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The future of the NHS? Lessons from the market in social care in England

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The market in social care services in England provides the best available example for policy makers of what happens to the quality of care and the terms and conditions of the care workforce when competitive pressures are used to bring about a reduction in the cost of care to the taxpayer.

The Health and Social Care Act 2012 puts in place a framework to create a competitive market in NHS-funded care services in England, and places requirements on local commissioners to put many NHS-funded services out to competitive tender. And this is all happening at a time of financial restrictions and rising need.

Whilst there are many differences between the current structure of the NHS and that of social care, there are nonetheless a number of lessons which policy-makers can learn from the experience of social care markets in England for the future of the NHS.

This discussion paper highlights the following **four** main lessons based on the evidence from the operation of social care markets over the past two decades, and asks whether what has happened in social care could be repeated in the NHS in England.

Lesson one: The growth in private sector provision of state-funded social care services was rapid

Social care provision was not nationalised under the 1948 settlement, however local authorities and central Government still provided a significant share of residential and nursing-home and domiciliary care services ('home care') until it became explicit policy under the Thatcher and Major governments to create a market in this area.

Thus in 1979 the proportion of residential and nursing care services provided by the state was 64%. By 2012 this had fallen to just 6%. In state-funded home-care services the private sector provided 5% in 1993. By 2012 this had risen to 89%.

Most of this shift occurred in the 1990s and 2000s following the Community Care Act reforms, which required local authorities to purchase care services in the independent sector, required them to demonstrate 'best value' in the care that they purchased, and encouraged the transfer of local authority care homes to the private sector.

Could this happen in the NHS in England?

During the passage of the Health and Social Care Bill the government assured parliament that the vast bulk of NHS care would continue to be provided

directly by the NHS once a market was created. However, if the experience of social care is anything to go by this is unlikely to be the case.

As a result of the policies which began under the last Labour government, almost 10% of NHS care purchased by clinical commissioning groups is now purchased from the independent sector. In the last 5 years there has been a 55% increase in privately-provided NHS care, with huge growth for the private sector in the community health services sector in particular. And this has occurred before the Section 75 regulations of the Health and Social Care Act, which require the competitive tendering of some NHS services to the private sector, have started to have an effect.

The government has now put in place levers similar to those used to create the existing social care market to potentially bring about a substantial switch from state-provided to privately-provided health care, including provisions to transfer not only services but whole NHS hospitals to the private sector.

Lesson two: Introducing competition as a means of reducing costs impacts significantly on the quality of services

A market in social care was introduced, in part, as a way of keeping the costs of state-funded social care under control. By restricting the funding available to local authorities to provide care services at a time of increased need, successive governments have forced local authorities to generate 'efficiencies' through contracting with the lowest-cost operators in the independent sector.

This competition between providers to win contracts from local authorities on a lowest-cost basis has driven down the quality of care in many instances to the 'minimum quality level allowed'. Indeed the current Care Minister, Norman Lamb, has acknowledged that the current system 'incentivises poor care, low wages and neglect, often acting with little regard for the people it is supposed to be looking after'.

Could this happen in the NHS in England?

The government has ostensibly ruled out competition on price in the NHS through setting a national tariff, with the intention that competition between providers should only take place on the basis of quality. But price competition remains a possibility as there are opportunities for commissioners to set prices at local level below the national tariff.

In addition, the market in NHS care is being created at a time of rising need when there is also significant pressure on commissioners to generate efficiency savings, including proposed reductions in the amount paid to providers of 3-4.5% next year.

Moreover, with the prediction that by 2065 health care funding could consume 23.5% of GDP unless something is done to bring about further efficiencies, it

is unlikely that future governments will not seek to use competitive market pressure to keep prices down and costs under control once the market in NHS-funded care services has been established.

The implications for the quality of NHS care remain uncertain but the experience of social care suggests that using competition to keep costs under control at a time of rising need has a negative impact on the quality of care provided.

Lesson three: The drive to keep costs down through competitive market pressures has led to the de-regulation and casualisation of the social care workforce

The impact of marketisation in social care services over the past two decades can also be seen in the current state of the social care workforce. Social care workers often receive pay below the minimum wage and a significant proportion are operating on 'zero hours contracts'. The 1.4 million care workers in England are unregulated by any professional body and less than 50% have completed a basic NVQ2 level qualification, with 30% apparently not even completing basic induction training.

Yet despite this, the tasks which care workers are undertaking are becoming increasingly complex, whilst the needs of those that they are looking after are becoming more serious as a result of the growth in the number of people with Alzheimer's Disease, diabetes and dementia.

Because the main cost of care provision is the workforce, any private care provider seeking to compete in a market designed to drive down costs will inevitably respond by reducing rates of pay, limiting the training available to workers whilst expecting them to take on more complex tasks, at the same time as the vulnerability of their clients has increased.

Could this happen in the NHS in England ?

As was revealed in Robert Francis' report into Mid Staffordshire NHS Trust, NHS hospitals facing intense pressures to keep costs down are now relying on unregulated and poorly paid healthcare assistants and other 'auxiliary workers' to provide the care formerly delivered by nurses.

