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Care-home closures in England: causes and implications

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ABSTRACT
In the United Kingdom, as in many other developed countries, there is an established market in the provision of long-term care-homes for older people. Implicit in the market mechanism is the assumption that homes will close, but it was not until 1999–2000 that closures of care-homes received widespread public attention. This paper draws on a multi-method study that investigated home closures in England from several perspectives. The rate of home closures rose substantially between 1998 and 2000 and, although sources give different estimates, it subsequently appears to have remained at about five per cent each year. The net result has been a reduction in capacity, particularly in smaller homes. While their emphases differed, both regulators and providers broadly pointed to the same factors behind the closures: the local authorities, the majority purchasers of care-home places, were under pressure to keep fees down, and national policies that raised costs were coming into force or were anticipated, notably the *National Minimum Wage* and the *National Care Standards*. Other factors, such as problems in recruiting suitable staff, particularly those with nursing qualifications, also played a role. The government's response, driven primarily by concerns about the effect on delayed discharges from acute hospital beds, was to retreat on the *Standards* and to increase funding to local authorities. While this has been a helpful step, more needs to be done to prevent good homes closing and to provide incentives that will retain and promote diverse provision.

KEY WORDS – care-homes for older people, closures, long-term care market, regulation.

Introduction

In most developed countries there is an established market in the provision of long-term care-homes for older people. The nature and longevity of these markets differs by country, but the central role of for-profit and voluntary organisations in care-service delivery is now widely accepted. The arguments for a market in long-term care are similar to those for any

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other industry: competition leads to improvements in quality, choice and value for money. Unlike other industries, however, the 'product' is the welfare of vulnerable people, and this sits uneasily alongside some aspects of market forces by which quality improves and value for money is achieved. While some providers may be stimulated to better performance, thus increasing the wellbeing of their residents, others will not perform so well and will leave the industry. This may be through voluntary exit or through the assertion of statutory regulations that seek to maintain minimum care standards and protect residents.

Implicit in the operation of competitive markets is that homes will close. Ideally, it will be the poorer quality and less efficient homes that close, thus raising both the overall quality of provision and efficiency in the industry. Inevitably there will also be short-term losses of welfare and, possibly, health, even if in the long-term the affected residents benefit from moving to a better quality home. As a society, the short-term welfare loss for a few is the price of the greater welfare gain for the many that we assume results from the operation of a market. Nevertheless, it is clear that to maximise welfare, the number of closures should be minimised. On top of the short-term welfare losses to individual residents, there are the potential longer-term implications of a shortage of capacity to meet future needs. This is particularly relevant for acute hospitals, as discharges to care-homes are delayed, reducing the availability of beds.

Given these factors, and the publicity surrounding individual closures, any suggestion that the rate of home closures is excessive is a cause of public concern. In the United Kingdom, closures of care-homes have recently received considerable public attention (House of Commons 2000; Bunce 2001; Mitchell 2001; Pollock 2001; Steele 2001). During the same period, press reports and industry warnings about widespread facility closures among nursing homes in the United States caused widespread anxiety among consumer advocates, state officials and policy makers (Kitchener *et al.* 2002). Similar concerns have been expressed in Australia in response to the introduction of care standards (Howe 2003).

In September 1999, the proposed *National Minimum Standards* for English care-homes were published for consultation (Department of Health 1999). These included physical standards, such as the percentages of beds in single rooms, door and corridor sizes, as well as requirements for staff qualifications, and standards related to choice of home, health and personal care, daily life and social activities, complaints and protection, and management and administration. The *Standards* were announced in March 2001, and included the requirement that existing homes would have to provide at least 80 per cent of their places in single rooms by April 2007 (Department of Health 2001*d*). After further consultation, and lobbying by the care-home

sector about increases in costs, amended *Standards* were issued in March 2003 (Department of Health 2003). An important change was that homes in existence before April 2002 were to maintain environmental standards rather than to meet the requirements for newly-registered homes.

