The Care Act and the Care Market

Conference summary

THE STRATEGIC SOCIETY CENTRE
ANALYSIS • EVIDENCE • POLICY

advice and support for older age
Independent Age

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About Independent Age

Independent Age is a growing charity empowering thousands of older people across the UK and Ireland to live more fulfilling lives. Founded 150 years ago, we are an established voice for older people and their families, committed to making a positive impact through the 'ABC' of advice, befriending and campaigning.

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1. Introduction

The Care Bill passed into law as the **Care Act** on May 14th, 2014. The Act represents a fundamental overhaul to the law governing care and support in England, as well as providing the necessary legislative framework for the implementation of the 'capped cost' reforms to long-term care funding.

During the long process toward becoming the Care Act, a growing number of stakeholders flagged **potential uncertainties and risks** around how implementation of the Act will affect the operation of **England's residential care market**.

For this reason, during May 2014, **Independent Age and the Strategic Society Centre convened a summit** for residential care providers, local authorities, civil servants, academic researchers and social care campaigners. The event examined current issues in England's residential care market, and considered potential scenarios following the changes due to be implemented under the Care Act in April 2016.

This document summarises some of the key themes and insights from this conference, which took place under the **Chatham House rule**.

2. The Current Picture: Funding, competition and top-ups

According to the market research company Laing & Buisson, the number of residents and percentage of total private and voluntary care homes for older and physically disabled people, by funding source, in the UK, is:

- Self-funders: 177,000 (44%)
- Local authority only: 143,000 (36%)
- Local authority with third-party top-ups: 54,000 (13%)
- NHS 27,000: (7%)

This section reviews some key current issues in England's residential care market that provide the context for implementation of the Care Act.

2.1. Local authority funding of care

Budget cuts for local authority adult social services departments provide the key context for implementation of the Care Act. Local authority expenditure on residential and domiciliary care had been rising steadily until 2010, but has since 'flat lined', reflective of broader public spending cuts affecting local government. Simultaneously, need for personal care and support across the population is increasing.

In this context, it is inevitable that **local authorities are grappling with the sustainability of care markets**. Indeed, the 'market position' statement of some local authorities suggest they do not intend to increase usage of beds in line with demographic trends, but instead plan to develop and deploy other models of support.

2.2. Fee pressures and business decisions

From the perspective of larger care providers, these trends are resulting in some individual homes - even the majority of stock for some providers – **not generating revenue to cover the 'cost of capital'**, with the effect that providers cannot invest in buildings and facilities to improve quality.

More widely, pressure on fees is challenging the whole business model of some providers, who note that in other types of sector – such as financial services - they would have already left the market. In short, there is a **strong business-case for some providers to exit the publicly funded residential care market**. The effect of such pressures can already be seen in the **proportion of new-build care homes being built in areas of high-wealth**, where there are commensurately fewer local authority-funded care home residents. However, despite such trends, some not-for-profit care providers maintain their position in publicly funded, low-wealth areas as part of a broader social commitment to impacting people's lives.

In addition, **local authority responses to budget pressures remain a concern**, for example, with some authorities reportedly failing to take a consultative approach, and in some urban areas, making unilateral cuts in fees on the basis of comparison to other local providers. This process is observed to effectively 'thin-slice' services and fees, and can result in a race to the bottom that redefines what services comprise care and support.

2.3. Resident profiles

In the context of local authority funding cuts and pressure on fees, care providers report that **average levels of dependency among residents has increased**. Some providers have found the average 'length of stay' has reduced from 26 months to less than a year, reflecting higher levels of acuity.

2.4. Price differentiation and cross subsidy

The residential care market in England has always involved some individuals self-funding their care, and others having their fees paid for by a local authority. The differences between the rates paid by self-funders and the state has been **an "uncomfortable truth" for 60 years**, and is recognised as an issue of concern by local authorities. Providers of residential care also recognise that price discrimination results in **cross-subsidy** from self-funders to councils.

However, the operation of price differentiation and cross-subsidy can be seen as a consequence of the requirements and incentives in place for local authorities and care providers. Some argue that without specific legislative requirements to operate differently, the practices of price differentiation and cross-subsidy are set to remain.

