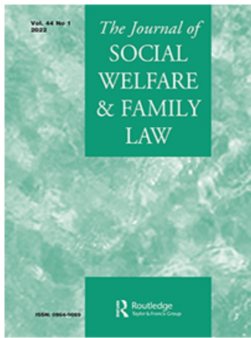

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The problems of social care in English nursing and residential homes for older people and the role of state regulation

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ABSTRACT
The problems facing English care homes for older people have largely been defined in terms of funding. This paper starts from the position that it is vitally important also to address the big issue of the social care system, especially the changing nature of private provision since the introduction of a quasi-market almost three decades ago, such that large corporations have become increasingly dominant. The paper focuses on the implications of a fragmented, for-profit system of provision for financial sustainability and care quality, particularly in terms of workforce issues. It argues that heavy reliance on regulation via the market and operating through competition and choice is misplaced and that state regulation can play a crucial part in securing improvement in these fields. It concludes that the Government's recent (2021) proposals, which are mainly confined to funding and designed to prop up the current system, are unlikely to provide the 'long-term fix' that social care needs.

KEYWORDS
Care homes for older people; English social care system; changing nature of privatisation; problem of sustainability; problem of quality; problems of the workforce

Introduction

Social care, particularly its funding, has received considerable analysis and comment since the publication of the Royal Commission on Long-Term Care (1999) (see Jarrett 2017, Powell and Hall 2019/20). Indeed, the social care system in England has long been declared 'broken' and in need of 'fixing', by academics, independent and government commissioned reports, and ministers. The last Labour government set out a ten-year plan for achieving a National Care Service just before losing office in 2010 (DH, 2010) and in the same year Jon Glasby argued that doing nothing about social care was not an option, something he had to repeat in an article published ten years later (Glasby *et al.* 2010, 2020). The independent Dilnot Commission, which focused primarily on the amount that older people seeking social care are charged and on limiting the potentially catastrophic costs, also voiced similar sentiments in the foreword to its Report on the funding of social care published in 2011 (Commission on Funding of Care and Support, 2011), and they were echoed by the King's Fund (2011, p. 4) when it said that the question was 'not whether we can afford the Dilnot proposals but how can we afford not to'. These proposals were accepted, but not implemented, by the then Conservative/Liberal Democrat Coalition government. In the meantime, the proportion of people over 80

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who are most likely to need social care has continued to rise. Most recently, a revised and somewhat extended version of Dilnot's proposals have again been the main focus for government in three documents published in late 2021 (Cabinet Office, DHSC and PM's Office, 2021; Prime Minister's Office 2021, DHSC (Department of Health and Social Care) 2021a).[1]

Adult social care has many different groups of users, including people who are older, living with a disability or a mental illness. It provides personal care at home or in care and nursing homes, as well as 'reablement' services and aids and adaptations for people's homes. The focus here is on care and nursing homes for older people and the role of regulation in addressing key problems of the social care system and enhancing quality. Dilnot's proposals and the Government's recent approach to social care reform, which the latter claims to constitute 'long-term changes' to social care provision (Cabinet Office, DHSC (Department of Health and Social Care), and Prime Minister's Office 2021, Foreword) focus on public funding for the social care system *as it stands*. This has tended to eclipse how money is used within what is a fragmented system that consists of some 15,517 care homes, 80% of which are private for-profit, run by more than 5000 providers. It is a system that has become disproportionately dependent on the now close to 50% of residents who pay their own way as 'self-funders' (Office for National Statistics 2021). These people cross-subsidise what has become the bare minimum funding that is distributed by local government after the austerity policies of the 2010s, to support residents who are declared eligible for state support. So far proposals for reform have focussed on the problem of what the Dilnot Report called the 'fairness' of funding, meaning how much self-funders should pay and for how long, together with the nature of both the eligibility assessments and means tests administered to those seeking state support. Thus, the social care system is now characterised by profound divisions as well as fragmentation, between different types of providers and, within the private for-profit sector, between small and corporate operators; and between self-funders and state funded residents. In short it bears little relation to many other social services, particularly the National Health Service, which has maintained universal access and is tax funded.

The system has changed considerably since the implementation of a quasi-market in social care in 1993, particularly in terms of the growth in for-profit provision and the growing dominance of large corporate chains, something that is insufficiently acknowledged in proposals for reform. Yet the nature of the system has major implications for care home residents, who require secure, sustainable, well-managed, comfortable and affordable accommodation, together with the attention of kind and competent staff in order for the all-important 'care relationship' to be established. For as Fixsen *et al.* (2005, p. 46) have observed: 'in human services practitioners *are* the intervention' (see also Lewis and West 2014) and good quality care thus depends disproportionately on the care workforce.

There have been growing calls for 'system reform',[2] but both the path to achieving it and the form it might take have remained largely unspecified. The recent Government proposals may be enough to 'keep the show on the road'. But this will do little to address the core problems of sustainability and the quality of provision, let alone the constantly growing problem of unmet need as the proportion of people over 80 increases and as demands made on unpaid, family carers intensify, especially since 2010, as the money made available to local government to support those seeking state funding has shrunk

substantially (Bayliss and Gideon 2020, Burchardt 2021). There is no clearly articulated strategy for state involvement in the substantially privatised system of social care, despite the level of need that exists, the amount of public money that is involved and the implications of a fragmented and poorly functioning system for the policy ambition to integrate health and social care.[3]

Very broadly, the state can finance, provide and regulate a social service. Having sought to exit the direct provision of social care, the state continues to occupy a major role in funding and regulating both the financial health of private providers and the quality of social care. This paper draws particular attention to the importance of regulation. Increasing privatisation of social provision has resulted in regulatory growth rather than deregulation (Braithwaite 2011), but regulation has also become more 'light touch'. After all, for many the creation of a market constitutes in and of itself a regulatory mechanism operating through choice and competition. Indeed, the fine line between ensuring a competitive market and protecting vulnerable clients has been hard to tread and the regulation of the social care market has been developed in such a way as to be minimally intrusive. Thus while the state regulation of care quality has a long history, practices have changed, for example in terms of how assessments of quality are reached, with less emphasis on inspection and more on data analysis. Financial regulation is a much more recent phenomenon, prompted by the increasing dominance of large corporate owners, whose failure threatens the security of provision, but the state regulator lacks teeth.

