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STABILISING THE CARE HOME SECTOR & PREPARING FOR IMPLEMENTATION OF PART 2 OF THE CARE ACT IN 2020

A **White Paper** written by William Laing

November 2015

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CONTENTS

1. EXECUTIVE SUMMARY	2
2. OBJECTIVE	7
3. BACKGROUND	8
4. PROSPECTS FOR CARE HOME SUSTAINABILITY	10
5. HOW DO THE DILNOT REFORMS NEED TO BE MODIFIED?	19
APPENDIX 1 LONG TERM CARE MARKET CHARACTERISTICS	25
APPENDIX 2 MARKET MECHANISM FOR RESTORING EQUILIBRIUM	28

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1. EXECUTIVE SUMMARY

1.1 Imminent care home capacity crisis

There is a real and imminent danger of a care home bed capacity crisis hitting many localities in the course of the next few years (**Section 3**), as the margins of operators serving state-paid residents continue to be squeezed, as investment in new capacity ceases and as existing capacity exits the market, against a background of rising demographic pressure of demand.

Evidence to support this view comes from declining capacity trends (**Figure 1**) and an acceleration in underlying demographic pressure (**Figure 2**).

1.2 How will equilibrium be restored?

Our realistic conclusion is that the 2% Council Tax 'precept' flexibility to supplement social care funding, announced in the 2015 Comprehensive Spending Review, will *not* throw a financial lifeline to the care home sector (**Section 4.3**). It may pay for initial National Living Wage cost increases, but councils will want to spend most of the additional funding on meeting demand pressures (service volumes) and downward pressure on unit prices and margins will in all probability continue, reinforcing provider disinvestment.

At some stage, ordinary market forces can be expected to resolve any care capacity crisis, but only when it is full blown. At that stage, falling capacity will make it increasingly difficult for councils to make placements locally at their usual prices. With rising occupancy rates, market power will shift to providers and a point will be reached where central government has no other realistic option but to provide councils with the means to re-incentivise sufficient investment in care home capacity to enable councils to fulfil their statutory duties.

The resolution may be complete by 2020, by which time the cost to the state of paying for long term care for people without the means of their own will probably be substantially higher than it is today.

1.3 Minimising the pain and establishing a framework for more effective market management

If this conclusion is correct (that the care home sector's equilibrium will ultimately be restored by market forces rather than pre-emptive financial support from central government) then the next few years are likely to witness a spate of financial failures and home closures[1].

In these circumstances, the question may be posed: are there any policy prescriptions which could help to minimise the disruption at the same time as creating the conditions for more effective market management than has been achieved by central and local government to date (**Section 4.4**)?

The single proposal in this White Paper is the transfer of care home property cost funding from local authorities to Housing Benefit and the creation of a national Economic Regulator function for the care sector **(Section 4.4.1) -** an 'OfCare' comparable with OfGem and OfWat.

1.4 Rationale - weaknesses in the present system of state funding of social care set up in 1993

The rationale for this proposal lies in the weaknesses that have been exposed in the state funding system for social care established by the 1993 community care reforms (**Section 4.4.1**), weaknesses that have been exacerbated by austerity measures since 2011/12[2]. These include:

- Failure to deliver one of the original purposes of the 1993 reforms, which was to avoid the need for top-ups which were endemic (in more affluent areas) under the former Income Support funding regime, and to pay fees sufficient to offer a reasonable return to care home providers;

- The development of a 'stand-off' between central and local government in which central government argues that it has made adequate financial provision and that it is up to each council to make best use of its (adequate) resources, while councils for their part argue (probably correctly) that the funding is not adequate and therefore they cannot pay providers reasonable prices, and in turn providers cannot afford to pay carers a living wage**.** In effect, no part of government is taking full responsibility for good market management of the care home sector.
- It is this absence of good market management (including failure to fund social care adequately) which has allowed the care home sector to evolve into its present highly polarised state, with inadequate profits in areas highly exposed to public pay and super-profits earned by some providers in areas of high private

[1] In the past, home closures have been concentrated in the small home segment, but the future may see closures extended to larger scale homes as well.
[2] We leave aside here the issue of combining health and social care budgets. The proposal in this White Paper would remain equally valid under pooled budgets.

pay. It is also the root cause of endemic cross subsidisation, with private payers now paying an average 40% plus premium over public payers for like for like accommodation, **Table 2**. It is worth emphasising that it was the scale of this price differential that was at the heart of concerns that implementation of Part 2 of the Care Act would destabilise the care home sector by undermining the cross subsidisation upon which it depends;

- The challenge of maintaining high level market management skills in all 150 CASSRs in England. This issue is now being brought to a head by Part 5 of the Care Act 2014, under which councils have a specific duty to promote 'diversity and quality in provision of services' and 'ensure the sustainability of the market';

- The specific challenge of 150 CASSRs each maintaining a sophisticated understanding of the minimum return on capital sought by investors, which impacts strongly on benchmark fees output by any costing model. Absence of common ground on Return on Capital is at the heart of most if not all judicial reviews of the care home fee rates offered by councils, and taking this element out of local fee negotiations would greatly reduce the scope for disagreement and the likelihood of judicial processes being set in motion at all.

Setting a return on capital benchmark for the care home sector is a function calling for the skills and focus of a national economic regulator, comparable with an OfGem or an OfWat. Several commentators in the UK care sector have in the past recommended viewing publicly funded care home property as a utility subject to transparent regulatory rules, including a target return on investment for property which reaches, but does not exceed, a defined standard.

1.5 Proposal for central government action

In response to these inherent weaknesses in the present state funding system for social care, our proposal for central government action in this White Paper can be simply stated as follows (**Section 4.4.2**):

- Create a national economic regulator function for the care home sector, the regulator to be charged with:

    - setting a target rate of return for care home property used for council placements
    - based on CQC physical environment standards, establishing a process for determining local capital cost benchmarks per room, taking into account local land prices (and local construction / maintenance costs if necessary)

    CQC would be the obvious candidate for this extended economic regulation function since (a) it is already responsible for light touch financial regulation of larger providers and (b) CQC physical environment standards (such as minimum room size) are key determinants of benchmark capital costs per room.

