THE STATE OF RESIDENTIAL CARE SUPPLY IN ENGLAND:
LESSONS FROM PSSRU'S MIXED ECONOMY OF CARE
(COMMISSIONING AND PERFORMANCE) RESEARCH PROGRAMME

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EXECUTIVE SUMMARY

Residential care for older people in England faces some major challenges. These include local authorities’ constrained abilities to pay ‘reasonable’ fees, limited opportunities for independent sector providers to earn profits sufficient to entice or keep many of them in this particular market (with tougher times ahead as national and European employment directives take effect), and with the quality standards now being implemented by the National Care Standards Commission (NCSC) with their major attendant cost implications.

The purpose of this paper is to summarise findings drawn from the Mixed Economy of Care research programme (‘MEOC’, now transformed into the ‘Commissioning and Performance’ programme) in order to understand the nature of the situation in more depth. Little of the work in the programme was initiated with the intention of looking at care home closures per se, but the evidence on, for example, supply propensity, provider motivations, commissioning styles and contract forms has relevance for the discussion of them.

This paper argues that the supply of residential care needs to be understood as part of a social care system in which micro-, meso- and macro-level considerations all come into play. At the macro level are the local and national political economies in which provision is embedded, which shape what is possible in local social care markets. At the meso level are the institutions created by public purchasers as they design contracting regimes, as well as the less visible ‘relational’ aspects which take shape in this context. Together these mediate resource flows, of course, but also create the environment for feedback, recognition and trust.

At the micro level we can see how most providers have had little choice but to adapt to increasingly hegemonic local authority demand. Many providers are today heavily reliant upon their local SSD purchasers and - over time - have typically found themselves accommodating increasingly dependent residents, many of them with mental health problems, at fee levels that generally are not keeping pace with costs. Three important micro-level dimensions are motivations, profits and price levels. Across the care homes market one can see ‘knightly’ (altruistic), ‘knavish’ (financial gain) and ‘mercantile’ (autonomy and control) aspects to providers’ core motivations. They tend to come in particular packages: most independent providers can be portrayed as either ‘empathisers’ or ‘professionals’, for whom the goals of meeting clients’ needs and professional accomplishment are given more weight.
than financial performance. Income generation is a means to these other ends rather an end in itself. There are also a few providers in a third category - ‘income prioritisers’ - whose motivations are more oriented towards monetary reward.

The potential profits for a theoretically fully profit-oriented operator in this care homes market were extremely low by economy-wide standards in the mid 1990s. They would almost certainly have declined further since then, not just because of the continuing efforts of local authorities to contain fees despite the rise in resident dependency levels, but also because many providers face local labour market difficulties. On cost grounds alone, the labour-intensity of residential care makes this situation worrying. But the relational nature of the social services - where the quality of care is so contingent upon the skill, experience and personality of the carer - must raise serious concerns about the achievement of outcomes (in terms of client welfare). Because providers appear only able to afford to pay low wages and continue to invest too little in staff training, the workforce is basically low-status, high-turnover, and largely untrained.

Providing the encouragement or wherewithal for public sector purchasers to pay higher fees would be an obvious advantage in these circumstances. Meso-level interventions might also help: Providers would quite naturally like to face less uncertainty, to which the response could be some degree of price contingency in contracts and greater predictability in relation to quantities purchased. In other words, contracts could be agreed that smoothed providers’ revenue flows and demands. There has been rather limited use of ‘contingent’ pricing procedures in social care markets to date, designed to respond to variation in client dependency at the time of admission and/or to reflect how dependency changes subsequently, although providers express preferences for such arrangements over fixed-price agreements. They express less enthusiasm for contract types that offer guarantees as to the future level of local authority demand, such as ‘block contracts’, despite the fact that this would potentially lower the risk they carry. One reason is that such guaranteed arrangements could undermine a provider’s control over admissions, frustrating their desire for autonomy in running their business. Another fear is that it could reduce user choice by limiting supply-side diversity.

Finally, the paper reviews how far social capital (including trust) - which can be seen as an external ‘factor of production’ - has been generated by local contracting regimes. On the positive side, few providers report difficulties in relation to delayed payments or delayed assessments (at admission or subsequently). Moreover, purchasers have learnt that the ‘knavish’ side of motivation is not dominant, and that ‘knightly’, caring and empathetic goals are important drivers. Set against this improved level of trust, there were other factors which have undermined the maturation of purchaser-provider relationships. Foremost among them has been a failure to account for the ‘mercantile’ motivation among providers when designing contracting regimes, leaving providers with a marked sense of facing over-bureaucratic, dirigiste procedures. There were also some practical problems, such as providers feeling they were not adequately consulted about placements and reporting difficulties with key local authority purchasing staff. A third source of unease was a diffuse sense of ‘unfairness’ regarding local contracting regimes in cases where user choice appeared to be frustrated because (often) ‘in-house-first’ policies were still operating. When coupled with concerns that prices were ‘unreasonably’ low or inflexible, the result has often been loss of faith in the local authority and a ubiquitous sense of resentment and distrust.
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1. BACKGROUND

Trends in residential and nursing home markets, especially the rapid closure of a number of facilities in some localities, are raising concerns about the abilities of local care systems to meet the needs of older people in a timely, effective and efficient fashion. In response, the Department of Health (DH) commissioned a number of research and review activities. As part of the review of evidence this paper summarises some findings from the Mixed Economy of Care (MEOC) programme of research jointly undertaken by the PSSRU at the London School of Economics and the Nuffield Institute for Health, University of Leeds. Although the MEOC programme has been wide-ranging, this paper is based in large part on evidence gathered in two studies (based on postal surveys with parallel interview sub-studies) of residential care for older people undertaken in 1994 and 1997 (MEOC team, 1995, 1998). The basic features of the methodology and sample are at Appendix 1. Much of this research has also been summarised for dissemination purposes in two Evidence bulletins (numbers 1 and 5) and has fed into academic journal articles (for example, see Knapp et al., 2001; Kendall, 2001).

Our two studies of independent sector residential care providers have taken place alongside research on domiciliary care provision in 1995 and 1999, relating to user choice, and focusing on local SSD purchaser attitudes and actions. This paper also draws upon that evidence where appropriate. Indeed, one of the features of the MEOC programme evidence on residential care for older people is the extent to which it allows us to contextualise that market with reference to other elements of the social care system. The other primary MEOC input into the review process has come on the purchasing side, through a special survey of ‘commissioning’ arrangements conducted in 2001 which builds heavily upon earlier work developed within the programme (MEOC team, 2001).

Two other features of the MEOC residential care provider studies generate added value, supplementing the more extensive research evidence from other PSSRU surveys (Netten et al., 1998) and Laing & Buisson’s regular survey series (Laing and Saper, 1998; Laing & Buisson, 2000). First, the studies have involved not only postal questionnaires, but face-to-face interviews with providers situated in a representative sample of local authorities in England, thus providing a valuable combination of quantitative and qualitative data. Second, we have collected evidence on some aspects of providers’ situations - expectations about future developments, the structural and relational nature of linkages with local authority purchasers, and their motivations - which is otherwise unavailable in systematic form.

Set against these advantages are three pertinent limitations. First, while great care was taken to ensure the representativeness of the local authorities and the providers, it should be acknowledged that our samples are considerably smaller than in the other PSSRU surveys or the Laing & Buisson surveys. Consequently, MEOC indicators of central tendency are surrounded by comparatively large confidence intervals, and differences in sample estimates have to be relatively large for us to be confident that they reflect differences in the population. In what follows, we therefore focus particularly on evidence and argument relating to characteristics and factors which were not addressed in other studies, and for which MEOC research provides a valuable repository of information. Second, Laing & Buisson surveys provide a longer time series, and are more up-to-date than MEOC estimates relating to basic economic data on such aspects as fee levels and occupancy rates. For these
and other reasons, findings from the MEOC data should be read alongside, and seen as complements to, conclusions that can be drawn from those other sources. Third, our empirical evidence relates to residential care homes, some of which are dual registered, but not to nursing homes per se.

2. A STYLISTED PICTURE OF RESIDENTIAL CARE SUPPLY

Figure 1 offers a representation of how residential care supply for older people in England is situated in a complex web of public and private relationships and transactions. At the micro level, the market comprises public and private demand, with which it interacts in a process that sets (observable) prices and quantities of services. This figure also draws attention to three other features. First and most obviously, product supply is dependent upon the factor market. In the case of social care, this necessarily involves heavy reliance on labour (and in the case of residential care, paid labour). Second, this market is unlike those that account for most economic activity in the sense that its performance is heavily contingent upon the activities of two public sector actors: the local authority, with its wide range of legal responsibilities and competences in this field, increasingly discharged by contractual means; and regulation and inspection by the NCSC, replacing the previous arrangements in 2002. These public sector bodies shape the meso-level and macro-level contexts thus constituting the ‘regimes’ in which care services are delivered. In this paper we will focus primarily on the contracting regime, because it is on this aspect that MEOC evidence available at the time of writing is concentrated.

The character of local authority contracting regimes influences supply in fundamental ways. Most visibly, a regime involves arrangements and policies designed strategically to influence market scope, scale and functioning. There are obvious decisions to be made as to the mechanisms for price adjustment, choices over the mix or balance of contract types, and implicit or explicit ‘competition policies’, especially those which intentionally or de facto serve to build or eliminate barriers to market entry and exit. Inter alia, these local regimes affect the distribution of risk between purchaser and provider, and hence the dynamic patterning of actual and anticipated revenue streams and profits.