In what follows the paper addresses first, the changing nature of the social care market, particularly in respect of the for-profit providers and the business models they use. It then explores the effect of these changes on sustainability and on quality (with particular attention to the workforce), and the nature of state regulation. Finally, it offers some reflections on 'ways forward', beginning with the Government's 2021 proposals for funding and suggesting that these might exacerbate some systemic problems. In the absence of an appetite radically to work towards changing the fundamentals of the social care system (for example, by bringing it into line with the NHS by making it fully tax funded and available to all at the point of need), it explores the ways in which state regulation might be strengthened in order to work towards securing sustainable and good quality care and a more effective social care system.

The changing nature of the social care system and care home providers for older people

Care homes became increasingly privately owned after the introduction of early market-oriented reforms implemented in 1993 (Lewis and Glennerster 1996, Bridgen and Lewis 1999). These major changes gave local authorities responsibility for commissioning services, which in turn meant that provision was clearly separated from the National Health Service and distanced from central Government. By 2020, the sector's regulatory body, the Care Quality Commission (CQC), was referring to the 'unstructured relationship' between Government and a sector comprised of many thousands of businesses, most of which nevertheless receive public money (CQC 2020a, p. 5). People seeking state funding have faced both a test of their eligibility for services, which has

been progressively tightened, resulting in only those deemed to be high need/high risk being successful, and a means test to determine whether and how much they are required to contribute to their care.

Independent providers of care homes in the early 1990s were largely small scale, 'mom and pop' enterprises, but almost three decades later large-scale providers owning more than one home have a significant share of the market. The biggest 26 private providers control 30% of the registered beds and the five biggest some 17% (Kotecha 2019, Naylor and Magnusson 2019). Furthermore, these homes also tend to have more than the average number of beds (which is 31, according to the Office for National Statistics (2021)). This may in turn have implications for care quality. The motivations of small-scale independent for-profit providers have been mixed, with the need to make a profit often accompanied by a desire to act autonomously in the provision of care (Knapp *et al.* 2001). For the big corporate providers that have emerged in the sector, profit has been the dominant consideration.

Theory suggests that competitive markets will operate efficiently. The social care market is highly competitive with relatively low barriers to entry and exit. It should therefore provide care at lower costs and/or higher quality (Forder and Allen, 2011). However, low barriers to entry and exit are likely to result in a higher risk of failure, which poses challenges for providers and for vulnerable people seeking continuity of care. In addition, Forder and Allen (2011) have suggested that providers compete more on price than on quality, which may again prove particularly problematic for a social service providing care. The operation of the social care market also requires choices to be made by or on behalf of the potential resident about a preferred care home. Because it is a quasi-market,[4] in the case of people who receive state funding the commissioning of care is done by the local authority, which is likely to have to give priority to costs and therefore to price. Local authorities also face the need to ensure market stability through a guaranteed minimum of provision, and this may be traded-off against individual choice and quality (Curry *et al.* 2021). In the case of self-funders, the literature has provided constant reminders that their choice has often not been 'informed'. All too often the purchase of a care home bed comes at a time of maximum distress for a sick older person, who may also need to keep costs low, or above all want a care home to be close to relatives, and for whom an extended process of choosing a home is likely to be stressful (Needham *et al.*, 2020, see also Lewis and West 2014 on the limits of and barriers to choice). Both the characteristics of the way in which this particular quasi-market works and the nature of what is being purchased – care – pose difficult challenges to the achievement of sustainability and quality.

Furthermore, the nature of state regulation has also changed in parallel with the relatively rapid changes in the social care market and the increasing dominance of large private for-profit providers. In the case of financial regulation, the financial problems of some large corporate owners have proved more difficult for local authorities (which must maintain the stability of supply) to manage than those of single home proprietors. Nevertheless, the new forms of state regulation have been intentionally 'light touch', focussing on developing an early warning system as to providers in financial difficulty rather than exercising direct control. In the case of care quality, the focus has become the maintenance of basic standards and risk management, described by some as

the colonisation of longstanding systems of inspection by the tools of audit (Power 1997, David *et al.* 2001, Moran 2002, Rothstein 2006; Benish, Halevy and Spiro, 2018). A more formal and rule-based oversight relationship has become the norm .

The implications of changes in the care home market for sustainability and stability

Most recently, a CHPI (Centre for Health and the Public Interest) study of 4000 companies providing social care found that 25% were at risk of failure (Rowland 2021). But closing care homes is usually acknowledged to be very difficult for residents, although Allan and Forder (2015) have suggested that distress can be limited by orderly, timely and personalised relocation. However, the ADASS (Association of the Directors of Adult Social Services) and the LGA (Local Government Association) (2017) cited evidence (collected by Citizens Advice) showing that two thirds of the residents questioned would find that even a voluntary decision to move would cause considerable distress and possible harm. Furthermore, ADASS also reported in 2021 that 80% of Directors of Adult Social Services were concerned about the financial sustainability of some care home providers (ADASS 2021), having already found that 75% of local authorities had reported that providers in their areas had closed, ceased trading or handed back contracts in 2019. Even if failing care homes do not close but rather are broken up and 'sold on', as has been largely the case following the failure of two big corporate providers, this may still generate anxiety for residents (*pace* Laing and Buisson (2012, p. 4), a business intelligence provider, stating that large corporate ownership 'is broadly benign and non-disruptive to UK residents').

