

## **BETWEEN MARKETS AND NETWORKS: THE REFORM OF SOCIAL CARE PROVISION IN THE UK**

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### **Abstract**

*For over two decades there have been attempts across many countries to reform the management of public services and substitute market based provision for bureaucracy. But while these changes have been pursued vigorously, doubts about their appropriateness, feasibility and effectiveness remain. The aim of this paper is to contribute to this debate focusing on the specific case of social care markets in the UK. Drawing on ideas from institutional theory and a range of secondary sources it is argued that, in the UK, broad policy objectives of moving towards a mixed economy have been largely successful. However this review also points to costs associated with implementation and the reliance on low trust arms length contractual relations. Social care organisations are now seeking to manage these costs by attempting to move towards more collaborative networks, although the effectiveness of this change is open to question given prevailing institutional conditions in the UK.*

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## I. Introduction

Since the early 1980s there has been a significant drive across developed countries to reform the management of public services (Pollitt and Boukaert, 2000). Central to this is the idea that bureaucracy represents an inferior mechanism for delivering services to ‘contract based competitive provision’ (Hood, 1995, p. 96). This belief stems in part from the growing influence of neo-liberal, or New Right ideas in many countries, especially in the US and UK (Hutton, 2003). More generally it is argued that public services can and should copy models of organisation and management from the private sector (Clarke and Newman, 1997). Just as many large corporate firms have outsourced work in the name of improved efficiency and flexibility so too should public organisations. A dominant rhetoric of ‘market rationalism’ promoted the idea that all organisations should break free of bureaucracy and ‘thoroughly internalise the new dictates of the market’ (Kunda and Alion-Souday, 2005, p. 202). The message from academics and policy makers alike has been simple: “if in doubt contract out” (Milne, 1997, p. 4).

These reform ideas became particularly influential in the 1990s as most developed economies faced mounting pressures to contain or reduce levels of public expenditure (Whitfield, 2001). In some countries, such as France, Germany and Spain, outsourcing was introduced gradually to services such as hospital catering, garbage collection and highway maintenance (Bach and Della Rocca, 2000, pp. 90-91). Elsewhere, for example in the UK, change was more rapid and far reaching. During the 1990s a large number of professional support services in health and local government were subject to compulsory competitive tendering. Most recently, under the private finance initiative, the role of private firms has been extended to the running of core services within schools, hospitals and other organisations (Grimshaw *et al.*, 2002).

However, while these changes have been pursued vigorously, doubts about their feasibility and effectiveness remain. First, it is argued that markets may be hard to implement in public services. At best we are likely to see the development of ‘quasi markets’ in which the state acts as a surrogate purchaser on behalf of ‘consumers’ and where institutional constraints restrict both supply and competition (Bartlett and Le Grand, 1993). Implementation may also be held back by the lack of experience of public managers in defining and negotiating contracts and, in some cases, hostility to the very idea of commercialising services (Wistow *et al.*, 1996). Second, while market mechanisms in the public sector may deliver improvements in efficiency and choice, there may also be rising transaction costs, especially in services that are hard to specify, monitor and where a high degree of communication is required between purchasers and providers. In the US, for example, some studies show cost savings from subcontracting, others indicate cost increases after subcontracting (i.e., municipal services could be provided cheaper by public employees), but most show no significant differences between the costs of private, contracted out services and those provided by municipal employees (Hebdon and Kirkpatrick, 2004). Research conducted in the UK also casts doubt on the idea that outsourcing *always* delivers cost savings and improvements in services (Boyne, 1998). These concerns have led some to argue that, if markets are to be effective in public services it will also be

necessary to develop “engaged” modes of contracting in which the emphasis shifts to longer term, trust based relationships between clients and provider organisations (Colling, 2006). According to Brerston and Temple (1999) relational contracting could facilitate a new hybrid sector, incorporating the public values of quality service and accountability with private sector efficiencies. However, it is also noted that these kind of network-based relationships are hard to establish and, in some institutional contexts, hard to sustain (Marchington *et al.*, 2005).

The aim of this paper is to contribute to these debates, focusing on the introduction of market mechanisms in one area of the UK public sector: social care adults and young people.<sup>1</sup> Specifically the paper charts the development of markets in this sector since the early 1990s, focusing on the process of implementation and on the intended and unintended consequence of the reforms. The paper also considers how far, to date, it has been possible to achieve more ‘engaged’ or ‘network’ modes of contracting and explores some of the factors that have either supported or hindered such change.

