Commercialisation and care sufficiency: the privatisation of children's homes in England

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Although the commercialisation of care services is intended to produce markets that respond to care need, it is still unclear whether profit incentives align with population need. In this Health Policy, we examine the provision of the children's residential care market in England and whether it responds effectively to geographical need. We analysed comprehensive data on all children's homes in England between 2014 and 2023 and categorised providers as Local Authority, third sector, investment owned, individual owned, or corporate owned. We operationalised area need through net loss measures: the difference between the number of children placed outside a Local Authority versus those placed within it. Using Bayesian hierarchical models, we assessed the relationships between area characteristics, children's home locations, and ownership structures. In 2023, 852 (29·8%) of 2861 children's homes in England were owned by investment firms, doubling the number they ran in 2014 (414 of 1350 homes). All for-profit homes disproportionately located in areas of low need and investment-owned homes located more in areas with low house prices. Compared with Local Authority homes, investment-owned homes were less likely to operate in areas of high need and non-commercial homes were most likely to open in areas of high need. The commercialisation of children's social care provision has corresponded with less accessible services, contributing to sufficiency issues. Current market dynamics fail to address, and likely worsen, geographical disparities in children's residential care provision.

Introduction

Commercial entities exert a profound influence on population health. Defined as entities engaged in the buying and selling of goods or services for profit, commercial entities can sometimes undermine population health by promoting the consumption of harmful commodities, exposing individuals to hazardous environments, or restricting access to health-improving goods and services through financial barriers.[1] At the core of the commercial determinants of health lies the principle that the pursuit of profit can lead powerful entities to neglect or deliberately compromise public health. For example, tobacco or gambling consumption are well documented as harmful, yet related commercial entities have actively promoted the conditions for their expansion.[2,3] Mapping the entities involved in the production of such goods and services has become a vital intervention for protecting population health and ensuring corporate accountability.

Health and care services are also commercially determined.[4] The same norms underpinning industrial environments have been imported into the delivery of public services, either through explicit government policies that privatise and outsource health and care services or through incremental changes in the ownership of goods and services without the need for statutory changes.[5] Just as in other industries, evidence indicates that financial imperatives can override health considerations. To date, most empirical studies find that private health and social care providers engage in cost-cutting strategies, often by reducing staff or excluding specific patients.[6,7] Yet substantial gaps remain in our understanding of other pathways through which commercial entities might affect population health.

One such question relates to the availability and sufficiency of care. The availability of nearby hospitals, primary care services, and social care providers has been linked to better health outcomes.[8–10] Thus, the relationship between commercial influences and care sufficiency is of great importance to public health. However, it is not clear how this relationship might operate. On the one hand, commercial markets are theorised to respond well to the degree and specificity of care needs because financial viability depends on meeting demand. Therefore, some argue that by creating a market that allows private providers to compete in the delivery of care, service sufficiency could improve.

On the other hand, others argue that commercial markets cannot reliably deliver care sufficiency because commercial incentives are fundamentally indifferent to care equity.[11] Sufficiency requires services to be available where need is greatest, not where demand is most profitable. Importantly, the areas, services, and populations with the highest needs are not necessarily where the largest profit potentials lie. Commercial entities, it is argued, naturally gravitate towards areas with higher reimbursement rates, lower operational costs, or a more manageable case complexity.[12]

Children's social care, sufficiency, and health outcomes

Children's social care services are among the most invasive state interventions. The state takes on the role of providing a child with a new home and family and becomes responsible for the care of their all-round emotional, physical, and mental health. As such, the care experience has the potential to greatly affect the health and life outcomes of children. One approximate measure of these effects is the comparison in health outcomes between adults with experience of care and adults without experience of care. Adults with experience of care have been evidenced to have an adjusted all-cause mortality hazard ratio 1·62 (95% CI 1·43–1·86) times

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higher than adults who had never been in care.[13] Similarly, adults with experience of care are more likely to report their health as bad or very bad (odds ratio [OR] 3·5 [95% CI 2·2–5·6]) compared with adults who have never been in care.[14] Comparisons with populations without experience of care are not necessarily evidence of the effects of care itself; however, studies looking at adults with experience of care have also found that different types of social care provision variably affect mental health and wellbeing.[14,15] The effects of being placed in care on children's life chances vary by the form and quality of care provision.

