Understanding Public Services and Markets. Report Commissioned by the King's Fund for the Care Services Inquiry

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Preface

In 2004 the King's Fund 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 the market. 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. This paper reports on the results of this analysis. A companion paper (Netten et al., 2004a) summarises the main messages.

Some of the proposals put forward here are reflected in the Green Paper *Independence, Well-being and Choice* (Cm 6499, 2005), which was published after this paper was drafted. The emphasis on increased control for service users, strategic commissioning, shifting regulation to an outcome focus and reform of performance targets are very much in line with our proposals. However, the emphasis is on better use of existing resources rather than an increase in resources. We have identified here the impact on the market of the low prices that are currently being paid for services. It remains to be seen whether the move to an enabling ethos can be achieved without significant additional investment.

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Abstract

Much of social care of older people now takes place in the context of a market. As a result the welfare of many people is fundamentally dependent on the success of that market in terms of both availability of services and quality of care. This paper considers the functioning of that market to date and the challenges it is likely to face in the future.

Social care is unlike most other markets in terms of the nature of the product, characteristics of consumers, the relationship between prices, fees and charges, and the dominant role and influence of the public sector. This paper starts by describing and defining what we mean by social care and the context in which the markets have developed. The extent and nature of the market are then outlined in terms of levels, distribution and types funding, the development of the commissioning role by public bodies and the impact on the market of changes in the regulatory system. The role of and involvement of service users as consumers in this market is described before describing in more detail the markets for three services: home or domiciliary care, care homes and the emerging field of extra care housing. The final section looks considers overall market performance, future challenges and how some of the problems that are emerging might be addressed through existing and potential policy and practice levers.

1. Introduction

Social care services support various individuals and groups including older people, children and families, people with physical or learning disabilities, and those with mental health problems. Services may be delivered in clients' own homes, in residential establishments or in day care facilities, although the family remains both the frontline support and, quantitatively, easily the most important care provider. 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.

Compensation does not imply necessarily doing things for others: social care is provided in a variety of ways. In recent years the principal objectives of government policies for social care of older people have been:

- 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.

Locally elected local authorities take lead responsibility for social care services (150 councils with social services responsibilities in England). These bodies plan, commission and provide services. As we discuss in more depth below, since the early 1990s there has been rapid growth of private and voluntary sector provision, especially in relation to services supporting older people. This growth has been based substantially on 'contracting out' arrangements by local authorities. The private and voluntary sectors now deliver more services than the public sector for most user groups.

Social services are financed primarily by central government and to a lesser extent through local council tax, where there are limits on how much can be raised. Complex formulae are used to allocate the funding from central government to local authorities, taking account of different levels of need and costs. The Formula Spending Shares (FSS) system provides *indicative* amounts for social care expenditure, and authorities are largely free to choose the amounts that are actually spent. In fact most authorities spend above their share (i.e. they direct money away from other services for which they are responsible) – indicating that the

centrally distributed pot of funds is too small. Section 2 identifies overall levels of spending and discusses the sources of financial pressures on authorities.

Unlike health care, individual service users purchase a substantial proportion of social care, either directly or through paying charges. Individuals receiving publicly commissioned services and paying charges are usually subject to a means test and of course are subject to an assessment of their care needs. The current charging rules for care homes (residential and nursing homes) take account of residents' income and assets. Nursing care is now free at the point of use but personal care is subject to the means test. For home care (or 'domiciliary care') new rules introduced in April 2003 seek to improve fairness by making charging more consistent across English authorities. Local authorities are now obliged to offer older people assessed as having social care needs the option of receiving 'Direct Payments', enabling the individual to organise and purchase their own services (see section 3).

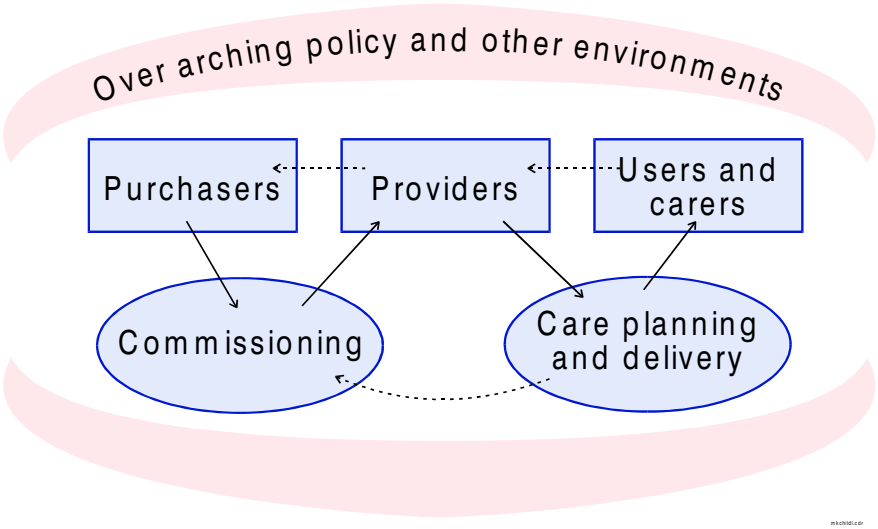
Social care markets

The 1990 *National Health Service and Community Care Act* introduced many changes to social care. One of the major developments was to stimulate social care markets (sometimes called quasi-markets). Provision of social care was gradually separated from purchasing and larger roles were offered to independent (private and voluntary) sector agencies. Generally, the 1990 Act can be seen as actively having promoted the *mixed economy of care* - the myriad arrangements for service provision, funding (and purchasing) and the interconnections between them.

A highly simplified representation of the mixed economy is shown in figure 1.1 (from Knapp and Wistow, 1996). This distinguishes three groups of actors or stakeholders linked by two processes, within an overarching policy context.

A key objective in encouraging and facilitating the development of the market in social care was obtaining value for money. The market mechanism was seen as a way both to keep costs down and also improve quality through competition. Initially, the main emphasis was on reducing restrictions on the market, to allow it to operate freely. However, the very fact that the principal purchasers are local authorities meant that right from the start public bodies had a profound influence in the management and on the development on the market. Moreover, the very nature of the product – care – and the consumers – in this case vulnerable older people – means that public bodies have a duty of care and protection that requires, at the least, oversight and, potentially, intervention in the market.

Figure 1.1: The social care market



As the framework shows the key players are purchasers, providers of services and service users and carers. The purchasers express demand and relate to providers through the commissioning process. The providers' response to this represents the supply of services. The safety net of regulation provides protection for service users, provides a baseline of adequate quality and, in the social care context, is often represented as ideally having a role in raising quality. In addition, the overall policy context will affect incentives and thus the behaviour of both purchasers and providers. Other environments, including related markets, particularly those in health, housing and labour, also form part of the overarching context that will influence the functioning of the market.

Demand

Demand for care can be defined as a need that is backed by the ability to pay for the services that will meet it. The *need* might be assessed formally by an agency such as a local authority or it might be what is perceived by individuals or their families. The former would establish the eligibility of the individual for publicly arranged services. The *ability to pay* might be an agency's willingness to purchase services from its budget, or the individual's own willingness to meet the costs of services from their own resources.

It is well known that the number of older people in the UK population is expected to grow and that this is likely to increase pressures on the long-term care system. Future demand for long-term care and related expenditure are projected to rise substantially in the next decades. However, there is inevitably a considerable 'funnel of doubt' when making long-term projections. For example, if improved health care or improvements in care practice were to have the effect of reducing dependency rates, this would at least partially offset expected

demographic pressures from rising numbers of older people (Comas-Herrera et al., 2004). Increases in the real costs of care (i.e. after adjusting for inflation) could also have an especially marked effect on the overall expenditure implications of future demand for care.

Increases in costs of care services above inflation are very likely. Costs of care are dominated by labour costs. The rise in demand for care services by definition implies a rise in demand for care workers. Given the considerable difficulties already faced by many service providers in recruiting suitable staff, and the requirement to improve staff training, the need for salaries to increase in real terms is clearly very pressing.

Demand for formal services is dependent on the largest and undoubtedly the most important provider sector: informal carers, principally composed of individual family members and neighbours. An estimate a few years ago suggested that there are now approximately 5.7 million carers in Great Britain - one in ten of the population - three-quarters of whom provide care to someone aged 65 and over (Rowlands, 1998). A small proportion of these carers provide highly intensive support and personal services to dependent older people, with nearly one million carers providing co-residential care (Pickard, 2000). Demographic and socio-economic factors mean that the levels of support from the informal sector may well be less in future years, with consequent implications for formal care services. The 1990 legislation sought to provide more support for family and other carers, and encouraged local authorities to involve them more fully in decision making. This policy theme was taken up by the Labour government, notably with its 1999 National Strategy for Carers.

Demand for social care for older people is also closely linked to demand and supply of health services. For example, during the 1980s reductions in the provision of continuing care by hospitals was facilitated by the growth of residential and nursing home places during that decade. More recently the focus has been on the relationship between social care and the use of acute hospital beds. The National Beds Inquiry identified that social care services should contribute significantly to the efficiency of the acute health care sector, by affecting the two ‘ends’ of acute care episodes: reducing entry by having a preventive effect, and shortening lengths of stay by reducing delayed discharges through timely and effective support following discharge (Department of Health, 2000a). Subsequent analyses of local authority data suggested that provision of both residential and community-based social care services significantly improved local acute sector performance measured in terms of delayed discharges, mean length of stay, readmission rates and hospital episodes (Fernández and Forder, 2002).

There have been numerous changes over recent years to the assessment procedures (most recently with the introduction of the Single Assessment Process in April 2004), the eligibility criteria (tightening or loosening with budget settlements, and more generally reflective of central and local priorities for the targeting of services) and the ability and willingness of individuals to contribute to the costs of their own services. All these are related to the expressed demand for publicly-funded social care. The key function in relating this demand to service provision is the commissioning process.

Commissioning

Commissioning, as an identifiable set of tasks requiring an acquired set of skills, is now quite well established in social care, but hardly got a mention in British social policy before the late 1980s. Commissioning occurs at different organisational levels. At the local authority or trust level these extend beyond the 'mere' procurement of services to include:

- the clarification of organisational mission as it relates to purchasing and provision
- the definition of need
- the identification and assessment of need
- the clarification of the services necessary to meet those needs (i.e. service specification)
- the negotiation of contracts with providers to deliver those services
- the monitoring of contracts, and especially of performance
- the re-negotiation, termination or extension of contracts (Wistow et al., 1996).

There are a number of 'styles' that can be deployed by a commissioning body. At the macro level, some local authorities are building long-term relations with their (preferred) providers, and others only on a shorter-term basis. Some are keeping commissioning links at arm's length, while others are much closer (sometimes even described as 'too cosy'). These styles can be combined with different commissioning *options*. These range from the broad choice of hierarchy (for example, using in-house services by preference) versus market as the principal means by which services are organised and delivered, through finer details such as contract type and mode of reimbursement. In section 3 we discuss the changing approaches to and variations in commissioning practice between authorities.

At the micro level, care managers commission services for individuals within the general contractual arrangements put in place by authorities. Care management tasks include case finding and screening, assessment, care planning, monitoring and review, and case closure (Challis, 2004).

Supply

The two dominant social care services are care homes and home care. The largest component of total public expenditure on social care services is on care homes for older people. By 2003 in England there were 218,500 publicly-funded residents aged 65 or over in approximately 350,000 care home places (Department of Health, 2003a; Dalley et al., 2004), with the vast majority of the remainder occupied by self-funders. The largest group of service users are 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 (Department of Health, 2004a). In recent years the number of commissioned home care hours has been rising rapidly, while the number of care home places has been falling. In sections 6.1 and 6.2 we discuss the markets for these services and factors lying behind these changes.

Another important, and rapidly developing, service that we discuss, is housing and care arrangements, most frequently referred to now as extra care housing. Information about the market for this service is much more limited but there is considerable policy emphasis on this type of arrangement, which is seen by some Ministers as a replacement for care homes in the future (MacErlean, 2004). The market for extra care housing is currently very different to that for care homes and home care (see section 6.3).

Clearly the markets for these services are inter-related. Services that provide care for people in their own homes can be substitutes for residential-based options, so the demand for one will be influence by the demand for the other. As we identified above, local authority commissioning policies in these and related areas will also affect how local markets develop.

Continued supply and capacity for expansion are dependent on barriers to entry into and exit from the market (Forder et al., 1996). Key barriers to entry are resource supply constraints, themselves dependent on the labour and property markets. To a degree barriers to entry and exit interact, as where there are barriers to exit from the market (such as sunk costs which cannot be recouped on exit), current suppliers are likely to keep prices down below a level that new entrants could sustain. Moreover, knowledge of the barriers to exit may in itself be a barrier to entry.

Service users

Since the 1990s there has been a growing emphasis in health and social care policy on involving service users and their informal carers in the planning, delivery, monitoring and

evaluation of social care services and consulting them about their needs, priorities and preferences (National Health Service and Community Care Act, 1990; Cm 4169, 1998; Cm 4310, 1999; Health and Social Care Act 2001; Health and Social Care (Community Health and Standards) Act, 2003). The importance of enabling service users to be involved in decisions about their care and of strengthening their choice has also been a key priority (National Assistance Act 1948 (Choice of Accommodation) Directions 1992; Cm 4169, 1998; Department of the Environment, Transport and the Regions, 2001; Cm 5503, 2002; Cm 6079, 2003). Commissioners' understanding of service users' perspectives is considered central to delivering responsive and good quality services, since consulting service users can identify where improvements are needed and establish the degree to which the market currently reflects their needs. In the context of the market the degree to which service users have a voice, and services reflect and respond to this, represents consumer power. In section 5 we discuss the degree to which service users' perspective is reflected in the social care market.

Regulation and performance assessment

A distinctive characteristic of markets for social care is the vulnerability of most of their service users. As a result, the issues of regulation and performance measurement are fundamentally important for the care industry and have a profound impact on the way markets develop. Government concerns about quality and protection were reflected in *Modernising Social Services* (Cm 4169, 1998), which had as key objectives protection and raising standards. Mechanisms to achieve these aims include contractual monitoring as part of the commissioning process, increased scope and specificity of regulation, regular reviews of performance and the use of a performance assessment framework (PAF). Radical revision of the regulatory process included the introduction of independent national regulatory bodies, now combined in the Commission for Social Care Inspection (CSCI) and the introduction of National Care Standards (see section 4). The PAF consisted of a number of performance indicators, based initially on readily available information (Department of Health, 1999a). Some of these performance indicators were used to feed into the Best Value regime that spanned all local authority activities and which aimed to promote efficiency in the sense of improving outcomes from given resources. The number and span of performance domains and indicators have grown each year, tied, of course, to the priorities of national policy.

Each of these forces – contractual monitoring, standards regulation, performance assessment and broader Best Value regime – obviously creates incentives (including 'perverse incentives') and applies brakes to actions that might otherwise be pursued within (unfettered

or less fettered) social care markets. The consequences for commissioner and provider behaviour within the developing markets for social care services often can be profound.

Boundaries of social care

Any discussion of social care markets, their functioning today, their evolution over the past two decades or their prospects for the future, must take into account the boundaries between social care and other fields of personal and collective responsibility and action. Among the more important boundaries for older people are those between social care and health care, housing and pensions. Planning or negotiating coordinated action across boundaries in respect of eligibility criteria, needs assessment, service delivery, funding, outcomes monitoring, user charging, standards regulation or strategic manoeuvring is an onerous responsibility. When those boundaries are blurred or shifting – and both characteristics have applied in England over recent years, particularly in relation to the health-social care boundary – then these tasks become all the more challenging. A great deal of emphasis is now being placed on improved collaboration between agencies – especially health and social care agencies – through joint commissioning and joint strategic planning and coordination. Movements of and across boundaries will potentially alter the levels and patterns of both demand and supply, and so also the likely performance of social care markets.

Conclusions

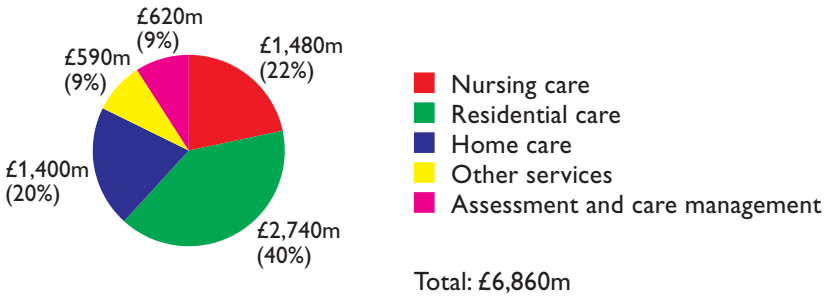
The majority of formal social care provision is funded by the public sector but provided largely by independent providers in a mixed economy of care. The influence of government policies and other public bodies, particularly those charged with commissioning care, on such a market is profound. We start our discussion by considering the sources and levels of funding before turning to the commissioning process and regulatory changes that have played such an important part in shaping the market. We reflect on the role of the ultimate consumer: the service user before examining the markets for home care, care homes and extra care housing in turn. Our final section looks forward to consider overall market performance and how some of the problems that are emerging might be addressed through existing and potential policy and practice levers.

