Towards a Real National Care Service for Scotland

SUMMARY REPORT

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This report looks at how we can build a National Care Service for Scotland worthy of the name. It was commissioned from APSE, the Association for Public Service Excellence. Drawing on APSE's work with local authorities across the UK the report makes the case for the direct public delivery of social care and maps out the first steps that can be taken to achieve this.

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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 Integrated Joint Boards/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 a National 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.

For more information: www.unison-scotland.org.uk/national-care-service-campaign

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