During the early 1990s, legislative changes had been introduced that gave local authorities the responsibility for assessing and purchasing publicly-funded places in care-homes. A primary objective was to encourage older people to remain in their own homes as far as possible, thus potentially reducing the demand for care-home places (Cm 849 1989). As the major purchaser of care (over two-thirds of care-home places are occupied by publicly-funded residents), local authorities took on the responsibility for managing the local care markets (*NHS and Community Care Act 1990*). In the wake of the 1990 reforms, there was a reduction in what had been a very rapid rise in the number of care-home places and shifts in the relative provision by different sectors. But it was not until 1999–2000 that considerable public concern about home closures arose.

This raises the questions of whether the proposed introduction of care standards and/or the policies of local authorities were directly responsible for the rise in home closures, whether it was just poor quality homes that left the market, and what are the implications for future capacity? In this paper we draw on a multi-method study that investigated home closures in England from several perspectives, to consider the evidence about levels of home closure, the factors lying behind closures, and the implications for policy and practice.

Method and response rates

Three linked studies were undertaken in order to investigate home closures. First, a national survey of all *Registration and Inspection* (R&I) *Units* in England was conducted in April 2001 to identify the rates of home closure and the underlying reasons for closures, including local demand and supply issues (Netten *et al.* 2002*a*). R&I units were responsible for registering and de-registering independent homes and had a unique perspective into both the rates of home closure and the influential local factors. At the time of the study, the *National Health Service* health authority R&I units were responsible for regulating nursing homes and local authority R&I units were responsible for regulating residential homes.[1] Of the 215 registration and inspection units identified, 177 (82 per cent) responded. The overall response from health authority registration units (86 per cent) was higher than that from either local authority units (81 per cent) or joint health authority/local authority units (76 per cent).

Second, a follow-up telephone survey was conducted with 39 R&I units. They were dispersed across the country and had been included in a previous national study of care-homes (Netten *et al.* 2001).[2] This allowed more detailed information to be collected about the factors that lay behind closures in those areas. The unit managers were also asked to rate the overall quality of the two homes that had most recently closed in their areas, and to identify the specific reasons. Information was collected about 69 homes that had closed during the previous two years, and the responses to the open-ended questions about the reasons are analysed in this paper.

Third, the proprietors and managers of the homes that had closed were interviewed in 2001 to gather their perspectives on the factors underlying the closures (Williams *et al.* 2002). To compile the sample, the inspectors who took part in the telephone survey of R&I units were asked to provide contact details or to forward a letter to owners or managers who had been involved in a closure during the previous two years. This group was difficult to contact, as many had moved on, but only two people refused to be interviewed. In-depth exploratory interviews were conducted with five owners and managers of homes that had closed between 1999 and 2001, and structured interviews with another 20. For the structured interviews, a list of possible factors behind the closure was drawn up. The list was based on the findings of the earlier national survey and reflected the issues identified in both the responses to the open-ended questions of the telephone survey about recent closures and during the five in-depth interviews with providers. The respondents were asked to identify the most relevant and decisive factors in the decision to close the home, and then to elaborate on each factor.

In seven cases it was possible to compare the provider perspective of the closure with that of the R&I unit. In all cases a similar picture emerged, although with differences of emphasis. In some cases, the background to the closure was amplified or clarified, *e.g.* in one instance it was clear that reduced demand reported by the provider was in response to regulatory concerns about the quality of care. In two other cases, R&I unit officers reported outstanding compliance notices that were not identified by the provider as a significant factor in the decision to close. While the objective was to identify the different perspectives, some caution is clearly advisable in their interpretation.

Rates of closure and effects on capacity

The national survey collected information from all responding R&I units on the numbers of closures and new homes opening during 2000–01, and

the total number of homes and places in independent residential, nursing and dual-registered homes in March 2000 and March 2001.[3] Many R&I units could not distinguish all dual-registered homes (for both residential care and nursing care places) so these are included in the results for both residential and nursing homes, with consequent double counting if the figures for residential and nursing homes are aggregated. About 17 per cent of residential, and 39 per cent of nursing, homes were dual-registered in 2001 (Department of Health 2001*a*).

The data supplied by the R&I units showed that during 2000–01 over 600 homes for older people closed, five per cent of all homes in the areas that they covered. This was a very similar rate to that reported for all homes in England during 1999–2000 (Department of Health 2001*a*), but much higher than in previous years. Between 1998–99 and 1999–2000, the rate of closure of independent residential homes more than doubled, and that of nursing homes increased by nearly 50 per cent. The overall effect on capacity depends on how many new homes were opened, on changes in registration status and on changes in the numbers of registered beds. The net effect of the changes during 2000–01 was a reduction of four per cent in independent residential homes and 4.8 per cent in nursing homes. These corresponded to reductions of 1.1 per cent of places in independent residential homes and 4.2 per cent of places in nursing homes, suggesting that the smaller homes were closing (Netten *et al.* 2002*a*).