Opinions differ about which types of care home provider are most at risk of failure. The CMA (Competition and Markets Authority) (2017) suggested that the 25% of homes where more than 75% of residents were funded by the local authority were most at risk, because of the low fees paid on their behalf. In other words, these were homes with less by way of cross-subsidy from self-funders, who pay as much as 41% more than is paid by local authorities on behalf of state-funded residents. Under central government's austerity policy of the 2010s, local authorities' spending power declined 29% in real terms (Comptroller and Auditor General 2021), while the Institute for Fiscal Studies has suggested that local councils will need an extra £3.3bn in real terms in 2024–25 to maintain services at their 2019–20 level (Ogden *et al.* 2020). In addition, local authority funding per head for social care declined most in deprived areas, where care homes were also more likely to have a large majority of state funded residents. This suggests that homes with a greater proportion of self-funders paying high fees are likely to be more stable; however, much depends on the business model of these homes. Allan and Forder (2015) suggested that non-profit providers (around 13% of the total) were at greatest risk, while Naylor and Magnusson (2019) found that both small homes with 7 or fewer beds and large ones (which tend to be run by for-profit chains) with 45 or more beds were at risk. This is significant because there has been an increase in large homes, not least because corporate providers are likely to buy out small scale proprietors as they retire.

Even if homes with a preponderance of state funded residents are at greatest risk of failure, most attention has focussed on the biggest for-profit providers who would be very difficult to replace. Local authorities were managing the closure of some 40 mainly

smaller homes a year prior to 2011 (Hudson 2015), but when a large-scale provider runs a significant number of homes in a particular region, failure is much more difficult to manage. Big providers with multiple homes have a significantly higher proportion of self-funders than those run by providers with a single home, but many also take state-funded residents. The fees paid by local authorities are low, but they do provide a reliable income stream. Nevertheless if they continue to fall further in real terms, more large scale providers may opt to take a yet larger proportion of self-funding residents. Certainly Grant Thornton (2018) (who offer audit, assurance and tax services) regards the development of care homes for self-funders as the way of the future for private providers.

It is unlikely that a growing preponderance of large chains with very different business models from those of single home owners was foreseen when the quasi-market in social care was established in the early 1990s. Private equity investors back three of the 'big five' care home providers: HC-One, Four Seasons and Care UK. A fourth, Barchester, has remained a public company but is registered offshore. These companies use a variety of strategies to avoid tax and maximise profit (Burns *et al*. 2016, Kotecha 2019). Company structures tend to be complex with multiple subsidiaries and ultimate owners resident in tax havens offshore. They use debt finance to fund their investment in care homes, which permits rapid expansion and allows investors to cover most of the price they pay with a loan, which again reduces tax. Private equity investors usually hold on to care homes for between three and seven years, after which they are sold on, accruing more debt. 'Sale and leaseback', which became available in the late 1990s, has also allowed these companies to sell the care home assets and then lease them back. The sale finances the debt; Barchester signed a sale and leaseback agreement for 160 of its homes in 2013 (Grant Thornton 2018).

Kotecha (2019) has estimated that £1.5bn a year 'leaks' out of the care system as a result of these practices. The companies must service their debts, meet rental obligations and pay management fees, as well as make a profit and issue dividends. The National Audit Office (Comptroller and Auditor General 2021) found that 55% of for-profit providers reported a return on investment of less than 5%, but 23% reported a big return of more than 10%. HC-One paid out a considerable sum in interest payments on a loan and on asset management fees to its owners and yet successfully sought support from the Government's infection control fund during the Covid-19 pandemic (Plimmer 2021, p. 6 December 2021). Certainly, Grant Thornton (2018) has taken the view that the care home sector represents a good investment, using the EBITDARM measure (earnings before interest, tax, depreciation, amortisation, rent and central management costs) as an indicator. To generate EBITDARM of 37%, a home needed 71 beds in 2018, much larger than the average 31 beds.

But these strategies also make large providers more vulnerable to low occupancy rates and lower than expected fee increases (Burns, Hyde and Killett 2016). For example, in 2011, Southern Cross was unable to service its debts and went bankrupt. It controlled 9% of the care home market and in parts of the Northeast 20% of beds (Hudson 2016). Many of its homes were taken over by Four Seasons, which was then sold several times; each time the new buyer made a profit by further loading up debt. It is also noteworthy that a letter from HC-One to local authorities dated 19 April2020 asked local authority commissioners to guarantee income at the equivalent of 90% occupancy at a time when the pandemic was reducing occupancy rates from 87 to 79% in nursing homes and from 87 to 82% in homes without nursing (Skills for Care 2020).

Defence of these new forms of care home businesses has been intense and stresses that only these large corporate owners are able to make the investment needed to modernise homes, build new ones, and provide the kind of desirable residential accommodation that self-funders increasingly expect. Indeed, Grant Thornton (2018) has advocated pricing differentials for better quality accommodation and maintains that the solution to the problems of sustainability, stability and quality is more money from central government in respect of state-funded residents.

Financial regulation

It has been above all the fear of the closure of the care homes run by a big chain that has resulted in a measure of financial regulation. Thus, while efforts to regulate quality in the sector have a long history, financial regulation that might address the problem posed by large chains does not.

