

LaingBuisson

The healthcare experts

**STRATEGIC COMMISSIONING OF LONG TERM CARE
FOR OLDER PEOPLE
CAN WE GET MORE FOR LESS?**

A LaingBuisson **White Paper** written by William Laing
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**Smith &
Williamson**

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1. EXECUTIVE SUMMARY

This LaingBuisson **White Paper** seeks to analyse the state of the UK market in care services for older people, to identify the market failures (and achievements) and to ask if there are any ways to correct the failures – especially the key issue which dogs providers of care services working for a publicly funded clientele, which is the mismatch between public sector commissioners’ need to contain costs in an extended period of austerity, and providers’ need to earn an adequate return in order to sustain existing services and develop the new ones.

The **White Paper** concludes by making the case for a new style of outcomes-based, long term contracts with lead providers (which we call Social Care Maintenance Organisations or SCMOs) covering the entire care pathway including advice and guidance, homecare and residential care. We then set out the *a priori* reasons why the SCMO model might be expected to generate sufficient efficiency savings – even from already stretched system - to allow the correction of the endemic failures which currently damage the healthy functioning of the UK care services market for older people.

1.1 Privatisation of supply – with no possibility of reversal

1. The bulk of UK supply of long term care services for older people, which until the 1970s was dominated by the public sector, has been privatised over the last four decades. There is no possibility of this process being reversed for the foreseeable future. For better or for worse, therefore, the welfare of older people with care needs is, and will continue to be, dependent on a healthily functioning market.

1.2 Market characteristics

2. The characteristic features of the UK social care market for older people today are:
 - Competitive on the supply side;
 - High degree of monopsony purchasing power on the public sector demand side;
 - Fragmented;
 - Limited economies of scale;
 - Mixed public / private sources of funding;
 - Endemic cross subsidies from private to public payers in the care home space;
 - Polarisation of local care markets between affluent areas with high private pay demand and non-affluent areas dominated by publicly paid demand;
 - Highly regulated
 - Information deficit: the market is not fully transparent, with private-pay cross-subsidies to public-pay usually hidden, and there are poor information flows generally;
 - Private payers’ market power is weak for once-in-a-lifetime purchasing decisions in crisis situations with little assistance from intermediaries.

1.3 Market failures and successes

3. The notable achievements of the care market which has emerged in the last 4 decades include:
 - On the supply side, attraction of investment of about £30bn over 4 decades, which has created new capacity of over 350,000 beds;
 - On the commissioning side, assessment of need introduced by English councils in 1993 has largely eradicated unnecessary, publicly funded admissions to care homes. There are now 250,000 fewer

older people in residential care settings than there would have been if placements had continued at the same level as in the peak demand year of 1993.

4. The principal **commissioning side** market failures which have become rooted in the older care sector over the past four decades are:
 - Use of monopsony purchasing power by most councils to drive publicly paid prices below the level necessary to sustain investment in existing facilities and to incentivise investment in new capacity;
 - Whole-scale adoption by public sector of a fundamentally flawed ‘task and time’ model with time units of as little as 15 minutes in response to an imperative to contain costs
 - The failure of most statutory bodies to make significant progress in integrating publicly funded health and social care commissioning, despite joint working and integration being on the policy agenda for at least 3 decades;
 - Finally, there is arguably a specific market failure where acute NHS Trusts have on the whole been unwilling to sub-contract post-acute care and rehabilitation to independent sector care home providers despite the massive cost differential between NHS hospitals and independent sector care homes;
5. The principal **supply side** market failures which have become rooted in the older care sector over the past four decades are:
 - The ‘silo’ approach to service provision which is most marked for larger scale care service providers;
 - The information asymmetry which exists between private purchasers and care home providers which facilitates the charging of premium prices to private individuals and supports the system of cross subsidies to public payers which is endemic in the care home sector.
 -

1.4 ‘Fee wars’ in 2016

6. The Dilnot funding reforms which are incorporated in the 2014 Care Act will be implemented during the period from April 2015 to April 2016.

Though not directly relevant to the principal question posed by this **White Paper**, of how to resolve care service market failures, the planned changes are nevertheless flagged here because of the potential for further destabilising the care home market for older people in England, with unpredictable market dynamics which could lead to further pressure on care home margins for publicly paid clientele.

1.5 Can enough efficiency savings be extracted to pay for correction of market failures?

7. Despite the swingeing cuts that councils have already made since central government grants were cut severely in 2011/12, there are at least four broad approaches which offer scope for further efficiency savings:
 - Outsourcing remaining in-house homecare and residential care services, for the minority of councils which still operate them, typically at twice the cost of outsourced services;

- For a larger minority of councils, addressing those issues, which will vary widely, which cause indicators of efficiency to lie well below the average, in the light of high levels of variability in councils' performance according to data from the Health and Social Care Information Centre;
- Probably for most councils, extending outsourcing outside the traditional front-line services such as residential, home and day care into core areas of councils' social services operations which have hitherto been reserved to council in-house staffing and management. It is notable that In-house assessment, care management & SSMSS overheads together absorbed a little over 20% of gross revenue spending by CASSRs on older people's social care services nationally in 2012/13, and it is unlikely that all possible efficiency savings have been extracted from cost heads;
- A shift to outcomes based, capitated contracts for lead providers to arrange the entire pathway of social care services, in the expectation that appropriate alignment of incentives will lead to more optimal decisions for service users and a more cost effective mix of services than is typical at present.

1.6 SCMOs as a solution to market failures

A Social Care Maintenance Organisation (SCMO) is the name we have given to any not-for-profit or for-profit organisation, or a statutory body or arms-length company owned by a statutory body, or indeed a consortium made up by any of these, which would contract with one or more Councils with Adult Social Services Responsibilities (CASSRs), NHS Trusts and Clinical Commissioning Groups (CCGs) as well, to act as a lead provider for a broad range, ideally a comprehensive range, of services for social care older people with assessed care needs.

We have considered three stages in the possible evolution of SCMOs. The basic SCMO model is capable of being introduced immediately for publicly funded service users, with no need for changes in legislative, regulatory or budgetary arrangements.

1.6.1 Basic SCMO model

In the basic model, SCMOs would bid in competitive tenders for capitated, outcome based 'lead' contracts to arrange a wide range of publicly funded social care services for older people in defined geographical areas.

SCMOs would be expected to deliver sufficient efficiency savings to address, in part at least, the principal market failures, by means of:

- Outsourcing any remaining council in-house provision of homecare and residential care;
- Responding to incentives and disciplines associated with competition generally;
- Replacing change-resistant, in-house management;
- Accessing innovative potential which may not be fully expressed in the unchallenged elements of statutory services;
- Contractually-based focus on outcomes, with more flexible transitions between care settings;
- Contractually-based focus on service integration through the entire social care pathway and across elements of social care and healthcare as well;
- Contractually based share in any rewards from reducing healthcare utilisation through investment in preventive social care services, thus making it possible to draw money into social care budgets from larger and relatively less constrained health budgets.

1.6.2 SCMO ‘plus’ with extended choice for publicly paid subscribers

The key feature of what we have called SCMO ‘plus’ is that it would allow older people with assessed care needs to choose their SCMO. This should be seen as a second stage evolution from the basic SCMO model, since it would depend on the prior existence of market capacity in the form of a number of SCMOs with a track record of delivering integrated services through outcome based contracts with capitated funding from CASSRs and their health partners.

Under SCMO ‘plus’, older people receiving social care services from an SCMO contracted by their ‘home’ authority would be empowered to transfer their ‘subscription’ to any other accredited SCMO of their choice which was willing to commence operations in that area.

In addition to introducing the powerful, service quality promoting, ‘carrot’ and ‘stick’ stimulus of consumer recruitment and exit, such a transition would enable enterprising SCMOs to expand outside a single geographic base with all the advantages of economies of scale and scope, opportunities for systems development and organisational learning, etc. that would bring.

A move to the SCMO ‘plus’ model would, however, require the introduction of new layer of market regulation which does not presently exist, including:

- Accreditation of SCMOs;
- A transparent formula for money to follow the service user from one SCMO to another, probably based on projected care costs to death;
- An economic regulator (corresponding to Monitor for the NHS) to undertake these and other market management functions;
- Rules to ensure that accredited SCMOs cannot turn away any valid request to join (in order to avoid cherry picking of good risks).

1.6.3 SCMO ‘double plus’ (open to private as well public subscription)

The key feature of what we have called the SCMO ‘double plus’ model would be to extend SCMO’s service offering to privately funded individuals as well those who are publicly paid.

The extension of SCMO activity into the private pay space could interpose powerful intermediaries between individual, once-in-a-lifetime purchasers of care services with weak market power on the one hand, and service providers (e.g. care homes) with relatively strong market power (in respect of private payers) on the other. Though intermediation has a cost, its introduction would address this market failure issue.