More recent figures from the *National Care Standards Commission* show that there was an overall loss of six per cent of independent homes for older people between 2002 and 2003, and that available places reduced by 1.6 per cent (Dalley *et al.* 2004). Inconsistent definitions and collection methods for the different sources mean that direct comparisons are not straightforward, but as homes that provide nursing are about one-quarter of all care-homes, these figures suggest that rates of closure and loss of places were continuing at a similar rate as in previous years. Clearly, more homes were closing than in the past, with long-term implications for capacity. It is important to understand what lies behind this rise in closure rates.

The regulators' views of the local factors that influenced closures

Table 1 shows the frequency of the factors that were associated with the closures by R&I managers in their areas. The inspectors most frequently cited local authority pricing policies as an influential factor, more particularly for nursing homes (72%) than residential homes (66%). Many respondents linked inadequate fee levels to the homes' rising costs

TABLE 1. *Factors identified by Registration and Inspection Units as associated with care-home closures*

Factors associated with closures	Residential homes/places		Nursing homes/places	
	Number	Per cent	Number	Per cent
Number of units	94	100	78	100
Supply				
Over-supply of homes	28	30	16	21
Growth in alternative types of provision	15	16	9	12
Demand				
Lower demand for self-funded places	6	6	4	5
Lower demand for publicly-funded places	6	6	13	17
LA use of residential places for high dependency residents	19	20	32	41
Pricing and contracting				
Local authority pricing policies	62	66	56	72
Local authority contracting arrangements	10	11	15	19
Inputs				
Problems recruiting basic care staff	46	49	35	45
Problems recruiting nursing care staff	14	15	63	81
Local wage rates	37	39	36	46
High property values	34	36	26	33
Care standards				
Poor quality homes	27	29	17	22
Concerns about care standards	43	46	37	47
Other	15	16	4	5

(particularly for staff), and noted the effect of their interaction with home size and the level of borrowing on viability. The most widespread concern with reference to nursing homes was the shortage of nurses – over 80 per cent of the R&I unit managers cited this factor. The supply of care staff (without nursing qualifications) was identified as affecting closures in just under half the areas. The introduction of a *National Minimum Wage* (NMW) in 1999 was cited as having an important effect, particularly for its impact on the relative wages of care and non-care work. Although care-staff wages had been low in the past, usually they were higher than for other low-paid jobs. The NMW meant that staff now could be paid the same in other sectors for much less stressful work.

At the time of the study, only one-third of the inspection units identified the imminent *National Minimum Standards* as affecting closures in their area. Several respondents noted a widespread concern among the homes that they would not be able to meet the new *Standards* at the then current fee levels. In one instance, it was reported that rumours about the likely effects of the new care *Standards* had led some providers to over-react and to

leave the business. As was expected, the influence of rising property prices, and thus the ability to sell the building, varied by region. Nationally, about one-third of the R&I unit managers identified property prices as an issue: the percentage was highest in the south.

The contractual arrangements made by local authorities were seen as influencing home closures by a minority of respondents (11 % with respect to residential homes; 19 % to nursing homes). It appeared that block contracts were being offered to the larger homes, and some respondents commented that the contracting arrangements favoured large providers and increased the relative pressure on smaller homes. Indeed, one respondent noted that, 'anecdotal evidence suggests that the local authority wants "sixty bed sheds"'. The contracting arrangements were not, however, necessarily seen as putting the homes out of business; it was more that they were adding to the pressures upon, rather than supporting, homes.

A little against expectations, several factors were rarely identified as major factors in the closures, such as the overall reduction in demand, competition from alternative types of provision, and local excess supply. Two-fifths of the health authority R&I units did, however, report that demand for nursing home places was being affected by an administrative change: residents who would formerly have been admitted to nursing homes were being placed by local authorities in residential care-homes at a 'high dependency' fee rate.