The strategic task of 'market shaping' was given to local authorities by the 2014 Care Act to ensure stability, and to promote individual choice and the personalisation of care. As late as 2021, just prior to publishing its proposals for funding the social care system, the Government insisted that local authorities were 'best placed to understand and plan for the care needs of their populations, and to develop and build local market capacity' (DHSC 2021b, p. 10). However, as the CMA (Competition and Markets Authority) (2017) and the Comptroller and Auditor General (2021) have both acknowledged, local authorities have few levers or tools to actively shape the market, and as ADASS (Association of Directors of Adult Social Services) and LGA (Local Government Association) (2017) have also argued, efforts to shape the market need to build on a market that is sustainable. The task of market shaping becomes extremely difficult in the context of rising demand, austerity funding, lack of capacity and capability on the part of local authorities (particularly in respect of insufficient, often inexperienced staff), weak consumer power and poor information flows (Needham *et al.* 2020). Furthermore, the lack of a long-term funding settlement makes it difficult for local authorities to commission effectively (HoC Health and Social Care Committee 2020). The 2014 Care Act required local authorities to draw up 'market position statements', but the Comptroller and Auditor General (2021) reported that fewer than half had done so since 2016. The shape that the market has assumed over the past two decades has not been subject to state regulation and local authorities have little by way of regulatory force (see also Hudson 2015).

This is also broadly true of the Care Quality Commission, which was given the task of 'market oversight' in 2015. The purpose was to provide 'light touch' regulation of providers with either 2000 beds or more, or with more than 1000 beds and a significant regional presence. The CQC is primarily a quality regulator, indeed the HoC Health Committee (2013) wanted Monitor, the financial regulator for the NHS, to be given oversight of social care as well, but was overruled. While the association between poor quality and poor financial performance (CQC (Care Quality Commission) 2014); Weech-Maldonado *et al.* 2019) suggests that a role for the CQC might be logical, the regulator was already over-burdened and underfunded. However, it is likely that the main policy concern centred on minimising the disruption to the market that would be caused by the failure of a large provider (Rowland 2019). Furthermore, the accounts of

private equity backed providers are often difficult to access and in five years the CQC has only issued two final stage (Stage 6) notifications of imminent failure (Comptroller and Auditor General 2021). Indeed, the CQC has no levers to prevent financial collapse and no powers to require care home-owners to stabilise or improve their financial position (Curry *et al.* 2021). It assures providers that it treats the information it obtains as commercially sensitive and only makes it available on a need-to-know basis (CQC 2020a). Thus the powers of the CQC are strictly limited, as is its regulatory force and expertise. Its main role is to provide early warning of provider failure to local authorities so that they can try to take steps to ensure that adequate supply is maintained. Responsibility for the effects of failure on residents and taxpayers is not borne by the private provider.

The implications of changes in the care home market for quality

Quality is hard to define, residents (and their families) prioritise different dimensions of care provision, whether the nature of accommodation; the responsiveness, skills and competence of carers; or the appeal of the food and activities on offer. A strong feminist literature has long stressed the importance of the care relationship between care worker and care user for achieving good quality care, and has questioned, for example, the idea that care work can ever be reduced to 'timed tasks' for the purposes of commissioning. The nature of the care system has long been considered crucial for the development of the care relationship. (e.g. Ungerson 1987, Lewis and Meredith 1989, Tronto 1993, Himmelweit 1999). Competitive markets are supposed to ensure quality via choice, but choice may be difficult for the older person to exercise at the outset, when it is deterioration in health that usually determines the need for a care home and which also makes changing homes later extremely difficult (see above, p. 4). If choice is difficult to exercise, then it is also less likely that poor quality providers will be driven out of the market, while governments seeking to regulate provision are likely to give highest priority to basic considerations of safety and the level of risk. The changing nature of the social care market has contributed to these problems.

The literature on care quality and different types of provider has increasingly tended to raise questions about both large corporate chains and large homes, emphasising the extent to which cutting staffing is a way of reducing costs. Even though the increasing number of large homes enjoy economies of scale, these savings are as or more likely to be used to reduce prices as to improve quality (Forder and Allan 2011, Barron and West 2017). In the US, where big for-profit providers, often backed by private equity investors, became common earlier (in the 2000s) than in the UK, the evidence, while mixed, has become more negative over time in respect of quality. As Pradhan and Weech-Maldonado (2011) pointed out, the commonly accepted view was that private equity involvement would extract maximum economic returns because they were well placed to provide 'adequate' quality while still managing to keep a tight leash on costs. They reported that despite a decline in the number of registered nurses in homes backed by private equity investors, in terms of quality metrics they differed little from other for-profit homes, and suggested that this might be because they better utilised their nurses. But by 2014, Pradhan et al. had found nurse staffing patterns in private equity backed nursing homes to be 'troubling', while Bos and Harrington's (2017) study of what

happened to a large US nursing home chain after private equity investors took over found that the new investors reinforced the profit-seeking strategies already in place. Similarly, Spanko's (2021) study of 18,400 nursing homes in the US, 1,674 of which were backed by private equity, found that the hours worked by nursing assistants and quality ratings fell as lease payments and interest payments on debt rose after acquisition by private equity investors.

In England, while Gage *et al.* (2009) found that large for-profit homes charging higher fees had better trained staff and were less likely to fail basic standards, Burns et al. (2016) reported that for-profit homes had been identified as more likely to reduce the number of qualified nursing staff, increase staff ratios, rely on unpaid training delivered online, remove paid breaks and no longer pay enough to cover handover meetings at the beginning and end of shifts. Barron and West's (2017) analysis of Care Quality Commission data from 15,000 inspections of care homes between 2011 and 2015 concluded that for-profit homes tended to be rated lower quality than not-for-profit and public homes. Lower levels of staffing and training, higher staff turnover and lower pay levels have all been associated with large, for-profit homes, many of which are controlled by companies backed by private equity (see also Blakeley and Quilter-Pinner 2019). Nevertheless, while for-profit homes with more than 100 beds struggle to maintain high quality, the trend is towards more profitable larger homes (Naylor and Magnusson 2019).

