Section 18(3) and Fair Cost of Care implementation

Analysis of potential risks

20 January 2022

This research was commissioned under the previous administration (11th May 2010 to 5th July 2024) and therefore does not reflect the policies of the current government. The views expressed are the authors' and do not necessarily reflect those of the government.

Key messages

DHSC asked Frontier Economics to develop a framework that it could use with local authorities to better understand local risks in the residential social care system associated with implementation of the Fair Cost of Care (FCOC) and Section 18(3) of the Care Act 2014. The framework might be developed into a full toolkit to support local authorities in assessing their risks as they prepare for the implementation of 18(3) and FCOC by October 2023.

The most important risk for the social care system, for local authorities and for individual care users would be to the overall supply and continuity of care in an area. There may also be a risk for some individual providers through a change in demand, even if that does not affect the overall supply for the area. It is possible that staff and individual care users may then be affected, for example if a care home were to close or move premises.

The analysis looks first at the impact on providers, and then the supply and continuity of care, bearing in mind the impact for users in the transition.

Some providers will be largely unaffected by these reforms, particularly those with fee rates which are similar for local authority-funded and self-funded residents, and similar to the FCOC, or providers with few self-funders. However, the impact of 18(3) may be to reduce some providers' revenues and potentially lead to some provider exit or reduction in available capacity.

Assuming that local authorities introduce the FCOC, self-funders may still pay a higher rate than the fair cost where:

- the provider offers a higher level of service (e.g. a premium home) that is in demand from self-funders who are unlikely to seek lower prices for a more basic level of service.
- the provider charges a higher rate than is required to meet their costs and is able to do so as a result of an ineffective local competitive market, perhaps due to a lack of information on quality and prices of local providers. This may occur where a greater profit is made from self-funders, which could be in order to make up for economic losses on state-funded clients.
- the provider has higher costs than the FCOC, but these costs are either flexible, or if the costs are fixed, can be deferred for the period needed to reduce the cost base.
- the provider has higher costs than the FCOC, but these costs cannot be flexed easily and cannot be deferred.

Taking these four categories in turn: providers will be largely unaffected if they can continue to attract self-funders as in category 1. Although there may be some difficulty in the loss of income for providers in category 2, the FCOC rate does allow these providers to maintain at least an efficient market return (profit). The risk from s(18)3 also seems manageable for

providers who can flex their costs to match the rates that self-funders wish to pay, as in category 3. It is really only those in category 4 who face a clear risk from s18(3). These are providers which are relatively cost-inefficient, and currently rely on self-funders paying prices which exceed the FCOC, but the introduction of 18(3) will improve self-funders' options and may erode this income. They were only viable as long as information and choice in the market was restricted. Local Authorities will need to monitor the situation to ensure residents of such providers receive appropriate care and support while the providers respond to the more fully revealed preferences and choices of better informed care users.

At the local area level, it seems that the supply of good quality care in an area will only be at risk if a substantial part of the supply in the area currently lies with category 4 providers. With their responsibility for market oversight, the LA may already have a plan for improving supply in the area, to enable self-funders to have the choice they want, and rely less on high fixed cost providers. LAs who do find themselves in this position may need some central support and guidance to enable them to manage through the situation.

For those local areas that do face some risk, the magnitude of these risks will depend upon:

- **the size of market adjustment required in response to FCOC and 18(3)** – in particular the extent to which the local authority currently pays below the FCOC, self-funders currently pay more than the FCOC, and the take-up of 18(3).
- **the ability of the provider base to adjust** – in particular the fixed costs faced by providers and the extent of 'switching' by self-funders taking up 18(3). Providers with high fixed costs (above the level reflected within the FCOC) may be most at risk of reduced demand, while others are better placed to manage the transition. However, we note that the social care market is currently facing many challenges.
- **the ability of the local authority to meet any additional funding needed**, recognising that for a local authority paying the FCOC, the additional cost is only likely to be a transitional one, to ensure sufficient supply of care at the FCOC and enable high fixed cost providers to adjust to a new equilibrium as necessary.

This report is about risks. In passing, it is worth noting that there may be substantial benefits from these reforms. First, for the strength of the overall supply of care and the care market, due to payment of the FCOC; and second, for individual self-funders due to introduction of 18(3) which will mean they can rely on the local authority to help them navigate the care market and obtain a competitive price.

Our best estimate is that these risks will be most significant during a transition phase of 1-2 years. It will likely take this long for 'full' take-up of 18(3) to be observed, and providers' fixed costs will become more flexible beyond this transition period.

We have applied our framework illustratively to show how it works. Using imperfect data, our analysis suggests that using different measures, some local authorities may appear more or

less ‘at risk’, and a rounded assessment will be required at local level to conclude whether the market adjustment required is likely to be problematic. Better data is required to allow a full and robust risk analysis, which we expect will be undertaken by each local authority for their own area. Data collection should focus in particular on identifying the extent of high fixed cost provision in the local area and on the likely take-up of 18(3) by self-funders (particularly amongst those which might otherwise be placed with high fixed cost providers). This will allow for local authorities – with the support of central government – to mitigate potential risks as far as possible.

We recommend extensive pre-implementation engagement between local authorities, providers and central government. This should be used to gather more data and develop a greater understanding of the impact on local markets. This will allow the social care system as a whole to identify and plan for risks and to maximise the benefits of implementing FCOC and 18(3).

Introduction

Frontier has analysed the potential impacts on the residential social care market of implementing Section 18(3) of the Care Act 2014 and introducing the Fair Cost of Care (FCOC). Two sets of analysis preceded this report: a survey of providers and local authorities to understand how they might act in light of the changes; and an analysis of the potential for charging reform to increase market innovation and free up household savings.