The focus on social services is illustrative for a number of reasons. Firstly, in many countries, it represents a key area where governments have sought to extend markets to produce ‘mixed economies’ of care (Anttonen and Sipilä, 1996; Harris and MacDonald, 2000). Social care is also a useful case because of the complexity of services and the obvious difficulties this creates for writing and monitoring contracts (Mackintosh, 2000). A great deal of work with children and families is highly developmental and unstable making it hard to anticipate, control or evaluate outcomes. This may be especially true in the case of looked after children where ‘needs’ are hard to define and there is considerable debate concerning the value of different policy interventions. Such problems have led some critics to argue that market relationships may be inappropriate where users are vulnerable and outcomes difficult to define or measure.

The reform of social care markets is, of course, by no means unique to the UK. That said, with the possible exception of New Zealand, it is the country where such change has progressed furthest (Flynn, 2000). As we shall see, during the 1990s there occurred a radical shift in the nature of social care provision away from public authorities to private and voluntary sector organisations. Given this one might argue that the UK represents one of the best illustrative case of the new public management (NPM) reforms in action.<sup>2</sup> Indeed, looking at the UK experience can tell us much about both the advantages of this kind of restructuring and also some of the wider costs and risks associated with it.

What follows contains *four* main parts. The first section introduces ideas from institutional theory to help frame the analysis. Following, section two looks at the historical development of social services in the UK and the reforms that initiated a shift towards markets. The third and main part of the paper then offers an evaluation of these changes, drawing on a range of published secondary sources. Finally, in the conclusion it will be argued that the transition to a market system has not been wholly unproblematic. While attempts are underway to move towards a more collaborative form of contracting, questions remain about how far this will work and can be sustained given the particular nature of regulatory institutions. As such the main contribution of the paper will be to highlight certain problems associated with the implementation of

markets in social care and the reasons for these problems. It will not be argued that market reforms have failed or even that they will do so in future. Rather, the point is that the specific conditions and demands of social care generate important (if not always insurmountable) obstacles to such change.

## II. Analysing Social Care Markets

Recent efforts to assess the effectiveness of markets as a means of organising the delivery of public services owe much to conceptual models derived from institutional economics (Lane, 2001). A key insight from this literature is that there are limited possibilities for the development of open, competitive markets in public services. Bartlett and LeGrand (1993), for example, have labelled emerging forms as 'quasi markets'. That is, markets where the state acts as a surrogate purchaser on behalf of 'consumers' and where institutional constraints restrict both supply and competition. More generally, this literature is also useful for setting out broad propositions that state under what conditions markets are likely to function as efficient mechanisms for coordinating the delivery of services. Here attention has focused on the way markets are structured, on the nature of contractual relationships and the differing modes of governance these imply.

The notion of market structure points to the necessity for markets to be competitive. There need to be many purchasers and providers to avoid problems of both supply or demand monopolies, and at least the potential for new providers to enter the market relatively freely. Of necessity there is a requirement that markets should allow prices to reflect the interaction of supply and demand for a given service (Bartlett and LeGrand, 1993). The consequences of a failure to meet these conditions may be 'structural losses', for example, where a 'monopoly provider' is able to 'inflate prices beyond the costs of production' (Wistow *et al.*, 1996, p. 141).

The effectiveness of social care markets also has much to do with the nature of contractual relationships between purchasers and providers and the relative transactions costs these imply (Lapsley and Llewellyn, 1997). In the literature it is noted how a number of different governance structures (emerging from these contractual relationships) may be possible (Sako, 1992; Lane, 2001). At one end of the spectrum are low trust and highly formalised relationships that are 'arms length' or distant. Here the emphasis is on purchasers using short-term (or spot) contracts with limited repeat business. A key advantage of this approach is that it may help to drive down costs by encouraging competition and allowing the purchaser to shop around for the lowest price. However, arms length contracts may also be costly, leading to adversarial relationships, problems of coordination and high transaction costs associated with contract specification and monitoring. These costs may be especially high in areas such as health and social care. According to Walsh *et al.* (1997, p. 37) these services represent 'credence goods', where: 'In the extreme, neither client nor contractor may be very clear about what is happening in complex and ill-understood technologies'.

At the other extreme are market relationships based on greater collaboration and mutual dependency between purchasers and providers (Thompson *et al.*, 1992).

