A market for residential care services

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SMF Social Market Foundation

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EXECUTIVE SUMMARY

The focus of the policy debate surrounding social care in recent years has been on how to fund the system, and the level of financial protection that should be offered to those who need to access social care services. What is often overlooked in this debate is the need to see and analyse the provision of social care as a market.

A market is an arrangement wherein suppliers of a product sell that product to a buyer in exchange for a price agreed between the two parties. By this definition, residential care in England is provided by a market – or perhaps, more accurately, by a series of local markets. In this report we seek to analyse the performance of the social care market, to ask how that market could work better for the people in it, and to encourage others to consider this issue in the same way.

In 2017, the Competition and Markets Authority produced its market study into residential care. However, since then very little attention has been paid to how the market for care is operating. This report is intended to inform and stimulate debate about the market for care. It is not intended to be a comprehensive prescription for policy change. Rather, it aims to raise the questions and facilitate the further fresh thinking that are the necessary precursors of useful new policy.

The state of the market

During 2018-19, 141,185 people aged over 65 received long-term care support in a residential care setting in England. The North West of England clearly has the largest number of people receiving residential support throughout the year. Demographic changes mean the number of people requiring care, both self-funding and local authority funded is expected to increase over the next 20 years.

Whilst the requests for services are increasing the number of individuals receiving long term has decreased every year since 2015/16. This has been driven by a reduction in the number of people above the age of 65 receiving long term care, a reduction of 39,060 in the three year period. Expenditure on adult social care has been on an upward trend since 2014-15 but has yet to recover to the levels seen in 2010-11. The cost of providing social care is also increasing.

Competition, sometimes based on the number of suppliers in a market, is often used an indicator for a healthy market. Over the last five years, the social care sector has become more fragmented. Overall, the supply of residential care beds has reduced in recent years, whilst demand has increased.

There is a risk that this already fragile market will be made significantly worse off by coronavirus. Increased costs faced by providers combined with reduced occupancy rates in care homes will inevitably increase the chance of providers going out of business.

Competition and Markets Authority market study

In the CMA study, two broad areas of concern were highlighted. These were:

- Decision making in the residential market; and
- The model of service provision and its sustainability.

The focus of this report is on that second area of concern. The CMA highlighted the differential fees paid by local authorities and self-funders. On average, self-funders pay 41% more for their care per week than local authorities, equivalent to £236. While differentials sometimes draw adverse attention, there can be valid reasons why fee differentials may occur, such as the ability of the local authority to bulk purchase and different services being offered to self-funders, such as a bigger room or better view.

The study also reported that there is a significant amount of uncertainty among providers about the shape of future policy and the level of local authorities' fees. This type of uncertainty can lead to an absence of investment focused on provision for local authority residents, resulting in a lack of such capacity and, eventually, increased costs for local authorities when procuring care.

The CMA also recommended the creation of an independent body that would have a range of responsibilities including oversight of local authorities and the facilitation of transparency around future fee levels.

Lessons from elsewhere

The fourth chapter of this report looks to Scotland, Germany and Japan for lessons on how to future-proof the social care system and provide greater transparency on fees and costs.

Policy recommendations

In the policy recommendation section of this report we explore the specifics of the independent body and needs of the social care market. Based on the findings in the CMA report and the current state of the market in social care, we see it having a minimum of four main functions. These are:

- Providing guidelines of funding;
- Future-proofing;
- Holding local authorities to account;
- Monitoring levels of competition and market power.

We put forward four recommendations for the independent body, which we believe should form part of the CQC's remit. The recommendations are as follows:

- **National guidelines -** the Government, in partnership with the independent body, should create national guidelines for the minimum cost of social care services. It should be designed in a similar way to the NHS national tariff and allow for local variance in cost due to unavoidable differences.
- **Demand forecasting -** the independent body should have a duty to provide government, local authorities and providers of social care with forecasts for future demand by need and place.

- **Cost of care forecasting -** it should provide government and local authorities forecasts on how the cost of care delivery may change. This should account for changes in need, wages and other local costs. This would ensure that decisions on where to allocate social care funding is made based on the best available evidence.
- **Monitor competition -** it should monitor levels of competition and concentration in residential care markets at a regional and local level and carry out regular assessments of the market power of both buyers (local authorities and self-funders) and sellers. This evidence would help ensure policymakers considering social care are properly informed.

CHAPTER 1 - INTRODUCTION

The focus of the policy debate surrounding social care in recent years been firmly on how to fund the system and the level of financial protection that should be offered to those who need to access social care services. There has been much discussion about 'floors' and 'ceilings', yet due to the political difficulty of raising more money for social care, change has not been delivered.

The coronavirus pandemic has put a spotlight on the care home sector and raises important questions about the treatment of the sector by politicians and political parties. Whilst the question of funding remains unanswered and a promised Green (or perhaps even White) Paper unpublished, very little attention is paid to the other issues apparent in social care.

One such area is the market for residential care. Irrespective of where government policy on funding is going (or not going, as the case may be) there remain issues with how the market for residential care is operating.

It may not come naturally to think of residential care as a 'market' but that is what it is – there is supply and demand and there are buyers and sellers. The aim of this report is to reinvigorate and build upon the work conducted by the Competition and Markets Authority (CMA) in their care home market study from 2017.

This project was started prior to the coronavirus pandemic in the UK and builds upon ideas discussed at an SMF roundtable in February 2020. That roundtable, held under the Chatham House Rule, brought together national and local government policymakers, industry participants and experts. This report reflects some of their observations and contributions, but this document reflects only the views of the authors and the Social Market Foundation.

Social care can be provided in the home (domiciliary care) or within a residential setting with or without nursing care. The nations of the United Kingdom have different policies regarding the provision and funding of social care. This report will focus purely on the market for residential care services in England.

The social care sector provides support to individuals of all ages, however this report focuses on older social care, since this was the remit of the CMA report in 2017.

The report structure is as follows:

- **Chapter 2** discusses the premise of considering social care as a market.
- **Chapter 3** looks at the current state of the residential care market.
- **Chapter 4** focuses on the conclusions of the CMA market study.
- **Chapter 5** reviews the international evidence on residential care.
- **Chapter 6** puts forward a range of recommendations to help policymakers address the market based issues in residential care.