But authorities also shape the regime in more low key and less tangible ways. In particular, they set up the institutions and procedures which frame mutual communication, and jointly with suppliers create the social networks which transmit information and underpin relationships. These ‘external’ linkages contribute to local systems’ functioning alongside the more obviously important ‘internal’ linkages within the immediate production process involving relationships between users, care staff, owners and managers. How these arrangements are constituted is crucial to supply, not least because, as we emphasise in what follows, providers of social care tend to be motivated not only by business objectives and the ‘internal’ rewards of meeting user needs behind closed doors. Their motivation is also

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1 To define regime, we follow Lipsky and Smith (1993) thus: ‘a set of stable relationships that transcend simple common practice and reveal assumptions about the way the world works. As we choose to understand the term, a regime is a set of ‘principles, norms, rules, and decision-making procedures around which actor expectations converge in a given issue-area’ (Krasner, p. 185). The notion of regime reminds us that normal systems of interaction, with their own rules, values, and sanctioned expectations, can and do emerge out of the regularized interactions that ultimately are sustained by the force of law’
contingent upon ‘external’ relationships with purchasers because it is through these that they can potentially achieve both recognition for their professionalism, and the right balance between respect for their autonomy, and support via monitoring and control.

**Figure 1: Residential Care Supply in Context**

That the nature of internal and external networks is relevant to supply is encapsulated in the notion that they act as repositories for social capital – propensities to add value facilitated by trust and shared understandings. To an extent, this can be thought of as a ‘factor input’ like other forms of (physical) capital. However, it is qualitatively different to the extent that it inheres in relationships between actors, rather than being associated with human and other resources which are tradable in conventional factor markets. The figure emphasises this ‘non market’ aspect by situating social capital in the bottom half of the scheme, whereas other factor inputs are visibly traded. To an extent lying behind this soft underbelly of production, in ‘production of welfare’ terms, are the ‘non resource inputs’ which affect production, including the care environment, staff attitudes and client characteristics (Davies and Knapp, 1981; Knapp, 1984). However, the concept of social capital draws our attention to the relational aspect of production. The diagram makes clear that social capital is significantly shaped by the character of the local contracting regime, and is generated by human interaction.

In sum, the quality of relationships between purchasers and providers, in terms of trust and mutual understanding, is intimately bound up with supply-side decisions. For a given set of micro market conditions in terms of costs, prices, profitability and barriers to entry or exit, different supply-side decisions (including whether to exit, invest or diversify) are likely if social capital stocks are high, compared to when social capital stocks are low. Policies which successfully nurture such relationships in a way that improves the functioning of the market
(which could involve more or fewer market exits, or greater or lesser levels of diversification depending on the particular local market conditions) can be thought of as ‘productive’ investments in social capital. The essential point is that meso-level context needs to be taken into account alongside product market, factor market and market structural considerations in diagnosing the condition of local social care markets, and assessing the policy options that follow from such a diagnosis.

A third point highlighted in the figure is the extent to which the local residential care markets and the regimes in which they develop are in turn nested within the yet wider macro contexts of broader local and central government policies, as well as wider economic influences: that is, in a wider political economy of decision making. The local political economy reflects generic policies and actions not specific to social care, but nevertheless spilling over into it. These non-social services and corporate policies of local authorities have been recognised as significant for some time. Most obviously, social services managers lean on the expertise of colleagues from finance, legal and contracting divisions in developing models for the financial and legal aspects of their relationships with providers (adopting and adapting models for contracting, jointly establishing systems for payment and invoicing). Local economic development and regeneration policies may also be of relevance, as with any generic policies on encouragement and support for small and medium sized enterprises or measures to improve the employability of local populations. Increasingly, the expectation will be that such broader policies are developed by Local Strategic Partnerships (LSPs) and reflected in their community strategies and public service agreements.

The final level, that of national political economy, captures the influence of the country-wide factors which, by design or accident, shape social care market possibilities. Some arrangements for decision making have been inherited from the previous administration. These include the SSA settlement institutions, the central government special and specific grants system, local level inter- and intra-departmental allocations, and decisions on local taxation rates (including council tax). These are all part of the national macro context. So, too are DH, SSI and Audit Commission policy guidelines, circulars and reports. The first wave of new policy influences on supply from the macro-level working their way through the system under the new government arose from the encouragement for partnership and flexibility in local authority-NHS relations following the 1999 Health Act; national implementation of generic Best Value policy for local government responsibilities; national social exclusion policy; and national employment policy, including the minimum wage and the working time directive legislation. Given the heavy reliance on paid labour in residential care, these measures significantly alter the costs faced by suppliers. Also, the 1998 White Paper *Modernising Social Services* (chapter 5) proposed development policies specifically focused on the social care workforce for the first time (see Matosevic et al., 2001, for a comprehensive mapping). The General Social Care Council and the Training Organisation for Personal Social Services will seek in the future to widen training opportunities and increase

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2 Decisions regarding how to distribute funds between client groups are part of this process. Traditionally, not only have specific and special grants from central government tended disproportionately to favour services for client groups other than older people (in the sense that such grants account for a much higher proportion of social care expenditures on those client groups), but local authorities have on average underspent on older people’s services relative to central government’s ‘indicative’ allocations (cf Royal Commission, 1998; Laing & Buisson, 2000).
levels of qualification, with knock-on effects for social care labour markets, and thus for
residential care supply.

Since 2000, against the wider backdrop of the NHS Plan and the government’s limited
adoption of the Royal Commission recommendations, a second wave of macro policy
initiatives with implications for older peoples’ care home supply has built upon the inherited
structures, and the first wave of change set out above. In 2001, the government announced an
agreement to promote ‘partnership’ including action checklists for stakeholders in care
demand and supply, and announced a new cash injection of £300 million to those local
authorities where it perceived residential care supply and bed blocking problems to be most
severe (Department of Health, 2001b; Community Care Market News, October 2001). This
tactical initiative built upon more strategic measures, including the elaboration of the
National Service Framework for Older People, associated performance assessment
frameworks, the establishment of the Care Standards Commission, and the National
Minimum Standards announced in March 2001, pursuant to the Care Standards Act 2000,
which replace the provisions of the 1984 Registered Homes Act. Most of the latter standards
are now beginning to be implemented, but those relating to single room sizes and proportion
of shared rooms are not legally required until 2007. These required standards are clearly
having a direct bearing on residential supply in imposing compliance costs on care homes
that would otherwise have been below the new national standards’ thresholds and that would
not otherwise have spontaneously upgraded their facilities.

Anticipation of the new standards was already significantly affecting local residential care
markets in 2001. At this point, the proposals were already affecting the anticipated net
present value of future income streams: ceteris paribus those homes which would be required
to incur additional costs in order to comply with the new standards post March 2001
obviously have the net present value of their expected future income stream reduced. (Indeed,
even prior to the announcement of the new standards, anticipation of the cost-raising
implications of these regulations had already prompted providers to exit the market in many
areas of the country; see Community Care Market News, March 2001.)

Finally, other factors influence supply-side residential care decisions from outside the social
care policy domain. The macroeconomic climate, and general economic policies (over and
above the employment and social policies referred to above) that contribute towards that
climate, are critical. Two particular influences should be singled out. First, the interest rate
decisions of the Bank of England Monetary Policy Committee are clearly relevant, since
many care home providers have financed their businesses through borrowing. The regulations
on the policies and practices of the banking sector with regard to lending, including measures
specific to small business, affect suppliers’ costs. The field remains predominantly a ‘cottage
industry’, with corporate penetration of residential care very low by modern economy-wide
standards in general, as well as in comparison with the adjacent nursing care home field.
Mortgages and other bank loans have consequently probably remained the single most
important source of finance for residential care homes. Second, developments in the property
market, which are highly sensitive to macro economic factors, are clearly relevant to supply-
side residential home decisions, as these affect the value of the alternative uses to which
residential care facilities can be put, especially bearing in mind that most are not purpose
built. If national (and local economic) conditions combine to generate changes in the value of local property for a given residential care market, then the opportunity cost for owners of using their physical assets clearly shifts.

This paper concentrates on the two levels at which MEOC evidence is concentrated, the micro and meso levels. However, it is crucial to note that these influences are in turn situated within these wider local and national political economies. This is a highly complex and interdependent system, and the supply of residential care for older people should always be seen in this broader context.

3. THE MICRO-LEVEL SITUATION: MEOC AND RELATED EVIDENCE

The areas in which MEOC evidence is potentially valuable at the micro level are: the current and future composition of demand (especially in terms of dependency) and concomitant supply-side responses and experiences; motivational attributes of existing residential care suppliers; price setting and its relationships to costs; and the character of local labour markets.

3.1 Product market demand and supply parameters

The MEOC research provides evidence on how the level and composition of demand as experienced by providers changed over the (earlier) period of 1994 to 1997. At the sample home level, the data suggest these broad national trends hide considerable variation between homes. More than half of the sample, 56%, indicated that the level of expressed demand had changed over this period, with most indicating a net decline. The data suggest that the national picture of stable self-pay effective demand conceals contrasting experiences for individual providers: while half of the sample did report no change, a third (32%) reported decreases in the proportion of private payers, compared to just 18% with increases.