Given the central importance of the care relationship for good quality care, the state of the social care workforce is key (Carr 2014, Lewis and West 2014). The DHSC has final responsibility for the overall state of the workforce, however, in the course of an excoriating assessment of the part it has played in respect of social care, the National Audit Office noted that the last workforce strategy was published in 2009 and has become so dated as to give 'responsibilities to some organisations that no longer exist' (Comptroller and Auditor General 2018, p. 43). Furthermore, the terms and conditions of care workers are fundamentally a matter for each and every independent care home owner.

Lack of improvement in the pay, conditions and training of care workers has been a major problem for the quality of care, not least because turnover and vacancy rates have continued to climb. Staff shortages mean hiring expensive agency staff, which increases costs and weakens care relationships: 'care becomes functional rather than person-centred' (Curry *et al.* 2021, p. 30).[5] In 2021 Skills for Care reported 105,000 vacancies in the sector being advertised on an average day and a turnover of 28.5%, although an earlier report in 2017 pointed out that it had been possible for a minority of providers to achieve a less than 10% turnover. In addition, Skills for Care (2020) reported that providers with higher quality ratings from the CQC experienced lower turnover, while those providing the most training and development opportunities had the best staff retention. Paying at least the National Living Wage (NLW) and investing in staff development are key, but the percentage of care workers paid at or above the Real Living Wage actually decreased from 25% in 2012 to just over 10% in 2019 (HoC Health and Social Care Committee, 2020), in part because of high levels of zero hours employment. Nor is a care home obliged to have a particular staff mix. Indeed, while 50% of staff in Wales and Scotland have an NVQ (SVQ in Scotland) level 2 qualification (Oung *et al.* 2020), in England care workers have continued to be regarded as essentially unskilled labour by Governments and employers.[6] They are still only expected to have, or

be working towards, a basic care certificate. In addition, 5% of care homes had no registered manager, crucial for ensuring quality (and in Grant Thornton's (2018, p. 42) view a 'commercial imperative'), despite the requirement for regulated adult social care establishments to have one from 2010. In fact, there is very little difference in pay between frontline workers and managers, and manager turnover is high; yet CQC data shows a clear link between a care home's poor score for safety and also for leadership (Comptroller and Auditor General 2018, Skills for Care 2020). Nevertheless, just prior to the publication of its proposals for reform of social care funding, the Government stated firmly that responsibility lay with local authorities to ' … work with care providers to determine a fair rate of pay based on market conditions' (DHSC 2021b, p. 79), despite the cuts made to their budgets.

Better trained staff with better pay and conditions cost money. So funding is obviously an issue, particularly when local authorities have held down the fees they pay to providers for state funded residents. Indeed, local authority procurement, which often prioritises costs, has been called 'irresponsible' (Kingsmill 2014, p. 34 – the Review was commissioned by Ed Miliband, then leader of the Labour Opposition). However, this ignores both the squeeze on LA budgets during the long years of austerity since 2010, and the tension that exists between achieving high quality via good pay, conditions and training for care workers on the one hand, and the pursuit of profit that has become more intensive with the changing nature of the care market on the other. Better regulation, grounded in greater understanding of the importance of the care relationship and the nature of care work, together with their centrality to the achievement of better quality is key.

The changing nature of state regulation of care home quality

The approach of the state regulator of care homes has also changed as provision has become overwhelmingly private for-profit. But the way in which the CQC has come to assess and measure quality may be inadequate to ensure good care relationship.

When Day and Klein (1987) and Braithwaite *et al.* (2007) looked at the regulation of care homes in England and the US[7] they found differences between the professionally dominated, compliance model of regulation in England, and the deterrence-based model in the US with a focus on punishing wrongdoing. While US regulators were already dealing with much larger homes and were focused on risk and the quantitative data that might measure it, the English regulator focused more on qualitive data derived from inspections. Inspectors acted more as 'street level bureaucrats' (Lipsky 1980), cajoling and negotiating with care homeowners to improve quality. Braithwaite et al.'s comparative study explicitly addressed the extent to which the emergence of the 'steering state', characterised by the privatisation of services and regulatory growth, relied on box-ticking 'ritualistic regulation', with practices that looked increasingly like audit (see also Power 1997). They gave the example of a US resident's problem being documented with a plan, but the plan not necessarily being carried out, probably due to staff pressures. They observed that while the regulatory state took comfort from the plan, the resident continued to suffer discomfort.

The CQC began work in 2009 and was the first regulator to take responsibility for the quality of both health and social care. It regulates individual establishments and system change is not part of its remit. According to the Department of Health: 'The regulation model was set up as a light-touch, risk-based model, consistent with other regulators' (DH 2012, p. 27). Indeed, the large number of health and social care establishments made it difficult to operate any other kind of model. Evidence received by the HoC (House of Commons) Health Committee (2011, p. 12 and Q. 215) made it clear that even if the budget for the regulator was quadrupled it would be impossible to employ enough inspectors to continue the earlier regulatory approach. However, the quality of the data available for the operation of a risk-based system that relied heavily on surveillance was patchy; indeed there are no national data sets available for social care (Comptroller and Auditor General 2011, 2015; Office for Statistics Regulation 2020), something Helen Whatley, the then Minister for Social Care, was reported to have found difficult to understand (Humphries and Timmins 2021).

