

Will 2018 be the year the adult social care market in England collapses?

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Abstract

The privatisation of adult social care has transformed the way in which these services are provided in the UK since the 1980s but has been the subject of relatively little critical examination. This article explores the nature and extent of privatisation and suggests that the model is reaching a tipping point in terms of funding, workforce, consumerism and market sustainability. An agenda for addressing these problems is outlined.

Keywords: Adult social care, privatisation, limitations of markets, regulation

Introduction

The term adult social care (ASC) refers to personal care and practical support for adults with physical disabilities, learning disabilities or mental health issues, as well as support for their carers. The care needs of such 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 (Health and Social Care Information Centre, 2015). Policy responses to this situation are acknowledged to have been inadequate and it is now common to refer to ‘the crisis in social care’. This article examines the longstanding fragility of the ASC sector and suggests that the service is reaching a multiple ‘tipping point’ in terms of funding, workforce, choice and market sustainability. Some options for change are then identified.

Policy failure and service fragility

The first major post-war policy shift on ASC came with the publication in 1968 of the Seebohm Report (1968). Structurally the report proposed (at local authority level) the amalgamation of a host of small sections and functions into one powerful and overarching social services department with its own chief officer. This was to be matched at national level by a minister in central government with a corresponding field of authority. It resulted in a few short-lived years of coherent policy-making. Since then ASC has been shaped by two key policy parameters – the growth of marketisation and the reduction in public funding following the global recession. The ways in which these factors have evolved and intersected has led to an ongoing crisis in ASC. Four ‘fragilities’ are identified: funding; workforce; consumerism; and market provision.

Fragility of funding

Local government services have borne much of the brunt of the Government’s austerity programme since 2010 and despite efforts by councils to protect ASC there have been significant service cuts since 2010. In the case of older people, a joint report from the King’s Fund and Nuffield Trust (2016) has estimated a reduction of 26% in the numbers receiving help. More broadly the Association of Directors of Adult Social Services tracks social care budgets and expenditure annually and in its most recent report concluded that the sector had reached ‘tipping point’ (ADASS, 2017). It was pointed out that the pressure is not simply arising from higher numbers of older people but also from the increasing care needs of younger adults with learning or physical disabilities or mental health problems.

These funding restrictions have also 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 (House of Commons Library, 2017). Most importantly it has impacted upon vulnerable individuals and their families who have had to increasingly fund their own care without any limit to the amount they are required to spend. All told a recent report from Ipsos MORI (2017) estimates that the number of older people in England unable to get the social care help they need has reached 1.2 million – a 48% increase since 2010.

It is not, however, simply the volume of support that has been affected, but the quality. The recent national review by the Care Quality Commission (2017) rated a fifth of services as requiring improvement or inadequate, with almost a quarter deemed to be unsafe. The granularity of what this means for daily life is indicated in a survey of over a thousand care workers by Unison (2017) which reveals the lack of time to wash, bath or shower residents (or even converse with them), along with rationing of basic supplies like continence pads, wheelchairs, wet wipes, gloves and hoists.

Fragility of the workforce

The ASC workforce is now characterised by low pay and insecure working arrangements. A review by the House of Commons Public Accounts Committee (2015) 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 direct care workers were being paid below the statutory minimum wage; and around one third of care workers were on zero-hour contracts whereby they had no guarantee of how much work they might have, when they would be required to attend and had no access to sick pay, holiday pay or employer pension schemes. More recently the underpayment of staff doing sleep-in shifts has been ruled unlawful by HM Revenue and Customs (Community Care, 2017).

There are, moreover, differences between workers in the statutory, not-for-profit and private sectors. Research carried out by The Smith Institute (2014) comparing the median hourly wages by occupation across the three sectors shows the private sector performing comparatively badly, and the gap widens further when other payments, training and pensions are taken into account. The point has arguably been reached where it is broadly no longer a feasible ambition to acquire skills or a profession and pursue a stable career with an enduring and reliable organisation in ASC.