- Transfer responsibility and funding for paying care home property costs from CASSRs to Housing Benefit. The effect of this would be to rationalise funding for all care modalities, placing care homes on the same basis as extra care for older people and supported living for younger adults with learning disabilities and other needs;

- Set up a process for classifying each care home with a council contract with an appropriate physical environment grade, linked to a complementary set of locally based care home Housing Benefit bands.

The benefits of these limited reforms would include:

- Facilitation of a more rational approach to council fee setting, allowing CASSRs to focus negotiations with local care providers on the current cost elements of the care home operation which they understand better than the property investment element and which are easier to quantify and cost (staffing, consumables, etc.);

- Better alignment with Part 2 of the Care Act and avoidance of the sort of inequitable outcome illustrated in **Table 2** (below), where care home residents in non-affluent areas would have benefited far less from the (now postponed) Care Cap than care home residents in affluent areas;

- Offering investors greater certainty over the reimbursement of their property costs, which may in turn act to reduce the target rate of return;

- Rationalisation of councils' funding streams for different modalities of care, putting care homes, extra care and supported living on a similar basis and elimination of perverse incentives to 'game' funding streams.

If this set of proposals were viewed as having merit, the next step would look at practical details and costs. It is very possible that they could prove cost neutral in terms of overall public spending.

1.6 Dilnot funding reforms

Serious reconsideration is merited for one important feature of the Dilnot funding reforms, as crystallised in the run of to the (now postponed) implementation of Part 2 of the Care Act. This is the decision to have a single, fixed national rate of £230 per week for 'daily living costs'.

It has now become apparent that this would have led to highly inequitable access to 'Care Cap' benefits in different localities, as illustrated in **Table 2**. To address this issue, it is recommend that 'daily living costs' be set locally (**Section 5.2**).

This solution would be fully compatible with the proposal set out above to transfer care home property cost funding to Housing Benefit and create a social care economic regulator function charged with determining a target rate of return for publicly funded care home property.

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2. OBJECTIVE

The objective of this White Paper is to stimulate debate on two linked topics:

- What is needed to stabilise those segments of the care home sector which mainly serve older people in receipt state funding and which are moving into crisis at a variable pace in different parts of the country? and

- How should the Dilnot funding reforms be modified to avoid the pitfalls that became evident in the run up to postponement of Part 2 of the Care Act (if it remains the intention of the government to implement the Dilnot reforms in 2020)?

A third topic can also be added:

- What new initiatives could be started now to improve the functioning of the care market, within existing legislation and without the need top-down structural reform, on the part of different stakeholders – central government, local authorities, the NHS, regulators and consumers and their advocates?

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3. BACKGROUND

In September 2014 LaingBuisson published its first White Paper entitled: *Strategic commissioning of long term care for older people: Can we get more for less?* Its summary of market characteristics, market failures and market successes is repeated in **Appendix 1**.

In the year that has elapsed since (a year of abortive preparation for Part 2 of the Care Act) nothing of substance has changed, other than financial pressures bearing down even more strongly on providers serving state funded clientele.

The September 2014 White Paper concluded by stating the case for care commissioners to make use of existing powers to evolve outcomes-based, long term contracts with lead providers (which it called Social Care Maintenance Organisations or SCMOs) covering the entire care pathway including advice and guidance, homecare and residential care. It 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 some correction of the endemic failures which currently damage the healthy functioning of the UK care services market for older people. We continue to believe that this is a practicable way forward, emphasising that the ultimate goal should be to allow consumers choice of which SCMO they belong to (which implies a multiplicity of SCMOs competing in any one geography) and open enrolment rules to avoid cherry picking by SCMOs.

There have been a number of other contributions in the last year to the debate on how to improve the functioning of the older people's care market, most notably from Ian Smith, chairman of Four Seasons Health Care[3], who proposes the introduction of integrated care organisations (ICOs) closely aligned to academic health and science centres (AHSCs).

There is much in common between these and the LaingBuisson proposals. Both look forward to genuinely integrated services operated by accountable organisations tasked with re-engineering whole pathways as necessary. Both draw their inspiration from the 'whole-patient-health' approach adopted by single-provider integrated-delivery systems in the US, such as Kaiser Permanente, Intermountain Healthcare, and the Geisinger Health System, in the belief that a similar approach can yield similar benefits for older people's social care in the UK.
All of these remain desirable goals for policy makers to promote, but they have understandably taken a back seat to immediate concerns about the financial sustainability of care services for state funded users, given the 6% real terms fall in average English council paid care home fees for older people since 2011/12[4] and

[3] http://iansmith.consulting/introduction/

[4] http://www.laingbuisson.co.uk/MarketReports/LatestMarketReports/tabid/570/ProductID/663/Default.aspx

the imminent implementation of the National Living Wage (NLW) in April 2016, which LaingBuisson estimates will require a 3.5% to 4.0% increase in fees to restore care homes' profitability status quo.

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4. PROSPECTS FOR THE CARE HOME SECTOR IN THE IMMEDIATE FUTURE

In the absence of significant additional central government funding, see below, the financial prospects for care homes serving mainly state-funded residents look bleak in the short term, and are likely to remain so until the balance of market power changes. In contrast, care homes catering mainly for self-paying resident have generally good financial prospects, supported by long term sustainable funding in the form of the usually un-mortgaged housing wealth of older people. The main focus of this White Paper is on the former, financially challenged, state-funded sector.