2. Funding

Public funding of social care for older people has been increasing above the rate of inflation in recent years and is planned to continue to increase at 6 per cent above inflation until 2008, linked to long term government objectives to improve health and social care services (Department of Health, 2002a). For the three years thereafter it is planned to grow at 2.7 per cent in real terms (Cm 6237, 2004).

In 2002/03 gross public current expenditure on social care was £15.2 billion, of which £6.9 billion or 45 per cent was on services for older people. Charges to clients recouped about a quarter of all expenditure on older people. Nearly two thirds (62 per cent) of gross expenditure on older people was on residential provision, 29 per cent on day and domiciliary provision and the remainder on assessment and care management (see figure 2.1). The Department of Health reports that this reflected more than double overall expenditure on social care compared with 1992/93 in real terms (Department of Health, 2004b). However, 'in real terms' uses a deflator based on prices in the economy as a whole and much of the price pressures in the social care field are due to wage inflation, which was at a considerably higher rate during the period.

Figure 2.1: Expenditure on older people by service type, 2002/03



In 2002, 85 per cent of authorities reported a gap between the cost of meeting all expected demand within existing eligibility criteria in 2001/02 and the budget available (LGA/ADSS 2003). Moreover, in the review of the Formula Spending Shares undertaken in 2001/02 there was a major shift away from funding allocated to the care of older people towards the funding of services for children. This shift did not reflect a policy change in the way resources were expected to be used by authorities, it reflected historical reality – that is how local authorities were in fact spending central government funding. Only education funding is ring fenced so

there is no guarantee that increases in government funding will actually reach the care of older people.

Local authorities are under financial pressure both through these competing demands on their funds and through specific government policies. Efficiency targets were set in 1999. Authorities were expected to achieve 2 per cent, 2 per cent and 3 per cent improvements in efficiency in each of the financial years 1999/2000, 2000/2001, 2001/2002 (Department of Health, 2000b). Efficiency is difficult to measure and unit costs are often taken as indicators of efficiency. In the case of independent care homes and home care services the reported unit cost is the price. On top of these overall requirements, the Best Value target set for authorities that were not in the lowest unit cost quartile within their local authority type was that they should be at that level by 2004–2005 (Department of Health, 2000b).

Thus all the incentives for authorities, the dominant purchasers of social care, are to keep prices down. For the most part authorities were very effective in doing that even before the introduction of specific targets. Between 1995 and 1999 there was in total just a 10 per cent increase in average price paid per week for care home places (Laing & Buisson, 2000).

In an attempt to address increasing concerns about the social care market, in 2001 the Department of Health launched a concordat between the independent and statutory sectors aimed at building capacity in the independent sector in both home care and care home services (Department of Health, 2001a). The primary motivation behind this planned increase in expenditure was concern about the effect of restricted capacity in the social care system affecting the delivery of acute health care, through unnecessary admissions to or delayed discharges from hospital. Increased levels of funding were made available to local authorities to enable them to enter into long-term agreements with independent sector providers and, where necessary, to increase fees, in order to develop and improve services and to help stabilise the care home sector (Department of Health, 2001b; 2002b). Further funding was also made available as part of an initiative by which local authorities will be charged for the costs of acute beds occupied by people who are ready to be discharged (Department of Health, 2002c, 2002d). These specific grants were on top of the annual 6 per cent real increase in long term funding (Department of Health, 2002a).

The commitment to raise fees for those receiving long-term care, particularly those in care homes, has long-term implications for authorities with no clear view of how these will be met in the future. In some instances authorities used increased funding associated with the new concordat just on new admissions as there is a huge cost and little incentive, beyond a concern to maintain capacity, for them to raise fees for all the residents they are currently

supporting. However it is fees from current residents that represent the bulk of care homes' income. In many instances authorities will be wanting to direct the funding to alternatives to care homes, alternatives that are in line with the policy to maintain people in their own homes as long as possible, and which do not carry the same long term financial commitment. Moreover, there is little incentive for authorities to direct additional funding toward small homes that individually represent relatively small effects on overall capacity. Nevertheless, Laing & Buisson reported that for care homes fee inflation exceeded wage cost inflation in 2002/03 for the first time in many years (Laing & Buisson, 2003b). However, they noted that increases in the fees paid varied considerably between local authorities.

Specific grants have also been made to local authorities to address recruitment and retention problems among social care staff. These are intended to benefit the independent sector as well as directly employed staff. At present it is not known how these grants are being used.

Clearly, there are moves to reduce the pressure on markets through increased funding. However, the impact of such funding will depend both on whether the overall level is sufficient and whether it finds its way through to the social care market. That will depend on local authority priorities.

The boundaries of social care are far from clear. Historically support for people in certain specialist accommodation, such as sheltered housing, often has been funded through housing benefit. From 2003, the financial arrangements for state supported tenants were replaced by the arrangements set out in *Supporting People* (Department of Social Security, 1998; Department of the Environment, Transport and the Regions, 2001). These were intended to replace the fragmented system of funding arrangements for housing and care and to overcome legal restrictions on the use of housing benefit for care services. These arrangements also were intended to promote independence, by removing the link between support and tenure, so that services could be provided without the person needing to move into supported accommodation. Personal care services were to be provided separately following a social services' or health assessment and the funding of the 'care' element transferred to local authorities to administer. In theory this funding was to be limited initially to those people who previously would have had care funded through housing benefit. However, there has been a considerable overspend on this source of funding. In 1998 the estimated level of spending was £700 million per year. In December 2002 expenditure had grown to £1.4 billion and the grant for 2003/04 was £1.8 billion (Sullivan, 2004). In section 6.3 we discuss the relevance of this to the rapid development of housing and care arrangements.

Conclusions

The overall levels and incentives built into the funding of social care will have a profound impact on the development of the market in care services. Historical pressures have been to keep funding down, and while there have been substantial increases in funding in recent years it is not clear that these are sufficient to address all the pressures on social care markets. The levels of overspend on *Supporting People* funding demonstrate this. However, it is not just levels of funding that are important; it is also how the money is spent. For that we need to turn to the process of commissioning.

3. Commissioning

As figure 1.1 makes clear, commissioning lies at the heart of the mixed economy of social care, and fundamentally affects the way that markets develop. We start by outlining the origins of the commissioning process, before describing how these have developed and led to current patterns of commissioning behaviour, with their attendant benefits and drawbacks. Two important developments are described that are likely to have a profound impact on commissioning in the future, although there is limited evidence to date: joint commissioning and direct payments.

Historical basis of commissioning

During the course of the 1990s, as the momentum created by the 1990 NHS and Community Care Act was carried through the system, the role of local authority Social Services Departments (SSDs) changed fundamentally. Interacting with individual external providers to secure specialist and niche market services had long been an important function of SSDs in discharging their statutory duties towards vulnerable people. However, it was not until the 1990s that guiding and managing local markets for social care assumed a central position in their portfolio of activities. The shift was spurred by hard financial incentives, directions on user choice and consultation, and a barrage of other advice and guidance from central government (including the Department of Health, Social Services Inspectorate and Audit Commission).

In 1999 the two most economically significant forms of social care for the largest client group, residential care and domiciliary care for older people, were both predominantly purchased from external agencies for the first time. This represents a remarkable shift, for in the early 1990s, even as the balance of care was demonstrably beginning to change, there was marked resistance, and even hostility, towards market commissioning as a mechanism for securing services. Some of this resistance simply reflected more general institutional inertia and a desire to defend the home power base (interpreting direct services as a natural corollary of local democratic control, at a time when local government in general felt under siege from the centre). There were also ideological objections from traditional Statist local authorities. But some of these sentiments were specific to social care, and based on principled objection. Foremost amongst the rationales for this hostility were perceived incompatibility between markets and social care from across the political divide, because of the vulnerable situation of many social care users; and perceptions that for-profit provision in particular involved making profit inappropriately out of the weak (buoyed by anecdotal evidence and myths about widespread making of ‘excessive’ profit).

Transformation of commissioning attitudes and behaviour

What changed during the 1990s? Clearly, to some degree, there were cultural and political shifts. Beliefs were changing in the mid 1990s, with traditional Statism tending to give way to more pragmatic 'what works' attitudes in certain locales, reflecting the broader national trend of the political Left. More generally, local authorities were beginning to realise the extent to which some orientation towards profit did not typically mean crude profiteering but a richer combination of empathetic, professional and financial motives, worthy of the respect and support of public authorities. There was also a growing awareness that profit making was in any case rather precarious in these markets, with limited or very low financial returns the general pattern (Kendall, 2001). The desire to access capital, not available through traditional in-house arrangements in the current climate, and the drive to economise also became increasingly prevalent.

The understanding that greater utilisation of externally provided services would allow savings was typically based upon fairly crude comparisons of hourly costs, including, of course, employment costs. The early 1990s reforms mentioned earlier had already pushed public purchasers in this direction, but added impetus was provided by the all-embracing Best Value regime from 1998 onwards.

Most recently, three important factors have probably served to soften opposition across local authorities as a whole. First, it is now just over 10 years since the pivotal provider-purchaser separation was fully implemented. It may not be insignificant that this is the length of time many policy scientists suggest it takes for a 'policy community' to become 'mature' in terms of the durability of its institutions, and the mutual recognition of its actors' beliefs and motivations (Sabatier and Jenkins-Smith, 1993). Hence, there should now be relatively little reason for significant persistence in basic misunderstandings of motivations. Second, the introduction of national regulatory standards and a national regulator, while clearly still in their infancy, provide some assurance concerning minimum quality standards (although the sufficiency of the forms of 'quality' in practice is a controversial issue: see section 4). Third and most arguably, a more comfortable relationship between central and local government makes the latter more receptive to the former's promotion of the use of the market in social care.

Such developments suggest that recent reforms have had a relatively positive impact on the scope and legitimacy of the local authority commissioning function. However, it is important to set it in context in order to appreciate the challenging situation in which local social care actors operate. First, the elaboration of an increasingly centralised bureaucratic regulatory

apparatus may have benign effects, but it also concentrates power. This seems to offset countervailing gains associated with the new 'localism', and leaves some local authorities feeling ambivalent about the thrust of change (see Hudson, 2000, for a negative interpretation of the social care case).

Second, a significant proportion of independent sector providers do not seem to experience their relationships as unambiguously supportive, largely due to SSD-sponsored average fees still typically being set unrealistically low, especially in residential care, and perceptions of unfairness associated with preferential treatment for what remain of Councils' own services (Kendall et al., 2002).

Third, there has been a lack of evidence of commissioning innovative services, a tendency to stick to traditional service definitions and boundaries.

Finally, research has identified a range of significant implementation problems of commissioning at the micro level, especially in the case of older people (Ware et al., 2001, 2003). These problems include fragmentation of the care management process, with different staff responsible for different elements (initial screening and assessment, devising and arranging care services, actual service provision, and review). Consequently, users and carers have experienced such arrangements as 'episodic' and counterproductive in terms of the resulting lack of familiarity with their overall circumstances and personal and relational needs. In terms of priorities, an over-emphasis on bureaucracy has driven out the ability of care managers to foster longer-term relationships and holistic approaches to need. In addition, choice was predictably limited where users' preferences were not aligned with systemic priorities. (For example, some users who would have preferred a significant practical care element to their package have not received it, because local policy practices are increasingly geared towards delivering personal care.) Finally, despite the reticence of this client group to complain and their tendency to have low expectations of service delivery, a significant number of users did articulate clear concerns about quality. Echoing other research, prominent worries reported by users have often revolved around problematic relationships with domiciliary care workers — difficulties in assuring valued continuity, and problems with reliability, attitudes and timeliness.

Variation in local authority commissioning arrangements

It is very important to underline that local social care markets are *extremely* diverse so that, if anything, we have overplayed the common trends and patterns in the above discussion. At the very least we need to recognise that local authorities have moved in the shared direction

portrayed from very different starting points, at very different paces, and proved able and willing to engineer change in traditional attitudes and orientations to different degrees. In terms of the externalisation of provision, there are also major differences between types of care. For example, while domiciliary care has latterly begun to 'catch up' with residential care in terms of withdrawal from mainstream in-house capacity, in day care local authority owned and controlled facilities have remained prominent, and the voluntary sector rather than private enterprise has dominated independently provided services (Kendall, 2000).

Commissioning arrangements vary in terms of pricing strategies, devolution of budgets, arrangements for selecting and involving providers, and contract types. The most flexible or 'contingent' approaches - where prices vary with individual clients - have been favoured particularly in London authorities[1], and also the East Midlands and the South West; while at the other extreme, authorities in the North East, Yorkshire and West Midlands have tended to opt for uniform prices. Interestingly, commissioners in London were also more likely than elsewhere to report significant provider influence on pricing policies, perhaps reflecting out-of-borough purchasing strategies (MEOC team, 2001).

In the main, local authorities have adopted relatively simple arrangements for conducting transactions with providers. This is evident in the types of contracts and reimbursement mechanism used. Box 1 describes the five main types of contract used in social care. Price-by-case arrangements are now dominant (including 'spot' and 'call off' contracts), and this holds nationally for externally purchased residential care and domiciliary services. However, there are marked variations in the use of block contracts (involving payments even if the facilities are not used), and London again varies significantly from the overall picture. London is most noticeably different in its heavy use of block contracts for external domiciliary care services (79 per cent of boroughs reported these contracts, compared to 47 per cent nationally); and in the significant use of relatively long term block contracts in residential care (30 per cent of boroughs reporting the use of 10 years or more duration for their typical block contracts for residential care, compared to 12 per cent nationally). This greater propensity to utilise block contracts could be linked to out-of-borough arrangements, but also other factors, including disproportionate reliance on fully independent sector corporate and floated off/hybrid trust schemes.

[1] In the capital, this form of flexible pricing was the single most common type, accounting for 45 per cent of the 22 London Borough respondents. Nationally, this was the second most important approach, accounting for 36 per cent of all respondents.

Box 1: Contract types in social care

- ***Spot contracts*** **and** ***call-off contracts*** are price-per-case arrangements. prices and other terms are agreed in relation to individual units of service, usually around the person receiving care, and thus payments are made for services used by individual clients. Call-off contracts differ from spot contracts in that the price per unit of *supplied* service is set in advance and fixed for the contract period. Spot contracts have the price and other terms agreed in relation to particular units of service, to be consumed by specific clients. Thus, throughout the financial year the price of an hour of domiciliary care under a spot contract can vary from one client to another. With call-off contracts, prices are set in advance and cannot vary in response to specific user contexts.

- ***Block contracts*** are characterised by payment being agreed in advance and made for a quantity of service regardless of whether that service is actually consumed by users. Block contracts involve the purchase of the total quantity of service anticipated to be required over a period of time. Usually, therefore, the block of supply purchased is sufficient to cover the service requirements of many users. Indeed, were block contracts only used to purchase services for a very few clients they would differ little from call-off contracts.

- ***Cost and volume contracts*** are hybrids of block and call-off arrangements: payment is agreed and made for a block of supply, but additional payment is only made for service units beyond this level if they are actually consumed.

- ***Grant contracts***: providers are paid a lump sum with the expectation of meeting the service needs of a nominal number of clients. But the actual level of supply is not explicitly agreed and only broad service specifications are laid out. Thus, it is essentially providers who determine the quantity of service.

Taken from Forder et al. (2004).

Joint commissioning

During the 1990s distinctions between health and social care widened as models of commissioning continued to diverge and the number of independent social care providers increased. This led to decreased capacity to provide continuity of care for service users for whom positive outcomes require inter-agency collaboration, and for whom the distinction between health needs and social care needs is often relatively arbitrary. Central government concerns about the costs and consequences of this led to the promotion of integration between health and social care as mandatory policy for primary care trusts (PCTs), the new institutions of primary care and community health.

The policy of integration was formalised in the Health Act of 1999, which allowed for certain flexibilities:

- The establishment of pooled budgets between health and social services, in which the pooled resource effectively loses it's health or local authority identity.

- Lead commissioning arrangements where either the local authority or the PCT takes on a delegated commissioning lead in commissioning services on behalf of both organisations.
- Integrated provision where local authority and health services can be merged.

