Over the past 25 years, and more recently driven by the 1990 NHS and Community Care Act, the balance of social care provision has shifted from a position of in-house dominance towards a situation where the independent sector accounts for the majority of activity. This trend has been developing since the 1980s in residential care, but the independent sector only became the largest domiciliary care provider as recently as 1999. By 2001, it was offering 60% of all contact hours.

The survey explored the range of commissioning arrangements used by local authorities, with at least two questions in mind. Do arrangements in practice conform with current policy thinking, and are local authority in-house activities treated symmetrically with external provision, now an issue with particular salience in domiciliary care?

**DIFFERENT APPROACHES TO COMMISSIONING**

Authorities were asked whether they approached the commissioning process for activities retained in-house in the same way as they did for external providers.

Two-thirds of the authorities indicated that there was no difference in relation to residential care. In the area of domiciliary care, where in-house provision still accounts for a major (though decreasing) proportion of services, the majority was smaller: 56%.

Theoretically, these different approaches might be: explicit policies, and therefore available to all stakeholders; internal Council matters, not in the public domain; or they could have emerged in day-to-day practice as ‘street-level’ behaviour, rather than reflecting a deliberate policy position.

A small majority of local authorities did claim to have explicit policies on this issue. Reference to the research we carried out in 1996 offers one way of understanding this approach, which may be inconsistent with central government’s Best Value policy: box 1 overleaf shows some of the possible rationales used then to defend direct services. These arguments have been employed in the past to justify the differential treatment of external providers.

But there are two reasons why having

**Key Findings**

- Two-thirds of local authorities claimed to treat in-house and external providers in the same way.
- Some tolerated implicit policies which were in danger of damaging the potential for constructive purchaser/provider relationships. Others supported explicit policies which continued to favour in-house services, when such policies may not have been defensible in terms of robust local evidence.
- Some authorities located their purchaser/provider separation at different levels of the organisation for externally commissioned care and in-house providers.
- While performance specifications had been defined for most external providers, significant minorities of in-house providers had no performance criteria at all.
- Many authorities do not significantly include external providers in planning, delivering and reviewing local services, despite the recent partnership agreement.

**The Research Team**

The PSSRU staff who conducted this study were Julien Forder, Martin Knapp, Jeremy Kendall and Tihana Matosevic from the Unit’s branch at the London School of Economics. The project secretary is Angela Mehta (020 7955 6238; e-mail A.Mehta3@lse.ac.uk). This summary was edited by Annabelle May.
Box 1. Possible rationales for ‘protecting’ in-house provision

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<th>Concerns about alternative provision</th>
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<tr>
<td>that it is unavailable</td>
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<td>that it does not cater for some groups (‘cherry picking’)</td>
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<tr>
<td>failure/withdrawal: therefore need safety net</td>
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<td>inferior employment rights and payment rates</td>
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<th>Pride in public provision</th>
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<tr>
<td>high quality services</td>
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<tr>
<td>local authority as ‘quality employer’</td>
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<tr>
<td>quality of personal relationships between providers and users</td>
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<tr>
<td>continuous drive for service improvement and innovation</td>
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<tr>
<td>flexibility and continuity of service</td>
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<td>public accountability and public service ethos</td>
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<th>Choice for users</th>
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<td>Public want LA provision: local democratic support</td>
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<td>Benchmark against which to measure independent sector</td>
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| different processes could be seen as problematic, both from the current policy perspective and from the viewpoint of independent sector providers. First, in the case of explicit policies, when the claims listed in box 1 cannot be substantiated or defended in terms of robust local evidence. Second, where policies are implicit, when no attempt is made to justify the status quo to external stakeholders. Our previous research has shown how opaque decision making can foster a perception of unfairness in external providers, damaging the potential for constructive purchaser/provider relationships based on trust. Such negative perceptions can undermine the legitimacy of the local social service delivery system. |

Regarding purchaser-provider separation, 34% of local authorities initiate separation at the Assistant Director (AD) level, while 47% split purchasing and providing at the management level below AD (3rd tier). The remainder, 19%, locate this split at the next management tier down (4th tier). But there was a high degree of regional variation. In Yorkshire and the East, the SSD split was more likely to be two tiers or more below AD level, while few SSDs split so far down the management hierarchy in London and the North West.

Authorities were also asked about the nature and degree of devolved budgeting: who key budget-holders were; did arrangements vary for internal and external purchasing; and were there differences between residential and domiciliary services.

Budgetary devolution for external purchasing was strictly limited: over three-quarters of respondents for both types of care had budgets situated at purchaser team manager or local authority/SSD finance level — apart from the South East, it was mainly the former. A different pattern emerged for in-house budgets, where the most frequent arrangement was devolution to providing team managers. This level accounted for 39% of budget holding in residential care, and 44% in domiciliary care.