2. DEVELOPMENT OF THE MARKET 1975-2014

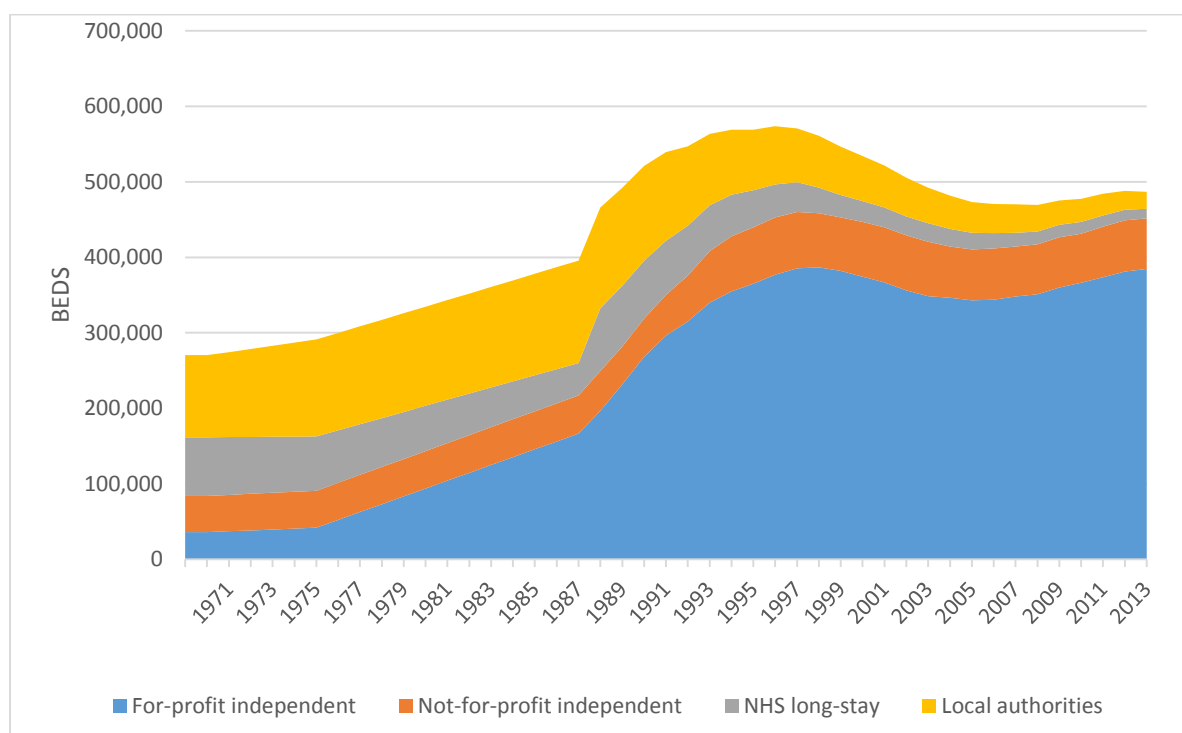
2.1 Privatisation of supply

2.1.1 Care in residential settings

The principal structural features of the UK social care market were set during a period from the mid-1970s to the early 1990s. The key events were:

- The economic crisis of 1975 which led the government to seek support from the International Monetary Fund. The conditions for the bail-out included swingeing cutbacks in public sector capital programmes, leading to a halt, among other things, to development of new local authority care homes – leading in turn to shortages of capacity;
- The emergence of income support as an open-ended source of funding for care homes at the very end of the 1970s, initially through lobbying by voluntary sector organisations, though for-profit companies soon became the main beneficiaries as income support, fuelled massive growth in capacity in response to growing demand from an ageing population;
- As income support spending spiralled out of control, the government responded by giving budgetary responsibility for adult social care to budget-capped local authorities in 1993 and terminating open-ended income support funding for new claimants;
- From 1993, assessment of need via local authorities was introduced for the first time, leading to an overall decline in demand, despite continued ageing of the population, as eligibility criteria were applied and unnecessary placements diverted to other services or nothing at all.

Figure 2.1 Privatisation of supply of care in residential settings for older people, UK 1970-2013



Source: LaingBuisson research

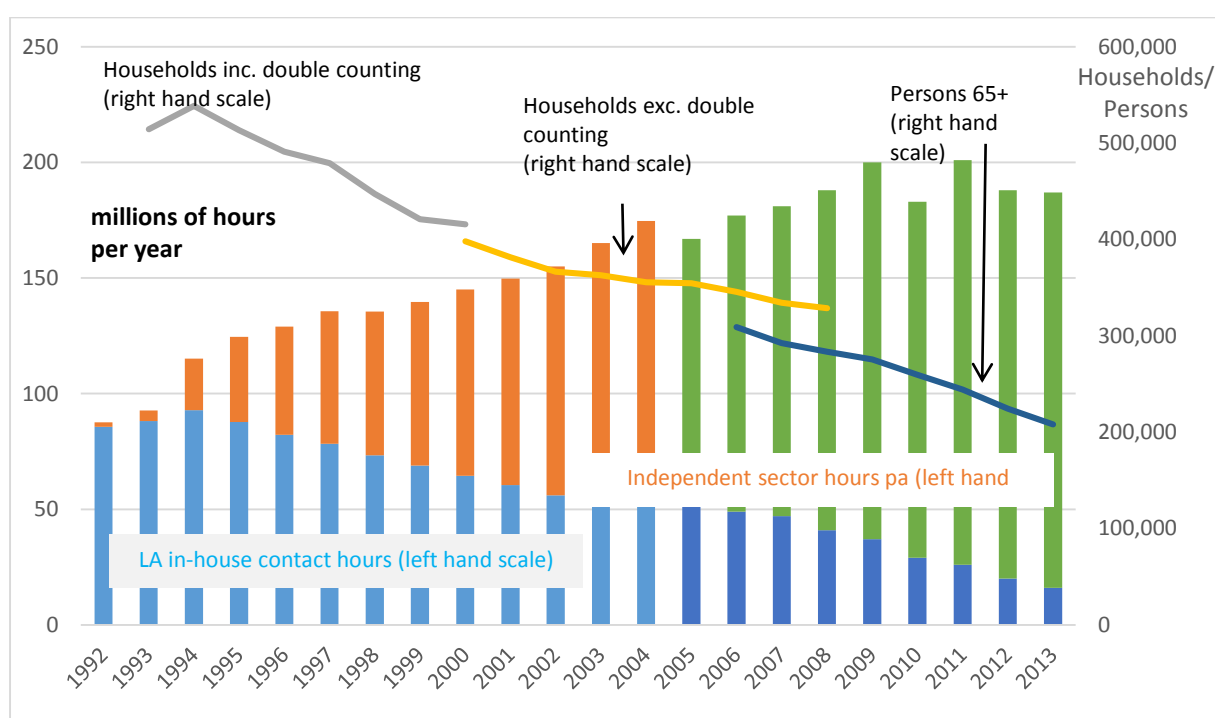
By 1995 the care home sector for older people had doubled in size compared with 1975 and the independent sector (mainly for-profit) had replaced the public sector (councils and the NHS) as the principal source of supply, Figure 2.1.

2.1.2 Homecare

A parallel process of privatisation of supply took place in homecare services, Figure 2.2,

As with care homes, the period since 1993 has also witnessed a decline in the number of people in receipt of council funded homecare services, despite population ageing.

Figure 2.2 Annual home help/care contact hours purchased by local authorities by sector of provision and number of households / persons aged 65+ receiving local authority funded homecare services at a given point of time, England 1992-2013



Source: HH1 returns for one week in September / October, up to 2008, and PSSEX1 returns as published by the Health and Social Care Information Centre NASCIS resource from 2004/05

2.1.3 Underlying drivers of supply privatisation

The last 4 decades have witnessed a remarkable transformation in the supply side of adult social care, from a sector dominated by the traditional welfare state model of state funding and state supply to a large scale market in which the state (via local councils) has outsourced the bulk of provision.

The underlying drivers of outsourcing were, and continue to be:

- The private sector is not bound by public sector pay agreements and undercuts the public sector by paying non-qualified staff close to National Minimum Wage;
- Responding to a Value for Money imperative, councils do not require outsourcing partners to do anything more than fulfil statutory obligations on pay rates;

- Private sector organisations have access to large amounts of capital, not available to the public sector, which has been used to expand and to some extent modernise care home stock;
- Public social care interests were and remain weak, and offered little resistance to privatisation (contrast healthcare); and
- Competition has driven efficiencies in:
 - o *development costs;*
 - o *operating costs; and*
 - o *managing financial risk*

As a result, independent sector provision of both care homes for older people and homecare is now about half the cost of public provision, according to English councils' data collated by the Health and Social Care Information Centre.

Nothing intrinsic prevents public sector organisations from competing on equal terms in a market place, but they have not done so.

The clear conclusion is that the privatisation of adult care services which has taken place in the last four decades will not be rolled back - certainly not in times of public sector austerity. Private sector organisations operating in a competitive market, therefore, will continue to dominate supply for the foreseeable future.

