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# Understanding Public Services and Markets: Summary Paper of the Report Commissioned by the King's Fund for the Care Services Inquiry

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The **PERSONAL SOCIAL SERVICES RESEARCH UNIT** undertakes social and health care research, supported mainly by the Department of Health, and focusing particularly on policy research and analysis of equity and efficiency in community care, long-term care and related areas — including services for elderly people, people with mental health problems and children in care. Views expressed in PSSRU publications do not necessarily reflect those of funding organisations. The PSSRU was established at the University of Kent at Canterbury in 1974, and from 1996 it has operated from three branches:

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# Understanding Public Services and Markets: A Summary

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## Introduction

The King's Fund has established a Committee of Inquiry to consider care services for older people in London and whether there are likely to be sufficient care services of the right design and quality to meet needs in the short and longer term future. Much care provision, particularly social care services, now takes place in the context of market conditions. PSSRU were commissioned to produce an analysis of social care markets to inform the Inquiry, covering their operation, the role of public bodies and potential and actual levers that could be used to influence the market. The results of this are reported elsewhere.<sup>1</sup> This summary draws out the main messages of that report.

<sup>1</sup> Netten, A., Darton, R., Davey, V., Kendall, J., Knapp, M., Williams, J., Fernández, J.L. and Forder, J. Understanding Public Services and Markets, PSSRU Discussion Paper 2111/4.

We start by describing the nature of the social care market, including the objectives of social care, the extent of public and private purchasing and provision, and factors affecting demand and supply, before turning to an analysis of the performance of that market. The reasons why various problems have arisen are explored together with a discussion of likely future challenges. We end by discussing ways that public bodies might address these.

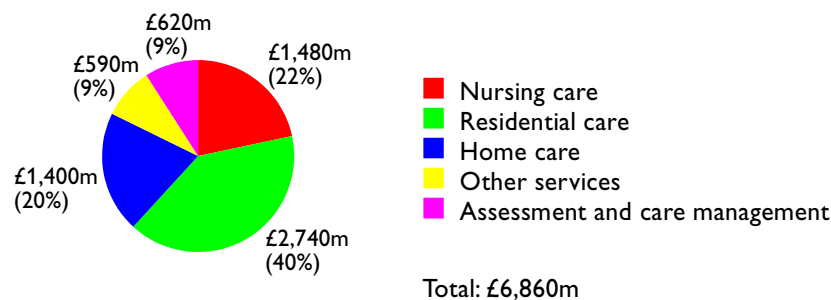
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## The nature of social care markets

For older people, social care services are concerned primarily with compensating for the impact of physical or mental impairment. This is closely linked to, but distinct from health care, where the focus is treatment or mitigation of impairment. For the most part, social care is provided by the 'informal' sector, that is, friends and families. Compensation does not imply necessarily doing things for others: social care is provided in a variety of ways, with increasing policy emphasis on actively enabling people to increase or retain independence and the prevention of deterioration.

In 2002/03, £6.9 billion of government expenditure was on services for older people. Of that, £4.2 billion (62 per cent) was on care home provision and £1.4 billion (20 per cent) was on domiciliary or home care (see figure 1). It is in the fields of home care and care homes that social care markets are most developed and where we focus much of our discussion. It is important to bear in mind that markets are much less well developed for other services such as day care, equipment services and meals services. Moreover, there is much policy emphasis currently on extra care housing where the market is still very dominated by public sector provision. Extra care housing has its genesis in sheltered housing, which in turn developed from provision for older people in the social rented sector. In the

**Figure 1: Expenditure on older people by service type, 2002/03**



small private sector (about 9 per cent of units in 1997) emphasis has traditionally been on the property and property-related services rather than care and support.

If we are to evaluate the performance of the market in delivering social care we need to be clear what the principal objectives are. In recent years government policies have focused on:

- maximising independence
- maintaining older people in their own home wherever possible
- increasing value for money
- providing and increasing choice
- user led services
- protection of vulnerable people
- raising standards or improving quality
- the impact on the use of NHS resources

Maximising independence has primarily been addressed through maintaining people in their own homes for as long as possible, although more recently there has been increased emphasis on prevention. The twin objectives of improving value for money and providing choice lay behind the encouragement and provision of incentives to develop and manage markets in social care in the early 1990s, following implementation of the NHS and Community Care Act (1990). This gave local authorities the responsibility for assessing all publicly-funded admissions to care homes. These objectives remain very important but the current government has also put increased emphasis on drawing on the user perspective at all stages of service delivery, from strategic planning to evaluation of service performance, and on regulation to protect vulnerable consumers and raise standards of care. However, as we illustrate below, policy in the field of social care for older people is also heavily influenced by central government concerns about the use of NHS resources.