However, the most striking finding on the changing nature of demand relates to its character rather than its level: a large majority reported increased levels of dependency among people wanting to enter their homes (53% a considerable increase, and 28% a slight increase). References to this phenomenon in the interviews almost all referred to the extent to which this reflected the influence of local authority-funded demand. In terms of physical dependency (measured by ability to undertake activities of daily living) the PSSRU survey of residential care data indicated a 22% increase in the average Barthel score within homes in the period 1986 to 1996.

The study revealed significant variation by sector in the extent to which the supply-side patterns of residents’ characteristics in homes simply mirrored demand-side patterns, or were mediated by active formal or informal admissions polices. While in most homes in both sectors, the dependency mix was claimed to reflect prevailing market demand, there was a significant minority in the voluntary sector claiming otherwise. This implied some combination of disproportionate market power and/or control over the admissions process in

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3 The 1996 PSSRU survey found that two thirds of private sector residential homes were not purpose-built, but originally constructed as private residences (50%) or hotels (16%) (Netten et al., 1996, table 3.3), which could potentially therefore revert to their original use. A very different pattern emerged for local authority and voluntary sector homes, with purpose-built facilities dominating (93% and 53% respectively).
these homes. In addition, a significant minority of voluntary sector care homes were also selective in the sense that they chose their clientele on the basis of professional, religious and occupational attributes as a reflection of organisational goals and policies: this was true of 39% of those homes in this sample (compared to just 6% in the private sector).

A greater sense of market power flowing from higher levels of deliberate or de facto specialisation in voluntary sector homes was also revealed through responses to questions concerning competitiveness of local markets. While both sectors were experiencing an increasingly competitive environment between 1994 and 1997, this was most acutely felt in the private sector. In a panel of sampled providers, the proportion of private sector homes experiencing ‘a lot of competition’ increased from 31 to 50%, compared to an increase from 17 to 25% in the voluntary sector.4

The demand-side trends and changes and accompanying supply-side changes referred to above suggest a situation in which local authority purchasers - through a combination of their rapidly increasing share of residents, greater competitiveness on the supply side, and the more general existence of a buyers’ market (with most admission decisions essentially demand-driven) - wield an enormous and increasing amount of market influence. The remainder of this section will focus on the direct micro-economic implications of this massive concentration of power, while its meso-level implications, somewhat more removed from core economic processes but nevertheless relevant to supply-side decision making, are the focus of the next section.

3.2 Motivational attributes

The foregoing discussion of selective admissions policy already implies that the provider motivations which underpin supply-side decisions in the voluntary sector case in particular often do not correspond to classic textbook models of profit maximisation or market share capture. However, the motivational distinctiveness of social care providers is not confined to the voluntary sector, but characterises the independent sector more generally. MEOC research has shown that providers tend to combine financial goals with other, care-related objectives in distinctive ways. Most can be portrayed either as ‘professionals’ rating highly a sense of professionalism, the development of expertise and creative achievement in line with their health and social care professional backgrounds, or as ‘empathisers’ gaining intrinsic satisfaction from meeting residents’ needs and/or fulfilling felt social duties and obligations. ‘Income prioritisers’ form a third, minority group - and even these, while attaching comparatively more importance to financial goals, claim to combine them with caring aspirations as well.

Typically co-existing with and cross-cutting these motives is a desire to feel in control of their own operations, in the private sector with an individualistic emphasis on autonomy

4 Voluntary sector providers’ more discriminating approach to admissions, with many voluntarily restricting themselves to particular market niches, might theoretically imply lower levels of effective demand, while conversely greater insulation from market forces through specialisation could allow them a more assured market. That the latter effect has traditionally dominated at a national level is suggested by PSSRU comparative occupancy level data. In 1996, the PSSRU study found occupancy levels in the private sector were at 85%, compared to 91% in the voluntary sector (Netten et al., 1999, table 3.7). More recently, however, this difference seems to have narrowed: the Laing & Buisson survey for 2001 found rates of 90.4% and 91.2% respectively (Laing & Buisson, 2001, table 6.10).
A study of domiciliary providers in 1999 that used the same methodology provided similar results regarding motivation, with a profit weighting of 81% (Forder et al., 2003). Interestingly, providers who were grant-funded had a much lower profit weighting (21%).

Our residential care finding that core motivations appear fixed in the medium term was echoed in the domiciliary care study (Kendall et al., 2003).
(26%) indicating that there was some or limited scope for negotiation, and only 10% indicating that prices reflected to a major degree their own input.

The result of this (predominantly) one-way process was that average prices were pitched systematically at rather low levels compared to costs (and concomitant profit possibilities). In our 1997 sample, as a specific result of their local authority’s pricing policy, 42% of providers stated that they had, already by that point in time, purposefully tried to reduce costs (MEOC team, 2000). Some 22% stated that they had seriously considered market exit due to local authority pricing. Given that we have seen that a much lower proportion of providers nationally actually ceased to operate since 1997 (even allowing for population-level net effects of entry and exit), there has been a gap between stated aspirations and actual practice, an explanation for which is explored below.

Providers who had already reduced costs were asked about the form of this cost cutting. The majority said they had reduced ‘business surplus’ (i.e. mark-up). This might initially appear to suggest that purchasers had been successful in securing efficiency gains from providers (redistributing ‘excessive’ producer surplus to purchasers on behalf of the taxpayer). However, financial and other analysts have taken the view for some years that (even given the relatively low-risk attributes of this market), current and expected profit levels have been very poor (and of course, too low to prompt large scale corporate penetration). Moreover, there are at least two persuasive reasons from PSSRU and other evidence for believing the mid to late 1990s squeeze on revenues, and the subsequent intensification of pressures that has resulted from low local authority fee levels up until 2000 (Laing & Buisson, 2000) should be interpreted predominantly as causes for concern and not congratulation.

First, actual profits were already rather low in absolute and relative terms as early as 1996 (the year to which the PSSRU residential care survey data relate). Potential mark-up rates were about £52 or 19% of average weekly revenue at the margin or £31 (11%) on average costs. (The latter is lower since homes have economies of scale: the additional costs of serving an extra resident are lower than for the average resident, but revenue is the same.) When adding in the 73% weighting reported above, the mean price mark-up on average cost is just £23 per resident, or 8.3%. For an average sized home, this implied a gross annual surplus at that time of just £36,500. Even at the lower end of the estimated range for business valuation (£1m to £1.5m), estimated annual profit amounts to less than 4% of valuation, a poor return on investment by commercial standards in the current economic climate.

However, for larger homes the picture is more healthy financially. Economies of scale can push average mark-ups closer to the marginal figure of £43, assuming that ‘nonprofit’ goals

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7 This imposition of (average) prices by fiat is symptomatic of immature contracting regimes, in the context of underdeveloped social capital in general, and communicative relationships in particular, between purchasers and providers. That the distribution of prices, and bases for price variation, also tend to be underdeveloped is treated here as closely related to contractual choice and hence contractual regime, and is therefore discussed in the next section.

8 In addition, providers were also asked how they would respond to a hypothetical future reduction of prices by 10% for new local authority sponsored residents. The largest single response was that they ‘would absorb from surplus/revenues’, accounting for 26% of respondents. Only two other responses accounted for more than 1 in 5 providers, with 22% indicating such a development would ‘threaten their viability’ (the same proportion as were already considering market exit, cf. para 36); and 22% that they would try to ‘recruit more private payers’ (MEOC team, 2000, p. 16, table 19).
come into play to the extent identified (or which would go as high as £52 for any homes exclusively operating to make profits, according to this model).

It should be emphasised that this was the position some six years ago, before most recent revenue stagnation trends and not accounting for subsequent increases in costs resulting from, for example, increases in client dependency. On the basis of changes in costs and revenues in the decade before 1996 (Forder and Netten, 2000), the projected 2001 price-average cost mark-up would be as low as £15 (5%). During the ten year period, residential care prices increased in real terms by only 4% (and nursing home prices actually fell).

On the expenditure side, the two most important cost-push factors to have borne down upon providers are the possible continuation of the 1994-97 dependency increases (noted earlier to have been the case for 81% of providers) and labour market pressures. The MEOC study has highlighted the likely significance of the former. Controlling for confounding factors, a significant negative relationship has been estimated using those data between reported levels of dependency and mark ups (MEOC team, 2000). The quantitative impact of the latter in the context of new domestic and European legal requirements have been discussed elsewhere (see Laing & Buisson, 2000; and see below), and Forder and Netten (2000) have confirmed that the underlying relationship between basic pay and mark-up is a negative one.

Overall, this suggests that the cuts in mark-up sustained by providers who have stayed in the market in 1997 and beyond should be thought of not merely as eroding their already marginal ‘commercial viability’ as ‘entrepreneurs’, as the dominant discourse tends to argue (Laing & Buisson, 2000; Royal Commission, 1998). The continued operation of most providers under such extreme adverse price-cost conditions typically implies a remarkable choice to sacrifice further what are already very modest rewards, which is symptomatic of their empathy and professional commitment motives; and/or is a consequence of an inability to exit the market in search of alternative opportunities, despite aspirations to do so. The latter is a problem, not only because such an economic situation leaves providers feeling ‘trapped’ and hence demoralised and jaded, but also because there was little evidence in the late 1990s that the meso-level environment was sufficiently supportive of non-financial motivational attributes to ‘compensate’ for poor economic conditions (see next section).

