Towards a Real National Care Service for Scotland

FULL REPORT

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apse solutions

UNISON Scotland

APSE (Association for Public Service Excellence) is a not-for-profit local government body working with over 300 councils throughout the UK. Promoting excellence in public services, APSE is the foremost specialist in local authority front line services, hosting a network for front line service providers in areas such as waste and refuse collection, parks and environmental services, leisure, school meals, cleaning, housing and building maintenance.

APSE provides services specifically designed for local authorities, such as benchmarking, consultancy, seminars, research, briefings and training. Through its consultancy arm APSE delivers expert assistance to councils with the overt aim of driving service improvement and value for money through service review and redesign. APSE delivers in excess of 100 projects a year and clients benefit from the consultancy's not-for-profit ethical approach to consultancy services.

Contents

Foreword

I'm proud to introduce this important report from APSE on how to build a National Care Service worthy of the name.

Our care system is struggling. It is underfunded and beset with a crippling staff recruitment and retention crisis that is having an impact across the length and breadth of Scotland. Structural problems make themselves felt on the quality of services being received and on the working lives of care staff.

Funds are drained by profiteers who see those accessing care services not as vulnerable people to be helped but as a source of revenue. Equally they see the staff providing services not as an asset to their community but as a resource to be exploited. We cannot keep spending public money on such an inefficient and unjust system.

The need for wholesale change is urgent. As they currently stand the Scottish Government proposals set out in the National Care Service (Scotland) Bill will not deliver the aspirations for care outlined in the Independent Review of Adult Social Care and the Fair Work Convention's Fair Work in Care report.

This report draws on APSE's work with local authorities across the UK. It makes a compelling case for the direct public delivery of social care and sets out the initial steps Scotland can take towards this.

We need a proper national conversation about the alternatives and how to create the sort of care system that Scotland deserves. I commend this report for the valuable contribution it makes. Its proposals require detailed consideration by local and national government.

Lilian Macer
Regional Secretary
UNISON Scotland

1 Executive summary

The Case for Change

1.1 The current adult care system in Scotland and the rest of the UK is in crisis and not fit for purpose. Care staff are demoralised and difficult to recruit and retain; services are patchy, with many care recipients forced to top up fees to secure residential care or left with minimal care-at-home.

1.2 The Bill for a National Care Service for Scotland (NCSS); replacing local authority commissioners with nationally appointed commissioners and altering the balance of accountability between local and national government, does not address the root problems.

1.3 Neither will these root problems be addressed by simply increasing funding.

1.4 The success of the NHS in replacing a broken private health care system with a universal, free at the point of delivery, comprehensive service, clearly illustrates the central significance of direct provision.

1.5 Without a core of public provision, a national service is only a nationally commissioned service that does not fundamentally change the failing system of commissioner/operator/holding company/financier. If Scotland is to achieve the radical change promised, it must include 'publicly provided' as a necessary element of a National Care Service.

Profiting from Care

1.6 The last forty years have seen a shift away from public sector provision as social care was opened up as an opportunity for private companies to profit in a market. Residential care is now almost entirely provided by external companies and the private sector is the biggest provider of care-at-home. A handful of big multinationals occupy a disproportionately dominant market position. Many of these are ultimately owned by private equity companies whose main interest is driving returns to their investors.

1.7 The companies involved in residential care often have opaque and complex structures, created to extract a high percentage of cash earnings from front end care businesses. This inevitably impacts on care staff and undermines quality of provision.

1.8 The home care business is subject to similar drains on income. Holding companies strip income from operators, creating strong imperatives to minimise operating costs, which are mostly staff costs.

1.9 A major expansion of publicly owned and operated provision, capitalised through public borrowing, could counterbalance the private, resource extraction-based model by creating a financially transparent alternative to the private market.

The Public Alternative is Affordable

1.10 The Independent Review of Adult Social Care (IRASC, the 'Feeley Review') recognised that to be on a par with the NHS, social care must be provided on a needs-driven basis. Access to free at the point of delivery health care is a universal right, whereas access to social care is rationed through variable eligibility criteria.

1.11 Feeley also recognises the urgent need to improve pay and other conditions, concerns about "leakage" from the care system and expresses agreement with those who question the role of for-profit providers in publicly funded social care.

1.12 However, the Feeley Review rejects the obvious answer to this which is to expand direct public provision, preferring instead 'a more actively managed market'. Dismissing public provision as unaffordable based on limited, somewhat anecdotal, evidence.

1.13 Feeley comes out against what it calls 'nationalisation' on the basis that taking care provision into public ownership would be prohibitively expensive. This conclusion is not underpinned by an assessment of what the costs would actually be.

1.14 On a business case by business case basis local authorities are in fact well placed to develop existing or new services. Detailed assessment of the financial implications of this indicates that it is not, as Feeley suggests, the capital cost that is the stumbling block. The public sector has access to much cheaper capital than the private sector.

1.15 The financial stumbling block is the increase in staff costs associated with public sector pay rates and pensions. It is the fact the wellbeing of the workforce is integral to the organisational vision in the public sector, that makes council and NHS provision more costly than private provision. All other elements of running costs are likely to be lower or around the same, with some significant drains on revenue disappearing altogether.

The Public Alternative is Necessary

1.16 Public provision would save the public purse millions of pounds. Low pay and pension provision are a significant factor in the failure of the current system. An increase in frontline costs must be

factored into any solution. It is particularly important to ensure that any increase in public spending on care services does not go to shore up yields to speculative investors.

1.17 Something in excess of 20% of income leaks from the care system to the owners and financiers of operators. To this can be added the loss of tax revenue to the state through companies' use of 'tax efficient' structures.

1.18 In these circumstances the higher staffing cost publicly provided alternative, could be far more price competitive than might first be assumed. Particularly when all the 'hidden' additional costs of using private providers are accounted for (procurement, contract management, supplier failure etc). The 'propping up' of low pay in private care providers via in-work benefits is another hidden cost the public pay for the current system.

1.19 The UK care market continues to be attractive to global investment funds. This is evidence that current fee levels are capable of delivering returns to investors.

1.20 Retaining these funds in the sector will ensure that public funds are used for their intended purpose to the benefit of the Scottish public and the Scottish economy. The insourcing of social care should be regarded as an important component of local Community Wealth Building strategies.

1.21 The inter-dependency of health and social care is well understood and it is clear that a large part of the cost of expanding public provision could be offset (potentially fully off-set) by cross-sectoral efficiency gains. Just increasing the level of care to a level that would allow the timely discharge of elderly hospital patients would save the public purse many millions of pounds in delayed discharge costs.

1.22 Creating a fully integrated system that could drive up end to end synergies, from low level preventative home help, through to post hospital residential care, requires a degree of joining up unlikely to be achieved in a system dominated by suppliers with their own organisational objectives, which often end up prioritising yield to investors over the wellbeing of those in their care.

1.23 A National Care Service that does not incorporate a renewal of public sector provision will miss a major opportunity to move away from a market that increasingly works at the expense of the Scottish public and economy. Allowing a market model to continue, will mean care workers will remain underpaid and retain pressure on companies at the delivery level to follow a lowest-cost model.

The Way Forward

1.24 The change we need can best be achieved by supporting and facilitating local authorities, NHS Boards or Integrated Joint Boards/Care Boards to plan for the expansion of publicly owned provision.

1.25 This can be achieved through the buyout of going concern providers on the open market, or the takeover of failing providers, as has happened recently in some English local authorities. The development of brand-new provision would also be a good approach to entering the market.

1.26 Bringing care staff into the employment of councils or the NHS would improve rates of pay and working conditions and give access to decent pensions. The private sector would have to respond to remain competitive but with more public provision available, pressure to increase fees would be lessened.

1.27 Research by APSE and others illustrates that municipal insourcing is a sustainable approach that can deliver substantial benefits in terms of service resilience, improving workforce terms and conditions and achieving services more accountable to citizens.

1.28 When they end, contracts can be brought in-house. Social care contracts are often for short-term blocks of provision based on framework agreements. These can be replaced or supplemented with direct provision, as and when it becomes available. In this way, 'remunicipalisation', can be achieved on an incremental basis as part of a strategy to rebalance provision in favour of public delivery.

