ADULT SOCIAL CARE: AN IRRETRIEVABLE OUTSOURCING?

Introduction

The outsourcing of public services to non-statutory providers, especially the private sector, has been the delivery model of choice in the UK for around thirty years. The budget devoted to such contracts is hard to estimate but is reckoned to be in excess of £100bn (Walker and Tizard, 2018), equivalent to about 8% of Gross Domestic Product. The model has also changed in nature over the years, moving beyond back-office functions and into front-line service delivery.

A number of high profile problems and outright failures, from Carillion to rail franchising, have brought the model into more prominent view, but much less interest has been paid to the longer-standing privatisation of adult social care (ASC). This is a large market worth in excess of £22bn and rising as the care needs of adults intensify and become more complex (King's Fund/Nuffield Trust, 2016). This blog explores the reasons for this relative lack of interest in the issue of ownership, identifies some problems associated with the outsourcing of social care and considers the issues involved in attempting to secure a different balance of provision.

Adult Social Care: An Intractable privatisation?

The relative absence of policy interest in changing the ownership structure of ASC may be due to three related factors – market penetration, market fragmentation and market fragility. Together these make the prospect of some 'big bang' change in market structure seem unlikely and impractical.

*Market Penetration***:** The longer the period over which outsourcing has taken place and the greater the penetration of the market, the more difficult it is likely to be to reverse the situation. This is the situation with adult social care, where the process has been in train for over thirty years and the current structure is deeply embedded. In 1979, 64% of residential and nursing home beds were still provided by local authorities or the NHS; 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% (Centre for Health and the Public Interest, 2013).

*Market Fragmentation***:** There is no compact adult social care service that can be easily repatriated into public sector ownership. Rather the sector is characterised by a multiplicity of fragmented, competing providers. The care home sector supports round 410,000

residents across 11,300 homes from 5500 different providers ((Competition and Markets Authority, 2017). The situation in home care is even more diverse with almost 900,000 people receiving help from over 10,000 regulated providers. Nor is it any longer the case that the state is even the dominant commissioner of these services – the privatisation of care alongside tighter access to local-authority-funded care has resulted in a large growth of self-funding 'customers'.

*Market Fragility***:** The third complicating feature of the adult social care market is its fragility and the politically toxic consequences of market failure. The first major casualty was Southern Cross in 2011 – a large national care home provider which had 9% of the market nationally but a much greater share in certain regional areas. Much of the Southern Cross provision was eventually taken over by another major provider, Four Seasons, which is itself now at high risk of going under. Either through financial collapse or strategic withdrawal the market model is at tipping point.

A NEW APPROACH to SOCIAL CARE?

There is a growing view that the problems associated with the outsourcing of adult social care need to be addressed, but if no immediate 'big bang' change is feasible, what are the alternative options? Better and fairer funding is a prerequisite and has been exhaustively explored elsewhere (Barker Report, 2014), but the local state (as the biggest commissioner of services) and national government (as policy-maker) can also act in other ways that could create better care quality and reshape the provider mix. The key to this is a different approach to the way support and services are commissioned.

Currently commissioning is often a hand-to-mouth process devoid of a wider purpose. Any sustainable alternative model has to go beyond the notion that the role of the state is to 'fix' or somehow forestall market failure (Hudson 2014); rather it is to act as a catalyst for innovation. One variant here is that promoted by Mazzucato (2012) with her proposal for 'mission-oriented' public investments where the task of the state is to determine the direction of change by 'transforming landscapes and creating and shaping markets'. It is worth exploring what this might look like in the case of ASC. Four dimensions can be identified: commission local and small; commission holistically; commission individually; and commission ethically.

Commission Local and Small

The trend in the residential sector is for small operators to be replaced by large provider chains with more than fifty care homes. Recent building of new homes in a standard format

with sixty or more en-suite beds has been dominated by chain operators, while many of the remaining smaller businesses are likely to exit in the next decade by selling homes which are valuable property. Industry estimates (Knight Frank, 2017) indicate that as care homes grow in size they become more profitable, with the highest margin for those with over a hundred beds. The paradox here is that while the market is moving towards large-scale provision, the evidence from the social care regulator is that smaller facilities tend to receive better ratings for quality of care (Care Quality Commission, 2017).

A focus on smaller and more local commissioning is needed to counteract this trend – a challenge for public sector commissioners who generally favour larger less complicated organisations. This fits in with ideas around Asset-Based Community Development (King's Fund, 2018; Coalition for Collaborative Care, 2018) – a focus on interdependence as people share skills and support – and on supporting communities to rebuild their own social infrastructure by harnessing community businesses (Power to Change, 2017).

Complementary to this level of 'micro support' is the concept of Local Wealth Building (DCLG/Cooperatives UK, 2017), a growing movement in Europe and the USA based on the principle that 'places' hold significant financial, physical and social assets of local institutions and people. The key is local 'anchor' institutions (public, social, academic, commercial) and their procurement role in supporting the local supply chain. This will include opening markets to local small and medium enterprises rather than looking to national and international chains. The experience of Preston, Lancashire in the UK is seen as an exemplar (Chakrabortty, 2018). Through the Public Services (Social Value) Act, public authorities can also embed social value into the design of services and decision-making criteria rather than fixating on cost and efficiencies.

Commission Holistically

It no longer makes sense to think of social care commissioning in isolation; rather the focus is upon 'holistic' or 'place-based' commissioning. Most social care is commissioned separately from other place-based interventions. The most frequent concerns about potential intersections are those with the NHS where social care is felt to be adversely affecting delayed transfers of care from hospital. However, market-shaping is a much broader strategic task spanning several council departments and other partners – social care, planning, transport, housing, economic development, health, education, criminal justice, community safety, training providers and more. Coordination on this scale would require significant investment in capacity, skills and structures – in effect the reinvention of robust

local governance. In this respect social care has to be considered as part of a much broader shift in the way decisions are made and resources are allocated.

