Chapter 44. The Growth and Consequences of Quasi-markets in Long-term Care

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Abstract

This chapter investigates how the extension of markets in Western Europe's long-term care (LTC) systems has shaped the provision of care over the most recent decades. The chapter pays attention to the provision of formal LTC, with a special focus on public and private relationships, taking into consideration the relevance of national and regional contexts. The chapter outlines present relevant conflicts that quasi-markets and New Public Management (NPM) logics have brought to care economies. It shows the extent to which the impact of quasi-markets on care provision is mediated by specific market dynamics, such as who is available to provide good quality care and political economy contexts, including power relations between different actors. The chapter's last section explores the introduction of quasi-markets in nursing homes in Germany, Italy, Spain, and the United Kingdom in relation to two main issues: the impact of market structures and concentration dynamics on determining outcomes and the capacity to monitor, regulate, and hold private actors accountable in these four countries. The authors draw the conclusion that concentration dynamics in the nursing home sector should be carefully assessed, especially when it comes to understanding how investment capacity and capital accumulation affects public control. The exploration of recent quasi-market dynamics in the nursing home sector of the four countries studied here poses the fundamental question of how to reconcile the interests of powerful market actors and the responsibility of the state toward providing for good social care for all.

Keywords: long-term care, LTC, quasi-markets, market structures, nursing home sector, social care

1. Introduction

Marketization refers to an increase in price-based competition between providers; this usually leads to privatization, that is, an increase in provision carried out by non-government providers (Krachler and Greer 2015). Since the late 1980s and early 1990s marketization strategies have been introduced by governments across the globe to purposely limit state intervention, reduce taxation and promote the merits of individual choice and responsibility. Markets have substantially changed the way in which welfare states function, but the degree and manner of marketization vary significantly across countries, as well as across different welfare state domains. Right-wing governments have willingly pushed forward neoliberal agendas but, as Gingrich (2011) rightly argues, market reforms are not just about the relative power of the Right. Left-wing governments have also been introducing pro-market reforms for quite some time now, although with seemingly different goals. For progressive governments, pro-market reforms respond to pressures on demand. In some instances, mostly in health and social care, growing demand due to an ageing population has clashed with severe budgetary constraints. In other cases, the general public's discontent with excessive administrative bureaucracy, scarce accountability and a rigid, uniform model has spurred policymakers to introduce changes in the functioning of the welfare state. Although the left has by and large maintained its commitment to a strong solidaristic welfare state, it has opened itself up to markets as a way of introducing social services that are more diversified and oriented to individual needs, by providing solutions that aim to be more tailor-made and less one-size-fits-all. Ultimately, a more diversified public/private supply has been seen as a good way to respond to existing pressures. As Gingrich (2011) points out, the strongly normative pro-market versus anti-market debate does not leave space to reach an understanding of how market reforms were introduced with seemingly different goals and have led to very different results. Furthermore, as we know, welfare state reforms are path-dependent, with different institutional structures prompting different kinds of reforms. Both the capacity to 'resist' marketization and the capacity of markets to break into policy domains controlled by the state vary depending on these pre-existing structures.

In contrast to what happened to other key pillars of the welfare state, such as pensions, health care or education, most European social care systems expanded at a time in which the finances of public systems were under increasing pressure and calling for more social

spending (via higher taxation) was becoming increasingly difficult to sustain politically. Thus, the marketization trend coincided with the expansion of LTC systems in Europe, within a context of increasing tensions between universalization and strong budgetary limitations (León *et al.,* 2014). Precisely because of the combination of financial hurdles on the one hand and pressures to expand and improve on the other, many welfare states combined a more pluralistic LTC system with tighter targeting mechanisms, which often implied a re-definition of needs (Rostgaard and Szebehely, 2012). In addition to an increase in the participation of private agents in the provision of care, the externalization trend, together with a more pluralistic system of delivering care, also fostered the growth of informally paid-for markets. In a number of countries, the public sector has been actively involved in the creation of cash-for-care schemes that give users the chance to freely purchase care. In Southern and Central Europe this has given rise to an unregulated market with a low-paid, mostly immigrant workforce (Van Hooren 2014).

In this chapter we investigate how the extension of markets in western Europe's LTC systems has shaped the provision of care over the most recent decades. We pay attention to the provision of formal LTC with a special focus on public and private relationships, taking into consideration the relevance of national and regional contexts. We present relevant conflicts that quasi-markets and New Public Management (NPM) logics have brought to care economies. We also show the extent to which the impact of quasi-markets on care provision is mediated by specific market dynamics (who is available to provide good quality care) and political economy contexts (power relations between different actors). Looking at the nursing home sector we conclude that the dynamics towards ownership concentration in this sector should be carefully assessed, especially when it comes to understanding how investment capacity and capital accumulation affect public control.