The key characteristics of social care markets in contrast with other markets are:

- The nature of consumers: people are often making decisions or choices at extremely stressful stages in their lives; by definition the vast majority have physical or mental impairment, and they may be unwilling or involuntary users of services that they find difficult to leave or influence.
- The dominance of public purchasing: about 70 per cent of residents in care homes are publicly funded. In home care estimates of the proportion of publicly-purchased hours ranges between over 70 to about 60 per cent.
- Charges paid by consumers of publicly-funded services are not directly related to the price of the services but charged on a means test basis.
- There is considerable variation between the markets for different social care services but these are interrelated and interdependent.

The demand for social care for older people is affected by:

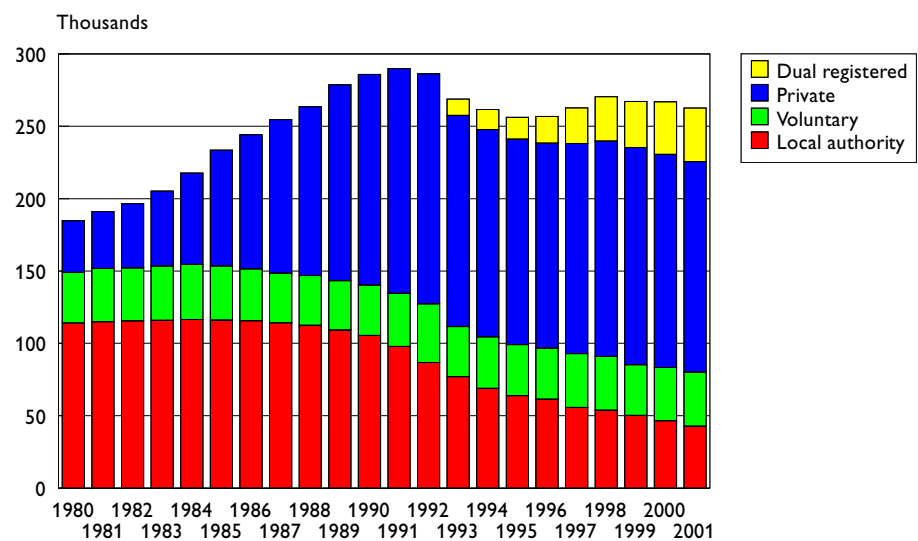
- **Demographics:** the numbers of older people, their levels of impairment and the supply of the principal providers of social care — informal carers.
- **Central government policies:** in particular, levels of funding and the boundaries set around what constitutes the demand for publicly-funded social care. For example, in the 1980s and 1990s the NHS withdrew from the provision of continuing care, increasing the demand for care homes and community care of very dependent older people.
- **Local government policies:** in terms of both how they implement central government policy and their use of independent or in-house provision.
- **Other markets:** for example, the performance of the NHS will affect levels of impairment among older people and the availability of accessible housing will affect people's ability to remain in their own homes.

The supply of both care homes and home care is currently characterised by:

- A large number of small independent providers.
- Being highly competitive with relatively low rates of return.
- Professional and empathic rather than primarily profit motivation among many providers.
- Pressured input markets, with severe shortages of staff, particularly for direct care and nursing staff and with high and rising property prices.
- High levels of risk and uncertainty, some of which is associated with increased levels of regulation in recent years.