The CQC itself reported that during the 2010s its practice had become more reliant on assessment data and that its aim (from 2021) was 'smarter regulation', making use of shorter inspection reports to build digital platforms (CQC, 2021). This was likely to result in the loss of the relational aspects of the inspector's role, but in any case it was difficult to rely on street level bureaucrats to deal with big care home chains. Indeed, Braithwaite *et al.* (2007) commented that in the early 2000s English regulators felt that quality was difficult to achieve in a home bigger than 30–40 beds. Risk-based approaches used standard-setting and enforcement activity to manage the highest priority risks, which were defined above all in terms of safety (Beaussier *et al.* 2016). Professional inspections focussed on process rather than outcomes which provoked criticism, however it is process that determines the quality of the care relationship and the comfort of the resident. As Braithwaite *et al.* (2007) commented, the process of caring was likely to be valued more by the resident than whether they lived a bit longer or became slightly fitter. As Norton (2009) argued, while inspection requires assessment that is standardised and measurable, it is also very much about professional judgment and should also include user expertise (see also the conclusions of the independent Munro report on child protection (2011); and Benish *et al.* 2018).

The CQC experienced considerable problems in its early years, when it had only a generalist inspectorate and experienced high vacancy rates. Its slow rate of progress in setting up adequate systems attracted widespread criticism from the HoC (House of Commons) Health Committee (2011), the HoC Committee of Public Accounts (2015) and the National Audit Office (Comptroller and Auditor General 2011). The CQC did not aim to define and encourage better performance. Rather, in line with its risk-based model, it developed as a 'safety net' regulator, assessing providers against essential standards (Nuffield Trust 2013). However, reliance on a risk-based system of regulation did not succeed in preventing a series of care home scandals involving the abuse of residents (e.g. in 2013 the case of Orchid View in West Sussex, run by Southern Cross) and more recently the CQC has sought to link its assessments of providers to key questions about safety, effectiveness, care and responsiveness to people's needs, and leadership.

However, the CQC's budget was reduced by 13% between 2015/16 and 2019/20 despite it having taken on more work (Comptroller and Auditor General, 2017), and increasingly it was expected to recover fees from providers, which made what the Department of Health termed 'engagement' with some providers more difficult (DH 2012, p. 26). Income from fees reached 66% in 2017 and was due to rise to 92% by 2019/20. The CQC told the HoC Committee of Public Accounts (2018) that it would live within its reduced budget by reducing staffing (mainly inspectors) and developing further its risk-based approach to regulation based on surveillance and intelligent monitoring. Ultimately the Department of Health, which changed its name to include social care in 2018, was responsible for the CQC, but exercised little oversight (HM Treasury 2012), indeed it did not appoint a Director General for adult social care until June 2020, prompted by the Covid-19 pandemic.

The CQC designed an overall rating system for homes, which it used from 2014. The classifications have remained: outstanding, good, to require improvement, or to be inadequate. The meaning of inadequate can be chilling, including in the case of care homes for older people, the smell of urine; no hot water; toilets without soap, towels or bins; and the risk or evidence of injury (CQC 2018). For 2020–21, the CQC reported that 1% of homes fell into this category, while 14% were judged to 'require improvement' (CQC 2020b). The percentage rated 'outstanding' was 5%. Nursing homes gave most cause for concern. Nor did care homes necessarily improve following re-inspection, or manage to retain a 'good' rating. Indeed, over the period 2014–17, 38% retained their 'requires improvement' rating and 26% of those rated good deteriorated (CQC 2018). Nevertheless fully 80% of care homes were rated 'good', making it possible for ministers and bureaucrats to claim that social care is generally of 'good quality'. But some judged 'good' will inevitably be closer to adequate, a category that is notable by its absence. While large scale providers of care homes may well have the greatest capacity to ensure 'quality assurance', the aim is likely to be to provide 'adequate' quality while also keeping costs down (Pradhan and Weech Maldonado, 2011). As Smithson *et al.* (2018, p. 18) have noted, echoing the findings of Braithwaite *et al.* (2007), providers have sometimes sought to achieve 'superficial or ritual compliance'. There is little unequivocal research evidence that larger homes and big care chains have succeeded in raising quality.

A state regulator has difficulty negotiating quality improvement with predominantly private providers. It cannot interfere with the way in which care homes go about their work, in a way that was common a quarter of a century ago; it can only monitor and assess. Government has reduced funding for the CQC and encouraged more data driven surveillance which is difficult to achieve given the number of establishments and lack of adequate data. In addition, given that care homes are highly competitive, they may not be willing to share learning from inspections (Smithson *et al.*, 2018). Nor is there any regulation of workforce training levels or staffing ratios, other than the requirement that care workers should start training for a basic care certificate, that each care home has a registered manager and each nursing home a registered nurse. The terms and conditions of an increasingly depleted workforce are poor. Thus the limits experienced by users who are expected to exercise choice and of the nature of regulation that prevails in a competitive care home market are problematic for achieving quality.