Implementing 18(3) and FCOC offer significant potential benefits from ensuring a sustainable supply of care, tackling perceived unfairness in the rates paid by many self-funders and enabling the cap on care costs to function effectively. In this separate note DHSC have asked for a high-level overview of the potential risks arising from these possible policy interventions. The main objective of setting out the risks is to develop a consistent framework that local authorities could use – perhaps with further development into a toolkit – to assess their local risks. Applying the framework, locally and nationally, would help identify the extent and location of risks from the changes.

This note explores what risks there are in the system, how they arise, how risky they are likely to be, and the likely lines of mitigations.

The social care market (residential and nursing care homes) is currently facing many challenges, including workforce recruitment and retention, occupancy, investment and innovation. Together with changes from the planned charging reforms, these factors create some risks (compared with reform in a more stable market) that are beyond the scope of this note, which focuses upon the impact of 18(3) and FCOC. However, it is important to note that these wider challenges create less capacity overall to plan for and properly implement these changes.

Assumptions

This note builds upon other work, by Frontier Economics and others, and we have not repeated the evidence base or all the previous reasoning and analysis in this note. Based upon discussions with DHSC, our previous work and understanding of the market, we have made some assumptions. These are inputs to our analysis, which could be varied in future if new evidence emerges. We have described in this note where our analysis depends upon particular assumptions.

Based upon discussions with DHSC, noting that the detailed plans for implementation are not yet finalised, we have assumed the following about the **implementation of 18(3)**:

- Implementation of 18(3) will occur in October 2023, with all individuals able to take up 18(3) from that point.[1]
- Individuals taking up 18(3) will be offered the same placement options, at the same fee rates, as local authority-funded residents.
- 18(3) will be implemented such that local authorities will:
  - arrange the care home placement on behalf of the individual;
  - contract with the care home provider on behalf of the individual; and
  - offer the individual the same fee rate as would be paid by the local authority if it were placing a local authority-funded resident.
- In addition, it might be possible – if this is agreed by local authorities and providers – that additional fees / 'top-ups' could be paid by individuals, in exchange for additional or higher quality services. This option would also continue to be made available to local authority-funded residents.

In addition, based upon our previous work on the social care market, we have assumed:

- Awareness of 18(3) is reasonable amongst local authorities but currently very low amongst providers.
- Amongst all self-funded individuals (who are potential 18(3) 'switchers'):
  - there are a proportion who may not take up 18(3), as they are in the market for premium-end homes, and these will likely not be available at the local authority FCOC rate for the area; and
  - amongst those who consider taking up 18(3), they will compare the quality (broadly defined) and price of alternative care homes.

[1] It is possible that some locations will implement 18(3) earlier, which would provide invaluable insight into the potential impact in other locations.

- Currently the quality differential between self-funded and local authority-funded care (excluding the premium-end homes) is perceived to be small by potential residents and by local authorities.

Based upon discussions with DHSC, noting that the detailed plans for implementation are not yet finalised, we have assumed the following, about the **implementation of FCOC**:

- Implementation of FCOC will occur from April 2022 onwards, with local authorities undertaking cost of care exercises to inform appropriate fee rates.
- The FCOC rate will be determined locally, supported by national guidance.
- The FCOC rate will reflect the long-run costs of provision, including investment, estates maintenance and a reasonable rate of return on capital employed.

Based upon previous work, for example the Competition and Markets Authority's (CMA) care homes market study, we have assumed that:[2]

- On average, there is underpayment by local authorities relative to FCOC.
- On average, self-funder rates are higher than local authority rates for the same quality.

We have also abstracted from the availability of new funding. We focus on exploring the other risks which might follow implementation. However, we note that:

- if funding is insufficient, the risks to the sector will be far greater, and that this may also change which particular local authorities are most at risk;
- the distribution as well as amount of funding will be important – in this note we explore the variation in circumstances across different local areas which might inform the most appropriate targeting of funding; and
- there is a distinction between 'transition' and 'steady state' risks – in some cases funding may only be necessary for a shorter period to support the market in transitioning to a new steady state; in other cases longer-term funding may be necessary.

Definition of risk

We consider the possible **risks to the supply and continuity of good-quality care**. This follows from the potential risk to provider profitability and financial viability, or their ability to plan and deliver good-quality services. Providers facing reduced demand may be at risk of exit, with negative consequences for their residents and staff.

We consider this across the provider base in a given local area, recognising the fact that risks to any particular provider do not necessarily pose a risk to the overall supply of care. Market

2 CMA (2017)

exit may be more problematic if one large provider, or multiple smaller providers, are affected simultaneously.

We also consider the **risk to local authorities**, either from the absence of sufficient good-quality residential social care, or due to increased costs of care faced by the local authority.

These in turn lead to potential **risks to individuals receiving care**, if they are unable to access good-quality care, or the continuity of their care is affected, or the costs of care to the individual increase.

Given all of the above, there is a broad **risk for Government** in ensuring the effective functioning of the residential social care market and achieving value for money from public spending in the sector.

Framework

We have considered the level of risk in three stages:

1. Size of market adjustment required
2. Ability of provider base to adjust
3. Ability of local authority to meet additional funding need

In reality, stages 2 and 3 will be tested simultaneously. In each local market, the council and providers constantly negotiate to agree short-term demands (e.g., placements and fee rates) and to shape longer-term supply (e.g., future capacity and type of care required). Nevertheless, we believe it is helpful to consider these two sides of the market separately before bringing them together in the overall assessment.

Stage 1: Size of market adjustment required

First, to what extent will the market need to adjust?

For the introduction of FCOC, the impact will be determined by the **existing FCOC gap (if one exists)** between the rates that are typically paid by the local authority and the FCOC level. Previous work suggests that fee rates vary across placements and over time, such that most local authorities will be paying different rates simultaneously. For many local authorities, on average, the rates paid fall below the FCOC. The larger this gap, the greater additional funding will be necessary from local authorities.

