



# Going to market! An exploration of markets in social care

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## Abstract

One of the most striking reconfigurations of Irish social care has been the entry of private for-profit companies into a sector previously regarded as outside the market. This article examines the policy context that has given rise to these developments and the impact of marketisation on both the quality of care provision and the employment conditions of the workforce. Whether for-profit provision of care is a positive development is the subject of intense debate, and the arguments for and against are outlined alongside a range of empirical evidence. International research evidence is not convincing about the capacity of markets to deliver on quality or efficiencies. The article concludes with recommendations for further research to enable analysis and debate in the Irish context.

*Keywords:* Markets, social care, for-profits, research

## Introduction

If the use of markets and market mechanisms to deliver care is one of the most significant and contentious ways in which welfare states have been transformed (Gilbert, 2002), there has been little discussion about the extent to which such developments have reshaped the Irish social care landscape. This article initiates such a discussion by examining the policy contexts of marketisation and privatisation in social care and the implications for the quality of care and the

conditions of employment of the social care workforce. Gaining recognition of care work and social care as a distinct set of skills meriting respect and legitimacy has been a difficult task. Contracting out public services has reduced government spending on human services, lowered workplace conditions and protections, and provided an explicit role for private markets as the solution for social and individual problems across many western countries (Baines & Cunningham, 2015; Cavendish, 2013; Cunningham et al., 2014; Eurofound, 2013; Himmelweit & Land, 2008).

Through the funding of voluntary organisations and religious orders to provide social services, the Irish state has maintained a historic separation of the funding and administration of vital services such as health, education and social care (Considine & Dukelow, 2009; Linehan et al., 2014). Since the early 1990s the Irish Government has embarked on an extensive programme of public sector reform (Scott, 2014). From a social care perspective, this has included an expansion of the policy of outsourcing care services and deeper integration of private sector management principles in both public and non-profit sector provision. While there are theoretical and policy analyses of outsourcing in the public sector (Ní Lochlainn & Collins, 2015; Ryan, 2013) and empirical research on the impact of expenditure cuts on the community and voluntary sector (Harvey, 2012; McInerney & Finn, 2015), there is a dearth of analysis about marketisation in social care.

This article proposes salient features to be considered. It addresses the policy context, the arguments for and against for-profit care, the current trajectory of markets in social care, the empirical evidence available on for-profit care and finally the implications for the Irish context. The policy context for marketisation is explored in the context of New Public Management (NPM) and the particular features of the Irish social care landscape. This is followed by an outline of the debates between proponents of care as enterprise and those who see a clash of values and interests in for-profit care (Meagher & Cortis, 2008). The processes involved in the marketisation of children's residential care, home care and nursing home provision for older people, child and family services and intellectual disability services are described. A range of empirical evidence is then outlined about the impact of markets on both the quality of care and the costs and conditions of employment for the workforce, with a view to informing the debate in the Irish context. The article concludes that research is needed to address the significant shortfall in empirical evidence in the Irish context.

## **For-profit provision of social care**

Adopting market-based or market-like mechanisms in the provision of care services is part of a programme of wider NPM reforms that has been adopted across all OECD countries, albeit with considerable variation in the timing of such reforms and the extent of their realisation (Bach & Bordogna, 2011). These developments have given rise to intense debate between proponents of care as enterprise and those who see a clash of values and interests in for-profit care (Meagher & Cortis, 2008). The following section provides an overview of such debates.

A major source of inspiration for proponents of marketisation and contracting out reforms is the neo-liberal economic school of thinking propounded by economists such as Milton Friedman and James Buchanan. Their ideas form the ideological and theoretical foundation for public choice theories and NPM thinking about 'less government and more market' (Petersen & Hjelmer, 2013, p. 5). Public choice theory proposes that markets should lead to higher efficiency, better quality, greater diversity and less bureaucracy in the delivery of public services. This belief is based on two arguments: ownership and competition. Private organisations are more effective than public organisations because private ownership incentivises the running of a business in an effective manner. Also, competition is greater in private markets than in public monopolies. Providing services in the private domain exposes suppliers to greater competitive pressure, leading to improved cost-effectiveness and service quality (Petersen & Hjelmer, 2013, p. 6). Proponents suggest two main types of benefits that flow from delivering services through markets. Firstly, giving services users (or their agents) purchasing power should empower users by enabling them to exercise consumer sovereignty. Secondly, such sovereignty should improve the quality of services and reduce the cost to purchasers by forcing competitors to compete for business (Brennen et al., 2012, pp. 379–80).