The regulators' views of individual home closures

Of the 69 most recent closures, 28 (41 %) were nursing homes, 34 (49 %) residential homes, and seven dual-registered homes. The representation of nursing homes was higher than nationally, for in England about 23 per cent of the closures were nursing homes, 68 per cent residential homes, and 10 per cent dual-registered. The over-sampling of nursing homes was produced by the identification of homes at the R&I unit level. As was expected, the most recently closed homes were smaller than the national average. There were on average 15 places in the residential homes that closed, compared with a mean of 22 in the entire stock (Department of Health 2000*b*). The average size of the closed nursing homes was 24 beds, compared with 35 in the national stock (Department of Health 2001*a*). The dual-registered homes, as is typical nationally, were larger (mean 28 places). Most of the homes (38) were the one home owned by the organisation, and only ten were run by chains with three or more homes.

The inspectors identified the reasons for closure in 68 of the 69 cases (Table 2). The most frequently cited main causes were financial problems

TABLE 2. *The main reason and contributory factors for two most recent closures as cited by Registration and Inspection Unit managers*

Reasons for closure	Number of homes	
	Main reason	Factor
Demand factors	5	10
Pricing and contracting	2	5
Inputs		
Staff-related factors	6	14
Value of premises if sold	3	8
Care standards		
Concerns about current standards	8	15
Unable/unwilling to meet new standards	5	18
Change in personal circumstances	17	21
Financial reasons[1]	17	21
Enforcement action[2]	5	10
Other	0	4
Sample size	68	68

Notes: 1. Including size of home and excluding low occupancy. 2. Includes likely/threatened action. While enforcement notices were outstanding in 12 instances these were not always cited as the reason for closure.

and personal circumstances. Both factors were reported as the primary cause in one-quarter of the cases and cited as a factor in one-third. The financial problems were rarely directly attributed to local authority pricing policies, but most frequently related to the viability of the home: either the bank was about to foreclose or the owner was over-committed. The personal circumstances identified by the regulators included wanting to retire and the death of a spouse. Such reasons for closure apply to all small family businesses and have always been seen in the care-home market. At the time of the study, however, it was becoming increasingly difficult to sell homes as going concerns, so homes that formerly would have changed owners or management were more likely to close, especially as property prices had risen making it possible and profitable to exit the market.

The providers' unwillingness or inability to meet the new care standards were cited as the main reason for less than 10 per cent of the two most recent closures, but as a factor underlying one-quarter. Problems with staff recruitment, the most widespread factor identified at an area level, was only identified as a contributory factor in six instances. The inspectors gave an overall rating of the quality of the care for 68 of the closed homes (Table 3). Although, as expected, some were reported to be providing poor quality care, as indicated by those with outstanding enforcement actions (Table 2), the majority were providing at least satisfactory (or 'OK') care. Views of the quality of care provided before closure varied by type of

TABLE 3. *Inspectors' assessment of the quality of care provided by the homes prior to closure*

Quality of care	Residential homes		Nursing homes		Dual-registered homes		Total	
	Number	%	Number	%	Number	%	Number	%
Excellent	3	9	3	11	0	0	6	9
Good	8	23	9	32	1	14	18	26
OK	10	29	4	14	4	57	18	26
Fair	5	15	8	29	0	0	13	19
Poor	7	21	4	14	2	29	13	19
Total	33	100	28	100	7	100	68	100

Note: The quality of care provided in one residential home was not known.

home. In nursing homes, the quality was most often rated as 'good' (followed by 'fair'), whereas in residential homes it was typically rated as 'OK' (followed by 'good').

The providers' reasons for closing

The sample of 20 proprietors of closed homes included the owners or managers of six nursing homes, 11 residential homes and three dual-registered homes. The majority (17) were privately owned. The average home size at the time of closure was 28 places, with the range being from a dual-registered home with 99 places to a residential home with nine places. There was at least one home in each region of the country and, although small, the sample represented the range and balance of types of home in England at the time of the study.[4]

Table 4 shows the factors that the proprietors identified as underlying the closures of the homes. In most cases, more than one factor was seen as decisive in the decision. The most frequently cited factors were the prices paid by local authorities and the cost implications of the new *National Minimum Standards*. None of the homes closed through bankruptcy. Rather, all but two had been discontinued to avoid further losses or because the business was not earning an adequate return. The other two closed following enforcement action, in one case specifically associated with high refurbishment costs, and in the other because the value of the property exceeded that of the business.