These results raised doubts about the relatively low proportion of authorities who admitted to treating in-house and external providers differently. If the picture presented was accurate, we would have expected purchasing budgets to be at the same level in both cases. For residential care only a third of authorities reported no difference in their treatment of in-house providers and had the same budget-holding arrangement. Regarding domiciliary care the equivalent figure was 22%. Furthermore, if we add the additional requirement that pricing policies are the same between in-house and external providers, the rate falls to 15% (residential) and only 5% (domiciliary).

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<th>SETTING PRICES</th>
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The Government’s new agreement with the independent sector states that ensuring ‘appropriately’ flexible pricing is an important means of achieving the policy goals of building capacity and confidence and reducing instability. Commissioners are exhorted to ensure that fee negotiation recognises providers’ costs and other relevant factors. In that context, the survey offered SSDs three ways of describing their external purchasing practice:

- Option 1: A single price for all publicly-funded providers in the authority (zero variation).
- Option 2: A price that varied by provider but not by (publicly-funded) client (inter-provider variation).
- Option 3: A price that could vary by client (intra-provider variation).

In residential care, no single option predominated nationally; all three were present, although options 1 and 3 accounted for 75% of the sample. But there were some significant geographical variations. In the North East, Yorkshire and West Midlands, option 1 predominated, while in three other regions — the East Midlands, South West and London — option 3 was the most frequent. The high use of option 1 seems to reflect the persistence of shadowing of DSS income support.

In domiciliary care, by contrast, two-thirds of respondents indicated that they adopted option 2 (inter-provider price variation) and option 1 was relatively rare. In this area, the lack of any external benchmark price such as the DSS income support rate used for residential care may make purchasers more willing to consider adopting a contingent approach.

Where price contingency did exist, this could reflect factors such as local labour costs, perceived differences in care quality or outcomes, or differences in user characteristics, such as dependency. Price contingency with regard to client dependency was claimed by 49% of the whole sample; quality was a contingency factor for 22%. In domiciliary care, the figures were 21% and 26% respectively.

Asked whether their arrangements for purchasing nursing care were the same as those adopted for residential care, the majority said they were identical: only 12% indicated a slight difference.

Overall, reimbursement of in-house services demonstrated far less contingency at least in regard to client characteristics. In domiciliary care, two-thirds of SSDs indicated that there was no difference at all in their rates of unit reimbursement. In-house payment variation was only found in residential care, where there were differences between homes (if not residents) in 55% of the sample. But unlike independently provided care, these ‘pricing’ differences were not driven by either client dependency or care quality, and possibly reflected a combination of geographical, historical, political and economic factors.

We also sought to probe aspects of the power relationship between purchasers and providers. Our previous research had documented the independent
sector providers’ perspective, revealing that most of them felt beholden to local purchasers when it came to pricing and perceived their own influence as limited.

This pattern was endorsed by the commissioning survey, as SSDs felt they had ‘total’ or ‘greater’ influence on pricing for both forms of externally commissioned care. Significantly, however, this balance was reversed in the case of in-house providers, where over three-quarters of purchasers said they had ‘no’ or only ‘some’ influence over them.

SELECTING AND INVOLVING PROVIDERS

Among the different arrangements for selecting independent sector contractors, a preferred provider list with accreditation proved by far the most popular. Dominating the arrangements for domiciliary care, in residential care this option also accounted for 47% of respondents even though more ‘free market’ procedures existed in that area.

From an economic perspective, a preferred provider list might have the disadvantage compared to ‘free market’ alternatives of insulating providers from competition. However, it also brings considerable economic benefits to purchasers in terms of lower transaction costs, derived mainly from restricting sub-standard providers from entering the full contracting process. Moreover, providers who satisfy the relevant criteria achieve increased security as well as gaining advantages for forward planning and clearer business expectations.

The recent partnership agreement between the Department of Health and the independent sectors states that it is essential for providers to be involved in the planning, delivery and review of local services, not least because of their proximity to users in a service delivery role. Moreover, social care is a public service whose quality is intimately bound up with provider motivation. Providers are only likely to feel co-operative and trustful towards purchasers if they can express their own care goals: professional values, expertise and an appropriate sense of control over the form and content of care services.

Our 1997 residential care study found that this was far from the case, while our study of domiciliary care also revealed a decidedly mixed picture, with only half of all providers tending to be satisfied with their relationships with purchasers. The remainder felt either ill-at-ease or deeply demoralised and frustrated. (For details of previous work, see the list of previous publications at the end of this summary.)

The present survey (2001) confirmed that there is a considerable gap between what is happening on the ground and the aspirations articulated in the DH agreement. Our results revealed that it is not only the providers who see their involvement in important aspects of care process design and implementation as often marginal or piecemeal. Purchasers themselves acknowledge this shortcoming.