When markets are working well, they 'compel producers to serve the public interest by providing goods and services that are efficiently produced, of reasonable quality, and at prices that are close to costs' (Cleveland, 2008, p. 3). Private for-profit provision of paid care shares an assumption that care is like any other good or service, best produced and distributed through markets (Meagher & Cortis, 2008, p. 4). Markets work best when certain conditions are met: information

on price and quality of competing providers is freely available to consumers, the cost of changing supplier is low and suppliers operate in a competitive market (Brennan et al., 2012, p. 380).

The arguments against for-profit care suggest that markets have a corrosive effect on the moral and emotional dimension of care, seen as essential to human flourishing (Meagher & Cortis, 2008). Firstly, profit is viewed as a poor incentive for the achievement of social goals given the view that care is a public good better produced and distributed according to human need, rather than investors' self-interest (England, 2005). For example, the transaction costs of signing contracts, controlling for-profit providers and following up with audits can be considerably higher than the transaction costs associated with provision of the same services within the public sector (Brown & Potoski, 2003). In addition, governments often need to offer clients significant fiscal incentives to take up services, so eliminating the fiscal gains of reducing direct expenditure in the first place (Meagher & Cortis, 2008).

Secondly, care markets are imperfect for several reasons. Care recipients and those purchasing care on their behalf can access only imperfect information, as care takes place over extended periods of time and is highly personal, making it difficult (and expensive) to monitor quality (Folbre & Nelson, 2000). Because the intangible aspects of care are difficult to measure, monitor and regulate, they are likely to be sidelined by providers in the pursuit of cost control (Gilbert, 2002; Stone, 2005). This raises risks that opportunistic for-profits will exploit consumers' inability to fully monitor services by charging high prices but skimping on those aspects of quality with which consumers find it difficult to observe and respond (Morris & Helburn, 2000).

Thirdly, where markets become too concentrated, competition no longer improves efficiency (National Audit Office, 2011; Scourfield, 2007). Providers with too much market power can set their own prices, raising costs to government and to service users. Finally, it is argued that profitable care and quality care conflict because care involves relationship-building, so that an increase in productivity will reduce quality. Competition lowers costs only if staffing ratios are reduced or less-qualified staff are employed, both of which tend to reduce quality (Brennan et al., 2012, p. 380; Centre for Health and the Public Interest, 2013, p. 18). 'Caring' motivation – a guarantee of quality and effectiveness – can be squeezed out, with the risk that care is

performed impersonally and to minimum standards (Folbre & Nelson, 2000; King, 2007, p. 203).

Central to the perspective that it does not matter who delivers care is the argument that it is the involvement of money, not profit per se, that is the key problem in care provision. In this frame it is not (only) the pursuit of profits, but paying for care, contracting for care and bureaucratising care that risk reducing care to mundane, physical, measurable elements (Meagher & Cortis, 2008, p. 8). This may ignore the emotional aspects of care, which cannot easily be costed or detailed in contracts.

Some analysts see concern over for-profits' status as exaggerated. As motivations for care are complex and layered, the pursuit of profit will not inevitably squeeze moral virtue or quality out of care (Meagher & Cortis, 2008). For-profit provision can embody a range of values and strategies; some may pursue only small profits alongside social goals rather than being driven by 'financial gain above all else' (Folbre & Nelson, 2000; Nelson & England, 2002, p. 5). Government contracting can neutralise differences in for-profit and non-profit behaviour. Regulation and quasi-market competition drive providers to both mimic each other and emulate the government agencies on which they depend (LeGrand, 1998). Professional provision of services means workers adhere to norms and practices conducive to good care which are defined by their occupations rather than by the organisation for which they work, regardless of ownership (Meagher, 2006). These arguments suggest it is *how* care services are delivered, not *who* delivers them, that matters most (Meagher & Cortis, 2008, p. 8).

Finally, ownership for some groups such as disabled people is not a critical determinant of service quality and access, but rather choice – choice over who provides assistance and control over when and how that assistance is provided (Clarke et al., 2005). Control may be important to service providers also and may eclipse profit-maximising as a primary goal, particularly among small, owner-operated for-profit providers (Meagher & Cortis, 2008, p. 8).

The theoretical arguments presented above map out the debates on the compatibility of profits and care, highlighting a range of influences which make assessments of for-profit care challenging. The following section will address this challenge by grounding the discussion in the Irish social care policy context, setting out the particular trajectories of marketisation therein and reviewing a range of empirical research evidence available internationally.

## **Social care: The policy context**

Ireland did not develop a strong welfare state comparable to those of other Northern and Western European countries in the post World War II era (Lynch et al., 2012). Since the foundation of the state, nationalism and Roman Catholicism have exerted an overriding influence on social care and welfare formations. Historically the application of the Roman Catholic principle of subsidiarity dictated that care should be provided, whenever possible, by the social unit closest to the person in need of care: the family and other informal carers, followed by the church and (religious) voluntary organisations (Doyle & Timonen, 2008).