Demand

The reduced demand for publicly-funded places was identified as an issue by six of the 11 residential home providers, compared with just two of the

TABLE 4. *Frequencies of factors relevant and decisive to proprietor decisions to close*

Factor	Decisive	Mentioned
Care standards		
Cost implications of new *National Minimum Standards*	10	15
Building could not be adapted to meet the new standards	3	4
Training requirements of new standards	1	5
Commissioning environment		
Contracting arrangements	1	4
Local authority prices not covering costs	10	14
Local authority prices unlikely to cover costs in the near future	8	13
Demand		
Low occupancy due to reduced demand for publicly-funded places	8	8
Low occupancy due to reduced demand for self-funded places	2	4
Low occupancy due to general drop in demand	3	4
Relationship with Registration and Inspection Unit	6	6
Value of premises/land if sold	4	5
Staffing		
Increases in running costs, including staff costs	3	11
Recruiting care staff	2	8
Retaining care staff	1	5
Recruiting nursing staff	1	3
Retaining nursing staff	0	1
Recruiting/retaining managerial staff	2	4
Personal factors		
Wanted to retire	3	5
Wanted to change direction	1	1
Other factors (including cost of modernisation)	7	13
Sample size	20	20

nine nursing or dual-registered home providers. Residential homes are generally smaller than nursing homes, and for smaller homes a relatively small drop in demand can reduce the business to break-even point or below. Occupancy in these eight homes during the 12 months before closure ranged from 75 to 40 per cent. Five of the providers had concerns about increases in residents' dependency during the time that they had run the home. In some cases they felt the dependency levels of the most recent placements were inappropriate for the type of home.

Pricing and contracts

Nearly three-quarters (14) of the 20 providers reported that their decision to close was influenced by the local authority prices not covering the costs. Of these, ten said this was the decisive factor. Seven of the providers indicated that the level of fees had been a long-term problem. When asked about preferred contract types, one owner emphasised that it was the fee

level rather than the type of contract that was the problem. Another said that she would have preferred a block contract even if it had incorporated lower fees. Several interviewees commented on the low and inconsistent fee increases over time. The issue was frequently linked to high and rising costs, particularly given the proposed *Standards* (see below).

Costs and workforce supply

Among the providers of the homes that had closed, the recruitment and retention of care workers, nurses and/or managerial staff was more often cited as a background factor than as decisive in decisions to close. The problems were attributed to insufficient income to offer attractive salaries, skills shortages, the keen competition for staff in local labour markets, and the very demanding nature of the work. In two of the 20 homes, the recruitment and retention of managerial staff was a decisive factor. Staff costs dominate the costs of care, and not surprisingly providers identified increases in salaries and wages as eroding their financial viability. They pointed to the NMW and the paid-leave entitlements in the *European Working Time Directive* (EWTD) as having increased costs without compensating increases in fees. The EWTD was implemented in the UK in 1998 under the Working Time Regulations and from 2001 the right to four weeks of paid annual leave was extended to all employees, rather than only to those who had been employed for 13 or more weeks.

Property values

One-quarter of the interviewed providers identified the value of the premises or land as a factor in the decision to close. Four of the five providers reported it to be a decisive factor, and one provider said it was the single decisive factor. For two of the owners, high property prices offered an opportunity to sell when there was little prospect of selling the business as a going concern. The business was failing and it was a chance to exit the market: 'it was worth more as an empty building'. In some cases, property developers had approached owners with offers. For others, the value of the site was so high that continuing to run a business that would never be worth as much as the property or site could not be justified.

Standards

Table 4 shows that three-quarters of the sample of proprietors identified the proposed introduction of the *National Minimum Standards* as a factor underlying the closure, and for half it was decisive. Proprietors' concerns

related to the level of investment required to meet the *Standards*, repeated increases in running costs, and the reduction in the value of the business. Some providers noted all of these pressures, others one or two. The owner of one nursing home estimated that meeting the *environmental standards alone* would cost £400,000. Such investment was considered unviable for small businesses, even if the capital were available, 'unless they [councils] were prepared to pay a proper fee and you were very sure you were going to have a continuing contract at a proper price. You couldn't take on a large debt like that and service it'. Another owner pointed out that small homes did not have the cash flow to support such investment. One manager described the difficulty of borrowing money to invest in businesses that were 'cash negative':

> If we went to our bank and said, right, we want to borrow £250,000 to invest in this home to meet the new standards and to continue operating, they're going to look at our balance sheet and say, sod off, you know, you're losing money.