The chapter is structured as follows. The next section overviews the main ideational drivers behind the introduction of quasi-markets in the delivery and management of welfare services. Section three studies the historical and institutional context in which quasi-markets where introduced and depicts differences and similarities in different welfare regimes in western Europe, with special focus placed on LTC. After decades of introduction of quasi-markets in personal services, section four reviews the theoretical and empirical literatures for what they say about the implications of the introduction of

quasi-markets in personal services, including dubious gains in efficiency, poor labour conditions, inequality and growth and imbalances in power relations, especially due to tendencies of market concentration. Section five takes forward some of these critiques and studies them in the case of nursing homes, using as reference points Germany, Italy, Spain and UK. Compared to the provision of other social services, where non-profit providers dominate provision, in these four countries the asset specificities of nursing homes and the mix with private market allows the generation of important cash flows, attracting international investment. Therefore, it is here where we can gain important insights regarding the dynamics and limitations that quasi-markets have with respect to the introduction of for-profit motives in welfare state provision. Section six concludes with a short overview.

2. Quasi-markets: conceptual definition and main ideational drivers

The quasi-market as a concept refers to the idea of introducing market principles into the provision of goods and services. It leads to the introduction of new, usually rather complex, public-private relationships in the provision of public services. Quasi-markets differ from conventional markets in that, on the supply side, competition is not directed only to maximize profits and services are not necessarily privately owned. On the demand side, purchase is not always expressed in monetary terms (e.g. vouchers) and the immediate consumer might delegate choice to a third party (social services, health authorities, etc.) (Le Grand, 1991). Therefore, quasi-markets mainly refer to the constraints of introducing market principles in personal services where the public sector plays a significant role. As we will see later in the chapter there are various ways in which market principles can be introduced, from a cash-nexus in public service delivery and/or private actors in regulated public service delivery to externalization by allowing private management of publicly-owned services.

Quasi-markets gained widespread attention in the 1990s, when states started to withdraw from their role as producers of goods and services, and NPM ideals began to transform public administrations. NPM is key to understanding how quasi-markets have been developed, with the focus they place on quality control, the separation of the purchasing and provider functions, customer choice and competitive tendering (Rostgaard, 2014, p. 198). Similarly to NPM, the quasi-market concept is rooted in rational choice theories, which have traditionally signalled the pitfalls of the state as a direct provider, especially for sensitive areas such as social and educational services. As we will see in the pages

that follow, in many countries, quasi-markets and NPM became a powerful ideational frame that managed to change well-established organizational arrangements in public service delivery.

The main prescription of quasi-market theorists is that public servants should meet demand for personal services in the most efficient way possible, including the use of prices and market competition as tools. According to standard economic theory, individualism and consumer sovereignty ideals lead to efficient equilibria: consumers will be satisfied, and inefficient producers will be expelled from the market. By contrast, centralized state provision is seen as being burdened with a bureaucratized management and politicized public servants: all this hindering innovation, efficiency and quality (Le Grand 1991).

Theorists of quasi-markets assume that introducing market principles to personal services requires maintaining a certain degree of public regulation, given that the recipients of such services might not have all the information required to choose providers and cannot always express their desires, especially if they are of advanced age or experience ill health. In addition, demand is satisfied not only through the client paying the provider directly, but either indirectly through vouchers given by the government to citizens or through direct public transfers to providers. Given these constraints and the limitations of public regulation, as we will discuss later, the mission-oriented non-profit sector is considered the best kind of partner for governments to work with, one that is more aligned with the public interest of providing quality over generating profits in sensitive sectors (Besley and Ghatak, 2003).

In sum, quasi-markets are part of the neoclassical philosophy that aims to put individual satisfaction as the central goal or quest, based on utilitarian principles that have dominated economic thought since the nineteenth century. According to this liberal legacy, economic incentives and competition between self-interested individuals, usually aiming to maximize profits, should foster efficiency, quality and innovation while overcoming bureaucracy in social services where markets have not been developed and where moral bonds prevail.