This is often referred to in the literature as a form of relational (or obligational) contracting based on goodwill trust, loyalty, reciprocity and shared value systems (Sako, 1992). Instead of seeking to drive down the price by taking advantage of competition in the market, purchasers enter into longer term contracts with a select number of preferred suppliers. One advantage of this arrangement is that transaction costs may be greatly reduced. A climate of trust between purchasers and providers can ensure (in theory at least) that neither side will act opportunistically. Contracts may be left implicit or open ended with less need to specify the obligations of each side in detail or engage in extensive monitoring. In social care, where there is often ambiguity concerning the means and ends of service provision, this may be especially beneficial. A degree of trust and mutual understanding between parties could make it easier to negotiate service requirements and to anticipate and respond in more flexible ways to changing circumstances. Because contracts are embedded in more particularistic social relations between trading partners with a sense of mutual trust, transactions can take place without prior agreement on all the terms and conditions of trade. This means that contracts can be incomplete, and contingencies, which are not fully specified can be overcome without recourse to protracted legalistic bargaining and arbitration. Finally an “engaged model” of contracting might facilitate joint approaches to problem solving, innovation and, in some cases, even shared equity arrangements to pool risk and share benefits (Colling, 2006). In social care, these arrangements might be supported by the fact that many independent sector providers themselves have extensive professional training and, quite often, past experience working within public organisations, thus helping to engender trust and mutual understanding.

This literature therefore draws our attention to the theoretical choice between different modes of governance and market formation. However, at the same time, it is important not to lose sight of the fact that markets are also conditioned by the broader national, regulatory contexts in which they are embedded (Whitley, 2002). Some national contexts are highly supportive of engaged or network modes of contracting, while others are more likely to promote competition and uncertainty (Lane and Bachman, 1997). Italy and Germany are frequently cited as examples of the former. In Germany it is suggested that strong forms of regulation through, *inter-alia*, trade associations, financial institutions and unions encourage ‘systems trust’ that make cooperative forms of behaviour more likely and profitable for all concerned (*ibid*). By contrast, in the UK one finds relatively weak institutional supports for high trust cooperative market relations. Here financial institutions (focused on short term value for shareholders) and supporting legal frameworks have tended to encourage shorter term, more transactional forms of behaviour. To be sure these conditions do not entirely prohibit the emergence of high trust relationships, but they do make them harder and more risky to negotiate. They also mean that the dominant tendency is for more powerful organisations within a network to seek to displace risk, in the pursuit of shorter-term gains, rather than engage in longer term risk sharing (Marchington *et al.*, 2005). As we shall see pressure to use markets to drive down costs in the public sector may also work against a high trust contractual relations (Kirkpatrick, 1999). Hence, while institutional and regulatory conditions do not prevent choice, they do

shape the way actors perceive their interests and consequently the particular forms of governance that emerge.

### **III. Social Care in the UK: From State Bureaucracy to the Market**

Turning now to the case of social services it is useful to consider briefly the historical context. A marked feature of the welfare state in the UK compared to other countries has been its incremental and piecemeal development. Responsibility for personal social services (to the elderly, children and mentally ill) was initially dispersed between different branches of local government and the national health service (NHS) (established after 1948) (Clarke, 1993). In fact, it was not until the early 1970s, following the recommendations of the Seebohm report (in 1968) that the system was consolidated. This report led to the formation of unified social services departments (SSDs) under the control of local government and effectively ended the “balkanisation” of the personal social services.<sup>3</sup> For the first time responsibility for the planning and provision of services to different client groups was brought under the control of a single organisation (Webb and Wistow, 1987, p. 49). A key feature of the new arrangements was that they reinforced the idea that the state should both plan and provide services. Working alongside the NHS, SSDs were made responsible for the development of a patchwork of residential and domiciliary services for the elderly, mentally ill and children. This did not mean a complete monopoly over service provision. From the start there had existed a ‘mixed economy’ of care (Charlesworth *et al.*, 1996), with a small but influential role being played by voluntary organisations and, from late 1970s, also by private firms (especially in the area of residential care) (Evandrou and Falkingham, 1998). But while important this role was always assumed to be secondary. State ownership and control over service provision was believed to be not only unavoidable but also desirable (Clarke and Newman, 1997).