One important factor in care provision is sufficiency, defined as having the right care services in the right place at the right time for each child. Care sufficiency can be achieved in a few ways, one of which is by ensuring stable environments and relationships for children. Research on the experiences of children in care often describes the importance of consistency in relationships.[16] Placement stability is also identified as an important predictor of mental health outcomes in quantitative research.[17] A care system with sufficient provision will allow children to not only find a home that suits them but also allow them to stay there.

Another way that care sufficiency is key for health is care location. Disconnection from family and friends, schools, and social workers can all contribute to shock, isolation, and loneliness.[18] In England, the close locality of homes to children has been a long-term policy aim, despite data showing placement locality worsening over time.[19] A care system with sufficient provision will ensure that care entry does not mean geographical displacement.

Thus, having a care system that is child-centred and a service that is available to meet their needs is integral for public health. Identifying if commercial markets improve or worsen the service being child-centred and available is essential, not only for our knowledge about the mechanisms for the commercial determinants of health, but also for policy responses to care provision.

Do commercialised care markets provide sufficient services in places where they are needed? Understanding this question is crucial, because the answers could clarify an additional pathway through which commercial determinants of health systems influence population health. To explore this issue, this Health Policy draws upon a comprehensive data resource containing complete and nationwide data on the openings and closures of children's homes in England between 2014 and 2023. We first categorise children's home companies according to theorised profit motives, before assessing how the categories relate to area sufficiency by evaluating the geographical distribution of services.

The first objective is to test whether or not the residential market in children's social care is responding to area need. The second is to test whether profit motive is related to children home location and, if so, how.

See **Online** for appendix

Methods

The target sample of this study was all children's homes in England that operated between 2014 and 2023—the period in which the independent regulator Ofsted inspected children's homes on the same framework and published digitised data.[20] We excluded schools that were registered as children's homes because their number of registered places (beds) might not solely serve looked-after children and they are therefore not comparable with other residential providers. In addition, the opening and closure of schools depends on a combination of care and school functions. The final sample was produced (appendix p 6) and comparisons made of the characteristics of excluded and included children's homes (appendix pp 9–10). Homes with missing data for the organisation that owned them were removed, all of which were for-profit homes that closed before 2018 (before 2018, Ofsted did not report the name of a company running a children's home) or opened after 2023. These homes were labelled as unlinked for-profit in our supplementary analyses to test for bias. We categorised children's homes into five different ownership categories: Local Authority, third sector, investment owned, individual owned, and corporate owned. To distinguish between different types of private ownership, we analysed the shareholders, people of significant interest, and global owners across the entire corporate group of each organisation registered by Ofsted to run children's homes. We analysed more than 5 million different combinations of shareholders and owners from FAME,[21] which is a registry of company information comprised primarily of information from Companies House, in which company accounts and relationships are often uploaded via PDF or in bulk datasets, making the information difficult to parse and harmonise. We used FAME data to identify the entities involved in ownership structures of children's home companies. See the appendix (pp 2–9) for a full description of the double-coding process, a decision tree, and a list of the manual and systematic checks conducted to verify the ownership categories.

