Chapter 8

Impoverishing care

Ann Stewart

> 'The dystopian prospect is of an oligopolised sector dominated by financialised chains whose operating subsidiaries are financially fragile as they provide institutional care in a high cost format which is socially unaffordable and of inconsistent quality because their workforce is under resourced, ill paid and ill trained.' (Burns et al 2016)

Introduction

The Health Act 2009, section 2 requires health bodies, including the Care Quality Commission (CQC) as the key regulator of the health and social care sectors to have regard to the NHS Constitution. Its first key principle is as follows:

> The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation or belief. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population. (DoH 2015)

'It is difficult to think of a more explicit statement of a human rights- and social solidarity-based approach' to guide regulation (Prosser 2010, 134). No such ringing statement of social purpose informs the work of the CQC in relation to its social care responsibilities. Its primary objective is 'to help protect and promote the health, safety and welfare of people who use health and social care services' (Health and Social Care Act 2008, s. 3(1).

As many of the contributions to this collection stress it is important not to reinforce ageist constructs which align growing older with vulnerability and frailty or alternatively with independence and an impossibly vigorous self-reliance (Bedford) which requires older people to fight rather than celebrate their changing bodies (Herring). While it is the case that overall the 'baby boomer' cohort (those born between 1945 and 1965 is much better placed than their parents' generation to shape what ageing means and to age well, this chapter focuses on those who have substantial care needs and on the highly contentious issue of the way in which social care is presently provided. It addresses the darker side to being old in contemporary Britain. The way in which social care is provided has profound effects on the lives of those in receipt of the care and on those who love and care for them. Other contributors to this collection address issues relating to accountability in the allocation of public resources (Clough and Bedford)

This chapter assesses the extent to which state provision has been able to ameliorate the effects of inequalities generated over life courses in older age. Ageing tends to deplete the social, economic and political capital of those who need and provide significant amounts of care. However, those that have been less able to accumulate assets over their life course, often women, are most affected by the vagaries of the social care market (See Easton for a discussion of the way in which state

provision for older prisoners also exacerbates such inequalities). This chapter shows how the present market which depends, to a large extent, on public funding is failing to provide decent services for all. It is reproducing and exacerbating existing socio-economic inequalities. The way in which we care for our elderly often impoverishes not only those in need of care but also those who provide it either as informal carers or as paid care workers, again the majority of whom, but by no means all, are women. The social care system does not provide its key resource, the workforce with decent conditions and wages.

The chapter explores the way in which the social care market has developed to demonstrate the complex melding of the public and private in social care provision as increasing numbers of individuals (and their families) are obliged to fund their own care costs in a market still dominated by local authority (LA) tendering processes. In particular it looks at the evolving relationship between the state which funds social care for those who are eligible, those who provide institutional forms of care and those who are responsible for regulating the market which now include LAs.

It is clear that many individual providers offer good care but the sector as a whole is unable to provide consistently high quality services. It is argued by influential stakeholders that those who provide care services are also being impoverished by the lack of funding. While the majority of services are provided by debt burdened and under -capitalised small providers who often struggle to make a reasonable level of profit, the social care market is becoming more dependent upon and influenced by large private equity financed providers whose investors expect to make a return of 11-12%. It is argued in this chapter that the market is developing in ways that suggest that inequalities will deepen as consolidation increases. Individuals able to pay well for services are likely to have choices and to receive better care although such care is not necessarily guaranteed given the business model presently adopted by market leaders. Those reliant on state funding or who have limited resources will find their options even more constrained.

The chapter then moves on to consider the role of regulation. To what extent can the parlous state of affairs relating to increasing inequalities and precarious provision in the social care market be tackled through interventions in the market? The public interest in and funding of the provision of care for vulnerable adults ensures that this has become a heavily regulated sector which raises questions about the nature of regulation and the extent to which decent care services can be provided to all within a regulated market? If so what form of regulatory intervention is most likely to support this objective? This chapter explores the role of the CQC and LAs with new responsibilities under the Care Act 2014 to shape, oversee and regulate the market.

Despite the absence of the political will to treat entitlement to care in the same way as health, it is argued that substantial levels of public intervention are essential if elderly vulnerable adults and those who care for them are to be treated with the respect and dignity to which all citizens are entitled. The chapter ends with suggestions as to how this might be achieved.

Inequality in older age

There are 11.6 million people aged 65 or over (18.5% of the total UK population). This group is projected to rise by over 40 per cent in the next 17 years to over 16 million. By 2040, nearly one in four people in the UK will be aged 65 or over. 1.5 million people are aged 85 or over. There are more people in the UK aged 60 and above than there are under 18 years of age (Office for National

Statistics 2016). These statistics are often associated with words like 'burden' or concepts such as 'dependency ratio' in policy circles. Yet older people are healthier and wealthier than ever before. They contribute to society in a wide range of ways including caring for their contemporaries and future generations.