To date, implementation of the flexibilities has been relatively slow, particularly for older people's long term care services where lead commissioning has been the least popular of the new arrangements (Hudson et al., 2002; Davey et al., 2004). A study conducted in 2002-03 found that joint arrangements were held together by a belief of the importance of having health and social care agencies plan, prioritise and review services together and the need for a simple flow of finances between health and social care (Davey et al., 2004). However both parties wished to retain the capacity to scrutinize the origin of funds within all transaction, such that transaction costs would not be greatly reduced but accountability for funds would be ensured. It was also found that SSDs with pooled budgets with PCTs, were negotiating to ensure that they took the lead on strategic aspects of commissioning older people's services. This would mean that the dynamics between social care purchaser(s) and providers would remain largely unchanged. Moreover, in social services and primary care there is limited capacity for large-scale investment in specialised integrated provision in terms of facilities, ability to secure capital, workforce supply and managerial skills.

This is not to say that the integration of budgets between SSDs and PCTs is unlikely to affect the market for social care in any way. Aside from the institutional arrangements that have been offered with the Health Act flexibilities, there now exists a realm of new policy frameworks for service planning and prioritising. Local strategic partnerships bring together purchasers, providers and other stakeholders from a variety of areas related to the needs of different service user groups. These forums are expected to plan together, sharing information about current activity to explore priorities, challenges and opportunities across 'whole systems' of services. As leaders of the forum, PCTs and social services departments are required to produce a five-yearly Local Delivery Plan which details how appropriate balances between services to meet the needs of the local population, will be achieved. Local Strategic Partnership Boards are set to become central to providers particularly those providers who are willing and able to offer flexible relatively low-cost services that serve prioritised need. Local Strategic Partnership Boards may also provide effective impetus for service re-design.

Although citizen participation remains relatively weak in these structures, their membership is increasingly broad. This fact should help to ensure that the preferences and needs of service users within a community are more effectively understood. Ultimately their impact

on the social care market will pivot upon the extent to which these bodies challenge the role of mainstream service provision. Local Strategic Partnership Boards in conjunction with pooled budget arrangements and policies of social inclusion and the promotion of independence appear to have augmented the provision of relatively marginal services operating at the niche of the market by local community and voluntary organisations. These included exercise classes for people from black and ethnic minority groups, cookery and shopping classes and pre and post hospital discharge support by volunteers. These services were commissioned to promote and sustain independence generally but often particularly to meet specialist needs (such as culturally specific needs) and tackle the problems that such communities have related to poor access to services. Resource centres and outreach teams working to improve access to information on pensions were also a priority for social inclusion. It was reported that discharge, welfare and support services provided by community and voluntary organisations were prima facae 'surprisingly effective' in meeting needs and achieving objectives (such as reducing hospitalisation) (Davey et al., 2004). This was serving to challenge ways of thinking regarding commissioning social care – commissioners hypothesised that such services could function as effective substitute for low-intensity domiciliary care services. Commissioners were therefore keen to reconfigure domiciliary care services to a more intensive and more specialised service (Davey et al., 2004). Early discussions of this with providers were said to be underway. Skills training is likely to be facilitated/funded by social services although it seems that local authorities are currently focusing more on training for in-house services despite provision of funding to provide training to both sectors (Alcock, 2003).

Since April 2003 PCTs have also become responsible for funding nursing care in nursing homes. This reinforces PCTs' future position in commissioning long-term care. Further to this the policy requirement for health and social services to integrate first-level needs assessments through Single Assessment has led many PCT and social services partners to seek to develop models of co-delivery of community care assessments over and above the minimum requirements of Single Assessment. Joint assessment teams are expected to impact positively on the service users experience of assessment and continuity of care. These combined changes have led local authorities to encourage PCTs to take a lead role in micro-commissioning arrangements, provided that action is taken to enhance understanding of the needs of independent sector providers in the commissioning process – an area in which PCT commissioners and health personnel have little experience (Davey et al., 2004).

The area in which health and social care commissioning is most rapidly developing is in intermediate care services. Intermediate care features various guises operating via community or residential settings with large variations in therapuetic inputs and staff ratios.

Social services departments have tried to promote intermediate care as rehabilitation for people in crisis and at risk of requiring more intensive care packages and/or residential or nursing home care. In practice most of the intermediate care that has been commissioned focuses on preventing hospital admissions and increasing secondary care throughput, some argue acting mostly as a substitute for secondary care and thus not fulfilling its conceptualised role. Health have tended to promote the use of highly skilled staff, and have dominated the commissioning process, despite their newness to commissioning. Despite requirements for both PCTs and social services' to advertise for and consider competitive tenders, most areas have favoured in-house staff as providers of care partly as a way of providing incentives to staff through providing enhanced career opportunities. As yet evidence of the benefits and cost-efficiency of intermediate care is weak and the unit costs of this niche market remain high. Contractual arrangements with intermediate care providers are often weak and local models relatively unevaluated despite a variety of good practice guides (Department of Health, 2001c; Stevenson and Spencer, 2002). A number of evaluations have also shown problems associated with less than optimal use of services (Carpenter et al., 2003; Patel et al., 2003).

Recently, concerns have been raised regarding the sustainability of resources for intermediate care, due to the perception that the new financial framework for PCT commissioning provides a disincentive to promoting pathways that shift the burden of care from the secondary care sector to primary care (Department of Health, 2003b). Health and social services' commissioners are also concerned that the new foundation trust hospitals pose further uncertainty at the interface of primary, community and secondary care. If however the role of intermediate care is strengthened, health and social services will need to draw upon more independent care providers to provide services. Early findings suggest that social services have been involved less with small residential providers than with medium to large corporate providers of intermediate care

Direct Payments

Considerable policy emphasis is being put on Direct Payments where, based on an assessment of needs, the individual is allocated funds and (to a lesser or greater degree) support to organise and purchase, or commission, their own services. Direct Payments have been an option for younger disabled people for some time but became available to older people in 2000 (Department of Health, 2000c). Aside from the very significant influence of disability groups in promoting Direct Payments policies, Direct Payments has been driven forward due to a number of perceived benefits:

- Providing choice, control and flexibility to service users, thus recognising both the autonomy and individual rights of people requiring social care.
- Providing more efficient and effective matching of resources to needs and potentially improved outcomes as people decide on services that reflect their personal preferences.
- Expanding the potential pool of caregivers with flexible arrangements appealing to personal contacts and to people who would find employment with an agency too restrictive.
- A reduction in the administrative costs typically associated with local authority social services departments' management of service packages.
- Increasing the number of consumers in the market place and hence theoretically increasing competitiveness and thus quality, responsiveness and/or prices.

Such 'cash for care' schemes are developing in a number of countries with differing restrictions in terms of regulation and of who can be paid for care (Ungerson, 2004). In England paying close relatives for care has been discouraged (except in exceptional circumstances). More recently however, attitudes and policy towards this have relaxed particularly in recognition of the needs of black and minority ethnic communities where family care can still remain both the norm and the only culturally acceptable form of care.

Take-up among older people has been very slow in relation to the proportion of older people receiving community care services. In a position statement on Direct Payments provided by councils in September 2002, it was found that only 1,032 older people were receiving cash payments in lieu of social services (Department of Health 2003c). This was nearly double the number of Direct Payments made to older people in the previous year (Social Services Inspectorate, 2003), but still represented a small proportion of the overall 7,882 payments being made. Most payments, 5,459, were being made to people with a physical disability. Despite their marginal position Direct Payments are steadily growing: Department of Health figures from 31 March 2004 show the overall number of payments as 14,000, of which 3,200 were for older people (Department of Health, 2005).

Ongoing research on Direct Payments has identified that although in some authorities the level of Direct Payments reflects local agency rates, in many cases local authorities operate Direct Payments as a way of reducing the cost of care packages (through providing a lower rate for a direct payment then they would pay to domiciliary or other services). These authorities argue that this is equitable as it involves a reduction equivalent to overhead costs, but it places service users at a disadvantage as an independent purchaser in the market place.

The same research found considerable variations in the provision of support available to Direct Payment users. Support services vary in their philosophies and mode of delivery despite offering similar core services. Some operate arms-length support aimed at empowering users to maximise independence. Others offer heavily brokered forms of support to arrange services and manage the direct payment including options where alternative management of a direct payment can be achieved if the person so unable to manage the direct payment themselves (i.e. through a trust).

Some commissioners are seeing Direct Payments as the spot purchasing for the future. Some authorities are promoting Direct Payments for call-off contracts that would otherwise be arranged by the local authority (such as periodic respite services). While this enables the service user to achieve increased flexibility, in some cases there is no change to the service commissioned and little variation to the arrangements for care (i.e. which weeks care is purchased). In this scenario, it appears that local authorities are keen to shift the burden of responsibility for arranging services on to service users.

In authorities where Direct Payments uptake has reached significant levels there are reported impacts on commissioning strategies. Scottish research suggests that local authorities with a high rate of block contracts are disinclined to promote Direct Payments for fear that they will end up paying twice for services (Direct Payments Scotland, 2003). This is considered to be one of the main reasons that uptake has remained slow, alongside the impact of paternalistic values among care managers. Commissioners are widely discussing the need to free up resources from block contracts.

Potentially, Direct Payments could have a profound impact on the market for social care, as personal commissioning can support more informal approaches to care that more closely reflect household or family production of care. There are, however, dangers of exploitation on both sides and in many instances (for example, where people have dementia) the older person themselves will not be in a position or want to manage their own care.

Conclusions

Expertise in the field of commissioning services has developed rapidly in local authorities. However, there remain a number of problems and new challenges presented by the move to joint commissioning and the use of Direct Payments. The role of commissioning is central in the social care market where such a high proportion of care is funded by the public sector. Past practice has had a profound impact, primarily in keeping prices down and loading the risk on to the provider. Moves to improve commissioning practice need to address all levels

of the process, from strategic planning, through to care management and support of those managing their own care.

4. Regulation

Regulation plays a key role in social care markets, which cater almost exclusively for vulnerable people. In contrast with previous administrations that had emphasised a 'light touch' to facilitate the development of the market, under the current government increasing emphasis has been put on the importance of regulation in protection and raising quality of care. As a consequence the current regulatory framework has had an important impact, particularly on the care home market. We describe this impact in section 6.3. Here we describe the basis for the current regulatory system, potential influences on the market and providers' perspectives on the current system.

Current regulatory arrangements

With the creation of the National Care Standard Commission (NCSC) in April 2002 social care regulation, which had previously been administered by local and health authorities, was placed on a national footing with a national system for judging service quality across domiciliary care agencies, as well as residential care services for adults and children. From 2004 the Commission for Social Care Inspection (CSCI or Commission) took over the work of the NCSC, as well as that of the Social Services Inspectorate (SSI) and the Joint Review team of the SSI/Audit Commission.[2]

Proposed national minimum care standards for care homes were published in September 1999 in *Fit for the Future* (Department of Health, 1999b). These standards were very input based, including physical requirements and existence of evidence of managerial arrangements and staff qualifications. This is in contrast to a more outcome-based approach adopted by Ofsted, which took over the responsibility for regulating services for children and families. Outcome-based regulation places the responsibility on the provider to demonstrate that they have made adequate arrangements to ensure, for example, safety, rather than identify specific safety measures that need to be in place.

[2] Other regulators operating in the social care field include the Health and Safety Executive and the General Social Care Council. The Health and Safety Executive has a responsibility to enforce health and safety at work legislation and is likely to take the lead in enforcing general safety management, the safety of employees and building/facility management in care homes, with the CSCI taking the lead in enforcing service user safety. The social care workforce is being regulated for the first time by the General Social Care Council, which will register the workforce, introduce codes of practice, and regulate education and training. To date it has focused on introducing these measures in relation to the more qualified segment of the workforce.

The publication of standards in March 2001 was met with considerable opposition, focused on fixed staffing ratios and physical standards, particularly for bedrooms. In the wake of these the government issued guidance in January 2002 (Department of Health, 2002e), proposed amendments in August (Department of Health, 2002f) followed by an amended set of standards in March 2003 (Department of Health, 2003d).

The toning down of the approach to implementing standards meant that the amended standards were to be treated as good practice for all homes, but many standards would not be a requirement for homes that existed prior to April 2002. For example, all new homes, extensions and first time registrations have been required to provide all places in single rooms from April 2002. Existing homes are required to maintain the proportion of single rooms at the level that prevailed in August 2002. However, an important (and costly) standard to be applied both in home care and care homes is the standard that at least half of all direct care staff should be qualified to at least NVQ level 2. Although only in place for a very short time these standards are already under review.

It was not until 2003 that there was any requirement on home care providers to register and be subject to care standards. This reflects in part the fact that until recently most home care was provided by local authorities, which were not themselves subject to regulation of their services.

Impact of regulation on the market

The current roles allocated to the Commission mean that it can influence demand in three ways. Funding allocations by central government and target setting by local commissioners are likely to draw on information provided by the Commission about the availability and quality of the services its regulates. It also has a statutory duty to provide information to the public and thereby potential individual purchasers. Less directly, regulatory costs to providers may be passed on to residents in the form of higher prices.

The influence on market supply is more direct. The quality of market entrants is regulated via the registration process and the nature of supply influenced via the de-registration or cancellation of very poor quality services. Such entry and exit regulation can bring about unintentional consequences such as an imbalance in geographical supply, although there is no evidence of that in England to date. In the absence of public provision under-supply could also result from a lack of quality entrants.

One unintended consequence of regulation for which there is substantial evidence is the need for private providers to comply with standards which will reduce the financial viability of their businesses to the point that they decide to exit or are dissuaded from entering the market. The prospect of the introduction of national care standards was identified as a significant factor contributing to a dramatic rise in care home closures between 1998/99 and 1999/2000 (see section 6.2) and was a contributory factor to the modification of the care standards as described above.

In home care the care standards that have been introduced that are likely to have most impact on the market are those that relate to the care workforce. By April 2008 50 per cent of direct care workers should be qualified to NVQ level 2 or above (Department of Health, 2003e). The cost of this is a matter of considerable concern to providers, as is the potential for increased turnover as those who do not wish to be qualified leave for other types of work or retire and those who become qualified leave for better paid work in other agencies.

One very clear objective of regulation is to maintain or improve the quality of care provided. If the rise in care home closures was in response to the introduction of care standards and limited to poor quality homes it could be argued that this was a desirable effect. However, the evidence suggested it was smaller, more vulnerable homes, not those providing lower quality care that were lost (see section 6.2).

In terms of improving the quality of care of homes that continue to operate, it is as yet too early to tell. The first year of inspections of care homes usefully identified that performance varied across different standards and identified the most common deficiencies (Dalley et al., 2004). This provided benchmark information against which future changes could be judged. However, the degree to which any future improvement in quality can be attributed to the process of regulation, or other factors shaping the market, will be difficult to establish. Moreover, the CSCI is reviewing the existing regulatory approach.

The resources available to the regulator and costs of the regulatory process to those regulated will also have an impact on the market. The costs to those regulated include both direct charges and the opportunity costs incurred during the process. There is limited information about the latter, although some insight from the provider perspective on the current regime is described below. In terms of charges, after a long period during which the ‘light touch’ to regulation resulted in no increases in registration or annual fees being paid by homes, the government adopted an explicit policy to pass on the full costs of regulation to those regulated. This resulted in substantial, although phased, increase in fees. From 2002 these were based on a study of the resources used under the regime prior to the NCSC (Netten et

al., 1999) although this drew protests from the industry (Independent Healthcare Association, 2003).

A study of the resource requirements of the NCSC found that the time taken to carry out inspections had increased substantially, compared with the time taken by local authority and health authority managed units in 1998/99 (Netten et al., 2003a). The budget for the NCSC had been set on the basis of the resources used under the previous regime. Thus the increase in resources used requires consideration of whether the approach taken needs to be modified or streamlined by the CSCI in order to be able operate within resource constraints, and/or the additional costs passed on to those regulated in the form of increased fees.

Incentives, enforcement and sanctions

Recent (unpublished) research into providers' perspectives on regulation suggests the beneficial effects on provider motivation, and ultimately on services, of supportive relationships between themselves and their regulators. 'Supportive' relationships were those where the initial framing of the process by regulators recognized provider competence and skill, as much as paper-based routine; where sustained feedback and communication characterised the regulatory process throughout; where fair but realistic account was seen to be taken of the constraints faced by providers; and where there was believed to be proportionate distribution of time as between inputs and user outcomes in inspection, with opportunities for dialogue on the latter. Moreover, from the same study there was evidence that the new national regulations could empower managers at the front line of service delivery within large organisations. Home level managers in corporations who were not themselves authorised to hold the budgets to resource home improvements were able to point to national standards as a tactic to engineer or accelerate the upgrading of their establishments. They were thus internally reinforcing the existing pressure to allocate additional resources at the home level that higher level budget-holding corporate managers were already feeling from external stakeholders (Kendall, 2004).