3. Quasi-market introduction in different welfare state regimes

As already argued in the introduction to this chapter, whilst market reforms have been introduced by governments of different colours, their goals have differed and, as a consequence, so have their outcomes. To an important extent, differences in outcomes can also be explained by different welfare state regime configurations, which are themselves a product of historic public-private relationships (Esping-Andersen 1990: 109), and also by the type of service under discussion: education, health or social care might each have a different symbolic or moral value in different countries and regions (Amirkhanyan, 2007). This section will examine the introduction of quasi-markets across a range of welfare state settings.

Social care in the Nordic countries is often described as belonging to the public service model, where the state retains the main responsibility for the organization, provision and financing of care (Rostgaard 2014, p. 183). Universalism is the main principle sustaining this model, with good quality, affordable, flexible and accessible public services being financed via general taxation. In these countries, LTC systems have been universalized since the 1970s, and political commitment to the socialization of care has always remained strong. In Denmark and Sweden, LTC dates back to the 1950s and was subject to systematic expansion in the decades up to the 1990s (Ranci and Pavolini 2013, p. 270). These countries already had an extensive and intensive network of direct and decentralized public provision in place when quasi-market ideas were introduced into their administrations; this made them more 'resilient' to privatization dynamics. However, the marketization trend did penetrate the Nordic model, replacing the fully public service model with a more hybrid one (Rostgaard 2014, p. 184). During the 1990s, increasing financial constraints, debates about deinstitutionalization and calls for more diversified provision, coming especially from organized movements for the rights of disabled people, triggered a gradual change in the public/private mix. The number of non-profit and for-profit organizations grew, but public institutions continued to dominate the sector (Eikas and Selle 2002; Meagher and Szebehely 2013; Harrington *et al.*, 2017). Comparatively speaking, public spending has always remained strong in the Nordic countries. There, increased marketization also was introduced via NPM principles employed in the organization of social services. Greater choice of service providers and types of benefits (including cash-for-care options) brought about more participation from private providers. In the case of Denmark, for instance, Rostgaard explains that under

NPM needs assessments became more standardized, thus leaving less room for professional opinions and carer flexibility (2014, p. 199).

In the liberal welfare model, the state takes responsibility for care for the elderly on a needs basis, which is very different from the universal approach of the Nordic countries. The subsidiary role of the state in providing LTC has resulted in weak public regulation and coordination mechanisms, which have in turn paved the way for a relatively easy penetration of the market. In England, for instance, reforms introduced by conservative governments as early as the 1980s made it easier for eligible means-tested beneficiaries to obtain social assistance funding to pay for private residential and nursing home care. This demand-driven voucher system led to a sharp rise in the participation of the private sector in home care provision, going from 2% in 1992 to 60% in 2001 (Glendinning 2013, p. 186). Direct public care delivery has been progressively scaled down over time. As a result of these reforms, there is now a high prevalence of private organizations (over 85% of residential care places), high devolution to the local level, and weak coordination mechanisms (Daly 2020).

In Continental and Southern Europe, social care systems were either residual or non-existent until the 1990s. The strong role of the family in caring for its older members meant that long-term care was not fully identified as an essential service that needed to be protected by the state, and thus public involvement in the direct provision of services remained limited. This meant that governments could introduce market reforms as a way of expanding coverage without generating serious political or social tensions. In countries like Italy or Spain the very weak regulatory framework firstly paved the way for private for-profit and not-for-profit actors to take on an important share of formal care delivery; secondly, it created a significant informal market sustained by the work of mostly immigrant women in private homes. In many countries, the 2008 economic crisis accelerated the marketization of care (through cash-for-care schemes and the privatization of institutional care).

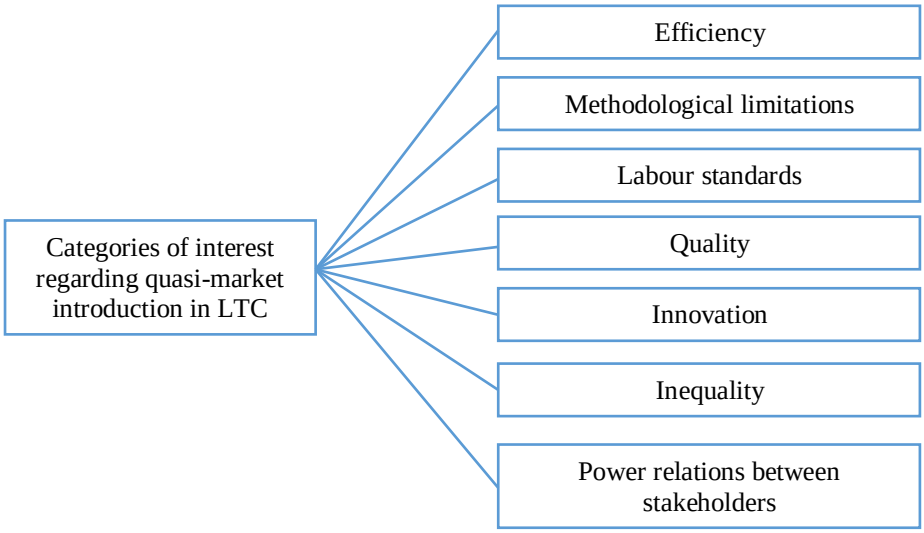
4. Quasi-markets dilemmas: theoretical and empirical lessons