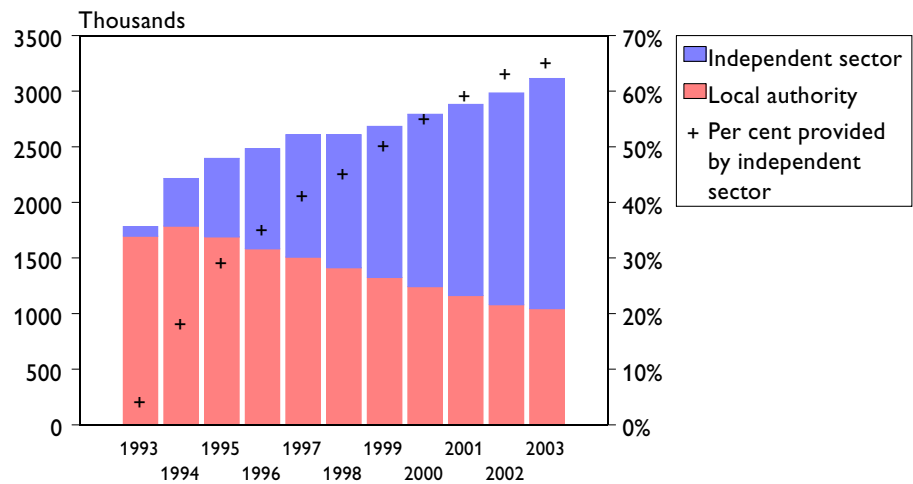
Figures 2, 3 and 4 show the changing levels and balance of supply over recent years for residential care homes and home care respectively. Comparison over time is made difficult by changing definitions and quality of data for care homes, but figure 2 shows the general trends in overall supply of residential care (places for younger physically disabled people account for only 3 per cent of total places). By 2003 in England there were 218,500 publicly-funded residents aged 65 or over in approximately 350,000 care home places. The largest group of publicly-funded service users is users of home care. Over three million contact hours of publicly-funded home care were provided to around 362,800 households (or 373,500 clients) in 2002/03 in England. In recent years the number of commissioned home care hours has been rising rapidly, but the number of households receiving home care and number of care home places has been falling.

**Figure 2: Places for older people and younger physically disabled adults in residential care homes in England: 1980-2001**



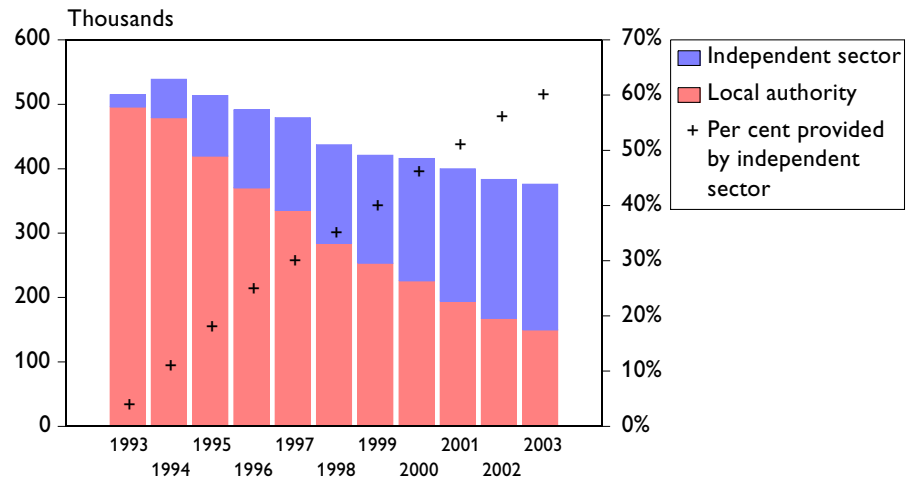
Source: Department of Health statistics

**Figure 3: Home care contact hours by sector of provision in England: 1993-2003**



Source: Department of Health, Annual Return HH1, table 1

**Figure 4: Number of households receiving home help or home care, by sector in England: 1993-2003**



Source: Department of Health, Annual Return HH1, tables 2a, 2b and 3a (2000 onwards)

Clearly, public bodies in the form of central and local government and associated agencies such as the Commission for Social Care Inspection (CSCI) have a profound influence on the market for social care through policy, funding and targeting decisions, and through regulation, both directly of social care services and indirectly through regulation of input markets. The dominance of local authorities in terms of market power means that their commissioning practice has a profound influence on local markets, which, partly as a result, are very diverse.

## Market performance

A successful social care market should deliver what is required:

- adequate capacity both overall and in terms of diversity
- value for money
- quality
- consumer power and choice.

There is some evidence of success. In terms of capacity overall, figures 2 and 3 demonstrate that the independent sector expanded rapidly in both care homes and home care in response to demand in the 1980s and 1990s. Moreover, the motivations of providers mean that downward pressure on profits and specific market shocks have not resulted in the numbers exiting from the market that we might otherwise expect, suggesting stability.