Not all elderly people are vulnerable and in need of social care and not all elderly people are poor. Indeed, increased rates in state pensions, more people contributing to private/company pensions and working for longer, and importantly more women working and contributing to their future security has ensured that poverty in 'young pensioners' has decreased significantly (Corlett 2017). There is a growing view that the 'baby boomers' (born approximately between 1946 and 1964) are entering older age having benefited disproportionately or at the expense of the younger generation (Leach et al 2008; Willetts 2011).

While these broader developments have ameliorated pensioner poverty, they do not compensate for differences in life courses. Intra generational and inter-generational inequalities have been growing since the 1980s (Corlett 2017). Those who are poor during their working lives, whose work is precarious and/or interrupted by caring responsibilities or by health or other problems, have far fewer resources to enable them to be resilient in older age. They also tend to be less healthy and to live in environments which are less supportive. '1.6 million (14% of) pensioners in the UK live below the poverty line and less than 26% of pensioner couples have more than £1500 in savings' (James and Spruce 2015, 468). The very elderly, the majority being women, are the poorest cohort of pensioners and still among the poorest in society. They tend also to be in need of considerable support. For others a sudden life changing event such as a stroke or a longer term condition such as dementia can have a devastating social and economic effect.

Caring for adults is still highly gendered although significant numbers of men particularly in older age care. Women 'care for longer hours and for a longer duration than men and are more likely to give up work as a result …are more likely to be dual-carers … who care for their children and elderly dependants … more likely to care during the 'peak age' for caring (Corlett 2017, 45–64), when caring is likely to have the most significant impact on their careers and earning power' (James and Spruce 2015, 466-7). Withdrawal from the labour market creates potential long term vulnerability. 'In a UK study of 4000 carers, almost half cutback on essentials such as food (43%) and heating (44%) and ended up in debt in order to make ends meet; two in five carers who have given up paid work or reduced their working hours reported that they were between £10,000 and £20,000 a year worse off' (James and Spruce 2015, 468).

Addressing poverty: the evolution of social care policy

The means tested social care system has been a key source of support for poor adults and in recent times their carers. Social care was not part of the original post war welfare state settlement. 'Personal social services' only emerged as a legal concept and into an important area of activity for Local Authorities (LA) with the implementation of the Local Authority Social Services Act in 1970. The nature of the support and the way in which it has been provided has changed radically since 1945.

The first stage (1945 to 1980s) involved the LA as direct provider of 'old peoples' homes' and 'home helps' and other targeted services. The work force were public sector employees who through

collective bargaining were able to negotiate reasonable terms and conditions of employment. Stage two which began in the 1980s, involved a move to privatisation and choice for individuals. The 1990 National Health Service and Community Care Act re-cast local councils as 'enabling authorities' which were required to spend 85% of funding on commissioned services (Hudson 2016). Care workers became predominately non-unionised private sector workers.

The resulting change in ownership was rapid: 'in 1979 64% of residential and nursing home beds were still provided by local authorities or the National Health Service; … by 2012 it was just 11%'. The 'bulk of the adult social care workforce – around 72% – is now employed in the private and voluntary sectors, along with another 14% employed by individual service users making use of 'personal budgets', leaving just 14% employed by local authorities' (Hudson 2016, 7, 8).

The third stage in the development of the relationship between the state and the market, reflected in the Care Act 2014 has been to place individual well-being at the heart of policy making. This is achieved through direct payments to eligible individuals to purchase the services they need although LAs still procure significant numbers of services. State support is still means tested (excluding anyone with assets over £23,250 not including their home in the case of domiciliary care and potentially including in the case of residential care). LA have expanded responsibilities to 'broker' services for all who have identified care needs (Sloan 2016) and to ensure that an appropriate/functioning market exists to enable them to purchase care services.

In summary despite the huge changes that have occurred in the way in which social care has been delivered the original fault lines between a national service funded through taxation and free at the point of delivery (the NHS) and a means tested local service available only those on very limited means and subject to changing policy prescriptions and resourcing persists.

Deepening inequalities through austerity

While needs are rising, the ability of LA to meet these is increasingly constrained by reductions in the funds available to them. Since 2010 austerity measures, imposed by central government, have resulted in a real 5% decrease (Jarrett 2017). These funds are not ring fenced within LA budgets and must compete with statutory obligations and other services. One million fewer people now receive services (Humphries et al 2016). Given that state social care provision is means tested these cut backs hit the least able to absorb them –those in need of care and their carers.

The growing crisis in social care has come to public attention resulting in a number of policy responses including permission for LAs to raise a 'social care precept' on council taxes amounting to no more than 6% over 3 years until 2019. The £380m generated in 2016 amounted to less than two thirds of the £600m that was needed to maintain services due in large part to the introduction of the National Living Wage (NLW) (ADASS 2016). The promised increase in 2020 will add a total £2.3bn to wage costs (D'Arcy and Kelly 2015). In poor areas the amount raised will be substantially less than in more affluent areas while the need for services in these areas is higher. The result is greater social and economic impoverishment in already less affluent areas.

