



Right Care, Right Price

A discussion paper exploring the way in which the price of care is determined and its implications for social care policy



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Executive Summary

Analysts have long identified problems with the way in which the price of domiciliary and residential care in England is determined, whether this is paid for by local authorities, 'self-funders' (and their families), or a combination of these sources.

However, unprecedented pressure on local authority budgets, and the government's plans to reform long-term care funding in England, are pushing the issue of how the price of care is determined to the forefront of social care policy debate.

This discussion paper identifies a number of issues with how the price of care is determined in local care markets, including:

- ▶ Local authority monopsony power;
- ▶ Relationship between price and quality;
- ▶ Price discrimination and excess quality premiums.

The report also identifies how the way in which the price of care is determined affects the broader objectives of social care policy, with key issues including:

- ▶ The price of care is not understood by the public;
- ▶ Public ignorance of what local authorities pay for care;
- ▶ The effect of price discrimination on long-term care funding reform.

The report argues that to address these issues, the government should:

- ▶ Ensure financial sustainability among care providers coherent with investment and quality;
- ▶ Strengthen the link between prices and quality across the market;
- ▶ Boost the public's knowledge of the price of care in their area;
- ▶ Improve 'consumer knowledge' among families paying for care
- ▶ Improve public understanding of local authority commissioning of care and the prices paid

The paper concludes by arguing that with the local authority care system in England facing the toughest public spending outlook ever experienced, and with the government committed to achieving new guarantees and peace of mind among self-funders of care in England, the time is now right for a radical rethink of how the price of care is determined.

1.Introduction

Social care provision in England is a ‘mixed economy’. Some people receive informal (family) care and others receive care from a paid care worker.

Individuals may receive paid care in their own home (domiciliary care), or for those with more substantial needs, in a care home (residential care).

The vast majority of domiciliary and residential care is provided by the ‘independent sector’: organisations in the not-for-profit or private sectors. Domiciliary or residential care is usually paid for by:

- ▶ Individuals themselves or their family;
- ▶ The local authority; or
- ▶ A combination of these sources.

In addition, a small percentage of care home places are funded directly by the NHS.

1.1. Is the price of care working?

The price that individuals, families and local authorities pay for care is determined through the operation of local care markets.

In economic theory, an ‘efficient market’ is one in which prices are determined through the interaction of supply and demand.

However, analysts have long identified multiple problems with the way in which the price of domiciliary and residential care in England is determined.ⁱ For example:

- ▶ Given their considerable buying power, local authorities may be able to push down the price of care they pay for, putting pressure on the financial viability of providers;
- ▶ As consumers, individuals and families often struggle to identify and evaluate different levels of quality in the context of care services, so can be unwilling to pay higher prices for better quality services, making such services uneconomic and reducing choice and quality across the market.

Importantly, the way in which the price of care is determined is not just important to the functioning of care markets or outcomes for care users. It also has much broader implications for public policy on social care, for example, attempts to encourage individuals to plan ahead for the cost of care.

Although issues with the way in which the price of care is determined have been identified for

ⁱ For example, Appendix 1 contains the conclusions of a report on the care market undertaken by the Office of Fair Trading report in 2005.

many years, several factors are now bringing these issues to the forefront of debate on social care policy:

- ▶ **Public spending cuts** in England are putting downward pressure on the fees that local authorities will pay for care, exacerbating longstanding issues such as poor staff conditions and the financial sustainability of providers, in a way that some feel is no longer tenable;
- ▶ **Long-term care funding reform**, and the government's commitment to implement in 2016 a fairer partnership between individuals and the state in paying for care built around the principle of capping people's care costs, will ultimately be undermined without changes to how the prices paid for care by local authorities and 'self-funders' are determined.

1.2. Right Price, Right Care

This discussion paper seeks to advance policy thinking on the issue of how the price of care in England is determined by asking: where are we now and where do we want to get to?

In **Chapter 2**, the report explores in more detail some of the current issues with how the price of care is determined, and the functioning of local care markets.

Chapter 3 explores how issues around the price of care affect broader social care policy aims, in particular, reform to the partnership between individuals and the state in paying for care.

In **Chapter 4**, the paper sets out what outcomes policymakers should be seeking to achieve in relation to the way in which the price of care is determined.

Chapter 5 concludes the paper with key messages for policymakers.

The operation of care markets is highly complex, so this discussion paper does not seek to make definitive recommendations around reform, nor undertake detailed evaluation of reform options. However, in order to advance policy discussion, **Appendix 3** of the report does identify and summarise a range of potential reform options.

2. Where are we now? Pricing and the operation of care markets

Multiple issues have been identified with the way in which the price of care is determined among local care markets in England.

Three principal types of agents are active in care markets:

- ▶ **Providers** of domiciliary and residential care;
- ▶ **Local authorities** as purchasers of care for those entitled to means tested care and support;
- ▶ **Individuals** (and their families) who 'self-fund' their own domiciliary or residential care.

The Department of Health estimates that over 1.5 million adults in England receive paid care in some form:

User and funder	Number
LA-supported older people receiving domiciliary care	532,000
LA-supported working age adults receiving domiciliary care	350,000
Older people funding their own domiciliary care	325,000
LA-supported older people in residential care	170,000
LA-supported working age adults in residential care	54,000
Older people funding their own residential care	125,000

Source: Department of Health (2012) Caring for our future: progress report on funding¹

The vast majority of domiciliary and residential care is provided by private and non-profit organisations, although some local authorities do retain some care homes themselves. Across the UK, the market for paid care is estimated to be worth around £23 billion, of which around two-thirds is residential care.²

2.1. Price Setting in Care Markets: An overview

Across a market of 349,000 people in residential care in England, councils contribute to around 224,000 places, i.e. around two-thirds of the market.

This potentially places councils in a position of quasi-monopsony in some sections of the market, for example, poorer areas where the majority of care home residents may be entitled to means tested council support. The monopsony power of local authorities may also be enhanced by the fact that the residential care sector is characterized by a large number of small individual providers, who may be in a relatively weak negotiating position.

According to 2010 data from the Care Quality Commission (CQC), 74% of all care homes (and 80% of care home places) in England were in the private sector and 19% (13% of places) were from the voluntary (non-profit) sector. In April 2010 there were around 9,300 providers of care homes in the UK, of which 78% owned just one home. Of the 11,200 care homes for elderly people in the UK, around 70% have fewer than 25 places, 60% have fewer than 20 places and 30% have fewer than 15 places.

With significant monopsony power in some sectors of the market, councils may be able to use this power to set prices.