There is some evidence to suggest that the market and commissioning of publicly-funded care has delivered value for money. Since local authorities took on the responsibility for commissioning services, prices in the independent sector have been kept well below input price inflation, although it should be noted that the transaction costs of the commissioning process are rarely taken into account. Value for money means getting the best from resources that are always, to a greater or lesser degree, limited. One approach to getting the best from resources is to divert people from high cost residential-based services by targeting community services on those people who will benefit most. There is evidence of improved targeting. The objective of diverting people from care homes does appear to have been achieved. Fewer households now receive much more intensive packages of care through local authorities (see figure 4). Thus increasingly services are being delivered to those with the greatest capacity to benefit. While this has been at the expense of those with lower level needs and the provision of domestic support, it could be argued that those with lower level needs are better placed to organise their own domestic support. Indeed, there has been a considerable increase in privately-purchased care during recent years.

In terms of quality, it has long been established that the independent sector provides both the best and the worst levels of care and variability in quality of care continues to be the case. There is evidence that physical standards in care homes were improving as a result of market pressures long before the proposed introduction of care standards, particularly in terms of provision of single rooms.

However, there are a number of problem areas. The picture in terms of overall capacity is very variable throughout the country (much lower levels of supply in London are longstanding). There are also widespread concerns about capacity in terms of delivering an adequate supply of services for older people with mental health problems and appropriate services for people from black and minority ethnic groups. More generally, observers of the commissioning process have identified a lack of development and innovation among the services being commissioned.

Many of the concerns that are currently expressed about the social care market have their roots in the rise in home closures, particularly among smaller homes, that occurred during 1999 and 2000. The evidence suggests that homes that closed then and are continuing to close are just as likely to be good as poor quality homes. One specifically market induced problem in terms of quality is the time around a 'voluntary' home closure. This is a time when standards can fall dramatically as staff leave and there is evidence of inconsistency and confusion about responsibilities and practice during the process.

In home care there is also concern about the quality of services. Moreover, there is the issue of inequity arising from restrictions put on what is provided through the contracting process. Where providers or, more frequently, workers are prepared to bear the cost (care workers do things for clients in their own time) older people get more than where people stick by the rules.

While we note above how increased targeting could be interpreted as increasing value for money, there are concerns about unmet need, and the withdrawal of domestic support services does not take into account how much older people

value help with domestic chores. It could be argued that this is a matter of ensuring an adequate level of income so people can purchase such support (the function of disability-related benefits), rather than a problem with public services. However, there is a body of opinion that low-level support provides a monitoring function that could anticipate and prevent the need for more intensive services. At present there is no research evidence to support this.

The key elements required for consumer power are diversity and availability of service provision, information about options, empowerment and control. The evidence does not suggest that consumers are exerting meaningful choice in practice, indeed there are problems in all areas. In particular, there is a lack of information and restrictions on care managers in providing the type of advice people need. The situation becomes particularly acute during a home closure, when a lack of alternative places can be exacerbated by tight deadlines and competition for places becomes obvious among residents.

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## Sources of market problems and future challenges

Why have these problems arisen? Capacity problems are primarily associated with one of the prime motivators for introducing the market: the emphasis on value for money. Local authorities have predominant market power and have used that power through the commissioning process to keep prices down. Their motivations for this are not just related to levels and competing demands on central government and locally raised sources of funding. There are also specific government targets in terms of efficiency and Best Value that are measured in terms of unit costs, which to the purchaser of services are prices. Sustained downward pressures on prices during a period when costs were rising as a result of other government policies, such as the introduction of the minimum wage, meant that providers were ill-placed to address the introduction of national care standards that had, in many instances, profound investment cost and future revenue implications. This was compounded by problems associated with the labour market and opportunities to exit provided by the rising property market. In addition, there is a shortage of capital funding for existing providers.

Many of the problems associated with quality, diversity and consumer power can, to a greater or lesser degree, be put down to poor or unimaginative commissioning practice. Commissioning encompasses a wide range of activities from strategic planning at the highest level through to individual care management, a process now described as 'fragmented' rather than the empowered and empowering process that was originally envisaged. In addition, there are again resource problems: developments in extra care housing are said to be restricted in part through a shortage of capital funding, although it is notable that the rapid response that the private sector showed in the 1980s and 1990s to increased demand is lacking with respect to extra care housing.

In addition to the specific problems associated with the way that social care markets are currently functioning, there are a number of challenges that will need to be addressed in the future:

- Increased demand from an ageing population with rising expectations.
- Increased home ownership affecting more people's entitlement and attitudes to purchasing care.
- Increased barriers to entry through higher property prices and, critically, through loss of confidence among potential providers. Other potential barriers include problems associated with acquiring land and planning for the increased demands of these resources from extra care housing.
- Continued shortages of labour, particularly nurses, affecting both the informal and formal sector.