2.1.4 Characteristics of the adult social care market

The characteristic features of the social care market for older people today are:

- **Competitive on the supply side:** (there are few council area in which any one provider controls 25% or more of the local care home market), and homecare supply is even more fragmented;
- **Fragmented**, with the four leading providers controlling 16% of the care home market nationally and 14% of the homecare market nationally;
- **Limited economies of scale** above about 25-30 beds at the individual home level, and there are also limited economies of scale at the organisational level from operating large portfolios;
- **Mixed public / private funding:** nearly all registered services (both care homes and homecare) have mixed funding from both the public sector (councils and the NHS) and the private sector (private individuals);
- **Endemic cross subsidies:** from private to public payers,
- **Polarisation:** local markets are highly polarised between affluent areas with high private pay demand and non-affluent areas dominated by publicly paid demand;
- **Market power** typically lies on the demand side in areas dominated by public pay, as local authority commissioners exercise monopsony power over the purchase of services (both older people's residential and homecare) which are usually fulfilled locally;

In contrast, market power typically lies on the supply side in areas dominated by public pay, since consumers are typically faced with a once in a lifetime purchasing decision (for care homes) and

there are no powerful intermediaries to exercise (in contrast to say, private healthcare, where medical insurers dominate purchasing transactions effectively as ‘agents’ of consumers);

Risk to providers from councils’ market power: providers in areas with high exposure to public pay are at high risk of councils using their monopsony purchasing power to depress margins below a level necessary to sustain investment in either existing or new capacity. Since the swingeing cuts in central government funding of local authorities from 2011/12, this risk has manifested itself in declining profitability of care home portfolios with high exposure to public pay, though there has been no similar decline in the profitability of larger publicly paid homecare businesses;

- **Highly regulated:** providers have limited discretion over the main element of cost, which is staffing levels;
- **Information deficit:** the market is not fully transparent, with private-pay cross-subsidies to public-pay usually hidden, and there are poor information flows generally for typically once-in-a-lifetime purchasing decisions in crisis situations.

3. MARKET FAILURE AND SUCCESS

3.1 Market success

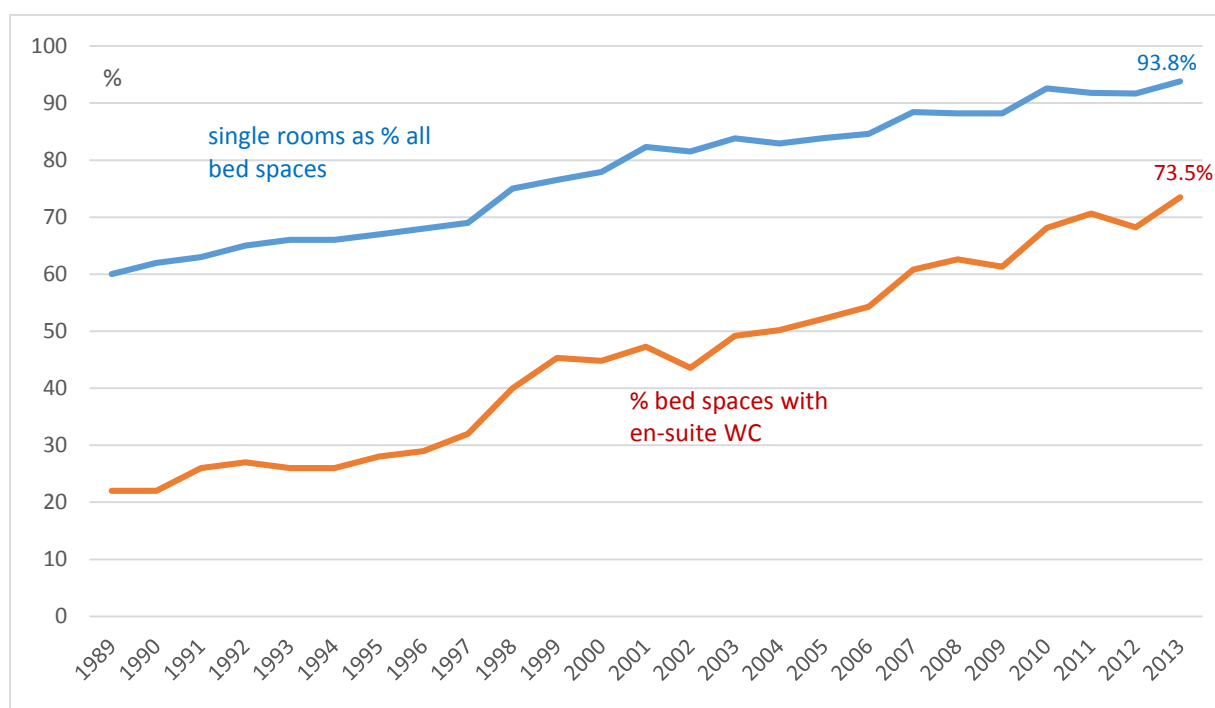
3.1.1 £30bn plus of investment

The care home market for older people which has emerged over the past four decades has been remarkably successful in many respects.

On the supply side it has attracted investment of about £30bn which has created new capacity of over 350,000 beds (Figure 2.1, above). In doing so, it has replaced wholly inappropriate long-stay capacity in the NHS (previously, often in Nightingale wards) as well as most of the 1950s and 1960s local authority care home estate

Though a substantial amount of old stock now needs to be replaced, nevertheless even old stock has benefited from upgrading through continued maintenance capital expenditure, as evidenced for example by a continuing rise in the proportion of single rooms with en-suite facilities (Figure 3.1), most of which has taken place through upgrade of existing facilities rather than replacement of old stock with new facilities

Figure 3.1 Single rooms as percentage of bed spaces and percentage of bed spaces which have en-suite WCs, for-profit residential homes for older people, UK 1989-2013



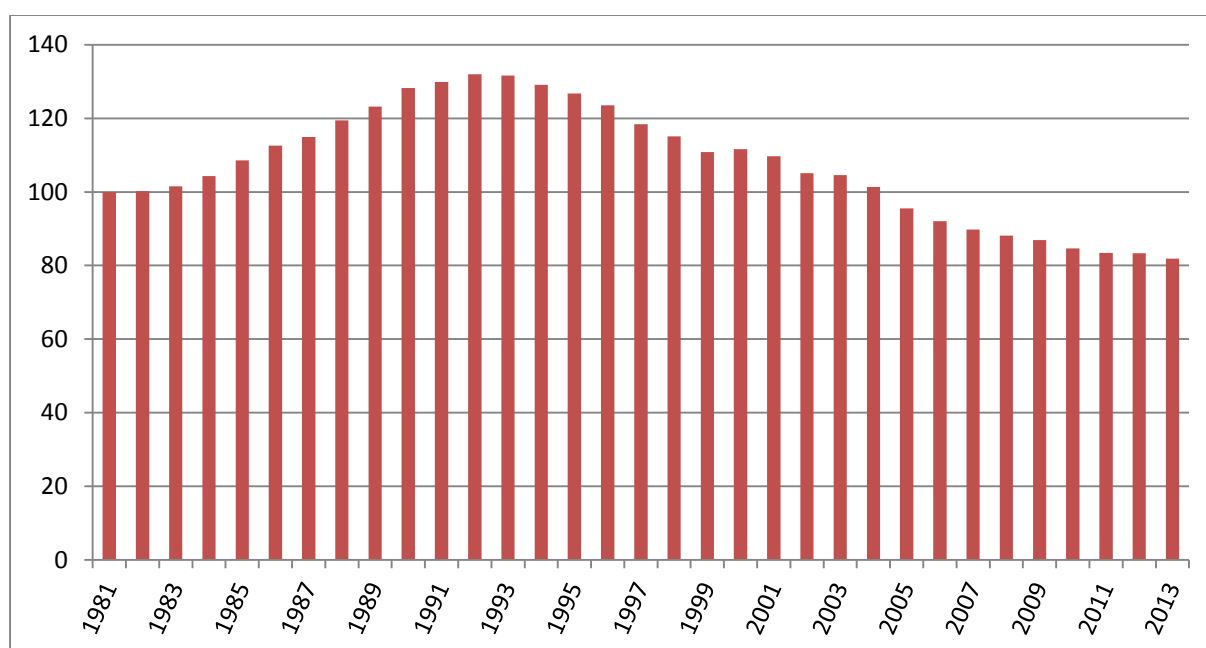
Source: LaingBuisson, Care of Older People Market Report, 26th edition.

3.1.2 Diversion of unnecessary care home placements to support in the community

On the commissioning side, councils successfully took control of the pre-1993 phenomenon of unnecessary care home admissions, where individuals took advantage of easy access to income support funding to enter a care home without an assessment of need. The impact of needs assessment introduced by budget-constrained local authorities after 1993 can be measured by looking the trend in numbers of persons being cared for in residential settings of one sort or another, after adjusting for the effects of the ageing population, Figure 3.2.

In each year between 1981 and 1992, the combined number of older or physically disabled people resident in private, voluntary or public sector homes or long stay hospitals grew faster than would be predicted from demographic change alone. By 1993 there were an estimated 33% more older and physically disabled people in long term care establishments than there would have been if age specific rates had remained unchanged from a base year of 1981. From 1993, age-adjusted care home demand started a continuous decline and by September 2013 it was 18 percentage points below the 1981 baseline level. This is equivalent to a ‘diversion’ of some 250,000 residents to other forms of non-residential care, comparing 2013 with the peak year of 1993.