4.1 CSR does not provide enough additional funding to resolve the care sector's financial problems

Our realistic conclusion is that the 2% Council Tax 'precept' flexibility to supplement social care funding, announced in the 2015 Comprehensive Spending Review, will *not* throw a financial lifeline to the care home sector. It may pay for initial National Living Wage cost increases, but councils will want to spend most of the additional funding on meeting demand pressures (service volumes) and downward pressure on unit prices and margins will in all probability continue, reinforcing provider disinvestment.

The likely scenario over the next five years is described in an extract from LaingBuisson's recently published *Care of Older People UK Market Report*[5] reproduced in **Appendix 2**. Essentially, it reiterates the expectation that central government will *not* provide sufficient additional funding to avert what is now a serious and imminent risk that capacity will decline to a level at or below demand, at a variable pace, in many less affluent areas.

As and when capacity constraints begin to bite - one, two, three or perhaps more years from today, depending on local market conditions - market forces will eventually dictate a substantial price increase which government will have no realistic alternative but to accept if councils are to get access to sufficient capacity to fulfil their statutory responsibilities. Moreover, such new capacity as will be created to fulfil demand will be more expensive than such old capacity as has been lost.

In summary, if this scenario holds, the state funded care home sector will eventually (probably before the end of the decade) emerge from the bottom of its business cycle (where it is now) by dint of market forces. When recovery has taken place, the cost in public expenditure will be significant higher.

[5] Based on running expected National Living Wage pay rates through LaingBuisson's *Fair Price for Care* model.

4.2 Evidence of an imminent capacity crisis

The scenario set out in **Section 4.1** is predicated on the assumption that there *is* a looming care home capacity crisis in many parts of the country, though it has to be said that this is not a universally accepted view. Many will remain sceptical about the assertion that care home demand is about to outstrip supply, in the light: of the following considerations:

- The professional consensus in favour of care in non-residential settings, which is believed to be in accordance with the preferences of older people who require care and support;
- The success of councils in containing demand for care in residential settings in recent years, as evidenced by individual council initiatives and national returns to the Health and Social Care Information Centre, which show that numbers of older people supported by English Councils, while no longer declining as rapidly as they were, have nevertheless continued to fall gradually, even in face of upward demographic pressure[6];
- The observation that councils' level of commissioning of residential care is highly variable and the conclusion that if 'poorer' performing councils could emulate the success of 'better' performing councils then overall national placements of older people could be greatly reduced;
- Scepticism may be strengthened by a perception that care home interests have 'cried wolf' in the past about accelerating home closures.

The counter argument is that the profile of care home residents is now so highly dependent that it is difficult to conceive of the possibility of diverting much more demand away from care home settings, even with more vigorous implementation of preventive measures, investment in reablement or more extensive use of homecare for older people are on margin of home and residential placements. There is also a major question mark over the quality of homecare as it is currently delivered under typical local authority contracts.

While projecting demand and supply into the future remains an inexact science, the two charts presented below illustrate what LaingBuisson believes is a real and imminent danger that a care home bed crisis may be about to hit many areas of the country over the next few years.

Figure 1 shows cycles of new openings and closures over the past 25 years. Historically they have run together in tandem and broadly follow cycles of profitability with some time lag. Across the UK as a whole, openings are headed downwards at present while closures are headed upwards, with capacity reductions concentrated in areas where investment returns on care home operation are low. Across the UK as a whole, older care capacity in the independent sector fell by 1,500 places to 451,400 in the year ending September 2015, the first time a capacity reduction has been recorded in ten years.

[6] http://www.hscic.gov.uk/catalogue/PUB18663

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At the same time, **Figure 2** shows that the UK has recently entered a period of accelerated population ageing from 2014 to 2022. Other things being equal, this means that it will be increasingly difficult for local authorities to contain demand and prevent the gap between demand and capacity from narrowing to a point where they have difficulty in finding locally available spaces.

Figure 1
Components of national capacity change over time, private & voluntary care homes for older and physically disabled people, UK 1991-2015

