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ABSTRACT
Most long-term care for older people in the UK has been provided by independent organisations since the 1980s. This article draws on interviews with various stakeholders in the sector, as well as secondary sources. The evidence shows that government policies in the areas of funding, regulation and the labour market are facilitating the concentration of long-term care provision. Three areas of related concern are identified: firstly, the effects of increased ownership transfers; secondly, issues relating to standardisation; and thirdly, the possibility of a decline in the quality of care if local monopolies emerge. It is concluded that government regulation must be concerned with the structure of the market, as well as the conditions within care homes, if the interests of residents are to be protected.

KEY WORDS – Long-term care, private provision, regulation, economics, policy.

Introduction

Since the 1980s shift towards the private provision of long-term care for older people in the United Kingdom, there has been a substantial growth in provision by large for-profit firms.[1] Concentration of ownership in the sector accelerated during 1996 and 1997 through a series of mergers and acquisitions. Although in comparison to other 'industries', concentration in the long-term care sector is still relatively low, it is likely to increase in the near future, giving rise to the possibility of local monopolies and raising concerns about the nature and quality of the services provided. Whether intentional or otherwise, the main driver of this concentration process is government policy.

This article draws on both published sources and interviews with stakeholders in the sector, including for-profit providers, voluntary organisations working for older people, unions active in the sector, and

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inspection and registration officers.[2] The article begins with a review of the underpinning economic logic and mechanisms of concentration as apparent to date. It then analyses government policy and its likely impact in three main areas: funding, regulation and the labour market. Finally, the implications of concentration for the nature and quality of care provided are discussed. It is concluded that government regulation must be concerned with the structure of the market, as well as conditions within care homes, if the interests of residents are to be protected.

Concentration in the long-term care sector

The dominance of the independent sector in long-term care is evinced by the fact that by 1998 it provided 88 per cent of all residential care and nursing home places in the United Kingdom (Department of Health, 1998*a*). As important is the recent trend towards concentration in the sector, as revealed by the statistics compiled by the market analysts, Laing & Buisson. Between 1988 and 1997, the major providers (defined as organisations with three or more homes) more than doubled their share of the for-profit care-home market (Laing & Buisson, 1997: A186). During calendar year 1998, their share of the market rose by 3.6 per cent; in 1999 it rose by a further 1.7 per cent to 31.4 per cent; and in December 1999, there were 267 major for-profit providers (Laing & Buisson 2000–2001: 185–6). There has however been substantial consolidation in the sector. By the end of 1999, the ten largest operators owned or leased 15.1 per cent of total United Kingdom for-profit capacity, whilst the three largest owned or leased 8.1 per cent. According to *Community Care Market News* (CCMN) (November 2000), a monthly magazine published by Laing & Buisson, by November 2000 the largest of these operated 233 homes with 16,625 beds, whilst its nearest rival operated 145 homes with 8,326 beds. As with other providers, both of these organisations grew rapidly during 1996 and 1997, as a result of multiple mergers and acquisitions.

Corporate penetration is greater in nursing home than residential care provision. This is partly because nursing homes tend to be larger, and consequently afford greater economies of scale in provision. For these to be realised, however, large-scale initial investment in property is required, which large companies are best placed to make. Large companies in this sector also make substantial use of bulk purchasing, as for medical supplies. This gives them a significant advantage over the small homes which have traditionally characterised the sector.

Andrews and Phillips (1998: 10), for example, found that in Devon, 70 per cent of the homes operating at or below their margins of profitability had 15 or fewer registered beds. Many small proprietors were disillusioned with the residential sector, and over one-third of home owners stated that they would sell their business if it were possible. Small homes are not necessarily owned by small *companies*, but on the whole this is the case, partly because large companies have commissioned more new buildings to achieve economies of scale. In addition, financial barriers to entry have risen for small providers, as the average home size has increased, and as lending institutions have imposed stricter terms as their confidence in the long-term care market has fallen (Laing & Buisson, 1999–2000: 178). Large firms by contrast have made use of sale and leaseback, which allows them to separate the costs of investing in property from actual operation, and thus expand at a faster rate.