In contrast, among the 125,000 self-funders of residential care in England, their market power as individual purchasers is significantly more limited when compared to local authorities who are able to 'bulk purchase' and drive economies of scale, potentially creating scope for price discrimination by providers, which is explored below.

Domiciliary Care

Across a market of 1.2 million adults in receipt of domiciliary care in England, councils contribute to the care of around 882,000 people, i.e. around two-thirds of the market. As with residential care, this potentially places councils in a powerful market position.

However, under the 'choice and personalisation' agenda, the last decade has seen significant changes in the way in which those entitled to local authority financed care in their own homes receive this support.

Following a needs assessment and means assessment, those entitled to council support have a right to receive their support as an unrestricted, cash-based Direct Payment, or as a 'Personal Budget' managed jointly by the individual and their council.

Local authorities determine the value of a Direct Payment or Personal Budget by applying their 'Resource Allocation System' (RAS). However, there continues to be wide variation among local authorities in the operation of RAS procedures, as well as issues around transparency, consistency and the understanding of those being assessed.³

Although the choice and personalization agenda remains a work-in-progress, more and more individuals in receipt of council support are procuring services as individual purchasers, rather than relying on their council. The National Audit Office has estimated by March 2011, out of a total of one million eligible users, around 340,000 people had a Personal Budget, representing £1.5 billion of the overall spend on care services.⁴ Of this group, 125,000 received this as a Direct Payment and the other 215,000 as a managed budget.

Nevertheless, there is relatively little reliable data on:

- ▶ The unit price for care and support these individuals pay, in particular, those in receipt of Direct Payments;
- ▶ How the price they pay for care compares to similar services procured by their council.

Indeed, it is entirely possible for individuals to pay for domiciliary care from their own resources without ever having made contact with their local authority.

The result is that, when compared to the residential care sector, the relative power of local authorities, providers and individuals in the domiciliary care market is much harder to ascertain.

2.2. Pricing Care: What are the problems?

The key issues identified around the way in which the price of care among local care markets in England is determined relate to:

- ▶ Local authority monopsony power;
- ▶ Relationship between price and quality;
- ▶ Price discrimination and excess quality premiums.

As well as affecting the operation of care markets, these issues also have implications for broader social care policy, which are explored in the next chapter.

2.3. Local authority monopsony power

The potential monopsony power of local authorities in domiciliary and residential care markets was described above.

As far back as 2005, an investigation by the Office of Fair Trading received evidence from care home providers that: “the fees paid by [Local] Authorities to care homes for older people do not cover the full costs to the care home of providing care, plus a reasonable profit margin.”⁵

However, in the context of the government’s deficit reduction programme, public spending on social care via local authorities has come under intense pressure, with no respite likely for the rest of this decade.

In a 2012 survey of the prices paid by local authorities for nursing and residential care, a market research company estimated that English councils were paying just £480 per week for residential care, approximately £50 - £140 less than a ‘fair market price’ range calculated using a ‘fair price’ calculator.⁶

As a result, there is growing concern that the unit cost of care paid to some providers by some local authorities is unsustainable.

Previous analysis of the market has also identified as problematic the approach of some local authorities to achieving savings and efficiencies in response to budget cuts:

“One authority we spoke to told us that cost savings are often pushed through the whole organisation in a very top-down manner, without taking into account the potential impact on the market. “We were essentially told, ‘Adult social care – we want you to find 15% this year’, which immediately affected what we felt able to pay in the market.”

Source: PwC (2011)

Why does this matter?

- ▶ **Quality** – inadequate fees can force down levels of quality in provision;
- ▶ **Staff conditions** – unsustainable pricing puts downward pressure on staff pay and conditions – which are often already low – with implications for staff turnover and retention, returns on staff training, quality of care and morale;
- ▶ **Sustainability** – inadequate rates of return may see investors exit the care sector, with implications for overall supply and capacity;
- ▶ **Returns on capital** – where pressure on fees reduces returns on capital investment, this is over the medium-to-long-term likely to result in an overall deterioration in the quality of care home facilities.

2.4. Relationship between price and quality

In markets that are functioning well, the price of a product or service will reflect its quality, and the willingness of consumers to pay for different levels of quality. For markets to work effectively, consumers must be able to distinguish and recognise differences in quality and be in a position to evaluate price proportional to quality.

However, in relation to care services in England – particularly the quality of accommodation in residential care – it has been observed that the relationship between price and quality has become dysfunctional, in that quality is insufficiently recognised or rewarded by both local authorities and self-funders (and their families).

What factors cause these outcomes?

- ▶ Local authority commissioning practices

Some local authority commissioning processes are felt to be incapable of ensuring both that providers are appropriately rewarded for quality of provision, and that competition between providers occurs on more than just price. Indeed, in response to public spending cuts, local authorities have been accused of ignoring variations in quality, and commissioning for care and support services solely on the basis of price.

- ▶ Consumer knowledge of quality

Among self-funders and their families, it is felt that knowledge of care markets, and different dimensions of quality of care is low. In many instances, moves into residential care represent a ‘distressed purchase’ made quickly and at a time of emotional turbulence, leaving families little time to truly research and understand the quality of different care services available. Furthermore, the general public has very little knowledge of the care market – as the next chapter explores – so upon becoming ‘consumers’, many families may be ill-equipped. As a result, considerations of quality, and price to quality ratios, among self-funders and their families can be inadequate to achieve a well functioning market.

Previously, social care regulators did produce publicly available ‘star ratings’ to distinguish quality in care homes, and following a review,⁷ the government has recently stated its intention for these to be reintroduced. However, there remain profound questions around

attempts to define 'quality' in care, owing to its subjective nature, lack of agreement around what outcomes are actually being sought, as well as difficulties of measuring these outcomes.⁸

Why does this matter?

- ▶ **Raising standards** – when market prices do not adequately reflect differences in services and quality of accommodation, this limits the incentive – and financial sustainability - for providers to raise standards and improve quality, particularly when improving quality of services might require investment, for example, in new building facilities or staff training;
- ▶ **Value for money** – in some instances, self-funders and their families may use poor information or inappropriate signals to try and determine the quality of services, resulting in poor value-for-money.

“One of the worst care homes in our area is also one of the most expensive. But it has a big chandelier in the lobby and a fancy staircase. That’s what people see when they go to visit.”
Quote from local authority commissioner cited in PwC (2011)

2.5. Price discrimination and excess quality premiums

Domiciliary and residential care providers are able to charge different prices to local authorities versus 'self-funders', and among different local authorities and different self-funders.

In some instances, such 'price discrimination' may reflect the operation of market forces and the fact that economies of scale can be gained through bulk-buying. In other sectors, such market forces have led to the emergence of services to help consumers compare prices, such as price comparison websites for hotel bookings.