After decades of quasi-market introduction in western Europe, *laissez-faire* utopias of the advocates of quasi-markets have clashed with the fears of more critical voices. Scholars from new institutional economics and public policy research have raised concerns about the practical application and limits of quasi-markets. Studies have examined efficiency

gains (and the methodological limitations to measure these), labour conditions, quality of service, inequality, capacity for innovation and imbalances in the power relations between the private and the public sector.[1] Each one of these aspects is examined briefly from both a theoretical and empirical perspective. This section serves the purpose of creating an analytical framework to assess quasi-market introduction in LTC, which will be applied in the subsequent section.

[1] Also, transversal to these issues is the effect of quasi-markets on participation and democratic processes.

Figure 1: Categories of interest regarding quasi-market introduction in LTC



Source: own elaboration

In terms of efficiency, the contracting-out of personal services requires the creation of incomplete contracts, meaning that there are serious limitations suffered by the principal (the public sector) in selecting, monitoring and holding the agent (the private provider) to account.[2] The main reasons for this relate to information asymmetries, where the agent is permitted to underperform because the principal must take on numerous transaction costs to monitor performance. In addition, the benefits of contracting-out will also depend on the situation of the market, the institutional or regulatory regime and any existing informal rules and bounded rationality that put serious limits on market competition and public control (North 1984; Sclar 2001, p. 100; Petersen *et al.,* 2017). Given the complexity of public administrations and service provision in modern welfare states, including the rise of NPM, it should be of no surprise that quasi-markets might lead to even higher transaction costs (i.e. bureaucracy), therefore creating the very opposite of the efficiency effects intended when introducing them.

However, while the theory clearly signals potential problems, in practice, there are serious methodological issues in evaluating and comparing overall costs between alternative

[2] See Sclar (2001) pages 101-121 for a brief explanation of the problems of contracting-out services raised by new institutional economics.

provisions. Data and measurement deficiencies, especially in personal services, make it difficult to perform clear-cut economic calculations, especially when it comes to calculating overheads (Sclar 2001, p. 65; Petersen *et al.,* 2017). But even if we merely consider the reduction of direct costs, which is something that is relatively easy to calculate, the literature provides mixed results regarding the benefits of quasi-markets (Bel and Fageda 2008), especially when it comes to social services (Petersen *et al.,* 2017). Usually, if there are net economic benefits from quasi-markets, these are limited to specific departments, economic sectors and situations, which are dependent on time and context. Given that organizational restructuring is usually an effort that absorbs a considerable amount of time and resources, the introduction of quasi-markets (or its reversal in case of failure) is a costly process which causes much political and administrative friction. In this sense, the cases studied in Sclar (2001) show us that internal restructuring of public organizations can lead to optimal and efficient outcomes, both in terms of costs and efficiency, without the need to externalize to private actors.

In the realm of the welfare state, the lowering of labour standards because of cost-efficiency pressures has been signalled as negatively affecting the quality of service in labour-intensive sectors such as LTC (León et al., 2014). We find clear evidence in the literature that outsourcing and externalization of personal services leads to lower labour standards, less job satisfaction and higher turnover rates. It also triggers union fragmentation and the creation of non-standard forms of contracts (Domberger and Jensen, 1997; Vrangbæek et al., 2015). According to several studies, these features are more prevalent in for-profit management (Choi et al., 2012; Wendsche et al., 2016). It is not surprising, therefore, that quasi-markets have created labour supply problems in domains such as health and social care. The COVID-19 pandemic has further exacerbated this problem (Daly 2020).