The perceived unfairness of this means tested system of public support for care was addressed in the Dilnot Inquiry (2011, discussed in Hopkins and Laurie 2015). The costs of a life-changing event such as a severe stroke or the long term effects of dementia can impoverish an individual with

modest to reasonable assets. One in ten will need to spend £100,000 on care although it is impossible to predict who this will be. Care must be privately funded until such time as such funds are reduced to the level which attracts public funding. The revised proposals incorporated into the Care Act 2014 have been shelved for the time being (officially until 2020 but many suspect kicked into the long grass) ensuring that for some although not all, care costs still have a devastating effect (Sloan 2016).

Entrenching poverty: Impoverishing providers and workers?

Until the mid-1990s, care home operators were mostly a combination of small, family firms operating one or a couple of homes, using the medical or nursing experience of the owners, some non-profit making/charitable associations, and LA run homes. In 2016 there were about 18,000 care homes in Britain (roughly 487,000 beds) and 7000 domiciliary care agencies reflecting the change in policy to provide services at home. The bulk of these are still small private owned and run businesses. The proportion of nursing homes has increased to cater for the growing number of people who are living longer with multiple health conditions and in particular with dementia.

New providers have entered the market: financialised operators who have built up chains of homes because the activity has been seen to generate reliable state backed cash flows. Contrary to the earlier providers who use their properties as a means to provide care – their business is caring, the business model of these operators is property based with rents provided through their care services. The ten largest providers account for around 20% of the care home market whilst the top 20 providers account for around 28% of the market. In some parts, such as nursing home beds in London, the big chains already provide a majority of the beds available (Hudson 2016).

LA are seeking wherever possible to reduce the price they pay for commissioned services. Providers argue that LAs are driving down the price below the cost of the level of provision that is required to meet CQC quality standards. There is a huge need for investment (in excess of £15bn) to upgrade facilities to meet such standards and rising consumer expectation. It is estimated that 85% of the sector is using buildings over 50 years old which are now close to obsolescence. There is however a chronic shortage of finance available to smaller providers. 'High street' banks are unwilling to lend partly because the businesses are already heavily indebted. Owners must resort to riskier, higher interest loans adding to their indebtedness. Industry analysts confirm that profitability in the sector is low. Research undertaken for the BBC found that 5,871 individual owners make, on average, about £60,000 profit as operators and that on average, each care home makes £17,647 in profit before tax (BBC Radio 4 2016). They have also had to absorb the increased cost of staffing, constituting 60% or more to total costs, which result from the introduction of the NLW and its proposed increase, raising serious questions as to the ability of providers to continue to absorb these costs through price rises or profit reduction. About 5,000 homes are at risk of closure because they carry too much debt and do not make enough profit to cover loan repayments.

41% of residents pay privately, 37% are fully funded by the state, 12% are paying fees topped up by LAs, and 10% funded by the NHS (Hudson 2016, 12). Overall private funding accounts for £10 billion while public funding accounts for £14 billion per year (Hudson 2016, 12). Where possible, providers rely on self-funded clients who are estimated by sector analysts LaingBuisson to be paying 43% more for exactly the same level of provision, thus cross -subsidising their publicly funded counterparts.

This is not fair on self -funders particularly given the present low cap for public funds and has the effect of potentially creating a two-tier market.

While the evidence relating to the vulnerable position of the smaller providers is compelling, the position of the new large entrants is much less clear. They have undoubtedly contributed to investment to the sector, around £30 billion, and created over 350,000 beds in care homes (Hudson 2016, 9). However, there is considerable evidence to suggest that their financing model involving debt based financial engineering is creating unnecessary risk and high profit taking. The model evolved in the early 2000s when interest rates were low and bond holders required lower rates of return than shareholders. Debt was relatively cheap.

> The purchase of care home businesses could be funded by selling debt; this caps returns on that portion of capital to the benefit of the private equity fund which has unlimited equity rights to the upside from operating or selling on. Their shareholders expect to make a return of 11-12% which is the 'going rate' for high risk, high return finance sectors. (Burns et al 2016, 4)

The aim is to bring earnings forward and pass liabilities on. Complex multi-level company structures use tax havens making tax difficult to trace. The business can easily change form. It is possible to make use of an op co/prop co structure, 'where the care home operator pays rent to a property company for homes which it previously owned. The cash released by selling property can be taken out of the business or used to fund rapid expansion through buying smaller care home businesses' (Burns et al 2016, 5).

Recent building of new residential and nursing homes in a standard format, designed to minimise labour costs, with 60 or more en-suite bedrooms has been dominated by the chain operators. There are huge pressures on working practices to reduce costs. One recent study identified a range of changes including restricting annual leave, reducing the numbers of qualified nursing staff, increasing resident-staff ratios, removing sick pay, moving to unpaid on-line training to be completed at home, removing paid breaks and no longer paying for handover meetings at the start and end of shifts (Hudson 2016, 9). Such employment practices are not restricted to the residential sector. The recent case involving SevaCare a major home care provider revealed the extent of bad practice (Bradley 2016). Workers were required to provide 24-hour care to care user with severe dementia but only paid for their waking hours. The migrant workers involved said they felt like slaves.