All of this has led to a workforce crisis in ASC with growing problems of recruitment and retention. There are over 80,000 vacancies in the sector and annual turnover rates are alarmingly high at around 27% (Skills for Care, 2016). 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 and emergency closure. The impact of immigration policy on the UK social care workforce is now set to deepen with the introduction of a 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 settle permanently. One survey (Independent Age, 2015) suggests that migrants from outside of the EU make up the largest number of foreign nationals employed across the UK adult social care sector – for every seven care workers, one is reckoned to have been born outside of the EU. There is now the additional 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 consists of EU nationals but this rises to 12% in London (Skills for Care, 2016a).

Fragility of consumerism

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 – entry is often unplanned, is made in response to a personal crisis and with very low rates of switching to a different provider in the event of dissatisfaction (National Audit Office, 2011; Competition and Markets Authority, 2017). In the UK 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 be taken into account, depending on circumstances. The costs people face can be catastrophic – one in ten who enter the care system at their own expense end up paying over £100,000 in fees.

This requirement to use the value of assets and savings, allied to the tightening of restrictions on access to state funded care, has resulted in a large growth of self-funding ‘customers’ whose existence has seemingly become vital to the survival of care providers. By 2014 around £10 billion was being spent by people paying for their own care and support compared with £14 billion spent by councils, and in some wealthier parts of the country self-funders constitute the majority of the care market. Overall only about 37% of older people have their care home fees fully met by local authorities; another 12% pay ‘top-up’ fees on top of this funding, 10% are paid by a different statutory body (the NHS) and 41% are paying wholly on their own account (Local Government Association, 2014; House of Commons Library, 2016).

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. 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 (Laing Buisson, 2015). 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. Indeed, the Competition and Markets Authority is now threatening to enforce consumer law to prevent any such cross-subsidy, which could further reduce the financial viability of care homes dependent upon local authority funded residents (Competition and Markets Authority, 2017a).

Fragility of market provision

The election of a Conservative Government in the UK in 1979 under Prime Minister Margaret Thatcher quickly led to a questioning of the post-war welfare settlement and of the role of professional and bureaucratic models of service delivery. At first a policy shift towards outsourcing was confined to compulsory competitive tendering for such services as school meals, rubbish collection and leisure services, but the aspiration was much bigger – a belief that the best corrective measure was to promote choice through the extension of markets into state welfare services.

The policy significance of social care services is that they have been part of this trend for many years – indeed they could be regarded as the first neo-liberal public services pilot. In 1988 the Conservative Government commissioned Sir Roy Griffiths (the head of a supermarket chain) to review the funding and organisation of community care. His rapidly completed report (Griffiths, 1988) proposed an increased role for the private and voluntary sectors in residential and domiciliary services, but with the local social services authority assuming the lead role in commissioning this care. His recommendations fed into the subsequent 1990 National Health Service and Community Care Act under which local councils were recast as ‘enabling authorities’. Funding for this new role was accompanied by a requirement that 85% of it should be spent on the ‘external’ purchase of services.

The transformation towards an ASC market has progressed steadily since the passage of the 1990 Act. 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 it 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% (CHPI, 2013). This also means the bulk of the ASC 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' (Institute of Public Care, 2014).

A 'tipping point'?

In combination these four fragilities raise serious questions about the sustainability of ASC services and support. The Government's response broadly consists of the injection of small amounts of funding, usually accompanied by complex restrictions and requirements. This has included the option for councils to impose a 2% (later 3%) social care levy on council tax and the transfer of some funding from the NHS via the Better Care Fund, accompanied by the imposition of fines for delayed transfers of care from hospital (ADASS, 2017). None of this has been sufficient to prevent the service slipping towards tipping point.

The most serious problem with the creation of this 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 covering thousands of service users leaving the care market. The first major casualty was Southern Cross in 2011 (Scourfield, 2012), a large company responsible for 31,000 older people mostly concentrated in one geographical area in the north east of England.

A review of the stability of the care market in England (Institute of Public Care, 2014) identified a range of reasons for the collapse of Southern Cross: a high rental bill as a result of the terms of its leases following the sale and lease back of its properties which amounted to £250 million pa; a drop in income that resulted in a reduction in property maintenance which in turn led to lower occupancy; loans attracted higher interest rates because the company had no properties against which to secure loans; market confidence fell and share price dropped; poor management and quality of care 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'.