Funding policy

The private provision of long-term care expanded rapidly during the 1980s when the Conservative governments made it possible for residents entering private sector homes to claim board and lodging to pay for their care (Bradshaw, 1988: 177). Residents being cared for in the public sector could not use this provision, so local authorities encouraged residents to opt for the private sector, which allowed the release of income through the closure and sale of public facilities (Harrington and Pollock, 1998: 1806). However, as the social security budget spiralled, there was increasing concern about the rising costs as well as the skewing of expenditure towards nursing and residential care rather than community-based services. The government's solution was the *National Health Service and Community Care Act 1990*, the community care provisions of which were implemented in 1993, and which made local authorities responsible for purchasing care packages from a 'mixed economy' of providers. Authorities had however to spend 85 per cent of the 'special transitional grant' (STG), which funded the changed procedures, on independent sector services. The Conservative government was thus able both to limit local authority spending and to ensure the continued expansion of private provision. As Knapp *et al.* (2001: 292) point out, however, one of the effects of the 1990 Act was to 'undermine providers' fairly secure fiscal environments'.

Limitations on local authority budgets have subsequently led to marked over-capacity in the private sector, as supply has exceeded

effective demand. Although there are significant local variations, in March 1999 overall occupancy rates stood at 85.7 per cent for private nursing homes and 87.1 per cent for private residential homes (Laing & Buisson, 1999–2000: 182). Yet local authority budgets have consistently fallen behind what is needed to sustain the level of provision, even taking into account the desire to support people in their own homes where possible. The year 1999 saw the third annual decrease in capacity across the sector, and the sixth year in succession in which capacity growth fell short of what would be expected from demographic pressure (Laing & Buisson, 1999–2000: 163). Nevertheless, private sector capacity continued to expand at the expense of the public sector, as local authorities transferred their remaining provision into the independent sector.

Research published by the Joseph Rowntree Foundation (Laing, 1998) claims that there are frequent disparities between the fees paid by state agencies and the true cost of long-term care. It is estimated that £80 million a year is spent on bridging the gap between care-home fees and the amount that state agencies are willing to pay. The research suggested that, at 1997/98 cost levels, fees of around £350 per week for nursing home care offered a reasonable return to an efficient provider of good quality amenities and care. This was £40 above the Department of Social Security (DSS) rate, and more than most local authorities were prepared to pay. The NHS funded about 15,000 residents – fees paid by them were typically more generous than those paid by local authorities, so the issue of disparities rapidly arose, although they accounted for only a small minority of publicly-funded residents. Only half the 95,000 residents receiving DSS 'preserved rights' payments were having their fees covered in full. The research also identified hidden disparities, as when the full fees met by local authorities or the DSS were being cross-subsidised from other sources. This included voluntary sector homes with access to their own charitable funds, but also for-profit homes where self-paying residents were being charged more than publicly-supported residents for identical accommodation and care.

Whilst local authorities are constrained by the funding that they receive from central government, they often have a near monopoly purchasing position (monopsony), giving them considerable leverage when setting fee rates. Where there is an absence of other significant purchasers, the providers' reliance on local authority income allows the authorities to keep fee rates down. This imposes economic constraints on both large and small providers, but it is the latter, which may be operating at the limits of their financial viability, which suffer most.

Rather than engage in new-build, it has therefore been cost-effective for corporate providers to acquire smaller providers that may be unable to survive in the current financial climate. As one interview respondent from a large provider put it: 'there will always be one-man bands that do exceptionally well [at providing high quality care], and all credit to them. And when they're for sale we'll buy them'. However, as argued below, this may change as a result of regulatory reform, with large providers opting for new, purpose-built homes. Funding restrictions also increase the likelihood of more mergers between large firms, as they respond to falling profits by increasing their economies of scale.