The recent government-commissioned report into health care assistants found that there was an increase in the number of healthcare assistants employed in the NHS 2011-12 but an overall decrease in the number of nurses with health care assistants undertaking increasingly complex health care procedures.

In addition, one of the benefits identified by the government of using the private sector to deliver care was the fact that they were not constrained by NHS terms and conditions. Greater private sector involvement at a time of financial restrictions will inevitably put additional pressure on the terms and conditions of the workforce.

The extent of these changes will, however, depend on the professional associations and trade unions representing medical and other health care professionals, which are significantly stronger than in social care.

Lesson four: Provider failure is an inevitable consequence of any care market, with significant implications for patients, care users and their families

The experience of social care markets in England is that care homes and home care providers go out of business. In many ways this is an expected and desired consequence of any competitive market. The high rate of care home closures in England – with nearly 1400 closing between 2003 and 2010, often with less than 4 weeks' notice – and the harmful effects that this has had on the residents of care homes and their families is a central lesson from the operation of social care markets. Again, one of the chief factors forcing care homes out of business is the squeeze placed on the fees paid to them by local authorities seeking to generate savings.

The social care market has also witnessed a significant consolidation, particularly in residential care services, with 20 companies now owning 30% of all the care home beds. This amount of consolidation has started to worry the government, particularly following the collapse in 2011 of one of the largest care home providers, Southern Cross, which owned 31,000 beds. The financing arrangements for these large providers suggest, according to the government, that 6 major providers will collapse at some point in the next 10 years.

Could this happen in the NHS in England?

The government acknowledges that providers of NHS funded care will go out of business in the new market, which includes both NHS providers and independent providers, and a number of NHS trusts have already entered into administration.

In addition, the private health care sector which will provide services to the NHS in the future is, like the social care sector, largely dominated by a small number of large operators. Thus just four companies owned 61% of the current independent acute medical and surgical hospital sector. On this basis, the possibility of a major provider of NHS services collapsing in the future cannot be ruled out.

Conclusion

The lessons from the development and operation of markets in social care are clearly important and have direct implications for anyone who reflects on the creation of a market in the new NHS in England. This is particularly the case given the already rapid growth in private for-profit provision of NHS-funded health care, even before the Sector 75 regulations have started to impact on the amount of care commissioned from the private sector.

The justification given for introducing market competition into the NHS is that it will improve quality for patients and increase their ability to choose the health care services that meet their needs, which will in turn act as a spur to innovation and improved performance by public providers of health-care services. However, as this discussion paper shows, the experience of the introduction of social care markets in England over the last two decades is that competition has driven costs down with a significant impact on quality, has led to the casualisation and de-professionalisation of the workforce, and has left care users and their families vulnerable to a major provider collapse. It suggests that the NHS is susceptible to similar outcomes and unintended consequences as the market in NHS-funded care grows.

In many ways, the Government appears willing to accept these negative aspects of its policy as it believes that only market competition and the incentive structure that this imposes on care providers will allow the NHS to become efficient and therefore affordable. In doing so it places significant trust in an increasingly complex regulatory framework to counteract the worst aspects of market failure.

However, a further lesson from the operation of social care markets is that both financial and quality regulation have been ineffective in ensuring either the security or the quality of provision, and thereby in maintaining public confidence.

The experience of markets in social care are not all directly transferable to the NHS, but the issues and lessons that are highlighted here raise significant questions which at the very least call for public debate and the development of informed mitigation strategies.

Introduction

1. The Health and Social Care Act 2012 has, amongst a range of objectives, the explicit intention of creating a market in the provision of NHS-funded care in England. Under the regulations created under Section 75 of the Act commissioners of NHS care – Clinical Commissioning Groups (CCGs) – are required to invite private sector providers to deliver NHS funded care. The Act also provides sanctions for CCGs and other bodies which engage in 'anti-competitive' behaviour which might prevent this market from developing.[1] As a result, many public providers of NHS care will over time be replaced by private providers which will deliver health care to patients under contracts with local commissioning bodies. In addition, a growing range of private providers will be designated as 'Qualified Providers' – under the Any Qualified Provider (AQP) scheme – which individual patients are free to choose treatment from.

2. The same process of 'market-making' began in social care nearly 25 years ago with the Community Care reforms of the early 1990s, and with many of the same aims as the Health and Social Care Act. As a result, there are a number of important lessons which policy-makers can learn from the experience of what happens when a market is used to deliver care services, particularly when there is significant pressure to reduce the cost to taxpayers.[2]

3. This report sets out four key lessons from the operation of markets in social care which policy-makers and the public should be aware of when considering the development of a market in NHS care in England – particularly at a time of financial austerity – and the prospects that this holds, in particular, for the quality of health care for patients and the terms and conditions of the workforce.