However, it has been argued that in response to downward fee pressures and the monopsony power of councils, some providers in care markets in England will charge higher fees to self-funders:

- ▶ For care of broadly equivalent quality;
- ▶ For higher quality care that includes an excessive price 'premium'.

It is argued that such price discrimination effectively represents a cross-subsidy from self-funders to local authorities. This issue is not new. For example, in 2005, an Office of Fair Trading investigation identified concerns that: “care homes may be charging higher fees to self funders in order to cross subsidise publicly funded residents.”⁹ More recently, two surveys of the residential care market noted:

“Self-pay fees are still typically £50–£100 higher than local authority fees on a similar service and similar amenity basis, though premiums may be lower in areas of acute capacity shortage where local authorities have been forced to match self pay rates.”

Source: Laing and Buisson (2011)¹⁰

“The residential care homes market is a 'buyers' market but [Local] Authorities appear to lack a full understanding of the impact of their decisions on the market, with a short term focus on price...”

“... with local authorities driving down price as far as possible when budgets are stretched, care homes

increasingly look to self-funders to sustain their revenues, resulting in those who are privately funded either cross-subsidising publicly funded places or being priced out of the market and unable to access the required level of care.”

PricewaterhouseCoopers (2011)

Recent downward pressure on the fees paid by councils has resulted in growing worries that the extent of price discrimination may be increasing, as well as the extent of cross-subsidies from self-funders to local authorities.

Why does this matter?

- ▶ **Fairness** – cross-subsidies from ‘self-funders’ to local authorities are felt to be unfair, and are sometimes described as a form of ‘hidden taxation’;
- ▶ **Unmet need** – academic analysis has pointed out that where local authorities negotiate a low price which pushes up the price for self-funders in consequence, this may result in a – albeit small – group of individuals (a ‘squeezed middle’) who are not entitled to state support, but unable to afford ‘self-funder’ care home fees because of price discrimination;¹¹
- ▶ **Care funding reform** – different models for reforming the partnership between individuals and the state in paying for care – including the reforms scheduled to be implemented in 2016 – are ultimately undermined if the benchmark level of fees paid by local authorities (the ‘usual cost’ rate) is unsustainable for providers. This issue is explored further in the next chapter.

2.6. Conclusion

This chapter has explored issues around the way in which the price of care is determined among local care markets in England:

- ▶ Local authorities may have monopsony power that enables them to exert downward pressure on the fees they pay to providers;
- ▶ The relationship between price and quality has become dysfunctional in some care markets, both in relation to local authorities and families procuring care;
- ▶ Price discrimination by providers may result in effective cross-subsidies being made from self-funders to local authorities.

The next chapter explores some of the implications of these issues for the wider goals of public policy on social care.

3. Where are we now? Care pricing and implications for social care policy

The way in which the price of care is determined is not just important to the efficient and effective functioning of local care markets in England.

The price that different agents in local care markets pay, and the public's knowledge of these prices, has very important consequences for broader social care policy, which this chapter explores.

3.1. The price of care is not understood by the public

The general public has little knowledge about the price of care in their local area, in large part because of the functioning of the care market, and exacerbated by the limited role that domiciliary and residential care has in the lives of most people.

In an online omnibus survey of 2,271 UK adults aged 16-64 undertaken in preparation for this discussion paper, respondents were asked: "On average, what do you think is the weekly cost of a place in a typical residential care home per week?"

Fully 49.8% of respondents were only able to say "Don't know". This suggests half of working-age adults in the UK are unable to guess how much the price of residential care is in their area.

Among the 50.2% who did provide an estimate in response to the survey, the mean amount suggested was £396.58. This is around £140 below the average care home fees across the UK for the 2012-13 financial year of £531 per week. (Source: Laing & Buisson, 2013)

These results suggest many individuals have no knowledge of the price of care, and among those that do, they typically underestimate the true average price by a substantial margin.

Several factors may explain the public's ignorance about the price of care:

- ▶ Variation in pricing

A key factor that may contribute to public ignorance of the price of care is variation in prices for different types of care, at different times of the year, and among different geographical areas. There is no standard price of care for any individual care home, and prices may fluctuate and vary widely.

As such, although organisations may undertake periodic market surveys to establish the price of care in different local areas, the price of care is actually a moving 'spot price' that reflects particular conditions and factors at a particular time.

▶ Information constraints

Relatively little information on the price of care is available to the public. For example:

- ▶ **Limited advertising about prices** – advertising and promotional material produced by care providers rarely contains information on prices. In part, this may be because providers prefer to undertake individual assessments of a person’s needs before suggesting a fee. It is also likely to reflect a preference among providers for flexibility in pricing, and commercial confidentiality, as well as for promoting the services they provide on the basis of quality and outcomes, rather than price;
- ▶ **Absence of price comparison sites** – although there has been strong growth in recent years of price comparison websites for hotels and financial services, there has been no equivalent for care and support services. In part, this may reflect that price comparison services are most effective when goods and services are directly comparable. However, by their nature, care and support services are frequently very difficult to compare directly.
- ▶ Lack of contact with the care system

Much of the population has little contact with the care system. The same survey of working-age people described above also found that two-thirds of the working-age population had no contact with the care system in the last five years, and as few as 12.5% reported experience of being involved in arranging the care and support of someone during this period.

In an online omnibus survey of 2,271 UK adults aged 16-64, respondents were asked: “Thinking about your family and friends and people you know have any of them received care and support from a paid care worker during the last five years, whether in their own home or in a care home?”

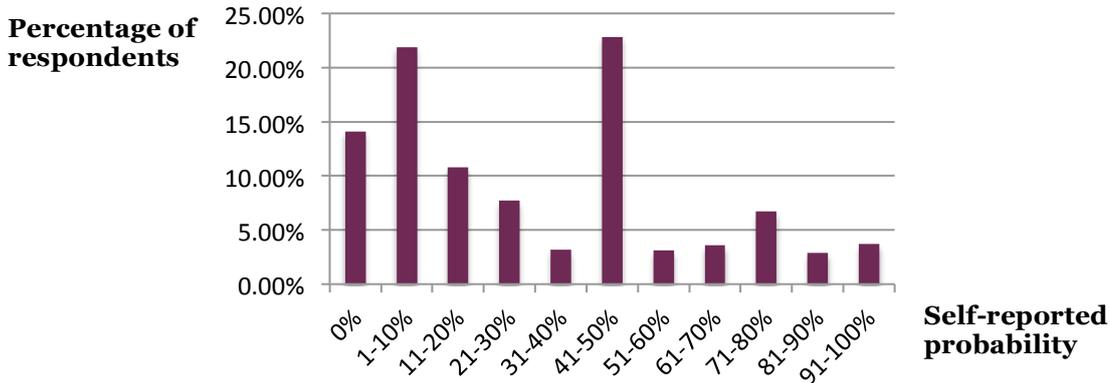
Only 32% of respondents answered positively to this question, suggesting around two-thirds of the working-age population have not had any recent experience of the care system. Among the group responding positively, only 38.7% were actually involved in helping to arrange care and support.