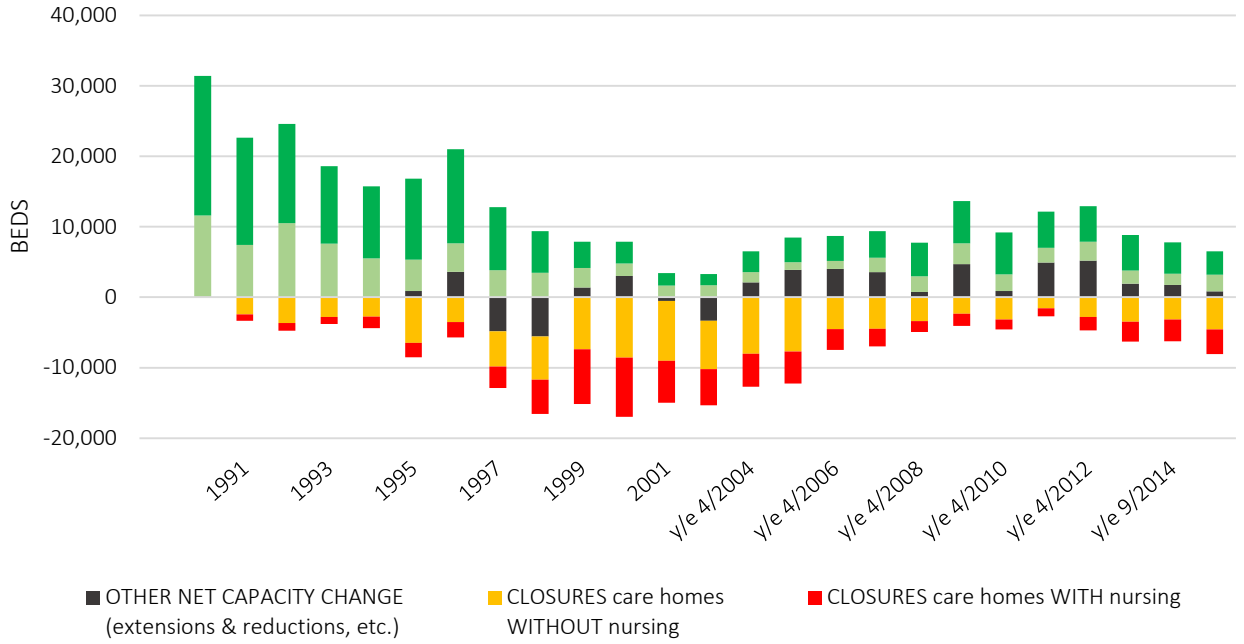
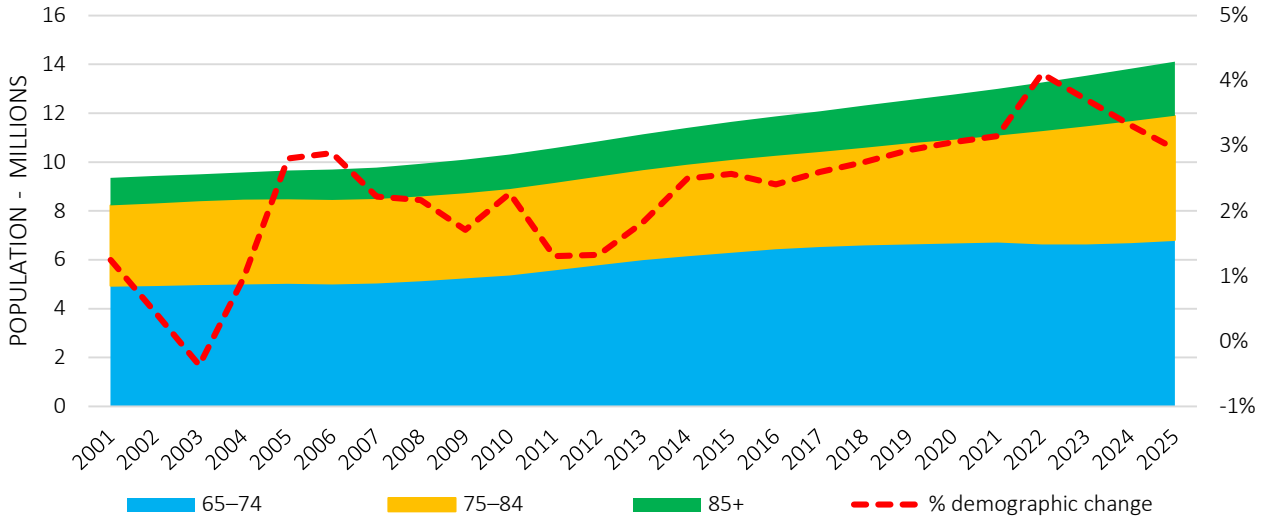


Figure 2
Projected demographic change UK 1901 – 2081



Sources: 1901-2001, Census data; Following 2001, successive principal national projections (the latest being 2012-based) from the Office for National Statistics and (formerly) the Government Actuary's Department. % demographic change calculated by applying 2014 age specific demand to projected future populations.

4.3 Conclusion on the immediate prospects for the state funded care home sector

In summary, our realistic conclusion is that sufficient additional funding for state paid care home residents will *not* be forthcoming from the CSR, providers' margins will continue to be squeezed and a care home capacity crisis is likely to hit large numbers of council areas over the course of the next few years as capacity exits the market. The crisis, or series of local crises, will be resolved by dint of market forces. Rising occupancy rates will shift market power in favour of providers until central government has no other realistic option but to provide councils with the means to re-incentivise sufficient investment in care home capacity to enable councils to fulfil their statutory duties.

The resolution may be complete by 2020, by which time the cost to the state of paying for long term care for people without the means of their own will be substantially higher than it is today.

4.4 Minimising the pain and preparing for more effective market management

If the conclusion in **Section 4.3** is correct (that the care home sector's equilibrium will ultimately be restored by market forces rather than pre-emptive financial support from central government) then the next few years are likely to witness a spate of financial failures and home closures[7].

In these circumstances, the question may be posed: are there any policy prescriptions which could help to minimise the disruption at the same time as creating the conditions for more effective market management than has been achieved by central and local government to date? No overall solution is offered in this White Paper but one important step is proposed, which is that the part of state funding which pays for the property cost element of care home services for individuals who are financially supported by local authorities should be transferred from the non-ring-fenced central government grant to CASSRs to the Housing Benefit budget, where it could be accessed subject to the usual means testing rules by any person placed in a care home by a CASSR.

The strong reasons for proposing the transfer of care home property cost funding from local authorities to Housing Benefit are explained below (**Section 4.4.1**). Before doing so, it should be pointed out that such a change would at the same time rationalise public funding of different modalities of care, since it would place care home funding on the same footing as extra care for older people and supported living for younger adults. In both these latter cases the care and support element of services is paid by local authorities and the housing or 'property' element is paid by Housing Benefit[8]. The change would also have the added advantage of making the funding system better aligned with the requirements of the (postponed) Dilnot care funding reforms, should they be implemented in 2020 (see **Section 5**).

4.4.1 Why transfer care home property funding to Housing Benefit? What's broken in the current system that more money wouldn't cure?

The current system of social care funding in England was set up in 1993 under the community care reforms which transferred the primary responsibility for funding adult social care services for people with insufficient means of their own from Income Support to CASSRs (Councils with Adult Social Services Responsibilities). It was

[7] In the past, home closures have been concentrated in the small home segment, but the future may see closures extended to larger scale homes as well.
[8] The local authority cost package could also include domestic living costs such as food and utilities.

an important watershed since councils immediately introduced assessment of need, which had been completely absent from Income Support funding[9]. It also replaced poorly calibrated flat rate national fees for residential and nursing homecare with local fees set with the knowledge of each CASSR.

These were fundamentally important improvements and it would of course be a retrograde step to revert to social security funding if that were to entail loss of local fee flexibility and less rigorous assessment of need established since 1993.