These precepts coincided with the Irish state's preference for a minimalist role in matters affecting the individual and the family (Linehan et al., 2014).

The Church came to dominate health and social care provision in twentieth century Ireland and the state adopted a hands-off approach, delegating many aspects of health, social care and education to religious orders and voluntary organisations (Sweeney, 2010). As responsibility for social service provision by the Catholic Church declined steadily in the latter part of the twentieth century, the choice facing the government was to embark upon a programme of public investment or encourage the private sector to take up provision. Ireland followed the market route, through tax-incentivised for-profit provision across a range of social care sectors (Coulter, 2013). In the context of this discussion, the social care sector refers to both the disability and older persons' services, which are the remit of the Health Services Executive (HSE, 2015), and child and family services, which are the remit of Tusla, the Child and Family Agency. The following case studies highlight different forms of marketisation in the following sectors: children's residential care, older persons' care, child and family services, and intellectual disability services.

## **Children's residential care**

There were 6,398 children in state care in February 2016, of whom 337 were in residential care settings and the remainder in foster care (Dáil Éireann, 2016).

The gradual withdrawal of religious orders from children's residential care in the 1980s and 1990s resulted in a shrinking of the voluntary/non-profit provision in this sector. Children's residential

care is now provided through a mix of public, for-profit and non-profit providers, with varying terms and conditions of employment for social care workers. Tusla provides forty-three residential homes. Twenty-eight homes are provided by non-profit sector organisations through Section 56 funding (Child & Family Agency Act, 2013). Public sector terms and conditions of employment apply in both. The for-profit sector is the largest provider, with approximately 105 houses (Office of the Ombudsman for Children, 2015). Funding arrangements with Tusla are based on a block-purchase system and spot-purchase agreements. In line with international trends on the impact of outsourcing, the pay and employment conditions of this predominantly female workforce have failed to keep pace with their counterparts in the public sector (Baines & Cunningham, 2015; Skills for Care, 2015). Current residential care workers' salaries in the public sector range from €30,293 to €44,306 with additional unsocial allowances. Salaries in the for-profit sector average €30,000–34,000 with additional unsocial allowances (C. Kelly, pers. comm., 24 June 2015). There are also less favourable conditions attached to working in the for-profit sector (e.g. overnight and shift allowance rates, sick leave and annual leave entitlements, shift patterns, etc.).

Krachler & Greer (2015) suggest that for-profit provision expands in a favourable funding and regulatory environment coupled with weak competition from the public sector.

Favourable funding and weak competition are the most relevant explanatory factors in this sector. Fees averaging €13,000 per child per week have been paid to for-profit providers of children's residential care since the market was opened up in 2000 (O'Brien, 2014).

Following a negotiation process, a cap on fees of €5,000 per child per week was introduced in 2013. While there has been no systematic study of care quality or cost-effectiveness to date, analysis by Tusla found that, on average, privately operated centres were more expensive (€330,000 per year) compared to public facilities (€225,000 per year) or those run by the non-profit sector (€140,000 per year) (O'Brien, 2014). It should be noted, however, that higher fees for specialist provision and single/dual-occupancy houses impact on these average costs.

The Social Services Inspectorate was set up in 1999 with a mandate to monitor and inspect statutory children's residential care against a set of national standards for children's residential centres. However, privately run homes – both for-profit and non-profit – are registered

and inspected by the local health boards, now Tusla ('Social Services Inspectorate', 1999). An investigation by the Office of the Ombudsman for Children reported significant inconsistencies and discrepancies in the monitoring and inspection of non-statutory homes, recommending responsibility for all registrations and inspection be undertaken by the independent inspection body, the Health Information and Quality Authority (HIQA) (Office of the Ombudsman for Children, 2015). There was no national oversight of the sector until late 2013, when a National Coordinator for Children's Residential Services was appointed. Regulation of the social care workforce will progress in 2017 when registration with CORU (the Health and Social Care Professionals Council) is opened. This is likely to limit the employment of those with no qualifications in the sector. Thus, several positive developments are likely to contribute to a regulatory regime that supports quality care and a sustainable workforce over time.

The final factor which influences the expansion of for-profit care provision is weak competition from the statutory sector. Public provision of children's residential care has been significantly reduced by a raft of closures, including all thirteen high-support centres and a substantial number of statutory mainstream centres (O'Brien, pers. comm., 7 April 2016). This has resulted in increased opportunities for the for-profit sector to respond with specialist provision. In summary, a favourable funding regime and weak competition from the public sector have contributed to the significant growth of for-profit provision where non-profit providers once dominated.