▶ Individuals underestimate the chances of needing care themselves

Members of the public may have little interest in the price of care because they do not believe they will ever be consumers of care themselves. Indeed, many members of the public may underestimate the probability that they will require domiciliary or residential care in future.

In an online omnibus survey of 2,271 UK adults aged 16-64, respondents were asked what was the probability of needing domiciliary care, with over half believing the probability was under 40%.

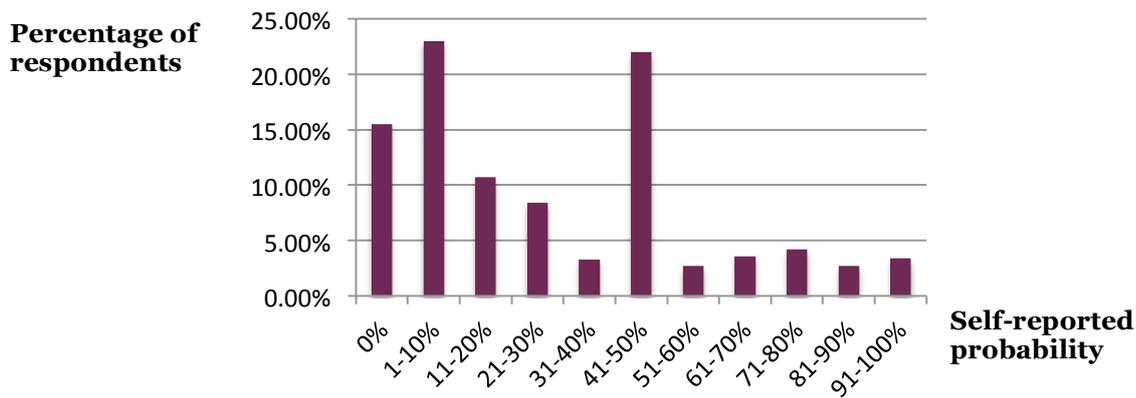
Self-reported probability of needing paid care in your home



Source: Online omnibus survey of 2,271 UK adults aged 16-64

In relation to residential care, the same survey found that a similar proportion of respondents believed the probability of them ever needing residential care was under 40%.

Self-reported probability of needing care in a care or nursing home



Source: Online omnibus survey of 2,271 UK adults aged 16-64

However, academic research into potential eligibility for council support under Fair Access to Care Services eligibility criteria (2009 levels) found that 65-year old males have a 68% chance of potential (FAC eligible) need before they die, while for females the probability is 85%.¹²

Overall, it appears that owing to the functioning of local care markets in England, as well as the nature of domiciliary and residential care, public ignorance of the cost of care in their area is widespread. Most people do not know the average cost of different types of care, and many would be unable to even suggest a typical price.

Why does this matter?

- ▶ **Financial planning** – individuals who do not know the average price of care are unlikely to engage in financial planning for future care needs, even though the accumulated cost of residential care can be very high. For example, among the one in two working-age individuals who have no idea of the average cost of residential care in their area, it is unlikely that such individuals would be motivated strongly to engage in saving in preparation for funding future care needs;
- ▶ **The politics of long-term care funding** – public ignorance of the cost of care may undermine the salience of long-term funding as a political issue. This has implications for political choices around levels of public expenditure on care observable at a national and local level. It is also important for the reform agenda around long-term care funding: if voters are unaware of how much care costs, they may be less likely to vote for politicians who make care funding reform a political priority.

3.2. Public ignorance of what local authorities pay for care

Despite being vital services provided to many of the most vulnerable members of the community, the public also has little knowledge of:

- ▶ The average price ('usual cost' rate) – or typical price range – that their local authority pays for domiciliary or residential care;
- ▶ The quality of care that their local authority will pay for;
- ▶ How their local authority procures care services.

In an online omnibus survey of 2,271 UK adults aged 16-64, respondents were asked: "Local authorities are often involved in paying for a place in care homes for people in need of residential care. What price on average do you think local authorities pay per week for a place in typical residential care?"

Fully 60.5% of respondents were only able to say "Don't Know". Among the 39.5% who did provide an estimate, the mean amount suggested was £350.88. This is around £130 below the average care home fees across the UK paid by local authorities for the 2012-13 financial year of £480 per week. (Source: Laing & Buisson, 2013)

Why is the public ignorant of the average price their local authority pays for care? This most likely reflects the fact that no local authority publishes this data, so it would be typically only available to an individual or organisation following a Freedom of Information request.

Why does this matter?

If members of the public do not know the price of care that their local authority typically pays, this has significant implications for:

- ▶ **Quality of services** – local voters may struggle to ensure that the quality of services provided to vulnerable members of their community is appropriate – as well as wider commissioning processes - if they do not know what their local authority pays for care;

- ▶ **Accountability of spending** – councillors may struggle to win public support for cost-effective preventative interventions, such as telecare, if voters are unaware of the unit cost of care services that their council pays for.

3.3. The effect of price discrimination on long-term care funding reform

In recent years, debate on long-term care funding reform in England has sought to achieve an improved, fairer partnership between individuals and the state in paying for care.

There will always be variations in what self-funders pay for care, in part reflecting varying levels of income and wealth, and the choice of wealthier individuals to opt for more expensive care.

However, as the previous chapter identified, price discrimination by providers between self-funders and local authorities is a feature observed in some sections of local care markets.

Crucially, if the local authority's 'usual cost' rate is below the fair price for care – perhaps because such rates reflect the monopsony power of local authorities to push down prices – this will ultimately undermine the objectives of any model of long-term care funding reform.

This issue is demonstrated by exploring the implications of price discrimination for the government's 'capped cost' reforms.