The raised standards for staff qualifications and training were also seen as prohibitive for small businesses by one-quarter of the interviewees, and one owner said that they were a decisive factor in the decision to close. Costs included course fees, the loss of staff time and the cost of cover. While some proprietors had closely investigated the likely impact of the proposed standards, in some cases there was clearly misunderstanding. Two providers cited the provision of *en suite* facilities as a problem: they seemed to expect to have to install these for all service users, rather than as the regulations require just in newly-built homes or extensions. Two people said that they would be unable to afford to spend three per cent of the gross salary bill on training and that such a proportion is unrealistic for a small business. In fact the relevant standard states that all staff should receive a minimum of three paid days training per year (about one per cent of a full-time equivalent member of staff) (Department of Health 2001*d*, 2003).

Motivation

A loss of motivation appeared to have been a factor in just under one-third of the decisions to close (reported in six of the 20 structured interviews, and two of the in-depth interviews). In the structured interviews, five of the six proprietors who identified a loss of motivation had not owned a care-home before. Several of these owners, and a couple of providers in the in-depth interviews, spoke of having wanted to own a care-home for 'years and years'. It had been a 'dream' or a 'life's ambition'. Four of those who reported feeling disillusioned or discouraged had indicated that their most important or second motivation for becoming a care-home owner had

been professional accomplishment and creative achievement. In one of the in-depth interviews, another owner linked her wish to be creative with that of wanting independence and autonomy:

> I'd worked in the health service for 15 years or so and I just had the feeling that I'd had enough of working for someone else – that 'I know what I'm doing now'. We wanted to produce something of our own – it's what every business person must feel: it's a creative thing.

The high level of bureaucracy in general was highlighted by four of these providers. The 'red tape' was described as 'horrendous' and 'crazy' for small employers. The many examples included the tax-credit system, the NMW and the EWTD. Two residential home owners described the sense that they had become 'glorified pen-pushers'. Another interviewee spoke of how the level of paperwork 'is absorbing so much time that (home managers) were not available for the actual client'. Another owner described not wanting to continue running the home as she felt that to do so would mean compromising the standards that the partnership had developed and set for themselves.

Frustration about the level of regulation and administration was linked by some to no longer wanting to work in the sector, while for others leaving was attributed more generally to the experience having been 'sheer pressure and hard work from day one'. One owner spoke of the home ceasing to be 'a home' because of the shift in emphasis from people to paperwork, and concluded with the rhetorical question: 'Why am I doing this?' since 'there is no life for you in the care industry if you actually care, as opposed to just look at it as a business'.

Discussion

To develop an understanding of what lies behind the recent dramatic increase in care-home closures in England, it is valuable to be aware of different perspectives. The regulators and the providers might be expected to have very different views of the causes, particularly the impact of increased regulation through the new *National Minimum Standards*. The findings of this research, however, have shown a consistent picture of the providers responding to various actual and anticipated pressures on prices, costs and contracting arrangements. It is important to understand these responses and their interactions to understand the implications for future care-home supply, policy and practice.

Clearly a key factor has been the downward pressure on prices exerted by the dominant purchasers, the local authorities. They in turn are under financial pressure both through competing demands on their funds and

through specific government policies. Early in 1999, efficiency targets were set that required the authorities to make efficiency improvements in each of the following financial years (of successively two, two and three per cent) (Department of Health 2000*a*). Efficiency is difficult to measure directly, so unit costs (such as the 'cost per resident week') are often taken as indicators. In the case of independent care-homes, the unit cost to purchasers is the price, so it is in local authorities' interests to minimise price increases. On top of these overall performance requirements, specific targets were set as part of the 'Best Value' regime for local authorities (Cm 4014 1998). Those not in the lowest unit cost quartile for their local authority type in 1999 were told they should achieve that level by 2004–05 (Department of Health 2000*a*).