Figure 3.2 Age standardised index of demand, UK 1981-2013 - older & physically disabled residents in all independent, local authority and NHS residential settings - Index, March 1981 = 100



Source: LaingBuisson, Care of Older People Market Report, 26th edition.

* Ratio of observed to expected residents, the latter being the number that would have been observed in a given year if 1981 age specific rates of occupation of nursing and residential homes (grossed up for older people receiving continuing care in the NHS) are applied to the population in that year.

3.2 Market failures

LaingBuisson believes that there are ‘strategic’ failures on both sides of the purchaser / provider divide, which have led to sub-optimal outcomes for consumers, providers and taxpayers.

3.2.1 Strategic commissioning failure

On the public sector purchasing side, the lack of strategic commissioning by councils (and the NHS) has been well rehearsed by independent sector interests:

- In the care home sector they cite a failure on the part of public sector commissioners to understand the need for an adequate return on capital in order to maintain investment in existing facilities and to incentivise investment in new capacity;

- In the homecare space they cite a ‘race to the bottom’ in hourly fee rates, and a fundamentally flawed ‘task and time’ model which cannot deliver good quality services to consumers.

There are now the beginnings of a move away from ‘time and task’ in homecare to ‘outcome based’ contracts (exemplified by Wiltshire and some other councils). But outcome based commissioning has yet to make a serious appearance in care home commissioning, or indeed in the commissioning of residential and community services combined.

There is also the even more fundamental strategic commissioning failure to integrate publicly funded health and social care (and indeed housing services as well). This can be viewed as in part a political failure to drive forward integration policies centrally, which has only recently given way to a strong commitment by the government to the Better Care fund, and even then there is no guarantee that this will achieve its objectives. But viewed dispassionately, the failure of health and social care service integration to move forward more rapidly must be seen primarily as a failure in strategic commissioning by both CASSRs (Councils with Adult Social Services Responsibilities) and NHS Trusts, since the main legal barriers to the integration of health and social care were removed a decade and a half ago by the former Labour government through Section 31 of the Health Act 1999, which contains important powers allowing for NHS and social services budgets to be pooled, for local authority agencies to provide some NHS services and vice versa, and for each to delegate to the other responsibility for commissioning both health and social care services. Partners may include all NHS bodies together with any health-related local authority service such as social services, housing, transport, leisure and library services.

Finally, there is arguably a specific market failure where acute NHS Trusts have on the whole been unwilling to sub-contract post-acute care and rehabilitation to independent sector care home providers despite the massive cost differential between NHS hospitals and independent sector care homes.

3.2.2 Consequences of strategic commissioning failure – risk of future care home capacity shortages for publicly funded clientele

A key structural issue in the publicly funded care home market is that investors and providers are exposed to a high risk that local authorities, as monopsony purchasers in their localities, may at any time use their market power to drive prices down to levels which are unsustainably low, in the sense that they are insufficient to maintain investment in existing facilities and to incentivise investment in new capacity.

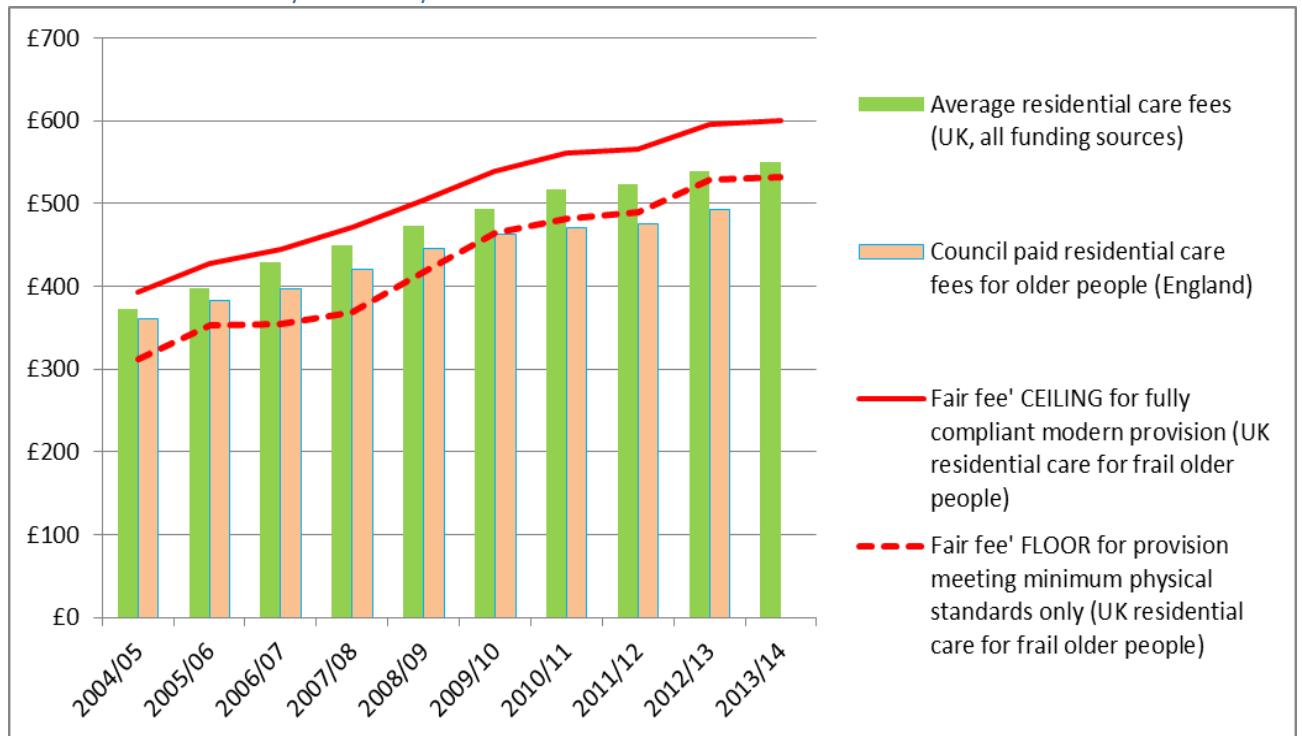
The phenomenon of margin squeeze by council commissioners was observed at the turn of the century when it contributed to the financial failure of a number of over-gearred care home groups.

Following a more benign period (for care home operators) in the mid-late 2000s, during which margins were re-built, margin squeeze has now re-appeared with public sector austerity measures following the global credit crisis and ensuing recession. This has led to a 5% real terms fall in local authority fee rates across England between 2010/11 and 2014/15¹, and a situation in which average fees paid by English councils are now below the floor of the ‘fair price’ range as calculated by LaingBuisson, Figure 3.3.

Pressure on prices and margins is reflected in the results of care home operators, Figure 3.4, where it is notable that the underlying profitability of all of the major groups with high exposure to public pay, including Four Seasons Health Care, Bupa Care Homes, HC-One and the failed Southern Cross have experienced declining profitability, while Barchester Healthcare, with its focus on private patients, has maintained and even increased its profitability.

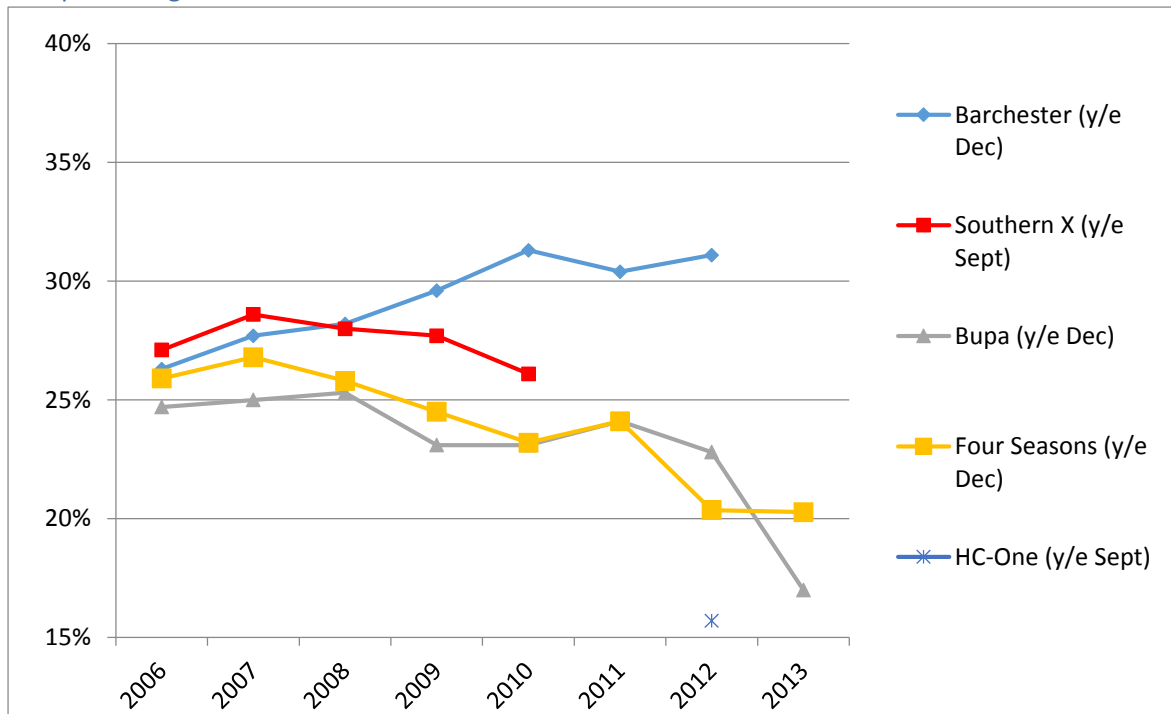
¹ Baseline fee rate surveys published each year in *Community Care Market news*, LaingBuisson.