A second reason for concern following from the MEOC evidence is that any late 1990s cuts into mark-ups typically took place not in isolation, but were accompanied by other responses to cost pressures which were said by providers to have undermined service ‘quality’, properly understood. In the 1997 survey, we found that nearly half of the respondents reported having cut costs by re-structuring the service provided; examples include reducing staffing levels or qualifications, reducing staff wages or benefits, or reducing the ‘extras’ provided to clients such as day trips, entertainment and so on. Hardy et al. (1999) provide a more detailed account of this cost-cutting, arguing that such re-structuring is likely to have reduced service quality.

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9 We are here taking into account the extent to which quality depends also on the situation of care staff in the context of ‘internal’ and ‘external’ relationships between stakeholders in the care process, as outlined in section 2. We are thus defining ‘quality’ not just in terms of the physical fabric of buildings and physical capital with which industry and financial (‘City’) commentators tend to be preoccupied when discussing infrastructure (Royal Commission, 1998; Laing & Buisson, 2000).
The above discussion relates to the cost-oriented actions of suppliers up to 1997, but also relevant here are responses to direct questions as to the relationship between fees and costs at the time of the survey. The 1997 survey found that local authority fees did not cover the costs of the relevant supported residents for 53% of providers (using the latter’s own definition of what it means to ‘cover costs’). A pooling of the 1994 and 1997 data produced a corresponding figure of 47% (113 respondents). Providers were asked how they made up the stated deficit of price relative to cost. The dominant response in the private sector was for providers to draw on their ‘own reserves’ (70% of those with prices below costs), while only 30% of deficits were supported by some form of cross-subsidisation from the income of other services (with private paying residents making a similar contribution). For voluntary sector providers, a higher proportion of whom claimed that prices did not cover costs, a more diverse range of deficit funding sources was drawn upon. In this sector, a proportionately more significant minority claimed to cross-subsidise with income from other non-residential/nursing services (unsurprisingly, given that these providers are typically already more diversified in character), and by topping up from external sources.

The immediate implications of these results for the economic situation of providers depend on what is meant by ‘own reserves’. If eating into ‘own reserves’ meant reducing ‘supernormal’ profits from above a reasonable rate of return to a level still at or above it, then economic viability concerns are clearly limited. The question here is what is meant by a reasonable return. Empirical studies for comparison are few in number but those studies that do exist show the price-cost mark-up to range from 11.4% in the UK new car market (Verboven, 1998) to service industries such as banking with estimates in excess of 40 or 50% (Bresnahan, 1988). The residential care market estimates of certainly less than 8% - and now in the region of 5% - therefore look extremely low from a comparative perspective.

As well as very low mark-up rates, providers voiced concerns about fluctuations in net income, arguing in some cases that they were subject to excess risk. The study reported in Hardy et al. (1999) and the MEOC team (2000) indicates that roughly half (47%) of providers reported some or a lot of ‘excess risk’ regarding their business. Risk comes in at least two forms. First, there is ‘capitation’ risk regarding the level of demand (i.e. placements) that the provider can expect. Low occupancy tends to increase average costs and reduce average mark-ups. Risk also arises when factors affecting marginal costs are uncertain and variable. A key example is resident characteristics. It is a standard economic result that organisations have higher reservation mark-up rates when operating with uncertain net revenue (Forder et al, 2000). Just as with pricing, risk can be seen as a policy variable at least partly within the control of local authorities. Reimbursement arrangements can be chosen that minimise risk to

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10 A failure to cover costs could theoretically be due to inefficiencies of various forms - x-inefficiencies most obviously, but also technical inefficiencies. However, economies of scale and scope are relatively limited in social care (compared to most economic activities) partly because of limits to the substitutability and service quality-dependency on labour noted in the introduction (cf. Baumol, 1967). In addition, achieving scale economies could be incompatible with other objectives, including facilitating user choice through supply-side diversity, and aspirations to limit provider market power (see also next section), especially in the context of the highly local character of most social care markets. As to inefficiencies more generally, notwithstanding the existence of some barriers to entry and exit (see next section), if these were pervasive, we would have expected to observe much more systematic penetration of the market by new waves of efficient providers, including perhaps corporations, able to push down costs and generate surpluses for given fee levels. This has not happened to any significant degree in mainstream residential care for older people (as per our earlier comment on City views re expected profit).
providers. For instance, block contracts provide some protection against capitation risk and these proved to be the preferred type among some of the sample providers, although for many these advantages were offset by other considerations (see section 4.1 below).

3.4 Local labour market conditions

Unlike health care with its still predominantly centralised machinery for setting pay and conditions, the costs of labour inputs in social care residential services are essentially determined by local labour market conditions. The main exception is the wage cost of nursing staff, since, other things being equal, pay rates must match or exceed those within the NHS. Yet qualified nurses account for only around 10% of all staff in residential care (Appendix 1; see also Netten et al., 1998, table 3.18); pay costs are dominated by remuneration for ‘care assistants’ or ‘care workers’ \(^{11}\) with very limited qualifications, the competitors for whose labour are largely local private sector services, and especially retail enterprises (see Comas et al., 2001).\(^ {12}\)

Within the MEOC programme, data relating to labour market concerns have been most systematically collected on the provider side in our recent domiciliary care study (Matosevic et al., 2001). Clearly, however, the wage bill for ‘care assistants’ or ‘care workers’ is the single most important cost item for both residential and domiciliary care. We have seen that by 1997, a few providers had sought to reduce costs in this domain. Yet - given the dominance of professional motivation, and an assumption that quality of care is significantly bound up with the quality of employees (the head of the Social Services Inspectorate has even stated that the quality of staff determines quality of care; see discussion in Kendall, 2001a) - most were, unsurprisingly, extremely resistant to reducing staffing levels, or cutting existing staffs’ conditions, in cognisance of perceived likely adverse outcomes for care quality. As one interviewee in the study tersely stated in explaining how they were cutting costs: ‘We just have to take a reduced profit, its as simple as that. We don’t reduce food and we don’t reduce staff’.

The generic labour market legislation subsequently put in place as a strand of general macroeconomic and social exclusion policy has since greatly limited the economic room for manoeuvre for any providers who might otherwise have wished, or been driven, to economise on costs by altering staff pay or conditions. Many, indeed, will have incurred significant additional costs as a result of the minimum wage legislation (and in the future yet more, in order to comply with any new staffing requirements under regulations that follow with the implementation of the Care Standards Act 2000). Care assistants, immediately prior to the new law, were among the lowest paid members of the labour force, with 59% paid below the threshold (Almond and Kendall, 2001). Consistent with this evidence, Netten et al. (1998) report that for approximately 90% of providers, basic pay levels for their staff were less than £4 in 1996. Nonetheless, the impact of basic pay levels on costs in the model described above

\(^{11}\) The appropriate label for those largely unqualified workers is debated, and usage varies. But we do know that by 1998, over half a million (514,000) people (predominantly women) self-classified to the ‘care assistant and attendant’ occupation in the Quarterly Labour Force Survey (Almond and Kendall, 2000, p. 19, table 9). As the largest client group, older people were of course the primary beneficiary of this labour (see also Comas et al., 2001).

\(^{12}\) Of course, in nursing homes, nationally determined staff costs are more significant, since 31% of staff in these settings having nursing qualifications (Netten et al., 2000, table 3.18).
is limited. Using a hypothetical minimum wage level of £3.50 for 1996, the impact on the above price-cost margin of £23 would be a reduction of less than £1.50.

The recent findings on this aspect of the MEOC domiciliary care provider study are relevant in this context (Matosevic et al., 2001). There are, of course, numerous differences in the nature of residential care work and domiciliary care work (in terms of content and rhythm of work, and users’ average frailty, for example), but there are sufficient similarities for there to be considerable common ground in terms of the character of the local labour markets with which providers must engage. The pool of (potential) employees upon which residential care employers rely can also, to a significant degree, be thought of as the one on which domiciliary care employers also depend. This study tends to underline the extent to which the internally generated pressures to remunerate employees appropriately are being increasingly compounded by external local market conditions. A high level of competition among providers for care workers is the norm, and this is especially intense for the relatively limited available stock of qualified and experienced workers. Unsurprisingly, therefore, most of these providers have had difficulties in recruiting suitable care staff.

In sum, providers face double jeopardy in terms of market power. Currently and recently, as well as being on the wrong end of a buyers’ market in terms of the services they provide, residential care homes are also on the wrong end of a sellers’ market in terms of the labour upon which they necessarily so heavily depend.

4 THE MESO-LEVEL SITUATION: MEOC EVIDENCE

We have seen that average local authority fee rates or prices, which powerfully shape the economic fortunes of the independent sector, especially the private sector, have been imposed at low levels in recent years. Set against the resultant, relatively stagnant revenue streams have been escalating micro-level cost pressures, resulting especially from increases in resident dependency, and a buoyant labour market. However, as indicated in the introduction, attending to these proximate economic factors is a necessary but not sufficient condition for understanding the supply side of residential care. We need to take into account how readily quantifiable features of local contracting regimes shape providers’ situations, and also examine the extent to which purchaser-provider relationships foster or undermine social capital. We now consider these in turn.