CHAPTER 2 - THINKING OF SOCIAL CARE AS A MARKET

A market is an arrangement wherein suppliers of a product sell that product to a buyer in exchange for a price agreed between the two parties. By this definition, residential care in England is provided by a market – or perhaps, more accurately, by a series of local markets. It may not sit comfortably with everyone to think of social care as a market but that is the reality.

To all practical intent, there is no national market in residential care. Few, if any, buyers shop for care among a nationwide range of potential suppliers. Instead, they mostly choose from the range of available suppliers in a given area.

In these markets the operators of residential care homes agree to house and care for care recipients in exchange for fees. Those fees are paid directly by residents, or on behalf of those residents by the local authority. The interaction between and among suppliers and buyers determines the level of those fees.

The purpose of this paper is not to debate whether this arrangement is the best way to provide social care and allocate resources. Our aim is narrower. We seek to analyse the performance of the social care market, to ask how that market could work better for the people in it, and to encourage others to consider this issue in the same way.

To be clear, this is not an endorsement – or any other comment - on the desirability or appropriateness of providing residential social care through a market. A comparison of the current model relative to other forms of provision is beyond our scope. Here, we seek only to name things for what they are, and to promote similar evidence-based analysis.

One striking aspect of the debate around residential care is that the market-based nature of provision is not commonly acknowledged, certainly in public discourse and, perhaps as a consequence, sometimes in policymaking circles. The failure (or perhaps, reluctance) to discuss the social care market as a market might help to explain why information about the market and its operation is sometimes lacking.

Any policy that affects the operation of a market should be based on good information about the operation of that market. How competitive is the market? Does market power rest with buyers or sellers? What is the extent of that market power? Does that market power contribute to unnecessarily inefficient resource allocation and/or pricing that is unfair and/or likely to thwart the aims of social care policy: the availability of good quality care at affordable prices to those who need it?

Within a market, there are also many questions that arise about consumers, and how easily they are able to reach well-informed choices about their purchases. Such questions are somewhat better explored than the market-wide issues we discuss here, not least by the Competition and Markets Authority study of 2017. These questions are also largely beyond our scope here.

There are a range of questions that spring to mind when thinking about the principles of a market for residential social care.

- What does a "fair market" in care look like?
- By what criteria do we measure fairness?
- Where does the balance lie between user interest and that of taxpayers?
- Should the risk of provider failure be seen differently in the care market, given that providers are producing what is deemed to be a social good with no satisfactory substitute? Are some seen as "too big to fail"?

At present there is a lack of transparency in the market relating to fees and the amounts paid by different buyers.[1] A lack of transparency is not a good starting position for discussions regarding fairness and equity. Not all of these questions will, or even can, be answered in this report, but they should form the starting point for a more open and honest conversation about residential social care as a market.

CHAPTER 3 - THE STATE OF THE SOCIAL CARE MARKET

The social care market has been under significant pressure for a while, yet there has been a lack of political appetite to address these problems. These issues will be exacerbated by the ageing population and coronavirus pandemic.

Demand for care services

Due to the changing demographics of the UK population there has been an increase in the demand for social care services. The most recent English statistics show that in 2018/19 there were over 1.9 million requests for social care – with 1.3 million (71%) coming from those over the age of 65.[i] This represents an increase in demand from those over 65 of 4.1% compared 2015/16.[2] More than half of local authorities (85 out of 152) saw an increase in requests compared to the previous year. Not all regions of the country have experienced the same level of increase in requests for support from those aged over 65.

Figure 1: Percentage change in number of requests for support received by new clients 65+ by region between 2015/16 to 2018/19

Source: SMF analysis of Adult Social Care Activity and Finance Report, England 2017-18 & 2018-19

It is clear from Figure 1 that there are major differences in the number of new requests for support that different areas of the country are receiving. Over the three year period between 2015-16 and 2018-19 local authorities in Yorkshire and the Humber experienced a 20% increase in the number of requests – whereas those in the South West of England and the West Midlands experienced a reduction in requests. As with all statistics even regional figures can hide the discrepancies between local authorities. Between 2015/16 and 2018/19, Hillingdon (in London) experienced a 312% increase in requests. In comparison, Portsmouth (in the South East) experience a 61% reduction in requests.[3]

[i] An individual can make more than one request for support hence these figures are not to be perceived as counts of people.

We can crudely divide the type of care delivered into two categories based on the location of care provided, in both locations there will be self-funders and individuals who receive financial support from local authorities based on means testing. The SMF has previously conducted research on the large number of unpaid carers within the domiciliary setting but this does not fall within the scope of this report.[4]

Location and funding for social care

- **Domiciliary care** - care provided in the home of the care receiver.
- **Residential care** - care provided in a residential setting including a care home or nursing home.
- **Self-funders** - individual pays for their own care as they are deemed to have assets above the means test threshold of £23,250.
- **Local authority funded** - care if funded by the local authority as the individual satisfies the criteria for local authority financial support.

During 2018-19, 141,185 people aged over 65 received long-term care support in a residential care setting in England.[5] There are large differences in the numbers receiving residential care support by region, as is shown in Figure 2. The North West of England clearly has the largest number of people receiving residential support throughout the year, at 22,535 – this is considerably more than the North East of England and London with figures of 11,645 and 10,115 respectively.