Figure 3.3 Council paid weekly fee rates for residential care of older people compared with ‘average’ fees and ‘fair fees’ 2004/05 – 2013/14



Source: Fair Price for Care model; and Health and Social Care Information Centre for gross weekly expenditure by English councils per older person in residential care ‘provided by others’ (which is a proxy for fees paid to independent sector homes for residential care) 2012/13

Figure 3.4 Underlying profitability of major providers of care homes for older people - EBITDAR (Earnings Before Interest, Tax, Depreciation, Amortisation of goodwill and Rent on leased premises) as a percentage of revenue



Source: LaingBuisson research, statutory accounts

Declining profitability across the publicly paid care home sector raises the risk of financial failures among operators and market destabilisation.

It is important, however, to distinguish between strategic commissioning failure from driving prices too low and, on the other hand, imprudent behaviour of care home providers which have geared too highly either through bank debt or sale and leaseback with inadequate rent cover.

The Southern Cross debacle showed that the market was remarkably responsive in redistributing the assets of a failed provider to other providers, with little impact on the welfare of residents. Underlying the absence of any real crisis for residents was the fact that nearly all care homes have a higher value open than closed, and the costs of financial failure were (rightly) borne by investors and lenders. Arguably the Southern Cross episode could be viewed as a market success rather than a market failure.

Nor should endemic cross-subsidies from private to public payers necessarily be viewed as market failure. There are many other sectors of the economy where prices for the same service vary across purchasers, with larger scale purchasers typically able to negotiate more favourable rates.

Rather, the essence of the market failure, in respect of strategic commissioning of care home services by local authorities, lies in the monopsony power that councils exercise (which is immune from challenge under competition law) combined with an unwillingness on the part of most councils genuinely to address the issue of what level of return is necessary to sustain existing facilities and incentivise investment in new ones.

LaingBuisson's *Fair Price for Care* toolkit uses a 12% return on capital as a reasonable benchmark. The appropriateness of this exact figure could be debated, but it is certainly greater than the figure of 6% return on capital which has been suggested by some authorities². If local authorities have got this wrong, and the evidence is that many of them have, there is a risk of a capacity crisis in many localities as underlying demography driven demand rises, as existing small homes exit the market and as new capacity fails to materialise.

The danger of capacity shortages has been raised in most of judicial reviews of local authority fee setting in recent years, and independent sector interests have been subject to claims of 'crying wolf' since the predicted shortages have largely failed to materialise. In part this can be explained by pre-existing excess capacity (notoriously in the North East) and the high degree of resilience of small scale providers who have limited options in realising the value of their assets. LaingBuisson believes, however, that without some reversal of the average 5% real terms reduction in council paid fee rates over the last 5 years it can only be a matter of time before the prediction of capacity shortages in significant numbers of less affluent council areas is realised.

3.2.3 Local variability

The failures of strategic commissioning properly to consider market sustainability are best regarded as a set of local problems with common features which have spread nationally. They are largely concentrated in less affluent areas where councils' fees are in the lower quartile.

Evidence from LaingBuisson's routine tracking of new and cancelled registrations from the Care Quality Commission (CQC) shows that little if any new capacity is coming on stream in those less affluent areas while development activity in the South East of England and other affluent areas, where cross subsidies from private payers are plentiful, is fairly buoyant. This supports the conclusion that local authority on fee rates is

² This is self-evidently true since the yield expected by investors in turnkey care homes is about 7% for tenants with a moderate covenant, which would leave nothing at all (indeed a negative amount) to compensate an operator for operating the home

stifling new investment. The high degree of local variability in care markets, in terms of prices paid each, is illustrated for care homes (Figure 3.5) and homecare (Figure 3.6).

Figure 3.5 Average gross weekly expenditure by English councils per older (65+) person in residential care ‘provided by others’ 2012/13

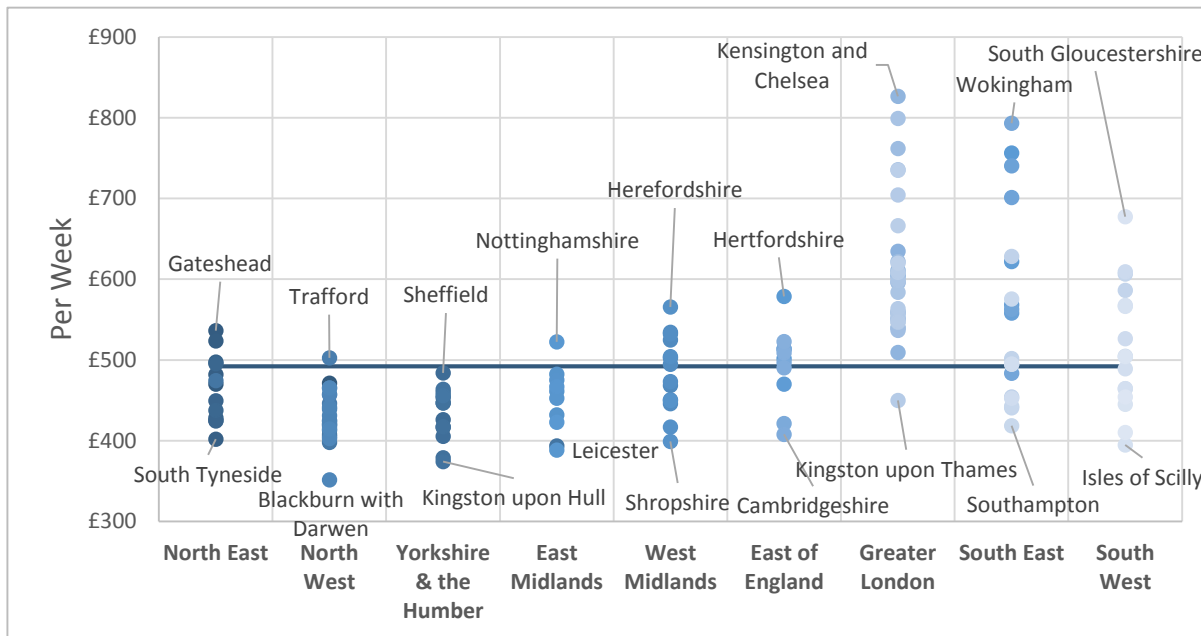
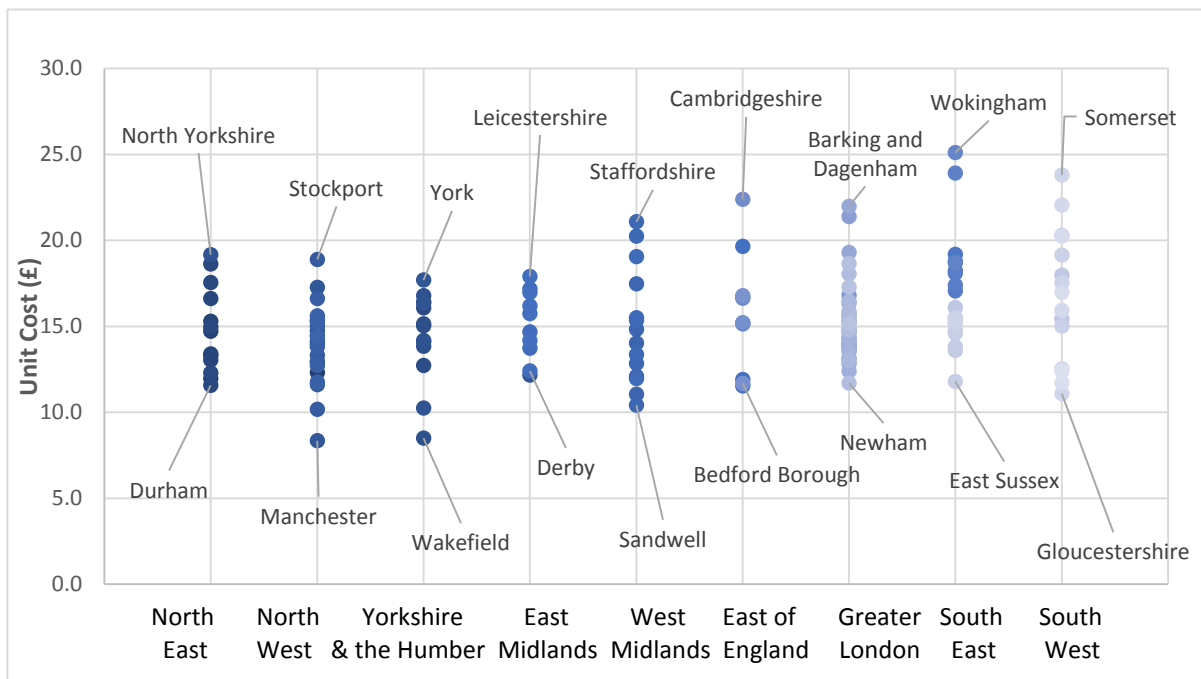


Figure 3.6 Average gross hourly cost for homecare by English councils ‘provided by others’ 2012/13



‘Others’ are mainly independent sector providers, but also include other local authorities than the ‘home’ authority. Source: Health & Social Care Information Centre. Personal Social Services Expenditure. & Unit Costs: CASSR-level unit costs.