However, despite the clear advantages of budget capped local authority funding over open-ended Income Support, the new system set up in 1993 is now failing to deliver one of its original purposes, which was to avoid the need for top-ups which were endemic (in more affluent areas) under Income Support, and to pay fees sufficient to offer a reasonable return to care home providers.

While the system may have achieved this objective at the outset, it is patently no longer the case. Over the two decades since the community care reforms a 'stand-off' has developed between central and local government in which central government argues that it has made adequate financial provision and that it is up to each council to make best use of its (adequate) resources, while councils for their part argue (probably correctly) that the funding is not adequate and therefore they cannot pay providers reasonable prices, and in turn providers cannot afford to pay carers a living wage. In effect, no part of government is taking full responsibility for good market management of the care home sector and the consequences, including instability of the care home sector, have been exacerbated by the austerity measures bearing down on council budgets since 2011/12.

It is this absence of good market management (including failure to fund social care adequately) which has allowed the care home sector to evolve into its present highly polarised state, with inadequate profits in areas highly exposed to public pay and super-profits earned by some providers in areas of high private pay. It is also the root cause of endemic cross subsidisation, with private payers now paying an average 40% plus premium over public payers for like for like accommodation, **Table 2**.
It is worth emphasising that it was the scale of this price differential that was at the heart of concerns that implementation of Part 2 of the Care Act would destabilise the care home sector by undermining the cross subsidisation upon which it depends.

A further inherent problem with how the post-1993 funding system operates, which was not seen as important at the outset, is that it ideally requires excellent market management skills to be available in all 150 CASSRs in England. This is an unrealistic expectation, especially at a time when councils are reducing expenditure on management as well as services in response to austerity measures. This issue is now being brought to a head by Part 5 of the Care Act 2014, under which councils have a specific duty to promote 'diversity and quality in provision of services', paying particular regard (among other things) to 'ensuring the sustainability of the market'.

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[9] Prior to the 1993 community reforms it was estimated that up to a quarter of people accommodated in care homes with the aid of Income Support. The introduction of assessment of need led to a sustained fall in council funded placements over two decades and LaingBuisson has estimated that a quarter of a million fewer people live in care homes today than would have done if usage of care homes had continued at the same rate per unit population as under the Income Support regime.

One of the major reasons why councils and providers have failed to engage effectively on market management issues in the past, and are likely to struggle in the future, is an apparent absence of understanding of the investment return requirements of care home operators. LaingBuisson has participated in several judicial reviews charged with considering the reasonableness of council fee levels, or more often the process that has been followed in setting them.

What is striking is that both sides (councils and providers) usually agree on the quantum of current operating costs (staff, utilities, consumables, etc.). Their disagreement nearly always revolves around an appropriate allowance for property costs (return on capital) and operator's profit. LaingBuisson has seen councils and their advisors adopt untenable positions, either from a lack of understanding or, possibly, disingenuously[10].

While some councils have, or could develop the expertise, it is difficult to conceive of 150 CASSRs in England each having an informed opinion on what investment returns are required to incentivise providers without offering too much. This is a function calling for the skills and focus of a national economic regulator, comparable with an OfGem or an OfWat. Several commentators in the UK care sector have in the past recommended viewing publicly funded care home property as a utility subject to transparent regulatory rules, including a target return on investment for property which reaches, but does not exceed, a defined standard.

There have been occasional examples of this approach among councils, for example in the north east of England where some authorities have linked fees to the independently assessed standard of physical environment in each home accepting council supported residents. But for the great majority of councils the return on property element is bundled up in an overall negotiation which is usually in the form of 'last year + x% uplift for inflation'.

4.4.2 Proposal to transfer care home property funding to Housing Benefit and create an 'OfCare' economic regulator function

In response to these inherent weaknesses in the present state funding system for social care, our proposal for central government action in this White Paper can be simply stated as follows:

- Create a national economic regulator function for the care home sector, the regulator to be charged with:
    - setting a target rate of return for care home property used for council placements
    - based on CQC physical environment standards, establishing a process for determining local capital cost benchmarks per room, taking into account local land prices (and local construction / maintenance costs if necessary)

[10] For example, LaingBuisson has heard an argument, supported by a major accountancy firm, that a 6% whole business return on capital benchmark is adequate to cover both property investment and operator's profit. This particular position we would classify as disingenuous.

CQC would be the obvious candidate for this extended economic regulation function since (a) it is already responsible for light touch financial regulation of larger providers and (b) CQC physical environment standards (such as minimum room size) are key determinants of benchmark capital costs per room.

- Transfer responsibility and funding for paying care home property costs from CASSRs to Housing Benefit. The effect of this would be to rationalise funding for all care modalities, placing care homes on the same basis as extra care for older people and supported living for younger adults with learning disabilities and other needs;

- Set up a process for classifying each care home with a council contract with an appropriate physical environment grade, linked to a complementary set of locally based care home Housing Benefit bands.

The benefits of these limited reforms would include:

- Facilitation of a more rational approach to council fee setting, allowing CASSRs to focus negotiations with local care providers on the current cost elements of the care home operation which they understand better and which are easier to quantify and cost (staffing, consumables, etc.);

- Better alignment with Part 2 of the Care Act and avoidance of the sort of inequitable outcome illustrated in **Table 2** below, where care home residents in non-affluent areas would have benefited far less from the (now postponed) Care Cap than care home residents in affluent areas;

- Offering investors greater certainty over the reimbursement of their property costs, which may in turn act to reduce the target rate of return;
- Rationalisation of councils' funding streams for different modalities of care, putting care homes, extra care and supported living on a similar basis and elimination of perverse incentives to 'game' funding streams.

If this set of proposals were viewed as having merit, the next step would look at practical details and costs. It is very possible that they could prove cost neutral in terms of overall public spending.