If local authorities have sufficient funding, the risks from introducing FCOC are small, and the benefits to market sustainability could be significant. The main risk is that funding is not targeted at the right local authorities, or that 'too much' funding leads to poor value for taxpayers.

For the introduction of 18(3), one of the key factors determining impact will be the level of **take-up of 18(3)** i.e., the number of self-funders who ask the local authority to arrange their care. This will likely depend upon the **level of awareness of 18(3)** amongst self-funders.

For self-funders who are aware of this option, they will weigh up the relative merits of arranging their own care (with whichever providers are willing and able to provide a placement) and asking the local authority to do so. Four important factors in whether they choose to take up the local authority 'offer' will be the **convenience, choice, quality and fee rates** available and how these compare with the privately-available options.[3] Taking each of these in turn:

- the convenience of the local authority arranging care may avoid the 'search costs' for an individual or their family doing it themselves, however this may be offset by 'delay costs' if the local authority is not very responsive in arranging care;
- the choice available via 18(3) may be more limited than for privately-arranged care, since it will be limited by existing local authority contracting arrangements;
- the quality available is likely to be similar, based upon previous research, if we exclude the 'premium end' of the market;4
- the fee rates are likely to be lower when arranged through the local authority, and the extent to which they are lower may be the single most important factor in determining 18(3) take-up.

Previous research suggests that, on average, local authorities tend to pay less than self-funders for the equivalent quality of care home placement. For local authorities where the 'LA-SF gap' is smaller, this will create a weaker incentive for take-up of 18(3). Note that **due to the introduction of FCOC, the 'LA-SF gap' will become the 'FCOC-SF gap' in future and will thereby become smaller in many areas**. **In local areas where the 'LA-SF gap' (or 'FCOC-SF gap') remains significant, there will likely be greater take-up of 18(3)**, due to the stronger incentive amongst self-funders to take advantage of lower local authority rates.

Additionally, in areas with a **larger proportion of self-funders** there will be a greater impact for any given level of take-up, due to the higher numbers of residents switching.

One countervailing factor to the above impacts is the presence of a **'premium homes' part of the market**. In areas where there is a higher LA-SF gap, and a greater proportion of self-funders, it is likely that this premium sector is larger. We currently assume that there will be relatively little impact on this sector from the reforms, with local authorities generally not offering placements in these homes, and individuals considering these homes therefore not taking up 18(3). We might choose to exclude this sector of the market from our analysis,

[3] The CMA (2017) noted that many self-funders make decisions based on relatively poor information and market understanding, which may somewhat reduce the impact of these decision-drivers.

[4] We note that local authorities will typically have better information than individuals about the quality (and choice) of care available.

which would suggest a smaller LA-SF gap and a smaller proportion of self-funders, both of which would imply a **weaker impact of implementing 18(3)** in areas with a larger 'premium homes' sector.

The **main risk from implementing 18(3)** is that significant take-up of 18(3) leads to providers receiving lower fee rates for a large number of residents or having lower occupancy, reducing their income and threatening their viability and thereby the supply of care. However, **if local authorities consistently pay the FCOC for placements this will significantly reduce the risk** to provider finances.

In such instances self-funders may still be charged above the FCOC if:

- the provider offers a higher level of service (e.g. a premium home) that is in demand from self-funders who are unlikely to seek lower prices for a more basic level of service.
- the provider charges a higher rate than is required to meet their costs and is able to do so as a result of an ineffective local competitive market, perhaps due to a lack of information on quality and prices of local providers. This may occur where a greater profit is made from self-funders, which could be in order to make up for economic losses on state-funded clients.
- the provider has higher costs than the FCOC, but these costs are either flexible, or if the costs are fixed, can be deferred for the period needed to reduce the cost base.
- the provider has higher costs than the FCOC, but these costs cannot be flexed easily and cannot be deferred.

Since a market level of profit is included within the FCOC, providers that charge self-funders more than the FCOC in order to earn greater profits should face limited risks under significant take-up of 18(3). An exception to this would be if the higher profit margins used to subsidize another portion of the providers business (i.e. services provided by the business other than residential care to elderly residents).

Even within non-premium care homes, some self-funders may be charged higher fees than the FCOC in exchange for extra services. If self-funders continue to demand these extra services once section 18(3) is introduced, there should be limited risks to providers.

The remaining risk would seem to be where the provider has **non-deferable fixed costs that are higher per resident than are reflected within the FCOC** for the area.[5] We consider that fixed costs are those which cannot be substantively reduced or avoided within a period of 12 months.[6] Possible fixed costs include rent, leasing costs, or debt interest. If providers are able to defer these costs, they may be able to adjust their cost base in the long term to ensure

5 We assume that the FCOC will also be sufficient to achieve a reasonable return on capital employed.

6 In practice, a provider has many different costs which range from highly fixed (possibly for multiple years) to highly variable (i.e., can be varied immediately).

they remain financially viable. However, these costs pose an even greater risk where deferral is not option (for example where a provider doesn't own a property outright and has rental commitments). Meeting these costs, if a provider's revenue falls, may lead to a **transition or short-term risk of provider viability** and a medium-term challenge to reduce these costs when it is possible to do so.

Many high-cost providers may be operating in the 'premium homes' market. Their higher fixed cost base is likely associated with high quality homes, with additional facilities, in desirable locations. As noted above, we expect these homes may be affected less by the introduction of FCOC and 18(3), which would suggest **fewer providers at risk due to high fixed costs and falling revenues**. However, in the absence of good evidence about the cost bases of all providers, it is **hard to say whether many other 'non-premium' homes may also be negatively affected and potentially at risk of unviability**. We discuss later in this note where better data and evidence may be valuable.