- Many of the above add up to increased cost pressures at all levels, from individual providers through to central government funding.
- Moves to joint commissioning with health services that, while facilitating greater co-ordination across services and innovative services, also create the potential problems associated with changing organisational structures and responsibilities.

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## Incentives and levers to address the problems

It is important to be clear that a number of actions have already been taken and policies introduced aimed at addressing some of these problems. The actual and potential levers include funding and financial incentives, targets and performance indicators, regulation, commissioning, use of in-house services and advice, guidance and training.

### Funding and financial incentives

Overall levels of spending are clearly critical and the government has increased expenditure in social care substantially, both in terms of general increases and specific grants in recent years. However, future planned increases are notably less than in the health sector and whether this increase in funding will find its way through to the social care market will depend on local authority priorities. Even if increased levels of central government funding do get through as intended, there is the issue of whether it is sufficient to address the problems identified. Given how low prices have been, it could be argued that previous and planned increases in funding are insufficient to address current problems, such as raising wages and meeting quality standards, let alone both increasing prices and levels of provision.

Putting the financial control into the hands of consumers themselves through Direct Payments explicitly addresses the problem of lack of consumer power identified above. Moreover, this may also go some way to address the workforce shortage problem by drawing people into the care workforce who would otherwise not have taken this kind of work. However, Direct Payments are not a panacea. There is the issue of how best to support people to organise their care, often a very complex task for the most vulnerable, to prevent problems of potential exploitation on both sides of a direct employment relationship, and a lack of levers for ensuring good practice.

Publicly-funded training of care staff is one way to address improving quality. There is an argument that public funding of such training would feed into the profits of private providers, so they should bear the cost. However, given the public good that should be generated through better quality care, and the potential to ensure that training provided will in fact generate that improvement in quality, it would seem reasonable at the least to subsidise the process.

### Targets and performance indicators

The current government has made extensive use of targets to improve performance and these have been very effective in influencing the behaviour of local authorities. However, generally targets are somewhat partial and distortionary, easily giving rise to false incentives. There are sufficient incentives to keep prices down through general fiscal restrictions. A reduction in efficiency-related targets from central government would be helpful. However, this is not likely given that the most recent Spending Review included “improved commissioning of social care to generate around 10 per cent of efficiencies”.



Other performance indicators, if not targets, may be helpful, however. Lower levels of satisfaction have been found among black and ethnic minority older people receiving care services. This is likely to have focused the minds of those authorities where there are substantial proportions of these groups on how to improve services. There may be potential for other performance indicators, preferably based on service user views and/or related to outcomes, which might assist in improving the range of types and quality of care services and the choices given to service users.

### **Commissioning**

The *Building Capacity* concordat aimed to improve relationships and enhance strategic commissioning to help to reduce uncertainty and facilitate the development of the market in specialist services where there are specific shortages. Regional-level commissioning can have the advantage of economies of scale in terms of commissioning expertise. Grouping of authorities such as London boroughs and adjacent smaller metropolitan districts where there is a lot of cross-boundary activity by providers might allow the sharing of expertise and information and potentially help providers in providing consistent administrative arrangements.

In negotiating contracts it is important that all the risk does not remain with providers. Long-term contracts enhance stability and enable forward planning. Talking to providers and understanding their cost structures allows sustainable contracts and price setting, facilitating providers to both deliver what the commissioning authority wants in the short term and to develop trust, which enhances flexibility, outcome-based commissioning and longer-term developments. Moreover, it can help to reduce information asymmetries that are a general problem with the commissioning process.

Contracts can also be used to clarify the levels of quality and quality assurance mechanisms expected and to ensure that good employment practice is used. Differential pricing can be used to encourage provision of specific services where there are shortages, such as care of people with dementia or severe dependency, and to encourage the provision of high quality care. Flexibility in contracting arrangements can potentially address some of the problems encountered by smaller homes and potentially prevent some closures.

The use of task-based micro commissioning and tightly specified individual packages of home care has arguably led to some of the quality problems that have been emerging. A move to outcome-based contracting, where funding is provided with the aim of meeting identified needs but the provider has the flexibility to negotiate with the older person, could potentially enhance flexibility and reliability of services. But such contracts require adequate levels of resources. If the aim is to encourage people to be as independent as possible it needs to be acknowledged that it takes much more time to help people to do things for themselves than to do things for them. Again, this type of contract requires the build-up of trust.