4.4.3 Transparent information to facilitate effective market signalling

Poor information flows make investment decisions more difficult and risky. Councils have in the past sought to aid providers by publishing market position statements indicating what councils' needs are. It is understood, however, that most market position statements have now been removed from councils' web sites because they

are not Care Act compliant. They will re-appear in due course, but a deficit is likely to remain in the information required by investors to inform decisions on the development of new services and modification of existing ones.

To assist councils and providers in predicting the outcome of quite complex market dynamics, LaingBuisson in association with Strategy Dynamics Ltd has developed a dynamic market model, called **Care***Sustain* which takes into account all quantifiable local variables in order to project the interplay between care home capacity and demand, interactively with users who may change parameters to test the impact (see **Box 1**).

Box 1. Care*Sustain*

Care*Sustain* has been developed by LaingBuisson and Strategy Dynamics Ltd, based on ground-breaking work undertaken on behalf of the County Council Network of the Local Government Association during 2014 and 2015 to analyse the potential impact of implementation of Part 2 of the Care Act (now postponed) on the stability of county care markets.

Care*Sustain* is designed to build on transparent sharing of public and non-confidential private data to improve the efficient functioning of markets to the benefit of all stakeholders. The user is able interactively to modify policy and other parameters and the Care*Sustain* model projects closures and openings based on the shared data and rules which realistically reflect real-world business and investment decisions.

These rules recognise, for example, that while decisions on opening new homes or closing existing ones are based in both cases on expected future profitability, the 'decision triggering' levels of profitability will be very different for each.

Investors may require a prospective return on capital of around 12% per annum to persuade them to develop a new home. On the other hand, it is rational for existing homes which not performing well to continue in business literally until cash runs out, at a return on capital close to zero.

Another feature built into the model is based on the concept of 'distressed costs', which recognises that an operator with a home in financial difficulties may reduce costs below a long term sustainable level, for example by ceasing expenditure on repairs and maintenance, before considering closure.

One of the aims of Care*Sustain* is to ensure that appropriate signals are sent to all stakeholders in order that rational decisions can be taken and normal market time lags minimised.

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5. HOW DO THE DILNOT REFORMS NEED TO BE MODIFIED IF THEY ARE TO BE IMPLEMENTED IN 2020?

The last section's conclusion on how the current care home funding crisis will be resolved has an important bearing on the prospects for successful implementation of the Dilnot funding reforms, if that remains the government's intention in 2020.

5.1 Why was Part 2 of the Care Act postponed?

By mid-2015 there was a growing realisation that the Dilnot reforms incorporated in Part 2 of the Care Act carried with them a high risk of destabilising the care home sector, particularly in less affluent areas of England. Research carried out by LaingBuisson on behalf of 12 counties within the County Councils Network of the Local Government Association, identified the principal factor as the very high level of **cross-subsidisation** which has become endemic in the care home sector[11], which can in turn be traced back to an inadequate level of public funding:

The **cross subsidisation** issue was (and is) so important because most care homes which cater for both privately and publicly funded residents depend on the cross subsidy to generate what they view as reasonable margins; and the reason why implementation of Part 2 of the Care Act raised such fears is that it threatened to undermine the cross subsidies from private payers without replacing the loss with additional money from public payers. The specific threats:

- Payor shift; and
- Market equalisation

are described in **Box 2**.

[11] Historically, cross subsidisation from private to public payers has long been a feature of the economics of independent sector care homes, ever since the emergence of income support funding for people entering care homes during the 1980s. Prior to that, public and private payers had been very largely separated, with private care homes catering for private payers and publicly paid residents being accommodated in local authority in-house homes, not-for profit homes funded by local authorities and NHS geriatric wards. The income support boom in the 1980s led to the establishment of a large independent sector with mixed funding and frequently different prices for publicly and privately funded residents. This continued following the transfer of public funding responsibility from income support to local authorities under the community car reforms of 1993. Price differentials (cross subsidisation) were reinforced by a period of sub-inflation council fee uplifts around the turn of the century and have now been further reinforced by the second period of sub-inflation council fee uplifts which started in 2011/12,

While the existence of cross subsidisation is well known, there has not until recently been any published research which has quantified typical differentials between privately paid and council paid fees. The work carried out by LaingBuisson for the 12 counties for the first time provided hard data.
The details are described in the report[12], and the summary results are presented in **Table 1**.

Table 1
Evidence of cross-subsidisation from private payers to council funded care home residents in homes owned by a sample of care home groups operating in 12 English counties in 2015

	Analysis of fee variances in 'unique room sets' (i.e. groups of rooms of similar or identical specification, where it was possible to compare private and council paid fee rates on a like-for-like basis)			
	Number of Unique Room Sets	Number of private payers in unique room sets	Weighted average ratio of private to council paid[1] fees within unique room sets	Percentage of cases in which privately paid fees were higher than council paid fees for like-for-like services
Nursing homes	147	776	1.41	94.6%
Residential homes	304	2,663	1.46	96.7
All homes in sample	451	3,439	1.43	96.0%

Source: LaingBuisson analysis of comprehensive fee schedules by funding source and room type provided by a sample of major care home groups in a survey commissioned by a consortium of 12 counties within the County Council Network of the Local Government Association
[1] Council paid means 'pure' council paid, with no third party top-up

[12] County Care Markets: Care Market Sustainability & the Care Act. https://www.laingbuisson.co.uk/MarketReports/LatestMarketReports.aspx

Box 2. How the Dilnot funding reforms could have destabilised the care home sector

The funding reforms in Part 2 of the Care Act posed two specific dangers to the care home sector. Each of them threatened reductions in care home profit margins at a time when many providers' margins were already under severe pressure: The two threats were:

- 'Payor shift'; and
- 'Market equalisation'

Payor shift is the term used to describe the transfer of a cohort of care home residents with modest assets out of private pay and into the ambit local authority support (at typically inadequate fee levels – unless topped up) as a result of proposed extension of the upper asset limit for local authority support to £118,000. Its impact would have been greatest in less affluent areas where prices of residential property (the main source of individual wealth) are clustered round the proposed £118,000. LaingBuisson research found that a third or more of privately paying care home residents in the least affluent areas of England would have become eligible for public support at a stroke. With private fees typically over 40% higher than local authority fees for like-for-like services, payor shift would have had a severe adverse impact on the margins of care homes (most of them) which cater for a mix of publicly and privately paid residents. In contrast, payor shift would have had little effect on care homes in affluent areas where few property owners have assets of less than £118,000.