3.2.4 Supply side market failure

On the supply side, the principal market failure, in LaingBuisson's view, is the 'silo' approach to service provision which is most marked for larger scale organisations which position themselves as either care home providers or homecare providers, with no large independent sector organisation having developed a comprehensive and integrated offering covering the entire advice and care pathway from modest support needs to residential and nursing care, including dementia care.

At the level of individual businesses, many care homes also offer homecare services, often on a franchise basis, and there are synergies in doing so, but this is much less common for organisations operating at scale.

As a result of the 'siloed' structure of independent sector services, it is likely that sub-optimal decisions are being made about the most appropriate or least resource intensive responses to changing care needs, especially the service provision 'ratchet' which may prevent older people with variable care needs moving down as well as up care pathways.

3.2.5 Market failure for private payers

Private payers' market power is weak compared with providers, especially in the purchase of care home services. Private payers face a once-in-a-lifetime purchase, often in a crisis situation. Though many sources of advice are available on-line, there are financial advisers who specialise in this area and increasing numbers of knowledgeable 'care brokers' are available to guide people through important practical decisions, nevertheless there is a widely perceived view that there is a deficit in publicly available information.

The information asymmetry which exists between private purchasers and care home providers facilitates the charging of premium prices to private individuals and supports the system of cross subsidies to public payers which is endemic in the care home sector.

Intermediation is rare between private payers and care providers and there are no strong intermediary organisations which effectively represent consumer interests (corresponding, for example, to the large medical insurance companies which effectively control the prices of private medical care services in the interests of their subscribers).

4. DILNOT ‘FEE WARS’ IN 2016

LaingBuisson’s most recent report on the older care sector³ highlighted the real danger that the incipient care home fee crisis described in this **White Paper** could be brought to a head when the Dilnot recommendations within the Care Act are implemented in April 2016.

Though not directly relevant to the principal question posed by this **White Paper**, of how to resolve care service market failures, it is nevertheless flagged here because of their potential for further destabilising the care home market for older people.

In April 2016 about 35,000 older residents of care homes in England will become eligible for council support by virtue of having assets between £23,250 (the old upper capital limit) and £118,000 (the new upper limit). Up until then these newly ‘enfranchised’ residents will typically have been paying fees which are higher than the council’s ‘usual costs’ because of the endemic cross-subsidisation of publicly paid fees by privately paid fees. Depending on the additional resources that councils are given by central government, most councils are likely to seek a reduction on the fees that these residents have hitherto paid as private payers. Most care homes, being reliant on cross subsidies, will resist such fee reductions. A move to less expensive accommodation may be suggested as an alternative, but this will be resisted by residents, their families and advocacy groups in what is likely to be a media storm. Besides, such will be the scale of any proposed migration that there will not be sufficient capacity for other care homes to admit them.

At the same time, about 115,000 more affluent private payers in English care homes with assets in excess of £118,000 will start to see their ‘independent personal budgets’. They will become aware that their private fees are (typically) well in excess of the ‘usual costs’ that are being accrued for them towards the care cap. Some of these residents and their families will seek to use their right under Section 18 of the Care Bill to ask the council to arrange care for them - at the ‘usual cost’ rate rather than the going private rate. This in turn will lead councils to seek reductions on fee rates, which will also be resisted by care home operators.

Both councils and care home operators are acutely aware of the risks, councils being concerned about upward pressure on the fee rates they usually pay and operators worried about downward pressure on private pay rates they have hitherto received. The dynamics of any fee ‘stand-off’ are difficult to predict, but LaingBuisson’s view is that the outcome will depend heavily on the final wording of the Care Act regulations in relation to ‘own resource’ top-ups (sometimes referred to by the government as ‘additional cost conditions’). The initial Care Act guidance published by the government for consultation in June 2014 indicated that the occasions on which own resource top-ups would be allowed would remain limited, as they are now (i.e. where residents are subject to a 12-week property disregard or where they have a deferred payment agreement in place with the local authority). But paragraph 4.20 of the subsequent draft regulations consultation document suggests that the government intends substantially to relax the restrictive rules. It states that *“the additional cost provisions will be expanded to enable a person to meet these costs themselves in more circumstances. This is being introduced to further support choice.* In essence, a relaxation of own resource top up rules will be a ‘get out of jail’ card for both councils and care home operators since it will provide a substantial pool of new money with which to facilitate the transition without detriment to either side, by diminishing (but by no means eradicating) the intended benefits of the changes to residents with a modest level of assets and their families.

³ LaingBuisson, Care of Older People Market Report, 26th edition.

5. CAN FURTHER EFFICIENCY SAVINGS BE EXTRACTED?

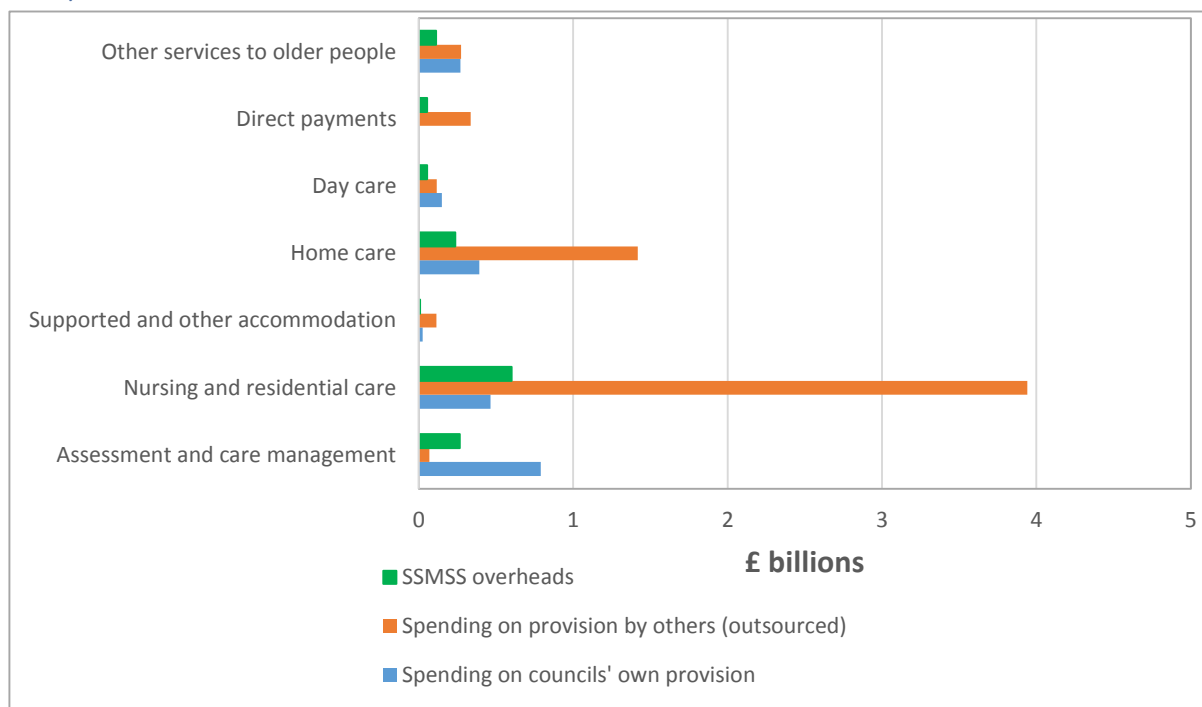
Councils have responded to central government austerity measures by cutting their own staffing levels, seeking back office savings and freezing or reducing providers' fee rates in real terms. They have, however given a high degree of protection to overall levels of front line spending on social services, with children's services receiving the most protection and younger adults with learning disabilities the next. Older people have been the least protected of social services client groups. The spending envelope for older people's services has probably declined in cash terms by about 4% between 2011/12 and 2014/15 (comparing 2014/15 budget estimates collated by DCLG with 2011/12 out-turns collated by the Health).