2.5. Market concentration, competition and quality

The residential care market in England remains distinctive for **very low levels of provider concentration**, i.e. lots of small providers. Around 94% of care homes are privately run, one in eight are 'voluntary', and around two-fifths of residents are self-funders. As such, viewed from a national level, England's residential care market appears highly competitive.

Economic theory suggests competition should increase quality and reduce prices. In research on care markets, areas with high levels of competition are typically found to have lower prices. But, there is an ambiguous effect on quality, not least because it depends on the circumstances of the buyers – for example, their knowledge of care - and whether a placement is a 'distressed purchase'.

A major study of 10,000 care homes in England for older people looked at the relationship between quality rating, price and the travel time to other care homes in a 10km radius as an indicator of competitive pressures. It found that prices were negatively related to competition, in particular, 10% higher than average competition resulted in 2.1% lower prices. However, there was also a negative relationship between quality and competition: downward pressures on price apparently resulting in cost cutting with negative consequences for quality - although this effect on quality was less strong for higher priced homes.

As such, **those homes operating with higher levels of competition than others appear to set lower prices, but operate with lower quality**. This suggests residential care markets are effective at delivering low-cost care, i.e. constraining excess profits and inefficiency. However, there is also an important role for commissioners in managing the market and - in particular - regulators using quality ratings and other tools to ensure quality does not sink too low.

2.6. 'Top-ups'

'Third-party top-ups' are financial contributions from the relatives of publicly funded residential care users, to pay for additional amenities and improved accommodation.

The usage of top-ups is subject to **complex guidance and rules**, but such guidance is clear that top-ups comprise a three-way relationship between the provider, family and local authority. The local authority remains responsible for ensuring top-up agreements are formally signed and adhered to, and that relatives are willing and able to provide third party payments.

Recent **research by Independent Age** found that across England, there is very **limited knowledge regarding the extent and nature of top-up arrangements**. For example, only one quarter of local authorities reported they knew about top-up arrangements in their area. Many care home providers have experience of arranging top-ups independently of councils, and many thought that the use of top-ups was increasingly common. However, over half of providers surveyed had experience of a relative struggling to meet the continuing cost.

In the context of local authority budget cuts, research found some residential care providers felt third-party top-ups were the only way to survive, and as such, top-ups represent a 'second subsidy' in the residential care market. However, more broadly, it was not possible to

determine in research whether third-party top-up payments are signed willingly, and to what extent are they signed because the care home 'makes it happen' to meet the costs of providing residential care.

2.7. Local authorities and market shaping

Although currently a formal responsibility for councils, there is **concern about the market-shaping role of local authorities**. One issue is the lack of monitoring of local authority performance of this role, reflected in the propensity for new homes to be built in wealthier areas. Another concern is simply how aware local authorities really are of their market shaping responsibilities.

As such, although the market-shaping responsibility of local authorities stretches back to the Community Care Act of 1990, some observers feel there has been little meaningful change besides small increases in the volume of 'extra care', and the number of homes in wealthy areas.

3.The Care Act: Potential scenarios

This section explores some of the ways in which implementation of the Care Act in England - and specifically the 'capped cost' reforms to care funding - may 'play out' in practice, by identifying some of the key drivers of change.

3.1. Price information

By April 2016, implementation of the 'capped cost' reforms to care funding in England will see all 100,000+ self-funders in residential care in England given means and needs assessments by their local authority. They will be provided with an Independent Personal Budget that explains what the local authority would pay to meet their assessed needs, and a 'Care Account' that will meter this amount, and record their progress toward the £72,000 'cap' no costs.

As such, by April 2016, **all self-funders of residential care in England and their families will for the first time know what the local authority would pay to meet their 'eligible needs'**, regardless of whether the person is entitled to financial support or the local authority has arranged their care.

In this way, the operation of **price discrimination in the market – and by extension, cross subsidy – will be much more explicit**. According to the market research company Laing & Buisson, average council fees for residential care are between £31 and £130 per week below the minimum or 'floor' level that a 'Fair Price' model calculates is necessary to offer investors and operators a reasonable return.

In care homes containing only self-funders, this may lead to conversations between managers and families around the level of fees. In 'mixed' homes, families of self-funders may query why their fees are higher than those paid by the local authority for services that are largely

equivalent.