In the event, other private companies were persuaded to take over the operation of the Southern Cross businesses and premises, but the IPC report suggested this was 'a fairly close run thing' and that if another major provider had collapsed at about the same time, the rescue might not have been possible. Moreover, the main company that took over the contracts – Four Seasons – is itself now suffering large financial losses and having its viability called into question (Dolan, 2016). As 2017 drew to a close this company – responsible for supporting 17,000 people – was reported to be on the brink of collapse, with only a US hedge fund said to be interested in providing a bail-out package (Guardian, 2017).

There is little confidence in England that further market failure can be avoided. A survey of almost half of all local authorities in England responsible for social care commissioning (Department of Health, 2016) found that 77% had experienced provider failure in the year 2015/16 and 74% thought another failure likely in the coming year; a further analysis warns of the loss of 37,000 beds in the care sector by 2020/21 (ResPublica, 2016). In the case of home care, two of the top five providers (Care UK and Saga) recently decided to pull out of the market. In the case of the latter, a declaration to the London Stock Exchange simply said that the activity 'no longer fitted with the Saga business model'. The Local Government Information Unit (2017) has accordingly warned of an imminent collapse in the home care market.

Where next?

The issue now is not so much whether or not ASC is in crisis but rather, what can be done about it? The fundamental prerequisite is better funding – sector leaders estimate a need for at least an additional £2.6 billion by 2020, along with reform to the ways in which individuals fund some or all of their care (ADASS, 2017). However, there is also a need to change the role and shape of the market in ASC. This could take the form of several ‘tests’ (CHPI, 2016).

Commissioning test

The remarkable stripping out of local authority provision since 1990 has simply not worked and the role of the local state also needs to be rethought. Local authorities have been deprived of the funding, knowledge, capacities and capabilities needed to manage change. These need to be restored and rebuilt, as does municipal governance in general. It is now time to think more radically about the meaning of joined-up services and support. This means looking at the interdependence of not just the NHS and social care but also housing, skills development, job creation, welfare benefits, schools and children’s services, transport, community safety and more. There is one logical home for all of this and that is a revitalised system of democratically elected local government with the skills and capacity to undertake an inclusive and comprehensive strategic role (Commission on Strengthening Local Democracy, 2014).

Transparency test

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. A ‘transparency test’ could stipulate that where a public body has a legal contract with a private provider, that contract must ensure full openness and transparency with no ‘commercial confidentiality’. Non-statutory providers could also be made subject to local political scrutiny processes and to the Freedom of Information Act from which they are currently excluded (Gash *et al.*, 2013).

Ownership/taxation test

The Southern Cross failure exposed the difficulty of regulating a private care provider owned by a mix of property investors, bondholders, banks, shareholders and landlords. 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. More forcibly, a taxation test could require private companies in receipt of public services contracts to demonstrate that they are domiciled in the UK and subject to UK taxation law (Corporate Watch, 2012).

Workforce test

Given longstanding concerns about the treatment of staff, a further test could be around workforce terms and conditions. All providers should be expected to comply with minimum standards around workforce terms and conditions, training, development and supervision. Commissioning bodies could also include procurement requirements designed to oblige all care providers to participate in collective bargaining and to outlaw such practices as blacklisting workers for taking part in trade union activities (Hendy, 2014).

Accountability test

Unlike public sector services, those public services provided by contract by private companies are often immune from penalty or accountability for their performance, even in the event of failure. At worst the big contractors are typically subject to short-term bidding bans (Bowman, 2015). Bringing democratic accountability into this situation is problematic. One option would be to explore the possibility of some form of public ‘right of recall’ where contracted out services are thought to be of unacceptable quality.

Ultimately, however, we need to question the place of large tax-evading private chains founded upon risky financial models having any place in the realm of personal care and support where the free market struggles to profitably supply the services required to meet people's needs. The general argument that markets have become detached from morals has been put forward strongly by Sandel (2012) 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. There may well be a place for a mixed economy of small, local private providers and voluntary sector providers alongside a revitalised role for local authorities, but the wholesale dash for privatisation in England cannot be deemed to have been successful in meeting the needs of service users. The threat of a collapsing market could be the catalyst for a radical recasting of policy.

References

Association of Directors of Adult Social Services (2017) *ADASS Budget Survey 2017*, London: ADASS.

Bowman, A. (2015) 'Business elites and undemocracy in Britain', in 'Elites on Trial', *Research in the Sociology of Organizations*, **43**, pp.305-336.