Remarkably, over a quarter of SSD respondents admitted that providers were not even substantially involved in care reviews, while the lack of engagement in user assessments and care planning was striking. A more balanced picture only emerged with regard to developing new services, although even here just under a quarter of the sample involved providers only in limited ways.

CONTRACTS AND PERFORMANCE

Three possible options for service contracts in social care have emerged from the confusion of the 1990s, in addition to grants. We asked whether LAs used each of the three options (see box 2).

The 2001 survey found the following (which is consistent with our 1990s findings):

- Nationally, price-by-case (mainly call-off) contracting dominated the field of external social services.
- Cost-and-volume contracts were rare, except in relation to external domiciliary care.
- 40% of SSDs relied on block contracting for day care. However, from an initial low level, nearly half of all purchasers (47%) were now using block contracts to purchase domiciliary care.

Grant finance continued to be used to support day care providers, reflecting the persistence of traditional support for the voluntary sector in this area. At the same time the data also revealed the increasing use of block and spot contracts for day care, indicating the emergence of new, contractual relationships with external providers. Somewhat unexpectedly, a significant minority of SSDs were using block contracts to purchase at least some long- and short-term residential care (26% and 34% of the sample), although we

<table>
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<th>Box 2. Contracts and grants in social care</th>
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<td><strong>Block contracts</strong></td>
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<td><strong>Spot and call-off contracts</strong></td>
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<td><strong>Cost-and-volume contracts</strong></td>
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<td><strong>Grant arrangements</strong></td>
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![Figure 1. Contract types for independent providers (% of LAs)](https://via.placeholder.com/150)
should note that ‘floated off’ ex-LA homes tend to attract block contracts. To a lesser degree, this pattern of block contract use was echoed in relation to short- and long-term nursing care (20% and 12% respectively).

In terms of contract duration, there is a need to strike the right balance between reasonable risk attribution, planning opportunity, stability and user choice. Regarding contracts not specifically tied to how long a client uses the service, such as block and cost and volume contracts, a significant number of LAs reported contract durations in domiciliary care of more than three years.

Asked about the ‘follow up’ rate for contracts (broadly, whether the contract placement was retrospectively assessed), 78% of respondents said they followed up two-thirds or more of residential care contracts within six weeks; in domiciliary care, 66% followed up the same proportion. Three significant issues emerged in relation to performance specification. First, process specifications — that quantify, for example, inputs such as numbers of staff — dominated over outcome measures, the latter concerning the effect of the service on users. Second, specifications were more likely to be in place for external providers: significant minorities of in-house providers had no explicit performance criteria at all. Third, there was little difference between types of care regarding the adoption of performance criteria.

**DISCUSSION**

The 2001 PSSRU survey shows that commissioning approaches exhibit considerable variety, ranging from less than complete separation of purchasing and providing to complete separation, but with contrasting arrangements for in-house and external providers. These different arrangements are in regard to the contract types and procurement procedures used; the practice of so-called ‘balkanised budgeting’; and the application of regulatory procedures for feedback, monitoring and control. Pricing arrangements with external providers take relatively little account of service costs, particularly in residential care, amid government concerns that such inflexibility threatens capacity. Purchasers also acknowledge the continued arms-length relationship with suppliers, as demonstrated by the widespread use of spot/call-off contracts, and shortcomings regarding the involvement of providers in care-planning and review.

**Previous Publications**

This summary is a sequel to the six Evidence briefing papers:

1. *In business: purchasing from home-owners in the independent sector*, Evidence 1, December 1996.

The Mixed Economy programme also published five Bulletins of between 16 and 24 pages:

- **Bulletin 1**, October 1992
- **Bulletin 2**, June 1994
- **Bulletin 3**, December 1994
- **Bulletin 4**, May 1996
- **Bulletin 5**, October 1996

Most of these are available on the PSSRU website. Where they are not out of print, paper copies are also available free of charge from the PSSRU librarian.

A 28 page report summarising findings from the 1999 PSSRU/Nuffield Institute domiciliary care study is available from the website, and in printed form, price £5 including post and packing, from the PSSRU librarian:


A number of journal articles have been published or are in press and two book length studies cover earlier work:


**About this Study**

This survey drew significantly on previous work with local authorities, conducted under the joint PSSRU/Nuffield Institute Mixed Economy of Care programme during the 1990s. Data gathering took place in the summer of 2001. The questionnaires were mailed out by the survey company Ipsos UK. Non-respondents were sent follow-up letters and further copies of the questionnaire. Some were subsequently followed up by telephone. Ipsos UK carried out data entry and cleaning; analysis was undertaken by PSSRU. Some 92 out of the 150 SSDs in England responded: 61%. This response rate ranged from 43% in the West Midlands to 80% in the East region.

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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