### **Older persons' care**

The population aged over sixty-five in Ireland is growing by approximately 20,000 each year, while the population aged over eighty-five, which places the largest pressure on services, is growing by some 4 per cent annually (HSE, 2015, p. 1). Eldercare in Ireland is a mixture of public, for-profit and informal provision, a large proportion of which is provided by women within the family (Barry, 2010).

Publicly provided home care services are delivered under the auspices of the HSE, including home help and home care packages. There are also social welfare supported schemes and the Nursing Home Support Scheme. Pressure to reduce the cost of the public health care system has resulted in outsourcing of HSE home care services to a highly competitive market vying to secure HSE tenders.



Although it is a relatively new sector, the home care industry has an estimated value of €340 million (Home and Community Care Ireland, 2013, p. 2). It has quadrupled in size since 2000, with approximately 150 companies providing home care nationwide (Hunter, 2010). Since July 2012 all new home care packages approved by the HSE are provided by organisations selected by the HSE following a detailed tender process. Despite calls from all sectors for tighter regulation amid public concern about low standards of care, abuse of older persons and the exploitation of the care workforce, there are still no regulation or sectoral standards (RTÉ, 2010; Timonen et al., 2012). The lack of regulation has resulted in a home care sector characterised by high fees, varied quality and standards of home care provision, poor terms and conditions for workers, and growing informality, serviced by migrant workers (Doyle & Timonen, 2009; Migrant Rights Centre Ireland, 2015). Pay rates for HSE full-time home help workers range from €25,001 to €30,830 (x 9 increments) per annum. Health care assistants earn €25,834–32,906 (x 9 increments) (HSE, 2016). While companies vary in their rates of pay, the average hourly rate for health care assistants in the for-profit sector corresponds to an average annual salary of €22,000, while home care assistants average annual salaries of €24,000 (see [www.payscale.com](http://www.payscale.com)). A review of literature on the relationship between family carers and home care support workers highlighted how a lack of training and supervision, workload pressures, unpredictable scheduling and unsocial hours, being taken for granted and low pay negatively affect the ability of home care workers to provide high-quality care (Care Alliance Ireland, 2014, p. 4).

Private nursing homes for older persons have been in operation in Ireland since the introduction of the Health Care Nursing Act, 1990. Several factors have stimulated the growth of privatisation in this sector. Firstly, tax breaks for building or refurbishing non-profit nursing homes and hospitals, introduced in 2000, were extended to for-profits in 2002. Approximately 1,000 beds per annum were added to the system overall in the period up to 2009, dropping to 339 beds annually between 2009 and 2012 as the recession deepened (Keena, 2015). As of 31 December 2015, there were 577 active nursing homes registered with HIQA, providing 30,106 registered beds in the sector. Of these, 76 per cent were provided by the for-profit sector, 3 per cent by the non-profit/voluntary sector and 21 per cent by the HSE (HIQA, 2016, pp. 11–12).

Secondly, competition from the statutory sector has been weak: the HSE closed 1,650 beds between 2010 and 2012, thereby further increasing the market share available for private providers. Thirdly, the Nursing Homes Support Scheme (operated by the HSE) provides financial support to people who need long-term nursing home care and is a significant source of funding for this sector (Barry, 2010, p. 10).

While working conditions appear broadly comparable between public and private service providers of nursing homes in the Nordic countries, this is not the case in Ireland, where workers employed by for-profit home care providers are required to be more flexible, and on average have lower wages and weaker social rights than their non-profit or public sector counterparts. The lower costs anticipated from marketisation and provider competition may therefore have damaging effects on the private sector care workforce (Rostgaard et al., 2011, p. 12).

## **Child and family services**

Family support and child-protection services are provided by Tusla, both directly and through service-level agreements and grant aiding of organisations in the community and voluntary sector. The financial crisis of 2008 led to dramatic reductions in funding to voluntary and community organisations, many of whom provided essential family support services. As a result, 36 per cent of organisations introduced pay freezes, 25 per cent reduced pay and 17 per cent cut working hours, impacting disproportionately on the predominantly female workforce (The Wheel & Crowe Horwarth, 2014, p. 5). The capacity of the statutory agency to provide family supports and protect children has been severely constrained by a lack of resourcing (Oireachtas Committee on Health and Children, 2015). Against this backdrop, commissioning guidance for future relationships between Tusla and the community and voluntary sector was published in 2013. Commissioning is defined as the process of deciding how to use the total resources available for children and families in order to improve outcomes in the most efficient, effective, equitable, proportionate and sustainable way (Tusla, 2013, p. 1). Tusla positions its guidance in a context of severely constrained financial and human resources, where effective resource allocation and governance is required (Department of Children and Youth Affairs, 2012). As commissioning in Tusla is at an early stage, it remains to be seen if the approach outlined in the

literature will contribute to the provision of quality care services and a sustainable care workforce.