4. There are obvious differences between the ways in which social care and the NHS are organised and funded which make direct comparisons and predictions difficult. These differences include the status and structures of the medical and nursing professions in the NHS, compared to those found in social care; the range and technological complexity of health care procedures carried out by the NHS compared to those in social care; differences in the facilities that are used to deliver care; and the relative strengths of the trade unions in the two sectors. However, this paper argues that the attempt to create a competitive market in state-funded health care is likely to produce outcomes broadly similar to those seen in social care, and that the experience of social care markets in England is the best example available to policy-makers of what effects a market in health care may have.

Lesson one: The growth in private sector provision of state-funded social care services was rapid

> ***"I want to reassure hon. Members that there is no question but that the vast bulk of NHS-funded health care will continue to be delivered by NHS bodies"'***
>
> (Paul Burstow MP, Hansard 7 Sep 2011)

5. The proponents of the Health and Social Care Act 2012 have steadfastly refused to admit that the introduction of competition amounts to the privatisation of the NHS. According to Paul Burstow, the Care Minister who helped to steer the Bill through the House of Commons, the vast majority of NHS care will continue to be provided by publicly-owned health care providers even after a competitive market has been created.[3]

6. However, the experience of market creation in social care suggests that this is unlikely to be the case. The community care market reforms of the 1990s ushered in a rapid switch from state provision to private provision, which given the current recent growth in private provision of NHS-funded health care looks likely to be repeated in the NHS in England.

7. In social care there are two dominant ways in which care is provided – residential care, which is provided in a care home or nursing home – and domiciliary care (or 'home care') – which is provided in a person's own home. Leaving aside primary care services, which are already mainly privately-owned by GPs or health care companies, the equivalents in the present-day NHS would be acute or secondary care and rehabilitative care provided in hospitals, and community health services, which are health care services often provided outside institutional settings. The equivalence lies in the fact that both residential care and hospital care are capital-intensive (they require buildings and equipment), whereas domiciliary care and community health services mainly rely on the deployment of a mobile workforce. In the community sector this has implications for the ease with which private sector providers might enter the market.

8. In the case of domiciliary care, in 1993 95% of care was provided directly by local authorities.[4] By 2002 this had fallen to less than 40%, and it currently stands at just 11%.[5]

9. For residential care, the situation was slightly different in that before the community care market reforms were introduced many care homes were provided by voluntary sector organisations, because this aspect of care had never been fully 'nationalised' in the 1946-8 settlement. But still, by 1979

64% of residential care and nursing home beds were provided either by local authorities or the NHS.[6] Nonetheless, the community care market reforms of the 1990s brought about as swift a reduction in state-provided residential and nursing home care as they did in domiciliary care. By 2012 the state's share had fallen to just 6%.[7]

10. These swift changes in the relative market shares of the public and private sector occurred for the following reasons. In the case of domiciliary care, local authorities were placed under a duty to demonstrate 'best value' in the services they provided. This meant that they were required to compare the cost of providing their own services with the cost of having them provided by the private sector, and because much the largest part of domiciliary care costs are in employing care workers, the lower rates of pay in the private sector meant that councils could achieve significant savings through outsourcing this service.[i]

11. In the case of residential and nursing care, the situation was different. Throughout the 1980s and early 1990s a legal loophole led to the social security budget, rather than local authority funding, being used to pay for long term care for older people, but this only funded care in private care homes. As a result, the private care home sector experienced a boom. From 1993 central government also gave local authorities grants to pay for nursing and residential care and other forms of community care, including housing, but on condition that 85% of the money had to be spent on care homes and other community care services not run or owned by local authorities. In addition, successive governments denied local authorities sufficient capital funds to either build or maintain their existing residential care homes, so that as new care standards were introduced – which local authority homes did not meet – large numbers of publicly-owned care homes were transferred to the private sector to own and run.[ii]

Could this happen in the new NHS in England?

12. Looking at the prospects for the market which is emerging in the NHS, it is possible to detect a number of similarities with the situation which occurred in social care in the 1990s and 2000s. In general, the various initiatives pursued by the last Labour government to introduce private sector providers to the NHS have already substantially increased the amount of care provided by non-NHS

i The current average hourly rate of pay for an adult social care worker employed by a local authority is £8.72 compared to £6.13 in the private sector. See: Skills for Care ' The state of the adult social care sector and workforce in England 2012' October 2012 Table 7.5

ii There is a striking lack of data on how many local authority care homes were transferred to the private sector during the 1980s and 1990s, but one study in 1996 found that over 12% of all private care homes had either been transferred or sold from local authorities. See: A Netten, A Bebbington, R Darton, J Forder, K Miles, *'1996 Survey of Care Homes for Elderly People (Final Report), Personal Social Services Research Unit Discussion paper 1423/2', 1998.*

providers. Thus NHS spending on non-NHS providers in England for all services increased from £5.60bn in 2006/7 to £8.67bn in 2011/12 – a 55% increase over 5 years.[8] This means that almost 10% of the total NHS budget spent by PCTs (the predecessors of CCGs) was now being spent in the independent sector.[iii] And this was before the Section 75 regulations, which require CCGs to put NHS services out to competitive tendering, had started to have an effect.