For some issues, for example meeting the needs of particular ethnic groups or funding housing and care schemes, alternative approaches to client-based commissioning might be more appropriate. For example, per capita funding to cover a certain population would allow community groups, voluntary organisations or even private companies the flexibility to use resources to meet needs in the most cost-effective way.

## Use of in-house services

Authorities often use in-house providers as a safety net in terms of types of provision where there are shortages. Such provision could also provide a way of exploring new types of service as exemplars that can be used to inform commissioning of such services from the independent sector. Continued provision of at least some in-house services also provides a potential source of experienced staff when crises occur, for example where a home is closing at very short notice. Where managers or care staff have left or are leaving, experienced in-house staff could potentially mitigate the impact on residents and allow more time for people to make considered choices about where to move.

However in-house services are used, it is important that there are clear policies and that these are transparent to independent providers so there is a sense of fairness. Lack of such policies and transparency leads to mistrust that undermines the potential to expand capacity.

## Regulation

The principal approach used to improving quality has been the introduction of National Care Standards. There is scope, however, to reconsider the care standards themselves. More focus on outcome-based standards would allow greater flexibility in the way that providers met the desired attributes for each service. Moreover, the standards are very much based around historical service descriptions, with innovative arrangements needing to be classified within these ('care home' or 'domiciliary care agency'). This can lead to distortions in provision compared to the best arrangement for service users as providers tailor services in order to take the least burdensome route in terms of the regulations required. There is also the danger of inadequate protection and regulation as new services fall outside accepted definitions.

One point when care standards are most under threat is during the closure of a home. Currently the CSCI has no explicit responsibilities during this time, and legal advice is unclear about the degree to which local authorities can step in to run homes, as there is no such thing as a temporary registration. There is a need for clarification on both these issues.

An area that needs very careful handling in terms of regulation is the direct care workforce. Both future capacity and service quality are fundamentally dependent on these workers. The move to professionalise this workforce through requirements to have qualifications through the rather dubious route of the NVQ<sup>2</sup> may drive out some of the most valuable workers. On the other hand, there is the new group of personal assistants employed by those receiving Direct Payments where there is no regulation at all.

## Information, advice and training

Often the reason poor practice persists or that individuals do not make the decision that would benefit them most is lack of information and advice. Some developments such as the Better Commissioning Learning and Improvement Network are already underway under the auspices of the Department of Health's Change Agent Team. Providers could also gain from easily accessible sources of advice on providing specialist services and improving quality and good practice in employment and human resource management. The Social Care Institute for Excellence (SCIE) has potentially a very important role to play in this process, but is dependent on the evidence available.

2. NVQs are qualifications, but only require that an individual has been assessed as competent in a number of areas, a high proportion of which are voluntary. Training is not necessarily involved and the delivery of the process is very variable.

There is much confusion over best practice when it comes to managing the process of home closures. There is a need for advice and guidance both to authorities on the need for and contents of local guidelines and protocols, and to relatives and friends of residents on how best to handle this very difficult situation.

For some purposes training is more appropriate than advice or guidelines. The Inquiry might want to look into what extent good practice in commissioning plays a part in social work training. Does any training provided associated with NVQs adequately address issues such as quality, care of people with dementia, and care of people from ethnic minority groups? To what extent should training be routinely publicly-funded rather than left to providers who invest in people only to lose them? Why should training nurses be seen as a public good but funding the training of care workers be the responsibility of providers?

A major issue for older people and their relatives, in choosing the most appropriate home or service, is the lack of advice. A number of one-stop shops providing advice on benefits, on services and advocacy are being set up around the country under the Modernising Local Government framework. One key aspect of the operation of Direct Payments is the use of support and advice services. These also may provide a model for supporting others in the decision making process. There is also a role for the Third Age service, which is replacing the experimental Care Direct service, now being introduced under the auspices of the DWP.

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## Conclusions

The welfare of a substantial proportion of the older population now depends directly or indirectly on the successful operation of the social care market. While events in recent years have led to concerns about the operation of this market, generally the market has been responsive to demand and delivered what has been needed. Policies and practice by public bodies have a profound impact on the operation of the market, and there is no doubt that in addressing the needs of both current and future consumers of care services, there are a number of problems and considerable scope for improvement. To a large extent the levers to bring about these improvements are present or being introduced, although there are some difficulties, such as input prices and supply, that may prove more intractable.