1.29 It is at the local level, whether led by Care Boards, Local Authorities or the NHS, that rebalancing of provision should take place, but the NCSS offers potential for this to be driven by a National Strategy.

A National Insourcing Strategy

1.30 The basic building blocks of such a strategy could be:

- Strategic level recognition of the benefits that would flow from rebalancing in favour of public sector provision. This includes recognising that improvements to the terms and conditions of care workers will be more affordable without the leakage of care funding to private profit and yields to investors.
- Support to local authorities and/or IJBs/care boards to develop business cases for insourcing.

- Financial capital support to facilitate the development of public sector care infrastructure, including the purchase or new build of residential facilities.
- Initial revenue support to recognise the transitional costs of creating supply capacity in local authorities that are currently geared up solely or primarily for commissioning.

2 Background and History

2.1 The creation of the welfare state after the second world war marked a watershed in the development of UK social policy. Based on the 'cradle to grave' vision of William Beveridge[1], it aimed to provide free, comprehensive, high-quality education, health and social care, along with income security, in a bid to eliminate what Beveridge had called, the five giants of want, disease, ignorance, squalor and idleness.

2.2 The National Health Service (Scotland) Act of 1947 delivered a universal, comprehensive health service for Scotland, under the control of the Secretary of State for Scotland but paid for out of UK wide taxation. As with the rest of the UK, the principal means by which this was achieved was the nationalisation of hospitals to provide the basis for a publicly provided service in which the level and quality of care was the same for everybody, regardless of means. There was no rationing via means testing or eligibility criteria, so provision was and mostly still is, determined primarily by clinical need.

2.3 The NHS was the jewel in the crown of the welfare state. Universal adult social care was part of the package, but the assumption that families would be the mainstay provider of care to elderly relatives effectively left state provision as a residual service. Seventy years on, whilst the NHS has largely survived with its universal, publicly provided principles intact, adult social care is generally acknowledged to be in crisis. The reasons for this are complex and relate in part to the success of the welfare state itself. UK life expectancy in 1948, when the NHS was launched, was just 68 years. By 2015 it had risen to 81. Because of this, and the changing nature of the family, many more people require care than the architects of the welfare state had ever envisaged and, because of advances in health care, they require it for longer. Governments have consistently failed to address the funding implications of this, despite a long standing, virtually universal, recognition of the need to do so.

2.4 Demographic change has undermined the welfare state commitment to universalism and quality of care; there has also been a dramatic change in the way that social care[2] is provided. The last forty years has seen a comprehensive shift away from

1 Beveridge W., Social Insurance and Allied Services, 1942

2 This report is primarily concerned with residential and domiciliary adult social care although services for children have been similarly affected by the shift away from direct public provision

public sector provision to a model based primarily on private sector for-profit providers. The Thatcher government's efforts to open up the public sector to private companies, via a mixture of privatisation and contracting out, was only partially successful in relation to most council service areas but had a huge impact on social care. Over a short period, the role of Local Authorities changed from being the majority provider of publicly funded residential care places to mainly one of commissioning, with external companies becoming the main provider. Official statistics show that in March 2022 just 10% of care home residents in Scotland were living in a facility run directly by a Local Authority or Health Board.[3]

2.5 The near withdrawal of both local authorities and the NHS from direct provision of residential care opened the way for social care to be recreated as an opportunity for private companies to profit in a market that all but guarantees a consistent and growing level of demand. For-profit provision now dominates that segment of the social care market, accounting for 82% of Scotland's care home residents in the 2022 data, against just 8% that were living in a home run by the voluntary or not-for-profit sector.[4]

2.6 The balance between private and public provision of home care is more even but geographically patchy. Of the total number of people in Scotland in receipt of home care during census week 2018, 35% were receiving it from a local authority only, compared to 41% who were receiving it from a private sector provider only. A further 9% received their support from a voluntary sector organisation only, although this accounted for 24% of the hours, suggesting that this sector tends to cater for those with the highest level of support requirements. The private sector accounted for 44% of home care hours whilst the public sector provided 21%5.

2.7 Health and Social Care policy and funding were both devolved to the Scottish Parliament in 1999. One early policy initiative was the implementation of free personal and nursing care in 2002. Since then, the legislative focus has been on three main aspects of provision; choice, integration and consistency.

2.8 The Self-Directed Support (Scotland) Act 2013 seeks to give people greater control and choice over how their care is organised

3 Care Home Census for Adults in Scotland, Statistics for 2012-2022, Public Health Scotland, 2022
4 Ibid
5 Insights into Social Care in Scotland, ISD Scotland, 2019

and delivered and by whom. This has been a consistent theme of UK social care policy, which, on the face of it, is heavily focussed on moving away from historically paternalistic models of provision to one which actively involves people in decisions about the sort of services they receive and how they are provided.

2.9 The Public Bodies (Joint Working) (Scotland) Act 2014 creates a duty on local authorities and Health Boards to prepare schemes for integrating certain services prescribed by the Act. Integration schemes can be based on lead authority arrangements but all areas other than Highland, opted to create so called, Integrated Joint Boards (IJBs).

2.10 IJBs are corporate bodies responsible for key functions delegated to them, along with associated budgets, under the provisions of the Act and associated Regulations. The functions include core local authority duties established by the Social Work (Scotland) Act 1968.

2.11 In the case of IJBs, the 2014 Act requires that each delegated function is the subject of a binding direction to the constituent local authority or Health Board in line with a mandatory strategic commissioning plan. In this way the Act separates strategic commissioning from individual needs assessment and the procurement and delivery of services. These are still mostly carried out by Local Authorities, albeit in accordance with the integrated commissioning plan, which must reflect and implement core requirements, established by Ministers who have extensive powers of intervention and are responsible for approving proposed schemes of integration.

2.12 Consistency is provided through Social Care and Social Work Improvement Scotland which registers and inspects care services across Scotland. It is commonly referred to as the Care Inspectorate.

2.13 As in the rest of the UK, there is widespread recognition of the benefits of preventative services aimed at maintaining people in their own homes for longer. The Christie Report, published in 2011, concluded that 'a shift towards preventative public spending is likely to be controversial, but we consider it to be essential'.[6]

2.14 An 11% fall in the number of people in residential care over the last 10 years[7] could be a positive indicator of movement towards

6 Christie Commission on the future delivery of public services, APD Group Scotland, June 2011

7 Care Home Census for Adults in Scotland, OpCit

preventative provision, but the absence of a corresponding increase in those receiving home care over the same period suggests that there has been an overall reduction in care provision, more closely associated with the squeeze on public expenditure and changes to eligibility criteria, than to a successful shift in strategy.

2.15 The policy thrust, with its preference for self-directed care, participative service design and integration is entirely consistent with the Christie Commission recommendations but as has been pointed out, progress has been slow.[8] As discussed below, the developing response of the Scottish Government continues to focus on arrangements for commissioning.

8 See for example Blog: Christie 10-years on | Audit Scotland (audit-scotland.gov.uk)

3 The developing vision for Scotland

3.1 The most recent development in policy focusses on the creation of a National Care Service for Scotland (NCSS). The concept of a National Care Service is not new and has had broad multi-party support since proposals were floated within the Scottish Parliament in 2010. The National Care Service Bill, currently before the Scottish Parliament, actions a SNP election pledge to make the creation of a NCSS a high priority, following publication of an Independent Review of Adult Social Care (IRASC) in 2020, known as the 'Feeley Review'.[9]

3.2 The Feeley Review was concerned with improvements to adult social care in terms of outcomes for users, their carers and the experience of those who work in the care services. Its recognition that, to be on a par with the NHS, social care must be provided on a needs-driven basis is highly significant. It goes to the core difference between the way that health and social care are organised and delivered; access to free at the point of delivery health care is a universal right, whereas access to social care is rationed through variable eligibility criteria.

3.3 The review identified unacceptable inequity of provision between councils but is clear that this is a result of the current eligibility system, which has been increasingly used to ration capped resources as demand for free personal and nursing care has grown, since its introduction in 2002.[10] Moving away from this to a system where resources broadly follow need, is seen as the key to establishing equality of provision on the basis of a right to service not subject to local affordability.