Market equalisation is the term used to describe a process in which the like-for-like cross subsidy from private to public pay (now over 40% on average) is substantially reduced. If the proposed 'care cap' had been introduced, many privately paying residents who registered for the cap would have realised for the first time that the 'usual costs' that councils were willing to pay fell far short of private pay fees set by care homes. The new price transparency, it was feared, would lead private payers and their families and advocates to seek a reduction in privately paid fees at least some way towards the local authority's 'usual costs', with an adverse impact on care home margins.

Section 18(3) of the Care Act was even more worrying to care home operators. This is the section of the Care Act which gives local authorities a duty to assist everyone to meet their care needs, including private payers as well as people who qualify for council financial support. If councils were to interpret this as a duty to 'arrange care' for anyone that asked (i.e. arrange contracts on their behalf with care homes), this would have opened to door to a massive expansion of the group of residents currently referred to as 'full cost payers', whose means are too great to qualify for mandatory financial support from councils, but whom councils have *voluntarily* agreed to assist in arranging care, with full recovery of costs. There may be around 10,000 of these full cost payers currently resident in care homes who have the means to pay private fees but who are paying at council rates and are indistinguishable from other council paid residents from the care home perspective. A major increase in their numbers would have had a substantial adverse effect on care home margins. The government did recognise the risk and planned not to implement Section 18(3) in 2016, before the issue was rendered academic by the decision to postpone implementation of the entire Dilnot package. Market

equalisation, in the form of private fees falling to public levels, would have affected the profit margins of care homes in all areas of the country, affluent and non-affluent, depending to the gap between public and private fees.

The market equalisation scenario would have posed a dilemma for government policy. It is hard to argue against price transparency, which is desirable in all markets, and there are many cases in which transparency would have had a salutary effect in reducing private fees in those cases where care homes have set them at 'super-profit' level, relying on the information asymmetry between care home operator and individual privately paying resident. But, because of the scale of the private to public cross subsidy that has become endemic in the care home sector, 'desirable' transparency would have had the undesirable consequence of destabilising the market. The only other answer is for market equalisation to operate in the reverse direction, with public fees rising some way towards private fees. But this is equally problematic because local authorities will argue that they cannot afford to pay more without additional government funding. This was at the heart of local government lobbying for postponement of Care Act.

Amid strong concerns about market destabilisation, the final straw that seems to have led the government to postpone implementation was the unexpected announcement of the National Living Wage (NLW) in the 2015 summer budget. Using LaingBuisson's 'Fair Price for Care' model, it is possible to calculate that the rise from £7.20 per hour (NMW) to £7.50 (over-25 NLW rate) in April 2016 will require an average 4% increase in fees in order to maintain operating profit margins as they were, and conversely no fee increase means a similar percentage point decline in operators' EBITDAR on average.

Presumably the view taken by the government was that it would be too risky to expose the care sector to the shock of both NLW and Dilnot implementation simultaneously at a same time of continuing public sector austerity. It may be significant that the Care Act Phase 2 postponement announcement came within days of the NLW announcement.

Although the research summarised in **Table 1** was restricted to the twelve counties, there is no reason to believe that these counties are unrepresentative, and confidence in the results is boosted by the fact that they are based on a *full* fee schedule by room type, home, funding source and resident type from each of the participating care home groups with operations in the 12 counties.

The headline result was that in 96% of cases (unique room sets) where like for like comparisons were possible, private payers paid a 'premium' compared with council funded residents without top-ups, and the average 'premium' or 'cross subsidy' was 43%. Some price differential is to be expected, as in any other sector of the economy where large purchasers seek and gain discounts. But it is the very high level of the 'premium' or 'cross subsidy' that renders the UK care home sector vulnerable to any attempt to bear down on private fees without addressing public fees at the same time, as explained in **Box 2**.

5.2 What changes are needed if and when Part 2 of the Care Act is implemented in 2020?

It follows from the commentary in the last section (**Section 3.2**) that the dangerously high level of cross subsidisation in the care home sector needs to be greatly reduced (through an injection of new money) before it would be safe to introduce the Dilnot funding reforms, with the attendant (desirable) move towards price transparency and downward pressure on private fees.

While this looks unlikely from the perspective of 2015, given the government's strong focus is on eliminating the public spending deficit, our conclusion from **Section 2.2**, above, is that by 2020 central government may well have been forced by a series of local care home bed capacity crises to make inject new money to enable councils to fulfil their statutory duties. If so, then the principal practical barrier to implementing Part 2 of the Care Act would have been removed.

There remains, however, one important feature of the Dilnot package, as worked up in detail by the Department of Health in the abortive run up to April 2016, which merits serious reconsideration. This is the early decision to have a single, fixed national rate of £230 per week for 'daily living costs', which is the element of care home fees which was *not* to be counted towards the care cap.

One of the principal findings of the research conducted by LaingBuisson on behalf of the 12 CCN counties was that a consequence of a fixed national rate for 'daily living costs' is wide geographical variation in older people's chances of benefiting from the care cap, from over 10% in some areas to vanishingly small in others. The reason is that the amount of money credited to each private payer's care cap account, according to the original plan, would have been the difference between the council's 'usual costs' (the gross weekly fees that a council usually pays for a person with similar needs) and the 'daily living costs'. If 'usual costs' are low, as they are in non-affluent areas, then the sums credited towards the care cap are low, and the length of time taken to reach the care cap could be six years or more, with very few care home residents remaining alive by the time £72,000 had been reached.

