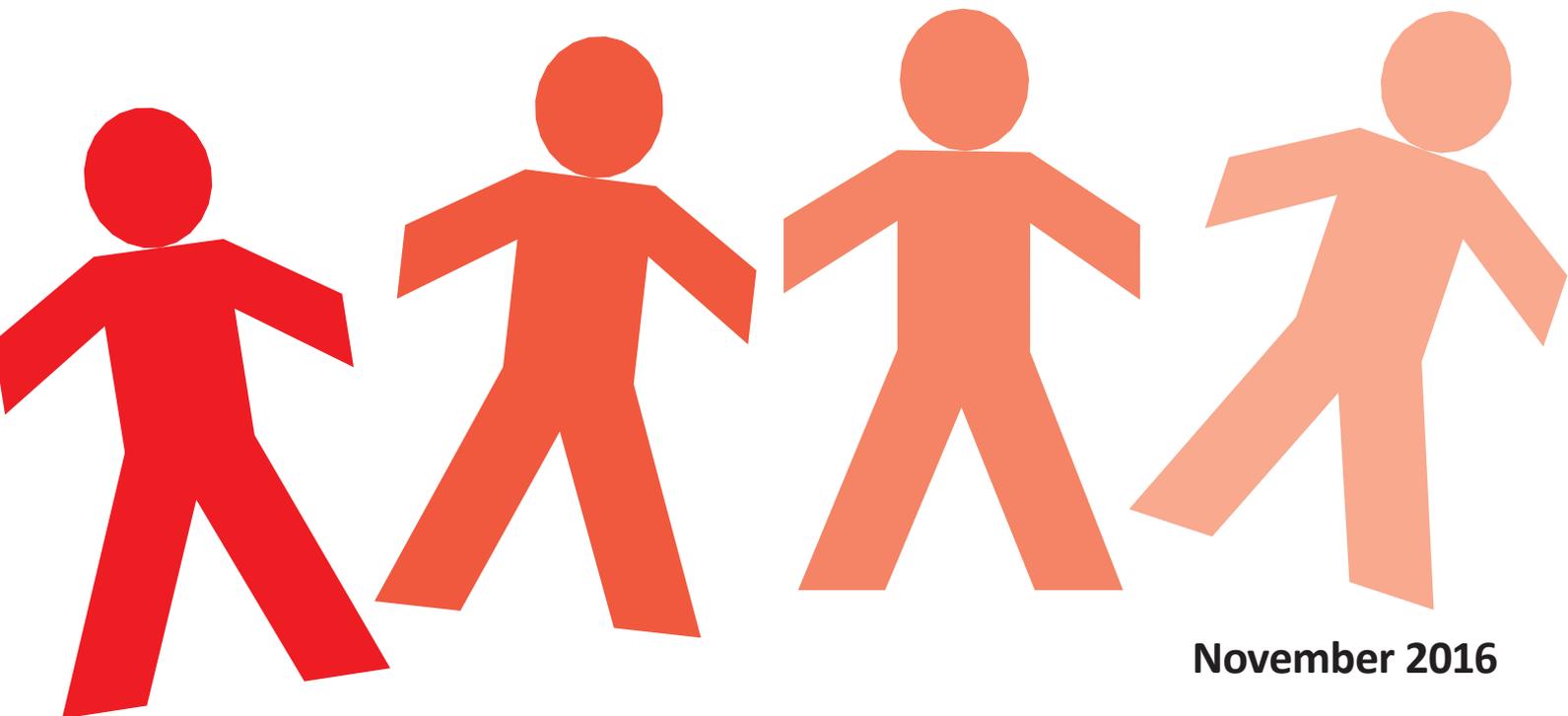


# The failure of privatised adult social care in England: what is to be done?



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## The author

### **Professor Bob Hudson**

Bob Hudson is Visiting Professor in Public Policy in the Centre for Public Policy and Health at the University of Durham, a position he has held since 2004. From 1995 until 2004 he was Principal Research Fellow at the Nuffield Institute for Health at the University of Leeds, and held earlier lecturing positions (in social policy) at the University of Durham and New College Durham. His main areas of work have been in public sector policy, and especially health and local government – topics on which he has undertaken national research and published widely in the academic and trade press. He has served as a local councillor, chaired local voluntary groups and worked as a special advisor to the House of Commons Children’s Select Committee.

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Email: [info@chpi.org.uk](mailto:info@chpi.org.uk)

[www.chpi.org.uk](http://www.chpi.org.uk)