3.4 The Bill establishes the NCSS by granting powers to Ministers to transfer social care powers and duties from local authorities to the new service. It lays down a set of principles that will guide the development and operation of the service. These are set out for consultation as:

- Embed human rights in care support.
- Increase equality and transparency.
- Ensure that the NCSS is an exemplar of fair work practices.
- Effectively co-design services with people with lived and living experience.

9 The Independent Review of Adult Social Care in Scotland, Scottish Government, February 2021

10 This issue is also explored in detail in: A review of free personal and nursing care, Audit Scotland, January 2008

- Ensure that the care workforce is recognised and valued.
- Improve outcomes through prevention and early intervention.
- Provide financially sustainable care giving security and stability to people and their carers.
- Ensure that the NCSS communicates with people in an inclusive way.

3.5 The principles are widely, if not universally, supported but the Bill has been criticised because of the sweeping powers it grants to Ministers to compulsorily transfer functions, staff and assets from local government to the new service. The Bill envisages but does not mandate, the service being provided at a local level through new Care Boards.

3.6 As with the IJBs, Care Boards will be corporate bodies but unlike IJBs, will have their membership determined by and will be wholly and solely accountable to Ministers. Ministers will have the power to remove members if they judge them unfit to continue as a member or are 'unable to perform the member's functions'. Ministers will also directly appoint the Chief Executive of each Board and determine the terms and conditions on which other Care Board staff are appointed.

3.7 The Feeley Review envisaged IJBs continuing to exist as partnership bodies between Local Authorities and Health Boards, albeit with responsibility for commissioning and procurement transferred to them. As the Bill stands, the proposed Care Boards, with membership determined by Ministers would be a critical departure from this, that would effectively remove an important route to accountability and democratic control.

3.8 Care recipients are often vulnerable and not well placed to protect their own interests. Well publicised cases of abuse and neglect illustrate the need for strong and transparent systems of accountability. The direct and geographically close relationship between councils and local people is crucial to this. Preserving and strengthening this will be a key aim of local government as plans for the service develop.

3.9 The Bill is likely to be amended as it passes through the Scottish Parliament.[11] Recent discussions between the Convention of

11 The current understanding is the Scottish Government intends to propose its own amendments to the Bill.

Scottish Local Authorities (COSLA) and the Scottish Government have been widely welcomed. The so-called Verity House Agreement, whilst not creating any legal obligations, commits to a collaborative approach between central and local government.

3.10 The most significant aspect of the Verity House Agreement, in so far as adult social care is concerned, is probably the adoption of 'local by default, national by agreement' as a key principle. This overt recognition of the maxim that the authority which is closest to the individual should be the one to exercise public responsibilities bodes well for the development of the NCSS. In line with this, the parties have entered into an initial Partnership Agreement on a National Care Service. According to COSLA the Agreement 'aims to establish who will be responsible for people's care once the NCS is established' with staff 'continuing to be employed by local authorities and councils still responsible for assets like buildings and delivery of services'.[12]

3.11 The Verity House Agreement also refers to monitoring and accountability and a need for transparency. For users of public services at a local level, accountability is best achieved through the democratic process. The ability to appoint or dismiss decision makers through the medium of the ballot box is critical to this but is only meaningful if elected representatives have a decisive say over the design and delivery of services.

3.12 Feeley concluded against what the report refers to as 'nationalisation', on the basis that it found no reason to see this as a route to improved quality and that it would be unaffordable. No detailed evidence is provided to support these conclusions.

3.13 Whilst not acknowledging the likely long-term impact on care quality or the causative impact of the care economy, the report recognises that care workers are:

'undervalued, badly paid for vital, skilled work, held in low esteem in comparison particularly to the health workforce, poorly supported in terms of learning and development, and generally under-represented'.

3.14 The report ascribes poor terms and conditions, solely to the fact that the social care workforce is 'highly gendered'. The report points out that; 'The sector is about 83% female'. The solution, the report concludes, is for the Scottish Government to establish

12 https://www.cosla.gov.uk/news/2023/partnership-on-national-care-service-published.

minimum standards of employment for care workers, to be enforced through revised commissioning practices.

3.15 The gender makeup of the social care workforce is undeniably a relevant factor and care workers will no doubt welcome government intervention to close the gender pay gap and improve pay and other conditions. However, gender balance does not explain why care work compares so badly to working in the NHS which is also predominately staffed by women.[13]

3.16 The most obvious difference between the two groups is that NHS staff are in the public sector where the well-being of the workforce is integral to the organisational vision. Collective bargaining, with strong trade union representation, ensures that this remains the case, whilst strategic decisions are driven solely by the wider public interest. Care workers, on the other hand, are predominately employed by private businesses, that have little choice, for the reasons discussed in detail below, but to keep employment costs as low as possible. Strategic decision-making prioritises the private interest of a narrow group of people who, in many cases, are relatively disinterested in the welfare of employees and organisationally and geographically removed from the point of delivery.

3.17 The outsourcing process itself, with its emphasis on price competition, adds to the pressure on suppliers to keep controllable costs low. From the perspective of the workforce, competition is a race-to-the-bottom as pay is by far the most significant element of controllable operational cost.

3.18 An Audit Scotland report from 2022 found that for home care in particular, the way that commissioning operates means that provider hours are drawn down from competitively tendered framework agreements. Because of this, care companies do not know in advance exactly what their day-to-day staffing requirements will be. This creates a demand risk which, given the tight operating margins at the front line, is commonly passed on to the workforce in the form of low or zero hours contracts. The report found that 20% of care workers were not on permanent contracts and 11% were employed on a zero hours basis. This, coupled with low pay (£9.75 an hour at the time), were contributing

13 Around 90% of nurses and 85% of personal and social care staff employed by NHS Scotland are women. Across the entire workforce 77% is female. NHS Scotland Workforce, Latest Statistics at 31 March 2023, An Official publication for Scotland, 6 June 2023

to overburdening (13% working more than 50 hours a week) and high vacancy rates (36% of services reported vacancies)[14].

3.19 Gender in-balance may explain why it has been allowed to develop as it has, but it is the delivery model itself that drives down the pay and conditions of care workers. Feeley may be right that if the social care workforce was male, it would 'not be as marginalised and undervalued as it is', but it is ingenuine not to see that it is marketisation, through a competition process that is predominately focussed on minimising staff costs, that is the most evident manifestation of this.

3.20 The Feeley Review argues strongly for what it terms 'commissioning for public good'. It sets out in some detail how both commissioning and procurement should change to become better aligned with policy objectives and less focussed on price competition. The report recognises many of the concerns about ''leakage'' from the care system in Scotland, pointing out that 'Significant sums leave the care economy, some of which could be better used to raise standards of care and terms and conditions for staff'. It nonetheless rejects the obvious answer to this which is to expand direct provision, in favour of 'a more actively managed market'.

3.21 The Scottish Government has increased funding to enable employers to increase pay. The average hourly rate (£10.50) is now higher than the National Living Wage and higher than for care workers in the rest of the UK. A recent announcement indicates an intention to further increase minimum pay to £12.00 an hour[15]. However, the underlying imperatives that drive cost minimising behaviour amongst care companies are still there. The Audit Scotland report speaks of a crisis that is so acute that it cannot wait for the NCSS to be implemented.

3.22 Moves to increase pay for care staff are very significant steps towards tackling the recruitment and retention crisis in the sector and will be very welcome to care workers. They will not address the disparity between pension provision between private sector care workers and their colleagues in the public sector. Neither will such an initiative do anything to stem the outflow of public funds, ostensibly spent on care which leaves the local and Scottish economy in the form of returns to private equity and care real estate investors. Tackling this, through an expansion of public

14 Social Care Briefing, Audit Scotland, 2022
15 First Minister, Humza Yousaf speaking at Holyrood on 18 April 2023

provision, would not only give care workers access to superior public sector pensions and other terms but would off-set at least some of the additional cost that uprating pay will create.

3.23 Feeley rightly points out that those who argue for nationalisation should address the cost of bringing care facilities into public ownership. A sudden wholesale buy out of all private sector provision, along the lines of the taking into public ownership of hospitals in 1948, would indeed be almost certainly deemed unaffordable. But this is not the only route to changing the balance between public and private provision. Halton Council in England recently purchased a number of residential facilities to run them directly, whilst Pembrokeshire County Council in Wales insourced homecare services provided by Allied Healthcare when it got into serious difficulties.