Thus all the incentives for purchasing authorities were to keep the price down. For the most part they were very effective in doing just that even before the targets were introduced. Between 1995 and 1999, there was a 10 per cent increase in the average price paid per week (Laing and Buisson 2000): this in a market with little scope for savings – the mean profit margin in 1996 was estimated as 10 per cent, suggesting that many homes were operating at very low rates of return (Netten *et al.* 1998). At the same time, a number of national directives and policies have had important implications for care-home costs, particularly the NMW and the paid-leave entitlement of the EWTD, which many respondents identified as burdensome. The NMW doubled the proportion of care-home staff that earned more than £3.60 per hour during 1999 (Cm 4571 2000). The limit on weekly working hours, also introduced in response to the EWTD, will have had less impact on care-homes than the NMW because those that work the longest hours, the proprietors, are exempt. Nevertheless, the overall impact on homes was estimated to increase the annual running costs of an average home by £3,500 (Pay and Workforce Research 1999).

Both regulators and proprietors attributed their problems in staff recruitment partly to the introduction of the NMW, but the most severe shortages were with nursing staff, for whom there was intense competition with the National Health Service (NHS). The general shortage of nurses led to Department of Health initiatives that encouraged qualified nurses to return to the NHS (Department of Health 1998). In the year that the NMW was introduced, the proposed *National Minimum Standards* were published for consultation (Department of Health 1999). No funding was to be provided for homes to meet the standards, and they were expected to meet the costs of any required adaptations or investment. With the exception of some new funding for local authorities to facilitate recruitment and retention in social care generally, this remains the case. As well as the specific misunderstandings about the *Standards* identified during the

fieldwork, since their publication there has been widespread confusion about their status and about compliance and enforcement. Moreover, a high proportion of care-homes, particularly the smaller homes in older converted premises, will find it difficult to improve their physical standards – these are the types of home most likely to close (Darton 2004).

The culmination of a period of downward pressure on prices, the introduction of the NMW, and the implementation of costly care standards could be seen as one-off events that caused businesses that were already in financial difficulties to go out of business, and for this unusual sequence to be the principal explanation of the sharp rise in closures during 1999–2000. Subsequent evidence suggests, however, that the high rate of closure has been maintained, as well as a low rate of new entrants. There have been widespread reductions in capacity, which many inspectors felt had gone well beyond adjustment to the reduced demand associated with the local authority policy of maintaining people in their own homes for longer.

The evidence suggests that it is not poor quality homes, but primarily smaller private homes and organisations with just one or two homes, which are the most likely to have closed voluntarily. If larger homes are having problems, purchasers will be concerned about the impact of their closure on local capacity, and be more likely to negotiate more favourable contracts or prices. Moreover, larger organisations have more opportunities to achieve economies of scale, more scope to bear the costs of regulation, and are the most able to invest in improved physical standards. The net result is reduced diversity in provision. The increasing preponderance of large homes run by incorporated organisations mean reductions in choice for future residents, in terms of both types of home and locations. Small homes in small towns and that serve largely rural areas, with low populations on which to draw, are the least likely to survive. Once the decision to enter a care-home has been made, location is the single most important factor for residents and their relatives (Netten *et al.* 2002*b*).

An adequate supply of care-home places is fundamental to older people's access to care and a key component of government policy (Department of Health 2002*a*). But most pressing of all in many parts of the country, in terms of the current government's objectives, is the effect of reduced capacity on delayed discharges from acute hospital beds (National Audit Office 2003). Several initiatives and policy changes have sought to address the problem of reduced care-home capacity and the knock-on effects. In 2001, the Department of Health launched *Building Capacity and Partnership in Care*, a concordat between the independent and statutory sectors which aimed to build capacity in the independent sector in both home-care and care-home services (Department of Health 2001*b*). Linked

to this, increased levels of funding have been made available to local authorities (Department of Health 2001*c*, 2002*b*). Further funding is to be made available as part of an initiative by which local authorities will be charged for the costs of acute beds occupied by people who are ready to be discharged (Department of Health 2002*c*, *d*).

These specific grants augmented a six per cent real increase in long-term funding linked to broader plans to improve health and social care services (Department of Health 2002*e*). Moreover, the continued concern about the ability of existing homes to meet the *National Minimum Standards* led the government in August 2002 to issue for consultation an amended set of environmental standards (Department of Health 2002*f*). As mentioned earlier, the approach was softened, with the amended physical standards to be treated as good practice for all homes, not a requirement for homes that existed before April 2002.