4.1 Price contingency and contractual forms

Not only is the average price or fee level significant in residential care: the distribution of prices is also crucial. Many factors that influence costs and revenues of residential care providers are variable and uncertain in advance. Provider reimbursement can be made to a greater or lesser degree contingent on these factors, that is, linked in size to factors that affect net costs. At one extreme, if fees are fixed in blanket fashion and needs fluctuate, then costs will fluctuate and so will surplus. At the other, if fees fully adjust to changes in needs (and costs), then surplus variation over time is ‘smoothed’. Similarly, if providers are guaranteed a level of demand in advance as in a block contract, then they can be certain about their revenues and scale-related costs. The perception of risk is clearly important to providers and has a pivotal role in decisions about provision levels and even market exit. In countless studies it has been shown that insulating stakeholders against significant net income
fluctuations can be so important to them that they are willing to accept lower, more certain net incomes in return (Forder and Netten, 2000). Put another way, a provider with a certain secure if modest income is more likely to stay in a market compared with a provider facing a more uncertain income.

A striking finding of the MEOC residential care provider study was the scarcity of both dependency-contingent pricing arrangements and also demand level-contingent arrangements (i.e. block contracts). Therefore, only a minority of providers were significantly insulated to any degree against need fluctuations, and hence cost fluctuations.\(^13\)

The most prevalent pricing policy experienced by providers was a combination of an imposed (‘pre-determined’) average price and a complete lack of dependency contingency; these arrangements were reported by 36% of respondents. Next most common were pre-determined average prices, with \textit{ex ante} but not \textit{ex post} variation - that is, a pre-determined tariff of two or more prices, rather than a single price - reported by 24% of cases. However, often this did not involve discriminating within the mainstream older people client group, but rather paying a different ‘enhanced’ rate for what is usually seen as anyway a separate group: people with dementia or other mental health problems.\(^14\) If these cases are thought of as a categorical distinction, then this would imply that close to half of all providers were experiencing contracting regimes with essentially completely fixed pricing structures.

Most of the remainder (22%) - the minority referred to above - were at or towards the other extreme in terms of price contingency. Not only were overall (average) prices not fully predetermined in the sense that they involved significant input from providers at the time of the annual contracting round (10% ‘real’, 12% ‘some’ scope for negotiation, as noted earlier), but there was also \textit{ex post}, client by client, pricing flexibility \textit{within} that cycle at the moment of admission, and possibly afterwards, if clients’ levels of dependency altered.\(^15\)

Significantly, providers systematically indicated a preference for the latter, more contingent form of pricing arrangement. Those \textit{without} dependency-contingent contracting tended to aspire to such an arrangement (63%), while those \textit{with} dependency-contingent contracting tended to be satisfied (60%) or want \textit{greater} levels of contingency (35%). This implies that \textit{ceteris paribus} (in terms of micro and macro arrangements), institutional redesign to increase levels of price contingency would result in higher levels of provider satisfaction - with potentially beneficial outcomes for supply-side stability.

The most obvious reason for this preference is economic: dependency-contingent pricing implies ‘smoothing’, and providers seem to be averse to dependency-related volatility: they prefer smoother to more jagged net revenue streams (for a \textit{given} net present value of expected

\(^{13}\) The survey also found ‘quality-contingent’ pricing to be rather rare, with only 6% reporting quality premia (MEOC team, 2000).

\(^{14}\) MEOC data do not allow us to analyse the micro-economic differentials in this case. But viewing these two categories as separate submarkets, there may be a difference between the ‘enhanced’ price-cost margin for the ‘submarket’ of care for older people with mental health problems and the mainstream price-cost margin. If the former were significantly larger, this might help to explain the growth of specialist providers reported earlier, although, as emphasised throughout this report, we should be wary of relying too heavily on narrow financial explanations in isolation in accounting for supply side behaviour.

\(^{15}\) This 22% includes two of the six other logical combinations of price contingency identified (MEOC team, 2000).
profits). In expressing this preference, providers might also have had in mind that
dependency-contingency would systematically relate to realism in terms of average prices,
and hence higher levels of net present value for expected profits. This expectation was
substantiated by analysis of the sample data: ceteris paribus in terms of a range of micro
factors, those providers who have contingent contracts were significantly more likely to be
experiencing accurate matching of prices to costs (MEOC team, 2000).

That providers are typically economically ‘risk-averse’ in this sense is relatively unsurprising.
First, the nature of the risk that providers face is heavily skewed towards a very high
probability of deterioration in user welfare, with its concomitant cost implications (see
above). Second, the professional backgrounds and motivations typical in this field imply an
obvious contrast with the raw risk-taking preferences of the stereotypical free market
entrepreneur, and the ability to plan with confidence seems to be regarded in a positive
light.16 Moreover, it is likely that they also prefer less pre-determined and more contingent
price setting arrangements for more social or psychological reasons, over and above any
economic implications. Willingness by purchasers to take into account, and act upon,
providers’ perspectives on prices may be seen as a sign of relational maturity, and
symptomatic of a broader process of fostering goodwill through recognition and respect.17

Another readily observable feature of a contractual regime is the choice that it involves
between types of contract. Each of the different forms - spot contracts, call-off contracts,
block contracts, cost & volume contracts and grants - involves different degrees of specificity
and ex ante commitment (see Box 1) As with choices over pricing strategies, choices over
the contract mix have implications for the distribution of risk between providers and
purchasers. In this aspect, risk has a projected revenue (economic) aspect, this time relating to
quantity, since revenue is determined by the product of price and quantity (occupancy).

16 Of course, in the wider economy, many suppliers of goods and services are not averse to bearing significant
risk concerning prices. This is likely to be the case if more structural market power is available, and/or when
producers may even prefer more risky to less risky situations for a given level of expected profit (‘risk lovers’).
However, the empirically substantiated claim being made here is that in the particular case of existing social
care providers in the context of hegemonic local authority purchasers, there tends to be a good deal of
preference for greater predictability about net revenue streams.

17 It is not being suggested that purchasers should not be robust in arranging prices, for that is clearly a
fundamental imperative of securing Best Value. The important point is that efficient institutional arrangements
for calibrating prices and costs in the context of changing and complex human needs are likely to involve
contingency, not least because this affects service quality. In addition, a willingness to conduct a dialogue about
price levels and distributions indirectly sends a powerful signal to providers that purchasers recognise their
motivations.
BOX 1: Contract types in social care

- **Block contracts** link service specifications and reimbursement to provider facilities – for instance, buying a defined number of residential care places – and payment is made regardless of whether the service is actually used. Because block contracts guarantee a level of revenue, small or risk-averse providers may be prepared to accept lower payments in return for predictability. However, purchasers run the risk of having either too few or too many places in the facilities that clients want to use. The larger the purchaser (or the purchasing budget) the lower the risk of a mismatch between demand and capacity.

- **Spot and call-off contracts** are price-by-case arrangements in that the individual service user is the basis for reimbursement: the provider is only paid if the client uses the service. Purchasers sometimes prefer the flexibility that comes from spot and call-off purchasing, but risk paying a premium for this, particularly in markets for highly specialised services. Spot and call-off contracts are usually more expensive to operate than block contracts because the latter offer economies of scale in drafting and negotiation. These contracts have a price band set prior to purchase, negotiated by a centralised purchaser, and occasionally with some variation to allow for the dependency characteristics of users. Care managers or other decentralised agents then call off services from the contract.

- **Cost-and-volume contracts** are combinations of block and price-by-case arrangements. A guaranteed level of service is purchased; beyond that level, additional reimbursement is made according to the number of users. There is also the possibility of more easily building in other contingencies. Linking purchaser payments to the (expected) volume of services provided can confer advantages on both purchasers and providers, but the associated transaction costs might be seen to be too high relative to block contracts, and the constraints on choice might be seen to be too great relative to spot contracts.

No providers reported using either block or cost & volume contracts - 90% were using call-off contracts, and 10% spot contracts. However, just under half (48%) of respondents claimed that either block or cost & volume contracts would be their preferred type. There was also a significant relationship between those claiming to be shouldering excess risk, and preferences for these types of contract.

The remainder of providers - half the sample (52%) - indicated that they preferred the apparently more risky call-off or spot contracts (under which they were all operating) to the security of the block or cost & volume options. *Prime facie* this might appear puzzling, and to an extent seems to confound the conventional wisdom, which emphasises the latter’s advantages in terms of risk distribution and potential transaction cost economies (Audit Commission, 1997). Moreover, this seems unlikely to be purely attributable to some innate sense of conservatism (better the devil you know): after all, the majority of providers were quite willing to indicate a preference for different pricing arrangements from those prevailing in the *status quo*. Surely, given the dominance of symptoms of risk aversion with regard to pricing outlined above, we should expect a similar pattern concerning capitation risk?