## **Intellectual disability services**

Unlike the services outlined above, the almost exclusive role of non-profit organisations (religious orders and secular organisations such as parents' and friends' associations) in providing intellectual disability services in Ireland has continued from the foundation of the state to the present day – providing approximately 90 per cent of services (Linehan et al., 2014, p. 3). The recommendations of the Expert Reference Group on Disability Policy (2010) and the *Value for Money and Policy Review of Disability Services* (Department of Health, 2012) are likely to result in wide-ranging and fundamental changes in how such services are configured. In line with previous reports, the Expert Reference Group on Disability Policy (2010) proposed reframing service delivery towards a model of individualised supports, delivered where possible via mainstream services with state funding, based on a standardised assessment of individual need. An individual budget will be determined from which support services will be purchased. The individual will therefore be the commissioner of his or her own support services, whether through direct payments (where the budget is managed directly by the individual) or alternative mechanisms, including brokerage (where the person identifies supports which are then commissioned and purchased by a third party) (Linehan et al., 2014, pp. 22–3). The *Value for Money and Policy Review* (VMPR) proposed the introduction of a competitively tendered process from which services will be commissioned (Linehan et al., 2014, p. 23).

The introduction of individual assessments of need and a personalised budget/direct payments policy seeks to give greater control and choice to disabled people in relation to the supports they require, and is a response to the lack of progress within the current system in enabling disabled people to lead full and independent lives. The roll out of personal budgets (PBs) is likely to produce markets for personal assistants (PAs) and other supports – an unintended consequence of a policy that is broadly supported by those who can access direct payments (Glendinning et al., 2008; Hatton & Waters, 2014). As such, it differs from other areas of social care discussed here because it is the capacity of this shift to deliver on policy goals which will be evaluated into the future. In contrast to other sectors, research to inform the roll out of this policy is ongoing in Ireland, including a

review of international research and an evaluation of four pilot projects on PBs (Anand Carter et al., 2012; Fleming, 2016; Flynn, 2010). The impact of marketisation on the labour force in intellectual disability services is as yet unclear. The VMPR Group recommended substituting non-professionally qualified social care staff (care assistants) for professionally qualified care staff to achieve pay savings, as well as reviews of rostering outside core working hours in order to reduce staffing costs (Linehan et al., 2014, pp. 24–5). The focus on this particular grade strongly suggests moves towards the de-professionalisation of social care workers (Healy, 2009), further undermining the workforce.

### **The compatibility of care and profits: The empirical evidence**

Marketisation led to the entry and expansion of for-profits in eldercare and children's residential care, with a diminution of the pay and conditions of the workforce in Ireland in both cases. Markets will be created through competitive tendering in the intellectual disability services and it is not clear how commissioning in child and family services will evolve at this early stage. The question of whether marketisation and for-profit provision of care are positive developments for citizens and the care labour force has been the focus of empirical research internationally. The remainder of this article will review the international evidence available in order to contribute to learning about the likely impact of marketisation in the Irish context.

### **Older persons: Nursing homes and home care**

Evidence from England, Sweden, Australia, Denmark, Canada and the US casts doubt on the assumption that for-profit nursing home provision can deliver higher-quality care at a lower cost. In a study of eldercare (and childcare) in England, Sweden and Australia, Brennan et al. found no firm evidence that either increased quality or lower costs had resulted from increased competition, marketisation or the penetration of for-profit service in eldercare and childcare. Crucially, increased marketisation has exacerbated inequalities among service users, with considerable evidence about the difficulties experienced by consumers in making informed decisions about care (Brennan et al., 2012, p. 388). In a systematic review of Danish and Swedish experiences of private provision of welfare services in home care of the elderly, childcare and nursing home care, Petersen & Hjølmer (2013,

p. 3) found no general evidence in support of improved cost-effectiveness or enhanced service quality within these three welfare areas. They recommend more detailed research across these sectors. An analysis of health and social care workforces in residential aged-care in Australia found that for-profits had fewer aged-care workers per bed, higher staff turnover and higher use of private agency staff (Martin, 2005). A systematic review and meta-analysis of the sector in the US and Canada found that, on average, not-for-profit nursing homes delivered higher-quality care than for-profit nursing homes, using benchmarks such as fewer deficiencies in government regulatory assessments, lower use of physical restraint, lower incidences of pressure ulcers, and more and higher-quality staffing (Comondore et al., 2009). A large proportion of studies, however, showed no significant trend, and the authors called for further research on the possible impacts of factors such as subcategories of for-profit ownership (e.g. chains vs non-chains), management styles and motivation (Comondore et al., 2009, p. 14).