This less assertive approach to regulation illustrates a general problem for the non-statutory care providers that experience low profitability, that there is a risk that the enforcement of quality standards will be lax so as not to drive the providers out of business. It was notable that, in its first year of operation, the *National Care Standards Commission* enforced the closure of very few homes (Dalley *et al.* 2004). Although this was probably primarily because of internal administrative pressures rather than market capacity concerns, there are implications for the role of the successor organisation, the *Commission for Social Care Inspection*, which has taken over the remit to 'improve quality'. There is a tension in the regulatory process between a rigorous approach, which in the absence of sufficient funding can drive out good quality providers, and too lax an approach, which may result in falling or static standards.

While the amended standards mean that homes will no longer be required to meet the increased costs associated with the original physical standards and, in some cases, suffer a drop in income (through a reduction in beds), the market pressures for more single rooms and improved physical facilities remains. To make such investments, or indeed to enter the market at all, requires confidence in the future. Decisions about whether to close, to continue operating or to open a home are dependent on the motivations and expectations of providers. It is these that hold the key to the future of the care-home market. Many of the closures will have been associated with the retirement of owners who had moved into the business during the rapid expansion of the 1980s. What is there now to attract new owners into the market to ensure an adequate capacity of care-homes (or alternative types of shelter with care provision) in the future?

Previous work has suggested that an owner's desire to continue working in residential care is at risk if the financial and regulatory environments no

longer allow them to operate in the way that first motivated them (Kendall 2001). One implication of the widespread demoralisation amongst providers is that if one provider exits or closes a home, no one is willing to replace them. A change in local authority pricing, contracting or strategic planning might not be a sufficient incentive to persuade such providers to preserve existing services or to establish new ones. The concordat identified good practice in strategic planning, including consultation with providers, and building confidence and stability (Department of Health 2001*b*). This is clearly desirable and, if achieved, is likely to have the benefit of both enabling providers to plan and to feel that they are valued as professional partners in delivering services.

Strategic planning and consultation need to address the fundamental problem of the uncertainty and high risk that characterise the current United Kingdom care-home market. For the most part, the commissioning arrangements are such that all the risk is borne by the provider. Local authorities primarily have 'call-off' contracts with their providers, whereby an agreed price is only paid while a supported resident is occupying a place (Mixed Economy of Care Team 2000). They have no commitment to pay when the places are not occupied. Moreover, where block contract arrangements exist, they can mean providers are committed to accepting, at a fixed fee, high dependency residents who are very costly to care for. When fees are relatively high, it is feasible for care-home providers to bear such risks. But the combination of increased regulation and low fees drives out the type of provider that is most prepared to take risks.

The most recent evidence suggests that, at least in some local authorities, prices are rising and the care market is responding (Laing and Buisson 2003). Nevertheless, central government funding is not ring-fenced and there are many other calls on local authority resources. Given the current patterns of funding, commissioning and regulation, there are real concerns about whether the market will be able to deliver the quality and diversity of residential care that will be required by an increasingly demanding cohort of older people.

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NOTES

1 By the *Care Standards Act 2000*, the R&I units were replaced in England with a unified system of regulation and inspection, administered by the *National Care Standards Commission*. In 2004, the NCSC took on related functions from other government agencies and was reconfigured as the *Commission for Social Care Inspection*. See the further comments in the closing discussion. Since 1999, when the reinstated Scottish Parliament assumed its full powers, social services including long-term care funding policies and regulation has been a devolved responsibility.

2 The areas and R&I units were selected for a follow-up survey of the registration status of homes included in a 1996 national survey. The selection represented the types of authority prevailing at that time, geographical location, socio-economic group, population density, and migration rates (Netten *et al.* 2001). Forty-five units were contacted, and 40 (89 per cent) responded. The results of the follow-up are reported elsewhere (Darton 2004).

3 Data were also collected about local authority managed homes and homes with fewer than four places but are not reported here.

4 At the time there were eight National Health Service regions of England: Northern and Yorkshire, North West, Trent, West Midlands, Eastern, South East, London and the South West.

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