We note that the impact – and therefore also the required adjustment – **will occur over time**. We expect that new care home residents will start to take up 18(3) from October 2023. Some existing residents may take up 18(3) straight away, however many may be reluctant (or unable, depending upon their needs) to do so if it meant moving between homes. The full impact of 18(3) will therefore only be observed once all 'new' care home residents have had the option to take up 18(3). Given the average care home length of stay is 2 years, it will take **around 2 years for the full impact of 18(3) to be observed**. It is also possible that it takes longer than this, for example if awareness of 18(3) builds over future years. The **impact of FCOC is likely to be faster**, assuming local authorities implement it for all new contracts following implementation (assumed in April 2023).

The combined effect of the above timing should be to reduce the speed at which local markets need to adjust. Also, we note that if our assumptions above regarding the timing of implementation are correct, the sector will have time to plan for implementation.

Where a larger market adjustment is nevertheless required, the impact will depend upon the ability of providers and local authorities to adjust, and their relative bargaining power.

Stage 2: Ability of provider base to adjust

The **social care market is currently facing many challenges**, including workforce recruitment and retention, low occupancy, low investment and innovation. In this context, **implementation of 18(3) and FCOC adds a further level of change and uncertainty**, and the impact upon the provider base should be monitored carefully in each local area.

Each local authority deals with dozens (or even hundreds) of care home providers. Many currently have spare capacity, particularly following Covid-19, although demand is forecast is

recover post-Covid and to continue to grow, driven in part by England's ageing population.[7] Over the longer-term (perhaps 5-10 years), the sustainability of good-quality supply will depend upon the market attracting new investment and increasing capacity to meet this demand.[8] This will require resolving some of the above issues, including attracting and retaining workforce and attracting new investment.

Currently, the **market for local authority-funded residents tends to be competitive**, with providers keen to fill their beds, offering local authorities the lowest possible fee rate for placements. In some cases, these low fee rates are only sustainable due to higher fee rates paid by residents in the 'self-funded side of the market'. In other cases, these low fee rates are in fact not sustainable long-term, with providers unable to afford maintenance and refurbishment of their facilities.

Introducing **FCOC may affect the supply of care significantly**. Amongst providers which are currently not sustainable in the long-term, the **increase in fee rates should secure this supply** for the future. Amongst providers which are currently sustainable due to higher self-funder fee rates, **competition could lead to a reduction in self-funder fee rates**. This depends upon competition between providers to secure self-funded residents. The 'textbook' conditions for effective competition include:

- the presence of **many providers** competing for many customers – both likely to be the case in most local social care markets;
- supply of a **similar (quality of) service** from many providers – likely to be the case in most local social care markets;
- **free entry and exit to the market** for providers – in social care markets barriers to entry and exit are generally low, although there are some conditions (such as regulatory and planning processes, and the ability to invest or disinvest capital) which mean that new entry can take two to three years;9 and
- **good information** regarding the service, held by all sellers and buyers – this is often not the case, as many self-funders tend to be poorly informed and are not always well-placed to make rational decisions.

All the above factors are affected by, and in some cases have an effect on, the size of fixed costs faced by providers. Higher fixed costs reduce entry, can make adjustment more difficult and changes in fee rates more important. We discuss the role of fixed costs in more detail below.

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7 LaingBuisson (2021)

8 We note that over the longer-term, the social care system is also likely to evolve towards a model where fewer people require residential care, which may reduce somewhat the demand for additional capacity.

9 CMA (2017)

The competitive context will vary across local provider markets, and this has led to self-funders tending to pay more than the FCOC for a few different reasons. For some providers this has been necessary to offset the below-FCOC rates paid by local authorities, and in this case the increase in local authority rates should allow self-funder rates to fall (subject to the competitive considerations above). Other providers have benefited from above-FCOC self-funder rates in the form of higher profits, and in this case, it appears the level of competition locally has been insufficient to reduce fee rates (indicating that the payment of FCOC by local authorities may have less impact on self-funder rates).

If self-funder rates fall, this would lead to a reduction in the LA-SF gap in these locations, and a smaller required market adjustment. However, as noted above (and in the CMA's 2017 market study), the market for self-funded care is less competitive than for local authority-funded care and it is possible that higher self-funder rates are not 'competed down'.

By increasing provider revenues, introducing **FCOC will therefore reduce the impact of 18(3)**. However, we expect that some providers will still be vulnerable (particularly in the short term) to any reduction in self-funder revenues. This is due to historical low fee rates, under-investment, variation in provider cost-efficiency and fixed costs, and possible variation in the payment of FCOC by local authorities over time and across particular placements. We also expect that even after payment of FCOC, many local markets are still likely to exhibit a LA-SF gap (or 'FCOC-SF gap'), which could lead to a **reduction in provider revenues due to self-funders taking up 18(3)**.

This **reduction in revenues will fall more heavily on some providers than others**. The impact on a given provider will depend upon its mix of residents (including self-funders and local authority placements, both in- and out-of-area) and the rates paid. For example, a provider which currently charges self-funders a similar rate to local authority residents would see little or no impact on its revenues. On average, however, we would expect that provider revenues will fall due to 18(3), and this may be problematic for some providers, and therefore potentially also their staff and residents.

Given the above competitive context, a local authority which manages its market effectively should be able to use competition amongst providers to achieve 18(3) fee rates which are in line with its local authority-funded rates and lower than the existing self-funder rates. The key question locally will be **whether providers – in aggregate across the local market – are able to adjust to lower self-funder fee rates if required?**

The **social care provider base is varied** in its nature. Providers range from small single-home operators to large corporate groups operating thousands of beds. The financial model of providers also varies widely. Some own the care home property and can benefit from capital asset growth, while others – particularly amongst medium-sized and larger groups – have sale-and-leaseback arrangements, freeing up capital for expansion. Some providers have also drawn upon private equity, often to fund expansion.