3.24 Halton and Pembrokeshire both see increasing the proportion of direct delivery as a strategic move, aimed at stabilising the market, workforce retention and service improvement. The initiatives are supported by sound business cases that justify the investment involved.

3.25 A recent move by Trafford Council in Greater Manchester to purchase residential care homes on the open market suggests that council investment in social care real estate may not be as unaffordable as the Feeley Review assumes. In a situation where 20% or more of front-line social care expenditure is lost to what has been termed 'extraction', it is appropriate to ask whether Scotland can afford to continue with provider arrangements that are shaped, not by public strategy but by the requirements of the big global corporations that increasingly dominate the care sector.

3.26 Many Scottish councils are already significant providers of adult social care services e.g. in West Dunbartonshire around 80% of care-at-home hours are reportedly provided in-house. There is however significant variation between council areas – City of Edinburgh Council (population 526,000)[16] delivers 5,500 home care hours per week in-house, compared to 11,000 hours weekly[17] delivered in-house by Fife Council (population 375,000). The challenge in relation to home care is to create geographical consistency as much as to grow direct provision. Direct council involvement in residential care is also patchy and mostly residual.

16 NRS, mid-year-population-estimates, 2021

17 Local authority data provided in response to a Freedom of Information request

But there are recent examples of insourcing to learn from, including that of Home Farm Care Home in Skye, referred to elsewhere in this report and Kintyre Care Centre in Argyll and Bute. The latter was acquired from HC-One following approval from the Argyll and Bute Integrated Joint Board in December 2022, on the strength of a business case that identified the move as the 'only viable option for providing residential nursing services in the area'.[18]

3.27 The insourcing examples referred to above are not 'nationalisation', as envisaged by Feeley. They are better described as remunicipalisation and very much in line with the growth in insourcing that has occurred over the last decade or so. Researchers at the University of Glasgow identify remunicipalisation as a global phenomenon reflecting a decisive shift away from the preference for market-based solutions 'implemented as part of the political project of neoliberalism from the 1980s onwards.[19] The research shows that the most common route to this is not the wholesale forced takeover of private companies but insourcing at contract end.

3.28 Research by APSE[20] and others illustrates that municipal insourcing is a sustainable approach that can deliver substantial benefits in terms of service resilience, improvements to workforce terms and conditions and alignment with what the Glasgow researchers describe as 'a clear desire for more collective, democratic and transparent publicly owned utilities which are more accountable to citizens'.[21]

18 Caroline Cherry, Head of Adult Care Services, HSCP, quoted by Argyl and Bute Council, Nursing home services secured in West Argyll and Bute (argyll-bute.gov.uk)

19 Mapping Remunicipalisation: Emergent Trends in the Global De-Privatisation Process, Cumbers A, Pearson B, Stegemann L and Paul F, University of Glasgow, April 2022

20 Rebuilding Capacity, The case for insourcing public contracts, APSE, 2019

21 The reference to utilities in this quote illustrates that the water and energy sector have been the most commonly remunicipalised services in Europe (including in Scotland), making up a combined 53% of total remunicipalisations. Health and Social Care (8%) also figure in the data, however as do local government services (15%), Op Cit.

4 The social care economy

4.1 Private companies dominate the provision of residential care in the UK. The market is attractive to investors because it is relatively low risk but offers returns on capital normally associated with higher risk investments. UK-wide, it is worth £15.2bn per annum, with over half of that coming from private individuals. Scotland spends over £5bn per annum on social care as a whole and £4bn on adult social care. Total public expenditure on care in Scotland amounts to £4.7bn.[22.]

4.2 Whilst there are many small companies in the market, a small number of international companies occupy a dominant position. According to the CHPI, '2,316 care homes in the UK (30.8% of the total number of registered beds) are owned by the 26 largest companies, whose investors see them as a source of income and profit'.[23]

4.3 The private care provider structure is somewhat opaque, with most of the big chain operators owned by holding companies. These companies, frequently owned in turn by private equity investors, extract a high percentage of cash earnings to pay for debt, asset depreciation, tangible and intangible asset amortisation and rent. It has been calculated that this can amount to 20% or more of so called, EBITDARM (Income Before Interest, Tax, Depreciation, Amortisation, Rent and Management costs), meaning that the operating companies, i.e., the care providers, often generate very low margins or are loss making. This may be tax efficient but inevitably leads to attempts to bear down on costs, of which staffing is the biggest contributor.[24]

4.4 As discussed above, social care operators are frequently part of complex business structures, topped by firms registered outside the UK. HC-One for example, which operates 16 homes in Scotland, claims to be the UK's biggest residential care provider. The immediate parent undertaking of HC-One, HC-One Holdco Limited, is registered in Jersey and its ultimate parent, Skyfall GP Limited, is registered in the Cayman Islands. HC-One is financed by the Dubai based private equity company,[25] Safanad, and was recently recapitalised through a £570m debt facility, provided by US health care real estate investment specialist, Well Tower.

22 Ibid
23 Centre for Health and Public Interest, Plugging the Leaks in the Care Home Industry, 2019
24 Competition and Markets Authority (CMA), Care homes market study Financial analysis working paper, 2017
25 Private Equity refers to funds invested in the purchase and subsequent resale at a profit of a range of private companies. Investors typically include private individuals, as well as institutional investors such as pension funds and insurance companies. The sole purpose of private equity funds is make profit.

4.5 Aside from creating structural complexity, frequent restructuring through consolidation-led acquisitions leads to inflated capital values. This in turn drives up the debt charged to operating company balance sheets, leaving them very vulnerable to any downturn in demand. As a result, the provider side of the private care market looks precarious, fuelling the widespread view that council fees are capped at too low a level with many providers depending on, so called, self-funders to generate sufficient income to survive. It is difficult to know how far this is genuinely the case and how far the financial difficulties of providers relate to the capitalisation model itself.

4.6 If fees were simply allowed to rise this would inevitably lead to further inflation of capital values and consequentially increased levels of debt charged to balance sheets. It would be unlikely to feed through into better pay and conditions, given the inbuilt imperative to reduce operational cost to minimal levels. Nor would it necessarily improve the position of the operators, given that inflated capital values would be charged against their balance sheets.

4.7 The UK social care market is particularly attractive to investors in property as there are thousands of small private providers, often occupying prime real estate in an economy where the value of land has risen consistently over many decades. Given the paucity of publicly owned alternatives, authorities have little choice but to continue to purchase from private companies. Demographic trends all but guarantee consistent if not growing demand.

4.8 The practice of the sale and lease back of residential care homes is another mechanism by which revenue is extracted from care businesses by investors. Despite the part this played in the 2011 collapse of the UK's then biggest care provider, Southern Cross, social care market analyst, LaingBuisson estimates that 'approaching half of capacity among medium-to-large for-profit groups... may be subject to leasing arrangements.'[26]

4.9 Recent research by the Centre for International Corporate Tax Accountability and Research (CICTAR) explores how companies, such as Belgian based Aedifca S.A., seek to profit from buying up social care real estate. According to its website, the company owns 113 care homes in the UK, with a value of 1,020m euros.

26 Quoted by CICTAR, Extracting Profits Through Care Home Real Estate: The Billion-Pound Property Speculation Fuelling Britain's Care Crisis, Kotecha V., Centre for International Corporate Tax Accountability and Research, 2023

This includes homes operated by Maria Malaband and Care UK in Scotland. The complex nature of its triple net[27] rental contracts ensures that the tenant takes the risk of empty spaces and any increase in buildings related costs. Rents are also index linked so that they rise with inflation, placing further pressure on care home operator tenants to keep staff costs as low as possible and to maintain high occupancy levels.