Figure 2: Number of people receiving residential support throughout the year 2018-19 by region (aged 65+)

Source: Adult Social Care Activity and Finance Report, England 2018-19

It is predicted that the number of people who will have social care needs is going to continue to grow. Research by the Personal Social Services Research Unit suggests there will be an increase in demand for residential care services from both self-funders and

those relying on support from local authorities, an increase from 2015 to 2040 of 87% and 67% respectively. The reason for the increase in self-funders is due to projected rise in the proportion of older people who own their own home and hence would not eligible for local authority support.[6]

Figure 3: Projected number of older residential care users (thousands) in England 2015-2040

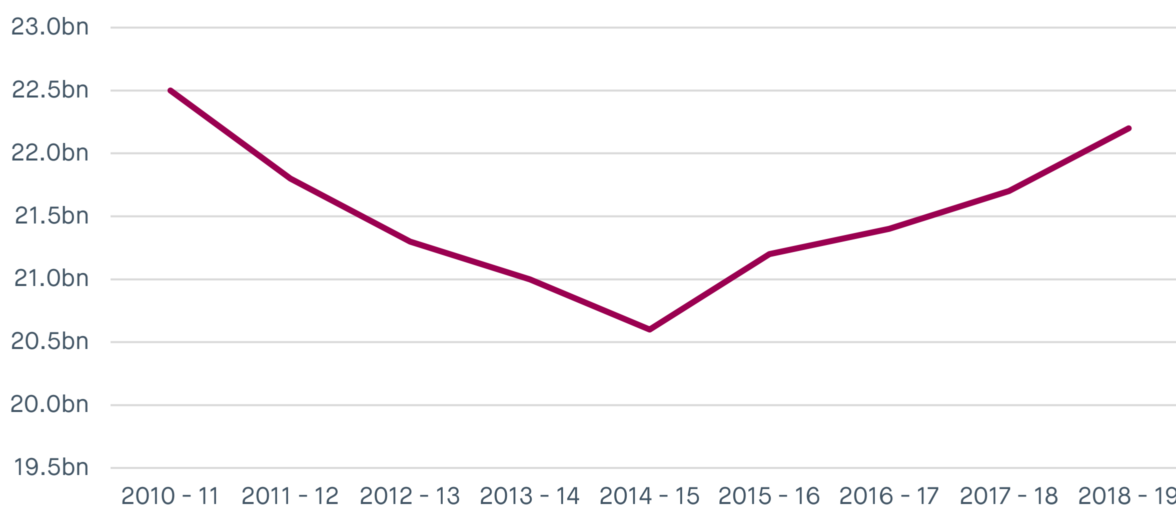
Source: Personal Social Services Research Unit (2018)

Supply of care services

Of the 1.3 million requests for support from those over 65 in 2018/19 many resulted in no services being provided (26%). Only 15% of the requests resulted in short term support to maximise independence being offered and just 10% resulted in long term support.[7] Whilst it is clear that the requests for services are increasing the number of individuals receiving long term has decreased every year since 2015/16. This has been driven by a reduction in the number of people above the age of 65 receiving long term care, a reduction of 39,060 in the three year period.[8] Levels of unmet need are a sign that the market is not effectively allocating resources.

Local authorities are facing a range of financial challenges. They have experienced cuts in funding of nearly 50% since 2010-11 and yet have had no changes to their statutory obligation to provide services – including social care.[9] Over the last decade local authority expenditure on adult social care has changed dramatically. Figure 4 shows the extreme reduction in social care expenditure between 2010-11 and 2014-15, falling from £22.5 billion to £20.6 billion. Expenditure has continued to increase since 2014-15, however in 2018-19 it stood at £22.2 billion, which is below the level seen in 2010-11.[10]

Figure 4: Total expenditure on adult social by Local Authorities, *2018/19 prices*



Source: The King's Fund (2019)

Historic levels of underfunding are likely to mean that resources are not being allocated effectively in the care market – particularly regarding residential care. Age UK have estimated that the number of older people in England with some level of unmet care need now stands at 1.5 million.[11] This suggests that the market is not allocating resources to those in need.

Cost of local authority social care

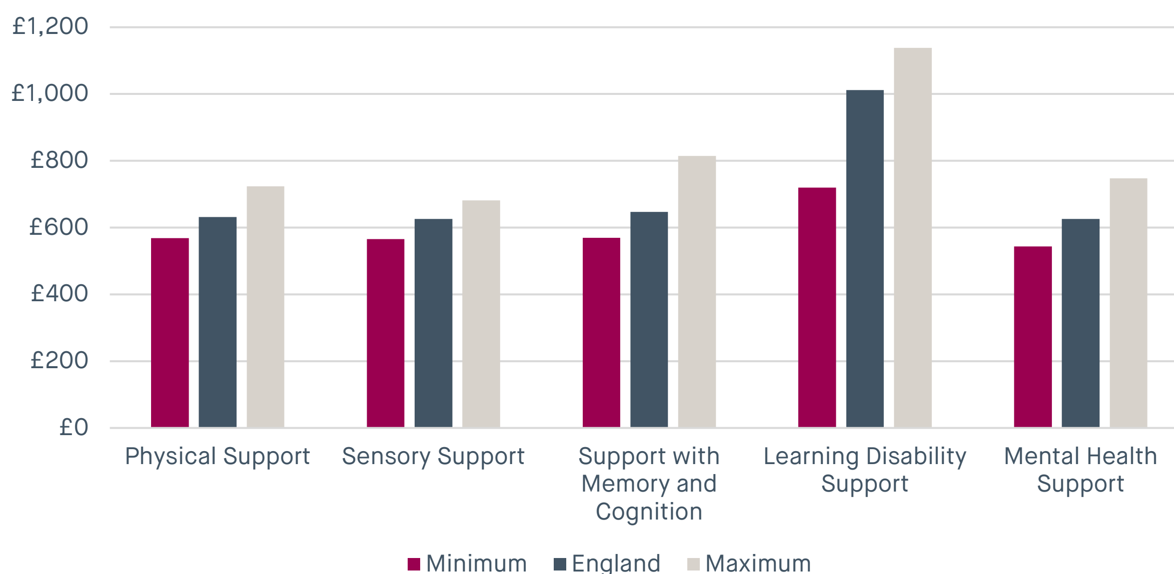
In 2018-19, the average cost of a local authority funded residential care home place for those aged 65+ was £636 per week. For residential care with nursing the figure was £678.[12] Across both care home settings, the English average was £650 per week. This is an increase of £35, or 6% compared to the previous year. As with all data presented above, the cost varies by region. Local authorities in the South West of England pay the most for residential or nursing care.