The overall issue of how long-term care should be paid for in the future, given the demographic trends that are likely to raise the ratio of people in need of such care, was examined by the *Royal Commission on Long-Term Care* (Department of Health (DoH), 1999*a*). The government rejected its main recommendation that personal care as well as nursing care should be free to all: only nursing care, however defined, is to be free, whilst personal care will continue to be subject to means-testing (DoH, 2000). The Scottish parliament has since taken the alternative course of agreeing to fund both nursing and personal care. In England and Wales, whilst the unconditional state funding of nursing care may alleviate some of the financial problems of private providers, it is likely to benefit large providers disproportionately, since they tend to provide more nursing than residential care. In its response to the Royal Commission, the government did, however, commit significant amounts of money to funding 'intermediate' care, with the aim of increasing the independence of older people and reducing their dependence on long-term care. To the extent that this is successful, it may lead to occupancy in the sector falling still further, increasing the financial pressures on providers. Some large providers have, however, situated themselves so as to meet the new demand for intermediate care beds. The overall effect of funding restrictions on the sector has thus been to hasten consolidation, because although the profitability of large providers has been damaged, they are the best placed to weather such conditions. The economic logic of the sector, in which economies of scale are an important factor, is insistently towards concentration.

Regulatory policy

The regulatory system for long-term care is currently changing. Until 2002, the regulation of care homes was fragmented, with local

authorities responsible for registering and inspecting residential care homes, and health authorities responsible for nursing homes. This fragmentation has long been recognised as generating several problems, including complaints that standards are inconsistent across the country, that local authority inspection units are insufficiently independent, and that the division between health and residential care is artificial (Burgner, 1996). The new Labour government's initial response to these problems was the White Paper, *Modernising Social Services* (DoH, 1998*b*), which envisaged the creation of eight regional *Commissions for Care Standards* in England, that would bring the regulation of all residential, nursing home and domiciliary care for both adults and children under their authority, and work to new national standards. The *Care Standards Act 2000* legislated for these changes, and replaced the *Registered Homes Act 1984* which had previously governed regulation. However, instead of the eight regional commissions, a *National Care Standards Commission* (NCSC) for England took over responsibility for regulation in April 2002. In Wales, a new arm of the National Assembly will carry out the regulatory function.

The Centre for Policy on Ageing was commissioned by the Department of Health (DoH) and The Welsh Office to draw up a set of *National Required Standards* for care homes for older people that will be enforced by the NCSC. The draft standards were submitted early in 1999, and published later that year as *Fit for the Future?* (DoH, 1999*b*). The final version has been published as *Care Homes for Older People: National Minimum Standards* (DoH, 2001*a*). The specified physical and staffing standards have produced much controversy. Among the physical standards are that: all residents should have the choice of a single room; that shared rooms in existing homes should account for no more than 20 per cent of overall resident places; that single rooms currently in use should be at least 10 m^2 in size; and that new conversions should have rooms with a minimum size of 12 m^2 and additional space for *en suite* facilities. The standards set out minimum staff ratios and qualification levels, including originally that one-third of nursing home staff should be registered nurses. This has been relaxed following objections that it cannot be met, especially during the current shortfalls in nurse recruitment. Nevertheless, these standards will impose significant new costs on all providers, and it is expected that many small providers will be unable to meet them. Provider associations such as the *National Care Homes Association* (NCHA) and the *Registered Nursing Homes Association* (RNHA) have argued that the proposals have not been properly costed, and will force many operators out of business.