The 'capped cost' model

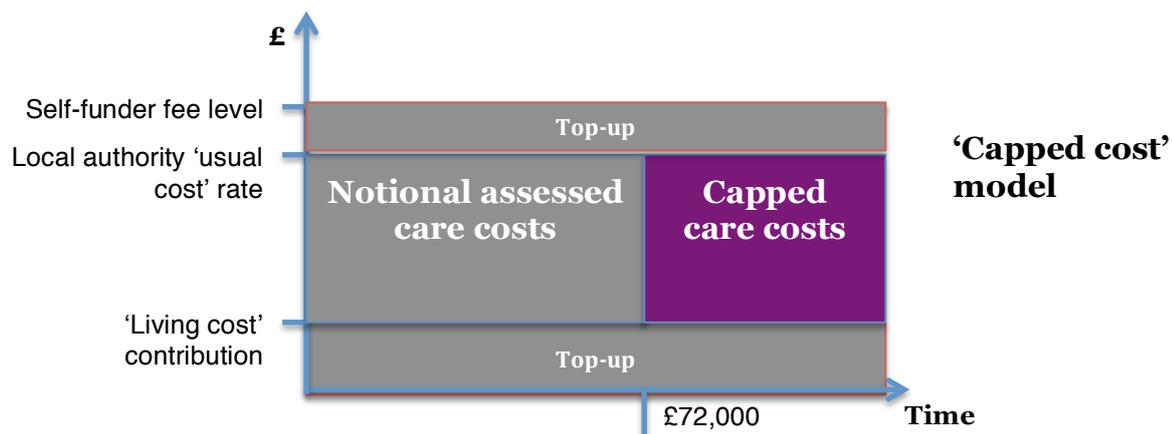
In March 2013, the government committed to introduce the 'capped cost' model of care funding in England from 2016, under which a person's lifetime care costs will be 'capped' at £72,000.

However, these reforms will in fact fail to 'cap' a person's care costs for the vast majority of self-funders in residential care, because most self-funders pay more than their local authority usual cost rate, and having reached the 'cap', individuals will likely have to continue to pay 'top-up' fees beyond it.

In part, such top-up fees will reflect the choice of individuals to use their income and wealth to pay for more expensive care than their local authority's 'usual cost' rate.

However – crucially – in many instances, top-up fees will also reflect the extra amount paid by self-funders above the local authority 'usual cost' rate for equivalent care, and the fact that in many instances, it is impossible for families to obtain the 'usual cost' rate for care.

The following chart is adapted from the government's own analysis of these reforms,¹³ and demonstrates the problem with price discrimination for the 'capped cost' reforms:



This graph shows that although the reforms will cap someone’s notional assessed care costs at £72,000, because the price paid by the self-funder is above their local authority’s ‘usual cost’ rate, they will have paid more than £72,000 by the time they reach the cap, and will go on paying toward their care costs beyond it.

In short, although the principal aim of the ‘capped cost’ model is to cap a person’s care costs, this is impossible in practice because of the self-funder fee differential and price discrimination by providers.

Such problems are not unique to the ‘capped cost’ model, but would also affect alternative care funding models. For example:

- ▶ ‘Free personal care’ would not in fact be free as many individuals would go on making out-of-pocket payments for what they felt was adequate care;
- ▶ The ‘Wanless Partnership model’¹⁴ would not in fact pay for a third of people’s care costs, because their assessed care costs would in many instances be below what they actually paid.

Appendix 2 explores further the effect of price discrimination on different models of long-term care funding reform.

Reform of care funding, price discrimination and cross-subsidies

Besides potentially preventing reform of care funding in England achieving its objectives, it is also important to note, as Hancock R et al. (2012) observe,¹⁵ that any increase in the proportion of places in residential care paid for by local authorities as a result of implementing reforms such as the government’s ‘capped cost’ model may affect both:

- ▶ The prices that local authorities pay for care; and
- ▶ The prices charged to self-funders.

Indeed, the authors identify implications of care funding reforms in which local authorities are responsible for funding a greater proportion of individuals in residential care in their area – such as the ‘capped cost’ model or ‘free personal care’ - for both the cost to the Exchequer of

implementing reforms and the outcomes – ‘protection’ - experienced by self-funders. The authors note that where this occurred:

“LAs could therefore have more bargaining power in negotiating fees but there would be fewer – and under some proposals no – self-funders to cross-subsidise publicly funded residents. The fee levels negotiated by LAs could affect the public cost of the reforms, the revenue, and hence profitability and supply, of care homes and the fees that any remaining self-funders face.”

Hancock R et al. (2012)¹⁶

The authors go on to note previous quantitative research, which demonstrated that:

“under the current means test there are enough self-funders for care homes to be able to recoup any losses on LA-funded residents via higher fees for self-funders, but that reforms to the means test could change this.”

Hancock R and Hviid M (2010)¹⁷

As the authors observe, for reforms – such as the ‘capped cost’ model - that would increase the proportion of residents who receive LA funding, an assumption that there would be no change in the fees paid by councils or remaining self-funders is one which is open to question, and which has a significant impact on the projected consequences of different reform options.

3.4. Conclusion

This chapter has explored the implications of the way in which the price of care is determined for broader social care policy.

It has shown that current mechanisms for determining the price of care contribute to public ignorance of care prices, and pose a profound challenge to longstanding efforts to create a fairer partnership between the individuals and the state for paying for care in England.

4. Where do we want to get to? Right price, right care

This paper has reviewed a number of challenges and issues arising from the way in which the price of care in England is determined.

These issues include:

- ▶ Local authority monopsony power;
- ▶ Relationship between price and quality;
- ▶ Price discrimination and excess quality premiums;
- ▶ The price of care is not understood by the public;
- ▶ Public ignorance of what local authorities pay for care;
- ▶ Long-term care funding reform and price discrimination.

As the Introduction identified, a number of these issues are becoming more acute given pressures on public spending, and the government's commitment to implement reform of long-term care funding in 2016.

4.1. What outcomes should policymakers aim to achieve?

In seeking to address these issues, what are the specific outcomes that policymakers should seek to achieve?

The government should:

- ▶ Ensure financial sustainability among care providers coherent with investment and quality

The rates paid to care homes should be adequate for investment in facilities and training, good pay and conditions, and a reasonable rate of return for investors.

- ▶ Strengthen the link between prices and quality across the market

The price of care should be more strongly linked to, and reflect, differences in quality, so that investment in quality is incentivised and rewarded.

- ▶ Boost the public's knowledge of the price of care in their area

Members of the public should be made aware of the benchmark cost of domiciliary and residential care in their local area.

- ▶ Improve 'consumer knowledge' among families paying for care

Self-funders of domiciliary or residential care should have adequate knowledge of the cost of different types of care in their area, differences in services and differences in quality.

- ▶ Improve public understanding of local authority commissioning of care and the prices paid

The public should understand what their local authority pays for different types of care, and how commissioning occurs, with such information publicly accessible.