But if the question is asked, *is there scope for more efficiency savings to be extracted without compromising front line services further?*, the answer must be Yes, in the medium to longer term at least, if not the short term. There are at least four broad approaches which offer scope for further efficiency savings:

- Outsourcing remaining in-house homecare and residential care services, for the minority of councils which still operate them, typically at twice the cost of outsourced services;
- For a larger minority of councils, addressing those issues, which will vary widely, which cause indicators of efficiency to lie well below the average, in the light of high levels of variability in councils' performance according to data from the Health and Social Care Information Centre;
- Probably for most councils, extending outsourcing outside the traditional front-line services such as residential, home and daycare into core areas of councils' social services operations which have hitherto been reserved to council in-house staffing and management. It is notable that In-house assessment, care management & SSMSS overheads together absorbed a little over 20% of gross revenue spending by CASSRs on older people's social care services nationally in 2012/13, and it is unlikely that all possible efficiency savings have been extracted from cost heads. According to Figure 3.7:
 - *Front-line spending on social care for older people amounted to £7.6bn in England in 2012/13, of which £6.3bn was outsourced;*
 - *English councils spent a further £2.1bn on assessment, care management and SSMSS overheads;*
 - *In-house assessment, care management & SSMSS overheads together absorbed a little over 20% of gross revenue spending nationally;*
 - *It might have been instructive to analyse these costs council by council, in order to quantify variability among the 150 English CASSRs and see whether any possibly explanatory patterns, but unfortunately the Health and Social Care Information Centre does not publish such detailed data at individual council level;*
- A shift to outcomes based, capitated contracts for lead providers to arrange the entire pathway of social care services, in the expectation that appropriate alignment of incentives will lead to more optimal decisions for service users and a more cost effective mix of services than is typical at present.

In summary, LaingBuisson believes there are good reasons for predicting that a competitive market for a much broader range of council functions than exists at present could generate significant efficiency savings in non-front line expenditure heads such as assessment, care management & SSMSS overheads, where independent sector organisations and indeed public sector enterprises operating in a national rather than geographically restricted market could exploit innovative potential and economies of scale and scope,

Figure 3.7 Gross annual revenue expenditure by English councils on social services for older people 2012/13



Source: Health and Social Care Information Centre

In summary, LaingBuisson believes there are good reasons for predicting that a competitive market for a much broader range of council functions than exists at present could generate significant efficiency savings in non-front line expenditure heads such as assessment, care management & SSMSS overheads, where independent sector organisations and indeed public sector enterprises operating in a national rather than geographically restricted market could exploit innovative potential and economies of scale and scope.

6. SOCIAL CARE MAINTENANCE ORGANISATIONS (SCMOs) A POSSIBLE MODEL FOR GENERATING MORE EFFICIENCY SAVINGS, GETTING MORE FOR LESS AND CORRECTING MARKET FAILURES

6.1 Desirable features of an efficiently functioning social care market

The desirable features of a social care market (or indeed any market) are summarised in Table 6.1. Any solution to market failures in publicly funded care for older people should address those not being met at present while preserving those that are met.

Table 6.1 Desirable features of an efficiently functioning market for social care of older people: do they exist at present

Feature	Does it exist?
Competitive market	Yes
Value for money	Yes, for public payers No, for private payers
Transparent pricing	Not yet, but it's coming with Dilnot
Adequate pay, training, investment in human resources	No
Adequate return for suppliers to sustain existing capacity and develop new capacity	No for public payers Yes for private payers
No super-normal profits ⁴	None for public payers Sometimes for private payers
Innovative capacity	Arguably inadequate (No 'one stop shop' covering full pathway from advice and guidance to homecare to extra care to care homes, and back again if appropriate)

6.2 Desirable features of a 'solution'

LaingBuisson believes that any 'solution' must meet the following criteria:

- Capable of implementation under existing legislation, regulation and public sector administrative and funding arrangements;
- Capable of delivering benefits to commissioners, providers and service users;
- Capable of functioning in a time of public sector austerity;
- Capable of being implemented locally, since the 'problem' of failing public sector commissioning and supply is essentially a local one repeated many times over;
- Capable of drawing support across most of the political spectrum;
- Capable of implementation without major transition or legacy costs;

⁴ Normal profit is defined as the minimum level of profit necessary to keep a firm in that line of business. This level of normal profit enables the firm to pay a reasonable salary to its workers and managers and to pay all other costs including a reasonable return to operators and investors. Supernormal profit is defined as extra profit above the level of normal profit.

- Capable of offering choice to consumers;
- Capable of supporting a competitive market with sufficient players to challenge incumbents;
- Capable of promoting innovation in the delivery of care services;
- Compatible with integration of publicly funded social care and healthcare services (and housing as well)

We believe that the basic Social Care Maintenance Organisation (SCMO) model is capable of meeting all of these criteria.

6.3 What is an SCMO and how would it operate?

6.3.1 Basic SCMO model

An SCMO⁵ would be a not-for-profit or for-profit organisation, or a statutory body or an arms-length company owned by a statutory body, or indeed a consortium made up by any of these, which would contract with one or more Councils with Adult Social Services Responsibilities (CASSRs), NHS Trusts and Clinical Commissioning Groups (CCGs) as well, to act as a lead provider for a broad range, ideally a comprehensive range, of services for social care older people with assessed care needs.

The reasons for making NHS agencies party to such contracts is two-fold:

- First, because NHS Trusts have responsibility for funding continuing healthcare and they are therefore significant commissioners of nursing home services for older people in their own right (though on a smaller scale than CASSRs) as well as operating a residual amount of (arguably highly inefficient) long stay capacity in-house;
- Second, because the evidence suggests that where health and social care services are effectively integrated, costs incurred in social care (for example, preventive interventions) generate benefits which are often concentrated in healthcare – with the level of net benefit overall determined by the extent to which NHS agencies can monetise reduced demand rather than continuing to incur legacy costs. Having access to an appropriate share of rewards from healthcare budgets, is therefore a potentially important element of generating the efficiency savings necessary for addressing market failures such as inadequate prices for publicly funded residential care and homecare.

Each CASSR would probably have only one lead contract (with an SCMO) covering the whole of its council population, though it is possible that larger CASSR's may wish to divide their geography into zones, each of which may have its own lead contract.

⁵ We have used the term Social Care Maintenance Organisation (SCMO) because of the similarities it has with Health Maintenance Organisations (HMOs) in the United States, especially the non-profit Kaiser Permanente with 9.3 million health plan members in California. Kaiser Permanente and similar HMOs have frequently been held up in the international academic literature as exemplars of excellence in the delivery of comprehensive healthcare services to their members. The core feature which is widely regarded as having contributed to the success of the model is the alignment of provider incentives with both payor and consumer interests, achieved through capitated payment, community rating in order to avoid 'cherry picking', competition among HMOs and other healthcare schemes and unencumbered exit and entry for scheme members.

The lead contract would be on a capitated basis, probably for a period of 3-5 years (subject to termination for failure to perform) with some risk sharing in the form of recalibration of contract terms in line with experience of demand and service mix.

The SCMO, as lead contractor, may take on many of the functions currently almost exclusively administered by CASSRs in-house, including assessment and care management, and recipients of direct payments might choose to use the SCMO as their budget holder. Much of the commissioning activity of CASSRs (e.g. managing fee rates and placement volumes within an overall spending envelope defined by the contract) could be transferred to the SCMO, though the CASSR would have to reserve some commissioning decisions to itself to avoid conflicts of interest.

SCMOs would, of necessity, be larger scale organisation with sufficient resources and a strong enough balance sheet to take on risk.

While some SCMOs would be capable of fulfilling much of the service need in-house for example if the SCMO comes from a service provision background, other SCMOs, for example those coming from a logistics background, would sub-contract most service provision to other providers of front-line services including care homes, homecare, daycare, etc., which in turn will span the entire scale range from large organisations to micro enterprises.

The lead contract may include some services within the ambit of healthcare, funded by CCGs. Alternatively, or in parallel, the SCMO's lead contract should have some provision for payments from CCGs to reflect savings to healthcare budgets which are demonstrably generated by SCMO expenditure on an enhanced range of preventive social care services.

In essence, the lead contract would transfer many functions currently undertaken by CASSRs in-house to independent SCMOs, and would require a corresponding downsizing of local authority staff in the departments and support services concerned. The question may then be asked: what evidence is there that such a transfer of functions from CASSRs to SCMOs could generate a level of efficiency savings large enough genuinely to deliver 'more for less' and allow some of the market failures such as inadequate rates of return and inadequate investment in staff development to take place.

The answer must be that there is no empirical evidence, because to our knowledge no local authority has yet market tested its assessment, care management and associated SSMSS overhead cost heads. Many councils will rightly be well satisfied with what they currently achieve on the budget they can afford and will see no need for disruptive change *A priori*, however, there are certainly other councils at the lower end of the performance league table where there could be quick wins from letting a lead contract which transfers as much of the cost of assessment, care management and overheads to an SCMO with full discretion over where services are provided as long as they meet the outcomes criteria built into the contract. The list would certainly include those 20 CASSRs which still maintain a significant in-house residential care department, as well as those with maintain in-house homecare departments.