Figure 5: Unit costs for clients (65+) accessing residential or nursing long term support by region 2018-19, *cost per week*

Source: Adult Social Care Activity and Finance Report, England 2018-19

Some observers have argued that the increase in costs of residential social care has come because the needs of individuals in these settings are becoming increasingly complex. This is in part owing to the increase in the needs-based threshold for support. Evidence shows that weekly care home fees paid by local authorities vary depending on the reason for care. Figure 6 shows how the cost per week varies based on the primary reason for support. It also shows the regional variations across England, showing the minimum and maximum fees paid for each category of care.

Figure 6: Unit costs for clients (65+) accessing residential or nursing long term support, by primary support reason 2018-19, *cost per week*



Source: Adult Social Care Activity and Finance Report, England 2018-19

Care home closures

Care home closures occur for a range of reasons including financial difficulties. In recent years there have been a number of large high-profile care home closures including Southern Cross and Four Seasons.

Competition - or the number of suppliers in a market - is often used an indicator of a healthy market. Over the last five years the social care sector has become more fragmented. In 2014 the top five providers of residential care provided 16% of the beds available across the UK. In 2019 this dropped to 13%.[13] Overall, the supply of residential care beds has reduced in recent years, whilst demand has increased.

The 2020 annual report on openings and closures in care homes for older people produced by CSI Market Intelligence found a net loss of 149 care homes in 2019.[14] There were 111 openings and 260 closures – whilst the evidence shows new care homes tend to be larger than those that close, there was still a loss of 1,109 beds in 2019.

The total number of care homes and beds in the country is a useful indicator of the state of the market, but arguably more important is matching local supply and demand. Making sure the allocation of resources is occurring efficiently – i.e. the right care is being provided where it is needed. In 2019, there were few openings of non-dementia homes, with residential only and nursing only losing 2.5% of beds.[15] Across England, the North

East was the only region to experience a net gain in beds in 2019, experiencing an increase of 49 beds.[16]

The CSI research finds that across the five years of reporting on the opening and closing of care homes, supply by local authority does not always match the local demand. They conclude that "care deserts" are being created in some areas of the country whereas there is an oversupply or too much competition in other. [17] Neither of these situations indicate that the market is allocating care resources effectively, that competition is present across the country or that consumer's economic welfare is being maximised.

Pressure from coronavirus

This research project was started, and the roundtable held, prior to the coronavirus pandemic in the UK. The pandemic has been particularly difficult for care homes. We have already highlighted the number of care home closures that occurred in 2019 and there is a risk that coronavirus leads to an increase in care home closures due to additional financial pressures. Research by the Association of Directors for Adult Social Services (ADASS) found that 82% of Directors were concerned about the financial viability of at least *some* of their residential and nursing providers before coronavirus. Now a quarter of directors have concerns about *most* of their providers and 7% are concerned about *all* providers.[18]

Research conducted by LaingBuisson, commissioned by the LGA and ADASS, calculated that the sector will face more than £6.6 billion in extra costs due to coronavirus, such as PPE, staffing and deep cleans, by the end of September 2020. Adult social care has had access to approximately half of the £3.2bn Emergency Funding to support the whole of local government's response to the pandemic, along with a £600m Infection Control Fund (£2.2bn total).[19] It is clear that some of the financial burden associated with coronavirus will fall onto the owners of residential care homes and local authorities.

The LaingBuisson research, which was produced in June 2020, found that a significant majority of councils have seen a reduction in care home occupancy since the coronavirus outbreak. The reduction is more prominent in homes occupied by mainly state-funded residents: 78% of councils saw a reduction in occupancy in these homes. Meanwhile 51% of councils saw a reduction in occupancy in homes mainly providing services to self-funders.[20] Furthermore, more than half (53%) of councils have received direct requests for financial support from care homes where there has been a significant reduction in self-funding residents.[21]

There is a risk that this already fragile market will be made significantly worse by coronavirus. Increased costs faced by providers combined with reduced occupancy rates in care homes will inevitably increase the chance of providers going out of business or deciding the exit the market.

CHAPTER 4 - CMA MARKET STUDY

In 2017, the CMA published a market study into residential and nursing care for older people.[22] The CMA concluded that there were two broad areas where problems were occurring in the market. These were:

1. Those requiring care need greater support in choosing a care home and greater protections when they are residents. Decisions are often made in urgency and under distressing circumstances.
2. The current model of service provision cannot be sustained without additional public funding; the parts of the industry that supply primarily local authority (LA)-funded residents are unlikely to be sustainable at the current rates local authorities pay. Significant reforms are needed to enable the sector to grow to meet the expected substantial increase in care needs.

Decision making in the residential care market

The first of the CMA's areas of concern related to decision making and protections afforded to consumers of care services. Choosing a care home can come at particularly difficult point in people's lives, often coming at the point in which they are most vulnerable. The CMA report states that decisions are frequently made with urgency and under extremely distressing circumstances – such as following a recent illness, injury or loss of a carer. It is in this difficult moment that people are faced with the daunting prospect of understanding the complex social care system - including their eligibility for funding - and finding a suitable, available care home. Once in a care home it can be very difficult for residents to change their mind and move to another home.

The CMA's recommendations in this space can be grouped into three broad areas;

- Helping people to make good decisions about their care options;
- Protecting residents and their consumer rights; and
- Making the complaints system work well for care home residents, their representatives and families.[23]

A range of recommendations were put forward and progress has been made on implementing them. The focus of our report is on the CMA's second area of concern: the long-term sustainability of the supply-side of the care market.

The model of service provision

The second area of concern highlighted in the CMA market study is the model of service provision, particularly state-funded care, both now and in the future. As shown above, public expenditure on adult social care, of all types, has been under pressure since the financial crisis and subsequent period of fiscal austerity in the UK. It is in this section of the study we see the fragility and causes for concern in the market for care services.

Differential fees

The CMA report highlighted the differences in fees paid by self-funders and local authorities. The proportion of those in residential social care who self-fund varies by

region. This is likely to be due to varying levels of wealth and home ownership: in areas where property values are higher, more people are likely to be above the threshold for LA-funding.