4.2. How can policymakers achieve these outcomes?

The range of outcomes identified above is broad, and will be challenging to achieve in the context of the complex operation of local care markets.

It is beyond the scope of this paper to provide a detailed, evaluation of the full range of reform options available. Instead, **Appendix 3** contains some different options for policymakers and summarises key advantages and disadvantages. Nevertheless, it is possible to identify three broad approaches for improving the way in which the price of care is determined, although some pose immediate and significant drawbacks.

- ▶ Information and transparency

The government could take steps to ensure greater transparency and provision of information among different agents in the care market. This might include councils being required to public and update their 'usual cost' rate on a regular basis.

- ▶ Regulation

The price of care could be regulated, and specifically linked to quality. For example, care homes that do not achieve certain quality ratings could be barred from charging more than a defined fee-range.

- ▶ Competition and market forces

The operation of competition and market forces in local care markets could be enhanced. For example, the monopsony power of local authorities could be reduced through requiring local authorities to use third-party care brokers who may also work for self-funders.

5. Conclusion

This discussion paper has explored issues around the way in which the price of care is determined, and broad approaches for improving current practice.

The issues identified are numerous, broad, complex and interdependent with each other. They have also been discussed extensively over the last decade.

However, with the local authority care system in England facing the toughest public spending outlook ever experienced, and with the government committed to achieving new guarantees and peace of mind among self-funders of care in England, the time is now right for a radical rethink of how the price of care is determined.

In many ways, the domiciliary and residential care sectors stand out from other areas of the private economy – such as defence – that feature high levels of spending by the state.

Many of the issues identified in this report arise from the operation of a mixed economy of public and private expenditure, as well as competing policy objectives, such as value-for-money in public spending versus guarantees around what private individuals will have to pay for care themselves.

In the background, the sheer complexity and levels of variation in markets for care and support are reflected in high levels of public ignorance. It is particularly striking that one in two of the working-age population are simply unable to offer an estimate of the weekly price of residential care in their area – a direct consequence of the way in which the price of care is determined, but a major stumbling block for the government's social care reforms.

In conclusion, major changes are needed with the way in which the price of care is determined if the government's vision for individuals with care and support needs, for the care system, and for long-term care funding reform, is to be realised.

Appendix 1: Office of Fair Trading, 2005

To put the issues explored in this paper into historical context, it is worthwhile setting out four areas of concern highlighted by the Office of Fair Trading in an investigation published in 2005:

- ▶ **Information about moving into a home** – there is a lack of awareness among older people and their representatives about sources of information on the process of moving into a care home. There is a confusing multitude of different sources of information, and no single clear reference point for people to consult;
- ▶ **Authority obligations** – there is confusion about what advice and support Authorities should be providing to older people and their representatives. In particular, there appears to be a lack of clarity about when additional third party payments (which can be used to pay for more expensive accommodation) are appropriate. There also appears to be some variation in what different Authorities offer to older people who are not eligible for Authority funded care;
- ▶ **Price transparency** – many older people and their representatives lack information about care homes' fees and services offered, and about terms and conditions for living in a care home. Older people and their representatives need this information quickly, prior to making a decision about moving into a care home, and in an easily accessible and high quality format;
- ▶ **Contracts** - we have identified a large number of contracts that are potentially unfair or have unclear fee related terms, giving care homes scope to introduce arbitrary fee increases. We also found that many contracts are unnecessarily complex or unclear, making it difficult to assess the true rights and obligations of the older person and of the care home under the contract.

Office of Fair Trading (2005) Care homes for older people in the UK, London

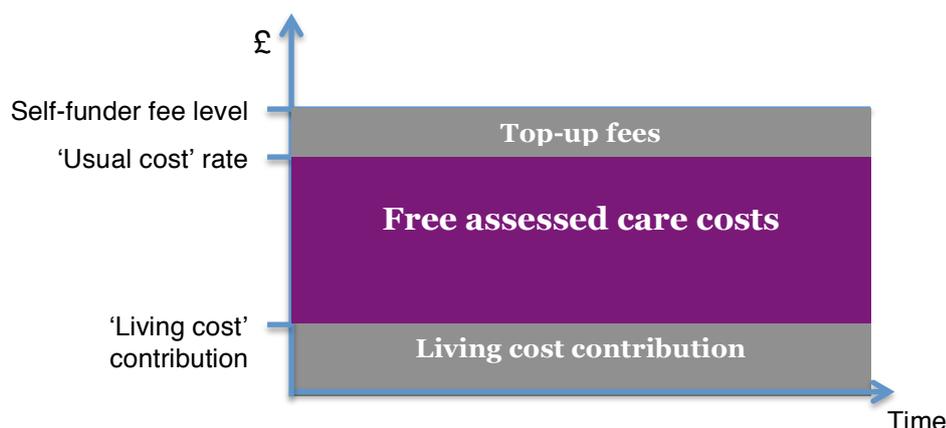
Appendix 2: Price disparities, price discrimination and reform of care funding

This appendix explores the implications of price disparities and price discrimination between what individuals and local authorities pay for care, for different models of long-term care funding reform.

A2.1 Free Personal Care, 'Building a National Care Service'

Free personal care was the central proposal of the 2010 White Paper 'Building the National Care Service'. However, because of the difference between the local authority 'usual cost' rate and what self-funders pay for care, in the vast majority of cases, individuals in residential care would not have experienced 'free care'.

Assuming that councils required a standardised living cost contribution from self-funders from their income, the result of 'free personal care' for many people would be as follows:

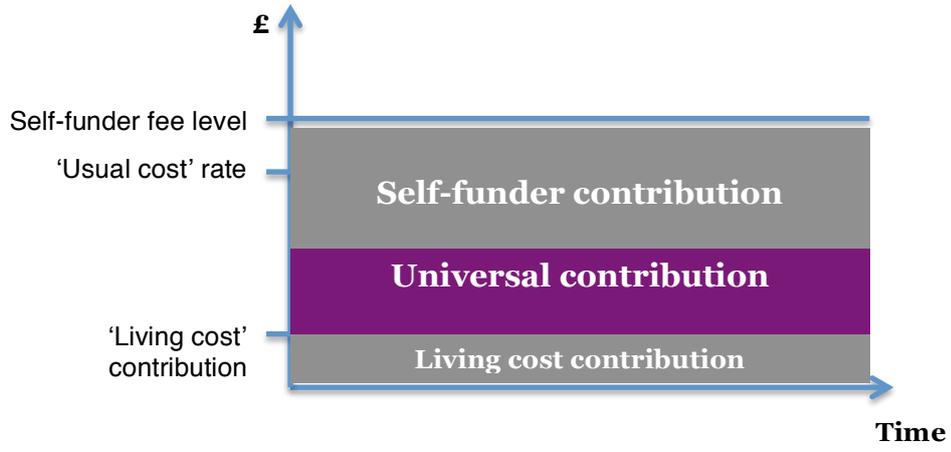


As this diagram shows, even under free personal care, individuals would have to pay both a living cost contribution and a self-funder 'top-up' fee.