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## Executive Summary

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1. This report looks at the growth in the market in adult social care in England and the problems which have resulted from this. It makes a number of recommendations to address the worst aspects of privatised provision.
2. The report finds that around £24 billion a year is spent on adult social care in England, most of which is spent on older people receiving care either in their own homes or in a residential or nursing home. The state, through local authorities, spend. £14 billion a year on adult social care, although cuts to local authority budgets over the past decade has led to a decline in the number of older people receiving state funded care services. As a result, there has been a growth in the number of older people who fund their own care, with many of these private payers subsidising the care costs of those paid for by the state – in some cases paying 43% more for their care than local authorities are charged.
3. The vast majority of both home care and residential care in England is now provided by private companies. A significant number of care home providers are large chains which are backed by private equity and are reliant on risky financial structures, leaving them exposed to collapse, with damaging consequences for care home residents. Although local authority budgets have been drastically cut by central government – forcing them to reduce the amount they pay to private providers – private providers can still achieve significant rates of return on their capital investment, 12% is normally expected. This is despite the fact that adult social care is essentially a low-risk sector – in other similarly low-risk sectors a 5% rate of return is considered reasonable.
4. Both the quality of care in adult social care and the terms and conditions of the workforce have declined over the past two decades as a result of privatisation. The report also shows that turnover rates are higher, and rates of pay considerably lower, in the private care sector than in the public sector. In addition, 41% of community-based adult social care services, hospice services and residential social care services inspected by the Care Quality Commission since October 2014 were found to be inadequate or requiring improvement..
5. In order to address the failures of market provision the report looks at three possible options – “**market shaping**”, “**market regulation**” and “**replacing the market**”. Whilst the Care Act 2014 provides local authorities with powers and duties to “shape” the market locally in order to achieve better outcomes this remains unachievable, given the current budget restrictions and the heavy reliance of local authorities on private providers to deliver services. Market regulation has been the approach adopted by the government, and the recent introduction of a market oversight role for the Care Quality Commission – to identify private care home providers which may be facing financial collapse – is an acknowledgement of the precarious nature of the care home market. But it provides no powers for the regulator to intervene to prevent a company

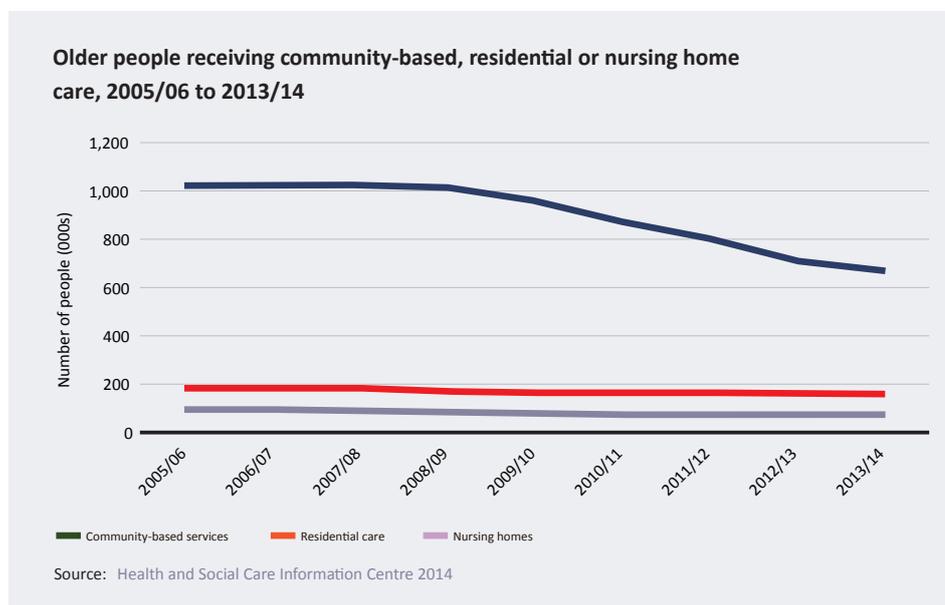
collapsing, merely an early warning system for local authorities who may be affected. Similarly the government's introduction of a "fit and proper" person test for directors of private companies applies to members of the boards of providers of adult social care has also had little impact on the potential for market failure in the care home sector, or on the pervasiveness of poor standards.

6. The report looks at other measures which could be introduced to bring about more effective regulation of the market such as a **transparency test** – whereby the contractual arrangements with a private provider should be fully open; an **accountability test** – whereby the local electorate could demand the ending of a contract with a private provider if there are concerns about performance; a **workforce test** – whereby the contracts with private providers would have to include requirements guaranteeing certain terms and conditions of the workforce, and collective bargaining rights; and a **taxation test** whereby private companies in receipt of public service contracts would be required to demonstrate that they were domiciled in the UK and subject to UK taxation law.
7. Whilst recognising the difficulties involved in replacing private provision by state provision, the report concludes that it would be possible to introduce a "preferred provider" policy, whereby local authorities would give preference to either their own provision or provision by the voluntary sector or user-led organisations. Similarly local authorities could require the return on capital achieved by private providers to be capped to a maximum of 5%. This would reduce private equity investors' interest in adult social care provision and help re-balance the market between state, voluntary and private provision.
8. The report recommends that the following policies should be considered by the government:
  - i) Where a public body has a legal contract with a private provider, the contents of that contract should be fully transparent.
  - ii) The ownership details of companies providing public services under contract to the public sector should be available for public scrutiny.
  - iii) Private companies in receipt of public services contracts should be domiciled in the UK and subject to UK taxation law.
  - iv) Consideration should be given to giving local electorates powers to call to account any provider judged to be providing an inadequate service.
  - v) All providers should be required to comply with minimum standards of workforce terms and conditions and to accept collective bargaining rights.
  - vi) There is scope to impose a contract on private companies that places an upper limit on what constitutes a reasonable return on investment. This scope should be exploited.
  - vii) Organisations with a social purpose should be defined as the preferred providers of care and support services.
  - viii) Steps should be taken to rebuild provision capacity in the statutory and not-for-profit sectors.