Sanctions available to the Commission include statutory notice of the changes required to comply with a regulation or law, notice that action is required within a given timeframe (urgent actions), and prosecution and/or the closure of a service[3].

[3] While we have restricted our discussion to the British context it is of interest to note that calls have been made for a greater range of sanctions in Australia (Braithwaite, 2001) and arguably service improvement would benefit from their introduction here. Intermediate sanctions introduced in the United States include financial penalties, the power to withhold payment for new admissions and the power to send in temporary management (Walshe and Harrington, 2002).

During its first year the NCSC took a light touch approach towards enforcement action and closed only four care homes for adults (National Care Standards Commission, 2003). Clearly this approach cannot continue, given that one in ten of the 12,685 complaints received by the NCSC during 2002/03 made a specific allegation of abuse (House of Commons Health Committee, 2004b), and one in eight (12 per cent) care homes for older people failed to meet the medication standard (Davies et al., 2004). The Health Select Committee on abuse of older people recommended that regulation require the reporting of adverse incidents in domiciliary care, the most common setting of abuse; the introduction of performance indicators to measure the amount and impact of adult protection work; the speedy introduction of the planned Protection of Vulnerable Adults (POVA) list; and the registration of domiciliary and other social care workers, including those employed through Direct Payments (House of Commons Health Committee, 2004a).

Providers' perspectives

The provider perspective of the process will fundamentally affect the impact of regulation on the market. How do providers themselves feel about the current regulatory regime? Unpublished Commissioning and Performance Programme research by the PSSRU at LSE has confirmed that no providers contest the basic legitimacy of developing a strong national regulatory framework. Almost all of the respondents welcomed the replacement of old local regimes with a new national regime that consciously sought to ensure a more 'objective' approach to regulation as a necessary corollary to the existence of enforceable national standards. The existence of a 'cowboy' problem, so serious with vulnerable users, was seen as a key rationale for the development and implementation of national standards. However, although the *Fit for the Future* consultations (Department of Health, 1999b) had claimed to be comprehensive and inclusive in breadth and depth, small providers in particular often felt that this had failed to adequately capture their concerns. A number referred to 'poor planning', regulations 'not thought through' and spoke of government modifications to regulatory requirements between 2000 and 2002 with considerable annoyance and, quite often, anger. Revisions were seen as panic-driven 'back tracking'; easily avoidable if only the initial consultation exercise had been undertaken more intelligently and systematically. These criticisms were not just 'academic', since in the light of the initial regulatory requirements, an incredible 46 per cent of small home operators had actually considered leaving the business (for both medium sized and corporate homes, the proportion was 25 per cent). A few were still planning to exit at the time of the interviews, in 2003, or were still considering the option. Although most had decided to stay once the revised regulations were put in place the confusion and turbulence generated by these developments has made a strong negative impression on many.

The way in which inspections are conducted and relationships developed also shapes providers' assessment of their regulatory environment. Four factors seem to contribute to positive assessments:

- Sustained feedback and communication in and around the regulatory process.
- 'Realism' in inspectors' approaches, for example allowing timescales for implementation to err on the side of generosity, in recognition that the environment for residential care operators was particularly fraught.
- Proportionate and appropriate distribution of time, particularly allocating a significant amount of time to speaking to residents, present relatives, and staff.
- Personal style conducive to mutual professional recognition and respect.

Conclusions

In a mixed economy of care with a large number of independent providers the role of regulation in maintaining and improving quality and protection is crucial. However, the way that regulation is implemented, both at the macro level in terms of setting standards and the basis for these standards and at the micro level in terms of implementing the regulatory regime has a profound impact on providers and thus supply of good quality services.

5. Service users

In theory individual consumers exert considerable influence on the social care market as purchasers. Consumer choice should promote competition amongst providers and drive up quality, efficiency and responsiveness at the local level, although the link between choice and improved quality is not guaranteed (Appleby et al., 2003). Poorly performing providers or those where there is insufficient demand should leave the market.

Promoting individual choice, however, has potential costs as well as benefits. One person's choice might be at the expense of another's (Appleby et al., 2003). Choice might also reinforce inequalities as take-up of choice can vary (Policy Commission on Public Services, 2004). Markets might polarize into good and poor quality services (6, 2003), although regulation should safeguard against this. As described in Section 3 the major purchasers of care are for the most part local authorities or PCTs rather than individual service users, although at the micro-commissioning level the care management process should, in theory, facilitate choice and empowerment. The choices potentially available to individuals include:

- the right to choose the type of care received
- the right to make an application for a particular provider
- the ability to choose the content, level and timing of care provided
- the ability to purchase care directly using Direct Payments.

Characteristics of the social care market, however, mean that choice and the market mechanism are far from straightforward ways of allocating resources. Service users may not be taking part in a voluntary exchange, may not pay for services, may not receive services because they fail to meet eligibility criteria and may find it difficult to change providers when standards or preferences are not met (Needham, 2003).

There is also some evidence that the salience of particular choices differs. Choice between domiciliary care providers, for example, has been found to be of less importance to service users in the community than choice about the content, timing and duration of services (Hardy et al., 1999). Choices vary by service and source of funding. Self-funded service users and those using Direct Payments, for example, have a more direct relationship with providers as purchasers than publicly-funded service users. Publicly-funded service users have access to care managers' experience and knowledge but care managers themselves have identified council budgets and relatives' ability to help pay for services as influencing definitions of need and decisions about the most appropriate type of service (Hardy et al., 1999). In terms of type of service, publicly-funded service users choosing a care home are restricted to homes that do not cost more than councils would usually pay, unless their relatives are able to

contribute additional payments. Service users in receipt of care in the community have potentially more choice than those choosing residential care as they can choose both the type of service and when it is delivered.

Limited choice between types of housing and care and particular providers restricts evaluation of the impact of the choice mechanism on the market. Relatives have reported having little choice but to agree to admit older relatives to nursing homes from hospital (Ryan and Scullion, 2000). Residents themselves are rarely actively involved in the process (Allen et al., 1992; Netten et al., 2002a), although greater involvement of patients and carers in the hospital discharge process is being promoted (Department of Health, 2003f). In addition to choices made when selecting service consumer power is felt through people deciding to change services that they are not satisfied with. This is particularly difficult when the change requires moving. Although people do often move in the first month or so after admission to a care home, thereafter moves are relatively rare (Bebbington et al., 2001).

A lack of choice of care home has been attributed to financial restrictions, the availability of places, the admission criteria of homes, and limited information about homes or how to choose between them (Myers and MacDonald, 1996; Davies and Nolan, 2003). A reduction in the choice of provider and care home size has also been attributed to the increase in corporate provision, resulting from market competition (Hardy et al., 1999). Block contracting arrangements, and cheapest or in-house first policies have been identified as restricting service user choice of domiciliary care agency; and tight eligibility criteria as removing the scope to choose the content and timing of services (Ware et al., 2003). There is limited information about the choices available to or influence of, users of sheltered housing and extra care housing to date. Studies investigating people's experience of moving to such schemes for the most part identified a similar pattern to those admitted to care homes; people said it was not a positive option at the time of making the decision, and felt pressurised by relatives to do the right thing (Bartholomeou, 1999; Oldman, 2000). An important exception was an evaluation of the Joseph Rowntree Foundation continuing care community in Yorkshire where people who had not previously considered moving decided to move on hearing about the scheme (Croucher et al., 2003).

Direct Payments brings choice 'closer to consumers' (Policy Commission on Public Services, 2004) and so should strengthen their market power. Direct choice, however, increases the need for information and the need for councils and providers to consider the diversity of service users' needs, attitudes and empowerment levels (Policy Commission on Public Services, 2004). Provision and use of Direct Payments has been geographically uneven and hampered by inconsistent implementation by councils, lack of information and support to

help consumers deal with providers and lack of awareness among care professionals (Carr, 2004).

There is a need to establish whether mechanisms for involving older people in shaping the market, other than the choice mechanism, are working. A lack of evidence, however, hampers any evaluation of the impact and outcomes of involving older people in planning and development (Carr, 2004; Policy Commission on Public Services, 2004). Local NHS organisations and councils have increased the level of service user involvement in health, mostly in terms of collecting information about what matters to them, but need to do more to bring about change as a result of such participation (Commission for Health Improvement, 2004). Investigation of the extent of involvement of older people in shaping public services in Scotland identified a similar lack of evidence; evaluation of the outcomes of older peoples' involvement was lacking, as was a strategic approach to involving them. Mechanisms for involvement included older people's forums, Better Government for Older People, an Older People's Assembly, older people's networks, user panels, day centre or care home user groups, older persons' services planning groups or forums and project-specific working groups. Most of these activities were conducted by single agencies and related to information giving and consultation. There was concern among professionals and older people that participation should be widened to avoid an over-reliance on the views of a small number of committed activists from local groups (Dewar et al., 2004).

There is increasing emphasis on the use of surveys of service users and the Department of Health has introduced annual surveys conducted by local authorities that feed directly into Best Value performance indicators (BVPI) (Cm 4169, 1998). The survey in 2003 was of older users of home care services. Analysis of more detailed questionnaires of 34 authorities participating in an extension to this survey suggested that the BVPI based on a general satisfaction question did reflect genuine variation in people's experiences (Netten et al., 2004b). An important finding both nationally and in this extended study was much lower levels of satisfaction among people from an ethnic minority background. There was no direct evidence from the extended study of consistently lower levels of access to services, although people from black and minority ethnic groups (BME) were receiving more intensive services, suggesting that they were at higher levels of physical and cognitive disability, and that this may in part explain their overall lower levels of satisfaction. BME service users' lower levels of satisfaction were more related to their views of care worker characteristics rather than service quality characteristics, suggesting that problems may be associated with cultural clashes or expectations about care worker behaviour rather than delivery of poorer services to this group. Whatever the cause, clearly the market is failing to ensure that the needs of these groups are met and that services are responsive to the diversity of service users in terms of

race and culture. The proportion of older people from ethnic minorities is growing, particularly in London. In the 2001 Census the national proportion of people over pensionable age that were from an ethnic minority was 5 per cent, varying from less than one per cent in a number of counties and unitary authorities to over 40 per cent in Brent. In London as a whole estimates based on the 2001 Census suggest that the proportion is over 13 per cent.

Conclusions

The key elements required for consumer power are diversity and availability of provision, information about options, empowerment and control. In other sections we have identified problems in terms of diversity of services, which, together with poor levels of information lead to a lack of choice in practice. In terms of empowerment and control there are a number of levels at which the current policy emphasis on the user perspective could and should be making its influence felt: high level strategic commissioning planning; individual preferences for types, characteristics and quality of service; regulating, monitoring and improving quality. We have identified specific policies and practices designed to improve consumer power, which is starting from a very low base. It is not clear that as yet they are having much impact. However, the potential is certainly there. The identification of lower levels of satisfaction among service users from black and minority ethnic groups suggests that the market is not meeting the needs of these groups and gives us a basis from which to measure the impact of interventions aimed to address this problem.

6. Social care service provision

We identified in section 1 that home care services and care homes were the predominant types of service. In this section we describe how the markets in each of these services has developed and appears to be currently operating and review the evidence about how they have been influenced by policy, commissioning practice and the regulatory environment. We then turn to the field of housing and care and describe the development of a very different market.

6.1. Home care services

Home care services are the key to maintaining frail older people in their own homes. Over the past fifteen years there have been dramatic changes in who provides and who receives the service and in the nature of the service itself.

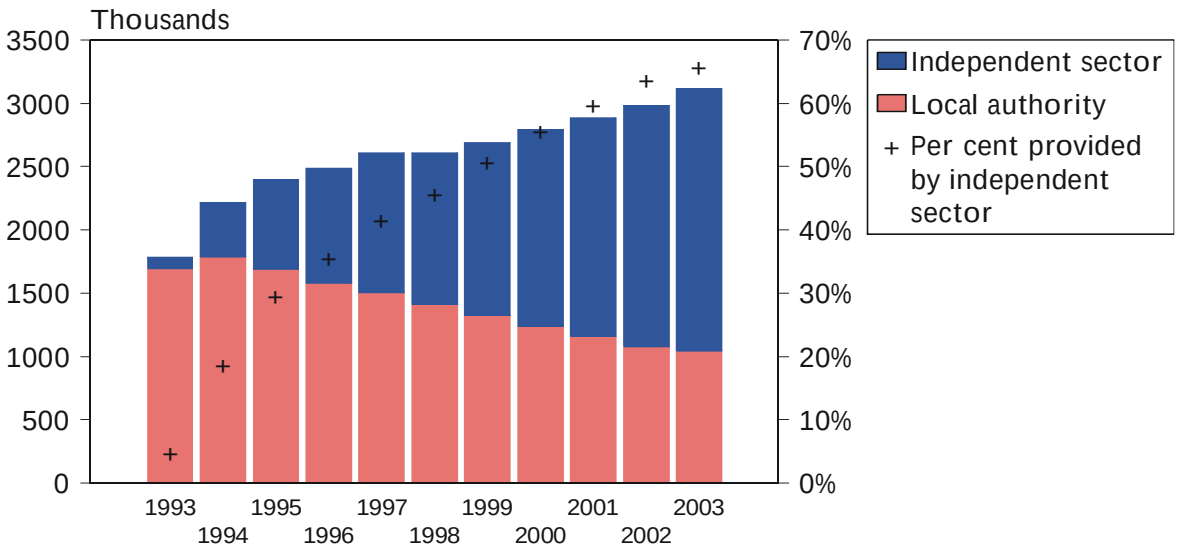
Structure of the market

Overall levels of publicly purchased care rose by 75 per cent between 1993 and 2003 (see Figure 6.1) when over 3 million care hours were purchased. The rise was due entirely to an increase in publicly purchased independent services. As Figure 6.1 shows, during the same period the number of local authority provided home care hours fell by 38 per cent. The picture varies regionally. In London there is a greater reliance on independent provision, with 74 per cent of care hours purchased from the independent sector in 2002 compared with 64 per cent in England as a whole (Laing & Buisson, 2003a).

The shift to independent provision of home care led to a rapid increase in the number of providers in the 1990s. In 2004 over 3000 home care providers were registered with CSCI. For the most part these are small-scale providers although there has been some consolidation of the market in recent years. At a national level larger companies such as Anchor and Nestor Healthcare have acquired smaller companies and there have been some moves by local authorities to deal with fewer larger organisations to economise on transaction costs and perhaps exploit economies of scale and scope from building relations with a small number of larger providers. However, overall Laing & Buisson (2003a) describe the market as 'fragmented' with relatively few large providers and many small ones. The majority (82 per cent) of independent providers are in the private sector, with half of these sole traders or partnerships and half private or public limited companies (Laing & Buisson, 2003a). In a survey conducted in 1997 Laing & Buisson found that only 37 per cent of home care providers were exclusively providing home care. Many services developed from nursing

agencies and some from the diversification from care home providers. In a survey of care homes 14 per cent of nursing homes and 19 per cent of residential homes were providing home care services (Laing & Buisson, 2003a).

Figure 6.1: Home care contact hours by sector of provision in England: 1993-2003



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

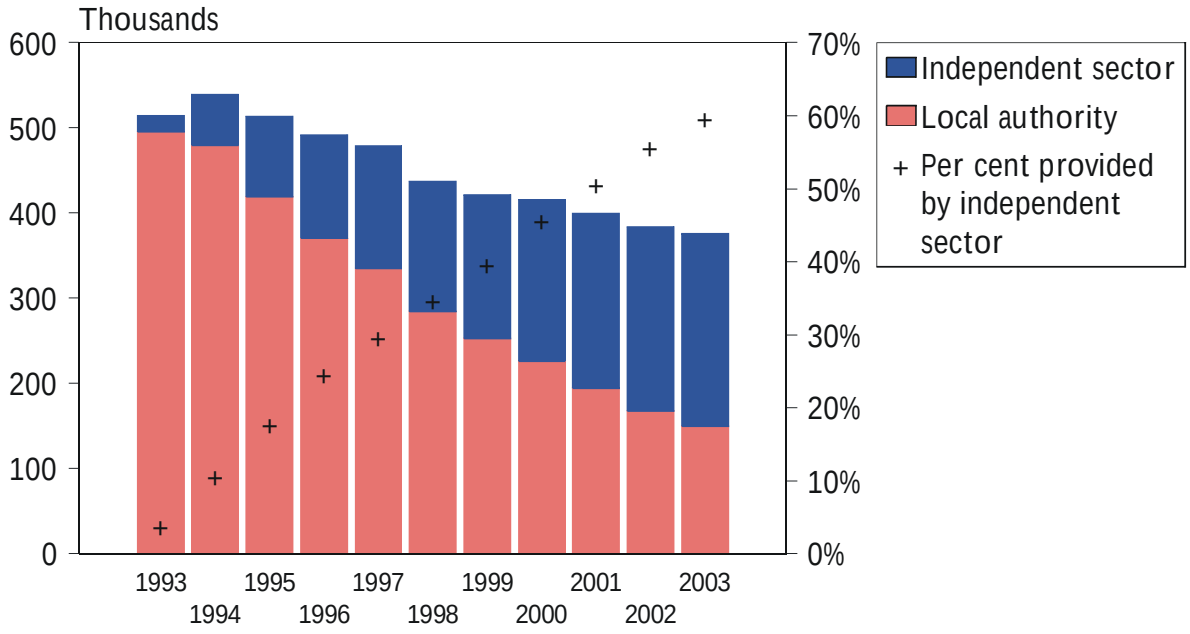
Intensification of services

While overall levels of provision have increased, the number of clients has decreased: the number of households receiving home care services fell by 27 per cent between 1993 and 2003 (see Figure 6.2) when 362,800 households (or 373,500 clients) were receiving the service. This focus on more intensive services for fewer people is demonstrated by the rise in the average number of publicly-funded home care contact hours per household, which more than doubled, from 3.5 hours per week in 1993 to 8.2 hours in 2003. Similarly the proportion of households receiving only one visit of two hours or less in duration decreased from 38 per cent in 1993 to 15 per cent in 2003 (Department of Health, 2004a).