4.10 CICTAR estimates that Aedifca recovers rental income of £6,748 per annum per bed space with an EBIT[28] profit margin of £5,635 per resident per year or £108 per week, which is 12% of the weighted average weekly fee paid and an 83% EBIT margin. The report quotes the company's 2022 annual report as saying 'We consider that the group EBIT margin is applicable to the UK, which has the highest gross yields of all countries'.[29]

4.11 Government intervention to force private operators to offer better pay and conditions would no doubt be welcome to care staff but under the current model would inevitably lead to demands for a major increase in fees for council funded residents. Any increase in fees would go at least in part to maintain yield levels for investors. If providers were to go out of business this would create a shortfall in supply, which, in turn would create inflationary pressures in a market where demand is more or less constant.

4.12 It is sometimes argued that the marketisation of public service provision drives efficiencies to ensure value for money for the public purse. The theory is that market competition pushes prices to the lowest level at which only efficient suppliers are able to survive. The loss of some public funds to private profit is seen as a price worth paying to push costs down to the lowest level at which the services, as specified, can possibly be provided.

4.13 There are a number of reasons why this simplistic view of markets does not hold true in general but it is particularly problematic in relation to essential public services, where the relationship between supply, demand and prices is not a straightforward one.

4.14 In a market with so called 'perfect competition', i.e., where suppliers are able to enter and leave at will, prices will fall to the lowest level

27 A lease agreement that makes the tenant responsible for all the running costs of the property including taxes, maintenance and buildings insurance

28 Earnings Before Interest and Tax

29 Extracting Profits Through Care Home Real Estate: The Billion-Pound Property Speculation Fuelling Britain's Care Crisis, Kotecha V., Centre for International Corporate Tax Accountability and Research, 2023

that allows efficient firms to cover their costs (which includes profit at a level that keeps them from switching to a market that offers better returns). Inefficient firms go out of business and efficient ones are motivated to constantly seek further reductions in their costs. Prices can also rise though to encourage new suppliers to meet higher levels of demand. In a normal market demand is sensitive to price increases and is therefore dampened by price rises. In this way price operates to balance supply and demand and, according to the theory, to ration finite resources, whilst at the same time, providing an incentive for firms to bear down on cost to ensure success against the competition.

4.15 In practice, most markets do not operate this way. Firstly, there is no such thing as perfect competition. There are barriers to both entry and exit to markets which act to reduce competitive threat. In many markets this can include incumbent suppliers actively organising to make it difficult for new companies to become established and in others, reflects barriers deliberately erected by buyers. The former includes strong trade associations and effective lobbying for industry standards, whilst the latter includes standardisation, onerous procurement systems and lengthy contractual terms. All of these things might be desirable in a different context but nonetheless, distort the relationship between demand, supply and prices.

4.16 In the case of goods or services that are seen by buyers as essential, the lack of effective supply side competition is compounded by an absence, or reduced level, of so-called price elasticity on the demand side – essentially rising prices do not lead to a reduction in demand for the goods or services concerned; buyers reduce demand for other non-essential goods and services first. This can be seen clearly in local authority expenditure data from the period after 2009 when spending on social care was far less affected than spending on neighbourhood services, for example, as austerity impacted on council budgets.[30]

4.17 The market for social care is characterised by both high supply side barriers to entry and demand that is insensitive to increasing prices. In investment jargon it is part of the so-called defensive sector, seen as a safe haven for investors, precisely because demand holds up in times of uncertainty. For this reason, it is

30 See 'Redefining Neighbourhoods, New Policy Institute, for APSE, April 2017 for a detailed analysis of how austerity impacted far less significantly on Social Care than on other council services.

not safe to assume that the existence of competition will ensure efficiency. Nor, for the reasons discussed above, is it right to assume that overall margins are low just because they are low or negative for front line provider companies.

4.18 Aside from the unlikelihood of marketisation delivering lowest cost, the use of private suppliers to deliver public services can raise overall cost in ways that are not always apparent. These are discussed below:

Loss of Economic Value to the Local and Scottish Economies

4.19 As discussed, the dominant financing model in the private social care economy sees something in excess of 20% of income leak from the care system itself to the owners and financiers of the operators. Most, if not all of these, are located outside the areas of the councils providing funding and in many cases outside Scotland.

4.20 In Scotland there are over 5,000 regulated services with an estimated direct economic value of £3.4bn and a gross value added (GVA) of over £5bn.[31] The loss of value associated with the investment model is therefore significant and will persist whilst care establishments continue to be owned by property speculators. Bringing a greater proportion of them into public ownership would directly impact on the proportion of expenditure on care that leaves the economy and further add to the significance of the industry to the Scottish economy.

Hidden cost of contract management and procurement

4.21 The cost of outsourced services is frequently expressed in terms of payments made to contractors. In fact, this is only one side of the cost equation. The other is the cost associated with client activities. Client-side costs include procurement costs and contract management which can be high, particularly when supplier performance falls short of requirements or expectations. Contractual mechanisms can be cumbersome, with attempts to invoke them often escalating into protracted and costly legal arguments. Clients can be reluctant to make use of penalty clauses where these will cause financial difficulties for suppliers and increase the potential for already precarious organisations to fail, as when they do, contractual supply-side risks generally revert back to the council or other public contracting body.

31 Scotland's Care Sector: an Economic Driver, Biggar Economics, Enable Scotland, 2021

Cost of 'picking up the pieces' when providers fail

4.22 In a theoretical market with perfect competition, the failure of inefficient suppliers is an essential aspect of how it works. Suppliers which are unable to cover their costs at the market price go out of business, to be replaced by ones that are better able to control their costs. In private markets this may inconvenience buyers (and of course, be catastrophic for employees) but in most cases is recognised as part and parcel of the economic system. This is not the case though where the service provided is a public service, particularly one that those in receipt of it have a legal right to. If a private care provider fails, the public body on whose behalf it is provided has no choice but to make alternative arrangements. The expense associated with this and the potential disruption to care recipients provide an incentive for public bodies to agree to fee increases to try and prevent failure but where it does happen, as in the case of Southern Cross, it is still likely to lead to increased cost.

4.23 The experience of Pembrokeshire County Council in Wales, faced with the uncertainties that arose when Allied Healthcare ran into difficulties, is a good illustration of how precarious outsourcing arrangements can be, even with a major and apparently secure supplier. Allied Healthcare was a typical example of a complex company structure. In 2015 the main service provider for domiciliary care in the group, Nestor Primecare Services, recorded revenue of just over £200m and a profit of £17m. The following year, on a similar turnover, it made a loss of £13m. The loss related to the non-payment of money due from other companies within the group and the purchase of the group by German Company Aurelius SE & Co KGaA.

4.24 In May 2018 Nestor entered into a Company Voluntary Agreement (CVA) with its creditors, which was followed by the Care Quality Commission issuing a so-called Stage 6 Notification, informing Local Authority customers that the company was at risk of failing. It went into administration in November of that year, creating major problems for its customers, its workforce and its clients. Pembrokeshire had already agreed in principle that creating an in-house service would remove some of the uncertainty created by wholesale reliance on private companies. The news that one of its suppliers was in imminent danger of failure reinforced this view and the Council moved quickly to create stable provision with a key aim being to secure the employment of the care workforce before they voted with their feet and sought alternative employment outside the care sector.

Inflationary impact of contract failure when there is no public sector alternative

4.25 Where providers fail and alternative arrangements have to be made quickly, it is very likely that they will be more expensive than the services they are replacing. This is because of reduced competition and the urgency with which arrangements must be put in place. With no capacity for direct provision, councils can be forced into short term contracts with inflated prices. Low pay and poor working conditions lead to difficulties in recruitment and retention, compounding the inability of providers, both public and private, to develop new capacity. This was one of the key factors that led Pembrokeshire to set up its in-house service.

Costs arising from high churn rates – training, recruitment etc.

4.26 Low pay, demanding work and onerous conditions inevitably mean that jobs in care are less attractive than many alternatives paying similar wages. There is no doubt that many people choose to stay in the sector, despite this, for vocational reasons but many nonetheless leave for better pay and conditions in less demanding employment. The result is high churn rates and consequentially high recruitment and training costs. These costs feed through into fees as providers seek to recoup costs. High levels of staff turnover also impact on the quality of services and have an adverse impact on many service recipients for whom continuity of carer is particularly important.

Cost to public purse of propping up low pay – benefits, reduced tax return etc.