However by the late 1970s political support for this model of organisation in the personal social services had begun to wane (Langan, 1993). There was growing concern amongst political elites on both left and right of political spectrum about spiralling costs (Deakin, 1994). Many questioned the need for local authorities and the NHS to maintain large and expensive residential services proposing alternative community based modes of care (Harris and MacDonald, 2000). Related to this was also the view that state-run bureaucracies were largely ineffective mechanisms for the delivery of public services. Important here was the growing influence of New Right academics and think tanks in the UK (Cochrane, 1993). Public choice theorists, in particular, drew attention to the way public sector bureaucracies had been captured by self-interested producer groups such as professions with monopoly control over service delivery. These ‘producers’ it was argued, were seeking only to exploit their position by claiming excessive budgets and oversupplying services. In the personal social services this meant that money was being poured into existing in house and costly residential services without regard for their efficiency or the needs of clients. Only by separating these services from local authority control and transferring them to the market, it was argued, might one avoid this outcome.

In response to these concerns the then Conservative government introduced major new legislation – the NHS and Community Care Act 1990 (see Kirkpatrick, 2006 for a more detailed chronology). A prime motive for reform was to limit the further growth of expenditure, or at least ensure that resources were more effectively rationed. To facilitate this government proposed a model of ‘care management’ in which professional social workers would assess needs and then commission ‘packages’ of care that were most cost effective. Local authorities were also given an explicit duty to promote user “choice and independence” and to seek ways of substituting domiciliary services for residential provision (Cm. 849, 1989). Finally, and most importantly from the perspective of this paper, was the goal of further extending the mixed economy of social care. The new legislation called for the development of a “flourishing independent sector” (Cm. 849, 1989) and the use of competition to improve both the efficiency and responsiveness of services.

The shift to markets was to be achieved in a number of ways. Local authorities were obliged to spend 85% of the resources transferred to them on the independent sector (including both private and voluntary providers). Beyond the requirement for private care homes to be registered and guidelines stating that ‘looked after’ children be placed close to their local communities there were few restrictions on where and from whom local authorities could purchase or on the kind of contractual forms used. A further change was to urge SSDs to reorganise their own services, separating purchasing roles (responsible for commissioning services on behalf of clients) and provider roles (those residential and domiciliary care services that remained in local authority ownership and control). This, it was believed, would force SSDs to move away from a situation in which resources were routinely allocated to their own in house services. Instead, all provider organisations –those publicly owned and independent– would be required to compete for contracts. Finally, local authorities were given the responsibility of “stimulating” social care markets to ensure diversity of supply of different kinds of care (Peat Marwick and SSI, 1993).

After the NHS and CC Act was passed through parliament in 1990 local authorities were given three years to implement the new structures and procedures (these had to be in place by 1993). Since that time pressures to move towards a market system have been relentless and continued even after 1997 and the election of a New Labour government. Whilst Labour have adopted a new rhetoric of modernisation and the maxim ‘what works is best’, the emphasis has been firmly on developing a thriving mixed economy of care (Orme, 2001).

#### **IV. Evaluating the Change: Social Care Markets in Practice**

Now that some of the objectives of reform have been outlined the aim of this section is to address the outcomes and consequences of change. For obvious reasons this will not be a full evaluation. Because social care markets, like any other, are in a process of constant evolution the task of assessment is always “one begun, not completed” (Osborne 1997). However at the same time it is possible to draw some general conclusions about the impact of the reforms set in motion by the community care legislation of the early

1990s. Firstly is the question of market structure and some general considerations about supply and demand. Second is the issue of contractual relationships between purchasers and providers and the extent to which these have been 'arms length' or collaborative.

#### 4.1 Market structure

A major concern of policy makers in the early 1990s was that deficiencies in the supply of various services provided by the independent sector would be a major obstacle to the development of the mixed economy. This problem was most acute where domiciliary and home care services for the elderly were concerned. In the early 1990s, supply barely existed outside of local authority sector (Charlesworth *et al.*, 1996; Wistow *et al.*, 1994). Elsewhere, for example in the case of residential care for the elderly, problems of supply were less acute. During the 1980s there had been a steady expansion of the private sector with the number of places in private run homes rising from 37,000 in 1979 to 98,000 in 1990 (Oldham, 1991). But even here there existed regional variations in supply, with a considerably larger provision in London and the South East of England (Means and Smith, 1998, p. 128).