# Introduction

1. Adult social care refers to personal care and practical support for adults over 18 with physical disabilities, learning disabilities or mental health issues, and to support for their carers. Expenditure on Adult Social Care support for older people in England alone has been estimated at over £22 billion, of which around £13 billion is attributable to residential care and £9 billion to non-residential care.. This figure can be expected to increase, since the care needs of adults are rising as people live longer and are beset with multiple health conditions and disabilities – the number of people aged over 65 in the UK will rise by more than 40% in the next sixteen years, and by 2040 almost one in four people will be over 65.
2. Despite these pressures the numbers of older people in receipt of adult social care provided by the state have largely declined over the past decade, or remained static, as the table below shows.<sup>2</sup> As a recent report from the King’s Fund and the Nuffield Trust<sup>3</sup> points out, six consecutive years of cuts to local authority budgets – who fund adult social care – have seen 26% fewer older people get help.

**Figure 1 Provision of state-funded adult social care 2005-2014**



Source: King’s Fund/Nuffield Trust (2016), Social Care for Older People: Home Truths.

3. The restriction on state funding of adult social care for older people has had a significant impact on NHS services, with hospitals having to admit patients who could be better dealt with in the community, whilst also being unable to discharge older patients into the community because of a lack of local authority-funded care services. It has also had an impact on individuals and their families who have had to increasingly fund their own care without any limit to the amount that they are required to spend.
4. However in addition to the restriction of state funding for social care the most startling long-term trend – the privatisation of provision – often goes unremarked. Over the past thirty years or so the provision of adult in England has shifted from a largely publicly funded and provided service to one that is largely provided by private companies, and one that is now funded by a roughly equal measure of state (via local authorities) and individual contributions. This report looks at the problems created by the privatisation of adult social care provision, and whilst it does not claim that public provision will resolve all difficult issues, it does suggest that wholesale privatisation has created problems that cannot continue to be ignored. Building on an earlier CHPI report,<sup>4</sup> which looked at the development of a market in social care and the lessons for the creation of a market in the NHS, this report charts the changing face of adult social care provision in England. It shows that the quality of care has declined, partly as a result of the privatisation and marketisation of provision, and that the care market is at serious risk of failure. In conclusion it makes recommendations for addressing these problems.

## The creation and evolution of the market in adult social care

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5. The privatisation of adult social care began in the 1980s. The creation of ‘personal social services’ as a ‘fifth social service’, complementing the four established pillars of the post-war welfare state – social security, education, housing and health – was only accomplished by the Local Authority Social Services Act of 1970; barely two decades later these services became a prime field for the new neoliberal policy of outsourcing public services to the private sector. Following Sir Roy Griffiths’ 1988 report for Margaret Thatcher on the funding and organisation of community care,<sup>5</sup> the 1990 National Health Service and Community Care Act re-cast local councils as ‘enabling authorities’ rather than providers of care services, such as care homes. Funding for this new role was accompanied by a central government requirement that 85% of it should be spent on the ‘external’ purchase of care services from the private sector, so that local authorities began to contract with private providers to provide care rather than deliver it themselves.

6. Since then the transformation towards a market in adult social care has progressed steadily, with no attempt by any government to halt or reverse the trend. Early talk of a 'mixed economy of care', with local authorities, private companies and the voluntary sector competing on a 'level playing field', soon evaporated. In 1979 64% of residential and nursing home beds were still provided by local authorities or the National Health Service; by 2012 the local authority share was 6%; in the case of domiciliary care, 95% was directly provided by local authorities as late as 1993; by 2012 it was just 11%.<sup>6</sup> This also means the bulk of the adult social care workforce – around 72% – is now employed in the private and voluntary sectors, along with another 14% employed by individual service users making use of 'personal budgets', leaving just 14% employed by local authorities.<sup>7</sup>
7. Just as important as the size of the private care market is the nature of the provider. Although just over 40% of care home operators have three or fewer homes there is a trend for small local operators to be replaced by large provider chains with more than fifty care homes each. The ten largest providers account for around 20% of the UK care home market – in terms of the number of beds – whilst the top 20 providers account for around 28% of the market. Recent building of new residential and nursing homes in a standard format with 60 or more en-suite bedrooms has been dominated by chain operators, and many of the smaller businesses are likely to exit in the next decade by selling homes which are valuable properties. In some parts of the market, such as nursing home beds in London, the big chains already provide a majority of the beds available.
8. As two recent reports from the Centre for Research on Socio-Cultural Change (CRESC) have pointed out,<sup>8,9</sup> most of the smaller care homes are in converted houses with few en-suite rooms, while the remaining local authority establishments are older, purpose-built homes from the 1960s and 1970s, which typically have all single rooms but with no en-suite. Over time, these will need decommissioning, because standards and expectations are rising, but councils have neither the income nor the borrowing powers to replace them. The future of residential care therefore belongs to operators who can replace retiring capacity with larger new homes that meet modern standards. This means private chains with access to finance from capital markets. One of the paradoxes of this trend is that whilst local authorities in the 1970s and 1980s were castigated for building 'institutional' care homes of 30-40 beds,<sup>10</sup> because they were seen as too big, the private sector now doubles that size in order to secure economies of scale. The CRESC report describes this as 'the Travelodge model', two or three-storey en-suite blocks that minimise the number of staff needed and maximise cash generation, rather than reflecting the needs of service users.<sup>11</sup>
9. The experience of the adult social care market has been influential in wider policy circles, and has contributed to a widespread belief that it does not matter whether it is the public, the private or the voluntary sector which provides the service – the role of the local state is seen as merely to research