According to *Community Care Market News* (February 1999), the proposal that no more than 20 per cent of places in any given home should be shared would be particularly damaging to some sections of the industry. Large numbers of small converted homes, owned primarily by small businesses, would be unable to meet these standards. The DoH (1999*b*) *Regulatory Impact Statement 2.8* estimated that 20–23 per cent of independent sector residential homes, 12 per cent of independent nursing homes, and 55 per cent of local authority homes would not meet the space and amenity standards, whilst 54–56 per cent of nursing homes would not meet the original staffing standards. Laing & Buisson's analysis suggested that even these figures might be optimistic (*CCMN*, Aug./Sept. 1999). Although the government has since signalled some flexibility over the implementation of the standards, including a date of 2007 for the implementation of the minimum room-size standard, most of the homes originally identified as being non-compliant would continue to be so (Laing & Buisson 2000–2001: 184).

As well as leading to the closure of many small homes, the standards are likely to lead local authorities to continue their withdrawal from provision, since many of their homes will be non-compliant, but fully subject to regulation for the first time (Jones, 1999: 2; Laing & Buisson, 1999–2000: 174). On the other hand, *Community Care Market News* (February 1999) argued that providers of new-build and other homes which did meet the standards would welcome them 'in private at least' because of their likely effect in cutting excess capacity. Laing & Buisson (1999–2000: 174) thought that the closure of small homes would lead to new investment in 'made to measure' facilities, which could best be made by larger providers. If the standards do encourage a new wave of new-build, this is likely to result in larger homes.

The standards are therefore likely to encourage greater concentration within the industry. As *Community Care Market News* put it: 'Despite the currently depressed state of the sector … there remain opportunities for investors in the nursing and residential home sector. These opportunities will be all the greater if the proposed *National Required Standards* do in fact precipitate an industry shake out' (*CCMN*, July 1999). The magazine also predicted that closures would accelerate, possibly leading to a shortage of supply if the transition period was too short. This might lead to 'a shift in the balance of power between providers and purchasers, in favour of providers', which in turn would push up fees (*CCMN*, Aug./Sept. 1999). Indeed, by the end of 2000 there was already evidence that the over-capacity in the sector was beginning to turn to scarcity in some areas, as small businesses sold their properties

to take advantage of the boom in property prices before the regulatory changes came into effect (*CCMN*, Oct. 2000). Whilst to date low fees have encouraged greater concentration in the sector, regulation policy seems set to take over as the principal driver of concentration by increasing the costs of compliance. Ironically, this may well lead to a shift in the balance of power between private providers and state purchasers, and therefore to higher fees. Indeed, there is the possibility that local provider monopolies, or near monopolies, will emerge.

Labour market policy

We have seen that both funding and regulatory policy are tending to reinforce concentration in the long-term care sector. Other government policies and economic trends also have a bearing. General labour market policies have a profound effect on the sector, because it is characterised by low waged and unskilled work. Whilst nursing homes must have a minimum number of qualified nurses on duty at any given time, the majority of care workers are unskilled and many are young, female and part-time. Furthermore, despite some successes in striking recognition deals, unionisation in the sector is generally low. As interviews with officers from all of the major unions revealed, they have had difficulty in organising a group of workers who are scattered among relatively small workplaces and whose employers are generally hostile to union recognition. Furthermore, *Unison* and the *Transport and General Workers Union* have their healthcare strongholds in the public sector, although the *General, Municipal and Boilermaker's* union has more experience of organising in the private sector. This is set to change to some extent as a result of the *Employment Relations Act 1999*, which implemented the proposals of the *Fairness at Work* White Paper (Department of Trade and Industry, 1998). Thus, employers must recognise unions where 50 per cent of the workforce are already members, or where a majority (of at least 40 per cent of the workforce) vote in favour.

The post-1997 Labour administration has introduced a series of initiatives to establish minimum employment standards for those in low paid or insecure work, and these will have a significant effect on the sector. Other than the *Employment Relations Act*, these include the 'National Minimum Wage' (NMW), introduced in April 1999, and the implementation of the European Union's (EU) 'Working Time Directive'. At an initial rate of £3.60 per hour, with exceptions of £3.00 per hour for 18–21 year olds, and £3.20 per hour for workers aged

22 years and older receiving training, the NMW was set substantially below what most unions had campaigned for, and the government has refused to consider an automatic up-rating. The main rate rose to £4.10 in October 2001.