Crisis?

Last year the CQC found a third of care homes required improvement and 7% were "inadequate". A recent survey of almost half of all LAs in England responsible for social care commissioning found that 77% had experienced provider failure in the year 2015/16, and 74% thought another failure likely in the coming year. Up to 37,000 beds could be lost by 2020/21 with a possible 50% of care homes thought to be 'non-viable'. Domiciliary service providers are also vulnerable. 'Two of the top five providers (Care UK and Saga) recently decided to pull out of the market … the largest not-for-profit care provider – Housing and Care 21 – [is] pulling out of the home care business it has been providing in over 150 local authority areas' (Hudson 2016, 14). Mears has withdrawn from contracts

in the North West, claiming that the fees being paid by LA amounted to 'encouragement to providers to breach the National Living Wage'.

Significant regional differences are emerging. In areas like the North East where there is much greater reliance on LA funded residents the large companies are not providing services and choices are much more limited. In the South West and East where average incomes are much higher and with more privately paying clients, LAs are less able to place and a two-tier system is developing. In London, the majority of residential places are publicly funded while the large players dominate the market. Here it may be the case that the large players are able to inflate their prices.

The market as presently structured is at risk of structural failure while some are 'minting' it (Laing 2017). It is struggling to provide decent standards of care for its elderly clientele, decent wages and conditions for its work force and a sustainable business model for its providers. It is also producing not addressing inequalities. The poor are increasingly vulnerable to poor conditions while those with more resources are not necessarily immune from the pressures on decent levels of service.

Addressing inequalities and impoverishment though regulation

Black (2002, 20) defines regulation as the 'sustained and focused attempt to alter the behaviour of others according to defined standards or purposes with the intention of producing a broadly identified outcome or outcomes, which may involve mechanisms of standard-setting, information-gathering and behaviour-modification'.

> Social and economic regulation has been designed to promote economic efficiency, to redistribute resources in a public-spirited fashion, to reduce or eliminate social subordination, to reflect collective aspirations, to protect future generations from irreversible losses, and to alter preferences that are produced by various motivational or cognitive defects…. (Sunstein, quote Prosser 2010, 11)

Thus regulatory laws may not be limited to correcting a market: they may 'serve to constitute market relations' as 'prior to, not secondary, to the market' (Baldwin et al 2012, 22) and can be used to achieve distributional justice. Prosser (2010, 12) points to two regulatory visions: 'regulation as an infringement of private autonomy, emphasizing rules, predictability and regulatory independence' and regulation 'as an enterprise, emphasizing collaboration with government, discretion, and responsiveness'. He favours the latter which is the way in which the 'pluralistic regulatory landscape' operates in relation to social care. He identifies four rationales that 'can be used to classify regulatory activities' and to provide 'the basis of normative arguments about how regulators should act': to maximise efficiency and consumer regulation; to promote human rights; to promote social solidarity; and as a means for deliberation and resolution of contending arguments.

Applying these rationales, a combination of which can be adopted by any regulator, facilitates an assessment of the role of regulation in tackling the tendency to impoverish and to entrench social and economic inequality. The fourth rationale which identifies the contribution of regulation to resolve problems and build consensus through procedural means will not be addressed specifically although this deliberative role forms an important part of the work of both the CQC and the LAs. It will emerge in discussion of the other three.

Both the CQC and LAs 'shape', 'oversee' and 'regulate' the market, all of which activities can fit within each rationale. 'The idea of shaping the market goes beyond the notion that the role of the state is to 'fix' or somehow forestall market failure; rather the role of the state is to act as a catalyst for innovation' (Hudson 2016, 15). We have seen the way in which the state has been involved in creating the market. Privatisation and 'personalisation' create customers. They encourage a change in normative understanding of older people: no longer vulnerable passive recipients of state services but active individuals who take responsibility for and plan for their later years (Herring; Bedford). As customers they seek choice of services to meet their needs (recast perhaps as desires) (Stewart 2012). Both commissioning and brokerage shape the market. The austerity budgets shape the market by creating significant fee differentials between state supported and self-funded customers contributing to the creation of a two tier market.

The Care Act 2014 and its guidance provides a specific meaning of market shaping and supports Prosser's first economically focused rationale. It repositions the state's role from one of control to one of co-production and collaboration with other parties. LA are required to promote the efficient and effective operation of a market in services for meeting care and support needs with a view to ensuring that any person in its area, however funded, wishing to access services in the market has a variety of providers and high quality services from which to choose and sufficient information to make an informed decision about how to meet the needs in question (s. 5(1)). The Statutory Guidance stresses the positive facilitative role that each LA has in shaping its local market (para 4.2). It is to 'signal to the market the types of services needed now and in the future…, encourage innovation, investment and continuous improvement…' (para 4.7).