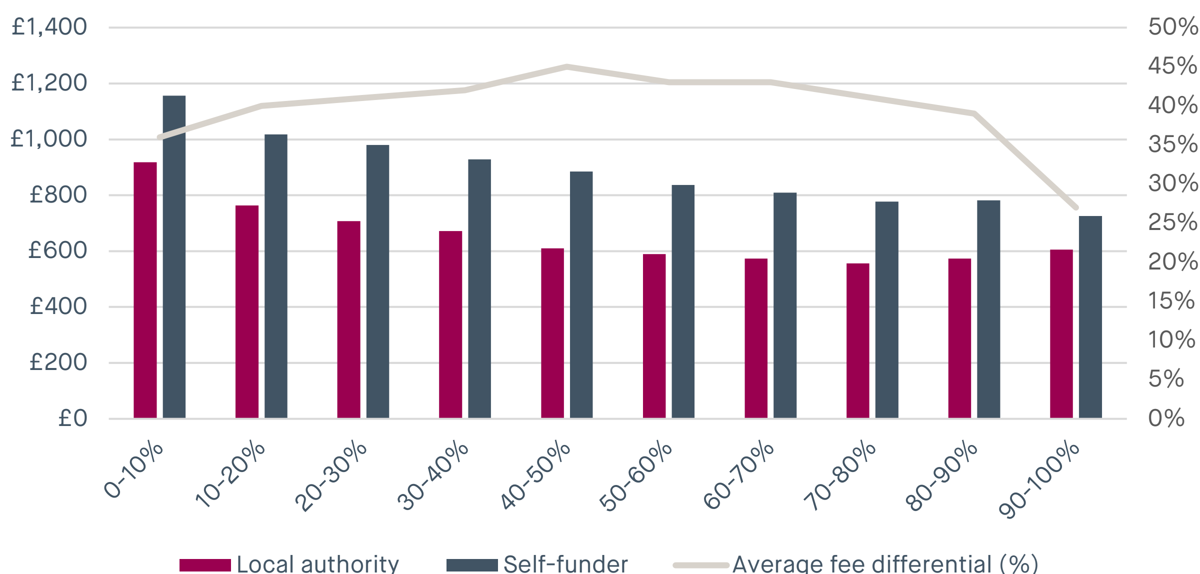
Figure 7: Proportion of self-funders by region

Source: LaingBuisson via CMA report (2017)

Across the UK, 41% of care recipients are self-funders and 49% receive local authority support. A quarter of the latter group then pay top-up fees. The NHS pays for the residential care needs of the remaining 10%. There is a significant gap between the region with the lowest proportion of self-funders and the highest. In the North East of England just 18% of care home residents are self-funders compared to 54% in the South East.

On average, self-funders pay 41% more for their care per week than local authorities, equivalent to £236.[24] The incidence of cross subsidisation has increased in recent years – in 2005 the Office of Fair Trading found only one in five homes charged differential prices.[25] The fee differential varies based on the proportion of local authority funded residents in the care home – as is shown in Figure 8. Care homes where there is an almost even split between LA-funded individuals and self-funders have the highest level of cross-subsidy (as a percentage).

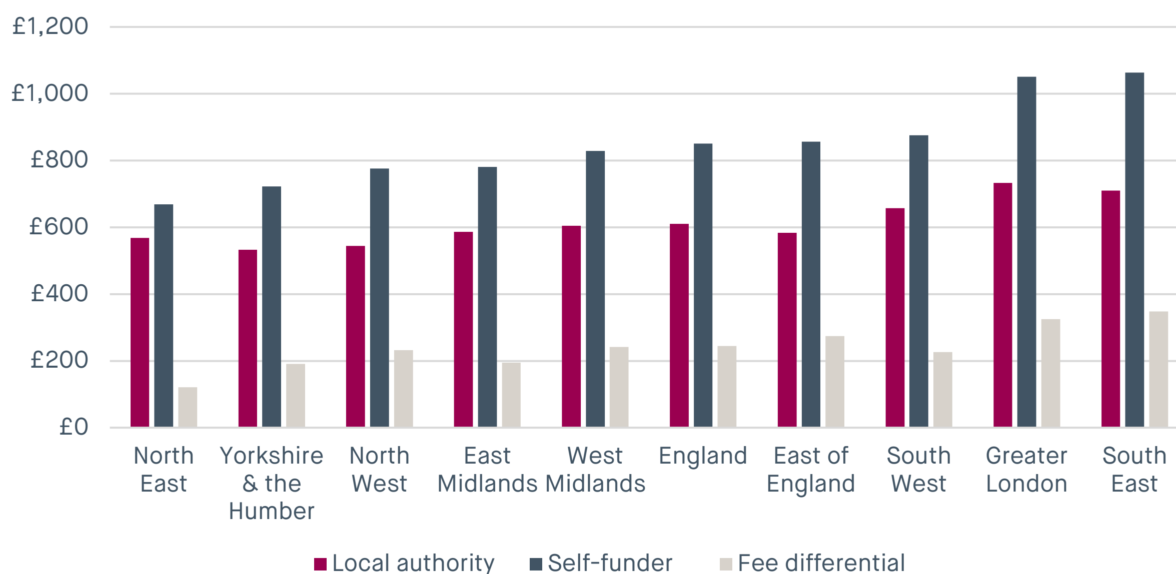
Figure 8: Average fee levels per week (£) and price differentials (%) by proportion of LA-funded residents



Source: CMA (2017)

The fee differential also varies across the regions of the country. Earlier we discussed the different fees local authorities pay for social care across the country and therefore it is not surprising that the gap between local authorities and self-funders varies too.

Figure 9: Level of cross-subsidy in the care market by region, *fee per week (£)*



Source: CMA Market study (2017)

The region of the country with the lowest proportion of self-funders has the lowest fee differential in cash terms, whereas the region with the highest proportion of self-funders has the highest fee differential. In cash terms, the North East of England has the lowest fee differential between local authority funded residents and self-funders – the fee differential stands at £121 per week, equivalent to £6,292 per year. In the South East of England, the fee differential is substantially higher at £348 per week or £18,096 per year.