Providers' **willingness and ability to compete for lower fee rates will be strongly affected by the extent to which their costs are fixed**. This depends, in particular, upon the nature of a provider's property costs. Where a provider owns its property outright, their immediate property costs are lower, and they may have more flexibility to manage a transition period of lower returns. By contrast, those with rental or leasehold properties are likely to be committed to payments which may be difficult to renegotiate. Operators of newly-built homes (particularly 'premium homes') tend to face higher fixed costs and less flexibility, as compared with established operators of homes which are more often owned by the operator.

Some providers' business models have separated property ownership from the operation of their homes, which may offer more or less flexibility depending upon the ownership and control of these separate parts of the business. Some providers also face significant debt obligations, which represent a high fixed cost to the business.

Where a provider faces high fixed costs, financial viability also depends on the extent to which these costs are deferable. For example, where providers own their property outright, fixed costs (such as maintenance) may be deferable in the short run. This could be less likely where the provider is subject to regular payments such as lease, rent or debt repayments. In this case ongoing costs will be a larger proportion of the total cost. Larger ongoing costs will mean that the provider could be less able to withstand any falls in revenue.

In the long term, all providers need to achieve a reasonable return on capital (including property) and failure to do so will make the business unsustainable. However, providers' willingness and ability to respond short-term is more varied and will depend upon their individual financial position across their P&L, balance sheet and cashflow.

The ability to adjust to lower self-funder fee rates will require providers to achieve some combination of the following:

- **Reduce profit margins**. If providers have higher profit margins, they may be more able to adjust to lower fee rates. However, this depends in part upon their financial structure and returns which are required e.g., by investors. Large corporates operating multiple homes may be better able to adjust to lower fee rates in some areas if rates remain stable in other areas, depending also upon the number of out-of-area residents they have. Larger operators may also have less flexibility due to leasing arrangements, debts and investor expectations. Across England, evidence suggests that profit margins are relatively thin, but with variation between providers.[10]

- **Reduce costs**. If providers have higher fixed costs, in the short term they will be more willing to take placements (at any fee rate) to offset these costs. However, in the medium

[10] LaingBuisson (2021)

term this may not be sustainable, and providers will need to reduce their cost base. This will put downward pressure on wages and associated training costs. Capital investment will likely be reduced, limiting the amount of refurbishment or expansion in the market. Operators with property leases may seek to renegotiate, although this may not be possible. In the longer term, reducing costs in this way may prove to be either impossible or create a risk to provider sustainability.

- **Increase revenues**. Providers will likely seek to increase their revenues through other means. One option will be to try to negotiate with local authorities to require 'top-up' payments from residents for certain services.11 This may allow providers to place 18(3) residents at fee rates which are above the local authority rate and thereby protect revenues. A second option will be attempting to diversify and/or re-focus on a different segment e.g., focusing on self-funders, potentially refusing local authority placements, or refusing 18(3) placements.12 Providers' ability to increase revenues will depend upon the negotiating power of the local authority and the competitiveness of their local market. They may also achieve higher revenues in the event of market exit by other providers (discussed more below), although this is beyond the control of individual providers.

A provider's decision about which (combination of) these responses to make will depend upon a range of factors, including those noted above e.g., their business model, ownership structure, nature and length of existing contracts and obligations, current financial position, and availability of staff.

If providers are able to respond in one or more of the above ways, then any reduction in fee rates due to the implementation of 18(3) may be **managed by the market in the short term**. However, we note that some of the above responses **may have a negative impact on the market over the longer term**. For example, keeping wages low or avoiding capital investment will further weaken the ability of providers to offer sustainable, good-quality care.

If the above responses are not possible, or are insufficient to meet the required adjustment, then **market exit may occur**. This may have a mix of positive and negative consequences. The exit of some providers would likely lead to an increase in occupancy levels for the remaining providers, increasing their revenues and profitability. If the providers which leave the market are those which are less well-managed, less cost-efficient and lower-quality, this would be less of a concern to local authorities.[13] If instead 'better' providers are those to exit, this may undermine the availability of good-quality care. In either case, market exit may negatively impact upon staff and existing residents, and may lead to a **short-term risk for**

11 These services could not be those which are included in an individual's care plan or meet eligible needs.

12 The ability to refuse 18(3) placements will depend upon providers knowing whether an individual is an 18(3) placement or a local authority-funded resident. This may or may not be the case, depending upon how 18(3) is implemented in practice.

13 This might also improve overall market outcomes and social welfare, so long as a sufficient supply of care is maintained.

the supply and continuity of care. Additionally, over the longer term, local authorities will likely increase their demand for placements and will need to ensure sufficient capacity (including new entry) to meet this need. To balance all the above factors, **local authorities should monitor closely the potential for market exit and entry**.

Stage 3: Ability of local authority to meet additional funding need

Some local authorities will need to **pay more to meet the FCOC**. In this note we do not directly address the total additional burden on local authorities, or how much financial support from central government might be necessary.[14] However, we note that:

- some local authorities will already pay at least the FCOC level, and the introduction of the FCOC policy will make no difference;
- some local authorities currently pay a little below the FCOC level and may need to pay a little more; while
- other local authorities will need to pay significantly more to meet the FCOC level.

If the introduction of 18(3) places pressure for self-funder fee rates to fall and the local provider base is not able to adjust (discussed in Stage 2 above), the impact will depend upon the willingness and ability of the local authority to pay the FCOC. Increasing the average rates paid by the local authority should have three beneficial impacts for provider revenues:

- revenues for local authority-funded residents increase where needed;
- the LA-SF gap declines, reducing the attractiveness of taking up 18(3); and
- the 'revenue lost' for each resident taking up 18(3) becomes smaller.