The outsourcing of NHS Community Health services

13. The mainly labour-intensive 'community health services' funded by the NHS – which are likely to become an increased aspect of NHS health care as services are moved out of hospitals and into the community – have also seen private sector providers take over significant amounts of NHS work. This has been because from 2010 primary care trusts were required to divest themselves of direct provision of community health services. [9] In 2006/7 PCT spending on non-NHS provided community health services was around £0.5 billion; by 2011/12 this had increased to around £1.5 billion.[10] And between 2012 and 2013 the independent sector increased its share of the community health care market by over a third. [11]

Subsidies to Independent Sector Treatment Centres

14. The situation in relation to secondary care provided in hospitals is more complicated and less directly comparable to the care home sector. However other strategies have been used to underwrite the risks of private sector entry into this area of NHS provision. Of particular note are the public subsidies which under the last government were given to for-profit Independent Sector Treatment Centres (ISTCs). These ISTCs provided NHS-funded diagnostics and elective care services such as hip operations, cataract surgery and knee operations.

15. The additional amount paid to the private sector for each operation, was on average 11.5% more than the NHS 'equivalent cost', ie what the Department of Health said would have been paid for an NHS operation at a cost to the taxpayer in the first 'wave' of the scheme of around £130million.[12] In addition, ISTCs were guaranteed payments irrespective of whether they actually undertook the contracted number of procedures. Although the actual subsidy is not known, it has been estimated that it may have cost the state an additional £220m.[13] Finally, the Department of Health also gave a guarantee that it would buy back some treatment centres at the end of the 5-year contracts at a potential cost of £187million.[14] This subsidy allowed the companies concerned to cover their initial start-up and capital costs and helped lead to 35 new private treatment centres being built. [15] These policies led to around £370 million being spent on secondary care from ISTCs in 2011/12, an increase of 42% since 2006/7.[16] The private sector now provides around 19% of all NHS-funded hip and knee replacements in the UK.[17]

iii The amount spent by PCTs on healthcare in 2011/12 was £91 billion.

16. The introduction of Any Qualified Provider policies has also had a significant impact on NHS spending on the private sector. Overall, spending by Primary Care Trusts in England on secondary care provided by the independent sector has increased rapidly from £4.74 billion in 2006/7 to £8.33 billion in 2011/12 – an increase of 76% in 5 years.[18]

The transfer of NHS assets to the private sector under franchising agreements

17. The experience of the transfer of care homes from local authorities to the private sector is also relevant to the situation that many indebted NHS hospital trusts currently find themselves in. Starved of state funds sufficient to meet their current costs – including payments on the debts incurred through Private Finance Initiative deals – many NHS trusts face the possibility of being transferred to the private sector. This has happened, for example, in the case of Hinchingbrooke hospital, which was transferred to Circle Health, and could well happen to some other financially insolvent NHS hospital trusts.[19] As more NHS hospitals enter administration the Government has recourse both to a mechanism and a reason to transfer their assets to the private sector, in much the same way that local authorities transferred their care homes to the private sector in the 1980s and 1990s.

18. Thus, if the development of the new NHS market follows the same trajectory as that of social care, the privatisation of services could be much quicker than most commentators seem ready to acknowledge. The section 75 Regulations – which in effect require CCGs to tender more and more health care services to the private sector – are likely to prove central to this, in the same way that the Best Value regulations and the requirements on local authorities to spend a percentage of their budget on private social care drove rapid growth in private residential and domiciliary care provision. The geographic distribution of privately-provided NHS services is likely to vary across the country, as will its rate of growth. But the government has now put in place levers similar to those used to create the existing social care market to bring about a substantial switch from state-provided to privately-provided health care.

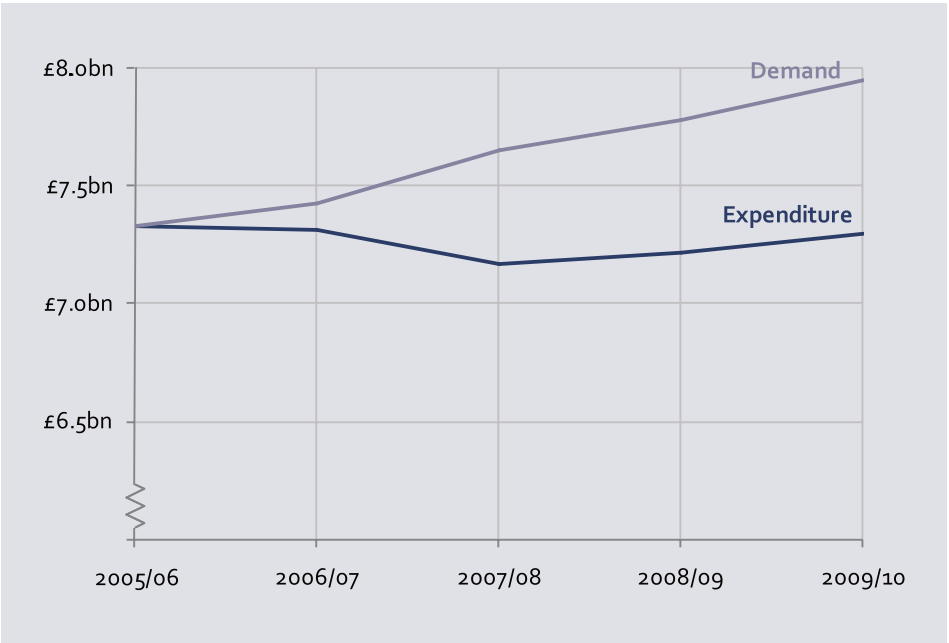
Lesson two: Introducing competition as a means of reducing costs impacts significantly on the quality of services