Ways forward

The 2021 Government proposals

Thus far, the Conservative Government has made funding proposals which are almost entirely confined to addressing the problems of the system for social care as it stands (Cabinet Office, DHSC (Department of Health and Social Care), and Prime Minister's Office 2021; Foster, 2021). There is as yet no stated intention to engage with major system change. The proposals focus on making care costs more predictable for self-funders, thereby ending the catastrophic costs which affect one in ten of the population at 65 and which result in the need to sell their homes, by imposing a lifetime cap of £86,000 on the amount that can be charged ('hotel costs' are excluded). The Government has stated that it will work with the financial services industry to encourage the provision of more products to help individuals cover their costs up to the cap (the Dilnot Commission had also hoped for greater involvement on the part of private insurance companies) (Taylor 2021). The value of the assets of the person seeking a care home place at which a contribution towards care becomes necessary remains low at £20,000, but only a proportion of the care bill will be payable up to £100,000. Given the state of local authority finances, the eligibility assessments for care are likely to continue to be set at a high level of need. Money will be raised to pay for the changes via a 1.25% 'levy' on national insurance contributions paid by the working age population, which has proved controversial, and a 1.25% dividend tax from April 2022. Over the next three years £36bn will be allocated to health and social care, but only £5.4bn of this money will go to social care, with the remainder going to the NHS. This provides £1.8bn for each of the next three years, yet the HoC Health and Social Care Committee (2020, p. 33) asked for £7bn per year by 2023–24 in order to cover the costs of increasing numbers of older people seeking care and rises in care workers' pay as well as protecting people against catastrophic costs. The reform proposals also list a number of much smaller pots of money, the most significant – £500 m – for workforce training, as well as yet smaller sums for housing adaptations and extra care, for technology and digitisation, local innovations, unpaid carers and to enhance the capacity of local authorities to improve market shaping and commissioning.

First, it is not certain that these proposals will prove to be adequate to address the issue of charging reform, let alone the larger funding issues. The Government Policy Paper issued in November 2021 showed that the cap on the amount anyone would pay for social care would not include means-tested local authority funding, and hence do rather little to help poorer homeowners retain some of their housing wealth (Cabinet Office, DHSC, PM's Office, 2021). In addition, the proposals say that if the cost to local authorities of implementing the charging reforms (including the cap and moving towards paying a fair rate to care providers) differs significantly from the projections, the Government will work with them to address the problem. However, it is also made clear that it is expected that the inevitable rise in expenditure arising from demographic change and increasing unit costs will be met through local council taxes, the dedicated social care precept that local authorities can raise, and 'long-term efficiencies' (Prime Minister's Office 2021, p. 19). Just as it is unlikely that there will much money left after making the proposed changes to the charging system, the scope for local authorities to increase the fees they

pay to providers may well be small. Nevertheless, local authority performance will in future be reviewed and assessed by the CQC, backed up by new legal powers for the Secretary of State to intervene in order to secure improvement.

Second, in respect of the all-important workforce, while new universal career structures and training opportunities are part of a 'ten year vision' (DHSC 2021b), there is no plan to address the high vacancy rate. Indeed, the only specified commitment is that all care workers should get the existing care certificate. There is no new money for raising pay above the NLW.

Third, the proposals may also exacerbate the complex divisions and problems that have arisen from a system that distinguishes between self-funding and state-funded residents, and which results in for-profit providers making calculations as to what mix of these two groups is possible and/or most advantageous financially. The Government's funding proposals make it clear that the same establishment should not be charging different fees in respect of self-funders and state-funded residents for the same care (albeit that it does not rule out 'top-ups' on behalf of the former[8]). But self-funders cross subsidise state funded residents (see above, p.5). Indeed, the CMA (Competition and Markets Authority) (2017) stated that they were not recommending the same level of fees for both groups in any specific care home because of the cost to the public purse and the likelihood that the market would split in two. Much depends on whether it is easier and more financially advantageous for private for-profit providers to 'tier-out' the market. Nearly all new care homes are already being built in areas where it is possible to focus on self-funders (CMA, 2017), something advocated in Grant Thornton's 2018 analysis of the social care market (see above, p. 6). But separating care for self-funders from state funded residents may impact additionally on quality. Logically, homes with higher proportions of high fee self-funders should already achieve higher quality care, but much depends on the business model in play and how much goes on paying profits and dividends. As the National Audit Office (Comptroller and Auditor General 2021, p. 9) has commented, there is no guarantee that higher fees will not 'result in higher profits rather than increases in care quality'.

Fourth, the proposals do not address the wider problems of unmet need and unequal access, (Burchardt *et al.* 2020, Burchardt 2021), just as they are silent on the issues of sustainability and quality. They are therefore very far from the promised 'fix' for social care. The social care quasi-market has not ensured sustainable or stable provision, or quality improvements. Indeed, the advent of large corporate chains has raised fears about sustainability, while demonstrating little by way of improving quality.

The proposals may be enough to keep the existing system going, albeit that they will do most to ease the position of better-off homeowners. The Scottish Government (2021) has committed to more radical system reform, by introducing a National Care Service (just as the last UK Labour Government did in 2010 (DH (Department of Health) 2010)), which could bring the health and social care systems more into line (and make some measures of integration easier). However, the rapid dominance achieved by big chains makes the full nationalisation of social care a daunting task and would doubtless meet (expensive) legal challenge.

Other ways forward

This leaves the possibility of a strategy focussed, initially at least, on reforming and strengthening financial and quality regulation by the state. This cannot constitute *the* answer for social care, which requires radical system change, but as an intermediate step could curb the worst excesses of the market and pave the way for system reform, particularly in terms of addressing some dimensions of the workforce crisis, which is in turn central to improving care quality. Ensuring both financial sustainability and tackling many of the problems experienced by care workers requires legislative backup, while the approach of the state regulator to securing good quality care in particular also needs reform.