In essence, therefore, the attractiveness of the basic SCMO model in any given area, and the scope for addressing market failures, would be a function of:

- The quantum of resources that could potentially be released from outsourcing remaining CASSR in-house residential and homecare service;
- The quantum of resources that could potentially be released from outsourcing remaining NHS in-house long-stay capacity;
- The overall level of efficiency with which the CASSR spends its budget for older people's social care – the less efficient and more resistant to change, the more attractive the SCMO option;

- The confidence with which market testing can be expected to reveal lead contractor (SCMO) candidates capable of delivering more for less by deploying resources more effectively than councils have been able to themselves. There are several *a priori* reasons for expecting a positive outcome from extended outsourcing of the kind described here. These reasons include:
 - *Eradication of cultural resistance to change by incumbent in-house management;*
 - *Incentives and disciplines which are associated with competition generally;*
 - *Access to innovative potential which may not be fully expressed in the unchallenged elements of statutory services;*
 - *Clear and contractually based focus on outcomes for SCMOs as lead contractors (and through them sub-contractors);*
 - *Clear and contractually based focus on service integration, through the social pathway and across health and social care;*
 - *Replacement of the existing ‘silo’ approach to service provision among fragmented providers with a clear lead contract focus on integration of the full social care pathway (from advice and guidance, to homecare, to daycare and to residential care) plus any community based healthcare services which might be incorporated in the lead contract.*

A good case for adopting the SCMO model widely could be based on these advantages alone. Moreover, there are no legislative, regulatory or budgetary barriers and the initiative would sit well within the current integration agenda.

6.3.1.1 *What outcomes to use in outcomes based contracts?*

With outcome based contracts a relatively new concept in UK social care, there is no ready answer from existing practice. Certainly measures of consumer satisfaction would be one element, but clearly not enough in itself. It is understood that the outcomes-based contracts pioneered in Wiltshire for homecare used admissions to residential care as one outcome indicator for older people. This may also be a valid indicator for a lead contract encompassing a range of social care services, including residential care itself. Indeed, success by lead contractors would help to generate the efficiency savings necessary to address the key issue of public sector failure to pay adequate care home fees – with the *quid pro quo* (for care home operators) of reduced placements.

Admissions to hospital may be another outcome indicator, with opportunities for lead contractors to influence hospital admission rates in two ways:

- *By developing preventive social care services for older people living in the community, which may pay off in containment of ‘frequent flyer’ admissions among the older population;*
- *By developing protocols which may be effective in containing the large numbers of emergency hospital admissions from care homes.*

In each case, however, either CCGs or NHS Trusts or both would have to be party to the lead contract and be prepared to reward the SCMO for success. Just as important, in order for payment to make sense, CCGs and NHS Trusts together would have to be capable of monetising reduced demand for emergency admissions and not simply incur continuing legacy costs by failing to downsize staffed provision and overheads.

Finally, it will be necessary to grapple with the issue of causality – e.g. was the recorded drop in hospital admissions attributable to the actions of the lead contractor, or was it due to some other unconnected cause?

6.3.2 SCMO ‘plus’ (with extended choice for publicly paid subscribers)

The limitation of the basic SCMO model is that it essentially replaces in-house statutory monopolies in the deployment of budgetary resources with a franchised, time limited, non-statutory monopoly, subject only to challenge and replacement at the time of renewal – similar to rail franchise model. Also, while existing guarantees of choice for publicly funded service user would continue to apply, including direct payments and free choice of residential accommodation for those willing to pay a top-up, the basic SCMO model does not allow consumers any choice of the lead contractor / SCMO, which is selected by the council alone following a competitive process.

The key feature of what we have called SCMO ‘plus’ is that it would allow older people with assessed care needs to choose their SCMO (or integrated services provider) in the same way that healthcare service users in California are free to change their health cover from HMOs like Kaiser Permanente to other HMOs or private insurance plans, and back again, according to their perceived value of the services they receive.

The application of such a model in older people’s social care services in Britain should be seen as a second stage evolution from the basic SCMO model, since it would depend on the prior existence of market capacity in the form of a number of SCMOs with a track record of delivering integrated services through outcome based contracts with capitated funding from CASSRs and their health partners.

Subject to the prior existence of a critical mass of competing integrated service providers (SCMOs) with geographical bases spread throughout the country, it is possible to envisage a transition in which older people receiving social care services from an SCMO contracted by their ‘home’ authority might be empowered to transfer their ‘subscription’ to any other SCMO of their choice which was willing to commence operations in that area.

In addition to introducing the powerful, service quality promoting, ‘carrot’ and ‘stick’ stimulus of consumer recruitment and exit, such a transition would enable enterprising SCMOs to expand outside a single geographic base with all the advantages of economies of scale and scope, opportunities for systems development and organisational learning, etc. that would bring.

A move to the SCMO ‘plus’ model would, however, require the introduction of new layer of market regulation which does not presently exist, including:

- Accreditation of SCMOs;
- A transparent formula for money to follow the service user from one SCMO to another, probably based on projected care costs to death;
- An economic regulator (corresponding to Monitor for the NHS) to undertake these and other market management functions;
- Rules to ensure that accredited SCMOs cannot turn away any valid request to join (in order to avoid cherry picking of good risks).

Widespread adoption of the SCMO ‘plus’ model for state-funded social care could potentially create a more rational regulated market less prone to failure than exists today, with a better alignment of incentives for

funders, providers and care service users. But – in the absence of more government funding - it would still rely on the release of efficiency savings through competition, harnessing of innovative capacity, exploitation of economies of scale and scope, organisational learning, plus opportunities to recoup some of the supposed 'health' payoff from preventive social care.

6.3.3 SCMO 'double plus' (open to private as well public subscription)

The key feature of what we have called the SCMO 'double plus' model would be to extend the service offering to privately funded individuals as well those who are publicly paid.

It seems plausible that an offering by a trusted, accredited, SCMO to arrange services along the entire care pathway from advice and guidance to residential care could gain traction among more affluent older people with care needs who typically pay privately for a share of any homecare services – and the entirety of care home fees (until the care cap kicks in post-2016).

The extension of SCMO activity into the private pay space could interpose powerful intermediaries between individual, once-in-a-lifetime purchasers of care services with weak market power on the one hand, and service providers (e.g. care homes) with relatively strong market power (in respect of private payers) on the other. Though intermediation has a cost, its introduction would address this market failure issue (see Section 3.2.5).

Advice and guidance would be a particularly important element of any SCMO service offering for private payers. While independent financial advice may be beyond its scope, advice on sources of public funding available to private payers would be a key element of the SCMO 'double plus' role.

On the downside, the level of risk involved in offering a comprehensive capitated service to private payers over a period of time would probably be much higher than fulfilment of a capitated public sector contract, and this may limit the number of willing market entrants.

6.3.4 Summary of potential benefits from the adoption of different SCMO models

The potential benefits from the adoption of different SCMO models are summarised in Table 6.2.

Table 6.2 Summary of potential benefits and associated costs of different SCMO models

Basic SCMO	<p>SCMOs to bid in competitive tenders for capitated, outcome based 'lead' contracts to arrange a wide range of publicly funded social care services for older people in defined geographical areas. SCMOs would be expected to deliver sufficient efficiency savings to address, in part at least, the principal market failures, by means of:</p> <ul style="list-style-type: none"> - Outsourcing any remaining in-house provision of homecare and residential care; - Responding to incentives and disciplines associated with competition generally; - Replacing change-resistant, in-house management; - Accessing innovative potential which may not be fully expressed in the unchallenged elements of statutory services; - Contractually-based focus on outcomes; - Contractually-based focus on service integration through the entire social care pathway and across social care and healthcare as well; - Contractually based share in any rewards from reducing healthcare utilisation through investment in preventive social care services, thus making it possible to draw money into social care budgets from larger and relatively less constrained health budgets.
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<p>SCMO ‘plus’ (with extended choice for publicly paid subscribers)</p>	<p>Free choice of any available, accredited SCMO for individuals covered by a ‘home’ SCMO contract.</p> <p>In addition to extending consumer choice it would enable enterprising SCMOs to expand outside a single geographic base with all the advantages of economies of scale and scope, opportunities for systems development and organisational learning, etc. that would bring.</p> <p>It would involve a new layer of regulation including:</p> <ul style="list-style-type: none"> - Accreditation of SCMOs; - Formula for money to follow the service user; - Economic regulator to undertake these and other market management functions; - Rules to ensure that accredited SCMOs cannot cherry pick good risks.
<p>SCMO ‘double plus’ (open to private as well public subscription)</p>	<p>Extension of SCMO service offering to privately funded individuals.</p> <p>Intermediation by SCMOs would address a key market failure by bolstering the weak market power of private payers <i>vis a vis</i> care home providers and exerting countervailing market power against cross subsidisation of public by private fees.</p> <p>Intermediation has a cost.</p> <p>Risk involved in offering a comprehensive capitated service to private payers would probably be much higher than fulfilment of a capitated public sector contract. This may limit the number of willing market entrants.</p>

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