19. Competition and the expansion of private sector provision of social care services was introduced for two explicit reasons; first, to offer people using state-funded care services a choice of who provided the service, and second, to keep the cost of providing services under control. Whilst quality was often referred to in the official justification for markets in social care, it is unclear how much consideration was given to this by local authorities, which were responsible for building and managing the market.

Competition was used to drive down the cost of social care services

20. The main reason for this was that local authorities, which had responsibility for arranging both residential and domiciliary care services, mainly for older people, were under significant pressure to keep costs down. As is currently the case in both the NHS and social care, demographic changes combined with budget restrictions to place enormous pressure on local authority social services departments to meet ever growing need. Current estimates are that demand is exceeding expenditure by 9% (see figure 1 below).[20]

Figure 1: Expenditure and demand: older people's social care (2009/10 prices)



Adapted from 'Fairer Care Funding The Report of the Commission on Funding of Care and Support' July 2011 p.14

21. As a result, local authorities have tendered for care services often purely on the basis of which private sector organisation offered the lowest price, whether per residential or nursing care bed, or per hour or per minute of domiciliary care.[21] The use of the so-called online 'Dutch Auctions' which were used by some authorities to select the lowest-cost provider of care has been widely criticised by both the Government and the media. However, it was in line with a statement made in 1993 by the then Secretary of State Virginia Bottomley to the health select committee, when the social care market reforms were first introduced: local authorities, she said, should use their bulk purchasing power to drive down the price of care, which is indeed what has happened.[22]

22. Thus, a gap has become increasingly evident between public expenditure on care and support, and what is believed to be necessary to raise standards. Research conducted for the Joseph Rowntree Foundation in 2008 reported that just to deliver the necessary and acceptable physical standards in care homes local authorities would need to pay an additional £540 million each year. But the research found that 'if "modernisation" is extended to include a professionalised workforce, paid accordingly, the additional cost would be substantially greater'.[23]

The impact of competitive pressures on the quality of social care provision

The current social care system 'incentivises poor care, low wages and neglect, often acting with little regard for the people it is supposed to be looking after'

Norman Lamb MP, Care Minister, June 2013

23. It is beyond doubt that using competitive markets to drive down the cost of social care has had a significant impact on quality. Analysis by the Personal Social Services Research Unit has shown in relation to nursing care homes that 'in markets where competition pushes prices down quality will be pushed down to the minimum quality level allowed [by the regulator for care homes, the Care Quality Commission]'[24]. In such situations, they argue, 'without robust regulation, and without a change in public commissioning behaviour, quality [will] deteriorate below acceptable levels'.[25] Further evidence to support this is provided by the Care Quality Commission's (CQC) rating of 1 in 7 for-profit care homes in England as poor or merely adequate.[26]

24. Similarly, in relation to care services provided in people's own homes, the 2011 Equality and Human Rights Commission Inquiry into Home Care found many cases of 'older people not being given adequate support to eat and drink (in particular those with dementia) [..]' and 'that there was neglect due to tasks in the care package not being carried out, often caused by lack of time'.[27] This is consistent with earlier evidence from the Commission for Social Care Inspection in 2006, which found that 30% of private domiciliary care agencies were failing to meet the registration standards, and that service users experienced the service as 'undignified and unsafe'[28] because of the use

of 15-minute care time-slots. More recently, the Care Quality Commission has found that 1 in 4 home care providers are not meeting all of the 5 essential standards, and that in London more than a third of all agencies required some intervention by the regulator to meet the basic standards.[29]

25. This has recently prompted the Care Minister Norman Lamb to acknowledge that the current system 'incentivises poor care, low wages and neglect, often acting with little regard for the people it is supposed to be looking after'.[30]

26. The lesson from social care markets is clear – if the contracting-out of care services to the private sector and the development of a competitive market based largely or solely on price occurs at a time of austerity and budgetary restrictions, with the aim of seeking to keep costs under control, the quality of care is likely to suffer.

Could this happen in the new NHS in England?