Commentators have already made substantial contributions on the financial regulation of for-profit providers, particularly the large chains, stressing the importance of securing registration in the UK for tax purposes to ensure full public disclosure and scrutiny, and transparency outside the procurement process (for example, in respect of ownership; contract arrangements, including staffing levels, as well as the terms, conditions and training of care workers; and profit, debt repayment and property costs (Hudson 2015, Kotecha 2019)). In short, care home residents and taxpayers should know how fees are spent. Blakeley and Quilter-Pinner (2019) have also suggested that regulators should require chains to hold a safe level of reserves. Going further, Hudson (2016) has called for a 'fair price' sufficient to guarantee a maximum 5% return for providers and a 'preferred provider' strategy favouring not-for-profit and state providers. In addition, some commentators have called into question the view that only large-scale for-profit providers can mobilise the capital to bring care home accommodation up to standard, calling for the state mobilisation of low-cost finance to support new provision by local authorities or social enterprises (Hudson 2015, Burns *et al.* 2016).

Without further regulation, money going into the system may well continue to 'leak' (see above, p.6) and lack of stability and quality improvement persist. Considerable thought would have to be given to the timing and nature of the introduction of more stringent financial regulation and its effects on social care. Rapid exit on the part of private providers cannot be accommodated by the social care system.

Changes in the nature of regulation in order to promote greater attention to securing improvement in order to drive good quality care rest on giving greater priority to professional inspections alongside an emphasis on improving available data. But large chains make it very difficult for 'street level bureaucrats' to negotiate and cajole owners of multiple care homes into different behaviour. In addition, given their importance to the experience and quality of care, more regulation of the workforce is an obvious area for attention. The 2010 Labour White Paper on building a National Care Service (DH (Department of Health) 2010) called for all care workers to be licenced. Wales and Scotland have brought in schemes for this (Oung *et al.* 2020) as well as making progress with securing a requirement to hold basic qualifications. Indeed, Wales, Northern Ireland and Scotland all have a non-departmental public body responsible for the regulation and registration of the care workforce. It is difficult for Government to regulate pay in privately owned establishments beyond doing considerably more to enforce the National Living Wage and closing the loopholes used by many private employers (e.g. not paying workers for handover sessions (see above, p.9) which result in a substantial majority of care workers failing to achieve even this level of remuneration in England (Cominetti *et al.* 2020). Fundamentally, there are no proper pay scales

and there is no career ladder, which also makes any specification of staffing ratios on the basis of training difficult and enhanced legal protections necessary.[9] Local authorities are 'cash strapped' and face difficulties in raising fee levels, which in turn makes them reluctant to challenge providers about workforce development (Comptroller and Auditor General 2021, p. 42). Private providers attribute blame for poor working conditions to the lack of money available for the support of state-funded residents, notwithstanding that self-funders provide substantial cross-subsidisation and often comprise the majority in large privately owned homes. There is no doubt that greater state responsibility for and regulation of the care workforce is necessary.

Big regulatory changes are necessary to mitigate the effects of the kind of privatisation of social care that has taken place and to begin to bring about system change. Pumping more money into the existing system without attempting to manage change is fraught with danger in respect of improving quality and sustainability. Profits and dividends can be very high for private provider chains, with little financial responsibility for failure and few requirements as to staffing or quality improvement beyond what a lay observer might deem to often be 'just about adequate' care. It is possible that increasing financial and quality regulation may make the social care sector unattractive to large corporations, which will in turn make new thinking about the nature of future provision and its finance necessary. However, at present the public and not-for-profit sectors play only a small part in the provision of care homes, and any increase in their contribution would require state intervention at the central and local levels. The problems of social care are systemic and there is little to support the Government's claim that their 2021 proposals will 'fix' social care, indeed it is not impossible that they prove to be more destabilising.

Notes

1. Keeping up with current debates and interventions is a challenging task, but there are many commentaries by journalists and think tanks that provide an introduction, e.g. Panorama, BBC1. *Crisis in care: follow the money*. 6 December 2021; and IPPR, 2021 State of Care Conference. London, 8 December 2021.
2. Recently and notably by Sir David Behan, former Chief Executive of the Care Quality Commission (the regulator for health and social care) and now the Non-Executive Chair of HC-One, one of the five largest corporate providers of social care. He told the Public Accounts Committee that the system needed more money, but that the money needed to go into (an unspecified) 'reformed system' (HoC Committee of Public Accounts 2018, Q.101).
3. The issue of 'integration' between health care and social care is not addressed in this paper, but see Lewis *et al.* (2021) for a rather critical assessment of the national pilot programmes, and Exworthy *et al.* (2017), who also found that the contribution of integrated care to improved outcomes remained 'unclear'. Successful integration is hard to achieve in the absence of wider social care reform in respect of access and funding. However, it would not necessarily be desirable for example, to merge training for health and social care workers (HoC Health and Social Care Committee 2020), or to make social care the handmaiden of the NHS (as happened in 2020 with the Covid-19 pandemic, when the main consideration of the NHS was how to achieve rapid discharge from hospital, without due consideration of the effects on care homes (Lewis 2020)).
4. In a quasi-market, typically the state continues to finance the service in whole or in part (as in the case of social care) and to purchase care, while provision is contracted out to a mix of independent sector (private and third sector) organisations. The aims of such a system are, in the main, to increase competition and hence efficiency and choice. Such a market is also intended to maintain equity and stability and enhance quality (Le Grand and Bartlett, 1993).

5. In her study of domiciliary care workers, Hayes (2017) has argued that the marketisation of social care has reduced caregiving to 'care for hire' and advanced the deregulation of labour.
6. However, a recent YouGov poll (18 November 2021) showed that 72% of those asked thought that care was skilled labour.
7. Braithwaite *et al.* (2007) also looked at Australia, which at the time of their research had more in common with the US than England.
8. Grant Thornton (2018) has suggested that private providers should consider differential pricing, e.g. for better accommodation.
9. Hayes (2017) has addressed this issue for domiciliary care workers.

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