4.27 Low pay reduces the costs to operators but creates costs for society. In-work benefits are essentially subsidies to low wage employers. Statutory minimum pay helps but many care workers are part time and have insecure employment, meaning that they often have to rely on universal credit to pay for housing costs and to make ends meet. There is an inverse relationship between provider costs and the cost to the public purse. The lower the pay bill, the higher the cost to society of supporting employees. Whilst some of this is offset by savings in fees, the economics of the care system mean that only the financiers benefit from low pay. Those who actually provide the care survive on low pay compounded by working conditions that can see them denied compensation for travel time, sleep-in supplements and even sick pay.

Tax revenue lost to 'tax efficient' structures

4.28 As discussed above, front line operators often work on low and in some cases, negative margins; they therefore pay little if any corporation tax. This can be beneficial to both the holding companies and the ultimate funders of care companies which can be private equity companies located outside the UK. In some cases, the various companies involved can be part of the same group and adopt structures purposely designed to minimise tax. They may argue that such arrangements allow them to operate at fee levels that would otherwise have to be higher but any savings to the public purse must be off-set against tax that is avoided.

Hidden subsidy paid by self-funders

4.29 As fees rise and public spending is squeezed, the thresholds for access to publicly funded provision have risen. The result is that many people are forced to fund their own care and many more find themselves having to top up the funding that comes from the council – over half of UK care revenue comes from private individuals. There is abundant evidence that many care homes are dependent on this source of funding and that self-funders pay higher fees for the same level of care as those that are funded by the council.

Disincentives to prioritise prevention

4.30 Although it is now universally recognised that providing for low level needs that fall short of personal care can prevent or delay the need for much more costly hospital admissions or entry into residential care, this is not always reflected in practice. Councils rarely provide help with things like cleaning, minor repairs, gardening and shopping, although there has been some progress on the development of mechanisms for transferring funding from the NHS to broadly preventative services, such as leisure, parks or libraries. In some areas of the country GPs are able to access leisure services on prescription, for example. On the whole however, the trend has been the other way, with council budgets suffering the brunt of austerity cuts and, in relation to domiciliary care, a steady increase in threshold requirements for service provision. So, whilst there are a few excellent examples of how help with household tasks can mitigate the need for formal care services and delay the need for residential provision, these are not widely available free of charge and not usually provided by local authorities.

4.31 In so far as public provision is concerned, the creation of joined up bodies (in Scotland the IJBs) to provide a vehicle for the

development of cross-sector strategy is an overt recognition of the need for a seamless approach but the structure of the care economy continues to incentivise investment in buildings-based services over the development of low-level care services. It is clearly not in the interest of the vast bulk of residential care providers to prioritise the scope or quality of domiciliary care, and, by extension, preventative personal or general public services. The commercial viability of residential care depends on constant demand with most operating on an assumption of 80% or above occupancy levels. The vision of seamless integration is unlikely to be realised in a system where the priorities of suppliers are unaligned with those of purchasers.

Fragmented provision

4.32 Whilst privately owned provision maintains its highly dominant position, there is no counterbalance to a model that inevitably prioritises return on investment over the well-being of carers or those they care for. Major expansion of publicly owned and operated provision, capitalised through public borrowing, would create that counterbalance by creating a financially transparent alternative to the opacity of the private market.

4.33 Interest rates on public sector borrowing are typically considerably lower than those available to private borrowers. Even without the inflationary impact of speculative investment in residential care, the capital cost of council provision is substantially lower than that of private investment.

Domiciliary Care

4.34 The home care business is very different to residential care in that it is comparatively asset light. It is nonetheless subject to similar drains on income, pertaining to debt incurred through speculative acquisitions and the balance sheet value of intangible assets such as goodwill. Goodwill typically refers to the perceived benefit that flows from being part of a group, amortised over maybe twenty years and charged to the operator's balance sheet.

4.35 Holding companies strip income from operators, creating strong imperatives to minimise operating costs, which are mostly staff costs. Low hourly pay is one element of this but evidence from care workers indicates that pressure to reduce costs also impacts on clients through practices like clipping, whereby insufficient time is allowed for travelling between clients which then eats into the time the carer is able to spend with them.

4.36 Home Instead is a national provider of home care services with several branches in Scotland. This company is part of a very complex structure, headed up in the UK by HI Global Holdings Ltd., which, through its subsidiary, Home Instead Ltd., acts as a franchiser to 250 UK franchisees, operating under the Home Instead brand. HI Global Holdings is ultimately controlled by Honor Technology Inc., a US Corporation that has been described as the world's largest senior care network and technology platform. When it acquired the US based Home Instead Inc. in 2021 it created a $2.1bn global home care service and 'affirmed itself as the largest player in the projected $500 billion homecare industry'.[32]

4.37 Home Instead provides a wide range of services to a range of adult clients. There is no reason to believe that its services are not satisfactory or that there is anything untoward about it being part of such a huge global network of care providers. The example is given to illustrate how adult social care in the UK is moving away from the public service model, even whilst it accounts for substantial amounts of direct public expenditure.

4.38 The Cera Care Group is another large company with a number of branches in the central belt of Scotland. Through its recent acquisition of the Mears Group's activities, it became the largest private employer in Scottish domiciliary care with just over 1,000 staff.

4.39 Cera is a rapidly growing European company, headquartered in London which describes itself as a 'digital first' healthcare-at-home provider with interests in care, nursing, telehealth and repeat prescriptions through its app. It claims to provide healthcare services to over 15,000 patients a day across the UK and Germany which it says is the equivalent to 40 NHS hospitals or 1,000 care homes. 'By 2025, Cera aims to serve 100,000 patients every day'. Its rapid growth (100 fold in three years) is funded through private equity investors, including Schroders Capital, a British multinational with global interests in a wide range of industries.[33]

4.40 The recruitment to Cera's leadership team of Executives from Deliveroo, Just Eat and Amazon may indicate the direction of travel towards a care future where profits are maximised through

32 Honor Acquires Home Instead to Transform the Senior Care Experience. August 2021

33 https://www.uktechnews.info/2022/08/04/cera-secures-260-million-investment-from-investors-including-kairos-hq-and-schroders-capital/

the minimising of human contact, all managed through an app-based system.[34]

4.41 Cera also now owns Allied Health Care. This was the provider in Pembrokeshire before the council made the decision that insourcing the service was the best way to ensure its future and to head off the likelihood of its staff leaving the care sector for more certain employment opportunities elsewhere.

34 Cera makes new executive hires from Deliveroo, Amazon and Just Eat (homecareinsight.co.uk)

5 Summary of the case for public provision

5.1 It is widely acknowledged that the current care system in Scotland and the rest of the UK is not fit for purpose.[35] Whilst private sector providers may argue that this is a function of fees being set too low, there is good reason to believe that simply increasing them will not on its own fix the problem. The way the market operates would see a significant proportion of any increased expenditure pass through as charges, fees and return on investment to the speculative investors who rely on inflated capital values to extract income from hard pushed operators. Without a dramatic increase in directly provided care services this is not likely to change, and the public is unlikely to get good value for the very significant levels of spending on this vital service.

5.2 The success of the NHS in replacing a broken private healthcare system with a universal, free at the point of delivery, comprehensive service, clearly illustrates the central significance of direct provision. Without it there will be an inevitable continuation of a multi-tiered service, leaving it well-short of what most would expect a National Care Service to provide.

5.3 Without a core of public provision, a national service cannot be anything more than a nationally commissioned service – simply a shift from local commissioning to national commissioning.[36] Whether this would improve standards or otherwise is a moot point but what is clear is that it would not fundamentally change the failing system of commissioner/operator/holding company/financier. If Scotland is to achieve the radical change ministers have promised it must include 'publicly provided' as a necessary element of a National Care Service.

5.4 It is very difficult to see how the much-vaunted ambition to create a wraparound service that can be truly person centred can ever be achieved in a system that depends on market mechanisms for major elements of it. Markets provide what is profitable to suppliers and investors and in a complex system like care, are highly unlikely to offer the full range of preventative, integrated services envisaged in the Scottish Government's vision for social care.