Given these early difficulties it is all the more remarkable that within ten years many (if not all) problems of supply had been resolved. One of the most marked changes was in the supply of domiciliary services, such as for home help and home care. Table 1 shows that by 2003, out of a total of approximately 3.1 million contact hours delivered in England, 66% (or 2,069,800 hours) was provided by the independent sector. This represents a quite dramatic turn around from the situation in 1993. At that time, not only was the overall level of service much lower, but so too was the involvement of the independent sector, which providing only 86,000 contact hours (or about 5% of the total).

TABLE 1

CONTACT HOURS OF HOME (DOMICILIARY) CARE PROVIDED  
BY SECTOR IN ENGLAND

	All sectors	Local authorities	Independent sector
1993	1,780,800	1,696,000	86,600
1994	2,215,100	1,787,000	428,200
1995	2,395,700	1,688,900	706,800
1996	2,486,700	1,581,200	900,900
1997	2,607,500	1,506,500	1,101,000
1998	2,607,400	1,410,500	1,197,000
1999	2,684,200	1,324,200	1,360,100
2000	2,791,300	1,241,100	1,550,200
2001	2,881,600	1,161,700	1,719,800
2002	2,983,200	1,078,600	1,904,600
2003	3,113,000	1,043,200	2,069,800

Source: National Statistics and Department of Health (2004a) *Community Care Statistics: Home Care Services for Adults, England*, London.



A similar transformation of supply can be noted in the area of residential care services for adults and mentally ill. By 2001 the private sector was providing over 174,000 residential places in England and local authorities only 50,850 places. The independent sector as a whole accounted for 92% of all homes and 85% of all places in residential care (National Statistics, 2001). The overall picture is of a steady decline in the number of adult clients who are directly supported by local authorities, from well over 100,000 in 1990, to approximately 50,000 by the mid 1990s (National Statistics, 2004). As is indicated by Table 2 this trend has continued since 1997, despite the election of a New Labour government.

TABLE 2

ADULT CLIENTS FINANCIALLY SUPPORTED IN RESIDENTIAL CARE BY SECTOR IN ENGLAND, AT 31 MARCH

	1997	1998	1999	2000	2001	2002	2003	2004
All homes	236,335	249,438	254,687	259,680	256,215	259,485	284,135	277,950
Local authority run homes	58,747	54,611	50,061	47,251	42,301	37,310	34,115	31,845
Independent sector residential care	111,530	121,923	131,159	138,575	142,070	149,515	166,340	164,695
Independent sector nursing care	66,058	72,904	73,467	73,856	71,845	72,665	78,400	75,805

Source: National Statistics and Department of Health (2004) *Health and Personal Social Services Statistics*, London.

Finally the 1990s saw a growing role of independent sector providers in more politically sensitive areas such as services for children and families. By 1997 children's day care services were almost entirely provided by the independent sector (Petrie and Wilson, 1999). Private and voluntary providers also came to play a more prominent role in foster care (James, 1995) and longer-term children's residential care (Kirkpatrick *et al.*, 2001). Statistics relating to the latter indicate that in 1993/94, local authority 'own provision' of residential care (of all categories) in England accounted for 63% of the total. However, even by 1996/97, this had fallen to only 53% (CIPFA, 1997).

This growth in the independent sector means that a key goal of the legislation, to establish a thriving mixed economy, has been largely achieved. The virtual monopoly of services once held by local authorities is broken. However, while supply has increased in most areas some structural deficiencies remain. This is especially the case in the area

of children's services. Focusing on foster care (family placement), Waterhouse (1997) found that 24% of local authorities in England were unable to purchase services that matched the needs of clients. Demand for long term residential care for children has also outstripped supply. In a survey of twelve authorities, Kirkpatrick *et al.* (2001) found that a majority were experiencing annual fee level increases above inflation, sometimes in excess of 30%. This finding was borne out by statistics relating to the London and South East market where, between 1995-97, annual fee inflation of 11 to 21% was recorded (Care Base, 1997, p. 16). One outcome of these deficiencies was a 'continuing mismatch between the types of resources requested...and the actual establishments available' (*ibid*: 13). Massive regional variations in supply also forced many local authorities to purchase services 'out of area', against the requirements of legislation (namely, the Children Act 1989).

These observations therefore suggest that while the social market has developed to meet demand, this process has been uneven. In some areas, notably child services, a variety of factors conspired to limit supply. Resulting from this have been "structural losses" such as those incurred when small numbers of providers are able to inflate prices beyond the costs of production (LeGrand and Bartlett, 1993).