As would be expected the intensive services have been targeted at those with highest levels of need. Comparisons between those receiving home care services in the mid 1980s and those in the mid 1990s show that those who were physically and cognitively more dependent were receiving social care services more frequently than a decade earlier (Bauld et al., 2000). Those with lower levels of need are increasingly purchasing support services independently of social services. The estimated number of older people with one problem with activities of daily living (such as bathing, dressing, feeding, washing and getting to and from the toilet)

who were receiving private domestic help increased by 151 per cent between 1995 and 1998 (Pickard et al., 2001).

Figure 6.2: 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)

A number of observers have identified how important domestic and associated help are to older people (Hirst et al., 1995; Quilgars et al., 1997; Clark et al., 1998). In addition to focusing on those with highest levels of need there has been a withdrawal from public purchasing and provision of these activities to focus on personal care and support. The withdrawal from practical support results in conflict between the policy objectives of taking into consideration user views (see section 5) and targeting services on those people and activities that are likely to delay or prevent admission to care homes. The reduction in the rates of increase in care home admissions (see section 5.2) and evidence from research (Davies et al., 2000) suggests that this latter objective is being achieved. However, current policies, such as the emphasis on Direct Payments, suggest that the emphasis on consumer choice and control may result in another shift in what is purchased from public funds. The impact of this remains to be seen.

Self-funders

We identified above that there had been a dramatic increase in the number of individuals purchasing private help. Clearly this includes private domestic arrangements between individuals as services from agencies. Evidence is mixed on exactly what the proportion of care from home care agencies is purchased by private clients. A study by UKHCA conducted in 2000 suggested that 40 per cent of care hours were purchased privately, compared with 27 per cent estimated by a study conducted by Laing & Buisson at the same time (Laing & Buisson, 2003a). Recent changes in VAT rules mean that home care is now exempt so prices to private purchasers will be reduced. However, aside from this, Laing & Buisson (2003a) identify that self-funders are routinely charged more than local authority service users, due both to what is purchased (in terms of tasks and qualifications of staff) and their lack of bargaining power compared with local authorities.

Contracts

Many providers of home care services have a combination of different types of contract with local authorities. The most predominant type of contract is the call-off contract (see Box 1) not associated with (or contingent on) any agreements with respect to quantity of services provided. Over half of providers in a study of 155 home care providers in 1999 were entirely dependent on this type of contract, and over 80 per cent had a contract of that type with at least one authority (Forder et al., 2004). Ware and colleagues (2001) reporting on the same study note that voluntary providers in some areas retained a protected place: grant aided or having partnership agreements with guaranteed contracts. The most preferred type of contract among providers was the block contract (34 per cent) or cost and volume (30 per cent) (Forder et al., 2004).

At the micro level services are frequently commissioned by care managers on behalf of services users in terms of a given length of visit for specific tasks for particular times of day. Patmore (2003) found that some providers had scope to amend the timing of visits but very few could make even very modest increases in the amount of time without express permission. In such circumstances the level of control that the provider has is minimal, reducing scope for flexibility in responding to changes in circumstances or preferences of the service user. We know of at least one instance (there may well be more) where a more global approach to commissioning services is being adopted, whereby a level of funding is provided and the details of service delivery are negotiated between the provider and service user. Clearly the level of trust between providers and purchasers needs to be much higher for this

type of arrangement to work, but there is potential for delivering care in a way that much more closely reflects both user preferences and variations in those preferences.

Prices and mark-up rates

In 1999 prices of home care were associated with nursing qualifications among care staff, dependency of service users in terms of incontinence and special needs and whether live-in services were provided. The mark up rate of price over cost was estimated as about 12 per cent (Forder et al., 2004). Demand and supply were found to be very responsive to changes in prices, with a 1 per cent price rise resulting in a 6.6 per cent reduction in demand and 8.1 per cent increase in supply (Forder et al., 2004). Subsequent analyses of local authority level data with long-run supply curves for home care were found to be even flatter than those for residential care (see section 6.2), which indicates a very high competition, and even lower rates of actual mark-up (4 per cent) (Fernández and Forder, 2002).

As in the care home market, local authorities have used their purchasing power to keep prices down. The prices paid to the independent sector are consistently below the estimated costs of in-house services (Netten and Curtis, 2003). Pressures on providers are increased by the general practice of local authorities paying on a per hour rate and then commissioning care for half-hour periods or less.

Rather than driving providers out of the market the implications of this downward pressure on prices appear to be primarily for the conditions of employment of the care workers and for the quality of care provided. For example, independent providers complain that no allowance is made in the fees for care worker travel between visits and as a result they frequently make no allowance for travel when organising care (Starfish Consulting, 2002; Patmore, 2003; Francis and Netten, 2004). This has implications both for the care workers (who often bear the cost in time and expenses) and for the reliability and level of service received by the service user, especially as the trend has been to provide more and shorter visits of half an hour or even less. It is common practice for care workers to have zero hour contracts. This means they have no guaranteed work and often take second jobs in order to secure more income (Francis and Netten, 2003).

In-house provision

In-house services play a unique role in the home care market. In the 1999 survey of providers none of the authorities had in-house provision organised as a free-standing service that contracted on the same terms as the independent sector. Lack of even-handedness was

identified as a problem for independent providers with preferential treatment given to in-house providers (Ware et al., 2001). In-house providers' costs are higher and provide better terms and conditions for staff compared with the independent sector. Probably as a result, there is also evidence that they provide higher quality services (Netten et al., 2004b).

In-house services are sometimes used as a safety net when authorities find it difficult to get the independent sector to provide services for particular types of client (such as those with challenging behaviours or those living in remote areas) or when services are required at short notice, for example following hospital discharge. In a recent small scale-study five of 11 in-house providers were found to be negotiating with purchasers new specialised roles as short term rehabilitation teams or services for complex disorders (Patmore, 2003).

Entry and exit

There are no data currently available on levels of exit and entry in the home care market. Clearly the barriers to both are much less formidable than those in the care home market. The principal administrative barriers to entry are the registration process and gaining contracts or accreditation from purchasing authorities. However, the industry is fundamentally dependent on the workforce and the very tight labour market conditions that prevail in many parts of the country constitute a potential barrier to entry and incentive to exit. Indeed there are few barriers to exit from the market, making it potentially unstable if subject to excessive regulation or further downward pressures on fees.

In encouraging supply it is particularly important to understand the motivations of those who manage and/or own the providing organisations. This is not just in terms of financial or monetary reward, but also in terms of respect for their autonomy as independent operators, and recognition of competence and professional achievements. There needs to be ample opportunity for communication and feedback between purchasers and providers in order to ensure the latter are not demoralised, or feel under-valued (which in turn, would have knock-on effects for those working at lower tiers).

Research suggests that in the case of as many as half of all domiciliary care providers in England, the institutional arrangements that local purchasers have set in place - in terms of participation in fora, review and planning processes, and contractual design for example - have failed to create such supportive conditions (Kendall et al., 2003). This underperformance could be expected to both block desirable market entries, and leave existing providers feeling trapped and frustrated.

Quality of care

Provision of high quality care is fundamentally dependent on the nature, commitment and practices of the direct care workforce. To service users the characteristics of the care worker is one of the most important aspects of quality of the service (Francis and Netten, 2004). Yet this workforce is paid low wages and often receives minimal training. Recruitment and retention problems are widespread and are not helped by the generally poor terms and conditions offered by employers (Francis and Netten, 2003). The impact on quality of care is observable with lower levels of satisfaction with services expressed in areas where there are relatively high levels of female manual wage rates and low levels of unemployment (Netten et al., 2004b).

Motivations and behaviour of care workers has a profound impact on the service user experience, particularly when care workers are working under the types of pressures resulting from increased targeting of services and contractual requirements identified above. Often care workers will provide additional care in their own time to compensate for what they see as poor quality care. In other instances they will be prepared to bend the 'rules' (Francis and Netten, 2003). The 'rules' about what can and cannot be done are applied differentially at local authority, provider and individual care worker level. While some service users benefit from providers and care workers who are prepared to bear the costs themselves, others do not. This suggests that under the types of pressures that currently apply, home care is fundamentally inequitable.

Conclusions

The market in home care has developed rapidly in recent years. The rapid expansion of independent provision reflects the general lack of barriers to entry. However, major problems face providers in terms of the downward pressure on fees paid by the major purchasers, local authorities, combined with rising costs and demands in terms of National Care Standards and quality requirements by purchasing authorities. There are shortages in the largely unqualified workforce, and recruitment and retention problems that are not helped by the generally poor terms and conditions offered by employers (Francis and Netten, 2003). Although there have been some central government grants allocated to local authorities to support recruitment and training, the majority of the costs of administering the NVQ process and any associated training will largely fall on businesses where there is no evidence of substantial surpluses on which to draw.

Prices, fees and the resource commitments they make possible are clearly key ingredients in determining what is and is not possible in terms of both the quantity and quality of the services provided. However, it is important to recognise that delivering home care is not purely a matter of performing particular tasks, or providing predetermined interventions. Social interaction between the user and the provider, involving the development of a relationship over and above the provision of discrete services, is also an important dimension of care (Gui, 2000; Ben-Ner, 2004). The current downward pressure on fees, tightly constrained forms of commissioning and consequent lack of time for care workers to spend with service users are all adverse pressures on the quality of care provided.

6.2 Care homes

Residents of care homes comprise one of the most vulnerable groups of people. It is not surprising, therefore, that concerns about the operation of the care home market in recent years have received considerable public attention (House of Commons, 2000; Bunce, 2001; Mitchell, 2001; Pollock, 2001; Steele, 2001). Most recently, in response to a request by the Consumers' Association, the Office of Fair Trading (OFT) has carried out a study to assess the impact of price information on competition and choice among care homes for older people (Office of Fair Trading, 2005). Here we start by describing the development and structure of the market, before discussing the impact of public policies on that market in recent years.

Development and structure of the market

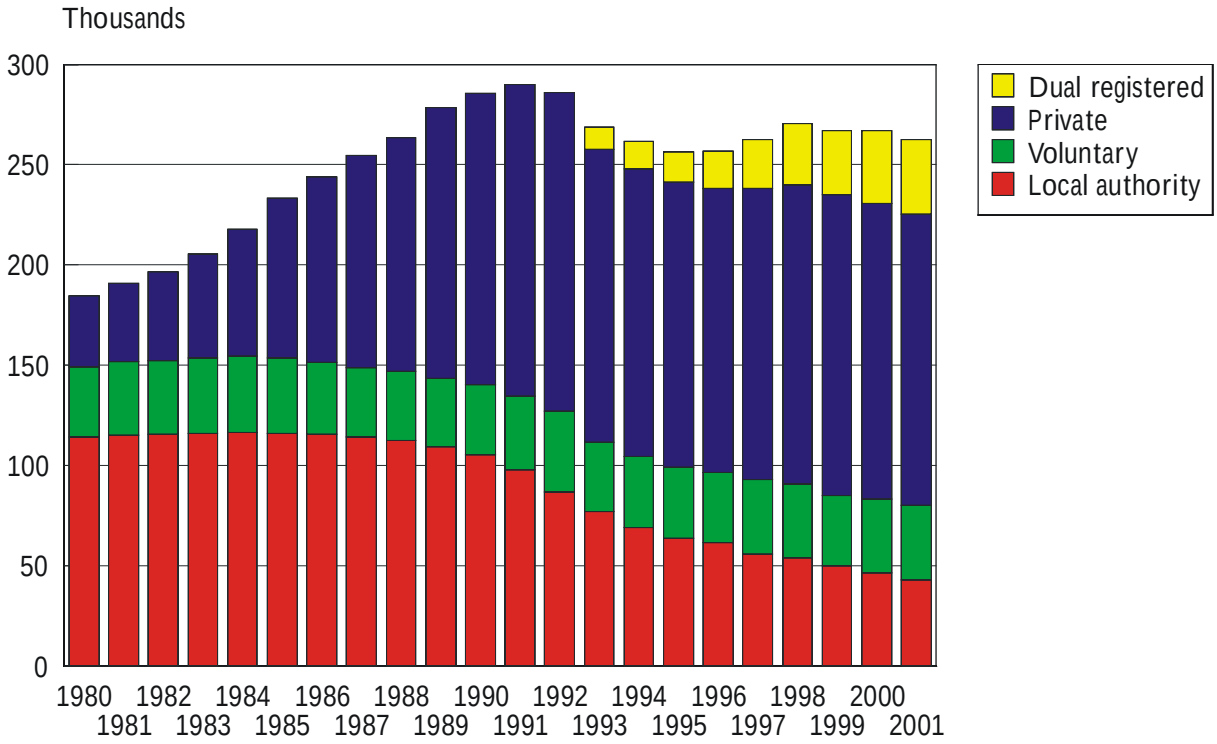
In contrast to home care, the growth and change in the structure of the market in care homes occurred during the 1980s (Darton and Wright, 1993). Until the introduction of the new regulatory regime in 2002, homes were registered as nursing homes, residential homes or dually registered to provide both types of care. Figure 6.3 and 6.4 show how the numbers of care home places rose dramatically during this period, fuelled almost entirely by growth in the number of private places[4]. In the nursing home sector, which was dominated by for-profit providers, which started from a lower base, the increase was even more pronounced. This was due largely to a change in the eligibility rules which resulted in an increase in the support available to residents from the social security system. The availability of social security funds, without any associated assessment of need, was identified as a perverse incentive towards institutional care (Audit Commission, 1986), contrasting with the long-standing policy objective to support people in the community with home-based care.

[4] Changing definitions make comparisons over time difficult. Figure 6.3 includes places for younger disabled people and 6.4 includes all nursing home places. However, in practice the vast majority of places are for older people, only 3 per cent of residential places are for younger disabled people.

Under the 1990 NHS and Community Care Act arrangements, introduced in April 1993, local authorities took on the responsibility for assessing all publicly-funded admissions to care homes and for meeting the costs of care. Although the transfer of responsibility to local authorities was associated with problems of implementation, the transition did not produce the anticipated fall in occupancy rates or closures of independent homes that had been feared (Laing & Buisson, 1995). Instead, as Figure 6.3 shows, the reduction in numbers of places in local authority managed homes that predated the Act accelerated. In 1982 50 per cent of all care home places were in the public sector. By 2001 this had dropped to less than 10 per cent of places and the NCSC estimated that in 2003 only 6 per cent of places for older people were in the public sector (Dalley et al., 2004). However, the level of occupancy in independent homes declined compared with the time just before the reforms were instituted (Laing & Buisson, 1997). Despite these factors, overall levels of residential and nursing home places in England continued to rise until 1998 (Department of Health, 2000d, 2000e).