Whether or not the local authority is **able to afford to pay more** will depend upon a range of local factors. If the area is more affluent, it may be easier for the authority to raise funds locally through council tax. If the local authority has financial reserves, it is possible that these might be able to support funding in the short run, although there may be limitations to how these funds can be used (e.g., in some cases these reserves must be held under Private Finance Initiative obligations). More generally, wider pressures on social care – including due to charging reform – or other local services may limit the ability of local authority to respond.

Separately, the local authority may or may not be **willing to pay more**. Historically, some local authorities have prioritised social care spending in their area and paid more, relative to its needs-based 'allocation formula share' under the Adult Social Care Relative Needs

[14] Later in this note we do provide an indication of the existing gap between local authority rates and the FCOC.

Formula.[15] In these areas the local authority may be less willing to increase its funding further, and indeed this historical spend may suggest that the local provider base may be more robust financially. Additionally, local authorities with a stronger market-managing capability may feel they are better able to manage a transition period (e.g., including allowing some provider exit) while the provider market adjusts. Local authorities which are willing to pay more for some placements, may choose to prioritise residents with particular needs (e.g., which can be best met in a particular care home) or to prioritise particular care homes (e.g., those most at risk and/or with many residents).

There will be a greater risk for local authorities where they are more reliant on providers which are particularly at risk from section 18(3) to maintain the overall supply of care. As stated earlier, providers that face high fixed (non-deferable) costs that are higher than the fair cost for the area are most at risk from section 18(3). However, the risk to local authorities in maintaining the overall supply of care in their area will be greater if they are more dependent on these providers to maintain supply. This could be the case if occupancy rates in the area are high with alternative providers close to full capacity. In this case local authorities may face greater transition costs as they may have to help facilitate new entrants to the market to replace provision from at-risk providers.

One further risk facing local authorities is the **additional administrative burden** associated with individuals considering taking up 18(3). All such individuals will require means and needs assessments, a choice of care homes will need to be sought on their behalf, and – for those taking up the offer – a placement agreed with the chosen provider. This will require additional administrative capacity, at the same time as the introduction of charging reform will also require additional administration. We expect that the funds required to cover these costs will be met through a combination of administration fees for self-funders (to cover commissioning costs but not for assessment costs), central funding and local funding (e.g., council tax). However, local authorities may have difficulties recruiting and training administrative staff, or managing this additional caseload and new processes, which may have an impact upon the **convenience of accessing care services**, or potentially even the **ability to access care services** in a timely manner.

Market scenarios and assessing local area risk

Based on the above framework stages, it would be possible for each local authority to diagnose the size of risk it faces. We developed the following illustrative 'market scenarios' which might exist across England, categorising the level of risk:

[15] We note that this may, in part, also reflect the ability of a local authority to pay more e.g., due to a stronger council tax base.

Table 1 Market scenarios

Scenario	Size of market adjustment required	Ability of provider base to adjust	Ability of local authority to meet additional funding need	Level of risk
1	Greater adjustment	Lower ability to adjust	Lower ability to fund	
2			Greater ability to fund	
3		Greater ability to adjust	Lower ability to fund	
4			Greater ability to fund	
5	Lower adjustment	Lower ability to adjust	Lower ability to fund	
6			Greater ability to fund	
7		Greater ability to adjust	Lower ability to fund	
8			Greater ability to fund	

Source: Frontier Economics

Considering each stage of our framework, greater risk is likely where:

- greater adjustment is required;
- the ability of the provider base to adjust is lower; and
- the ability of the local authority to meet the FCOC plus any transition cost is lower.

As discussed in the previous sections, the primary risk is the possibility of insufficient supply of good-quality care at a fair price in a given area. To identify cases where this might occur, attention should be focused on any areas where the local authority may not be able to pay the FCOC, or where particular providers with high fixed costs may become unviable due to take-up of 18(3) reducing their revenues. Identifying the local markets and particular providers affected by these circumstances will assist in targeting mitigating actions including short-term or transitional support where required.

The market scenarios reflect that Stage 1 – whether an adjustment is required – is relatively more significant in determining risk than Stages 2 or 3. Where no adjustment is required, the ability of the market to respond is less relevant. When an adjustment is required, the ability of providers to respond (Stage 2) is then likely to be a more significant driver of risk than the position of the local authority (Stage 3). There is also an interaction across these stages. In the following section we consider the extent to which local areas which are at greater risk under Stage 1 of our framework are also greater risk under Stages 2 and 3.

The above market scenarios are a simplification, and local authorities may in reality fall anywhere on this spectrum. The level of local risk is complex, depending on the above factors but potentially also other local circumstances (e.g., skills and capacity of social care teams within the local authority).

The framework also demonstrates that the risk may be greater during a period transition (e.g., managing market exit) or greater over the longer term (e.g., if short-term cost-cutting measures are exhausted or if there is inadequate investment in new capacity).

The framework and market scenarios above provide a starting point for understanding the level of risk in any given location. This should help to guide more detailed local assessments, undertaken by local authorities themselves.

Illustrative application of the framework to assess risk

In order to test its implementation, we have applied the above framework based on currently-available, imperfect data. This illustrative application will allow DHSC to refine the framework into a toolkit that they can then use collaboratively with local authorities. Working with local authorities would also allow DHSC to gain a greater understanding of which (types of) local authorities appear to be more at risk, and any other patterns which emerge e.g., whether they are concentrated geographically, and whether they tend to exhibit particular characteristics.

The data available is limited. We gathered data for the following metrics, for each local authority in England:

Stage 1:

- LA-FCOC gap[16]
- LA-SF fee gap[17]
- % of self-funders[18]

16 We have used unpublished DHSC data. The FCOC estimate is based on the rate for older people's care paid by the Scottish government, increased to reflect the fact that property rental costs are higher in England than in Scotland, and then geographically adjusted according to English variation in property rental costs as measured by one-bedroom Local Housing Allowance.