When it comes to quality standards, empirical studies usually assess quasi-market introduction by comparing public non-profits and for-profit organizations. In this vein, Comondore et al. (2009) conducted a meta-analysis of 82 studies. They found higher quality in non-profit nursing homes in staffing, prevalence of pressure ulcers, physical restraint use, and governmental regulatory assessments deficiencies. However, only the differences in the first two categories were statistically significant. With respect to public nursing homes, it is worth mentioning the study of Amirkhanyan (2008), who finds that

facilities that change from public to for-profit ownership perform comparatively worse in quality standards. However, the majority of such empirical studies are USA-based, most probably due to data availability. Extrapolations to the European context should therefore be undertaken with care. Also, it is important to take into account different types of for-profits, especially when it comes to their size. A relevant study in this direction is that of Harrington et al. (2017), who conducted an analysis of the 5 largest for-profit chains in Canada, Norway, Sweden, the UK and the US. In the US all 5 chains have lower quality standards than the national averages. In Europe, some of these chains have been through recent scandals, with the cities of Oslo and Bergen in Norway deciding in 2015 not to renew some of these management contracts.

In the face of quality problems of providers, we should expect consumers to exercise their sovereignty in punishing bad performers. However, users often have no capacity to easily switch poor-quality providers for higher quality ones, particularly in residential care. Continuity of care is important for them and exiting can be a costly strategy (Brennan et al., 2012). Furthermore, consumerist views on social care also pose problems when it comes to innovation, as there are no market mechanisms to reward innovative agents that improve care provision. In this respect, the role of the public sector in funding and controlling quality seems fundamental. Nevertheless, as we will see in Section 5, increasing monitoring and public control present problems of their own, as governments that have difficulties monitoring intangible aspects of quality, such as emotional care, might incorrectly incentivize cost-cutting strategies (Winblad et al., 2017). Proponents of quasi-markets also seem to downplay the capacity of the public sector in fostering innovation. Others, such as the economist Mazzucato (2011, 2015), claim that in order to reach optimal outcomes from a societal point of view, a role for the state in shaping markets is essential.

One of the biggest threats of market expansion in personal services is the potential effect on inequality. The theorists of quasi-markets have warned that consumer sovereignty requires market information, but that this is not equally distributed (Le Grand, 1991). An increasing focus on choice favours those with more resources and education, giving them an advantage in navigating the system, and therefore rendering them more able to purchase higher quality products and services (Eika, 2006 in Brennan *et al.,* 2012).

Similarly, by promoting decentralization, inequalities in different geographical areas' tax bases might translate into varying service provisions between poorer and richer regions. Furthermore, quasi-market introduction has also to be considered as part of a wider political agenda. By setting efficiency as their top priority, public officials have shown a tendency to ignore quality-related problems, growing inequalities and segregation in key public services such as education and health (Bradley and Taylor 2002; Lundalh 2002; Isaksson *et al.*, 2015). This challenges the generalized idea of the quasi-market theorists that a neutral regulator can look after broad redistribution issues when dealing with public-private relationships.

Finally, inequality, quality, labour standards and innovation issues have to also be seen at the macro level, in the power relations between governments that contracted out services and the private providers who run them. The growing presence of for-profit actors presents serious risks to the policy-making process and the ability of governments to control such providers. Neither standard economic theory nor new institutional economics contemplate power relations, but some authors have rightly pointed out that institutional agreements are actually designed to distribute power between agents (Hart 1995, p. 5). In this sense, it might be problematic that quasi-markets, along with increased out-sourcing, have advocated for decentralization and autonomy at the local level. By treating the state as a monolithic entity capable of enforcing contracts everywhere and anywhere, they have disregarded the fact that local governments are financially and technically weaker than national governments in the regulation of public-private agreements (Miraftab 2003).

In sum, the alleged efficiency gains of introducing market principles into the provision of goods and services are contestable and should be assessed very carefully. Different complementary and dynamic factors play a part in problems that might arise when for-profit firms enter into the provision of basic welfare state services. In the next section we take a closer look at quasi-markets in the nursing care sector in a number of European countries.

5. Quasi-markets in nursing homes: an institutional and political economy analysis

5.1. Investment levels and market structure in selected countries

Here we analyse two relevant concerns drawn from the previous section: firstly, the influence of market structures and concentration dynamics on determining LTC outcomes and stablishing different power relationships; secondly, the capacity of public servants at different government levels to monitor, regulate and hold private actors accountable. We focus on the general dynamics in four countries: Germany, Italy, Spain and United Kingdom.

As we see in Table 1, bed coverage varies significantly across the countries and time. Looking at the trends in public expenditure levels, measured as Purchasing Power Standard units per inhabitant over 65 years of age, Germany has made significant advancements, while Spain and Italy have only increased slightly and the UK has experienced declines. Combining the trends in total bed coverage and public expenditure, we can conclude that the former has hardly advanced without the latter and that the 2009 crisis had a significant impact in decreasing either coverage or spending in both Spain and the UK. Furthermore, the evolution of the UK seems to indicate a deinstitutionalization process.