Three or four explanations for the high levels of preference for spot contracts over block contracts can be suggested, each assuming that providers’ abilities to secure contracts from the local authority in the first place are not in question. First, there is a belief that block contracts would limit providers’ control over which clients are admitted. Particular clients may be seen as ‘inappropriate’ for the home because of apparently high (actual or anticipated) cost characteristics, or because it might be anticipated that they might not ‘fit’ in terms of a home’s collective ethos, style or atmosphere. Block contracts might then be perceived to involve a loss of control over cost-relevant and quality-relevant decisions.
Second, as we have stressed throughout, motivations tend not to be purely financial, and these other motivations may be important in explaining why block contracts are often not favoured. If we first look at ‘knighthood’ motivations, as discussed earlier, then set against the professional aspiration for forward planning with confidence which block contracts would seem to facilitate would be an altruistic or empathetic recognition of the desirability of user choice. Providers may have felt sufficiently concerned about the possible adverse effects on user choice of block or (to a lesser extent) cost & volume contracts that this more than offsets the preference they would otherwise have for the security that comes with such arrangements.\(^\text{18}\) (In contrast, it is not normally argued that greater price contingency is relevant to the exercise of user choice.)

Third, taking into account the mercantile face of motivation makes this contractual preference more understandable (Kendall, 2001). From the perspective of small businesses, while we have seen that many saw their role largely in terms of responding to effective demand, spot contracts could nevertheless be experienced as (or were \textit{anticipated} to be) relatively less of a constraint on the sense of ownership and control over their businesses which these providers tended to hold dear. As one provider simply put it, ‘We wouldn’t want to take who they say we’ve got to take.’ In addition, for voluntary agencies, this control was often especially significant to retain the balance of their clientele in line with their organisations’ constitutional objectives and ethos. In sum, we can conclude that the risk associated with securing referrals or not under a spot or call-off contracting regime was more likely to be seen as a fair or legitimate risk (rather than an excessive one) than the risk associated with the cost implications of dependency fluctuation. Providers’ remarks illustrating this sentiment include the following two: ‘Its just one of the risks of being in business isn’t it? You can’t expect people to come to you just because you are there’; and ‘The element of risk is always there in a situation like this … that is entirely up to you, however you choose to work the system.’

A further possible reason is that providers were not assuming that they would get a contract in the first place, and this conditioned their attitude towards the contract type options. Block contracts could be seen as potentially restrictive in terms of narrowing the number of providers able to operate in a local market: if converted into a large scale policy, it could potentially exclude some existing providers, and the fear that they might be thus excluded could have played a part in this process. In other words, in addition to the ‘mercantile’ motive to retain control over their home’s intake and the more ‘knighthood’ aspiration to promote user choice, a more obviously self-interested ‘knavish’ motive to safeguard their own business interests was probably at play.

4.2 Social capital

At the meso level, our definition of regime embraced not only the sorts of rules embodied in contracts discussed above, but a ‘softer’, more informal phenomenon. The label ‘social
capital’ can be used as a shorthand for the productive functioning of norms, procedures, and well-aligned actor (recursively reinforced) expectations and understandings. When functioning well, we have strong, responsive relationships, in which the stock of (well placed) trust capital is crucial, playing an active role in facilitating the smooth adjustment in handling problems and issues which inevitably emerge in the inter-working of purchaser and provider.

Clearly, opportunities for timely, systematic and meaningful (rather than tokenistic) exchanges of information, and the fostering of open and frank channels of communication are likely to be as crucial to mutual satisfaction with relationships in residential care as they have proven to be in domiciliary care (Kendall et al., 2003). This is important at a number of levels, but includes arrangements for dialogue as part of the contract renewal cycle; intra-cycle opportunities to discuss and adapt institutions and procedures; and most importantly of all, arrangements for responding to the needs of users in line with professional priorities and users’ expressed needs and preferences. Even though we did not ask directly about levels of trust and social capital, the MEOC residential care studies provide evidence on a series of symptoms whose presence would prime facie appear to make it easy for trust to be nurtured, given what we know about the motivations of the actors concerned.

One set of symptoms are, in a sense, just as formal as the structures of pricing and contracting discussed above. They are operational problems - delayed payments, delays with assessment to admission, insufficient clarity of purchasing intentions, incomplete information with respect to contracting, length of time taken to assess clients, and costs of contract/price negotiation. But although more formal, they are indicative of ‘street level’ working and to a large extent are trust-dependent, relational phenomena. Our findings point to relatively healthy relationships here, with these problems typically deemed absent by around three quarters of all providers, although this of course leaves a significant minority in difficulty.

Another healthy symptom of purchaser-provider relationships conducive to trust, and hence social capital formation is simply the extent to which purchasers have become increasingly aware of the mixture of core motivations we have discussed on the provider side. Over time, purchasers have learned that independent sector providers tend not exclusively to prioritise financial gain. At least at the strategic level of directors’ and councillors’ attitudes, and their crystallisation in departmental policy statements, there is now an unprecedented degree of recognition of the ‘knightly’ face, including the (benign) professionalism and caring values of many providers. This has involved incremental adjustment of beliefs in some cases, but in other cases value shifts either verging on Damascene conversions or resulting from generational changes of personnel (MEOC Team, 1999, pp. 3.1–3.4)
‘As far as I am concerned the home belongs to social services. The light has gone out … Social services do registration, they do the contract, the assessment … and they are using our capital and expertise and we don’t even get respect for it … If we could have sold it we would have got out; it’s the bureaucracy, the grind, the frustration … It’s a grind, it really is. I’ve worked in hospitals, in education, in the voluntary sector and I’ve never met anything like this. If you got home owners to talk honestly, they’d all say this … the light has gone out … Its depressing, its not just here. It doesn’t matter where you go, the good home owners are getting out … the owners have had enough’.

‘I’ve had enough quite frankly. Everybody want’s a ‘get out of jail card now’. And what’s so sad is that there are people who I know and respect in this industry, some really caring people and all of them want to escape’

‘You survive, but that is literally what you are doing … I’m just so tired of it all. I’m tired of all the office work and the endless meetings to go to. My enthusiasm has gone. Everybody is the same. They feel they are just hanging on … its gone full circle.’

Source: Residential care home provider interviews, 1997

However, set against this encouraging evidence are more worrying signs of malaise, which are especially damaging when viewed in conjunction with the pricing adjustment difficulties discussed earlier. These can be loosely grouped into three categories. First, in contrast with the implied recognition by purchasers of providers’ caring professional side referred to above, there was a continued, pervasive general sense of a lack of recognition of the significance of the ‘mercantile’ face of motivation. This was less likely to be expressed solely as a function of particular institutional arrangements, or in anger with particular individuals, but rather as a diffuse sense of demoralisation or in some cases, disillusionment, entrapment and even exhaustion, experienced as a result of a combination of prevailing micro conditions and the meso-level regime (see citations from three providers in Box 2).

Second, while operational problems were confined to a (significant) minority of providers, a worryingly high proportion indicated that they were not satisfied specifically by their relationships with purchasing staff in a number of senses. While there was a relatively high figure of 79% satisfaction with involvement in post-admission care reviews, providers tended not to be positive about other aspects of these relations. Only just over 60% were satisfied with their involvement and consultation about placement problems, and involvement in assessment and care management, and just under 60% were positive about their general relationships with ‘key local authority purchasing staff’.

Such a decidedly mixed picture in terms of problem perception and relationships is not conducive to social capital formation, because of the sense of dissonance and frustration it can produce among providers, which in turn will tend to condition their willingness to trust purchasers. In the downward spiral that may follow, this could affect the willingness of purchasers to trust them.¹⁹

¹⁹ In the more recent provider study focusing on domiciliary services, we attempted a more detailed exploration of the linkages between the institutions and relationships which constrain/enable providers on one hand, and their concomitant sense of motivational fulfilment (in terms of intrinsic and extrinsic motivations) on the other. We found that experiencing an ‘ambivalent’ environment - one which was supportive along some dimensions but not in others - tended to more than proportionately undermine providers’ satisfaction. The level of satisfaction of these providers (whom we labelled ‘ambivalence-experiencing go-getters’ and ‘ambivalence-
A final, continued source of deep anxiety for providers which undermined the development of their relations was a widely held perception of unfairness due to the view that many purchasers had failed to facilitate user choice in general, and to implement ‘level playing field’ provisions apparently outlawing ‘in-house first’ policies in particular. By the same line of argument concerning the potential adverse effects of some contract arrangements in particular on choice, the overall extent to which users experienced choice in their locale more generally mattered very much to providers. Many contracting regimes were thought to be characterised by the frustration of user choice, especially through the continued perceived use of ‘in-house first’ policies, since there was typically no credible evidence available that in-house or ex-local authority not-for-profit trust placements reflected user choice or cost-conscious decision making. Providers operating in what they judged to be unfair market situations could be nervous and edgy not only because of empathy with local users or even taxpayers, reflecting knightly motivation, but because they felt that as a result they were being denied a reasonable chance to provide services themselves. When coupled with concerns that prices were unfairly or unreasonably low or inflexible (section 5.1), the result could often be a loss of faith in the local authority, or to undermine the overall sense in which their local authority regime was perceived to be legitimate.