27. Following the outcry that greeted the publication of the 2011 Health and Social Care Bill the Government supposedly backtracked on the idea of permitting competition for NHS services on the basis of price, as occurs in social care.[31] However, in reality this is far from the case. Whilst there is a widely shared view that a National Tariff will be used by Monitor and NHS England to set the price paid for all NHS care, the Health and Social Care Act 2012 actually permits 'local variations' in the tariff which will allow a local commissioner (a CCG) to negotiate a price with a provider of care with the aim of achieving, amongst other things, 'better value for patients'.[32]

28. At the same time, the NHS is facing real-terms cuts in funding and unprecedented pressures to reduce costs as a result of the so-called 'Nicholson Challenge', with the need to find 'savings' of £20 billion over 5 years without increased growth. This has meant, according to the House of Commons Health Committee, that so far 'efficiency savings' have resulted in 'a reduction in the sums paid to NHS providers by NHS commissioners, consequently requiring the providers to find corresponding savings in their operations' – an experience which many providers of social care services will recognise .[33] The current proposal from Monitor and NHS England, which set the prices for care in the NHS, is that prices for NHS care should 'mimic competitive pressures'; as a result it is proposing to consult on a 3-4.5% reduction in the price paid to NHS providers in 2014/15 to achieve the required efficiencies.[34]

29. But they also recognise – perhaps learning from social care – that in setting prices at too low a level 'providers may not be adequately compensated for the services they provide, potentially leading to withdrawal of services, compromise on service quality, and/or under-investment in the future delivery of high value services.' [35]

30. Moreover, with forecasts such as that given to a *Reform* conference, that unless something is done to bring about further efficiencies, by 2065 healthcare funding will consume 23.5% of GDP, it is unlikely that future governments will not seek to use competitive market pressure to keep prices down and costs under control once a market in NHS-funded care services has been established.[36]

Lesson three: The drive to keep costs down through competitive market pressures has led to the de-regulation and casualisation of the social care workforce

31. There are currently an estimated 1.4 million social care workers directly providing social care services to mainly frail older people or physically disabled adults in England.[37] The average rate of pay for a care worker working in an adult residential care home in England is £6.45 per hour, and £7.00 per hour for a care worker providing domiciliary care services – for comparison, the current minimum wage is £6.31 per hour.[38] Research by the University of Leeds in 2013 has also shown that some domiciliary care workers are receiving less than the minimum wage.[39] The annual turnover rate for care workers is around 19%, and since 2010 the median gross pay for care assistants and home carers has decreased by almost 2%.[40] Furthermore, 60% of domiciliary care workers are on 'zero-hours' contracts, which means that the employer does not guarantee the worker a fixed number of hours work per week and only pays them for the number of hours that they work, while expecting them to be available to work at short notice.[41]

32. A fact which is little understood by the general public is that there is no requirement for any of these social care workers – except social workers – to be registered with a professional body (as nurses and doctors are required to be) in order to undertake, unsupervised, intimate tasks such as showering and bathing vulnerable older people. Nor is there any legal requirement for them to have acquired any qualifications before they deliver care. Currently less than half the workforce have completed a basic NVQ level 2 qualification.[42] Although there are some requirements on care homes and domiciliary care providers to ensure that staff receive some initial basic induction training, 30% of care workers have apparently not completed any.[43],[44] And even these minimal requirements do not apply to the 420,000 'personal assistants' who are employed directly by service users, using the money they are given directly by the state to pay for their care, known as a 'direct payment.'[45]

33. Yet over the years the tasks undertaken by these care workers have become increasingly complex, particularly as there has been a rise in the number of older people with conditions such as diabetes, Alzheimer's and dementia. Whereas

care workers were once responsible only for providing basic 'personal care' tasks, such as washing and bathing and helping someone to get dressed, a 2004 survey by the UK Homecare Association found that domiciliary care workers were routinely undertaking wound care, pressure care, catheter care and PEG feeding.[iv,46] A Unison survey in 2013 found that 40% of care workers were not being given specific training in working with people who had dementia or strokes.[47] The low-paid, poorly-trained and unregulated domiciliary care worker is now undertaking many of the tasks previously reserved to a District Nurse. And the situation is even more astonishing for personal assistants, where a report in 2008 found that around 53% of unregulated personal assistants were injecting medicines and undertaking other medical tasks.[48]

34. This change in the 'skill mix' – with the former roles and functions of qualified health care professionals being carried out by lower-trained and unregulated workers – is a familiar response of businesses responding to market pressures to reduce costs and achieve greater efficiencies, and it is not surprising that it has become a marked feature of market-driven social care. Because the main cost of care provision is the workforce, any private care provider seeking to compete in a market designed to drive down costs will respond by reducing rates of pay and limiting the training available to workers whilst expecting them to take on more complex tasks, at the same time that the vulnerability of their clients has increased.

Could this happen in the new NHS in England?

35. Currently, the NHS operates a much more regulated approach to the workforce, with specific roles and tasks being reserved to qualified and registered health care professionals. Yet even within the NHS the growth in the number of unregulated 'health care assistants' suggests that the market pressures which NHS trusts are facing has led to a shift towards more complex care being provided by 'ancilliary workers'. As a 2013 government-commissioned review into health care assistants found, between September 2011 and 2012 the number of registered nurses in England dropped by 2,283, whilst during the same period the number of HCAs rose by 2,691.[49] One of the least well-reported findings of the Francis report into Mid-Staffs NHS Trust is that when the board of Stafford Hospital came under pressure to find a £10 million saving, the ratio of nurses to health care assistants shifted from 60:40 in favour of nurses, to 60:40 in favour of unregulated health care assistants.[50]

iv PEG feeding or Percutaneous Endoscopic Gastrostomy is an endoscopic medical procedure in which a tube (PEG tube) is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate.