Provision in these four countries had traditionally been dominated by local governments and non-profit (often church-based) providers. These organizations acted somewhat like government partners through long-standing, informal, local agreement in which social services professionals had certain discretionary powers. Since the 2000s public nursing homes have either decreased or remained stagnant in numbers. In the UK (England) for-profit providers control over 80% of total provision; in Italy and Germany non-profits are still the dominant actor, with 58% and 55% of total nursing homes respectively, but their shares have been declining; and in Spain, while there is no national data, local data of different regions show that for-profits have an increasing and bigger share than non-profits and most of public nursing homes have their management externalized through public tendering (Palomera 2020).

Table 1: Marketization in Nursing Homes

	Germany	UK	Spain	Italy
Public and private bed coverage in long-term care facilities (per 1, 000 inhabitants of +65 years old)				
2005	49.3	56.4	19.2	15
2009	50.5	54.6	29.4	16.8
2013	54	50	44.9*	18.5
2017	54.4	45.6	43.9	18.6
Government and compulsory schemes financing in residential long-term care facilities (PPS per inhabitant of +65 years old)**				
2005	792.6	-	356.1	
2009	795.2	-	533.9	
2013	920.6	1078.1	487.6	425.6
2017	1123.2	1004.6	514.3	428.8
Share of nursing home beds owned by the private sector (for-profit and not-for profits)**				
2003	92%	-	74%	56%
2017	95%	97%	73%	79%

Sources: own elaboration with data from Eurostat, OECD, Eurofound (2017), León et al. (2021 forthcoming), and IPPR (2019). *Part of the increase in bed capacity between 2009 and 2013 is explained by measurement changes after 2009. ** We use the System of Health Accounts (SHA 2011) in Eurostat and the provider category HP.2 "Residential long-term care facilities". *** Given the lack of data on ownership status figures should be treated as approximations.

5.2. Increasing dominance of multinationals and investment funds

While an important consolidation of nursing home chains had already begun in the 1990s, in recent decades global investors and large for-profit providers have shown an increasing interest in the sector, compared to a stagnant and falling share of non-profit actors (Eurofound 2017) and relatively small nursing homes, such as in the UK (IPPR 2019). Today, in the UK, the top five providers control 35% of all nursing home beds (Harrington *et al.*, 2017). In Germany, the transaction volume in the care market reached 3 billion euros in 2016 and the top five providers control 11% of the market (CBRE, 2017). In the case of Italy, 70% of investment in Italian nursing homes in 2018 came from

just five investors (PwC, 2020). And in Spain, seven operators manage more than 50,000 beds (Cushman and Wakefield, 2019). It is worth mentioning that many of these providers are multinational companies and investment funds that seek short-term profits for shareholders through huge financial operations and by managing public services.

Two major factors at different government levels are facilitating the dominance of large for-profit companies in the sector. The first one relates to changes in the public sector organizational culture, and the second one relates to economic dynamics and policies.

Firstly, a fertile ground was created by the expansion of a more formalized LTC system in the 1990s, with higher standardization and efficiency rules under NPM. An increase in public spending in LTC has been accompanied by an extension of control and evaluation mechanisms that require a continuous generation of information, therefore favouring bureaucratic quality control systems that have efficiency evaluation at the core. In this context quasi-market introduction in LTC favours larger actors (both for-profit and non-profit) that are able to establish standardized procedures at low cost and fulfil bureaucratic procedures, especially in public tendering. Qualitative studies show that smaller organizations have difficulties in meeting such bureaucratic logics and new requirements (Ulsperger and Knottnerus 2008). In this sense, new investments under public-private partnerships have usually hinged on the construction and management of larger nursing home facilities, which might profit from greater economies of scale.

A second reason for the rise of big for-profit providers is the 2008 financial crisis, which led to an investment environment that propelled market concentration. Ageing societies and increasing (or at least constant) public spending on LTC makes the nursing home sector a relatively risk-free and profitable sector compared to other productive areas, especially after the construction bubble burst in Spain and elsewhere in 2008. In Italy, Spain and the UK austerity policies put limits on public funding, froze public prices and delayed payments from local governments, therefore benefitting actors which have a greater capacity to cut costs and to access credit in order to absorb losses. In turn, inequalities in access to credit have been exacerbated by central banks, which have used quantitative easing to fuel financial markets with cheap credit. Another comparative advantage of multinationals and investment funds is their complex, global corporate strategies; these help them reduce their tax bills and allows them to mount aggressive

investment schemes. For instance, it is common to conduct debt-led purchases of nursing homes in order to transfer the debt to subsidiaries, and also to use tax havens in the European Union itself (Burns *et al*., 2016; Rico, 2020).