Yet the evidence suggests that the NMW will have a significant impact on the long-term care sector, although it has been estimated that, prior to its introduction, less than 10 per cent of private care home providers had prepared a strategy to deal with its likely impact (*CCMN*, Feb. 1999). The NMW was expected to add 'millions of pounds' to the cost of care, with the number of business failures over the two years following its introduction likely to increase as a result. Laing & Buisson (1999–2000: 171) estimated that the cost to private and voluntary care homes would be over £90 million *per annum*, falling most heavily in the north of England. The impact of the NMW would be uneven geographically, reflecting local labour markets, a finding confirmed by interviewees from large firms that run homes across the country. Following the introduction of the NMW, the proportion of workers earning at least £3.60 in private care homes more than doubled (Department of Trade and Industry, 2000: 4.34). Laing & Buisson's analysis of the impact of the NMW (*CCMN*, June 1999) estimated that the rate of increase required to cover the costs ranged from £7.09 per week in Yorkshire and the Humber to 80 pence per week in London. Few local authorities in the areas most affected appeared to have made concurrent adjustments to fee levels, despite the *Low Pay Commission*'s recommendation that the government should make extra funding available (Department of Trade and Industry, 2000: 4.43). The inflation pay awards granted to NHS nurses in 1999 and 2001, in response to the widely recognised recruitment shortfalls, also increased the pressure for higher wages in the private sector (Laing & Buisson 2000–2001: 180). Recruitment problems across all providers of nursing services have also led to a rise in the use of (more expensive) agency staff.

The European 'Working Time Directive' (WTD) was implemented through the *Working Time Regulations* 1998, which came into force on 1 October 1998. These set a working time limit of an average of 48 hours per week, which applies to casual and agency staff as well as to those on permanent contracts. A report on the effects of the WTD (Pay and Workforce Research, 1999) on care home operators found that the increase in the wage bill resulting from the directive for the 'average' residential home was likely to be about £3,500 *per annum*, mainly as a result of the entitlement to three weeks paid annual leave (which rose to four weeks in November 1999). However, many unions have

criticised the facility for individuals to opt out of the 48-hour limit (in force until 2003), because it may provide a way for employers to intimidate unorganised staff (Trades Union Congress, 1998). The report by *Pay and Workforce Research* found that the proportion of employees working in excess of the 48 hour limit imposed by the directive was less than 2 per cent, but that staff in 74 per cent of organisations had signed an agreement to work more than an average of 48 hours per week where necessary. Both the NMW and WTD will therefore raise costs further for providers, adding to funding restrictions and the costs of the new regulatory measures in intensifying the logic of concentration.

The implications of increasing concentration

It has been argued that government policies towards long-term care will encourage greater concentration in the sector. Since this is not the stated aim of these policies, it may perhaps be regarded as an unintended consequence, yet there is a distinct economic logic to the process. Through the combination of its funding and regulatory policies, the government is seeking the highest possible quality-of-care for the lowest possible cost; while its labour market policies are raising the minimum standards of protection for workers in sectors, such as long-term care, that employ 'flexible' labour on low wages. This combination, of the highest possible quality-of-care and the lowest possible cost, can best be provided by large firms that can draw upon economies of scale, and for the same reason they will most be able to meet the costs associated with raised employment conditions. Several of these firms are international, and can thus draw on resources and expertise from abroad.

There are three areas of concern associated with this process of concentration: the effects of increased ownership transfers; the implications of standardisation; and the possibility of a decline in the quality-of-care if local monopolies emerge. These will be discussed in turn. The last intense period of concentration, during 1996–97, involved many mergers and acquisitions (M&As). The ownership transfers that result from mergers between large firms can disrupt both staff and residents – as several interviews indicated. Disruption for staff can relate to the problem of 'cultural fit', that is, trying to integrate staff from two or more organisations which operated in different ways (Johnson and Scholes, 1993: 234). Such problems may revolve around integrating different business systems or different professional practices.