36. There are currently an estimated 100,000 health care assistants working in the NHS in England, which is estimated to be around 24% of the total nursing workforce.[51] And, as in social care, these unregulated workers are taking on many of the more advanced nursing tasks, including taking blood samples and administering electrocardiography, to the extent that, according to the government commissioned review, 'the "core" of patient care has shifted from tasks performed by nurses to those performed by HCAs'.[52]

37. The NHS regulations protecting job roles and functions for regulated professionals do not apply within the private sector. Nor do the pay rates which have been negotiated by health professional trade unions under the 'Agenda for Change' apply outside the NHS – except under specific TUPE arrangements – and this provides much greater opportunities for private sector providers to keep their costs down by applying the same type of 'skill mix adjustment' as has occurred in social care. It also allows them to compete more effectively, at least in terms of price, with NHS providers – such price competition, as noted above, being one of the main reasons why local authorities were unable to justify keeping social care services in-house.[v]

38. The extent to which the deregulation and 'casualisation' of labour in NHS-funded health care occurs will depend to some extent on whether competition on price becomes a dominant factor in the new market-place. However, it will also depend on the extent to which the trade union bodies representing the health professions – notably the BMA, the RCN and UNISON – are able to protect the interests of their members. Already, these safeguards are being challenged in the health policy debate. Dr Penny Dash, a partner at the influential management consultant McKinsey and a former director of strategy in the Department of Health, recently told the think-tank Reform that it is necessary to 'loosen the stranglehold of professionals on health care delivery' if the NHS is to be sustainable.[53] In addition, if the attempt by the NHS South West Pay Consortium to move away from nationally-agreed NHS terms and conditions and introduce more flexible wage rates for NHS workers is successful, it could signal the start of a general move towards a lower-cost workforce, where the terms and conditions of healthcare professionals are gradually eroded. [54]

v The Impact Assessment into the Health and Social Care Bill 2011 identified that ' The statutory protections offered to NHS staff tend to restrict work place mobility and can make it very expensive to make staff redundant, which impacts on the costs of NHS providers and their ability to adapt to changing market requirements' and 'Non statutory providers can offer greater flexibilities in their terms and conditions than the NHS' See: Department of Health 'Health and Social Care Bill Impact Assessments 2011 Annex B page 45 Table B1: Fair Playing Field Distortions. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/147536/dh_129917.pdf.pdf

Lesson four: Provider failure is an inevitable consequence of any care market, with significant implications for patients, care users and their families

39. In any competitive market businesses fail and new companies enter the market. Indeed the Competition Commission – which now has the ultimate responsibility for overseeing markets in the NHS [vi] – sees an ideally competitive market as being characterised by 'rivalrous competition', which it describes like this: 'This rivalry may occur in a variety of ways. In some cases the emphasis will be on achieving the lowest level of costs and prices in order to undercut competitors. Where these factors are important, competition will often be characterised by uncertainty, turbulence and change.' [55]

40. When this approach is applied to the provision of care services, the same consequences of 'uncertainty, turbulence and change' are likely to follow. In the case of social care, this has been seen most clearly in the closure of care homes. Between 1996 and 2003 around 74,000 care home places were 'lost'; and between 2000 and 2003 around 800 care homes closed every year.[56] In one year alone, from 2000 to 2001, 1,113 or 5% of all care homes in England closed.[57] This troubling rate of closure slowed down following the introduction of national minimum standards and statutory national registration of care homes in 2004, but even so between 2004 and 2010 1,391 care homes closed.[58] This occurred partly as a result of the introduction of new regulatory standards in 2004, which smaller care home operators could not meet – leading to many sell-offs and closures prior to 2004 – but also because of declining profitability due to local authorities cutting fee levels for care homes as a result of the declining amount of public resources available to them.

41. Moreover, when private care homes close down, local authorities have to bear the responsibility of stepping in to ensure that temporary care is provided to meet the residents 'urgent care and support needs', including somewhere to live.[vii] So, as happens in any private market which provides essential services to the public, the risk of failure is borne by the state, with local authorities bearing the costs as the providers of last resort.

vi Under the Health and Social Care Act 2012 if it has reasonable grounds for suspecting that any features of the health care market prevent, restrict or distort competition, Monitor will be able to refer matters to the Competition Commission for in-depth investigation using its Enterprise Act 2002 powers.

vii Local authorities are responsible whether or not the cost of the care is being met by the state – i.e. they are equally responsible for re-housing residents who are paying their own costs. Department of Health Impact Assessment 'Market Oversight in Adult Social Care' 26th March 2013 para 54. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/197940/Market_Oversight_IA__FINAL_.pdf