Increase in competition and frozen public prices should make us wonder how smaller private providers, both for-profit and non-profit organizations, will be able to survive financially in the sector, especially if they want to attend to lower-income users. In this situation, many providers are pressured to partner with other organizations and increase in size, adopt homogenous managerial styles aimed at maximizing margins, or sell their infrastructure (especially in cities where land is more valuable). The ethnography carried out by of Rodriquez (2014, p. 37) is of especial interest to see how non-profit firms need to engage in business practices consistent with that of for-profit providers to survive organizationally. He suggests that the reason for this tendency is competition, financial uncertainty, and dependency on the workings of governments' medical reimbursement systems, which do not take into account community activities. Although his study covers only the US, all three factors are in some way relevant for the countries used as examples here, also when it comes to the dependency of nursing homes on the institutional structures of reimbursement systems.

However, in the countries studied the non-profit sector and small for-profit providers still retain an important presence, forming a fragmented and variable ecosystem in every region and town, marked by many small and medium-sized nursing homes. Given the lack of public provision and pressing demand, as well as the commitment of public servants to continue relations with well established actors in the field, alternative contractual solutions are found for these providers. Here, the 2014/24/EU Directive imposed new rules to further standardize and limit discrimination rules in public tendering in European countries. However, it also explicitly exempted personal services and social services from following these rules, leaving a door open for national and regional governments to transpose the Directive with their own regulations. Therefore, when it comes to the public-private mix, in the EU regional and local governments have some degree of discretionary powers to place social clauses above economic ones, and favour those actors that despite not setting the lowest price might provide other social returns.

The question regarding which actors should governments partner with remains open, given the great variability of factors that are independent of ownership type but that determine outcomes. In the end, as Kruse et al. (2020) theorize, different ideal types of management can reign in nursing homes – market, bureaucracy, professionalism and care logics. Which logics are followed by each type of provider might greatly depend on contextual factors such as physical and institutional structures, history and culture of each region. For instance, the organizational culture, the size of the building, and type of managers are among the factors to take into account in this regard. In terms of quality, big nursing homes might have difficulties in providing a homely environment. For instance, the qualitative evidence of Kruse et al. (2020) for the Netherlands shows that, compared to large bureaucratized non-profit providers, small for-profit provision in smaller facilities might have more opportunities for giving person-oriented care, especially when it comes to time to provide care. In this sense, it is significant that in the UK smaller nursing and residential facilities are rated significantly better than bigger ones (CQC 2017).

Nevertheless, when it comes to observable health quality outcomes, increased size might be beneficial to develop and expand good practices. For instance, Anderson et al (2003) showed in their empirical study that bigger nursing homes in the state of Texas, US, had fewer problems with restraint use. They explain this by virtue of the generation of information flows and the capacity to self-organize according to the information available. Therefore, their study empirically debunks the idea that top-down leadership is better for resident outcomes. Analysing nursing homes as adaptative complex systems, they find that managers' experience and tenure are important factors in improving residents' outcomes. Of course, we do not know which type of managers are hired by new big for-profit organizations to run their nursing homes. We can expect that they can afford well experienced and highly qualified managers in the nursing home sector. Nevertheless, managers in these organizations will also be pressured to generate short-run profits for their employers, maybe putting quality at risk.

5.3. The limits to monitoring and accountability

In the face of the increasing presence of powerful for-profit actors in the sector, can the public sector effectively monitor firms and hold them accountable? Given the limitations

for stakeholder participation under NPM styles, centred as they are around procedures and formal outcomes, the quality of a privatized provision depends highly on choosing the right providers by the public sector and increasing spending on monitoring (i.e. higher transaction costs). As for picking the right providers, traditional competitive procurements heavily focused on monetary costs and formal quality standards have serious limitations for various reasons (Brennan et al., 2012; Winblad et al., 2017; Palomera 2020). While public procurement keeps prices per bed down through competition, once a contract has been won it is easy for providers to cut corners on non-observable quality standards and other non-tangible aspects in nursing homes. In addition, the nursing home sector has low reputation mechanisms, especially because public procurement law, drawing on EU directives, makes it difficult to take previous experiences into account in procurement rounds (here again the 2014/24/EU directive regulates the possibility of establishing non-standard forms of contractual relationships in social services). Thirdly, as mentioned in section four, the elderly need service continuity, which makes it difficult to terminate contracts or change providers.