Studies of the motivations of for-profit domiciliary care providers across eleven local authority areas in the UK found that they are, like the motivations of residential care providers, mixed, with the desire to make money coexisting with the desire for professional satisfaction and to help others. The balance between intrinsic and extrinsic motivations may differ by ownership type, but the external environment may also influence the capacity to express intrinsic motivation. The researchers stress the role of contract specifications and the experience of day-to-day relationships with local authority purchasers in determining whether motivations that support high-quality care are crowded in or out (Kendall et al., 2003). A later study (Matosevic et al., 2007) found no difference in the intrinsic or professional aspects of home care managers' motivations across the for-profit, non-profit and local authority sectors. The principal motives were professional, financial, caring for older people and caring for vulnerable clients. Policy and incentive structures which assume that self-interested motivations dominate could undermine other aspects of people's motivation and be detrimental to the quality of care (Matosevic et al., 2007, p. 105). A study of 155 providers of domiciliary care in eleven English local authorities highlighted how the type of contract between purchasers and providers, rather than ownership per se, influences how home care organisations pursue profit. Regardless of ownership structure, recipients of grants (lump sums with broad service specifications) placed a lower priority on profit-making than those

engaged on contracts for specified quantities of service, or those contracting on the basis of price per case. The analysis demonstrated that contract choices do have a significant and substantial effect on market prices, which might also lead to changes in the quality of care (Forder et al., 2004, p. 218).

In light of the evidence of inferior quality of care in for-profit nursing homes, the case of Norwegian eldercare provides an instructive example of resistance to markets (Vabø et al., 2013). Efforts to increase the use of market mechanisms in eldercare in Norway have been fiercely resisted by the unions and other civil society alliances that have worked to raise awareness about marketisation and have monitored marketisation trends in public service provision. In a very public debate all statements on privatisation were hotly contested, no matter who or what the source of information (Vabø et al., 2013, pp. 185–6). The resistance led to the development of innovative, systems-wide alternatives to competition based on cooperation to bring about better and more efficient eldercare services (Vabø et al., 2013).

### **Personal budgets**

PBs enable individuals who previously received their care directly from the local authority to receive the equivalent funding and to manage a budget to purchase the care they require from a range of providers in the non-profit, commercial and public sectors (Hall, 2011, p. 590). A review of international research on PBs in eleven countries concluded that they have little impact on health outcomes, but have positive outcomes in terms of consumer satisfaction, feelings of well-being, and quality of life for the majority of users (Gadsby, 2013, pp. 4–5). This outcome depends on the degree of real choice that the programme affords individuals and the provision of appropriate support to budget holders (Gadsby, 2013, p. 37). A new market of voluntary and private-sector providers has emerged in the UK, from PB brokers to the provision of PAs, in addition to local state services (Hall, 2011, p. 595). Most benefits from PBs were gained by those who were more able, who already had care arrangements in place, and who had a strong support network of family and friends. Those not in this position were less able to take advantage of personalised care (Hall, 2011, p. 596). Satisfaction was highest among mental health service users and physically disabled working-age people, and lowest among older people (Glendenning et al., 2008; Hatton & Waters, 2014). One

result of the attention to the market is that local authority spending on collective projects of specific benefit to those needing care is much curtailed (Himmelweit & Land, 2008, p. 5).

A small-scale, in-depth study of how choice and competition were operationalised in six local care markets in the UK found small increases in user agency and in opportunities for older people to receive more personalised care at home, in which the quality of care giving was also optimised. However, there were increased risks and costs associated with the expansion of choice and competition both for the organisations providing home care (non-profit and for-profit) and for individual older service users. Many older people chose to trade less choice for less responsibility (Rodrigues & Glendinning, 2015, p. 661). There has been considerable debate about the efficacy of PBs in the UK in recent years in light of severe spending cuts, which studies claim have undermined the potential of PBs (Slasberg et al., 2012; 2013). An evaluation of four individualised funding initiatives for people with disabilities in Ireland made several recommendations, including the essentiality of a strong network of support for budget holders, easy and transparent access from the outset to those who wish to avail of PBs, training for PAs, and a focus on individual abilities and interests while guarding against overly protective instincts (Fleming, 2016).