Commission Individually

Policies on access to social care support have created two groups of 'individual commissioners' – those who fund their own care and those whose care is funded via an individual budget. Both are in need of greater support. A market requires consumers 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 (National Audit Office, 2011) - entry is often unplanned, made in response to a personal crisis and with very low rates of switching to a different provider in the event of dissatisfaction.

The obstacles facing those who fund their own support have been comprehensively identified by the Competition and Markets Authority (*op cit*) which notes: most individuals and families are poorly informed and have done little or no planning or research; they struggle with the notion of exercising choice and rarely move between providers; there are low levels of complaints, fears of retaliation in the event of a complaint; and lack of understanding of the formal procedure. In addition there is a litany of malpractices including: lack of information about prices; demands for substantial deposits and other upfront payments; a raft of hidden extra charges and surcharges; demands for top-up payments without local authority agreement; and fees charged after death.

It is not entirely clear how this situation can be transformed. The CMA report raises the prospect of enforcing consumer law, but others will take the view that it is simply not possible to replicate a market in the social care sector. However one option that can work for some people is that of personal budgets (House of Commons Public Accounts Committee, 2017) and more recently personal health budgets (Jones et al, 2017), though here too there are issues to be resolved around issues like making choices and decisions; receiving Information and advice; understanding allowance and spend; budget management, monitoring and review; and risk management and contingency planning.

Commission Ethically

The imperative to commission ethically is implicit in all approaches. It could encompass the following dimensions.

*Commission from ethical employers***:** Commissioners need to be able to distinguish between the workforce practices of different providers and prioritise those acting as 'good employers'. This might have several components such as prioritising providers that comply with minimum

standards around workforce terms and conditions, have effective training, staff development and supervision, and encourage staff to participate in collective bargaining (Burns et al, 2016; Hendry 2014).

*Commission from transparent providers***:** 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' outside of the procurement process. All providers of public services should– at a minimum – 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 (Gash et al, 2013).

*Commission from tax compliant providers***:** 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 services contracts to demonstrate that they are domiciled in the UK and subject to UK taxation law (Corporate watch, 2012).

*Commission from not-for-profit providers***:** A fresh approach to adult social care offers the opportunity to rethink the role of other sectors. Whilst wholesale renationalisation seems unlikely there is every reason to encourage local authorities to begin to build up their own in-house provision and to support all organisations with a social purpose, whether in the public, private or voluntary sector. This could include encouragement for user-led organisations, social enterprises, mutuals and others to recruit and train service users in innovative ways.

Conclusion

The privatisation of ASC in the UK has an unusual policy narrative compared with other sectors. Devoid of any real debate or stated purpose, a thirty year process of outsourcing has continued unabated and unchecked. The scale of penetration and the dismantling of alternative providers have resulted in a situation that fails to meet ordinary market standards around choice and control. And now, as a result of austerity politics, there is every chance that the private sector will lose interest and leave the market with dire consequences for those in need of services and support. Whilst it is not feasible to simply eliminate a model that has become so deeply embedded, a combination of better funding and smarter commissioning can, over time, reshape ownership structures, increase provider stability, focus on ethics rather than cost, and enhance the quality of care.

References

Barker Report (2014), *A new settlement for health and social care: Final report*

Burns, Diane., Hyde, Paula and Killett, Anne, (2016), 'How financial cutbacks affect job quality and care of the elderly.' Work and Employment Relations in Healthcare*. Industrial Labour Relations Review*

Care Quality Commission (2017), *The State of the Adult Social Care Services, 2014-17*

Centre for Health and the Public Interest (2013), *The future of the NHS? Lessons from the market in social care in England, pp. 10-11*

Chakrabortty, A (2017), https://www.theguardian.com/commentisfree/2018/jan/31/preston-hit-rock-bottom-took-back-control

Coalition for Collaborative Care (2018), *Commissioning Community Development for Health.*
Competition and Markets Authority (2017), *Care Homes Market Study, Final Report*
Corporate Watch (2012), *An unhealthy business: major healthcare companies use tax havens to avoid millions in UK tax*

DCLG/Cooperatives UK (2017), *Community Economic Development: Lessons from two years' action research*
Gash, T, Panchamia, N, Sims, S and Hotson, L (2013), *Making public service markets work,* Institute for Government
Hendry, J (2014), *Reconstruction after the crisis: a manifesto for collective bargaining,* Institute of Employment Rights
House of Commons Public Accounts Committee (2017), *Personal Budgets in Social Care: 2nd Report of Session 2017-17*
Hudson, B (2014), Dealing with market failure: a new dilemma in UK health and social care policy, *Critical Social Policy*, 35(2) pp281-292
Jones, K et al (2017), *Personal Health Budgets: Process and context following the national pilot programme* (PSSRU, University of Kent)
King's Fund/Nuffield Trust (2016), *Social Care for Older People: Home Truths*
King's Fund (2018), *Reimagining Community Services: Making the most of our assets*
Knight Frank (2017), *Care Homes Trading Performance Review, 2015-16*
Mazzucato, M (2012), *The entrepreneurial state: debunking private v public sector myths.* London: Anthem
National Audit Office (2011), *Oversight of User Choice and Provider Competition on Care Markets.*

Power to Change (2017), http://www.powertochange.org.uk/what-is-community-business/

Walker D and Tizard, J (2018), *Out of Control* (London: Smith Institute)

Professor Bob Hudson,
Centre for Health Services Studies,
University of Kent,
Canterbury