Measures may also have to be taken to ensure that one of the previously existing firms is not seen to dominate the others in the new structure. Where these kinds of problem are not handled carefully, a firm may lose numerous dissatisfied staff, and this has been the case for at least one large private provider. Even where staff are not lost, changes of ownership, and therefore of employer, may induce a level of insecurity in staff whilst the new regime is established. Whilst such difficulties will tend to be resolved over time, most firms experience a transitional period of adjustment. Any new wave of M&As is likely to cause further disruption.

Ownership transfers may have significant implications for residents, whether their home has been acquired from a small owner or another large one. Both the continuity and the morale of staff can have a significant impact on the well-being of older people (Wagner, 1988; Edsbaik *et al*. 1995). However, it is also the case that changes in the regime of the home often take place following a merger, as the acquiring organisation standardises practices across all its facilities. One interviewed home manager had overseen four changes of ownership and regime in five years. Such changes of regime may be disruptive of the lives and expectations of residents; how this is managed is therefore crucial. Potentially the most serious consequence of such ownership transfers is the closure of a home and the transfer of the residents to new accommodation. When a provider acquires new stock, it normally seeks to bring all the homes in its acquired portfolio up to the standard of its other homes. Acquired homes may not meet these standards, and the organisation may not consider it cost-effective to renovate them. Transfers of residents should, however, be kept to a minimum. Interview respondents from four different voluntary organisations working for older people said that residents find such transfers severely disruptive emotionally, psychologically and physically. In the worst cases, fatalities result. Interviews with registration and inspection officers showed that changes in ownership, and therefore sometimes in management personnel, may also be disruptive of the home's relationship with the regulating authority.

The second area of concern relates to standardisation. New Labour's regulatory reforms for long-term care have commanded a considerable consensus. Whilst they will be damaging to small providers, large providers have generally welcomed the introduction of a system that is expected to bring more consistency in registration, regulation and enforcement. One of the large providers' chief criticisms of the old system was that different demands were placed upon homes belonging to the same organisation by regulators in different parts of the country.

This created problems for large private providers because they usually aim to guarantee a common standard of quality across all their facilities. They can then market themselves on the basis of a brand name that lets the customer know what they can expect from homes belonging to that organisation. Such providers have their own internal quality assurance systems which aim to standardise the care delivered in all their homes. These quality systems are usually based on process standards that specify the tasks to be carried out by staff. Such standards are 'Taylorist' in nature, insofar as they are based on controlling the labour process by breaking it down into clearly specified tasks, rather than on the independent judgement of trained professionals (see Dominelli, 1997; Dominelli and Hoogvelt, 1996; Mintzberg, 1979; Pollitt, 1996).

Large private providers may therefore deliver relatively high quality care, but this tends to be standardised across all their homes. If the process of concentration results in local monopolies, this could have important implications for choice. The community care reforms were aimed partly at increasing choice for the 'consumer' through diverse private, voluntary and public sector provision in a 'mixed economy' of care. State services were often considered to be monopolistic and provider driven (Griffiths, 1988). Yet if government policy leads to a reduction in the numbers of small operators, alongside the continuing disposal of public provision, this may leave some purchasing authorities (and their clients) with little choice. As Andrews and Phillips (1998: 10) point out: 'Ironically, it is the smaller homes, being less ''institutional'', which sit best with the philosophy of care in the community' (see also Andrews and Phillips, 2000).