market trends and then devise, let, and monitor contracts. For governments looking to reduce the scale of state spending there is one clear upside to all of this – the shifting of capital expenditure from the Treasury and local authority balance sheets to the private sector. The industry estimate is that this investment now amounts to a cumulative total of around £30 billion<sup>12</sup> and has resulted in the creation of over 350,000 beds in care homes. Whilst significant funds have indeed been invested by the care home industry this has, however, sometimes been on the back of guarantees by local authorities which have transferred their homes to private providers and have funded capital investment in them through an additional element i. the price paid per bed. Although no up-to-date survey exists of the extent to which the current stock of private care homes are former local authority homes, one survey in 1996 estimated that around 12% of private care homes had been transferred or sold from the local authority to the private sector.<sup>13</sup> Thus even though most care homes are now privately owned their development and improvement has been underpinned by funding from local authorities.

10. However, even though the state has provided the funding that has allowed capital development to occur many further questions remain about how care homes are funded. how the capital is raised, what return is expected on it, and what are the consequences for those who work in, or use, the services provided.
11. Three inter-related difficulties will be examined: workforce problems, the need to create 'consumers', and market failure.

## Market Problems: Workforce

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12. Since the biggest single cost of providing personal care is the front-line staff who deliver it, this is the also the area where for-profit providers look to make operational returns and sustain profit margins. Tasks, working practices and jobs are standardised and reorganised to reduce the cost of labour. One recent study, for example, identified a range of changes including restricting annual leave, reducing the numbers of qualified nursing staff, increasing resident-staff ratios, removing sick pay, moving to unpaid on-line training to be completed at home, removing paid breaks and no longer paying for handover meetings at the start and end of shifts.<sup>14</sup> Revelations in the press about the poor working practices of care providers are now routine, such as a recent case in which a major home care provider required workers to give 24-hour care in a care user's home but only paid for their waking hours.<sup>15</sup>
13. The result is that the adult social care sector is now characterised by low pay and insecure working arrangements. A review by the House of Commons Public Accounts Committee in 2015<sup>16</sup> reported evidence that care workers' median pay was as low as £7.90 per hour; those working in community settings were frequently not paid for travelling time; up to 220,000 care workers were being paid below the statutory minimum wage; and around one-third were on zero-

hour contracts, with no guarantee of how much work they might have or when they would be required to attend, and no access to sick pay, holiday pay or employer pensions schemes.

- 14. Research carried out by the Smith Institute<sup>17</sup> comparing the median hourly wages by occupation across the public private and voluntary sectors shows some significant differences, with the public sector paying substantially more than both the private and the voluntary sector; and the gap widens further when other payments as well as staff training and pensions are taken into account.

**Table . Median Hourly Wage by Care Sector and Occupation, 2014**

Occupation	Sector		
	Public	Private	Voluntary
Residential Care Workers	£9.45	£7.23	£8.50
Senior Care Staff	£14.19	£7.30	£10.57

Source: Smith Institute/Unison 2014, *Outsourcing the Cuts: pay and employment effects of contracting out*.

- 15. Private sector employees in health and care occupations are less likely to have a degree or other higher education qualification than their counterparts in the dwindling public sector, and indeed are more likely to have no qualifications at all. The point has arguably been reached where it is no longer a feasible ambition for a care worker to acquire skills and pursue a stable career with an enduring and reliable provider of adult social care.
- 16. The way in which staffing costs are held down to support profit levels has been further exposed by the introduction of legal entitlements to a specific and higher minimum wage. In the years following the global financial crisis, care providers benefited from a ‘recessionary dividend’<sup>18</sup> in terms of low levels of overall staff cost inflation. This is coming to an end with the introduction from 2016 of a ‘national living wage’ for workers aged 25 and over of £7.20 an hour, rising to £9 an hour by 2020, to be paid by employers.<sup>1</sup> Given the high dependence of the care sector on low-paid staff and on workers over the age of 25 (only 11% are under this age), the introduction of even a modest wage improvement on this scale this will have significant consequences for the anticipated trading margins of private care providers. The home care provider Mears, for example, has already pulled out of its contracts in the northwest, claiming that the fees being paid by local councils amounted to ‘encouragement to providers to breach the national living wage’.<sup>20</sup>
- 17. All of this has led to a workforce crisis in adult social care, with growing problems of recruitment and retention. Nursing care in particular has become difficult to provide as nursing staff are often paid less in a social care setting than if they worked in a healthcare setting, and this has led many residential homes to close nursing home beds and concentrate only on providing social care, despite the growing numbers of people with multiple and complex

problems who need nursing care.<sup>2</sup> Industry staff turnover rates are also alarmingly high (averaging around 25% per annum), leading some providers to rely on expensive agency staff.<sup>22</sup> There is, however, considerable variation in staff retention rates across the public, private and voluntary sectors.<sup>23</sup>