## **4.2 The nature of contracts and relationships between purchasers and providers**

A further way in which it is pertinent to analyse markets is in terms of the nature of contractual relations and the emerging mode of governance. This however is harder to investigate from the available research. On the one hand, in most services, relations between purchasers and providers have, until recently, been overwhelmingly 'arms length' in nature (Wistow *et al.*, 1996; Walsh *et al.*, 1997; Means and Smith, 1998). Yet, at the same time, there are signs of change, albeit slow and piecemeal, to more relational forms of contracting. In what follows both of these developments are analysed in more detail.

### *Arms length contractual relations and their consequences*

A key feature of the emerging social care market in the UK during the 1990s was the dominance, in almost all areas, of short term, 'spot' (or case-by-case) contracts. One early study of 25 local authorities found that 100% of respondents were using these contracts for adult residential care services, with only two authorities using 'cost and volume' contracts (where there is some prior negotiation over prices and standards) (Wistow *et al.*, 1996). A similar picture emerges from research focused just on adult domiciliary care. Matosevic *et al.* (2001) for example note that in England spot contracts were used by 62.6% of all providers and in 27% of cases represented the only form of contract (this being especially true in the private sector). Often these were for very small units of service, with 15 minutes of care provision or less being quite normal. Finally, in children's services (residential and day care) the trend has also been towards a heavy reliance on short-term contracts (Petrie and Wilson, 1999, p. 187). Whipp *et al.* (2004) find that eight out of thirteen local authorities were using

spot contracts to purchase children's residential care 'all the time', with the remaining five using them 'most of the time'.

This dominance of arms length contracting can be attributed to a number of factors. First, for some specialised services (including certain kinds of children's residential care) it was largely unavoidable given the low volumes of care being purchased (Whipp *et al.*, 2004). Local authorities might purchase only one or two placements each year for children with severe learning disabilities, having to negotiate prices and requirements on a case-by-case basis often with quite different providers. The refusal of many local authorities to enter into long-term contracts is also attributed to the continued professional distrust of private sector providers (Wistow and Hardy, 1999). Some departments have been accused of adopting unwritten "in house first" policies, using the independent sector only to fill gaps in their own provision. Finally it is important to note how pressures on local authorities to control expenditure<sup>4</sup> have made it more likely, if not inevitable, that they will engage in short-term approaches to contracting (Colling, 2006). Indeed, there is a widespread perception amongst providers that, whatever the rhetoric, local authorities too often enter into contracts on the basis of price rather than quality considerations (Ware *et al.*, 2001).

Whatever the explanation for these trends, there are indications that a reliance on short-term contracting has had some damaging consequences. First it has tended to reinforce low trust and, sometimes, adversarial relationships between purchasers and providers (Hardy *et al.*, 2000). This, in turn, has been linked to a wider fragmentation of services, undermining the continuity of care that users receive. Focusing on domiciliary care, for example, Wistow and Hardy (1999) note how the tendency to purchase services on a spot or case-by-case basis from a variety of providers meant that many clients ended up receiving visits from different care workers. Quite often these care workers had limited knowledge of the client and little ability to forge longer-term. Low trust relationships, in some cases, also led to costs arising from moral hazard, adverse selection and provider opportunism (LeGrand and Bartlett, 1993, p. 25). Kirkpatrick *et al.* (2001) for example found that once contracts had been agreed, some providers of children's residential care were transferring clients into satellite homes with lower levels of staffing and service provision.

In addition to the above were costs for providers. Surveys of the domiciliary and children's day care sectors (Harvey, 1998; Nokak *et al.*, 1997) reveal how short term contracts were associated with high levels of provider uncertainty and financial instability. Where adult domiciliary care services are concerned these problems are exacerbated by the small size and turnover of most providers and the fact that, for the vast majority, local authorities were their *only* client. It is estimated, for example, that 70% of independent sector income comes from local authority clients, a fact that has generated considerable uncertainty (Laing and Buisson, 2000). Another survey of 155 domiciliary care organisations found that over one third of respondents perceived there to be some "excess risk" in their business environment (Matosevic *et al.*, 2001). Drawing on the same data Ware *et al.* (2001, p. 338) note that in 1999, 41% of independent providers had no information about local authority purchasing plans, with a further 11% stating they had no contact whatsoever with strategic purchasing staff.