The duty requires LAs to be aware of the needs of carers and 'the importance of fostering a workforce whose members are able to ensure the delivery of high quality services (because, for example, they have relevant skills and appropriate working conditions)' (para 5.2). Thus the workforce, both informal and formal, is recognised as a key 'factor of production'. The LA duty is best met through the production of a Market Position Statement which is created in close collaboration with providers, service users, carers and other relevant bodies (para 4.6). It requires a move beyond market engagement to market intelligence and market influence (Institute of Public Care 2016).

In principle, this duty supports considerable intervention to promote human rights and social solidarity as well as market efficiency. If used to full effect, it might be able to influence the market in ways that would ensure that all can access decent services. It could ensure that care workers have decent work and that unpaid carers' needs are catered for. However, there are severe limitations on use in this extended way not least of which are the budgetary constraints on LAs and the reliance on the present private providers to deliver services. Whether a 'shaping' duty could support restructuring of the market is a point developed later.

While LAs in collaboration with others shape the market, the CQC 'regulates' it in a number of ways including through its market oversight obligations in relation to the large providers. As Prosser identifies, there are debates over regulatory visions but risk management is thought currently to achieve 'better regulation' (Black and Baldwin 2010). This form starts with identifying the risks to be managed not the rules to be complied with and focuses attention on the quality of the firm's internal controls. It is often described as 'meta regulation' and responsive approaches to regulation

(Baldwin et al 2012). Understanding risk in the present context is important. The model adopted by chain providers is high risk, offering the possibility of a good rate of return for equity holders. In this sense it is a 'good' financial risk at the level of the organisation but can threaten the structural integrity of the market. The 'social' risk is not good: it can result in the collapse of a large care provider which cannot be replaced easily. Business failure among small providers is not as socially or structurally risky as long as all do not fail at once.

The Care Act supported by Regulations establishes the CQC's duties and functions.[1] 'The criteria are designed to be met by those care providers that, because of their size or concentration, Local Authorities would find difficult to replace were they to fail. The criteria relate only to how difficult a provider would be to replace and bear no relation to any judgement of actual or potential risk of failure' (Care Quality Commission 2015). They cover both residential and domiciliary providers. The CQC assesses the financial sustainability of the providers within the scheme and informs LA where business failure is likely to mean a provider may become unable to carry on the regulated activity for which it is registered.[2] Notification triggers the temporary duties placed on LA to meet the care and support needs of adults or of carers (Care Act 2014, s. 48).

The CQC (2015, 14) recognises that this a new function: 'financial oversight of private, 'for profit' providers of adult social care has not routinely been carried out by a public body …' It aims to minimise the burdens on those affected and to ensure that the process itself does not contribute to the potential for failure. Evaluation is staged, enabling the organisation involved to resolve the problems internally through, for instance, rescheduling debt or restructuring within a wider corporate group. Only at the last sixth stage is there external notification to the LA. Individual service users are not notified at any stage.

There is a separate requirement in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that all directors of registered providers are responsible for the overall quality and safety of that care under the 'fit and proper person' requirement. Registered providers or their partners must be of good character, possess the right competencies and skills and be physically and mentally fit to carry out the management function (reg 4). Directors of companies join nominated individuals (responsible for supervising the management of the regulated activity and liaising with the CQC) (reg 6) and registered managers (reg. 7) as regulated persons.

While this form of market regulation is an acknowledgement of the precarious nature of the care services market, the regulator has no powers to intervene to prevent a company collapsing. It is an early warning system for LA. Oversight does not change the business model or behaviour of these providers or influence the level of risk they take. While market oversight allows the business to fail, the responsibility for dealing with the 'social fall out' does shift to the public sector. The 'moral hazard' associated with a guaranteed public 'bail out' remains.

The fit and proper person test is likely to have little impact on the potential for market failure in the care home sector. To deliver consistently high levels of care requires highly skilled personnel with specialist management knowledge. It is not as easy as providing the routinized 'excellence' practiced

[1] Care Act 2014 sections 53 to 57; Care and Support (Market Oversight Criteria) Regulations 2015; Care and Support (Market Oversight Information) Regulations 2014

[2] The Care and Support (Business Failure) Regulations 2015 define the meaning of business failure.

in the hospitality/hotel industry. The CQC cannot prosecute for breach of the regulations although ultimately it can deregister a provider. Much responsibility is in reality devolved to the 'registered manager' for the particular care service. However the average annual salary for managers is £27,700 (Sodha 2016). One in four leave each year. This form of regulation cannot address issues does not ensure decent work including career progression for care workers and managers. It does not address the overall cost to fee paying clients (whether publicly or personally funded) of a high risk/high return model. This form of meta regulation seems to offer very little in relation to human rights and social solidarity objectives.