A2.2 'Partnership Model', Wanless Social Care Review

The 'Partnership model' put forward by the Wanless Review recommended that councils should fund a defined proportion of everyone's assessed care costs – for example, one-third – regardless of their means.

However, as the following diagram shows, even after taking account of a standardised living cost contribution, self-funders would not actually experience councils funding one-third of their costs, because of the operation of price discrimination and the existence of self-funder premiums:



Appendix 3: Options for Reform

How can policymakers address the issues arising from the way in which the price of care is determined in England?

Three broad approaches to reforming how the price of care is determined can be identified:

- ▶ Information and transparency;
- ▶ Regulation;
- ▶ Competition.

Information and transparency

▶ Better public knowledge of the price of care

Summary: The government undertakes a public information campaign to improve public knowledge and understanding of the price and quality dimensions of care.

How? Various levers are available, such as TV and billboard advertising. The government could also appoint a Minister for Older People to be a public figure to tell people to learn more about social care services and prepare for the costs of care.

Pros:

- ▶ Consumer knowledge – improved knowledge of the price of care would provide a better baseline for individuals who go on to become ‘consumers’ in local care markets.

Cons:

- ▶ Efficacy – public information campaigns can struggle to be effective.

▶ Price transparency

Summary: Address imperfect information in care markets that give power to local authorities and providers through regulation to require price transparency.

How? Registered care providers are required to list prices on their websites. Local authorities are required to publish their ‘usual cost’ rate, and/or, the number of places they pay for at different prices.

Pros:

- ▶ Competition – self-funders and their families would be able to more directly compare the price of different providers.
- ▶ Price discrimination – providers may be less likely to engage in price discrimination if differences in fees paid were made public, thereby reducing the cross-subsidies from ‘self-funders’ and compelling local authorities to pay ‘fair’ market rates.

Cons:

- ▶ Commercial confidentiality – providers may resist price transparency citing the right to commercial confidentiality;
- ▶ Oversimplification - providers take different approaches to pricing, for example, some operate a ‘basic price’ plus additional options;
- ▶ Excessive focus on price – price transparency could refocus decision-making on the basis of price alone, resulting in a diminution of care quality;
- ▶ Public expenditure – reducing the bargaining power of local authorities in procuring care would ultimately cost the Exchequer more.

3.2 Aggregated (‘star’) ratings

Summary: The government reintroduces the equivalent of ‘star ratings’ for the care sector to help self-funders evaluate the price of care provision.

How? Health and social care has previously seen the operation of ‘aggregate rating’ systems, such as the ‘star system’ in residential care. The use of aggregate ratings can help self-funders of care obtain a better understanding of the relationship between price and quality of accommodation in the market, and provide an incentive to providers to raise quality levels in order to improve their rating and be able to charge higher fees on this basis.

The Secretary of State for Health recently launched a ‘Rating review’ into whether aggregate ratings of provider performance should be used in health and social care, and if so how best this might be done.¹⁸ The Nuffield Trust identifies five overarching general objectives of an aggregate ratings system:

- ▶ To increase accountability to the public, users, commissioners of care, and (for publicly funded care) to Parliament;
- ▶ To aid choice by users (their relatives and carers), and by commissioners of publicly-funded care (mainly NHS primary care trusts and the new NHS clinical commissioning groups, and local authorities);
- ▶ To help improve the performance of providers;
- ▶ To identify and prevent failures in the quality of care;
- ▶ To provide public reassurance as to the quality of care.

Dixon K (2013) Rating providers for quality: a policy worth pursuing?

Pros:

- ▶ Salience – a basic aggregate quality rating system would be simple and understandable for the public;
- ▶ Quality – care providers would be able to charge more for a higher quality service if the public had access to a transparent rating system, thereby raising standards.

Cons:

- ▶ Accuracy – any basic rating system inevitably over-simplifies differences in quality and provision that some providers will feel is inaccurate;
- ▶ Gaming – any performance measurement system, particularly built around ratings of certain activities, can lead organisations to over-prioritise what is (or can be) measured, or even to forms of ‘gaming’. This may ultimately undermine the usefulness of the rating system.

3.3 Quality-dependent recommended price-points or price-bands

Summary: Councils or other third-party bodies provide information on recommended price-points or price-bands for different levels of aggregate accommodation quality rating, thereby providing help to consumers of care services.

How? Using aggregated quality-ratings and a standard 'fair-price for care' calculator or formula, information is published online indicating 'fair' prices for residential or home care of different quality ratings.

Pros:

- ▶ Transparency – self-funders would be able to see much more clearly the relationship between price and quality in the market;

Cons:

- ▶ Feasibility – challenge to derive 'fair prices' that accurately take account of very local variation in land costs;
- ▶ Innovation – would potentially stifle innovation among providers in relation to both value-for-money and service design (quality).

Regulation

3.4 Regulated tariffs

Summary: Local or nationally determined regulated tariffs for care which determine what care providers can charge to self-funders and councils.

How? A transparent, standardized 'formula' or 'calculator' would be applied in different areas to derive a benchmark 'fair price' for care. This benchmark either provides a ceiling on what providers can charge or is a benchmark used to derive a permissible 'band' of charges.

Pros:

- ▶ Pricing – prevents price discrimination against 'self-funders';
- ▶ Sustainability – councils would be compelled to pay a 'fair price' for care, based on the application of a standardised formula.

Cons:

- ▶ Feasibility – any formula or tariff used to calculate a fair price for care will inevitably have limitations, for example, in relation to accurately taking account of very local variations in land costs, staff costs, etc.;
- ▶ Quality – standardised formulas or calculators may struggle to cope with nuanced variations in quality or lifestyle factors, which providers and consumers feel merit price differences;
- ▶ Innovation – would potentially stifle innovation among providers in improving value-for-money.

3.5 Regulated price to quality tariffs or price-bands

Summary: The prices that providers can charge to local authorities and 'self-funders' determined by the provider's quality rating.

How? A standardized 'fair price for care' calculator or formula is applied in different areas, and used to derive single price-points or price-bands for different quality ratings.

Pros:

- ▶ Transparency – self-funders would be able to see much more clearly the relationship between price and quality in the market;
- ▶ Fairness – councils would be compelled to pay the 'fair' price for the care they procure.