Ultimately, such conversations may result in disputes between families and care homes. In places, this could potentially see breakdowns in trust and cooperation, renegotiation of fee rates, families protesting to local councillors and other bodies, as well families requesting that the local authority 'take over' the arrangement of the relative's care in order to access the local authority rate.

3.2. 'Self-funder top-ups'

The Care Act will result in far more individuals in residential care receiving financial contributions from their local authority toward their care fees. This will include, immediately in April 2016, an estimated 35,000 self-funders who will find themselves below the new, higher £118,000 means test 'Upper Capital Limit'. Subsequently, those individuals reaching the £72,000 'cap' from around 2020 onwards will also begin receiving a local authority contribution to their care costs.

The implementation of the Care Act will therefore significantly extend the number of individuals receiving a local authority contribution toward their residential care costs - in effect, **a new class of 'self-funder top-ups'**. Given individuals who become entitled to a local authority contribution to their residential care costs cannot be expected to move, these self-funder top-ups are therefore likely to be subject to existing rules on top-ups, which seek to protect local authorities, providers and families.

However, it is **unclear how local authorities could apply rules on top-ups to self-funders** and the implications of doing so for cross-subsidies in the market. For example, rules seeking to ensure those paying top-ups are charged a reasonable fee relative to what the local authority would pay to meet their eligible needs may force local authorities to effectively eliminate the self-funder premium and cross-subsidy in the market, even though these amounts have typically shaped what a local authority would have to pay to meet eligible needs.

3.3. Public engagement with price of care

Implementation of the Care Act, and the 'capped cost' reforms in particular, is likely to result in a **significant and unprecedented increase in public interest and engagement with the price of residential care**. This is because, alongside the reforms, the government is committed to a major public information campaign promoting awareness, and encouraging individuals to 'plan ahead' for care costs. In addition, implementation of the Care Act is likely to be accompanied by extensive media coverage of the changes - "what it means for you" - and a significant scaling up of existing information and advice resources from consumer organisations and older people's charities. In addition, at the 'front line' of the care system, over 100,000 self-funders in residential care in England are due to be given needs and means assessments by April 2016, such that they and their families will represent a 'critical mass' of individuals with a new awareness and understanding of how the price of residential care is determined.

However, given such potentially unprecedented public engagement with the price of

residential care in England, and new levels of transparency forced on market, it is **unclear whether existing price discrimination practices and cross-subsidy could survive the 'court of public opinion'**.

Indeed, if the issue of price discrimination reached much higher levels of public consciousness, together with complaints of inequity and unfairness, this could result in political pressures, for example, for government ministers to commit to ensuring that no one has to pay more than the level their local authority would pay to meet eligible need.

3.4. Potential implications

By driving change on a number of fronts in England's residential care market, the **Care Act could result in profound change**.

Existing practices on which the 'ecology' of local care markets are reliant could be made unsustainable. **Homes and local authorities could be confronted with emboldened, better-informed users and families, reducing scope for price discrimination and cross-subsidy**.

The result may be extensive renegotiation of fees, and higher average fee-rates overall. However, this process could be potentially turbulent and pose risks to the financial sustainability of local authorities and providers.

This in turn could accelerate the currently observed process of 'polarisation' in the residential care market, and have implications for investment, quality and the capacity available in different locations.

Ultimately, this process and the dynamics of the care market depend on the relative market power of local authority commissioners of care, residential care providers, and families.

4. The Care Act: Responses

This section considers some of the ways in which different actors – local authorities, government, providers – may respond to the potential scenarios described above resulting from implementation of the Care Act.

4.1. Local authorities, accountability and the cost of care

At present, and in future, local authorities are expected to take account of the 'actual cost' of care in setting determining what it would cost them to meet eligible needs.

Indeed, following the passage of the Care Act into law, the accompanying (draft) guidance to local authorities[1] specifically directs local authorities to assure themselves, and have evidence, that the fee levels they pay are adequate.[2]

[1] DH (2014) *Care and Support Statutory Guidance*, London

As such, some believe that greater clarity around the 'actual cost' of care resulting from implementation of the Care Act may itself be a solution to the potential issues raised, as local authorities will be subject to greater **pressure, accountability and transparency** to ensure they fulfil these duties, with accompanying pressure on central government to ensure local government funding is adequate.