The oversight duty sits uneasily with the rights based normative rationale of the CQC (2014) which 'put[s] human rights principles and standards at the heart of policy and planning'. To ensure compliance with legislative requirements under the Human Rights Act (HRA) 1998, the Equality Act 2010 and UN Conventions, this involves the promotion of equality, diversity and human rights to ensure that all health and care services provide people with 'safe, effective, compassionate and high-quality care, and to encourage them to make improvements' (CQC 2014, 4). The CQC is not inspecting for compliance with the HRA or with the Equality Act but to see how providers perform in relation to five key service questions: are they safe, effective, caring, responsive to people's needs and well-led; and to check that providers do not fall below the fundamental standards required by regulations.[3] The CQC is mindful of its role in relation to 'self- funders' given that the HRA only protects those who receive care when the care is commissioned or at least partially funded by a LA. (CQC 2014, 8) It uses the principles that 'are considered to underpin all international human rights treaties': Fairness, Respect, Equality, Dignity, and Autonomy (choice and control) and 'weaves' these into the key lines of enquiry which are used to guide inspections (CQC 2014, 7, 16). The approach uses 'Intelligent Monitoring to identify where the risks are for people using services – based on data and evidence and information from people' (CQC 2014, 18).

As we have seen the individual in need of care services is now at the heart of the policy agenda and the normative base for the Care Act. The CQC's rights approach to regulation supports this policy agenda although it achieves this through routinized and bureaucratized registration and inspection of care providers. It grades providers against the five service questions (outstanding, good, requires improvement or inadequate). These ratings must be published by the provider and by the CQC, and in this respect, adds to the economic objective of consumer choice. The CQC has powers to intervene to require cessation of services if there is a risk to safety or through deregistration of the provider if improvements do not occur. The CQC does not have powers to pursue individual complaints. This role is fulfilled by the Local Government Ombudsman if there is a public role in the individual's care provision.

Much has been written on the ability of regulation to provide either a reliable indicator of quality or a means to improve it (e.g. Black and Baldwin 2010). Risk based methods and meta regulation in part are responses to earlier critiques of rule based methods (Gray and Hamilton 2006). It means that there is a reliance on monitoring of provider processes to prompt organisational responses. It results in infrequent inspection of many providers not thought to be at risk. There is deep scepticism as to whether the present method is able to ensure decent (human rights compliant) and consistent quality of care (Burton 2017). Critics point to the inability of a centrally organised CQC to

[3] Health and Social Care Act 2008 Regulations 2014

spot abuse and neglect in local homes with cases coming to light through other means and to the very high level of poor quality provision. Generally, market informed mechanisms do not work well in a sector where 'distress purchasing' tends to be the norm. There is little scope for shopping around even if the care is privately funded.

The cost of regulation has a differential impact on small and large providers. While the large organisations are able to use specialists within their ranks to produce the necessary information and responses, the smaller providers must rely on their own skills or buy them in. To reduce its reliance on public funding, the CQC now charges for inspection: in effect 'each resident in the small home will pay £627 and each resident in the large home will pay £530 for one inspection visit and report' (Burton 2017, 14). At a wider level, it is argued that the large providers use their power and influence within the sector to shape, in their own image, an understanding of what constitutes good social care – hotel style, thus stifling innovation including the provision of what could be considered more socially risky but positively and if wished 'homely' care.

It is very difficult to see how this form of individualised human rights based regulation could be used to tackle wider structural inequalities. The workforce is marginalised in this rights framework. While providers are required by the CQC to recruit 'fit and proper' staff and to have enough suitably qualified, competent and experienced staff who must be given the support, training and supervision they need, its fundamental standards have nothing to say in relation to labour rights and protection.

Yet this workforce is central to maintaining a functioning market because 'care possesses the distinct characteristics of service work, that is, simultaneous production and consumption, intangibility in demands and the customer's presence in the labour process. Much of the customer's sense of satisfaction is gained from this direct interaction with workers' (Cunningham 2016, 652). There is often an inverse ratio between improving productivity through rationalisation and care quality. Technological innovation can be inconsistent with caring. ''Hard' HRM [human resource management] sees labour as a factor of production and a resource to be exploited and manipulated. 'Soft' HRM sees labour as a resource to be nurtured in order to encourage commitment' (Cunningham 2016, 653). The large providers tend to adopt the 'hard' approach, bureaucratising care relationships to achieve standardised excellence. As we have seen the most significant regulatory intervention in relation to the workforce has been the introduction of the NLW, providing an average pay rise of 9.2% for 57% of frontline workers although it has 'bunched' them with little potential to progress up the pay ladder (Gardiner 2015). With the planned increase in 2020, a low wage, high return model of social care will become even more unsustainable.

In Prosser's third rationale, regulation is directed to achieving social solidarity. This approach which seeks to avoid the fragmenting effects of markets and to promote universal access to public services of consistent quality informs the work of the CQC in relation to health provision given its different roots within the welfare state. There is little scope in social care where it is so sorely needed. CQC is not Offcare. It has no powers to set uniform 'tariffs'/prices or limit geographical disparities. An unimplemented section in the Equality Act 2010 offers a glimmer of possibility. Public authorities would have a duty 'in taking strategic decisions to have regard to the desirability of exercising them in a way designed to reduce inequalities of outcome resulting from socio-economic disadvantage' (s. 1).