Care Quality Commission (2017) *Annual Report and Accounts 2016/17*, London: CQC.

Centre for Health and the Public Interest (2013) *The Future of the NHS? Lessons from the Market in Social Care in England*, London: CHPI.

Centre for Health and the Public Interest (2016) *The Failure of Privatised Adult Social Care in England*, London: CHPI.

Commission on Strengthening Local Democracy (2014) *Effective Democracy: Reconnecting with Communities*, Edinburgh: CSLD.

Community Care (2017) *Government Gives Care Providers until 2019 to Settle Sleep-in Shift Backpay*, accessed at: <http://www.communitycare.co.uk/2017/11/02/government-gives-care-providers-2019-settle-sleep-shift-backpay/>

Competition and Markets Authority (2017) *Care Homes Market Study*, London: CMA.

Competition and Markets Authority (2017a) *Care Homes Market Study: Final Report*, London: CMA.

Corporate Watch (2012) *An Unhealthy Business: Major Healthcare Companies Use Tax Havens to Avoid Millions in UK Tax*, London: Corporate Watch.

Department of Health (2016) *Care and Continuity: Contingency Planning for Provider Failure*, London: LGiU.

Dolan, A. (2016) *Britain's Care Homes are Being Turned into Complex Financial Instruments*, Open Democracy.

Gash, T., Panchamia, N., Sims, S. & Hotson, L. (2013) *Making Public Service Markets Work*, London: Institute for Government.

Griffiths, R. (1988) *Community Care: An Agenda for Action*, London: HMSO.

Guardian (2017) *Urgent Talks Over Future of Four Seasons Care Homes in UK*, accessed at: <https://www.theguardian.com/business/2017/dec/10/urgent-talks-over-future-of-four-seasons-care-homes-in-uk>

Health and Social Care Information Centre (2015) *Community Care Statistics, Social Services Activity, England 2014-15*, London: HSCIC.

Hendy, J. (2014) *Reconstruction After the Crisis: A Manifesto for Collective Bargaining*, Liverpool: Institute of Employment Rights.

House of Commons Public Accounts Committee (2015) *Adult Social Care in England*, London: HC 518.

House of Commons Library (2016) *Social Care: The State of the Care Home Market*, London: HCL.

House of Commons Library (2017) *Delayed Transfers of Care in the NHS*, London: HCL.

Independent Age and the International Longevity Centre UK (ILC-UK) (2015) *Moved to Care*, accessed at: http://www.ilcuk.org.uk/index.php/publications/publication_details/moved_to_care

Institute of Public Care (2014) *The Stability of the Adult Social Care Market and Market Oversight in England*, Bath: IPC.

Ipsos MORI (2017) *Unmet Need for Care*, London: Ipsos MORI.

King's Fund and Nuffield Trust (2016) *Social Care for Older People: Home Truths*, London: King's Fund.

Laing Buisson (2015) *Care of Older People: UK Market Report, 27th Edition*, London: Laing Buisson.

Local Government Association (2014) *Towards Excellence in Adult Social Care*, London: LGA.

Local Government Information Unit (2017) *Paying For It*, London: LGiU.

National Audit Office (2011) *Oversight of User Choice and Provider Competition in Care Markets*, London: HMSO.

ResPublica (2016) *The Care Collapse: The Imminent Crisis in Residential Care and its Impact on the NHS*, London: ResPublica.

Sandel, M. (2012) *What Money Can't Buy: The Moral Limits of Markets*, London: Allen Lane.

Scourfield, P. (2012) 'Cartelization revisited and the lessons of Southern Cross', *Critical Social Policy*, **32**(10), pp. 137-148.

Seebohm Report (1968) *Report of the Committee on Local Authority and Allied Personal Social Services*, Cmnd 3703, London: HMSO.

Skills for Care (2016) *The State of the Adult Social Care Sector and Workforce in England, 2016*, Leeds: Skills for Care.

Skills for Care (2016a) *Nationality of the Adult Social Care Workforce, 2015*, Leeds: Skills for Care.

The Smith Institute and Unison (2014) *Outsourcing the Cuts: Pay and Employment Effects of Contracting Out*, London: The Smith Institute.

Unison (2017) *Care in Crisis*, London: Unison.

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