17 Data is only available at a regional level for this metric.

18 We have drawn upon unpublished Provider Information Return data for individuals aged 65+, provided by DHSC. We note that the ONS has recently published similar data (*Care homes and estimating the self-funding population, England: 2019 to 2020*), and this new data series may in future support better analyses.

Stage 2:

- Occupancy levels[19]
- Quality: % of providers rated Good/Outstanding
- Market Dynamism: % of entry/exit over 5 years in terms of care home beds[20]

Stage 3:

- Deprivation level
- LA spend vs allocation formula share: Estimate of historical spend

The choice of these metrics was informed by the framework outlined above, our previous work on understanding the social care market, and the data which was available. We note that future data collection (discussed further below) could allow for a more comprehensive analysis.

These characteristics of local market are correlated, due to the nature of the local area and historical context. For example, we find that:

- more affluent areas typically also exhibit a greater proportion of self-funders, since the requirement to self-fund is based upon individuals' financial means;
- areas where there is a positive LA-FCOC gap (i.e., local authority pays more than FCOC) will also typically exhibit a higher historical spend compared with allocation; and
- higher quality is associated with a positive LA-FCOC gap and higher historical spend compared with allocation.[21]

Stage 1: Size of market adjustment required

We have explored the size of market adjustment which might be required.

Across local authorities in England, we find that the LA-FCOC gap ranges from -28% to +26% with median value of -6%. This means that **many local authorities are already estimated to pay more than the FCOC and that no adjustment would be required**.

19 We have used Provider Information Return data, based upon CQC registered bed occupancy. We note that other data sources are available (including Capacity Tracker) and that multiple alternative measures of occupancy can be derived. Future analyses might explore the sensitivity of any risk assessment to the occupancy data used.

20 We interpret greater historical entry and exit as indicating a greater degree of market dynamism and ability of the provider base to adjust to changes in market conditions. However, we note that this might also indicate market instability which could have the opposite implication. We discuss later in the note where better data might allow a more robust assessment.

21 We note that there is little 'cross-sectional' evidence that higher fee rates are associated with higher quality. However, we would expect that over time, lower levels of payment would have a negative impact on quality.

However, some 97 (65%) local authorities are estimated to pay average fee rates which are at or below FCOC, indicating **some adjustment will be necessary**. Of these, around 47 (32%) local authorities are estimated to pay average fee rates which are 10% lower than FCOC (or below this level), with around 9 of these (6%) estimated to pay 20% lower than FCOC (or below this level).

Across local authorities in England, we find that the percentage of self-funders ranges from 0% to 73% with median value of 37%. This suggests **wide variation in the size of the self-funder market and likely take-up of 18(3)**. We also note, however, that we do not have data on the size of the 'premium homes' market, which will account for part of this self-funder market.

Across the regions of England (data at local authority level currently unavailable), the LA-SF fee gap ranges from 23% to 52% with mean value of 44%. Compared with the LA-FCOC gap (ranging from -28% to +26%) this indicates that **paying the FCOC is unlikely to completely close the LA-SF fee gap** for many local areas, unless self-funder fees also decline (which is possible, see discussion above). It is worth noting again that ideally we might exclude the self-funder rates paid in 'premium homes' market, however we do not currently have the data to allow this.

If we focus on the **'most at risk' quintile of local authorities** (20%, around 30) for each of the above metrics, we find that the quintile with the largest negative LA-FCOC gaps are estimated to pay average fee rates which are 13% lower than FCOC (or below this level). The quintile with the largest LA-SF fee gap are estimated to pay average fee rates which are at least 52% lower than the fees paid by self-funders. The quintile with the greatest share of self-funders are estimated to have, on average, a share of self-funders of at least 49%.

We have considered the combined impact of these factors. We find that **amongst those local authorities with rates that are 13% lower than FCOC, around 11 (7%) also have more than 50% LA-SF gap and around 1 has more than 49% self-funders**. This suggests that using different measures, some local authorities may appear more or less 'at risk', and a rounded assessment will be required at local level to conclude whether the market adjustment required is likely to be problematic.

Stage 2: Ability of provider base to adjust

We have also considered the ability of providers to adjust to lower fee rates, if necessary.

We find that occupancy levels range from 71% to 97% with a median value of 84%.[22] This suggests there is **potential for some market exit and for consolidation of revenues amongst fewer providers** in some areas. The quintile of areas with highest occupancy have

[22] We note that occupancy levels within individual care homes can occasionally be significantly lower.

levels of 89% or higher. However, we note that occupancy levels are recovering from Covid and further work would be necessary to confirm this picture.

Considering quality, we find that the percentage of providers rated Good or Outstanding ranges from 58% to 100% with a median value of 82%. This wide variation in the quality of care may indicate similar wide variation in the quality of provider management. The quintile of areas with lowest quality have 73% or fewer providers rated Good or Outstanding.

Considering market dynamism, we find that the percentage of entry/exit over 5 years in terms of care home beds ranges from 0% to 18% with a median value of 6%. This again suggests very wide variation in the nature of local markets. The quintile of areas with lowest dynamism had 3% or less entry/exit in the past 5 years.

Considering the combined impact of occupancy, quality and market dynamism, we find that amongst the quintile with occupancy rates above 89%, 4 (2%) are also in the lowest quintile for quality and around 9 (6%) are in the lowest quintile for market dynamism. Amongst those local authorities with a share of Good/Outstanding care homes equal or smaller than 80%, around 4 (2%) are also in the lowest quintile for market dynamism. This analysis suggests relatively little relationship between these metrics: they appear to neither reinforce nor counteract each other.

Stage 3: Ability of local authority to meet additional funding need

Third, we have considered the ability of local authorities to pay more for care, if this is required. This could assist DHSC in determining how best to target additional funding to support implementation of 18(3) and FCOC.