## **Children's residential care**

The international evidence here points to serious shortcomings in for-profit provision of care, with rising costs, varying quality of care and an inability to meet policy goals for children in state care. A study of the market for children's residential care in England and Wales found that the market was problematic, in both economic and policy terms (Kirkpatrick et al., 2001, p. 49). On the question of market efficiency, the mismatch between demand and supply of children's residential care, deficiencies in information about quality, and the underdeveloped purchasing function of local authorities all led to rising costs for purchasing authorities. Contracting out led to placements further away from children's local areas, the problem of control and surveillance was exacerbated, and matching needs and services, when attainable, came at a high price (Kirkpatrick et al., 2001, p. 65). The authors concluded that the further development and reorganisation of local authorities' own services alongside a considered use of contracts was central to future policy development

in this area (Kirkpatrick et al., 2001, p. 69). The role of for-profit providers in England has expanded and they now operate 73 per cent of children's homes. A report of the Expert Group on Children's Homes (Department for Education, 2012) reported problems with markets in children's residential care, similar to those identified by Kirkpatrick et al. (2001). These included limited information available to local authority social workers on costs, quality and capacity of homes; significant shortcomings in monitoring the quality of care; unnecessary use of out-of-area placements; an increasing demand for specialist services; and concentration of ownership. The for-profit children's residential care sector is predominantly a low-wage economy, with pay rates for managers and residential care workers lower than in the local authority and voluntary sector in the UK (Department for Education, 2012; Institute of Public Care, 2015, p. 19; National Children's Bureau, 2015, pp. 24–5).

Small-scale research by Gharabaghi (2009) of twenty private-enterprise directors of children's residential care in Canada suggested that the financial interests of the business often took precedence over the service needs of children in their care. This was evident in such practices as the filling of beds and allowing minimum time for children to adapt to the departure of a peer or to prepare for the arrival of a new child (Gharabaghi, 2009, p. 171). Directors stated they could not be competitive in recruiting and retaining staff because of the funding structure in procurement contracts, which limits their capacity to offer higher salaries, better holiday pay and sick-time benefits. Statutory salaries in Canada at the time the study was carried out were, on average, 50–70 per cent higher than in the for-profit sector.

A study of children's residential care in Sweden examined how and why the market in this sector emerged (Meagher et al., 2015, p. 2). The emergence of the for-profit private sector in residential care in Sweden represents a fundamental shift from state dominance to extreme private dominance – 70 per cent of care homes are currently provided by for-profit companies – within a traditionally strong social democratic welfare state (Meagher et al., 2015, pp. 2–4). The expansion of for-profits came about as a result of marketising and rescaling policies, the professionalisation of residential care and the financialising of the economy more broadly. Local authorities responded by purchasing places in for-profit homes rather than providing them in-house when emerging demand for a diverse range of specialist treatments could not be accommodated locally. A well-



funded, lightly regulated service offered profitable opportunities to large business interests using corporate practices and resources to offer diversified professionalised services (Meagher et al., 2015, p. 14). The result has been higher prices per placement and a higher usage of residential care. The use of 'spot purchasing' in emergency situations has resulted in local authorities finding themselves as 'price takers', while discovering and monitoring care quality were problematic (Meagher et al., 2015, p. 15). Similar problems of cost and efficacy have occurred in children's welfare services across England, Wales and the US (Colton et al., 2004; Rees, 2010; Ricucci & Meyers, 2008; Wilson et al., 2004).

A change in the mix of providers in the Swedish system occurred from 2006, and since then the Swedish state has assumed responsibility for between 2,000 and 4,000 unaccompanied refugee children annually (Migration Board, 2014). A total of 60 per cent of homes for these children are publicly provided while small companies and corporations each account for about 15 per cent. This development demonstrates that public provision is economically feasible under different incentive structures (Meagher et al., 2015, p. 15).

## **Commissioning**

A review of the literature on commissioning was carried out by the Centre for Effective Services (2015) to inform the work of the Departments of Public Expenditure and Reform, Children and Youth Affairs, and Health in this area. What follows is a summary of the findings of this review (pp. 1–4). Most of the literature on commissioning comes from the UK, where most of its application has occurred. There are challenges posed by the lack of consensus on defining commissioning, which appears to reflect diverging purposes and objectives, and divergence in how these are to be realised in practice. A variety of models of commissioning are being implemented across jurisdictions and these models have been applied at different levels, from locally based commissioning (the most commonly cited) to central government commissioning of a range of services. A key rationale for commissioning is to improve outcomes for service users, although there is limited evidence to date that commissioning approaches result in better outcomes. It is difficult to measure and demonstrate outcomes, particularly in preventive services and among service users and communities with complex needs, where any change may take years. The most cited risks associated with commissioning

relate to the possible impact of competition, markets and tendering, rather than to commissioning as a form of strategic planning and resource management. The evidence reviewed by the Centre for Effective Services suggests commissioning can have the potential to destabilise the pool of providers, especially where a few major providers supply a range of interdependent services, or where present provision is a poor match for population needs. There is also the risk of providers ‘cherry-picking’ clients with less complex needs. Finally, there is limited evidence on the costs of commissioning, and no cost-benefit studies were identified in the literature (Centre for Effective Services, 2015).