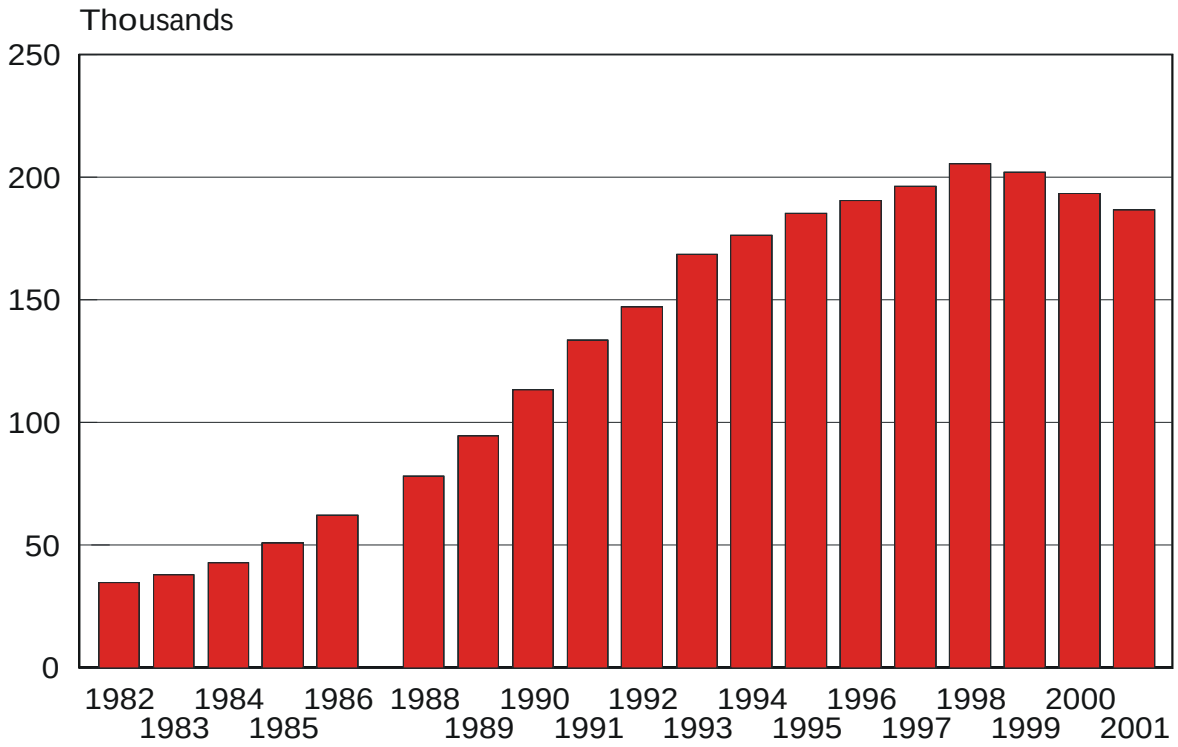
However, since 1998 there has been a downturn in the level of provision of residential and nursing home care, particularly of nursing home care. Between 1998 and 2001, registered beds in nursing and mental nursing homes in England decreased by 9.5 per cent (Department of Health, 2002g), and places for older people and mentally infirm older people in residential homes decreased by 3.2 per cent (Department of Health, 2001d). Changes in responsibility for routine data collections since 2001 make comparisons difficult. Laing & Buisson (2003b) suggested that care home de-registrations appeared to have passed their peak. However, according to the NCSC there was a decrease of 6 per cent in the number of registered independent homes between April 2002 and October 2003 (Dalley et al., 2004), which would suggest homes were continuing to close at a similar rate to the rate in 2000. The overall decline in care home places masks regional variations in provision. For example, in 2001 there were 437 residential care places per 10,000 population aged 65 and over in England as a whole, but the corresponding figures for inner and outer London were 280 and 343 respectively (Department of Health, 2001d).

Figure 6.3: Places for older people and younger physically disabled adults in residential care homes in England: 1980-2001



Source: Department of Health statistics

Figure 6.4: Beds in nursing homes in England: 1982-2001



Source: Department of Health statistics

Although care homes are no longer registered separately for residential or nursing care, it is helpful to maintain the distinction, as in terms of dependency of residents, size, costs and ownership these types of home remain very different. Nursing homes have more dependent residents, are larger and charge over £100 more per week. Ownership of private residential homes is concentrated among small organisations, with only 10 per cent of homes run by major providers (those running three or more homes) in 2003. Among nursing homes, however, major providers ran over a third (37 per cent) of homes (Laing & Buisson, 2003b). This represents a substantial increase in concentration of ownership. In 1992 major providers owned only 16 per cent of homes. However, Laing & Buisson (2003b) argue that 'the process of consolidation has a long way to go before it makes any major impact on market structure' (p.77). We discuss below some of the pressures that have led to the increasing levels of concentration.

Self-funders

The entitlements to public funding to meet care home fees are determined at a national level. Those whose assets exceed a certain level, £20,000 in 2004/05 (Department of Health, 2004c), are required to fund their own care ('self-funders'). The 1999 Royal Commission

(Cm 4192-I, 1999) recommended that personal care be removed from means-testing and made available according to an assessment of need. The government rejected this for England (Cm 4818-II, 2000), but did make a number of changes, including removing the anomaly that self-funded residents of nursing homes were charged for health care provided by nursing staff. Since 2001, self-funded residents have been assessed for payments based on three bands of nursing needs.

Although in the minority (about a third of residents), self-funders are a large group and are of growing importance as the rise in home ownership means that an increasing proportion of older people will be responsible for meeting their care home fees. From the local authority perspective, the perverse financial incentive identified by the Audit Commission in the 1980s remains for homeowners. While those with assets above £20,000 remain in the community, depending on local charging arrangements, a proportion of the costs of their home care will usually be borne by local authorities, whereas they will be responsible for all their care home fees, at least after the first three months[5].

A number of observers have identified that self-funded residents have tended to be charged more than publicly-funded residents for the same service (Darton and Wright, 1992; Laing, 1998; Netten et al., 2001). Clearly self-funders have very little market power in comparison with purchasers of publicly-funded care so it is not surprising that there is evidence of price discrimination. However, local authorities still have an interest in the level of fees being paid by self-funders as once they have reduced their assets (so-called 'spend-down') the authority becomes liable for their fees. Although technically they could require people to move into another home if the fees are too high, such moves are not in the residents' interests and tend to draw a lot of unwelcome publicity. In the past some authorities have had policies whereby self-funded residents are admitted to homes under the same arrangements as publicly-funded residents and then recoup all the fees. In other instances they have used their market power to keep fees for self-funders down in those homes where they purchase care for publicly-funded residents. Possibly it was as a result of these policies that there was some evidence that prices were tending to converge at the end of the 1990s (Netten et al., 2002a). However, pressures since then have been such that the latest Laing & Buisson market survey reports that self-pay fees are typically £50-£100 higher than local authority fees for similar provision (Laing & Buisson, 2003b).

[5] For those whose assets excluding their home are less than £20,000 the authority pays the fees for the first three months to enable people to return to their own homes.

Prices and mark-up rates

Analysis of factors associated with independent home prices in the mid 1990s found that although dependency characteristics of residents were associated with prices the relationship was very flat within home type, although there was a more marked relationship between price and dependency in voluntary than in private residential homes. The majority of the impact of dependency on prices occurred through the use of nursing or residential places (Netten et al., 2001). In terms of what the home was providing, the proportion of single rooms had the largest impact on prices in both residential and nursing homes, although the percentage difference in price was higher for nursing homes than in residential homes. Residential homes with fewer than ten places charged lower prices, single nursing home organisations charged higher prices and private homes were found to be slightly more costly than voluntary homes overall. However, all these effects were negligible compared with the effect of the local labour market. Female wage rates were used to proxy labour input prices. The relationship between wages and prices was particularly sensitive in residential care, with a one per cent rise in wages being associated with a 0.81 per cent rise in prices. This is of particular significance when we consider the subsequent pressures on homes discussed below. Overall mark-up rates were modest, estimated at about 10 per cent at the time of the study (Darton et al., 2003a).

Subsequent analyses at the local authority level, based on 1998-2000 data indicated that average mark-up rates over average costs were well below 10 per cent of total weekly revenue (Fernández and Forder, 2002). We cannot predict what constitutes a sustainable level of mark-up in the longer-run, but values below 10 per cent would certainly seem to raise questions about long-term sufficiency of supply. The analyses also indicated high levels of competition in the residential care market (Fernández and Forder, 2002). This finding is not surprising: the largest local authority in England has over 1000 residential and nursing homes, and the average is nearly 200.

The results indicated a very significant degree of geographical variability in market conditions. Even controlling for their local supply-relevant conditions, many local authorities were found to be operating with non-sustainable prices in the long-term. Some authorities had prices that were around £60 less than predicted long-term supply price for those authorities when accounting for their supply conditions (Fernández and Forder, 2002).

Market entry and motivations

High house prices constitute one potential barrier to new entrants. Most care homes are in converted premises, rather than new build. However, in the future a need to comply with the National Care Standards means that it is probable that new build costs and availability of land will be more relevant. Other barriers to entry include workforce shortages, uncertainty and lack of confidence in terms of likely returns.

Residential care providers, like domiciliary care operators (see section 6.2), should not be understood purely in terms of monetary reward and financial viability. While these aspects are important, so too is allowing caring professionals to develop their potential and putting a premium on a range of rewards and achievements (Kendall, 2001). Providers value a significant degree of autonomy (control over their own affairs) and the provision of opportunities for them to express their caring professionalism inside and outside the home. As in home care, arrangements between purchasers and providers need to find ways of facilitating mutual respect and acknowledgement, whereby committed and well-motivated providers feel recognised. There may also be implications for contracting and regulation strategies. For example, while block contracts carry well-rehearsed advantages in terms of risk sharing and planning, great care must be taken to ensure they do not inappropriately stifle providers' freedom of action, and do not result in too much loss of control over the admissions process. In terms of regulation, inspections and the arrangements that underpin them should not only focus on homes' input and structural compliance, but also find ample room for providers to demonstrate their empathy with residents, and express how this is reflected in their home's ethos, and in relationships within the home.

Market exit

The reduction in care home capacity since 1998 owes less to the general policy of maintaining people in the community than it does to a combination of other government policies, rising costs and opportunities to exit from the market. Our analyses of costs and prices discussed above suggested that rises in levels of dependency associated with delaying admission to care homes were less likely to be critical to homes than pressures on wage rates. In section 2 we described the downward pressure on prices being paid by local authorities resulting from central government efficiency targets and other incentives to keep local authority expenditure down. For much of the 1990s, fee increases for publicly-funded residents were kept below the Retail Price Index level, while staff costs were being affected by the National Minimum Wage, introduced in April 1999, the Working Time Directive,

introduced in October 1998, and a substantial pay award to nurses announced in February, 1999 (Laing & Buisson, 1999).

The same year that the National Minimum Wage was introduced, a consultation document was issued on the proposed National Minimum Standards (Department of Health, 1999b). No funding was to be provided, and homes were expected to meet the costs of any adaptations or investment required to meet the standards. With the exception of some funding provided to local authorities to facilitate recruitment and retention in social care generally (Department of Health, 2003g), this remains the case.

In addition to these policies, the situation in the markets for inputs was also adding pressure on homes. A national survey of regulators found that the most widespread factor perceived as influencing nursing home closures was the shortage of nursing staff (Netten et al., 2002b). This was potentially being exacerbated by government initiatives aimed at tackling shortages of nurses generally by encouraging qualified nurses to return to the NHS (Department of Health, 1998), again putting pressures on homes if they were recruiting from the same pool of staff. In areas of high employment there were particular concerns about the supply of direct care staff, and a number of respondents mentioned problems in recruiting management staff (Netten et al., 2002b). These pressures were also seen as threatening the capacity to care in homes that remained open as the recruitment of good quality, highly motivated staff is fundamentally important to quality of care. This was seen as particularly important in private residential care homes where the dramatic increases in levels of dependency since the 1980s meant that many homes that opened then were now caring for a very different population (Netten et al., 2002b).

The cost, policy and workforce pressures came together at a time of rising house prices, facilitating those owners, particularly of converted properties, to exit the care market. It was this opportunity to exit and lack of opportunity for selling homes as going concerns, rather than the opportunity to make a quick profit, that pushed people into closing homes. Interviews with providers of homes that had closed found that it was principally the combination of long-term downward pressures on fees, rising costs, need for investment to meet the new care standards together with little prospect of return that culminated in the decision to close (Williams et al., 2002).

Consequences of home closures

The rise in home closures reduced overall capacity. In some parts of the country, particularly the south, there were serious concerns about whether the market would be able to meet

demand in both the short and long term (Netten et al., 2002b). From a central government perspective the principal issue was the potential impact on acute beds in hospitals, and analyses did establish important links between the functioning of the social care market and delayed discharges (Fernández and Forder, 2002). The response was the 2001 concordat and associated expenditure (see section 2).

However, the issue is not just overall capacity, but what types of homes are being lost. In terms of local shortages, most concern was expressed by regulators at the lack of specialist accommodation for older people with mental health problems, particularly dementia (Netten et al., 2002b). Nursing homes have been reported as being particularly vulnerable because of the additional cost pressures associated with employing nursing staff, and reductions in demand associated with authorities adopting policies of placing high dependency residents in residential homes with additional payments (Netten et al., 2003b). Nursing homes that closed also appeared to have higher quality of care than residential homes (Netten et al., 2002b).

A 2001 follow-up of homes that had participated in a national survey in 1996 found that homes that closed tended to be smaller, to have had lower occupancy levels in 1996, to be the only home run by the organisation, and to occupy converted buildings, with poorer facilities and more shared bedrooms (Darton, 2004). There are a number of reasons why smaller homes are the most likely to be lost. If larger homes are having problems, purchasers will be more concerned about the impact of their closure on local capacity, and will be more prepared to negotiate more favourable contracts or prices. Economies of scale mean that larger organisations can bear the costs of regulation more easily than small businesses (Holden, 2002). However, a concentration of ownership would reduce the choice available to prospective residents. Although policy documents emphasise ‘homely’ or ‘domestic’ environments (Cm 849, 1989; Centre for Policy on Ageing, 1996; Department of Health, 2001e), there has been a long-term trend towards larger homes, particularly in the nursing home sector (Laing & Buisson, 2003b).

Standards of physical provision have shown steady improvement, in response to market forces, demands from local authority purchasers and the requirements of inspecting authorities (Laing & Buisson, 2001). Although homes that existed before April 2002 will no longer have to meet the national minimum standards for bedroom sizes, it is quite likely that market pressures will force them to upgrade their facilities to compete with homes that do meet the standards, or to close. The amended standards (Department of Health, 2003d) indicate that care homes should specify the details of the physical environment provided by the home so that people choosing a care home can make an informed choice. Failure to

upgrade facilities will lead to a two-tier system of homes that do and do not conform to the standards.

Although aspects of the physical environment will have an important influence on quality of life, for example privacy, the social climate or atmosphere of the home will be central to quality of life (Timko and Moos, 1991). Relatives of residents have cited the atmosphere as the most important factor in selecting a home (Netten et al., 2002a). In an analysis of data collected on social climate in the national survey in 1996, using the Sheltered Care Environment Scale (Moos and Lemke, 1994, 1996), homes identified as having a more positive social environment were those occupying smaller, converted premises and having lower occupancy levels (Darton et al., 2003b), exactly the types of home most likely to have closed.

The evidence suggests that it is not poor quality homes but primarily smaller private homes and organisations running one or two homes that are the most likely to close. The implication of this is a loss of diversity in provision. Fewer homes overall, and relatively more larger homes in corporate organisations mean reductions in choice for future residents, in terms of both type of home and location. Location is the single most important factor for residents and their relatives once the decision to enter a care home has been made (Netten et al., 2002a), and small homes in small towns, serving largely rural areas, are the least likely to survive. Where such homes do close, residents are faced with the problem experienced in all areas with low levels of supply, such as parts of London, namely that of travelling a considerable distance to find a suitable alternative. Current residents will be placed in the position of having to find a vacancy in a limited time period, and might feel obliged to agree to the first vacancy or home that is suggested to them by a care manager due to a lack of any alternatives (Williams et al., 2003). In cases where residents have moved to a home to be nearer to their children, they may be forced to move further away again.

The closure process

The care home market is like none other in that it so fundamentally affects so many aspects of consumers' lives. Moreover, the consumers are, as we have noted, by definition one of the most vulnerable groups of service users. Such a potentially stressful and traumatic event as involuntary relocation is likely to involve health and safety risks for current residents. There is a popular perception that care home closures cause increased mortality among residents, but evidence is ambiguous (Smith and Crome, 2000). Given the dependence of residents it is surprising that there is not more in the way of safeguards and guidance. Currently there is a lack of central policy guidance aimed specifically at how independent care homes close or

how councils safeguard residents' welfare. Not all councils have guidelines in place and where they do their recommendations vary or fail to address important areas of concern for residents and relatives, such as how best to support residents with dementia (Williams and Netten, 2003; Williams et al., 2003). It is likely that any risk to residents is affected by the way in which a home is closed and service users should be offered access to fair, flexible and responsive help and support during such a time of potential crisis and upheaval. In practice access to such support appears patchy at best. For example, case study research found there was no evidence of increased vigilance by inspectors to ensure that standards were maintained and residents' safety was protected (Williams et al., 2003).