Our analysis finds that the estimated historical spending of local authorities relative to their allocation formula share ranges from -40% to +42% with a median value of -2%. A little over half of local authorities (87, or 58%) are estimated to spend less than their allocation. The quintile of local authorities spending the least spend 15% below their allocation (or less).

This suggests that local authorities 'over-spend' as often as they 'under-spend'. The **risk from implementing FCOC and 18(3) may be greater amongst those local authorities which have historically spent less than their allocation formula share**. Our analysis suggests these authorities are likely to be **less affluent**, with **lower levels of quality and market dynamism**, and have a **more negative LA-FCOC gap** (all of which indicates higher risk), although they will typically also have **fewer self-funders** (which may somewhat reduce the risk).

Potential risk mitigation

Local authorities will undertake a detailed assessment of the extent of risk in their area, drawing upon local intelligence. Depending upon the nature and size of risks identified, it may be necessary for local authorities and/or central government to attempt to mitigate these risks.

The role of government (local and central) is not to support certain provider models or providers, but some support may be needed through the **transition** to a new 'steady state' in the market in order to avoid the process of adjustment negatively affecting the availability of good-quality care.

Potential risk mitigation which might be undertaken by **local authorities** includes:

- modelling the impact of FCOC on rates paid to different local providers and the aggregate impact on both local authority spending and provider revenues;
- engaging and informing providers about changes to fee rates due to FCOC to allow them to model the impact on their business;
- working with providers (and potentially directly with residents and their families) to gather data on the local self-funder population and possible take-up of 18(3);
- working with providers to agree changes to the placement process, including what options and rates will be offered to potential 18(3) residents;
- asking providers to estimate the impact upon their business under different 18(3) take-up scenarios;
- agreeing with providers whether top-ups of some form might be used and if so, how they would be defined and priced; and
- planning for the potential exit of some providers, both to manage short-term supply and continuity of care but also ensuring medium- and longer-term capacity will be sufficient to meet demand.

Potential support which might be provided by **central government**, to assist local authorities in mitigating risk, includes:

- **Supporting local authority decision-making**. Government could offer local authorities a 'toolkit' for risk analysis. Since every local authority needs to undertake this assessment, there will be economies of scale from providing guidance, potentially building upon the framework set out above. Government might also gather and disseminate best practice examples between local authorities.
- **Financial support for local authorities**. Central funds have already been committed to support the implementation of FCOC and 18(3). The optimal allocation of these funds should be guided by a full and robust assessment of local authority requirements and

risks. It may also be valuable to keep this support under review as the impacts of FCOC and 18(3) emerge, to ensure effective targeting and value for public money.

- **Regulation and oversight to promote effective competition**. Effective competition between providers will help to reduce the risks identified above, particularly in competing down self-funder fee rates and minimising disruption from market exit. This could be promoted through regulation with reduces barriers to entry and exit, builds investor confidence, and recognises and rewards good-quality provision.
- **Information provision to improve the self-funder market**. Effective competition also relies upon good information – about care home choice and quality – for potential residents, particularly in the self-funder market. Government can support local authorities by improving the quality of information available to social care users and their families.

Local and central government will need to work together to mitigate risk and to maximise the potential benefits from implementing FCOC and 18(3).

Next steps

Based on the analysis above, we recommend that DHSC considers the following next steps.

Engagement between local authorities, providers and central government

Local authorities are responsible for implementation of FCOC and 18(3). However, local authorities, central government and providers will all play an important role in the mitigation of potential risks.

To make best use of the current pre-implementation period, we recommend extensive engagement across all three parties. This could be used to:

- develop the framework outlined above, exploring possible market responses and clarifying the range of possible risks;
- undertake a detailed assessment of likely risks in every local area, reflecting both local authority and provider perspectives;
- gather better data to support this risk assessment and decision-making (see more on data collection below); and
- identify the most appropriate actions to mitigate risk and ensure successful implementation.

Open and constructive engagement with providers should be valuable from all perspectives.

- **Providers will benefit** from achieving a greater understanding of policy and its implementation. We note that our previous work identified very low levels of awareness of 18(3) in particular. Greater understanding amongst providers will allow them to plan

better and increase their ability to adjust to expected changes (Stage 2 of the above framework). Providers will also value the opportunity to raise concerns and to influence some details of implementation.

- **Local authorities will benefit** from greater intelligence about the views and intentions of providers. They would also benefit from any data or modelling which is shared by providers, for example regarding their financial position, occupancy levels or expectations around 18(3) take-up.
- **Government will benefit** from a deeper understanding of the variation across the provider base in different local areas, and the views and intentions of larger providers which operate across many locations.

This engagement will provide all parties with better information and enable more informed decision-making.

Future data collection

Further data collection would allow a more detailed and robust analysis of risk than was possible within this project. This will be essential for local authorities to understand their own position, but also for central government to better focus its attention on areas of highest risk.

Building upon the analysis above, we recommend considering whether additional data could be collected for the following potential variables of interest:

Stage 1

- Likely take-up of 18(3) (possible survey of current or potential residents)
- Number of 'premium homes'
- % of residents in 'premium homes'
- Self-funder rates paid within 'premium homes'

Stage 2

- Provider profit margins
- Levels of provider fixed / sunk costs
- Levels of provider debt
- Levels of historical provider investment
- % of beds operated by providers of different size / type

Stage 3

- Expected administrative costs for processing 18(3) applications
- Expected financial burden from charging reform – including likely timing

- Level of local authority market-managing capability
- Wider local authority pressures (perhaps qualitative rather than quantitative data)
- Level of local authority reserves (and their 'availability')

The above list is unlikely to be exhaustive. We would recommend that the proposed engagement across local authorities, central government and providers is used to identify further sources of information which can be used to assess local area risks.