**Table 3 Staff Retention Rates (average months of continuous service) by Care Sector and Occupation in 2014**

Occupation	Sector		
	Public	Private	Voluntary
Residential Care Workers	96	29	46
Senior Care Staff	132	60	132

Source: TUC New Economics Foundation 2015

18. This pressure has led some providers to employ staff without thorough checks on their immigration status, which in some instances has led to immigration enforcement procedures and emergency home closures. The impact of immigration policy on the UK social care workforce is also set to deepen from 2016 with the introduction of a new requirement that all skilled workers from outside the EU who have been living in the country for less than ten years will need to earn at least £35,000 pa to be allowed to settle permanently. Some jobs such as nursing are exempt; however unregulated social care workers from outside the EU, such as those working in care homes or in home care, are not and so will be required to earn £35,000 a year in order to be able to remain in the UK. This will have a significant impact on staff recruitment and retention in the care sector. There is now the further complication of the uncertainty of the status of EU citizens working in the UK following the vote to leave the EU; around 6% of the social care workforce – and 12% in London – consists of nationals of other EU countries.<sup>2</sup> All these changes are likely to add to the problems of staff recruitment and retention.
19. Taken together these trends can be predicted to have an adverse impact on the quality of care. When private care homes are fending off financial problems, 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 and entertainment, are cut back.<sup>25</sup> In the case of domiciliary care there has been wholesale adoption of a flawed ‘task and time’ model, with units of as little as fifteen minutes care per client imposed in order to reduce costs. Unsurprisingly the most recent annual report by the regulator, the Care Quality Commission, found that 41% of community-based adult social care services, hospice services and residential social care services inspected since October 2014 were inadequate or required improvement.<sup>26</sup>

## Market Problems: The Creation of ‘Customers’

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20. A market requires ‘customers’ who seek and digest information to inform their choice of product. From this perspective the care home market in particular has some characteristics of an inefficient market<sup>27</sup> – entry is often unplanned, made in response to a personal crisis, and there are very low rates of switching to a different provider in the event of dissatisfaction. Adult social care is what economists conceptualise as a ‘distress purchase’, in which the exact nature of the service is not known until after purchase and where the buyer is often choosing at a suboptimal time – yet in the case of social care an acceptable service will in practice often not be obtainable by shopping around for a better supplier.
21. This dilemma is intensified by the cost of paying for care. Currently anyone with assets of over £23,250 has to pay the full cost of their care – for those being cared for in their own homes that figure only takes into account any savings, stocks or shares, whilst for those moving into a care home the value of their home may also be taken into account, depending on circumstances. The costs people face can be catastrophic, with one in ten who enter the care system at their own expense ending up paying over £100,000 in fees over the period of their years in care.
22. Following the recommendations of the Dilnot Commission<sup>28</sup> the 2014 Care Act established the principle – for the first time – of a cap on care costs, set at £72,000 for adults over 65. There is, however, no firm date set for implementation and the consensus is that the issue has been consigned to the political long grass. The result has been a large growth of self-funding ‘customers’ whose existence has seemingly become vital to the survival of care providers. By 2014 around £10bn a year was being spent by people paying for their own care and support, compared with £14bn spent by councils, and in some wealthier parts of the country self-funders constitute the majority of consumers in the care market.<sup>29</sup>
23. Overall about 37% of older people have their care home fees fully met by local authorities; another 12% pay ‘top-up’ fees, 10% are paid by the NHS, and 41% are paying wholly on their own account.<sup>30 31</sup> There is now compelling evidence that these self-funding residents – often ‘choosing’ their care at short notice and in crisis – are paying higher fees and cross-subsidising state-funded residents, and that without this the social care market would not be considered viable.<sup>32</sup> Indeed, research by the best-known market analyst in this field indicates that self-funders are paying on average 43% more than state-funded residents in the same home, for the same type of room and the same level of care.<sup>33</sup> This has resulted in a scramble on the part of care providers to attract self-funding rather than state-supported users, with the attendant danger of the development of a two-tier market.