Conclusions

The evidence from the 1980s suggests that the care homes market was able to respond rapidly to economic signals. However, it could be argued that the development of the market was strongly influenced by a particular set of circumstances, including the availability of property suitable for conversion, the existence of suitably-qualified and entrepreneurial individuals, and a supportive political environment.

The culmination of a period of downward pressure on prices, the introduction of the National Minimum Wage and the proposed implementation of costly care standards could be represented as a one-off event, resulting in those businesses that were already in financial difficulties going out of business, and hence the dramatic rise in closures during 1999–2000. However, the evidence suggests that this rate of closure has been sustained in subsequent years, together with a dearth of new entrants, with the consequent implications for future capacity.

Cost pressures are particularly intense for those homes caring for the most dependent residents, nursing homes and specialist homes for older people with dementia. Particularly for people with dementia, there is some evidence of real shortages in appropriate provision. Workforce shortages have implications both for future costs and quality of care for increasingly dependent residents. Barriers to entry to the care home market have always included the capital costs of setting homes up. These will be higher than in the past, both because of the rise in house prices and because of the national care standards.

The decline in care home provision has been greater among the smaller businesses operating smaller homes, with less ability to re-negotiate financial arrangements with purchasers and operating in premises that do not meet the care standards. In addition to the impact of financial pressures on homeowners, some of the decline may be the result of a cohort effect,

with owners seeking retirement. This, together with the increased barriers to entry suggests that future developments may have to be sought from the larger providers of larger homes, which has implications for choice and diversity.

An industry comprising a lot of small businesses, as the care home market undoubtedly remains, is always going to have a level of turnover. This means that homes will always close 'voluntarily' as well as closure as the result of regulatory action. Necessarily there will be a loss of welfare to those residents affected, at least in the short-term. This can be mitigated by good practice during the closure. Policy makers, the CSCI and local councils need to review the extent to which home closures are monitored, managed or controlled.

6.3 Extra care housing

The term extra care housing has emerged in recent years, and covers a range of types of housing for older people characterised by the integration of housing and care, although since such a variety of schemes have been included under the umbrella term, definitions are very difficult. Housing and care schemes for older people can be traced back to the post-war reconstruction of housing. Although the immediate emphasis was on housing younger families, the need for a range of types of houses to meet the varying requirements of the population as a whole was recognised (Ministry of Health, 1949), including the provision of special accommodation for older people with the aim of freeing-up larger houses for families (Ministry of Local Government and Planning, 1951). Sheltered housing, which was originally intended for older people who were not in need of the degree of care provided in care homes, was seen as part of a continuum of care. At a minimum, sheltered housing provides an alarm system and warden (or equivalent) support (McCafferty, 1994).

The early developments of extra care housing, often termed very sheltered housing, originated in the late 1970s and early 1980s and were based on providing greater levels of care, including meals, to residents of sheltered housing. These schemes had enhanced design features, more extensive warden cover and domiciliary services were arranged to supplement the warden cover (Reed et al., 1980). More recently, local authorities have considered the development of integrated care and housing as an alternative to care homes, particularly for physically frail older people. For example, Wolverhampton has developed a new strategy involving the closure of local authority residential homes, the development of new very sheltered schemes, the establishment of resource centres for community support and the provision of specialist centres for older people with mental health needs (Bailey, 2001). A number of other housing models for older people are also being developed, in particular the retirement community model, derived from developments in the United States (Phillips et al.,

2001; Streib, 2002), and developments in other European countries are informing new forms of housing arrangements, for example co-housing (Brenton, 2002). It is not possible here to consider the international picture systematically, but it is worth noting that the types of housing and care arrangements that are developing do seem to vary between different countries, influenced perhaps by cultural factors as much as by market incentives and regulatory context.

A number of factors have been identified as stimulating the development of extra care housing: a greater need for care and support among people in existing sheltered housing; the unpopularity of some ordinary sheltered housing schemes; poor quality local authority residential accommodation; and developments in services and buildings enabling people to age in place (Fletcher et al., 1999). The government has supported the development of extra care housing by announcing plans for an expansion in provision and providing some funding (see below). Heywood et al. (2002) suggest that the changes in government views on the role of housing in community care were influenced by: the roles of home improvement agencies in enabling people to remain in their own home; the supposed potential of sheltered housing, especially very sheltered housing, to provide a cheaper alternative to residential care; and the greater profile of housing associations as reliable providers of services.

Ownership and tenure

The majority of extra care and sheltered housing is provided by the social rented sector, either by local authorities or, increasingly, by registered social landlords (RSLs). This contrasts with the dominance of owner occupation among older people as a whole. Private sector sheltered housing, which is usually referred to as retirement housing, is usually purchased on a long lease, or less often as a freehold (Laing & Buisson, 2003c). Developers of private retirement housing include for-profit and not-for-profit organisations: the term 'private' refers to the ownership of the property (Laing & Buisson, 2003c). However, some providers offer properties for purchase or rent. Private retirement housing has received very little attention in the literature (Dalley, 2001), although Laing & Buisson provide detailed information about housing and care in their annual publications. In private retirement housing there is an emphasis on the property and property-related services rather than any care and support provided, but providers are increasingly developing extra care housing (Laing & Buisson, 2003c). The number of private sector developments declined sharply during the 1990s, following the economic downturn in the early part of the decade (Dalley, 2001). The health of the market is closely connected to the general housing market, since purchasers need to sell their existing homes before purchasing retirement housing (Laing & Buisson, 2003c).

In recognition of the growth in home ownership, some providers of rented schemes have considered developing mixed tenure schemes, for example the ExtraCare Charitable Trust (Appleton and Shreeve, 2003). However, there are questions about the acceptability to residents of some developments, for example mixed tenure and schemes that provide facilities to other members of the community (Bessell, 2004, private communication).

Supply

Problems in defining extra care housing create difficulties when it comes to describing overall levels of provision. Sheltered housing in England, defined as accommodation with a warden, provides accommodation for around 600,000 people, of whom 86 per cent live in social or public sector schemes (Office for National Statistics, 2000). Thus, at the time, the overall levels of provision in sheltered housing and care homes were broadly similar (Audit Commission, 1998; Conway, 2000).

Initially, the growth in the provision of extra care housing was slow. By 1997 it only accounted for approximately 3.5 per cent of the *c*.500,000 sheltered housing and very sheltered housing units in England (Tinker et al., 1999). However, there has been considerable expansion since then by some housing associations, such as Anchor and Hanover, although some developments have been conversions of sheltered housing schemes rather than new build (Tinker et al., 1999). Private providers accounted for approximately 9 per cent of the units in England in 1997, and housing associations had increased their ownership to 35 per cent (Tinker et al., 1999). Taking a broad definition of extra care schemes, the Elderly Accommodation Counsel identified 596 schemes in England in 2003, providing around 21,000 dwellings (Department of Health, 2003h).

The government announced plans for a 50 per cent increase in the provision of extra care housing places from 1997 (Department of Health, 2002a), and this was subsequently quantified as an additional 6,900 places (Department of Health, 2002h). However, since the extra provision will be developed in conjunction with local authorities, housing associations and other providers, and some units may provide accommodation for couples, it is unclear how the additional number of places can be reconciled with the percentage increase to the figures given for 1997 by Tinker et al. (1999). In supporting the development of extra care housing, the government has recognised the need to identify whether it is to complement existing provision or to provide a substitute for residential care but, to date, has not clearly identified what they want to expand (Department of Health, 2003i). Successful extra care housing may need to accommodate residents with a wider range of levels of dependency than

are currently cared for in care homes, which could be difficult to justify on cost grounds. Whatever the objective, the projected growth is from a low current level of provision.

Funding

The availability of Housing Benefit has been central to the development of extra care housing, which has been able to develop opportunistically (Oldman, 2000). With the introduction of the *Supporting People* arrangements there were concerns that local authorities may develop extra care housing to transfer costs to social security funding (Laing & Buisson, 2003b). Such concerns have been reinforced by the growth in the *Supporting People* grant from the original estimates (see section 2). It is known that, in at least some instances, in private schemes that previously drew on Housing Benefit, *Supporting People* funding is being used to meet the revenue costs of care in extra care housing. Any attempts to cap the rapid growth in expenditure from this source would potentially have important implications for these schemes.

There is a shortage of capital funding needed to support these developments in the public and voluntary sector (Fletcher et al., 1999), particularly if provision is to expand as the government hopes. The creation by the government of the Extra Care Housing Fund (Department of Health, no date) provides the opportunity for a number of schemes to obtain capital funding, but limits on the funds in the first year available meant a large number of proposals were not successful (Department of Health, 2004d). New funding opportunities using Public Private Partnerships, such as the Private Finance Initiative, are being used to develop schemes, but further development of partnerships at the commissioning and development stages and innovations in construction and remodelling are needed (Fletcher et al., 1999).

Demand

Demand for specialised housing for older people cannot be viewed in isolation from housing more generally, since developments in housing provision will have an impact on the need for specialised housing. For example, the development of Lifetime Homes (Kelly, 2001; Joseph Rowntree Foundation, no date) represents a macro approach to design which attempts to accommodate the widest possible client group in mainstream housing, rather than the piecemeal adaptations and repairs that characterise the micro approach of tailoring older people's homes to their specific requirements (Hanson, 2001). Such developments should reduce the need for people to move because of design problems; the development of Staying Put and Care and Repair schemes undertaken by home improvement agencies (Harrison and

Means, 1990; Oldman, 1990) should maintain the housing fabric; the development of assistive technology (Tinker et al., 1999; Brownsell and Bradley, 2003; Fisk, 2003) should help people to create a more responsive environment; and the development of financial products to enable people to withdraw some of the capital invested in their homes should provide the resources for maintenance and improvements. However, these developments are not likely to have major impacts and, in the case of financial products, there are continuing concerns about their security and financial efficiency, following problems with equity release products in the past (Appleton, 2003).

For the increasing number of owner-occupiers, entry to a care home usually requires the sale of their home and the loss of financial status as a property owner, as well as the requirement to pay substantial weekly sums for accommodation and care, without any obvious means of separating the costs of care from the costs of housing. Extra care or very sheltered housing provides residents with a means of safeguarding their capital and a flexible package of care on the domiciliary model. Thus, residents are not constrained to purchase the equivalent level of care provided in a care home. Each resident has substantially more accommodation than in a care home and the privacy and independence given by self-contained accommodation. While for very dependent people the overall costs may well be higher than receiving the equivalent level of care in a care home, the clear distinction between care and accommodation costs mean fees are more likely to be more acceptable. It is likely, therefore, that the demand for this type of accommodation will grow as people become more aware of the option. The question remains, however, whether the market will respond.

Barriers to entry and exit

The previous discussion made clear the market in extra care housing is currently dominated by the public and voluntary sector, where a lack of capital funding is a major barrier to expansion. From the private sector perspective, although the greater size of the accommodation requires a larger initial level of investment, Laing (2002) argues that the greater potential for alternative use suggests that extra care housing developments are inherently less risky than care homes, so that long-term financing can be achieved at lower rates of return. Moreover, leasehold arrangements reduce the level of capital that needs to be tied up in these schemes. However, there does not seem to be a wholesale rush into this area of provision, although there are examples of companies converting existing homes into extra care housing schemes. One major issue is the availability of land, both physically and in terms of planning permission, as these schemes demand larger physical areas for each tenant or resident than care homes.

In terms of developing innovative housing and care arrangements, regulatory arrangements may cause some barriers. Where an extra care scheme provides personal care to the residents, it has to be registered as a care home, whereas if home care services are provided in the same way as to others living in the community, the relevant agencies must be registered for domiciliary care (Department of Health, 2003i). The burden of the regulatory process is such that schemes tend to avoid providing services directly, in order to avoid registering as a care home. Ideally, service developments would be driven by service user preferences and considerations of cost-effectiveness rather than regulatory concerns.

Conclusions

At present, extra care housing represents a small, and rather ill-defined, aspect of overall social care provision, and one where there is generally a lack of detailed evidence. However, it is a rapidly developing area that has considerable government backing, and early indications from our investigations suggest that it is a welcome development from the perspective of service users. Unlike home care and care homes, it is currently dominated by public and voluntary provision. Potentially, there is considerable scope for much larger private sector involvement. Barriers to expansion include the cost of the initial capital investment required and shortage of capital funding in the public sector. This type of development also demands land, with shortages in many areas and planning restrictions also potentially acting as barriers to new developments.

7. Market performance and levers

Assuming that there is not a dramatic compression of morbidity there will be increasing demand for social care for older people. The level and nature of this demand will depend on the boundaries set for publicly-funded care and on the degree to which home care, housing with care and care homes substitute for one another. We have seen in previous sections that the market for social care is fundamentally affected by the policies and practice of public bodies, by health services and housing and by the markets for inputs to the care process. The question is, given what we know about the historical and current operation of the market, are current arrangements likely to ensure an adequate supply of good quality care services for our ageing population?

Market performance

A critical difference between home care and care home markets in recent years has been that the care home market has been contracting while the home care market has been expanding. The policy to care for people in their own homes as far as possible meant that to some extent an adjustment in the care home market was required. It is important, therefore, that the markets for these services, which at the high end of dependency act as substitutes for one another, are considered together.

A successful social care market should deliver:

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

The evidence presented in previous sections suggests that there is some evidence of success. In terms of capacity overall, the independent sector expanded rapidly in both care homes and home care in response to demand in the 1980s and 1990s. Moreover, the nature of motivations of providers in social care means that the impact of price changes is mediated through people for whom profit is often not the primary motivation so they are prepared to continue in situations where in other industries providers would have exited the market. The result is that for the most part price rises and increases in demand have resulted in rapid expansions in supply but (real) price reductions have a less direct impact. It was not until a combination of circumstances came together that homes started to close in large numbers. Many of these circumstances were directly or indirectly attributable to central government

policies relating to the workforce, regulation of care and incentives and targets for local authorities.

In the care home market prices are now rising. The ability to raise prices has been due to an increase in government funding associated with concerns about capacity problems delaying discharge from acute beds in hospital in compensation. While there is no evidence[6] that capacity is increasing, it appears that the rate of reduction in places does seem to be decreasing as demand and supply adjust.

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 figures 6.1 and 6.2). 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. There is little evidence that low-level domestic support prevents further deterioration.

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.

As we discuss below, there is less evidence of consumer power, but it is possible to represent the market as functioning very effectively in responding to commissioner demand, with some of the potential disadvantages of a contracting market, such as instability, mitigated by the motivations of providers and care workers who have the welfare of older people at heart. However, there are a number of current problems and future challenges.

[6] Indeed the lack of consistent data on supply of care services is of some concern.

There are two types of problem that we need to consider. First there are problems in the way that the social care market works in practice. Second the implications of these and other factors on current and future supply.

Social care market problems

A critical factor in the functioning of the social care market is the lack of consumer power (or whether services reflect individuals' preferences). If the market is to truly reflect the preferences of older people these need to be expressed in the market place or there needs to be a better commissioning process. We have already identified that the key elements required for consumer power are diversity and availability of provision, information about options, empowerment and control. Previous sections have shown that there is often a lack of real choice, a lack of information and advice about the alternatives when they do exist and that older people themselves are often distanced from the decision-making about their care by their relatives, and the role of the local authority.

There are problems in the commissioning process at all levels. Although the situation is changing, there has been a lack of strategic commissioning in the past. Some authorities have used their market power crudely and there is widespread evidence that prices are currently set too low to deliver the quality of services that older people have a right to expect. There is also a lack of service re-design to reflect user preferences. Whilst the balance of care is changing, it is slow and by and large commissioners continue to buy the same things. In attempts to improve commissioning practice there are problems with measuring quality well, with information asymmetries more generally and high transaction costs of monitoring. Moreover, the policy of increased targeting of resources has meant that care managers as commissioners of services have restricted the range of tasks commissioned and the diverse application of such restrictions in practice have resulted in inequity in terms of the services received by older people.

While we note above how increased targeting through the commissioning process has resulted in increased 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.

One important restriction on increasing levels of supply is input market factors. These include shortages and (to an extent related) price rises of the key inputs: labour and capital. In terms of direct care workforce shortages we noted earlier that there are factors that might mitigate this, such as the recent enlargement of the EU, which means that there is a wider population that might be drawn on. The implications of workforce shortages are not just about quantity but also about quality of care, with associated costs of training and the need for the type of career structure and incentives to attract the most suitable care workers, including those with nursing qualifications.

Key inputs into residential-based care including both care homes and extra care housing is the capital investment in physical buildings and land. We have identified a shortage of capital funding in public sector for housing and care. In terms of the private sector high and rising prices in the property market represent a potential barrier to entry for these services, together with land shortages. Land shortages can create problems in terms of finding suitable physical locations, as under use of sheltered housing in the past has been associated with poor location of facilities, high costs and potential planning permission problems.