Cons:

- ▶ Feasibility – challenge to derive 'fair prices' that accurately take account of very local variation in land and other costs;
- ▶ Innovation – would potentially stifle innovation among providers in relation to both value-for-money and service design (quality).

Competition and market forces

3.6 Councils and self-funders use the same e-marketplace for care services

Summary: Self-funders and local authorities purchase care via the same 'marketplace'.

How? Single, comprehensive 'e-marketplaces' for local care services become the sole mechanism for individualised procurement by both councils and self-funders, with councils only able to procure on an individual basis.

Pros:

- ▶ Price discrimination – if purchases are of individual units of care then LA's would no longer be able to negotiate bulk buy discounts - as economies of scale would be lost.

Cons:

- ▶ Cost – average fees paid by councils would be likely to increase.

3.7 Third-party care brokers – self-funders only

Summary: To increase the buying power and market information deployed on behalf of self-funders, councils pay for third-party care brokers to procure care for self-funders.

Pros:

- ▶ Knowledge – the market knowledge of brokers will always be greater than that of self-funders.

Cons

- ▶ Outcomes - separating procurement from the individual may mean they have less control over the various factors to consider and the interplay of price, quality and lifestyle factors;

3.8 Third-party care brokers – councils and self-funders

Summary: Third-party brokers procure care for both councils and self-funders, such that at the point of purchase, there is no difference between a self-funder and council-funded placement.

Pros:

- ▶ Fairness and buying power – where ‘discounts’ can be secured from bulk-buying of care providers, this can be shared across local authorities and self-funders.

Cons:

- ▶ Strategic commissioning – separating the procuring role from local authorities may make it harder for them to undertake their market development responsibilities and powers – monitoring future supply related to projected demand – and other strategic commissioning functions;
- ▶ Public expenditure – may increase costs for local authorities.

3.9 Personal budgets for all

Summary: Local authorities give Personal Budgets to all individuals entitled to council support, including those in residential care, to purchase their own care privately.

Pros:

- ▶ Fairness – put self-funders on an equal footing with those receiving council support;
- ▶ Outcomes - quality, as defined by the end user of the service and/or their relatives, becomes the defining factor in their decision-making.

Cons:

- ▶ Limited buying power – the scope for price discrimination among providers may increase;
- ▶ Determining budgets – it is unclear how the value of Personal Budgets would be determined if the council was not procuring services itself to set its ‘usual cost’ rate.

3.10 Council procurement for all

Summary: Local authorities become responsible for procuring care for self-funders if they are requested to do so.

How? Although self-funders already have the right to request that their local authority arranges their care for them, there is little information on how frequently this duty is invoked, and how often it results in self-funders securing care at the council’s ‘usual cost’ rate.

Pros:

- ▶ Buying power – would potentially enable self-funders to secure fees equivalent to the local authority ‘usual cost’ rate.

Cons:

- ▶ Limits to buying power – the buying power of local authorities is typically limited to the lower end of the market, such that they may have no more power than the self-funder in relation to more expensive care;

- ▶ Price discrimination – unless councils only arranged care at their ‘usual cost’ rate, councils may be incentivised to ensure self-funders pay more for care, i.e. to ensure price discrimination occurs, in order release cross-subsidies;
- ▶ Effect on supply - driving all fees - including those paid by self-funders - down to the usual cost rate risks driving down quality to unacceptable levels and profit margins to the point where it will be unsustainable for some providers.

Appendix 4: Omnibus Survey Results

Results of an online omnibus survey of 2,271 UK adults aged 16-64

On average, what do you think is the weekly cost of a place in a typical residential care home per week?

(Please think about the cost of a middle range home so not the cheapest or most expensive)

		Base
Base		2271
Q3	£ (please specify)	1141
		50.20%
	Don't know	1130
		49.80%

Local authorities are often involved in paying for a place in care homes for people in need of residential care. What price on average do you think local authorities pay per week for a place in typical residential care?

		Base
Base		2271
Q4	£ (please specify)	896
		39.50%
	Don't know	1375
		60.50%

Thinking about your family and friends and people you know have any of them received care and support from a paid care worker during the last five years, whether in their own home or in a care home?

		Base
Base		2271
Q5	No	1538
		67.70%
	Yes	733
		32.30%

Were you involved in helping them arrange their care or support?

		Base
Base		733
Q6	No	449
		61.30%
	Yes	284
		38.70%

Have you thought about how to pay for any care and support needs you might have for yourself in the future?

		Base
Base		2271
Q7	I have thought about it in great detail	157
		6.90%
	I've thought about it a little	604
		26.60%
	I know I should have thought about it but haven't done so yet	415
		18.30%
	I haven't thought about this at all yet.	1095
		48.20%

What have you done to prepare for the costs of long-term care?

		Base
Base		761
Q8	Joined a company pension scheme	228
		30.00%
	Started saving with the intention that it could be used for when you are older	223
		29.30%
	Other (please specify)	126
		16.60%
	Set up your own independent pension scheme	117
		15.40%
	Any other financial planning related to your needs when you are older	111
		14.60%
	Paid extra contributions into a pension scheme	92
		12.10%
	Taken out insurance, for instance to cover illness or inability to work	90
		11.80%

	Consulted a financial advisor	64
		8.40%

Are you aware that government will be introducing a cap on peoples care costs of £72k in 2016?

		Base
Base		2271
Q9	No	1206
		53.10%
	Yes	771
		33.90%
	I thought there already was a cap in place	294
		12.90%

What expenses do you believe will be included in the cap on care costs?

		Base
Base		2271
Q10	The cost of care support in a care home	1091
		48.00%
	The cost of a room in a care home	1081
		47.60%
	Don't know	940
		41.40%
	The cost of paying for a carer to support you in your own home	846
		37.30%
	The cost of food / drink in a care home	788
		34.70%
	Other (please specify)	14
		0.60%

Which of the following statements do you agree with?

		Base
Base		2271
More should be done by Government to educate people about planning for and paying for care	Yes	1922
		84.60%
	No	349
		15.40%
The Government is prepared for the impact of an ageing population	Yes	520

		22.90%
	No	1751
		77.10%
One individual in the Cabinet should be responsible for ensuring Government is preparing for our ageing society	Yes	1724
		75.90%
	No	547
		24.10%

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- ¹ Department of Health (2012) *Caring for our future: progress report on funding*, London using data from NHS Information Centre and Laing and Buisson
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- ³ For example, see Slasberg C et al. (2012) “How self-directed support is failing to deliver personal budgets and personalization” in *Research Policy and Planning*, Vol. 29, No. 3, p161-177
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