## Market Problems: Market Failure

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24. The most serious problem of all with the creation of a market in social care is the prospect of significant market failure and the impact of this on people who are at very vulnerable stages in their lives. This is not a question of a handful of small individual providers failing to meet regulatory standards and being deregistered; rather it is the prospect of one or more major providers looking after thousands of service users leaving the care market. During the 1980s and 1990s care home closures were commonplace as the market adapted to the introduction of new regulatory standards, and consolidations within the industry took place. Smaller operators were bought out by larger operators or simply closed because they could not generate sufficient economies of scale to survive. However most of these closures – whilst causing significant distress to large numbers of residents – were confined to different localities. But as the larger operators began to dominate the sector and the state became reliant on a smaller number of private providers – often backed by private equity – the potential for a large-scale market failure became a distinct possibility.
25. This risk increased in the wake of the global economic crisis and the decisions, since 2010, by the government to prioritise reductions in local government spending (and hence on social care) as a prime austerity measure. One way in which local authorities have sought to cope with the resulting funding crisis has been to reduce the fees paid to care providers – an estimated national average reduction of over 5% in real terms between 2010/11 to 2015/16.<sup>3</sup> The significance of this is that for many private providers a tight market position has been turned into an unsustainable trading situation. The first major casualty was Southern Cross in 2011. Southern Cross was a large national care home provider with 9% of the market nationally, and a much greater share in certain areas. In parts of the northeast, for example, Southern Cross accounted for some 30% of all care home places. It quickly became clear that neither the local authorities nor the key national agencies had any contingency plans – indeed nobody even had any formal powers to compel action.
26. Not the least of the problems was the remote ownership of the company – a complex mix of creditors, property investors, bondholders, banks, shareholders and landlords. Here the interests of private companies had come face-to-face with the need for service continuity for highly vulnerable people in a new and politically explosive manner.<sup>35</sup> A review of the stability of the care market in England identified a range of reasons for the collapse of Southern Cross: a rental bill of £250 million a year. following the sale and lease-back of its properties:<sup>36</sup> a drop in income that resulted in a reduction in property maintenance, which in turn led to lower occupancy; loans attracting higher interest rates because the company no longer had properties against which to secure loans; a fall in market confidence and the share price; and poor management and quality of care, which led to adverse inspection reports and further decreases in occupancy levels. In effect, Southern Cross was in

a downward market spiral with no way of ensuring continuity of care for its thousands of ‘customers’.

27. In the event other private companies were persuaded to take over the operation of Southern Cross’s businesses and premises, but the main company that took over the contracts (Four Seasons) is itself now suffering large financial losses and having its viability called into question, and recently decided to close three of its care homes in Birmingham, affecting 156 residents.<sup>37 38 39</sup> Data from the Care Quality Commission exposes the wider scale of this problem, with eight English local authorities having a single care home provider responsible for over 25% of places in their area, and an even higher concentration in more specialist areas such as nursing care.<sup>4</sup>
28. There is little confidence that further market failure can be avoided; indeed as a previous CHPI report pointed out when the Care Bill was before parliament, the government even assumed that six large providers would collapse in the next ten years, affecting the homes of 19,000 people.<sup>41</sup> A recent survey of almost half of all local authorities in England responsible for social care commissioning<sup>42</sup> found that 77% had experienced provider failure in the year 2015/16, and 74% thought another failure likely in the coming year. One analysis warns of the loss of 37,000 beds in the care sector by 2020/21,<sup>43</sup> whilst the chairman of one of the largest providers (which rescued almost 250 care homes from Southern Cross) has recently claimed that 50% of care homes are ‘non-viable’.<sup>44</sup> In the case of home care, two of the top five providers (Care UK and Saga) recently decided to pull out of the market, the latter declaring that the activity ‘no longer fitted with the Saga business model’.<sup>45</sup> The ‘third sector’ is now following suit, with the largest not-for-profit care provider – Housing and Care 21 – pulling out of the home care business it has been providing in over 150 local authority areas.<sup>46</sup>

# Options for reform

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29. What can be done to deal with this crisis? Three broad options are open: shape the market; regulate the market; and replace the market.

## 1 Shaping the Market

30. The idea of shaping the market goes beyond the notion that the role of the state is to 'fix' or somehow forestall market failure; rather the role of the state is to act as a catalyst for innovation. One variant is that promoted by Marianna Mazzucato with her proposal for 'mission-oriented' public investments,<sup>47</sup> where the task of the state is to determine the direction of change by 'transforming landscapes and creating and shaping markets'.
31. In the case of adult social care the recent Care Act 2014 does impose a new 'market-shaping' role on local authorities. Section 5(1) states that each local authority 'must promote the efficient and effective operation of a market in services for meeting care and support needs' with a view to ensuring care users have a variety of high-quality providers from which to choose, and sufficient information to make an informed decision. In addition local authorities are given the duty of *fostering continuous improvement in the quality of such services and the efficiency and effectiveness with which such services are provided and encouraging innovation in their provision* and importantly ensure *'the importance of fostering a workforce whose members are able to ensure the delivery of high quality services (because, for example, they have relevant skills and appropriate working conditions'*. So the Care Act 2014 both recognises some of the problems with the market and places duties on local authorities to address them through their market shaping powers.
32. But given that – as indicated earlier – councils have had their budgets severely cut by central government in recent years, it is not clear how this is to be achieved or even what it might mean in practice. In terms of the state's role of 'transformer' or 'catalyst' with the adult social care market there seems to be no strategy to harness the outsourcing of public services to any strategic direction; rather the end product is simply market diversification and the extension of 'choice'. So whilst a "market shaping" role formally exists it is prevented from being implemented by the financial restraints placed on local authorities and the lack of tools available to local authorities to achieve better terms and conditions for care workers, or higher quality or more stable forms of provision.