On a proportional basis, self-funders in the North East pay 23% more for their care than local authority residents and in the South East the figure stands at 52%.

Within these regions there will be local authorities who pay different amounts and subsequently have different fee differentials. There is very little uniformity in residential care and local authorities act differently. They have different requirements and different costs. However, robust data is not available on a more granular level to demonstrate this.

At the roundtable held as part of this project, some suggested that since the publication of the CMA market study in 2017, local authorities have started "self-correcting" and the amount they pay for care is increasing. Other participants, by contrast, said they have seen no such "correction" since 2017. Due to the lack of regularly produced evidence it is not possible to say whether the amount LAs pay has increased enough to reduce the level of cross subsidisation in the market or whether any increases simply reflect the increased need profile of those in residential care.

The need to future-proof

The CMA study reported that there is a significant amount of uncertainty among providers about the shape of future policy and the level of local authorities' fees. This type of uncertainty can lead to an absence of investment focused on local authority residents resulting in a lack of capacity and increased costs for local authorities when procuring care.

Local authorities, as a major customer, have a duty to help facilitate planning in relation to the provision of care. In England, Market Position Statements (MPSs) were created to provide transparent information from local authorities to social care providers. However evidence suggests that these documents tend to be top level guides related to all adult social care[26] and contain no specific information related to forecasts on care home numbers or investment demands. Suppliers report that these details are essential for future planning in the sector.

Recommendations

The CMA study raised a concern related to the sustainability of the social care system, including the lack of future planning and the levels of fee differential.

It is not appropriate to say self-funders should never pay more than local authorities, since there are valid reasons why fee differentials may occur. These include the ability of the local authority to bulk purchase, and different services being offered to self-funders, such as a bigger room or better view. As part of the market study, the CMA considered recommending self-funders be charged the same as local authorities but rejected this course because it would impose significant costs on LAs and risk splitting the market in favour of those care homes that could concentrate on self-funders (particularly those that are well placed and with attractive facilities to meet areas of high local demand) and might want to stop serving LA-funded residents altogether.[27]

The market study recommended the creation of an independent body to:

- **Provide oversight of local authorities**, for example to assess whether the LA's current delivery of care is properly meeting its obligations; ensure that future plans are well informed and made and consistent with duties, that steps are being taken to ensure the need for investment in the plans is being met, and that in practice the investment required is being delivered and the rest of provision maintained as in the plans.
- **Support local authorities in planning by acting as a centre of excellence** in developing planning and forecasting tools and facilitating sharing of best practice. It could also provide supporting analysis and data as inputs for the local analysis of future needs and how these can be met.
- **Advise central government on the costs of providing different types of care to feed into funding decisions**. It could also advise on future needs for care services and capacity requirements.
- **Facilitate transparency on the delivery of social care, for example in relation to fee differentials.**

The report recommended that the Care Quality Commission (CQC) should take on this role in addition to its current responsibilities.

CHAPTER 5 - LESSONS FROM ELSEWHERE

The CMA report highlighted the need for greater collaboration between national and local government and the need for an independent body to oversee this and help with future proofing. There are examples both in the UK and internationally that show how national and local government can work together in the health and social care sphere and where independent bodies have proved effective.

Scotland

Scotland has a different social care system to the one used in England – Scotland provides "free" (i.e.: publicly-funded) personal and/or nursing care regardless of wealth or income, a policy in place since 2002. There are some components of non-personal care and residential care that are charged for.

To help plan future provision, Scotland uses an initiative called 'Scotland Excel', the Centre of Procurement Expertise for the local government sector. This was established in 2008 and is funded by Scotland's 32 local authorities.[28] The service is used to support local strategic commissioning of care home services for older people. There are four streams to the work of Scotland Excel:

- Market intelligence;
- Financial risk;
- Cost of care; and
- Procurement strategy.[29]

Scotland Excel has now taken over operational control of the national care home contract (NCHC) from Scottish LAs and will lead on the next phase of negotiations to conclude the outstanding elements of a new Care Cost Model. The final model will be used in the fee-setting process for 2020.[30]

Every year, local councils in Scotland set standard rates that they will pay forwards care home fees. Local councils are required to set rates for the care homes they own and manage at a rate equal to the actual cost of providing accommodation and care.[31]

Germany

In the last twenty years the social care system in Germany has undergone major reform. Prior to reform, Germany's social care system was in a similar position to England today. Both main political parties in Germany joined together to work on radical reform. The main elements of this reform were:

- Responsibility for social care was effectively transferred to national government as the federal states had been struggling with rising costs.
- Government pools the risk of social care across the whole of society. A mandatory long-term care insurance (LTCI) system was introduced in 1994, involving a tax on workers with employers meeting half of the costs on behalf of their workforce. The current contribution rate is 2.5% with childless adults paying slightly more.[32] Lower rates are paid by unemployed people, students and pensioners. The levy is

hypothecated and access to it is not means tested.[33] The LTCI is not intended to cover all costs of social care but offers universal access to care resources for basic needs.[34]

Irrespective of how the funds needed for the social care system are raised there are important lessons to be learnt from the German model.

Federal states are responsible for providing the infrastructure for social care, including ensuring there are enough nursing homes. Nearly all social care is delivered by private providers.[35] However, Germany sought to develop a stable and competitive market by creating a national regulatory framework which coexists alongside market principles. The federal government is not directly involved in the provision of care services, but it does provide a legal framework and oversight of the level and quality of services, their reimbursement and contracting. The payment system offers certainty for providers combined with flexibility on a state and local level. A basic fee is guaranteed at national level, but local negotiation is allowed for variations relating to costs. As part of the negotiation process, providers must agree the prices they will pay for bed and board.[36]

Prior to the price negotiations, providers submit evidence on the scope, content, type and cost of the care provided. It is not only the current costs that are taken into consideration but projections of future expenditure and costs, including wage changes. This works to ensure providers are fairly remunerated.[37]

Unlike in the UK where discussion often relates to the fragile nature of care home finances, the main concern in the German market is that providers can make large profits. However, as care benefits are set nationally and the full cost of care is met for those who are unable to do so, Germany is not experiencing 'care deserts' as in the UK.