5 CONCLUSION

The ‘crisis’ of residential care supply for older people in England is now usually diagnosed as reflecting certain main ingredients:

- in terms of current demand, local authorities’ highly constrained abilities to pay ‘reasonable’ fees, and problems of co-ordination between health and social care agencies to facilitate appropriate placements;
- in terms of current supply, the lack of opportunity for existing or potential independent sector providers to generate profit - particularly as they have become increasingly dependent on these local authority fees - and the knock-on effects for social care of domestic and European labour market legislation in terms of production costs; and
- future expectations. With regulatory quality standards now agreed and set to be implemented in stages between 2002 and 2007, the cost implications of compliance are anticipated not only to lead to higher exit rates than would otherwise have taken place, but to have already been factored into their decision making by providers, and to account for a significant proportion of the closures that have taken place thus far.
This paper began by arguing that the supply of residential care also needs to be understood as part of a social care system in which not only the relatively obvious and immediate micro considerations listed above come into play. There is the macro level, referring to the local and national political economies in which provision is embedded, which strongly shapes what is and what is not possible at the local level.

But there is also the ‘meso’ level, comprising institutions created by public purchasers as they have designed contracting regimes. Less visible and softer relational aspects which take shape within this context are crucial ingredients here. This is so not only because they mediate the flow of financial resources upon which providers depend, but also because they collectively create the environment upon which those providers depend for feedback and recognition. These ingredients are crucial constituents of care because suppliers’ motivations are multi-faceted. They depend not only upon the financial resources which allow them to operate as viable concerns, but also upon the balance of respect for their autonomy on the one hand, and supportive intervention and involvement on the other, consistent with both professional fulfilment and an appropriate sense of control over their own affairs. A failure to take these aspects of motivation seriously leads to distrust between purchasers and providers, and a sense of demoralisation and discouragement on the part of the latter: in other words, in networks characterised by shortfalls of external social capital. This deficit ultimately must also make it difficult to sustain the well functioning internal relationships which are more obviously so crucial in meeting the needs of care home residents.

With this in mind, we brought to bear a variety of MEOC and related evidence at both the micro and meso levels. Given the perceived lack of alternative options in the competitive markets that characterise this field, we stressed how at the micro level most providers have had little choice but to adapt to the demand which increasingly hegemonic local authority purchasers have presented. Notwithstanding the somewhat less beholden case of a significant minority of voluntary organisations, typical of most local markets is a situation in which many or most providers are heavily reliant upon their local SSD purchasers. As such, they have typically had little choice but to handle the significantly higher levels of dependency of the clients for whom local purchasers believe residential care to be appropriate. An increase in the average dependency of clients entering residential care which can be traced back over a fifteen year period seems to have intensified in the second half of the 1990s, as SSD purchaser funding has accounted for a steadily increasing proportion of all residents.

At the micro level, we also reviewed evidence on motivations, profits and price levels. Overall, there are ‘knightly’ (altruistic), ‘knavish’ (financial gain) and ‘mercantile’ (autonomy and control) aspects to providers’ core motivations. They tend to come in particular packages: most can be portrayed as either ‘empathisers’ or ‘professionals’, for whom the goals of meeting clients’ needs and professional accomplishments are given more weight than financial performance. Income generation tends to be seen as a means to these other ends rather an end in itself, although a small minority of ‘income prioritisers’ also exist who are more oriented towards monetary reward. Crucially, this is reflected in actual behaviour, since the average provider’s economic behaviour is not consistent with what would be expected were they to regard profit or net revenue as their sole maximand.
In fact, reflecting the typically very low level of local authority fees in relation to the actual costs of providing care, even the potential profits for a theoretical fully profit-oriented operator in this market were extremely low by economy-wide standards in the mid 1990s. They have declined significantly since then, as fees have failed to keep up with the increases in costs even if dependency were to have remained unchanged, let alone in the context of the cost-raising implications of the higher dependency levels mentioned earlier.

We also identified how providers have usually faced difficulties with regard to their local labour markets. The labour-intensity of residential care clearly makes this situation a crucial one on narrow cost criteria. But because social care is relational, so that the quality aspect of the service is heavily contingent upon the character of the human resources available and the character of the links with service users, this issue is central in terms of outcomes too. Much of the care input is provided by individuals who are among the lowest paid in the whole economy (with most paid at rates below what was to become the minimum wage prior to that measure’s implementation), and providers struggle to reward employees appropriately given the overall situation described above. Moreover, a high level of competition among providers for care workers is the norm, and this is especially intense for the relatively limited available stock of qualified and experienced workers. Unsurprisingly, therefore, most of these providers have had difficulties in recruiting suitable care staff.

At the meso level, we discussed first the state of affairs with regard to ‘hard’, readily observable features of the contracting regimes within which providers operate. There has been rather limited use of contingent pricing procedures which involve efforts to take into account variation in clients’ dependency at the time of admission, and/or to reflect how dependency changes once in the care home. Given providers’ aversion to avoidable uncertainty, and their aspirations to have their economic situation recognised and handled as flexibly as possible by purchasers so as to facilitate planning, there seems to be scope for a mutually beneficial shift towards greater price contingency.

This general aspiration towards greater predictability on the basis of price (because this can smooth expected revenue flows when dependency is variable) was to a limited degree paralleled by an aspiration towards greater certainty with regard to quantity too. A significant minority of providers certainly favoured more widespread adoption of those contract types which tend to offer guarantees as to the future level of local authority demand, such as block contracts. However, on the part of providers more generally, there is not a systematic wish for a policy shift towards more guaranteed forms of contracting to the same extent that greater pricing flexibility was favoured, despite the fact that this would also potentially help ease risk and reduce uncertainty on their part. The most important reasons for this distinction were that such guaranteed arrangements could undermine providers’ control over user admissions, frustrating, inter alia, the ‘mercantile’ motive to exercise autonomy in running their home; user choice could be frustrated - which intrinsically matters for providers to the extent that their professional and empathetic motives lead them to espouse this value; and a fear that such arrangements could close down the market, limiting supply-side diversity, and thus perhaps meaning that they potentially could be among the losers who would not be favoured with guarantees.

Finally, we reviewed the extent to which external social capital, also a ‘factor of production’ using an appropriately inclusive definition of residential care supply, seems to have been
generated by local contracting regimes. While not being able to quantify or measure this directly on the basis of available MEOC data, we were able to review evidence which points to the stock of trust capital. The picture that emerges is mixed. On the positive side, the majority of providers experienced much that was good in their practical relationships with purchasers; around three-quarters have limited or no difficulties in terms of such nitty-gritty factors as delayed payments, delays with assessment to admission, and length of time taken to assess clients. Moreover, to an extent, purchasers, at least at strategic director and councillor level, have learnt that the ‘knavish’ side of motivation is not dominant, and that ‘knightly’, caring and empathetic goals are also very important drivers.

However, set against these improvements and the increased levels of trust associated therewith, there were important offsetting factors which have worked in the other direction and undermined the maturation of these relationships. Foremost among these have been a failure to account for the ‘mercantile’ face of motivation in designing local contracting regimes, so that there is a marked sense of being subject to over-bureaucratisation and unwarranted dirigisme, undermining many providers’ sense of control, and leading to frustration and demoralisation. Second, there were particular practical problems which hampered the smooth functioning of purchaser-provider relationships, with around 40 per cent of providers not satisfied by involvement and consultation about placement problems and relationships with key local authority purchasing staff.

Third, there was typically a diffuse sense of unfairness regarding local contracting regimes where those were perceived to involve the frustration of user choice and involve ‘in-house first’ policies (see also MEOC team, 2001). When coupled with concerns that prices were unfairly or unreasonably low or inflexible the result could often be a general loss of faith in the local authority, or to undermine the overall sense in which their local authority regime was perceived to be legitimate. Even where relationships were more positive in other ways, as set out above, this could often lead to a ubiquitous sense of resentment and distrust, involving therefore counter-productivity in social capital terms.
6 REFERENCES


*Community Care Market News*. (2001b) 8, (October), Laing & Buisson, London.


Kendall J. (2001a)...[JK cited on p14 near bottom]


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APPENDIX: MEOC RESIDENTIAL PROVIDER STUDIES

METHODOLOGY AND SAMPLE

In our earlier research, data were collected on independent sector residential care providers for elderly people in summer and autumn 1994 (MEOC Team, 1995). We used both a postal questionnaire and face-to-face interviews with up to ten providers selected from each of eight local authority areas (three Shires counties, two London boroughs and three Metropolitan districts).

The eight authorities were selected in 1994 from the larger sample of 25 local authorities included in the PSSRU/Nuffield Institute research programme on the mixed economy of care. These eight authorities reflected national patterns of residential care provision for elderly people (in terms of sectoral market shares) and also the patterns of over- or under-provision. Within each of the authorities, homes were selected using sampling frames stratified by sector, size and ownership. The aim in 1994 was to obtain samples of ten independent sector homes per authority (sampling with replacement), although this was not always possible because of the small size of some markets and because some homes declined to participate. In 1997, we returned to each of the homes sampled in 1994 with a request for further information.

We collected data in 1997 through both a postal questionnaire and a face-to-face interview. Where possible, the postal questionnaire preceded the interview. Face-to-face interviews took between 45 minutes and two hours and were completed for a total of 53 homes. Postal questionnaires, four pages in length, were received from 41 homes. Table A1 summarises the response rates in 1997 and in 1994.