## 2 Regulating the Market

33. Rather than shape or reshape the adult social care market, the policy thrust has been to attempt to regulate it – to either prevent risks emerging or correct market ‘distortions’. Recent official guidance<sup>48</sup> from the Department of Health opens by stating that ‘care homes are people’s homes and people have the right to live there as long as they want’, but then proceeds to list the many reasons (including market exits) why this is untrue. The policy emphasis now seems to be on local authorities and regulators identifying ‘negative’ factors or risks that might give clues to the potential failure of provider companies.
34. The statutory regulator for adult social care in England – the Care Quality Commission (CQC) – has been given new powers by the government to seek to address market failure. First the Government introduced the ‘Fit and Proper Person Test’ to be applied to the directors of providers of any organisation registered with the CQC.<sup>49</sup> In the case of large national and multi-national organisations and investors, however, it seems unlikely that the fit and proper person test will be a serious consideration in their decision-making. Indeed, in response to concerns that the CQC is not doing enough to enforce the rule, a complete review of the ‘test’ is currently underway. The second power is the ‘Financial Oversight Test’ – an attempt to assess the extent to which a provider may be in such serious financial difficulty that there is a significant prospect of service cessation. A consultation paper on this power<sup>50</sup> was at pains to emphasise, however, that this would be a ‘light-touch approach’ and that the Government intended to be ‘mindful of the sensitivities’ and ‘would respect the commercial sensitivity of information’. None of this suggested an approach capable of seriously addressing the problem of market failure.
35. It should not be surprising that a government committed to a neo-liberal model of public services delivery has opted for a weak version of market regulation. A tougher model might instead comprise four provider ‘tests’: a transparency test, an ownership/taxation test, an accountability test and a workforce test.

### *A Transparency Test*

36. In England the Government has been keen to encourage citizens to scrutinise the spending of public sector bodies, but less interested in extending such transparency to private companies in receipt of publicly-funded contracts. In the latter case, basic details may be given about the total budget and the identity of the contractor but no detail on bidding, costings or performance information that might indicate efficiency or effectiveness. It is in this secretive contracting process that values around social responsibility can be quietly subjugated to the quest for quick and easy financial value extraction.
37. A ‘transparency test’ could stipulate that where a public body has a legal contract with a private provider the contract must ensure full openness and transparency, with no ‘commercial confidentiality’ outside of the procurement process. Support for such a test is growing. The Institute for Government,<sup>51</sup>

for example, argues that all providers of public services should publish details of the funding they receive, performance against contractual obligations, the suppliers to whom they subcontract services, the value of these contracts, and their performance and user satisfaction levels. More recently the Information Commissioner for England has made similar suggestions.<sup>52</sup>

### ***An Ownership/Taxation Test***

38. At a minimum the ownership of all companies providing public services under contract to the public sector, including those with offshore or trust ownership, should be available on the public record. At the same time a taxation test could require private companies in receipt of public service contracts to demonstrate that they are domiciled in the UK and subject to UK taxation law. The investigative organisation Corporate Watch<sup>53</sup> claims that some leading private providers have set up corporate structures that allow the avoidance of tax on millions of pounds of profits by making use of corporate entities in the British Virgin Islands, Luxembourg, Jersey, Guernsey and the Cayman Islands. These companies include some of the biggest private providers of health and social care services in the UK, such as Four Seasons, Barchester, Spire Healthcare, Care UK, Circle Health and the private equity firm Terra Firma. There is certainly acute irony in private care-providing companies avoiding tax while complaining that the British taxpayer needs to pay them higher fee levels.

### ***An Accountability Test***

39. Unlike public sector-provided services, public services provided under contract by private companies are often immune from accountability for their performance, or penalty in the event of failure. This has resulted in the creation of a largely unobserved world of co-dependence between government and large companies with little or no democratic accountability.<sup>54</sup> Bringing some form of democratic accountability into this situation is problematic. One option would be to explore the possibility of some form of public ‘right of recall’ so that where contracted-out services – such as care home services – are judged to be of unacceptable quality, termination of a contract could be initiated where a given percentage of the local electorate had formally petitioned the commissioning authority.

### ***A Workforce Test***

40. Given long-standing concerns about the treatment of staff, especially but not solely in social care, a further test could be focused on workforce terms and conditions. This might have several components, such as requiring all providers to comply with minimum standards of workforce terms and conditions, training, development and supervision, and to participate in collective bargaining and recognise a unionised workforce.<sup>55</sup>

### 3 Replacing the Market

41. The final option for dealing with the problems resulting from the privatisation of adult social care is some model of care market replacement, with a greater role for statutory or non-profit agencies and a reduced role for the private sector. This approach would both identify the ‘moral limits’ of markets and take a more positive view of the role of the state. The argument that markets have become detached from morals has been put forward most recently by Marc Sandel,<sup>56</sup> who argues that without any real debate there has been a drift from *having a market economy to being a market society*. As a result, markets and market values have penetrated into spheres in which they do not belong.
42. Perhaps nowhere is this more true than in the realm of personal care and support where the free market cannot profitably supply the services that are needed to meet people’s needs. The difficulty here is that the privatisation and marketisation process has gone unchecked for so long that there is now no feasible prospect of simple and total reversal and a return to state provision. As noted earlier, an estimated £30 billion has been invested over the decades by non-statutory providers in the construction and refurbishment of care homes to meet higher physical standards, although much of this has in effect been underwritten by the state as the main purchaser of care homes. Whilst there may be some justification for sequestering the assets of failing providers, it is unlikely that it would be possible to do so without providing some compensation to the financiers or shareholders. As a result the cost of ‘big bang’ public ownership would be prohibitive. Even in the less capital intensive domain of home care there would be immediate significant costs associated with workforce remuneration and development, as well as restoring service capacity and infrastructure to local government.
43. What is more feasible is a two-pronged approach – a gradual resumption of the statutory and third-sector role, and the imposition of a new, more equitable, business contract on private company providers. The former could be pursued through a ‘preferred provider’ strategy such that in the medium term there would be a more ‘mixed economy’ with (in the longer term) the prospect of the resumption of a publicly-provided service. Under this approach, organisations with a social purpose – whether in the public or the voluntary sector – would be prioritised as the default option for new or re-contracted developments. This is more feasible within the home care sector – care provided to people in their own homes – than the care home sector, as the state would not need to invest in new care home facilities or take existing private care homes back into public ownership. This approach could include encouragement for user-led organisations, social enterprises, mutuals and others, including rights to user and carer representation on company boards, and even the right for service users to take ownership of a firm when ownership changes hands.<sup>57</sup> More widely there is, as Will Hutton argues, a need to reform the Companies Act to require all businesses to deliver goods and services to meet social obligations rather than simply serve the purpose