A crucial factor will therefore be 'mature relationships' at a local level to work through this process. In part, this may be facilitated by more 'open book accounting' on the part of providers.

4.2. Acceleration of existing market trends

A potential response among providers to the implementation of the Care Act may simply be an **acceleration of existing market trends**, whereby providers exit those areas where fee rates are unsustainable for their businesses.

4.3. 'Selection' of residents by homes, and fee contracts

Individual care homes or chains may respond to the Care Act and the scenarios described above by **'selecting' residents through wealth**, i.e. only accepting residents who are unlikely to subsequently affect their bargaining position in relation to the local authority. For example, this might see homes refuse individuals with less than £200,000 in capital who are more likely to spend down wealth and become entitled to local authority financial support.

Another potential response may see care homes insist on **long-term fee contracts** with residents upon entering a home, effectively compelling families to 'sign-away' their chance to renegotiate fees at a later date, for example, by requesting the local authority take over arrangement of a person's care.

4.4. 'Contrived differentiation' among providers

A mechanism by which care providers justify higher fees to private funders is through differentiating services to self-funders from those paid for by local authorities. In response to market pressures resulting from the Care Act, some providers may use such '**contrived differentiation**' - i.e. the deliberate disaggregation of different elements of hotel and care services – to make it more difficult for users to compare services and prices. As such, an unintended consequence of the Care Act may be that the scope to compare and contrast different services in the market will become more clouded and harder for care users and families.

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[2] Section 4.28 states: "When commissioning services, local authorities should assure themselves and have evidence that contract terms, conditions and fee levels for care and support services are appropriate to provide the delivery of the agreed care packages with agreed quality of care, that will not undermine the wellbeing of people who receive care and support, or compromise the service provider's ability to meet the statutory obligations to pay at least minimum wages and provide effective training and development of staff. Local authorities should have regard to guidance on minimum fee levels necessary to provide this assurance."

In fact, some providers argue such differentiation has already begun in response to local authority fee pressures, with some large providers splitting their business models and services between public and private-funded markets.

To frame the effectiveness of such an approach by providers, this potential differentiation should be put in the context of existing research from consumer organisations, showing that families do not understand the different elements of fees for a care home, nor the different components of what they receive from the state.

4.5. Price pressure, prevention and reform

Some argue that budgetary and fee pressures resulting from implementation of the Care Act may simply result in long-overdue measures focused on **prevention and reform of the care pathway**, i.e. local authorities, domiciliary and residential care providers will come together to change the way in which individuals progress the care system, and eliminate the dysfunctional, sub-optimal decisions at the boundaries of health, care and housing. Some providers may seek out a competitive business advantage by concentrating on innovative models of care that minimise their exposure to below-inflation increases in care home fees. This could see some providers focusing to a much greater extent on providing select elements of care, for example, support around hospital discharge.

4.6. Regional mobility in residential care placements

It is often noted that England does not have one residential care market, but rather, hundreds of 'micro' markets. The capacity and stock in different areas can vary considerably.

As such, the Care Act may see both providers and local authorities incentivised to encourage users to move to another area, for example, individuals moving from Surrey to Sunderland to make the most of price differences between different areas. However, one countervailing pressure to note is that families are currently often willing to pay more for individuals to live in homes that are conveniently located for them.

5. Conclusion

The English residential and domiciliary care markets have long been at the frontier of an experiment in the delivery of mixed public services provision, and the implementation of the Care Act is simply another stage in this experiment, as policymakers seek to achieve greater fairness between the individual and the state in paying for the costs of care.

The implementation of the Care Act has the potential to transform the relationship between self-funders, residential care providers and local authorities. The nature of this transformation, and the extent of disruption to the existing market, is ultimately likely to turn on:

- The success of 'contrived differentiation' by providers as a mechanism to justify higher fees to self-funders;

- The effectiveness and activity of the media and ‘consumer bodies’ in informing and empowering families in the care system;
- The appetite of families for taking on providers and local authorities in order to reduce their fee levels, in the context of an average self-funder premiums currently worth around £7,500 per year.

Even prior to the Care Act, various longstanding issues and problems with England’s residential care market have long been identified, such as price discrimination, and the link between price and quality. As such, the changes brought on by the Care Act are also an opportunity for fundamentally rethinking and reviewing how the price of care is determined.

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