42. Despite this obvious level of market 'turbulence', and despite the potential impact on a large number of the nearly half a million older people and physically disabled people who currently live in these homes, no systematic study of the impact of care home closures on their residents has been commissioned by either this Government or the last. What is known is that when care homes close down they tend to do so very rapidly – often within 4 weeks of the decision to close.[59] There is some research evidence that this rapid closure has a significantly negative impact on care home residents – many of those who are transferred to new care homes die (and any move between homes is a risk factor), whilst others suffer from increased 'restlessness'.[60, 61]

43. Moreover when private care homes are fending off financial collapse, the quality of the care that they provide to residents has been found to diminish – the facilities deteriorate, staffing levels are reduced and additional 'services' for residents, such as outings or entertainment, are cut back.[62]

44. More recently, the care home market has stabilised, with a less dramatic though still substantial number of care homes going out of business; between 2009 and 2010 123 care homes closed.[63] Another issue has emerged, however. As in other 'mature' markets, the care home sector has started to consolidate, with larger corporate operators buying up smaller businesses with the aim of generating greater revenues and profits through economies of scale. Private equity companies have also started to buy up the larger care providers. This consolidation has meant that local authorities and residents paying for their own care are more reliant on a smaller number of businesses surviving the turbulence of the market. Currently 20 care-home companies provide 30% of the care-home beds. But size is no guarantee of longevity: when one of the largest care home providers, Southern Cross, became insolvent in 2011, due to a finance model which had left the company with unsustainable debts, the Government was left looking for alternative care home places for around 31,000 older people. [64]

45. The highly indebted nature of many of the larger care providers is currently starting to worry the Government, particularly as the debts held by some of these companies will need to be refinanced in the next few years – which the Government acknowledges will be 'challenging'.[65] As a result the Government has recognised that the current system is ill-prepared for this inevitable consequence of the market in social care and has made proposals in the Care Bill 2013 to allow the Care Quality Commission to put an early warning system in place, so that it knows in good time when major care providers are facing financial difficulties. It estimates that around 6 large care providers will fail over the next 10 years.[66] It does not, however, propose any other form of intervention.

Could this happen in the new NHS in England?

46. The problem of provider failure will also be an unavoidable consequence of the development of the market in NHS care in England. Thus far, the Government is ready to embrace the competitive market system and allow major NHS hospitals which have run into financial difficulties to go into administration, including Mid-Staffordshire NHS trust and South London Healthcare NHS Trust. Yet the problem is far wider in the NHS – a report for NHS London in 2011 'found that even if trusts managed to achieve an unprecedented level of cost savings, underlying deficits would remain. Its overall conclusion was that only 6 out of the 18 trusts concerned are financially viable in the long term'. [67]

47. The possibility of private health care companies supplying services to the NHS being 'too big to fail' also exists, with just four companies owning 61% of the current independent acute medical and surgical hospital sector, 47% of the private community health care and health at home sector, and 56% of the private mental health and learning disabilities hospital sector.[68] In addition, major private care providers to the NHS, which are backed by private equity, have also seen 'financial restructurings' and significant losses to investors, mainly due to the impact of the 2008 financial crash on their revenues and access to capital. [69]

48. One of the chief causes of the collapse of Southern Cross was the squeeze on the fees paid to it as local authorities sought to cut back after 2008. As noted above, the NHS tariff is being reduced to achieve greater efficiencies within the system, with potentially significant consequences for the financial viability of providers of NHS-funded care, both public and private. As the Kings Fund pointed out in 2012, NHS England will need to ensure 'that future tariffs are not set at such a level that a large number of trusts will not be able to remain solvent'. [70] And so, given the highly indebted nature of some current providers, the possibility of major providers of NHS funded care collapsing must remain high.

Conclusion

49. The lessons to be learned from the development and operation of markets in social care are clearly important and have direct implications for anyone who reflects on the creation of a market in the new NHS in England. This is particularly the case given the already rapid growth in private for-profit provision of NHS-funded care, even before the Sector 75 regulations have started to impact on the amount of care commissioned from the private sector.

50. The justification given for introducing market competition into the NHS is that it will improve quality for patients, and increase their ability to choose healthcare services which meet their needs, which will in turn act as a spur to innovation and improved performance by public providers of health care services. However the experience of the introduction of social care markets in England over the last two decades shows that competition has driven costs down, with a significant impact on quality; has led to the casualisation and de-professionalisation of the workforce; and has left care users and their families vulnerable to a major provider collapse. The evidence also suggests that the NHS is susceptible to similar outcomes and unintended consequences as the market in NHS-funded care grows.

51. In many ways, the Government appears willing to accept these negative aspects of its policy, believing that only market competition and the incentive structure that this imposes on care providers will allow the NHS to become efficient and therefore affordable. In doing so it places significant trust in an increasingly complex regulatory framework to counteract the worst aspects of market failure. However, a further lesson from the operation of social care markets is that both financial and quality regulation have been ineffective in ensuring either the security or the quality of provision, and thereby maintaining public confidence. The experience of markets in social care is not all directly transferable to the NHS, but the issues and lessons that have been highlighted here raise significant questions which at the very least call for public debate and the development of informed mitigation strategies.

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