In terms of monitoring by the public sector, Choiniere *et al.*(2016) found that in the countries with the highest levels of for-profit ownership, such as the UK, there are standardized, complex and deterrence-based regulatory systems in place, as well as strong regulatory enforcement. Despite this, serious lapses in standards and evidence of abuse have led to changes in national public inspection processes and to increases in their funding. Germany has a more transparent rating system, but the system still fails to differentiate between levels of quality; this has prompted experts and care associations to demand a review of the evaluation criteria (Choiniere *et al.*, 2016). And when it comes to monitoring labour standards, Choiniere *et al.* (2016) point out that even in UK and Germany, with apparently strong monitoring systems in place, quality indicators have not been extended to key issues such as staff education levels, workload or training. In Spain, data protection rules prevent access to this information.

In any case while increased funding for monitoring might serve to improve some quality indicators, the low risk of a contract being terminated makes inspections rather a poor tool for solving structural problems in the sector. Even if terminated, the same providers repeatedly win the same or similar contracts in the same or another administration (Sclar 2001). This is especially relevant in the nursing home sector, where institutional

fragmentation works against the creation of a coordinated information system capable of helping administrations to detect and deter opportunistic providers from winning contracts.

Finally, the international nature of corporations creates further threats to monitoring and accountability in quasi-markets. Multinationals, although they each act as a single unit of command optimizing world-wide operations for efficiencies, market share and profits, do not exist as single entities under the law (Ruggie 2018). This creates enormous barriers towards making the 'parent company' accountable, which is especially relevant given their propensity to take risks. As mentioned above, parent companies tend to debt-charge nursing home subsidiaries, increasing their risks of bankruptcy (Burns *et al.,* 2016). At the same time, there is an expectation that governments would bail them out if necessary in order to preserve the continuation of service. These types of practices can put regional and local governments at risk, given their insufficient technical and legal capacities to challenge these actors. In this vein, Innes (2017, 00:30:05), when commentating on the UK case, states that quasi-markets and supply-driven reforms in personal services "threaten not only the basic accountability of the state and the principle that the government can reverse failing or unpopular policies […] the trouble is that we find ourselves in a territory having created not just business constituencies determined to see the perpetuation of these policies but also businesses on whom the state is already structurally dependent".

6. Conclusions

Markets have been a key piece in the transformation of welfare states since the late 1980s and early 1990s. For some governments, market reforms have offered an opportunity to limit state intervention in welfare services; for others, a more diversified public/private supply appeared to be a good way to respond to increasing demand without dismantling the welfare state. In this chapter we have carried out a critical overview of the main arguments in favour of marketization and the main criticisms of those arguments. We also looked at how marketization has been implemented in different care regimes.

To a significant extent, differences in market reform outcomes between the Nordic, liberal, Continental and Southern European countries can be related to different welfare state regime constellations, which are themselves a product of historic public-private relationships. The last part of our chapter investigated how quasi-markets play out in the specific domain of residential care in four European countries: Germany, Italy, Spain and UK. Despite the fact that these four countries belong to different welfare state traditions, the increasing presence of for-profit actors is a common trend in all of them. Many of these providers are multinationals using investment funds that seek short-term profits for shareholders through large financial operations. The growing presence of these private actors runs in parallel to a decreasing or stagnant presence of not-for-profit actors in the nursing home sector. The 2008 financial crisis created a favourable environment for these market concentration dynamics in residential care, among other reasons because more limited public funding gave advantage to firms that could easily access credit. Rising privatization, and especially the penetration of global investors and large for-profit actors into the 'nursing home business' hinders states' capacity to effectively monitor these firms and hold them accountable. It also creates difficulties for monitoring labour standards and for apportioning value to care work that has no immediate translation into measurable, time-specific tasks. The real question is whether the system is delivering proper care to enough people. An exploration of the most recent trends of quasi-markets in the nursing sector of four European countries poses the fundamental question of how to reconcile the interests of powerful market actors and the state's responsibility towards some of the most vulnerable people in our society.

Finally, although we have not analysed the Covid-19 crisis in this chapter, post-pandemic studies trying to grasp the reasons behind the lack of an appropriate response in nursing homes in some countries will probably direct critical attention to political discussions of some of the quasi-market related problems discussed in this chapter. The ways in which market structures and dynamics shape outcomes and the limits to holding private actors accountable should be part of any long-term strategy with regard to the future of the care economy.

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