35 "The current social care system is in crisis and not fit for purpose." Labour, 2019. Social care system 'unfit for purpose' Anne Longfield, chair of the Commission on Young Lives and the former children's commissioner, 2021 Social care system 'not fit for purpose', say nine out of 10 MPs, The Independent, 2017

36 Whilst the term "commissioning" refers to an approach that is technically provider neutral it is widely associated with the letting of contracts to third party suppliers.

5.5 As discussed, the Feeley Review makes a point of recognising the moral argument for removing the profit motive from social care:

'We ..... want to record here that we share the unease expressed by many about whether it is right – in a country committed to health-care free at the point of need to all of its citizens, regardless of age or any other characteristic – that an important part of our care system is largely run on a profit-making basis'

5.6 On the face of it, this is support for a publicly delivered alternative, but the report is equally firm in its rejection of this as the answer. Instead, it calls for ethical commissioning and procurement. This is a concept which will have wide ranging support but it is difficult to know what it means in practice. Transparency and equality of access to public contracting opportunities are core principles of international trade agreements. As it stands, EU legacy rules make it very difficult to prefer non-profit or UK based suppliers in any way that fundamentally interferes with rights of access to UK markets and the ability to make profit of firms from other member states.

5.7 Even whilst the UK has left the EU and is no longer bound by its Directives, it is heavily invested in the pursuit of trading partnerships with other economic blocs. US-based companies have shown a particular interest in the UK health and social care markets. Pre-Brexit they were largely prevented from accessing the health element of this but a future relaxation of restrictions seems more likely than not. In this context it is difficult to see the UK adopting any meaningful measures that would remove profit from care services or perhaps more significantly, from investment in social care providers and social care real estate.

5.8 Within the parameters of the EU Public Contracting Regulations, the UK governments have made several changes to procurement practice aimed at widening selection criteria beyond price. The concept of best value (or in procurement jargon Most Economically Advantageous Tender) allows and to some extent, requires contracting authorities to take account of wider factors, including social value and the local economy. The Procurement Reform Act 2014 and associated statutory guidance e.g., on Fair Work, are good examples of how the Scottish Government has actively tried to enshrine ethical principles into procurement practice. The EU Regulations even allow for contracts to be reserved, at least initially, to social enterprise type providers.

5.9 How far these measures have been effective is a moot point. They have made little difference to the balance of provision of social

care. The growing involvement of global capital in the sector suggests that the services continue to generate good returns to investors. They may have benefited care workers to some extent but as is universally acknowledged, pay and conditions still lag behind those of publicly employed comparators.

5.10 Despite the minimal impact that attempts to put wider social value considerations at the ethical heart of procurement practice have had, they are nevertheless strongly resisted by supporters of market solutions. The English Social Value Act 2012 is a good example of measures which, despite a limited impact, are nonetheless the subject of scathing criticism on the grounds that they are unaffordable and damaging to small businesses.[37]

37 The Price of Everything, The Social Value of Nothing, Maxwell Marlow, Adam Smith Institute, 2023

6 Affordability

6.1 The Feeley Review is very light on assessment of alternative options for delivery. It dismisses public provision as unaffordable based on what appears to be limited, somewhat anecdotal, evidence:

'We have considered public value and how much it would cost to take the social care sector into public ownership. Examples such as the purchase of Home Farm care home in Skye at a cost to the public purse of £900K during the Covid-19 pandemic suggest that nationalising the sector would require an unaffordable level of public outlay, particularly in terms of investment in capital.'

6.2 Aside from ignoring the overwhelming public well-being case that led NHS Highland to take ownership of Home Farm,[38] assessing affordability in these terms is misleading. The capital cost of an asset is a relevant factor, regardless of who owns it, but affordability relates to the revenue cost of the capital involved. This can either be the direct cost of capital (debt), where the asset is owned, or to rental payments, where it is not.

6.3 This report includes multiple examples of how inflated capital costs create revenue pressures for private sector care companies. Leveraged buyouts by private equity investors, purchase and lease back by specialist real estate speculators and complex company structures, designed to syphon cash away from the point of delivery to ensure profits further up the chain of ownership, all mean that the capital cost of private care is higher than it would otherwise be. The cost of capital to the public sector is not inflated through any of these mechanisms but even if they were not a factor, costs would still be lower, as the public sector has access to preferential interest rates.

6.4 If the question of affordability, as Feeley suggests, was solely about capital, the financial case for increasing public ownership would in fact be overwhelming. Lower capital costs and an end to the significant leakage of money spent on care from local and in some cases, the national economy, are compelling reasons for moving to a publicly owned model. But the financial stumbling block is not capital cost; it is the cost of staff.

38 The move was prompted by the death of 10 residents during an outbreak of Covid 19 which was the subject of a scathing Care Inspectorate report and led to legal moves to have HC One removed as provider. Although this was later discontinued following an improvement at the home, the Care Inspectorate was supportive of the move by NHS Highland to take Home Farm into public ownership.

6.5 As the Feeley Review and virtually every other recent analysis of social care acknowledges, private sector care workers are under rewarded by comparison with colleagues in the public sector, both in terms of pay and pension provision. It is this that drives the commonly held view that publicly provided care is unaffordable. Bringing care workers into local authority or health service employment would add 20% to 30% to the pay bill. Access to public sector pension schemes on its own adds around 16%.

6.6 Ignoring the cost of capital, direct running costs are undeniably higher in the public sector than in the private sector. However, cost is not the same thing as price. In a market, prices are a function of competitive pressure, not cost. Economic theory postulates that the proximity of prices to costs depends on the relationship between supply and demand. In so called perfect competition, where supply matches demand and firms can enter or leave the market easily, prices will fall to the lowest level at which firms are prepared to stay in the business concerned. This level will be one at which suppliers are able to meet their costs, service their debts and generate a level of return that is sufficient to retain shareholder confidence.

6.7 Even in perfect competition then, prices will be higher than operational cost but the complex nature of markets for public services further erodes the relationship between unit cost and prices. As discussed above, suppliers may price at a level that returns a low, or even negative margin to them but which is still significantly higher than the direct costs they face, because they are obliged to service high levels of debt, incurred because of their own acquisition, or for capital to fund expansion.

6.8 Extraction can add 20% to 30% to operating costs. Aside from inflating prices, the model also creates an imperative for front line providers to minimise those costs that are under their control, impacting directly on both the front-line workforce and the quality of service. In these circumstances the higher staffing cost, publicly provided alternative, could be far more price competitive than might be first assumed. Moreover, the total cost of external provision also includes client-side costs associated with procurement, contract management and supplier failure that would not be incurred under direct provision.

6.9 The precarious operating environment in which many operators struggle to survive but which nevertheless continues to attract private equity investors, drives up the cost of social care but does little to address low pay and the associated recruitment and

retention crises. The potential for supply side failure inherent in this situation creates risks for service users and public authorities alike. For public authorities these risks are partly financial and should also be factored into any comparative cost appraisal.

6.10 A further related factor is the inherent dependency of residential care providers on high occupancy levels. In many cases, financial viability requires 85% or higher occupancy. There is therefore little incentive for these suppliers to participate in initiatives aimed at enabling users to remain in their own homes for longer. Moreover, provider profitability increases as users progress from the least costly option of basic home support, right through to the most costly, long term nursing care. This is not to suggest that residential social care providers act improperly but if it is accepted that prevention and reablement, coupled with high quality, effective domiciliary services are inherently desirable, including for reasons of cost, there is a prima facie case for designing a model that reverses this systemic bias towards residential services.

6.11 All these factors make it difficult to properly explore the financial case for increasing the level of direct care provision. It is nonetheless the case that the UK care market continues to be attractive to global investment funds. This is prima facie evidence that current fee levels are capable of delivering returns to investors in those funds. In the case of residential care, it is difficult to untangle the real estate element of this but the presence of global companies, including in Scotland, in the domiciliary care market indicates that social care is an attractive financial proposition, even without the return on bricks and mortar assets.

6.12 Whilst many front-line providers clearly do struggle to remain viable, this continued interest from hard-nosed investors suggests that the problems they face relate to the costs associated with the investment model, rather than the income they receive from front line provision. In these circumstances it is wrong to assume that the additional costs associated with direct employment make publicly delivered services unaffordable.