This, they note represented a major source of uncertainty for providers, especially when linked to “sudden changes in purchasing” by local authorities.

A consequence of the above is that many providers have been unable to engage in long term business planning or service development (Wistow and Harvey, 1999, p. 179). Financial uncertainty, it would appear, has also contributed to the generally low levels of pay and staff training in the independent sector (Ford *et al.*, 1998). According to Knapp *et al.* (2001), 20% of domiciliary care providers in England have been forced to reduce costs in response to local authority purchasing practices. One in eight said that prices failed to cover costs, and 11 per cent were considering leaving the market altogether. In combination these problems are thought to be a major factor undermining the confidence of providers and their ability to innovate and improve the quality of services.

### 4.3 Towards more collaborative relationships?

Partly in response to these difficulties there have been calls both from practitioners and policy makers to develop a more ‘engaged model’ of contracting. As early as 1996, the president of the Association of Directors of Social Services argued for “mature purchasing arrangements” based on trust and partnership (Kubisha, 1996). A similar message came from within the academic community (Walsh *et al.*, 1997; Lapsley and Llewellyn, 1997). Wistow *et al.* (1996, p. 171), for example, concluded that the most appropriate governance structure for social care was an intermediate form of quasi market, embedded in social networks and collaborative relationships. Others talked about how local authorities might forge links with voluntary providers more likely to share the same values and philosophy of care (Osborne, 1997).

By the late 1990s the government itself began to question the usefulness of a competitive market for social care. Guidance issued by the Audit Commission (1997) emphasised the need for local authorities to work in partnership with the independent sector. After 1997 –with the election of a New Labour government– this message was further reinforced. Labour adopted a generally more pragmatic stance towards public management and, in theory at least, keen to promote policy on the basis of what works is best (Newman, 2000). One aspect of this was a growing enthusiasm for the idea of networks and relational contracts. These, it was believed, represented best practice in the private sector (for example, in the automotive industry) and should be copied by the public sector (Milne, 1997). Emphasis was placed on developing “a third way, between hierarchies on the one hand and markets on the other” (Hunter, 1998, p. 18).

In addition to this policy debate were indications that many local authorities were also moving towards more collaborative ways of working. Wistow *et al.* (1996) for example, found that 84% of their sample (of 25 SSDs) had begun to develop approved lists of favoured providers. This system involved a pre-placement contract in which price and quality requirements were agreed and formalised in advance. The same research found that many SSDs were also planning to use more long term or block contracts with independent sector providers (mainly from the voluntary sector). These moves the authors conclude are entirely consistent with a trend towards more relational contracting model.

There are also indications that many local authorities are increasingly moving away from an exclusive reliance on short term, or spot contracts. Studies of domiciliary care report that since the mid 1990s the number of providers relying exclusively on spot contracts has declined steadily (Ware *et al.*, 2001). There is evidence of local authorities using a range of different contract types and sharing information on purchasing plans with providers in the local area. Similarly research on children's residential services reveals that many SSDs are developing 'pre-placement agreements' with select groups of 'approved' or 'accredited' providers (Kirkpatrick *et al.*, 2001). This goal has been pursued at the inter-authority level, through regional consortia headed up by representatives of the Association of Directors of Social Services. Nine of the twelve case authorities surveyed by Kirkpatrick *et al.* (2001) were actively contributing to the activities of four consortia in London, the North West, the West Midlands and Thames-Anglia regions. A common aim was to develop standard contracts and region-wide approved lists of accredited providers. This it was believed would help both to control price inflation and raise standards through longer term 'partnerships'.

These developments suggest a gradual shift towards more collaboration and risk sharing between purchasers and providers. This arrangement, policy makers and practitioners believe, will help to reduce many of the costs noted earlier associated with moral hazard and poor coordination of services. However, as yet there is no firm evidence to suggest that higher-trust contractual relations will deliver such improvements.

A note of caution is also required in case we exaggerate these trends. As noted earlier the dominant form of contractual relationship is still overwhelmingly 'arms length'. The extent to which local authorities –under pressure to drive down costs– engage with providers is also limited. All this suggests that what has emerged in the UK is a "very limited form of partnership" (Ware *et al.*, 2001). Despite almost a decade of policy guidance and advice, moves towards more strategic and long-term commissioning have been painfully slow. Local authorities themselves continue to face uncertainty over resources and in a context of changing policy demands and demographic trends, have often found it difficult to plan for the future. Added to this is perhaps also a lingering cultural hostility towards the private sector amongst some senior professionals and a desire not to enter into closer contractual relationships.