of short-term enrichment – a statutory framework that goes beyond financial reporting to cover investment, workforce development, equitable pay scales and environmental and societal obligations.<sup>58</sup>

44. A strategy with a more immediate impact would be the imposition of what the CRESC report<sup>59</sup> calls the ‘5% test’. Adult Social Care is a low-risk activity, since demand does not fall or vary and taxpayers cover the cost on half of all beds; it is a stable market on which low returns on investment should be expected. The ‘fair price’ argument – which is used in the care home industry to suggest that care home providers ought to be paid a “fair” price for the service they provide. has become the dominant care industry and political narrative, and implies that there is consensus on what constitutes an accurate and objective ‘reasonable financial return’ for providers of care home beds to local authorities. In reality this is an ideological construct – a financial assessment that is bandied about as if it is true – that suits the needs of large chains operating with fragile ‘quick win’ investment models. Implicit in the calculations behind the so-called “fair price” is the assumption that private providers should be allowed to maintain a very handsome return on capital of 12%. As the CRESC analysis notes, these returns would normally only be expected in very risky markets.
45. There is no compelling reason why the state should accept a responsibility to maintain these margins when they have become a financial necessity only through the reckless pursuit of short-term profit. The CRESC report argues for a more appropriate return of 5% on capital in recognition of the fact that adult social care is a low risk, and that both inflation and borrowing rates are very low. It is estimated that this measure alone would reduce the cost of a care home bed to a local authority from £550pw to £451pw and create headroom for improved and better-’rewarded staffing. More significantly for the longer term it would decrease the interest of private equity buyers in the adult social care sector and create the possibility of a sectoral shift in provision if local authorities and third sector agencies were incentivised to return to it.

## Conclusion

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46. The marketisation of adult social care in England is a salutary policy tale. It has been characterised by stealth over four decades – initially as a limited initiative to improve ‘choice’ and create a competitive ‘mixed economy’ and then to the virtual elimination of public sector provision. In this process there has been growing tension between the need for private companies to sustain a profitable business and the needs of vulnerable people for care and support. Local authorities have been reduced to the role of ‘commissioning authorities’ with ever-stretched budgets, and this in turn has led to the prioritisation of price over quality in the awarding of contracts.
47. Reduced access to public support has created a burgeoning market in care for people who pay for their own care, often at very high prices, thereby subsidising both state funded residents and the state. Despite this, the care market in England is highly unstable because of the significant cuts to local government budgets and the growing role of private companies operating business chains based on high-risk financial models. There has already been one major provider failure and there is every prospect of further failures in the near future. No serious thought has been given to how to deal with this prospect and those policies that have been introduced are too insubstantial to make any real difference.
48. The experience of adult social care in England holds lessons for marketisation policies in other policy domains– the NHS for example, as has been demonstrated by an earlier CHPI report<sup>60</sup> – and in other countries where the process is still at an early point such as Australia, where a Commission on outsourcing human services has been established. It shows the dangers of drifting unthinkingly from a market economy into a market society. A shift in sectoral provision will not in itself solve the many other problems besetting adult social care – the care cap cost dilemma, underfunding and reduced accessibility, the need for more personalised care, the potential of harnessing the digital revolution and more. However it does offer the prospect of returning to the public realm a policy domain that has been shown to be ill-suited to marketisation.

## Recommendations

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1. Where a public body has a legal contract with a private provider, the contents of that contract should be fully transparent.
2. The ownership details of companies providing public services under contract to the public sector should be available for public scrutiny.
3. Private companies in receipt of public services contracts should be domiciled in the UK and subject to UK taxation law.
4. Consideration should be given to giving local electorates powers to call to account any provider judged to be providing an inadequate service.
5. All providers should be required to comply with minimum standards of workforce terms and conditions and to accept collective bargaining rights.
6. There is scope to impose a contract on private companies that places an upper limit on what constitutes a reasonable return on investment. This scope should be exploited.
7. Organisations with a social purpose should be defined as the preferred providers of care and support services.
8. Steps should be taken to rebuild providing capacity in the statutory and not-for-profit sectors.

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