Intervention to support social solidarity and distributive justice

The manifest problems in the social care market provoke a critical assessment of regulation to address social solidarity and distributive justice objectives. While there is public support for regulation to protect adults in need of social care, there is much less consensus on the way in which such care should be provided. The move from state provider to state broker/market shaper is further muddying public understanding of social care. Social care was a targeted public service provided primarily to the poor. It is still associated with and dependent on public assessment of need via the Care Act 2014 and public funding, and to a great and probably growing extent reliant on non- market familial provision. However, it is increasingly transforming into a market based, price differentiated consumer service.

Market based governance:

> causes bureaucrats to reform or 'translate' aspects of social welfare that previously may have been expressed in the language of need, vulnerability or harm into the language of market failures or market distortion. Not only does this translation tend to silence certain critical modes of demanding justice, particularly those that rely on moral or distributive values, but the institutional solutions which bureaucrats advance to secure the 'translated' social welfare values render them politically vulnerable (Morgan 2003, 490).

Social care regulation provides a good example of this translation. The present forms of market shaping and oversight will not redress the way in which this fragile market is developing with growing reliance on forms of financing that provide 11 or 12% return on capital. Oversight is addressed through the social consequences of failure not because it is an unacceptable way of providing an essential social service. There is a pressing need to finds ways of providing care which values those who are poor and coming to the end of their lives while also caring for those who care for them. More generally the provision of care must be rooted in social welfare values of social solidarity and distributive justice. In theory, the market shaping duties of LA could support such innovation but politically and financially they are not in a position to support alternative visions.

What could be done given that there is no appetite for social care to be provided free at the point of delivery, supported through general taxation, as part of an extended and reshaped NHS? There is equally no likelihood of the social care market being replaced by state provision. However, below are a number of proposals made recently which would contribute significantly to restructuring provision (Burns et al 2016). They make full use of Prosser's fourth model of 'deliberative' regulation assuming that far more transparency and accountability could shape debate and encourage a new consensus of what constitutes a functioning and caring market.

- LA as a public body, to make the contents of contracts with private providers fully transparent;
- ownership details of companies providing public services under contract to the public sector to be available for public scrutiny;
- private companies in receipt of public services contracts to be domiciled in the UK and subject to UK taxation law.
- all providers required to comply with minimum labour standards and accept collective bargaining rights

A further more radical suggestion is to give local electorates powers to call to account any provider judged to be providing an inadequate service thereby offering a much more direct and political form of intervention than the bureaucratised form used by the CQC.

LA shaping could extend into restructuring. Organisations with a social purpose could be designated as preferred providers of care and support services. The state could challenge the high risk/high return model by seeking to replace it with a low risk/low return model that is not reliant on debt based financial engineering but on social funding with low cost capital. A start on this would be made through setting an upper limit on what constitutes a reasonable return (say 5%) on investment in contracts with private companies. This would reduce 'private equity investors' interest' and help 'to re-balance the market between state, voluntary and private provision' (Hudson 2016, 4).

A more positive approach would be to use the ability of the public sector to access low cost finance. LAs can borrow at 4-5% from the Public Works Loan Board although present Treasury policy seeks to limit investment in social infrastructure. Burns et al (2016, 10-11) suggest using LA pension funds:

> Currently many local authority pension fund investments earn no more than 5% net return (interest and capital gain) annually. Why not a national scheme in which local authority pension funds invest in the building of care homes which could provide 5% returns at very low risk?

This would enable the state, using 'mission oriented public investments' (Mazzucato 2012) to underwrite 'imaginative new experiments in social care rather than simply police the standardised provision by the chains' (Burns et al 2016, 9). With a 5% return (rather than 11 or 12%) it would also be possible to add a levy specifically dedicated for staff development and training.

Conclusion

As presently constituted and funded the adult social care system can impoverish those who have modest funds ensuring their increased vulnerability while not protecting all those who should be eligible for support. The tension, accentuated by the present lack of funding within the public system, between providing decent quality care which is also profitable passes the risk on to others including carers and care workers. Present regulatory measures which involve light touch market oversight by the CQC and limited capacity to market shape by LAs are inadequate. What is needed to tackle structural inequalities and the impoverishment of care is a rebalanced relationship between the market and the state with more aggressive measures to encourage socially responsible providers and innovation in the ways in which care is provided. Although LAs are 'shaping' local social care markets and the CQC nationally is regulating the business practices of providers, tackling the impoverishment associated with care for the elderly requires far more radical interventions in the market.