In contrast, in an affluent area where councils' 'usual costs' are high, the cap might be reached in three years and over 10% of residents may remain alive to benefit. The differences are illustrated in **Table 2**, taking actual examples but without revealing the identity of the counties.

This is a glaring inequity that can hardly be ignored, once recognised. A partial solution would be to set 'daily living costs' locally, just as housing benefit rates are set locally to recognise local differences in market rents. If locally set 'daily living costs' were to take property costs into account, then much (though not all) of the inequality in **Table 2** would be eliminated. A fuller solution is suggested in the proposal set out in **Section 4**.

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Table 2
Individuals' prospects of benefiting from the Care Cap: an affluent county and a non-affluent county

	Non-Affluent County	Affluent County
	£ per week	£ per week
Council's 'Usual Costs'	£421	£624
Deduct national 'Daily Living Costs)	(£230)	(£230)
Amount counting towards the 'Care Cap'	£191	£394
Years to reach Care Cap	6.7	3.4
Proportion remaining alive long enough to benefit from the Care Cap	1%	10%
Average private fee	£603	£867
Amount spent in private fees before reaching the Care Cap	£227,000	£158,000

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APPENDIX 1 CHARACTERISTICS OF THE LONG TERM CARE MARKET

Exit of the public sector from its former provider role

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.

Market characteristics

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 at the care home group level;
- 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, where some providers are generating super-profits; and
  - non-affluent areas dominated by publicly paid demand where profits are often inadequate to sustain continuing investment;
- 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;
- Absence of intermediation between individual consumers and service providers
- Exclusively rental offering (licensee tenure) for care homes, leasehold being reserved for extra care;
- Absence of franchise business model in care home sector, though franchises are common in homecare.

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Market failures and successes

The notable achievements of the care market which has emerged in the last four decades include:

- On the supply side, attraction of investment of about £30 billion over four 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.

The principal commissioning side market failures which have become rooted 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.

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.

Source: LaingBuisson White Paper *Strategic commissioning of long term care for older people: Can we get more for less?* published in September 2014.
https://www.laingbuisson.co.uk/Portals/1/Media_Packs/Fact_Sheets/LaingBuisson_White_Paper_LongTermCare.pdf

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APPENDIX 2 MARKET MECHANISM FOR RESTORING EQUILIBRIUM

(An excerpt from *Care of Older People Market Report – 27th edition*, published in September 2015)

The care home market is subject to a self-righting mechanism like any other market. Investment is curtailed when prices (as now) are insufficient to offer a reasonable return in areas of high public pay. As a result, against a background of rising demand, shortages can be expected to appear. Market power will shift towards providers, prices will rise and public authorities will be forced to find extra resources if they are to meet statutory duties. It is likely that this scenario will be played out at a variable pace in 200 council areas in the UK over the next five years.

Market imperfections (including non-transparency of market information together with development time lags) will predispose the market to overshooting equilibrium in both the contraction phase (which the care home market appears to have entered now) and any past or future expansion phase. There is also historical evidence of such cyclical patterns in the care home sector in the last two decades[13].

It is possible that the new Conservative administration may be persuaded by both local government and care provider lobbyists that the impending crisis in the care sector is so severe that it justifies a pre-emptive injection of substantial new funding sooner rather than later, before the emergence of shortages creates an absolute imperative to find new money. On the face of it, the government's commitment to eradicating the budget deficit in the course of this parliament (i.e. before 2020) seems to make this an unlikely scenario. However, two key government announcements in July 2015 have raised the chances of this happening. The first is the replacement of the adult National Minimum Wage (£6.70 from October 2015) with a new National Living Wage (NLW) (£7.20 from April 2016, rising to £9.00 by 2020). Without an at least partly compensating increase in government grants to allow councils to raise the care home fees they pay, the government can expect a wave of financial failures in the care sector. While the 'double whammy' of Care Act implementation with its own risk of market destabilisation has now been pushed back to 2020, the latter was to some extent a 'soft' risk, while the NLW is a hard risk, which the government will find difficult to ignore. Moreover, postponement of implementation of the Dilnot elements of the Care Act has at a stroke saved the government a substantial sum of money over the interim period, rising to about £2

[13] During the late 1990s through to the early 2000s the sector experienced a downturn in profitability (due, as now, largely to a squeeze on fees by local authorities), resulting in several financial failures around the turn of the century and a major shakeout of capacity. As occupancy rates rose local shortages became apparent and local authorities raised their fee levels above inflation, allowing care home margins to be rebuilt during the mid-2000s. The major difference in the mid-2000s (compared with the mid-2010s) is that local authorities at that time were benefiting from record increases in funding from central government under the Blair administration.

billion by 2020. In the event that the government does not make a pre-emptive injection of new funding, market destabilisation could be so severe in many areas that it threatens councils' ability to perform their duty of arranging care for vulnerable people.

Such a crisis would be likely to have two faces: (a) in areas of moderate to low occupancy, where market power lies largely with councils, where further pressure on fees could easily lead to widespread business failures and significant loss of capacity which in practical terms could only be rectified by an emergency injection of more public funds; and (b) in areas with high occupancy levels dominated by self-funder demand, self-funders will simply crowd out council supported residents unless council fee levels are raised.

The results of the 2015 Comprehensive Spending Review will be published on 25 November 2015. LaingBuisson's prediction is that some new central government funding will be made available to local authorities in order to help the market to withstand the shock of implementation of the National Living Wage. But whatever new money is injected it will in all probability be insufficient to re-establish the margins of care home operators with high exposure to public pay at the level they were prior to the 6% real terms reduction in councils' baseline fee rates since the beginning of public sector austerity in 2011/12. Therefore, the scenario described in the opening paragraph will in all probability continue to be played out at a variable pace in 200 council areas.

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