## **Discussion and conclusion**

Marketisation and for-profit provision have expanded in Irish social care as for-profits dominate provision in children’s residential care, nursing home and domiciliary care services. PBs and competitive tendering are central to the policy direction in intellectual disability services, while commissioning is underway in child and family services. The Irish social care landscape has thus been fundamentally altered. There is a need for more information about the impact of these policy directions on both the citizens using care services and the care workforce. There is a dearth of any such research in the Irish context. The international evidence suggests that the quality of care is lower in for-profit nursing homes while pay and conditions are less favourable also (Simonazzi, 2009). International research on the marketisation of children’s residential care is scarce (Meagher et al., 2015, p. 3), although the evidence available highlights major problems in relying on for-profit provision to meet the needs of this vulnerable group. Studies from the UK (Department for Education, 2012; Kirkpatrick et al., 2001) demonstrate that these problems have persisted over time and have not contributed to lower costs or higher-quality care, while pay and conditions have deteriorated. The experience of implementing PBs across a range of jurisdictions has been generally positive although with significant differences in access to, and capacity to use, budgets, exacerbated by spending cuts. Finally, commissioning is underway in child and family services so it is unclear how this process will impact on quality of care and employment conditions. What then are the implications for the future of social care? There are lessons arising for Ireland in each of these sectors.

In relation to the nursing and home care sector, there is extensive international evidence that for-profit provision has not delivered on higher quality and cost-effectiveness. However, the diversity of motivations among care home and home care providers, forms of regulation and contract specifications, and everyday practices between purchasers and providers are fruitful areas for further research to enable a more nuanced assessment of the contribution of the for-profit sector to inform policy.

With regard to PBs, research suggests that this policy direction is generally successful in other jurisdictions when budget holders are appropriately supported and funded, and PAs are provided with adequate training, guidance and remuneration. The drive towards PBs must not limit the funding of public provision to support those who do not wish to manage a PB but who are still entitled to supports adequate to meet their needs; otherwise the policy may well undermine public provision and engender unequal access (Hall, 2011).

In relation to children's residential care, there are relevant insights from the literature for the Irish context. It is important to maintain a balance of provision between the non-profit, for-profit and public sector, and to develop and reorganise public provision where necessary, rather than pursue a policy of public sector closures. This ensures a range of provision is available to meet children's needs at sustainable cost levels. The type of contracts established between purchasers and providers must be designed to maximise quality and cost-effectiveness. Ensuring an independent regulatory system with national oversight assists in identifying areas of innovation and good practice, as well as enabling comparisons across sectors. Policy regulation of pay and conditions can ensure a sustainable social care workforce, allowing for freer movement of staff and expertise between the for-profit, non-profit and public sectors.

When used as a strategic planning approach linking resource allocation with meeting assessed needs, commissioning has a strong rationale. Using evidence of need and best practice to underpin spending decisions, rather than funding on the basis of historical spending and funding patterns, is a logical approach (Centre for Effective Services, 2015, p. 4). A review of international evidence suggests the need for a coherent policy rationale for commissioning from the outset with clearly stated objectives and a shared understanding among all stakeholders of what is meant by commissioning. Defining outcomes, how they should be measured and who is

responsible for these data is crucial. A range of funding models are compatible with commissioning, including, but not restricted to, competitive tendering processes. Effective commissioning processes depend on complex infrastructure, specialist skills and a range of supports (Centre for Effective Services, 2015).

A central finding of this review is the lack of evidence about the impact of these changes in social care. Studies on commissioning (Centre for Effective Services, 2015), on outsourcing (Ní Lochlainn & Collins, 2015) and on PBs/individualised funding (Anand Carter et al., 2012; Fleming, 2016; Flynn, 2010) are valuable contributions. Research on the forms and implications of market provision across the social care sector is needed. In an era where the mantra of ‘evidence-based’ policy is ever-present, to date no research has been undertaken in Ireland to measure the impact of marketisation on the quality of care for citizens using services, the working conditions of staff or costs to the state. It is likely that the conditions for marketisation have evolved differently in Ireland, for example, than in the Nordic countries, the US or the UK (Meagher & Szebehely, 2013). Knowledge about the processes involved in marketisation, the mechanisms and instruments used, and the consequences is important in order to evaluate the appropriateness, or otherwise, of market solutions across different sectors of Irish social care.

## Acknowledgement

I wish to thank the anonymous reviewers, whose feedback was immensely helpful.

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