



The quasi-market for adult residential care in the UK: Do for-profit, not-for-profit or public sector residential care and nursing homes provide better quality care?



David N. Barron ^{a,*}, Elizabeth West ^b

^a Saïd Business School, University of Oxford, Park End Street, Oxford OX1 7HP, United Kingdom

^b Faculty of Education and Health, University of Greenwich, Avery Hill Campus, London SE9 2UG, United Kingdom

ARTICLE INFO

Article history:

Received 1 September 2016

Received in revised form

7 January 2017

Accepted 24 February 2017

Available online 27 February 2017

Keywords:

Residential care

Nursing homes

Ownership

Quality of care

Facility regulation and control

Public sector

Public services

Quasi-markets

England

ABSTRACT

There has been a radical transformation in the provision of adult residential and nursing home care in England over the past four decades. Up to the 1980s, over 80% of adult residential care was provided by the public sector, but today public sector facilities account for only 8% of the available places, with the rest being provided by a mixture of for-profit firms (74%) and non-profit charities (18%). The public sector's role is often now that of purchaser (paying the fees of people unable to afford them) and regulator. While the idea that private companies may play a bigger role in the future provision of health care is highly contentious in the UK, the transformation of the residential and nursing home care has attracted little comment. Concerns about the quality of care do emerge from time to time, often stimulated by high profile media investigations, scandals or criminal prosecutions, but there is little or no evidence about whether or not the transformation of the sector from largely public to private provision has had a beneficial effect on those who need the service. This study asks whether there are differences in the quality of care provided by public, non-profit or for-profit facilities in England. We use data on care quality for over 15,000 homes that are provided by the industry regulator in England: the Care Quality Commission (CQC). These data are the results of inspections carried out between April 2011 and October 2015. Controlling for a range of facility characteristics such as age and size, proportional odds logistic regression showed that for-profit facilities have lower CQC quality ratings than public and non-profit providers over a range of measures, including safety, effectiveness, respect, meeting needs and leadership. We discuss the implications of these results for the ongoing debates about the role of for-profit providers of health and social care.

© 2017 Elsevier Ltd. All rights reserved.

1. Introduction

Many countries are facing the challenge of providing health and social care to populations containing increasing proportions of elderly people. In the UK, for example, there are expected to be 3.2 million people over the age of 85 by 2034, more than double the number today (ONS, 2015). In addition, it is expected that a high proportion of elderly people will be living on their own, a factor strongly associated with the need to move into a residential or nursing care home. Faced with increasing fiscal pressures, many governments have been considering alternatives to public

provision of health and social care. Up to the 1980s over 80% of adult residential care was provided by the public sector, but today public sector facilities account for only 8% of the available places, with the rest being provided by a mixture of for-profit firms (74%) and non-profit charities (18%). The public sector's role is often now that of purchaser (paying the fees of people unable to afford them) and regulator.

In essence, then, residential and nursing care outside of hospitals in the UK, once provided mainly by the public sector, has been turned into a form of quasi-market, differing from a conventional market in that a significant number of providers are not-for-profit organizations and by the fact that a large proportion of the individuals who use residential and nursing care do not purchase the service directly; the state acts as purchaser on their behalf. (Le Grand and Bartlett, 1993). Even in these cases, though, the

* Corresponding author.

E-mail addresses: david.barron@sbs.ox.ac.uk (D.N. Barron), e.west@greenwich.ac.uk (E. West).

individual member of the public has considerable freedom of choice as to where they will receive their residential or nursing home care and significant numbers of people pay some or all of the cost of their care themselves.

Despite the fact that the marketization of residential care is so well advanced in the UK, there has been little UK-based research into the quality of care provided by for-profit providers as contrasted to that enjoyed by residents in local authority or non-profit operated facilities. The main question answered by this paper, then, is whether there are differences in the quality of care provided in adult residential and nursing home facilities in England depending on whether the facility is operated by a local authority, a not-for-profit organization, or a for-profit business. While this is an important question in its own right, we also discuss the extent to which it might inform broader debates about the impact of market-like structures in health and social care more broadly.

2. Theory

The current arrangements by which residential and nursing home care is provided to adults in England can be called a *quasi-market* (Le Grand and Bartlett, 1993). Such arrangements are similar to conventional markets in that the provision of goods or services is the outcome of an economic exchange between two parties, a *provider* and a *purchaser*, and in that there is some sort of competition among the set of providers. Quasi-markets differ from conventional markets in that some of the providers are not necessarily motivated by a desire to maximise profits; there may be publicly owned or non-profit organizations involved as well. Quasi-markets differ also in that at least some of the purchasing is done not by the individual service users, but by a public body acting on their behalf. In the case of care homes, significant numbers of residents are paying their own fees (41% in the UK in 2014), but most facilities have both self-pay and state-funded residents (LaingBuisson, 2014).