6.13 This report does not argue for wholesale ‘nationalisation’ in the sense that Feeley uses the term – a big bang, forced transfer of private care provision assets into public ownership. Such an approach could lead to sudden disinvestment which would be destabilising and counterproductive. A more sustainable strategy would be to support and encourage local authorities, NHS Boards or Care Boards to actively consider the case for expanding direct provision through a planned approach. This can be achieved

through the buyout of going concern providers on the open market, as in Halton. It can also be achieved through the takeover of failing providers as in Pembrokeshire and Trafford. In either case the purchases were part of a deliberate strategy to rebalance ownership and provision of social care.

6.14 The development of brand-new provision would also be a good approach to entering the market. Local authorities and NHS Boards often have significant land holdings on which care homes, care hubs or day centres can be built at relatively low cost.

6.15 Although capital savings can be expected to reduce running costs for public facilities by comparison with private sector ones, staffing costs, as discussed above, would be higher. How far the one offsets the other will vary but given that improving the terms and conditions of care workers is an overt policy, central to the NCSS proposal, it would not be unreasonable to expect any net increase to be met by the Scottish Government. The cost of doing so is likely to be lower than it would be to provide a similar level of enhancement to privately employed care staff as there would be no offsetting savings in other costs in relation to these providers.

6.16 One of the biggest barriers to the development of in-house provision for local authorities is the need to move from being primarily focussed on being a purchaser of services managed by others to being a supplier. Direct service management skills and commissioning skills are not always interchangeable. Many Scottish local authorities are already providers of domiciliary care and some also operate residential services. In these cases, rebalancing in favour of publicly provided services will be less challenging than for those creating services from scratch. For these there will be an initial spending requirement which may increase overall cost for a period whilst an appropriate balance between commissioning and provision is established.

7 Conclusions

7.1 There is widespread recognition that the current provision and funding model for social care in Scotland is not delivering key policy objectives as fully or as quickly as needed. Care providers are struggling to retain enough income to remain commercially viable; care staff are demoralised and difficult to recruit and retain; services are patchy, with many care recipients forced to top up fees to secure residential care or left with minimal, effectively residual, domiciliary provision.

7.2 The cost to the taxpayer goes well beyond that of care itself. The link between high quality, domiciliary care provision and the likelihood of elderly people requiring hospital care is well established, as is that between the time an elderly person spends in hospital and the availability of convalescent care, either in a person's home or in a residential facility. Preventative domiciliary care is generally recognised as being preferable to reactive health care and fit for purpose, residential provision, an essential element in a seamless wrap around package, that makes best use of public funds and looks after people when they most need it. But the social care system is fragmented, inconsistent and often not integrated with the other services that make up the Scottish welfare state.

7.3 The economics of social care are hopelessly entangled with the economics of real estate. A capitalisation model that relies heavily on private equity leaves providers exposed to cost pressures at the delivery level. These companies are very reliant on high occupancy levels and, to remain viable, they have little option but to try to push costs down to their lowest possible level. Given that staffing is the biggest controllable cost, it is inevitable that front line care workers suffer the brunt of this, not just in terms of pay but also working conditions, job security and pensions. By comparison with their council and NHS counterparts, private sector care workers are the second-class citizens of the caring professions. It is therefore unsurprising that the sector faces major recruitment and retention issues.

7.4 These issues will not be addressed by simply replacing local authority commissioners with nationally appointed commissioners. Nor, given the nature of the social care economy, will they be fully addressed by an increase in funding. Such an increase is no doubt needed, along with a fair mechanism for achieving it, but any increase in guaranteed income will drive up the capital value of care firms, making them even more attractive as targets for merger and acquisition and all that means in terms of debt charged to balance sheets and the drain on care home income

and by extension, the public purse. The likelihood of increased expenditure leading to any major improvement in the terms and conditions of care workers seems slim.

7.5 Given that low pay and pension provision is clearly identifiable as a significant factor in the failure of the current system, an increase in front line costs must be factored into any solution. For this to be affordable it is vital that the issue of leakage from frontline income is tackled. As discussed above, it is particularly important to ensure that any increase in public spending on care services does not go to shore up yields to speculative investors looking to profit from the Scottish taxpayer.

7.6 The interdependency of health and social care is well understood and clearly reflected in the vision of the Scottish policy framework. It is difficult to really know how much an improved and effective care service would cost but what is clear is that a large part of this cost could be offset (potentially fully off-set) by cross-sectoral efficiency gains.

7.7 Just increasing the level of care to a level that would allow the timely discharge of elderly hospital patients could save the public purse many millions of pounds in delayed discharge costs. But to create a fully integrated system that could drive end-to-end synergies, from low-level preventative home help, through to post hospital residential care, requires a degree of joining up that is unlikely to be achieved in a system that has hundreds of different suppliers, each with their own organisational goals and objectives which, in many cases, have little to do with the efficacy of the health care system as a whole and, as discussed, often end up prioritising yield to investors over the well-being of those in their care.

7.8 It is difficult to envisage a solution that does not involve a major expansion of public sector provision. Creating a critical mass of publicly employed care workers would be the best and most affordable way to push up the terms and conditions of this neglected section of the workforce, without creating an immediate crisis for frontline care companies. This could transform the sector and deal with the crisis of recruitment and retention that limits the ability of the sector to expand to meet rising demand and creates an associated crisis for the NHS.

7.9 Bringing care staff into the employment of councils or the NHS would improve rates of pay and working conditions and give access to decent pensions. The private sector would have to respond to remain competitive but with more public provision

available, pressure to increase fees would be lessened. Expanding public sector provision would also act to check the inflationary impact of merger and acquisition by ensuring a significant proportion of care is provided in buildings funded through lower cost public sector capital.

7.10 A National Care Service that does not incorporate a renewal of public sector provision will miss a major opportunity to move away from reliance on a market that increasingly works in the favour of disengaged private investors at the expense of the Scottish public and economy. Whilst funding can and should be increased, the impact of doing so will be reduced from what it could be if the extra funding ends up in the pockets of real estate investors and the often, non-UK Companies that sit above the complex commercial structures that characterise the industry. If this market model is allowed to continue, care workers will remain underpaid and there will be no end to the pressure on companies at the delivery level to follow a lowest-cost delivery model.

8 The way forward

8.1 The Feeley Review rejects wholesale nationalisation of current provision on grounds of affordability. This conclusion misses the point that insourcing of previously contracted out services rarely involves taking over private companies.

8.2 Contracts come to an end, at which stage there is always an option to bring them in-house. In the case of social care, contracts are often for short-term blocks of provision, drawn down from framework agreements. There is no reason why this cannot be replaced or supplemented with direct provision, as and when it becomes available. In this way, remunicipalisation, to use the jargon of the Glasgow University researchers, can be achieved on an incremental basis as part of a cohesive strategy to rebalance provision in favour of public delivery.

8.3 Local authorities are well used to following a business case approach that considers new ventures, including insourcing projects, on their merits. In this way they take proper cognisance of the strategic aspects of the move as well as operational and financial implications. The examples of adult social care insourcing referred to in this report were all carefully considered and subject to due diligence. Without a compelling evidence base they would not have gone ahead.

8.4 The exact way that strategy and delivery will work under the NCSS is yet to be determined but the Verity House agreement bodes well for a system that balances a national framework with local need and accountability. It is at the local level, whether led by IJBs/Care Boards, local authorities, or the NHS, that rebalancing of provision should take place, but the NCSS offers potential for this to be driven by a National Strategy.

A National Insourcing Strategy

8.5 The basic building blocks of such a strategy could be:

- Strategic level recognition of the benefits that would flow from rebalancing in favour of public sector provision. This includes recognising that improvements to the terms and conditions of care workers will be more affordable without the current level of leakage of care funding to private profit and yields to investors.
- Support to local authorities and/or IJBs/Care Boards to develop business cases for insourcing.
- Financial capital support, subject to sound business cases, to facilitate the development of public sector care infrastructure,

including the purchase or new build of residential facilities.

- Initial revenue support to recognise the transitional costs of creating supply capacity in local authorities that are currently geared up solely or primarily for commissioning.

For more information

UNISON Scotland National Care Service campaign

UNISON Scotland Positive Vision of a National Care Service

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