Table A1: Sample sizes in 1994 and 1997

<table>
<thead>
<tr>
<th>Number of:</th>
<th>1994</th>
<th>1997</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed interviews</td>
<td>62</td>
<td>53</td>
</tr>
<tr>
<td>Completed postal questionnaires</td>
<td>58</td>
<td>41</td>
</tr>
<tr>
<td>Homes which completed both interview and</td>
<td>50</td>
<td>38</td>
</tr>
</tbody>
</table>

A total of 40 homes were interviewed in both 1994 and 1997. Therefore, some 22 homes of the original 62 interviewed in 1994 were not available for the 1997 interview round. However, 13 new homes were added to the 1997 sample after attempts to replace drop-outs. Altogether in the two periods data were available from 115 interviews. Table A2 shows sample overlaps regarding those homes which provided questionnaire data and those which had both interview and postal questionnaire data.

Table A2: Sample overlaps between 1994 and 1997

<table>
<thead>
<tr>
<th>Number of homes</th>
<th>Interview in 1997</th>
<th>Questionnaire in 1997</th>
<th>Both in 1997</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interview in 1944</td>
<td>40</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Questionnaire in 1994</td>
<td>36</td>
<td>29</td>
<td>29</td>
</tr>
<tr>
<td>Both in 1994</td>
<td>36</td>
<td>29</td>
<td>29</td>
</tr>
</tbody>
</table>

The postal questionnaire was addressed to ‘the Proprietor or Manager’ of each home. It sought data on the following:

- sector (private business, charity, not-for-profit organisation);
The State of Residential Care Supply in England

- whether part of a larger organisation;
- details of registration and provider association membership;
- current level of provision (numbers of permanent and short-stay places), plans for change in these levels, and home-based day-care services for non-residents;
- funding sources of residents;
- additional services, activities or facilities available in the home, and whether there is an extra charge for them;
- home characteristics (rooms, facilities and additional services);
- residents’ characteristics (age, gender, dependency);
- pricing regimes;
- staff levels and qualifications, and numbers on waking or sleeping night duty.

The face-to-face interviews were conducted by Julien Forder, Brian Hardy, Jeremy Kendall and Martin Knapp, with assistance from Rachel Wigglesworth. Where possible we interviewed the proprietors of owner-managed private homes and the managers (or equivalents) of voluntary sector or ‘corporate’ private sector establishments. However, occasionally officers-in-charge were interviewed. The interviews were semi-structured and covered both quantitative and qualitative information. The topics covered were:

- details of home ownership, sector, legal structure and status, and acquisition;
- other facilities and services run by this same organisation;
- client mix, admissions policy, marketing and knowledge of other providers in the immediate locality;
- changes in patterns of demand and competition since 1994;
- pricing policies, methods and strategies, and effects of main purchaser’s policies;
- experience and perceptions of local authority regulation, including partnerships, contracts and specification;
- views of local authority planning and commissioning, and any operational problems (with payments, resident reviews, etc.);
- standards expected in contracts, accreditation, etc.;
- motivation and background of interviewee; and
- future plans for diversification.

The ‘unit of analysis’ was the home itself, rather than any organisation or federation of which it is a part, or of which it is a member.

Sample characteristics

The providers in our sample can be characterised by their legal structure, ownership and organisational size. Twenty (43 %) organisations were limited companies (table A3).
Table A3 Legal structure

<table>
<thead>
<tr>
<th>Legal Structure</th>
<th>Count</th>
<th>Per cent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing Association</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Private limited company</td>
<td>9</td>
<td>17</td>
</tr>
<tr>
<td>Public limited company</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Co. ltd by guarantee</td>
<td>13</td>
<td>25</td>
</tr>
<tr>
<td>Unincorporated trust</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Sole proprietor</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>Partnership</td>
<td>18</td>
<td>34</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>53</td>
<td>100</td>
</tr>
</tbody>
</table>

Some 24 (46%) organisations in the sample were single homes only. About one third of our sample were in the voluntary sector (Table A4). These types of organisation are slightly over-represented compared to the national average.

Table A4 Ownership

<table>
<thead>
<tr>
<th>Frequency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary</td>
<td>18</td>
</tr>
<tr>
<td>Private</td>
<td>35</td>
</tr>
<tr>
<td>Total</td>
<td>53</td>
</tr>
</tbody>
</table>

Tables A5 to A10 describe the size of homes, funding sources, accommodation, pricing and staffing arrangements.

Table A5 Size of home

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent places</td>
<td>26.21</td>
<td>15.16</td>
<td>8</td>
<td>85</td>
<td>38</td>
</tr>
<tr>
<td>Permanent residents</td>
<td>23.95</td>
<td>13.09</td>
<td>6</td>
<td>59</td>
<td>38</td>
</tr>
<tr>
<td>Short-stay places</td>
<td>0.26</td>
<td>0.60</td>
<td>0</td>
<td>2</td>
<td>38</td>
</tr>
<tr>
<td>Short-stay residents</td>
<td>0.45</td>
<td>0.69</td>
<td>0</td>
<td>2</td>
<td>38</td>
</tr>
</tbody>
</table>

Table A6 Funding source – average numbers of residents

<table>
<thead>
<tr>
<th>Funding source</th>
<th>Mean</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under contract with your local authority</td>
<td>9.73</td>
<td>8.45</td>
<td>0</td>
<td>37</td>
<td>37</td>
</tr>
<tr>
<td>Under contract with other local authority</td>
<td>2.22</td>
<td>3.87</td>
<td>0</td>
<td>14</td>
<td>37</td>
</tr>
<tr>
<td>Private means</td>
<td>7.19</td>
<td>5.46</td>
<td>0</td>
<td>20</td>
<td>37</td>
</tr>
<tr>
<td>DSS preserved rights</td>
<td>4.22</td>
<td>4.17</td>
<td>0</td>
<td>20</td>
<td>37</td>
</tr>
<tr>
<td>Income support, not preserved rights</td>
<td>0.54</td>
<td>0.99</td>
<td>0</td>
<td>3</td>
<td>37</td>
</tr>
</tbody>
</table>

Table A7 Types of rooms – average numbers of rooms

<table>
<thead>
<tr>
<th>Types of rooms</th>
<th>Mean</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single room</td>
<td>21.26</td>
<td>13.69</td>
<td>4</td>
<td>60</td>
<td>38</td>
</tr>
<tr>
<td>Double room</td>
<td>2.84</td>
<td>2.81</td>
<td>0</td>
<td>13</td>
<td>38</td>
</tr>
<tr>
<td>Single room - not en suite</td>
<td>10.41</td>
<td>11.62</td>
<td>0</td>
<td>40</td>
<td>34</td>
</tr>
<tr>
<td>Double room - not en suite</td>
<td>1.94</td>
<td>2.66</td>
<td>0</td>
<td>10</td>
<td>32</td>
</tr>
</tbody>
</table>
### Table A8 Age distribution – number of residents

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th></th>
<th>Female</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>n</td>
<td>Mean</td>
</tr>
<tr>
<td>75 – 84</td>
<td>2.03</td>
<td>2.41</td>
<td>35</td>
<td>6.29</td>
</tr>
<tr>
<td>85+</td>
<td>2.97</td>
<td>4.43</td>
<td>35</td>
<td>10.71</td>
</tr>
<tr>
<td>All ages</td>
<td>5.66</td>
<td>6.32</td>
<td>35</td>
<td>18.00</td>
</tr>
</tbody>
</table>

### Table A9 Prices per week – by funding source, sample average

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>Mean £</th>
<th>SD £</th>
<th>Min £</th>
<th>Max £</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents funded by private means</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum</td>
<td>288.26</td>
<td>62.96</td>
<td>222</td>
<td>485</td>
<td>30</td>
</tr>
<tr>
<td>Minimum</td>
<td>259.96</td>
<td>36.93</td>
<td>205.5</td>
<td>366.03</td>
<td>29</td>
</tr>
<tr>
<td>Mean</td>
<td>270.41</td>
<td>41.71</td>
<td>218</td>
<td>366.03</td>
<td>21</td>
</tr>
<tr>
<td>Residents funded under contract with the homes’ own local authority</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum</td>
<td>279.25</td>
<td>47.64</td>
<td>205</td>
<td>366.03</td>
<td>17</td>
</tr>
<tr>
<td>Minimum</td>
<td>265.92</td>
<td>43.79</td>
<td>200</td>
<td>347</td>
<td>17</td>
</tr>
<tr>
<td>Mean</td>
<td>262.10</td>
<td>34.65</td>
<td>205.37</td>
<td>340</td>
<td>12</td>
</tr>
</tbody>
</table>

### Table A10 Staffing – by qualification, sample average staff

<table>
<thead>
<tr>
<th>Qualification</th>
<th>Full-time</th>
<th></th>
<th></th>
<th>Part-time</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>mean</td>
<td>SD</td>
<td>N</td>
<td>mean</td>
<td>SD</td>
<td>n</td>
</tr>
<tr>
<td>Nursing (qualified)</td>
<td>1.34</td>
<td>2.46</td>
<td>38</td>
<td>0.50</td>
<td>1.08</td>
<td>38</td>
</tr>
<tr>
<td>Care staff (social work qualification)</td>
<td>1.97</td>
<td>3.98</td>
<td>38</td>
<td>0.66</td>
<td>2.07</td>
<td>38</td>
</tr>
<tr>
<td>Total staff</td>
<td>13.76</td>
<td>11.45</td>
<td>37</td>
<td>13.84</td>
<td>12.36</td>
<td>37</td>
</tr>
</tbody>
</table>