Japan

Japan has one of the oldest populations in the world: 28% of the population are over the age of 65; for perspective in the UK this figure stands at just 18%.[38] A compulsory long-term care insurance covers the needs of the population aged 40 and above. This scheme was introduced in 2000. The benefits are generous and are designed to cover the cost of care minus a 10% co-payment (with reductions available for those on lower incomes). One third of accommodation costs are covered, with the remainder subject to a means test.[39]

Approximately one half of revenue for the long-term care insurance scheme is raised through general taxation, one-third from premiums for people aged between 40 to 64, one sixth from people aged over 65, and the remainder from co-payments from users.[40] Since 2005, people using services have been required to pay 'hotel costs' for residential care and contribute to meals – these contributions are means tested and capped for those on low incomes.[41]

There is a growing number of residential care institutions in Japan, even though providers of institutional care are not allowed to be profit-making (with the exception of group homes).[42] Service prices are set by government and are universal across regions. Selection by service users is therefore made on the basis of convenience and (perceived) quality.[43]

In order to help shape the market and control the level of expenditure, Japan designed a national fee schedule. The fee schedule consists of seven unit-price levels which include an adjustment for cost of living, based on the salaries of local civil servants. This enables the government to tightly control what providers are paid per unit of care.[44] The fee schedule can be used to incentivise care in one setting over another, and governments have used it to adjust the balance between institutional and home-based care. There are three-yearly reviews of the system which provide an opportunity to review the provider market and identify gaps in provision or over-supply.[45]

Given the financial pressures in the UK system it is clear that a national fee system which adequately covers the costs of providing care could be something for the UK to explore. However there are risks from this approach such as the reduced ability to make profit and invest in facilities.

NHS Tariff system

Unlike in social care, there are nationally agreed unit prices for care in the healthcare system in England, known as 'national tariff'. Each year, NHS England and NHS Improvement publish the national tariff, which contains the prices and payment rules for commissioners and providers to use for the period April to March.[46] The national tariff includes a market forces factor which estimates the unavoidable differences in cost between healthcare providers based on their location.

The Office for Budget Responsibility

There is precedent in the UK for creating an independent body to oversee parts of government. The Office for Budget Responsibility was established by the coalition government following the 2010 election. It is funded by HM Treasury and is responsible for providing independent economic forecasts and analysis on public finances. It has five main roles:

- Economic and fiscal forecasting to accompany the Autumn Budget and Spring Statement;
- Evaluate the Government's performance against its fiscal targets;
- Assess the long-term sustainability of the public finances and analyse the public sector's balance sheet;
- Evaluate fiscal risks from 2017; and
- Scrutinise tax and welfare policy costings at each Budget.[47]

The OBR's forecasts include spotlight analysis on specific issues such as demographic pressures, economic downturns and changes in immigration. Whilst the OBR focuses specifically on the economic and fiscal position of the UK it provides a useful model of how independent bodies can be created to support and scrutinise the activities of government.

UK regulators

In the UK, statutory economic regulators are responsible for ensuring the market is operating efficiently and working in the best interest of consumers. As a result of this remit they monitor a range of different metrics to ensure good outcomes. These include:

- Levels of consumer switching in the market;
- Cross subsidy between consumers;
- Barriers to entry for providers / suppliers;
- Market share / levels of competition; and
- Levels of trust and confidence.

By contrast, the CQC has a limited responsibility as a regulator in the care market. Its main responsibility is to monitor and evaluate residential care homes rather than assess the performance of the market as a whole.

CHAPTER 6 - RECOMMENDATIONS

In this chapter, we explore how policy could be adjusted to ensure the market for residential social care works more efficiently. The CMA's recommendation to create an independent body was a welcome one. This recommendation has not been implemented and there are still questions about how best to create such a body in the social care market. The CMA recommended the creation of an independent body which would:

- Oversee local authorities;
- Support local authorities in planning by acting as a Centre of Excellence;
- Advise central government on the costs of providing different types of care to feed into funding decisions; and
- Facilitate transparency on the delivery of social care, for example in relation to fee differentials.

In the remainder of this chapter we explore the specifics of the independent body.

What functions should the independent body have?

Based on the findings in the CMA report, the current state of the market in social care and the contributions from our roundtable participants, we see the proposed independent body as having a minimum of four main functions. These are:

- Providing guidelines of funding;
- Future-proofing;
- Holding local authorities to account;
- Monitoring levels of competition and market power.

Funding and fees

The broader question of how the social care system should be funded and the level of protection given to those who use social care services is still unanswered. Steps must be taken in the meantime to ensure a more fair and stable system.

The question of fairness in the social care market was raised earlier in this paper. It was a question discussed at length during the roundtable. In some aspects, it may be fair that residents pay different amount for their care depending on who is paying for this: there are benefits to bulk buying and being able to pay for additional services. However, it is unfair if this is occurring simply because local authorities' fees do not cover the cost of providing care, requiring providers to make up the difference by charging self-funders more.

There is no guide set by the Government for how much care should cost or what constitutes adequate levels of funding – the lack of clear instruction from the Government is likely to be one of the contributing factors to the wide disparities across the UK.

As explained in Chapter 4, both Japan and Germany use a national fee structure for social care to ensure fees do not become too high or too low. This mitigates against the situation we are experience in England where some local authorities are paying below cost and self-funders are paying more to fill the gaps.

Recommendation: national guidelines

The Government, in partnership with the independent body, should create national guidelines for the minimum cost of social care services. It should be designed in a similar way to the NHS national tariff and allow for local variance in cost due to unavoidable differences. Local authorities proposing to pay less than the guideline level should be obliged to justify their proposals to the independent body for approval. The independent body should be empowered to reject fee levels it judged would undermine long-term supply in the market.

Implementing a national guideline for costs could help stabilise the financial position of residential homes in England and reduce the occurrence of "care deserts" in disadvantaged areas of the country. Whilst the scope of this report is on the residential care market, transparency on how much local authorities should be paying across all care settings would be welcome.

