing = 1)



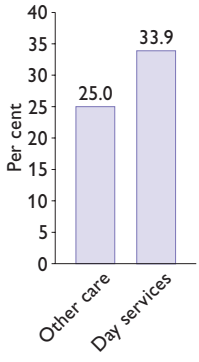
The figures in figure 23 indicate that in regard to business plans for the next year the majority of providers were in favour of 'controlled growth'. As one interviewee explained:

> We are aware that it is a growth area, a growth industry — but what we have been very careful about is having in place systems and staff levels so that we can supply a high quality service. We would have expended a lot more quickly, but probably lost the reputation, which is everything in the industry.

We were also interested in whether they had any business plans to diversify into day and other care services in the next year. Rather less than half had such plans (figure 24).

Finally we asked interviewees whether they anticipated leaving domiciliary care in the next year: none did.

Figure 24: Business plans, over the next 12 months, in terms of diversifying into other care and day services (n = 56)



11 Conclusions and summary

This PSSRU/Nuffield Institute study offers a statistical snapshot of independent sector publicly funded domiciliary care providers in England. The data were collected in eleven areas during 1999, through a postal survey and interviews. There is no reason to believe that the findings are not generalisable to the whole of the country. Other sources of information on domiciliary care markets — insofar as they overlap with this study — report similar characteristics and trends (Department of Health, 2000; Laing & Buisson, 2000).

The majority of organisations in our sample were private businesses, and a small proportion were charities or other nonprofit entities. Overall, there appears to have been an increase in the level of competition in the domiciliary care market, with more than a half of interviewees reporting more competition now than in 1993 or when they entered the market.

There has also been an increase in local authorities' influence on the final contract prices. Most providers were able to cover their costs for publicly-funded clients. However, the way they covered their costs was either by reducing their running cost or in some cases significantly reducing their profit. A shortage of care staff remains a major problem for independent sector domiciliary care providers. Many report a lack of suitable applicants, linked to competition from other employers.

Providers' relationships with local authorities have improved considerably since our previous study in 1995. However, the majority still aspired to greater information and enhanced communication. They would like local authorities to be more transparent about their purchasing intentions and in-house policies, in particular about the unit costs of in-house domiciliary care.

Findings from this study suggest that the domiciliary care market in England is still developing. We would expect to see considerable further changes over at least the next few years.

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www.leeds.ac.uk/nuffield/

English local authorities now purchase more domiciliary care than they provide directly. Furthermore, it is the more intensive packages of care which are more likely to be contracted out to independent sector organisations.

Who are these independent sector providers? What are their main characteristics? What are their market experiences and how do they respond to changes in the context of care, especially in relation to local authority commissioning? What is the nature of providers' relationships with purchasers? What were the motivations for entering the domiciliary care market? What are the working conditions and qualifications of staff? Finally, what expectations do providers have for the future?

This paper summarises findings from the 1999 PSSRU/Nuffield domiciliary care study, which was designed to give answers to these questions. The study was conducted as part of the Mixed Economy of Care Research Programme, which is a long-running joint endeavour by the Personal Social Services Research Unit, London School of Economics, and the Nuffield Institute for Health, University of Leeds. It follows on from a similar study by the same group in 1995.

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