## V. Discussion and Conclusions

The preceding discussion is testimony to the radical nature of the changes attempted by UK government during the 1990s. In social care and more generally, considerable effort was made to substitute market forms of organising for those based on hierarchical control. Even after 1997 this process has continued. It is now assumed, by a wide constituency of policy makers and academics, that moves towards the market are not only inevitable but also desirable (Boyne *et al.*, 2001). As Leach *et al.* (1994, p. 2) put it, the model of "traditional bureaucratic" authority...is best seen as the historical starting-point from which radical change has become necessary'.

A major goal of this paper has been to describe these reforms, focusing on the process of implementation and some initial consequences of change. What the analysis reveals is that firstly, in a relatively short period of time there had been a rapid expansion of the independent sector. While structural problems remained –most notably in the area of children’s services– one can say that a key objective of policy –to create a flourishing mixed economy– had been achieved. A second observation concerns the nature of contractual relations between purchasers and providers. Here it was noted how the dominant pattern in most areas was one based on short term, arms length contracts, and how this in turn made it harder to establish relationships based on trust. Although hard to quantify the available evidence suggests that this situation was costly for both local authorities and providers. In the case of local authorities it meant a greater likelihood of what Wistow *et al.* (1996) describe as “informational losses” associated with moral hazard and adverse selection. Finally, this review pointed to some emerging tendencies towards a different approach towards managing the market, one based on longer-term collaborative relations between purchasers and providers.

One limitation of this study is that, given the available evidence it is not possible to make hard evaluations of the relative costs of markets (both financial and in terms of service quality), relative to the previous regime of bureaucratic planning. That said, this analysis does have implications for how we understand the development of markets in social services and perhaps more generally. Firstly, it draws attention to the difficulties of implementation. In the UK, as we saw, it has not always been easy to align supply with demand for specific services (a fact resulting in structural losses). The initial tendency was also towards a low trust, adversarial and potentially very costly mode of contracting at the local levels. The shift to markets, therefore, has been far from smooth or unproblematic. This in turn raises wider questions about the wider benefits and pay-offs of such change. While the new mixed economy has undoubtedly increased choice –possibly allowing local authorities to achieve a better fit between needs and services for individual clients (Evandrou and Falkingham, 1998)– and may in some areas have improved efficiency, the available evidence suggests that these gains have been attained at a high price.

A second implication concerns the form that markets are likely to take in areas such as social care. The UK experience suggests tendency towards more relational or engaged modes of contracting. This model has attracted considerable support from policy makers, academics and practitioners as a possible way of making the market work better. Yet it would clearly be a mistake to overstate these trends. A theme running through much of the literature on networks in the private sector is that these modes of governance are hard to establish, maintain and may be associated with costs such as over-dependency in buyer-supplier relationships (see Kirkpatrick, 1999 for a review). In the context of UK public services there are also institutional and regulatory barriers to the emergence of networks. In some services legal regulations exist that require local authorities to openly tender services on a frequent basis. Beyond this are also financial pressures on local authorities that will continue to make it attractive to use spot contracts as a means of limiting expenditure in the short term. As Flynn *et al.* (1995, p. 546) suggest, there may be a “fundamental contradiction

between the pressure to seek collaboration and an infrastructure designed to stimulate competition". Hence one cannot assume that social care markets will be transformed in future. While the idea of relational networks may be desirable, only time will tell whether it is also feasible.

## Notes

- 1 In the UK, historically, responsibility for social care for adults, families and young people has been divided between local government and the (centrally managed) National Health Service (NHS). After 1993, however (with the implementation of the NHS and Community Care Act (1990)) the bulk of this work was transferred to local government.
- 2 For a more detailed discussion of the genesis and nature of the new public management (NPM) see Pollitt and Boukaert (2004).
- 3 In 2002 there were 149 local authority social services departments in England, employing approximately 277200 staff. Total expenditure on the personal social services in England stood at £ 15.2 billion in 2002/3.
- 4 In England and Wales local authority funding comes from three main sources: central government grants, local community taxes and business taxes. Grants account for approximately 70% of this spending, but during the 1990s failed keep pace with rising staff costs and local service demands. In this period central government has also maintained tight controls on the level of local taxation (through annual standard spending assessments).

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