The possibility of local monopolies prompts a third concern. Currently, one incentive that for-profit providers have to deliver high quality care is the competition from other providers. Without this, there would be little rationale for the importance currently attached to branding and marketing strategies. As we have seen, competition also raises concerns, since it is part of the economic logic driving the concentration process itself. But where competition is reduced, even locally, a greater responsibility rests upon the regulatory system to ensure high standards of care. Braithwaite (1993) has shown that the introduction in the United States during the 1970s of strict structural input standards, *e.g.* specifying the size of rooms and fire prevention measures in the design of buildings, hastened concentration within the industry. Large companies could most effectively meet the standards by building large homes that achieved economies of scale, as may happen in the UK. Braithwaite further argued that the combination of

large homes, in which management is separated from actual care provision, with regulation procedures that emphasised structural inputs led to 'ritualism' among providers. Ritualism entails providers fulfilling the formal requirements specified by the regulatory system regardless of the outcomes for residents.

While it is not inevitable that such 'ritualism' will develop in the UK, especially since the *National Minimum Standards* are less heavily weighted with 'structural input' standards, it is clear that more responsibility is placed upon the regulatory system when competition is reduced, especially if budget restraint continues to squeeze the profit margins of private providers. The regulators must therefore be concerned not only with the quality of care delivered within homes, but also with the providers' internal quality regimes and with the structure of the market as a whole. Indeed, the voluntary organisation *Counsel and Care* has called for a regulatory body for long-term care similar to those which have been created for other privatised services. The *Care Standards Act 2000* mandates the new *National Care Standards Commission* with the task of keeping the government informed of trends in social care and of monitoring both the quality and availability of provision. How this will be interpreted in practice was unclear at the time of writing.

Conclusions

This article has suggested that British government policies towards and that affect long-term care will promote increased concentration in the sector. The limited funds available to local authority purchasers, regulatory changes, and policies designed to provide minimum levels of protection for the staff, are all raising the costs of the providers. The larger providers are best placed to survive and expand in this environment, and the anticipated concentration raises several concerns: about the disruption arising from mergers and acquisitions, about standardisation and the reduction of choice, and about a possible decline in the quality of care if local monopolies emerge. Careful monitoring studies of these outcomes are needed.

The shift towards private provision during the 1980s introduced the disciplines and 'logic' of markets into long-term care provision more than any other British welfare service, but nonetheless government policy remains the dominant factor in determining how market incentives will shape the sector. There is some evidence that the government is aware of the trends outlined in this article. The

document, *Building Capacity and Partnership in Care* (DoH, 2001*b*), is in effect the second instalment of the 'concordat' with the private health sector. It stipulates extra funds for local authorities in return for a commitment to stabilise the market and to take into account the needs of social care providers through collaborative planning. One danger of the arrangement is that it may override the intended benefits of competition, partly through long-term block contracts (with large or small private providers), that will leave individual users with little choice of home. The paradox of the market in social care is that the government has to intervene repeatedly to balance the needs of residents, providers (both large and small), staff, and the public purse. Intervention aimed at advancing the interests of any one of these is also likely to have (possibly unintended) consequences for the others. This indicates a key problem in the shift towards quasi-markets: trying to combine the best of the market and of public service, through the purchaser-provider split, may lead not to an ideal 'best of both worlds', but to fundamental contradictions. The long-term development of the sector will depend ultimately on whether the government intends to rationalise the sector and reap the cost savings, of forcing smaller providers out of the market, or whether it seeks to cushion the smaller providers by extending attempts to manage the market, as with *Building Capacity and Partnership*. Much depends on how the *National Care Standards Commission* interprets its role of monitoring overall developments in the market, and on the proposals it makes to government.

NOTES

1 The term 'for-profit' is used interchangeably with the term 'private' to refer to all providers operating on a commercial basis. The term 'independent' is used as an umbrella term to encompass all non-state providers, including both for-profit firms and voluntary providers.

2 This article arises from a larger research project, and is intended to give an overview of significant developments in the UK long-term care sector. Semi-structured interviews were conducted with respondents from organisations chosen on a purposive basis. For an account of this larger project, see Holden (2002).

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