Quasi-markets have been replacing organization by government bureaucracies in several areas of public sector in the UK over several decades, including education, health, and social care. The rationale for the change is that, it is claimed, quasi-markets will prove superior to bureaucratic control in one or more of the following respects (Bartlett and Le Grand, 1993). First, services may be delivered more *efficiently*, in the sense that an equivalent standard of service is delivered at a lower cost. However, given that standards may be difficult to evaluate, a common concern of critics of marketization is that reductions in cost will be achieved by means of a reduction in standards. Second, private providers may be more *responsive* to user needs than their public sector counterparts. In contrast to possibly monopolistic public sector providers, the introduction of competition creates incentives to innovate and adapt to consumer needs and hence improved standards of care should follow. Third, quasi-markets are often associated with increasing the *choice* available to users. It might be that the availability of choice is intrinsically desirable, and it is in any case a logical requirement for there to be competition among providers. Choice might be associated with differentiation in the types of provision available, for example by size, geography and level of care provided.

In order to deliver these benefits it is necessary that there is an element of competition among providers, with at least some risk that those providers that fail to attract sufficient users, or are unable to operate within budgetary constraints, will be forced to cease operating. Competition is the essential mechanism by which quasi-markets differ from bureaucracies. It is particularly important that there is effective competition when, as in the case of residential care, there is a preponderance of for-profit providers. Such businesses, it is conventional to assume, are motivated by a desire to

maximise profit. Their desire to provide high quality care would, therefore, be the result of the expectation that they would only be able to attract residents by offering a sufficiently high quality of service. Hirth (1999) has pointed out that, where consumers purchase a service direct from a provider, assuming they are well informed, competition produces the expectation that for-profit providers will be of higher quality because they have a greater incentive to innovate than do public sector providers. However, the care home market is more complex than this because, while some residents do indeed purchase their care directly from the provider with no government involvement, others are in places that are funded by their local authority.

It has been argued that profit-maximizing may not be an accurate characterisation of the motivation of some private providers in this sector (Knapp et al., 2001; Kendall et al., 2003). For example, small business owners may have a “mercantile” motivation: they place value on the independence and sense of autonomy that derives from running their own business. The existence of heterogeneous motivations among for-profit providers may make the distinction between care homes in different sectors less clear cut.

The motivation of providers from the public and non-profit sectors is also unclear. Certainly in the case of non-profit providers that are charities, we might think that their motivation is to provide high quality care and therefore that they would strive to do so even in the absence of competition, assuming that there are enforceable restrictions on their ability to distribute any surpluses to owners, employees or trustees (Hirth, 1999; Grabowski and Hirth, 2003). They may not even need to break even financially if they have alternative, philanthropic sources of finance.

Is there reason to believe that competition among providers of residential and nursing home care in England is strong? Over 50% of care homes in England are operated by owners that run four or fewer facilities. There are no major brands in the residential care market in England (LaingBuisson, 2014), while the median size of these facilities is 23 beds. These factors imply low barriers to entry into the market, which reinforces the expectation that the market should be very competitive (Porter, 1980). Forder and Allan (2014) conducted an analysis of competition in the care homes market in England. While they did indeed find that there was evidence of competition, they also showed that this can have the surprising consequence of reducing quality because homes will find it harder to attract self-payers (who generally pay higher prices) while allowing the local authorities to push the prices they pay down. If for-profit providers are less concerned with quality, then it would be expected that quality will be lower in for-profit facilities even in the presence of competition.

In any event, competition will only have an impact if potential service users can accurately assess the quality of care they will receive, and if existing users are able to switch providers if they are dissatisfied. One reason why this may be problematic is that it may be difficult for people to evaluate the quality of facilities before they have moved in. People often move in to residential care in a time of crisis, such as the death of a spouse or deteriorating health, so they may find it difficult to visit candidate facilities in advance, and they may be relying on other people (such as family members) to choose for them. Even if pre-admission visits are possible, it is difficult to evaluate what the experience of living in a facility will be like during a short visit. This might not matter as much if it were easy for people to move to a different facility if they are unhappy with their first choice, but we know that such moves are very rare in practice, in part because of concerns for the adverse impact of such moves (Grabowski and Hirth, 2003). Under such circumstances, the incentive to compete on quality may be attenuated, with price becoming a more important factor in the minds of potential residents (Forder and Allan, 2011). In addition, for-profit homes may

Download English Version:

<https://daneshyari.com/en/article/5046632>

Download Persian Version:

<https://daneshyari.com/article/5046632>

[Daneshyari.com](https://daneshyari.com)