Even if the market were working perfectly we would expect an industry that included a large number of small businesses to have a relatively high level of turnover. In the case of care homes if homes close every aspect of residents' lives will be affected. In order to minimize the deleterious impact on resident welfare it is important that the home closure process is managed well.

Current and future supply

Historical evidence suggests that increased demand for relatively straightforward services, such as home care and care homes for people with some physical impairment, is likely to result in increased supply. This would suggest that the supply side of the market is sensitive to changes in demand and policies and that future supply should respond relatively quickly to increases in demand. However, there are some important caveats to be put about this. First, there is the degree to which we can generalise from the historical picture to the future: whether overall capacity will expand sufficiently. Second, there is the issue of whether the market will deliver the variety and type of services needed and, third, how to ensure future improvements in quality of care.

Although we have identified above that the independent sector had responded to increased demand rapidly in the past, the picture in terms of overall capacity is very variable throughout the country and lower levels of supply of care home places in London are longstanding.

Moreover, there are 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.

In the future threats to the market responding to increase demands include the fact that providers, particularly in the care home market, have got their fingers burnt in the past. While individuals may be prepared to take risks the threat of high level risk associated with low profits and high levels of regulation is unlikely to attract new entrants. We have identified above other potential threats from input markets, which may undermine future expansion. In terms of the degree to which supply expands to meet demand there is also the issue of current levels of unmet need among older people. We have seen that increased targeting of publicly-funded services has led to those who would have received services in the past purchasing their own home care and evidence that there may be some levels of unmet need among existing service users.

Other things being equal, the market is least likely to respond to increased demand where the barriers to entry are highest and risk is greatest. This is particularly true where substantial capital investment is required. There is an important question mark over the degree to which a shift to flexible housing and care options is possible, and if so whether it will be at the expense of more intensive care provision in nursing homes and homes caring for people with dementia and other mental health problems. Moreover, there is evidence that the market is not delivering services that meet the needs and preferences of black and ethnic minority groups.

There are real concerns about the quality of services and how this will develop in the future. The National Care Standards have been introduced in an attempt to address this issue. However, as we have identified, increased regulation together with the problems of financial viability of small businesses in the care home market can lead to a standardisation of care that results in a reduction in choice and loss of good quality homes delivering what people want.

Levers

It is clear that central and local government policies and practice have a profound impact on the social care market. As such there a number of levers that can be applied to ensure or at least facilitate the market developing in the desired direction. These include funding and financial incentives, targets and performance indicators, commissioning practice, use of in-

house provision, regulation and provision of information advice and training. Table 7.1 sets these against the problems identified above with illustrations of how the various levers might be used. We discuss the use of each lever in turn.

Table 7.1: Problems and levers in market performance

Market functioning	*Funding/ financial incentives*	*Targets & PIs*	*Commissioning*	*Use of in-house services*	*Regulation*	*Advice/ guidance/ training*
Lack of choice/ consumer power	Funding spare capacity. Direct Payments	Choice related Pis?	Contracting for spare capacity. Role of and resources available to CM in advising about services			Improve access and sources of advice
Commissioning practice			Regional groups for commissioning	Transparency and clarity of policies	Code of conduct	Guidance and change agent teams
Home closures	Funding to delay closure and maintain standards		Minimising closures of high quality homes through sensitive commissioning	Source of staff to help sustain quality	Staffing during closure	CG guidance to LAs, LA guidelines and sources of advice to relatives
Input market problems	Pricing to allow higher wages. Direct Payments bringing in other workers Capital funding		Including good employment practice in contracts?		Light touch to minimise impact of standards on labour supply?	Advice to providers on human resource management
Quality	Increased funding/ prices Resourcing training	BV PIs based on user views	Incentives and contracting for quality services		Standards on outcomes rather than inputs Process of inspection	SCIE advice to providers Training care staff
Increasing capacity	Increased funding/ prices	Abandon efficiency targets based on unit costs	Strategic commissioning Improve confidence of providers through long contracts, consultation.	Provide additional services	Consistency and predictability	
Specialist services (EMI, services for BME groups, housing and care options)	Pricing	Outcome or quality-based Pis	Capitation funding arrangements to religious/ethnic/cultural groups. Strategic commissioning. Contracts that minimise risk to provider.	Provide specialized services as exemplars and to meet need		Advice to potential providers?

Funding and financial incentives

Clearly, many of the problems identified above can be addressed through increased levels of resources. We have discussed how in the relatively short term planned expenditure on social services is set to grow by 6 per cent per annum until 2008 in real terms[7] and nearly 3 per cent above inflation thereafter. The primary motivation behind this planned increase in expenditure was concern about the effect of restricted capacity in the social care system affecting the delivery of acute health care, through unnecessary admissions to or delayed discharges from hospital. Whether this increase in funding is will find its way through to the social care market will depend on local authority priorities. Another key factor will be the funding associated with *Supporting People*. Current levels of spending suggest that any curbs associated with concerns about the growth in this expenditure will have an important impact on the rapidly developing extra care housing sector.

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. Clearly, increasing prices is likely to lead to increased levels of supply (given the caveats we have identified), however, given how low prices have been it could be argued that a simple 6 per cent real increase in prices paid would be insufficient to address current problems, such as raising wages and meeting quality standards, let alone both increasing prices and increasing 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 (Ungerson, 2004). 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. Moreover, if Direct Payments became the mainstream model there would be the problem of determining the appropriate level of payments.

Of course there are further resource implications resulting from many of the other levers we identify below. In Table 7.1 we have explicitly identified the need to fund spare capacity if people are to have a genuine choice, at least in terms of care homes and other housing and care options. This may be directly through commissioning authority contracting

[7] By 6 per cent above inflation until 2008 and 2.7 per cent above inflation thereafter.

arrangements or indirectly through prices paid (although we note below the lack of incentives to spend money in this way). There are also resource implications if standards are to be maintained while homes are closing and the process staged to prevent undue distress.

We have also identified that publicly-funded training 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 in social care in recent years (Department of Health, 1999a). These have been very effective in influencing the behaviour of local authorities. However, there is a move to reduce reliance on this approach, as 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. Moreover, authorities have more than enough market power to ensure that price rises are unlikely to be excessive. Using specific targets based on crude unit cost comparisons are not helpful and have probably contributed to some of the current problems in the market. Thus 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. We identified above the lower levels of satisfaction identified by black and ethnic minority older people receiving home 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. This is an area where research evidence is needed in order to help authorities to address the problem, but it is the use of the performance indicator that has both drawn attention to the problem and provided an incentive to address it. 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

Commissioning by local authorities or care trusts occupies such a central role in the functioning of the social care market it has been identified both as an area of concern and as a potential lever for ensuring the market achieves the desired goals. We discuss ways in which commissioning practice under current arrangements might be improved below in terms of regulation and advice and guidance. We need consider the levels at which commissioning takes place for thoughts about more radical changes to the commissioning process and the degree to which the process can be used to address market problems.

Currently the highest level at which commissioning for social care takes place in England is at the level of the local authority or trust. Elsewhere (for example, Australia) core commissioning activities for care home places, including setting prices, take place at national level. Centrally set prices could help to avoid accusations of a 'post-code lottery' in terms of access to services and appear to have resulted in a generally healthy financial situation for the majority of homes in Australia (Hogan, 2004). In Scotland there are moves towards agreeing price levels between representative bodies of local authorities and provider groups. However, such approaches severely restrict flexibility to reflect local input markets or to use incentives to meet particular locality needs. Moreover, it is worth noting that a recent review of pricing and the long-term prospects for the Australian care home industry identified that the heavily regulated arrangements make it difficult for prospective providers to enter the market, restrict consumer choice, curtail innovation in service design and delivery and adversely restrict enterprise mix and investment in the sector (Hogan, 2004). The recommendations of the review were largely deregulatory, although still retaining a high level of government control by comparison with England at least in the short and medium term.

Regional-level commissioning can have the advantage of economies of scale in terms of commissioning expertise and increasing market power. The previous discussion suggests that, if anything, local authorities have too much market power in most social care markets. For larger authorities it is more likely that regional level commissioning will add another tier of bureaucracy than result in economies of scale in terms of expertise. However, grouping of authorities such as London boroughs and adjacent smaller metropolitan districts where there is a lot of cross-boundary activity by providers might have advantages. In addition to sharing expertise, the process would allow sharing of information in terms of commissioning requirements and potentially help providers in providing consistent administrative arrangements.

At regional, local authority or trust level strategic commissioning, including population needs assessment, workforce planning and need for innovative care approaches, can assist current and future providers evaluate opportunities so facilitating expansion both in terms of general capacity and specific types of service or client group to be served. 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[8] 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. However, it is important to talk to all types of provider. If we want to maintain diversity of provision such conversations should not be limited to the large-scale providers who have very different cost structures to the small-scale businesses. Such approaches, together with flexibility in commissioning (rather than a standard price applying to all providers) may help to minimise home closures.

Joint commissioning provides both an opportunity and a challenge. A solution to limited capacity for integrated social service and NHS specialist services would be to draw upon capacity within the independent sector, within a partnership arrangement, blurring the boundaries between purchaser and provider. This could provide better continuity of care and examples that are being developed for intermediate care services might provide helpful ways forward for long-term care services. We identified in section 3 the promise shown in some areas through joint commissioning of relatively marginal services operating at the niche of the market to promote and sustain independence and often to meet specialist needs. However, both local authorities and health care agencies are notorious for constant reorganisation, the combination of the two could provide additional challenges to building up the expertise needed for sound and consistent commissioning.

Involving older people at the strategic level can contribute to consumer power. However, this is not easy to manage effectively, as the type of older person, or indeed service user, that is prepared and able to take part in this is not typical of older service users generally. However, there are growing numbers of groups of older people and service users throughout the country and consultation with these, though time-consuming, can provide helpful insights to people's experiences.

[8] UKHCA have commissioned a costing model to facilitate just such a dialogue between providers and commissioners.

As we identified above contracting could potentially be used to ensure that there is the level of spare capacity required to ensure that there is real choice in the care home market. However, there is no evidence this having ever been undertaken in practice and at present levels of occupancy are rising. There is little incentive for purchasers to use resources to maintain spare capacity as for most purposes this would appear as inefficiency rather than generating a positive output.

Contracts can be used to clarify the levels of quality and quality assurance mechanisms expected and to ensure that good employment practice is used. However there are problems in measuring quality well and the transaction costs of monitoring are high. 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.

Decisions need to be made about whether the diversity product differentiation and range of homely environments of smaller homes are valued sufficiently for commissioning arrangements to specifically address their greater vulnerability to market and regulatory pressures. If such variety if valued, purposive commissioning arrangements designed to support it need to be put in place. Otherwise, current trends towards greater concentration are likely to gather momentum, with small providers giving way to large corporations which may be less able or willing to put a premium on homely environments. To the extent greater corporate penetration involves external shareholding (including quoted) companies in particular, market power will necessarily be in the hands of stakeholders more remote from front line caring practices and processes.

This report has demonstrated that smaller care homes are particularly vulnerable to market and regulatory pressures. If these homes are to be supported, differential commissioning arrangements (for example, in terms of price or use of block contracts) will need to be put in place. However, such arrangements may lead to accusations of 'bias'. In seeking to find the right balance between support for such small business and the preservation of a level playing field between providers from different sectors and of different sizes, there may be unexploited potential in looking outside the social care field to other areas of policy, where thinking on the challenge of designing developmental policies which support – but do not inappropriately advantage – small businesses have already progressed. For example, social care commissioners and economic development experts within local authorities may well benefit from an exchange of ideas in relation to principles and practices. Above the local level, the small business service is currently being reconfigured between national and regional tiers. This could open up a useful opportunity to ensure the small and medium sized

enterprise component of the social care 'industry' is more firmly accounted for in the relevant structures than it has been to date.

We have discussed in section 3 the fragmentation of care management processes and some of the problems this has led to. If care management was working as originally intended, back more in line with the original experiments (Challis, 1999) and targeted on those with high level needs, older people would have substantial consumer power with the care manager acting as advocate and coordinator. There is a continuum between autonomous purchasing by consumers and fully-managed care with most care delivered at some point in between. In deciding the role and levels of care management input there is a balance to be achieved between scarcity and choice (Challis, 1992).

Thus it is more a problem with implementation than theory and changed practice might go somewhere to address the problem. However, there are a number of barriers to improving consumer power through the care management process:

- Local authority targeting policies that run counter to user preferences (for example, not providing the domestic support) thereby working against flexible and outcome driven use of resources by care managers.
- Inadequate level of resources both for the care management process and for service provision.
- Inadequate delegation of these resources to care managers and flexibility in their use.
- Restrictions on care managers on the provision of advice about services.

The use of task-based commissioning and tightly specified individual packages of home care have 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. This type of approach has been used in California in the On Lok scheme for Chinese elders (On Lok, 1987, Zawadski and Eng,

1988), has been attempted in this country for certain groups of older people (Davies et al., 1993).

Use of in-house services

Authorities often use in-house providers to ensure an adequate supply of those services that they find it difficult to get the independent sector to provide. This has applied in the past to short term care, care for people with dementia and people recently discharged from hospital. As such in-house provision can provide a safety net in terms of types of provision where there are shortages. It 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. Examples might include recuperative extra care housing arrangements where demand is uncertain and initial investment high. If such schemes are demonstrated to be cost-effective then the authority is in position to identify potential demand and informed about costs before approaching independent sector providers.

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

One obvious lever to improving quality is the introduction of National Care Standards, which were intended to ensure that a minimum level of quality was maintained, protect service users and to provide an incentive to improve the quality of services.

There is scope to reconsider the care standards themselves. We identified in section 4 the traditional focus on inputs rather than outcomes. 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 historically-based 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 aim 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.

There is a welcome emphasis on gaining the views of service users as part of the inspection process, but older people are often reluctant to complain, never more so when there may be a potential threat to withdraw the service on which they depend. Alternative approaches are possible. In the inspection of children's homes the Social Services Inspectorate made use of young people who had been service users and found that both the quality and quantity of information obtained from current young users of children's services improved (Hibbert, 2002). Lay inspectors for adult services were widely used before the introduction of the NCSC, but are now rarely, if ever, used (Netten et al., 2003a). Clearly regulation has an important role to play in raising quality and increasing consumer power, but the Inquiry might want to review the way that regulation and care standards could be used more effectively.

Inappropriate application and implementation of regulation can have precisely the opposite effect of that intended, undermining good quality providers and driving them out of the market (see sections 4 and 6.2). Consistency and predictability in the design and implementation of care standards is needed. On the other hand, evidence from providers showed that good relationships and good quality inspection are valued by providers, providing scope for direct improvements in quality of care.

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[9] may drive out some of the most valuable workers. On the other hand, there is the new group of personal assistants where there is no regulation at all. The Inquiry might want to consider the potential of regulation for both raising quality of employment and care and for the future supply of care workers.

[9] 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 (Witton, 2004).

Another area where regulation has a potential role to play is in the operation of the market itself. In other utility markets where there is a dominant supplier or purchaser there are specific bodies to oversee prices or other aspects of competition. While it is unlikely that this is appropriate in the care market the CSCI does have a role in the inspection of local authorities. In the past the SSI has been very effective in identifying good and poor commissioning practice. Where there has been less success has been improving practice. We discuss below the provision of information and advice. But would an enforceable or voluntary code of conduct in commissioning to be monitored as part of the CSCI responsibilities be helpful?

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. In the example just given about improving commissioning practice, authoritative sources of advice have a potential part to play. Some developments are already underway. The Better Commissioning Learning and Improvement Network (LIN) under the auspices of the Department of Health's Change Agent Team (CAT), which aims to spread best practice, was launched in March 2004.

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.

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. A major problem is how to provide information in a way that is easily accessible to them. Commissioning authorities have a potential role to play as part of the process of talking to their providers, however the authorities themselves need the information. Increasingly people use the Internet to access information and there may be other ways to improve information available. The Social Care Institute for Excellence (SCIE) also has a potentially very important role to play in this process, but is dependent on the evidence available.

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 training 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. Decisions are made under intense pressure, particularly when an existing home is closing. The successful operation of a market is predicted on the notion of informed consumers and rational choice. While voluntary bodies increasingly make advice available, it is unclear how well this is communicated to older people and their relatives. A major problem for people is knowing where to go for information and advice. One-stop shops providing advice on benefits, on services and advocacy to public and private payers can be very helpful. A number of these are being set up around the country under the Modernising Local Government framework (often linked to e-government). 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 Direct Care service, now being introduced under the auspices of the DWP. At the very least this could provide information about sources of advice on social care issues.

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 is 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.

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