BIBLIOGRAPHY

ADASS (2016), *Annual Budget Survey Association of Directors of Adult Social Services*. London, ADASS (www.adass.org.uk/adass-budget-survey-2016-full-report, accessed 2 March 2017
BBC Radio 4 (2016) *You and Yours* Broadcast May 4 2016

Baldwin, J., Cave, M. and Lodge, M. (2012) *Understanding Regulation: Theory, Strategy and Practice*. Oxford University Press.
Black, J. (2002) 'Critical Reflections on Regulation' (LSE Centre for the Analysis of Risk and Regulation Discussion Paper 4, 2002) (http://eprints.lse.ac.uk/35985/ (accessed 2/3/2017).
Black, J. and Baldwin, J. (2010) 'Really Responsive Risk Based Regulation' *Law and Policy* 132(2), 81.
Bradley, P. (2016) Minimum wage and working time for care providers (September 26 2016) (www.wrighthassall.co.uk/knowledge/legal-articles/2016/09/26/minimum-wage-and-working-time-care-providers/ accessed 2 March 2017)
Burns, D., Cowie, L., Earle, J. Folkman, P., Froud, J. Hyde, P., Johal, S., Rees Jones, I., Killett, A. and Williams, K. (2016) W*here does the Money Go? Financialised Chains and the Crisis in Residential Care.* London, CRESC.
Burton, J. (2017) *What's Wrong with CQC? A proposal to reform the regulation of social care.* London, The Centre for Welfare Reform.
Care Quality Commission (2014), *Human rights approach for our regulation of health and social care services* London, CQC.
Care Quality Commission (2015), *Market Oversight of 'difficult to replace' providers of adult social care Guidance for providers* London, CQC.
Corlett C. (2017) *As Time Goes By: Shifting incomes and inequality between and within generations*. London: Resolution Foundation.
Cunningham, I. (2016) 'Non-profits and the 'hollowed out' state: the transformation of working conditions through personalizing social care services during an era of austerity'*Work, Employment & Society* 30(4), 649.
D'Arcy, C. and Kelly, G. (2015) *Analysing the National Living Wage Impact and implications for Britain's low pay challenge.* London, The Resolution Foundation.
Department of Health (2015) *The NHS Constitution: The NHS belongs to us all*. London, UK Government.
Dilnot Inquiry, *Fairer Care Funding The Report of the Commission on Funding of Care and Support* (2011) (http://webarchive.nationalarchives.gov.uk/20130221130239/https://www.wp.dh.gov.uk/carecommission/files/2011/07/Fairer-Care-Funding-Report.pdf, accessed 2 March 2017).
Gardiner, L. (2015) *Care to Pay? Meeting the Challenge of Paying the National Living Wage in Social Care.* London, Resolution Foundation.
Gray, J. and Hamilton J, (2006) *Implementing Financial Regulation: Theory and Practice* London, Wiley and Sons,
Hudson, B. (2016) *The Failure of Privatised Adult Social Care in England: What is to be Done?* (The Centre for Health and the Public Interest, 2016).
Hopkins, N. and Laurie, E. (2015) 'Social Citizenship, Housing Wealth and the Cost of Social Care: Is the Care Act 2014 'Fair'?' *Modern Law Review* 78(1), 112.
Humphries, R., Hall, P., Charles, A., Thorlby, R., Holder, H. (2016) *Social Care for Older People: Home Truths* London, King's Fund/Nuffield Trust.
Institute of Public Care (2016) *Market Shaping Review: What is Market Shaping*? Oxford, Oxford Brookes
James, G. and Spruce, E. (2015) 'Workers with elderly dependants: employment law's response to the latest care-giving conundrum' *Legal Studies* 35(3), 463.
Jarrett T. (2017), *Social Care: The state of the care home market (England)* Briefing Paper Number 07463, London, House of Common Library.
Leach, R., Phillipson, C., Biggs, S., Money, A. (2008) 'Sociological Perspectives on the Baby Boomers Quality' *Ageing* 9(4), 19.
Laing, P. (2017) *The Bottom Line* BBC Radio 4 broadcast February 4 2017
Mazzucato, M. (2012) *The Entrepreneurial State: Debunking Private v Public Sector Myths*. London, Anthem.
Morgan, B. 'The Economisation of Politics: Metaregulation as a form of non judicial legality' *Social and Legal Studies* 12 (4) 489.
Office for National Statistics (2016) *Overview of the UK population: February 2016*. London: ONS.
Prosser, T. (2010) *The Regulatory Enterprise: Government, Regulation, and Legitimacy,* Oxford, Oxford University Press.
Sloan, B. (2016) 'Adult Social Care and Property Rights' *Oxford Journal of Legal Studies* 36(2), 428.
Sodha, S. (2016) 'Underfunded and overstretched – the crisis in care for the elderly' *The Observer* 10 December 2016)
Stewart, A. (2012) 'From family to personal responsibility: the challenges for care of the elderly in England' *Journal of Social Welfare and the Family Law* 34 (2), 179

Willetts, W. (2011) *The Pinch: How the Baby Boomers Took Their Children's Future - And Why They Should Give it Back.* London, Atlantic Press.