It is likely that local authorities would require additional funding from national government in order to implement the recommended fees set out by the guidelines. This would stop them needing to make tradeoffs between adequately funding care and providing other local services. It is important that any implementation of national guidelines should strengthen the position of local authorities and their ability to shape the market.

The CMA decided not to recommend that local authorities be given statutory guidance on how they must calculate the cost of care or the rates that they must pay to providers, nor that there be mandatory national rates that local authorities must pay. The CMA report gives the following reasons for not recommending this:

- Additional accountability would ensure capacity and delivery of investment in an area;
- Delivering cost of care models for the whole of England would be complex;
- It could reduce competition and set a focal price with lower incentives to drive efficiency, quality and innovation; and
- A standardised fee may not be effective in promoting quality.

We believe the evidence from German shows that national guidelines do have a place in a good market for care. The NHS tariff system also shows that there is precedent for this type of system in the UK and creates a starting point for the methodology of how to go about setting prices.

Future planning

The lack of planning and forecasting in the market is creating instability. Instability and a lack of investment in the sector would suggest a market that is not working as efficiently as it should. The independent body should facilitate improved planning and forecasting. Lessons should be learnt from Scotland Excel who have already paved the way for this type of activity in the social care sector in the UK.

Recommendation: demand forecasting

The independent body should have a duty to provide government, local authorities and providers of social care with forecasts for future demand, by need and place.

The forecasts should cover a long enough time horizon to enable all involved parties to work together to ensure changes to the supply of care are made in advance of demand changes. This would enable investment to be made in the right areas of the country and in the right services so to match the need profile of those who will require care.

It is not only the demand for care that is important to governments and providers of services but the cost of delivering that care.

Recommendation: cost of care forecasting

The independent body should provide government and local authorities with forecasts on how the cost of care delivery may change. This should account for changes in need, wages and other local costs. This would ensure that decisions on where to allocate social care funding is made based on the best available evidence.

It is important to recognise the current legislative landscape in this sector in order to avoid duplication. The Health and Social Care Act 2012 promoted greater accountability, including the creation of Healthwatch England,[48] as an independent consumer champion for health and social care. There is a local Healthwatch in every area of England. The main aim of the organisation is to understand the needs, experiences and concerns of people who use health and social care services and then to speak on their behalf.[49]

However, this role has little direct bearing on the function of the care market, and there is clearly more that can be done to promote transparency in that context, to ensure local authorities are held accountable for the decisions they make about the current and future provision of care. The CMA study suggests that the oversight / accountability function of the independent body would examine:

- The current delivery of care to ensure local authorities are meeting their obligations.
- Any future plans to ensure they are well-informed, quantified and suitable to provide for future care needs.
- The steps being taken by local authorities to ensure the need for investment in their plans will be met and their actions provide a basis for investors to have positive expectations.
- Whether the investment required is taking place and the provision of care is consistent with these plans.[50]

Market Power and the need for better information

If social care is to be provided by means of a market, policymakers should have much better information about how that market is functioning. This need is particularly acute with regard to the market power of buyers and sellers.

In both academic and official literature there is a lack of evidence about the levels of market power held by suppliers and buyers in care markets. A 2011 paper by Forder and Allen found a "surprising" lack of evidence about market power and its consequences. [51] In 2017, the same authors (with Katerina Gousia) again found that this issue was poorly-explored, and sought to fill the analytical gap with quantitative analysis of their own.[52]

In this context, we are struck by this observation in the CMA study:

> *"LAs (as they are major purchasers of care home placers) are **likely** to have considerable negotiating power to force prices down to levels that may not be permanently sustainable."*[53] *(emphasis added)*

It is surprising that a competition authority studying a market should observe the possibility of such a concentration of market power as to raise doubts about that market's ability to continue functioning, and yet not pursue that observation further.

Not least given that the CMA acknowledges the possibility that local authority market power could allow downward pressure on fees that would have the effect of reducing supply, we conclude that policymakers need greater information about market power in this market. If the structure and operation of the care market is jeopardising the supply of care, policymakers should know and be able to act on that knowledge.

Recommendation: monitor competition

The new independent body should monitor levels of competition and concentration in residential care markets at a regional and local level and carry out regular assessments of the market power of both buyers (local authorities and self-funders) and sellers.

We make this recommendation without expressing any view about what, if any, policy interventions should follow where market power is found to justify the fear expressed by the CMA about unsustainable prices. We simply conclude that those responsible for social care policy should know when the method employed to deliver social care (the market) is producing outcomes that raise questions about the future supply of social care. Better monitoring of competition in the care market would ensure that policymakers were better-informed about the performance (present and future) of the market and could act accordingly.

Who should run the independent body?

The CMA stated that the CQC should take on the additional responsibilities of the new independent body. This verdict proved popular with the attendees of the roundtable held

as part of our project; a common argument advanced was the need to avoid the complication and cost of creating another statutory body for the care sector.

The Care Quality Commission is the independent regulator of all health and social care services in England. If a provider wishes to carry out activities that are regulated by the CQC they must register and prove they satisfy a range of criteria. The CQC is then responsible for monitoring, inspecting and rating services provided by those in health and social care.[54] The CQC's role in registering and monitoring care market participants means it is well-suited to take on the additional duty of assessing and approving LA fees.

The CQC regulatory functions are funded both by fees paid by providers and by grant-in-aid from the Department of Health and Social Care.[55]

There is the option to create an entirely new body to oversee these responsibilities, similar to the way in which the OBR was established. However, attendees of the roundtable raised concerns that moving away from the CQC could put further pressures on local authorities to deal with another statutory body.

Recommendation: expanding the Care Quality Commission's remit

The functions of the independent body should become a part of the CQC's remit. This would ensure there is still one point of call for local authorities and providers of residential care.

In order to fulfil this brief, the CQC would need to receive additional funding from the Department of Health and Social Care. An increase in fees paid by providers may also need to be considered. In 2017, the CMA reported that their recommendations of additional oversight and an advisory role would cost an additional £15 million per annum – this is a relatively small increase to the £200 million budget of the CQC[56] and would be more than justified by the improvements in the functioning of the care market that an enhanced role could deliver.

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