We first analysed the number of all places in children's homes as a proxy for market capacity. We did this by aggregating the number of places within each home for Local Authority (municipality) areas to understand the availability and location of children's home places in England. We then analysed the homes' ownership to see if different types of providers behaved differently in the market. Local Authority and third sector homes are those identified by the regulator (Ofsted) as public or voluntary sector. Investment-owned homes are those with any owner in the corporate structure identified as an investment company via industrial classification (Nomenclature statistique des activités économiques dans la communauté Européenne [NACE]) codes or specific terms in their company names.[22] The search terms for investment firms were iteratively decided and

	N	Ownership type				
		Local Authority (N=682)	Third sector (N=286)	Individual (N=1034)	Corporate (N=594)	Investment (N=1014)
Quality: average inspection score	3453					
Median (range)		3·00 (1·00–4·00)	3·00 (1·00 to 4·00)	2·80 (1·00 to 4·00)	3·00 (1·00 to 4·00)	3·00 (1·00 to 4·00)
Mean (IQR)		2·89 (2·60–3·11)	2·86 (2·60 to 3·11)	2·74 (2·50 to 3·00)	2·83 (2·57 to 3·00)	2·86 (2·60 to 3·00)
Non-missing		608 (89%)	239 (84%)	1015 (98%)	587 (99%)	1004 (99%)
Quality: ever rated outstanding	3499	248/637 (39%)	85/248 (34%)	248/1020 (24%)	180/589 (31%)	385/1005 (38%)
Number of requirements per inspection	2554					
Median (range)		1·57 (0·00–35·00)	1·80 (0·00 to 32·00)	2·40 (0·00 to 18·20)	2·00 (0·00 to 15·00)	1·80 (0·00 to 16·00)
Mean (IQR)		2·12 (0·67–2·80)	2·86 (0·60 to 3·50)	3·14 (1·33 to 4·00)	2·30 (1·00 to 3·25)	2·19 (1·00 to 3·00)
Non-missing		522 (77%)	199 (70%)	625 (60%)	397 (67%)	811 (80%)
Age of home (months since registration)	3346					
Median (range)		197 (9–261)	106 (9 to 608)	64 (13 to 379)	79 (14 to 378)	98 (15 to 372)
Mean (IQR)		165 (78–242)	141 (61 to 218)	91 (36 to 126)	106 (41 to 154)	112 (57 to 150)
Non-missing		533 (78%)	217 (76%)	1023 (99%)	578 (97%)	995 (98%)
Children home size (places)	3605					
Median (range)		5·00 (1·00–38·00)	5·00 (1·00 to 60·00)	3·00 (1·00 to 16·00)	3·00 (1·00 to 20·00)	4·00 (1·00 to 29·00)
Mean (IQR)		5·41 (4·00–6·00)	7·44 (4·00 to 8·00)	3·44 (2·00 to 4·00)	3·63 (2·00 to 5·00)	3·90 (3·00 to 5·00)
Non-missing		680 (>99%)	283 (99%)	1034 (100%)	594 (100%)	1014 (100%)
Closed	3610	232 (34%)	122 (43%)	158 (15%)	75 (13%)	162 (16%)
Profit margin (%)	1306					
Median (range)		NA (NA–NA)	2 (–13 to 15)	16 (–5 to 27)	6 (–45 to 33)	9 (–29 to 34)
Mean (IQR)		NA (NA–NA)	2 (1 to 4)	13 (4 to 22)	4 (–3 to 8)	8 (1 to 11)
Non-missing		0	179	91	155	881
Chain size*	3492					
Median (range)		7 (1–22)	5 (1 to 19)	3 (1 to 16)	6 (1 to 60)	60 (1 to 225)
Mean (IQR)		8 (5–12)	6 (2 to 12)	4 (1 to 5)	15 (4 to 22)	98 (24 to 131)
Non-missing		640 (94%)	210 (73%)	1034 (100%)	594 (100%)	1014 (100%)
Government Office Regions	3540					
East Midlands		61 (9%)	22 (8%)	116 (11%)	81 (14%)	86 (9%)
East		43 (7%)	41 (15%)	85 (8%)	45 (8%)	73 (7%)
London		37 (6%)	31 (11%)	90 (9%)	39 (7%)	11 (1%)
Northeast		78 (12%)	29 (10%)	47 (5%)	19 (3%)	41 (4%)
Northwest		110 (17%)	46 (16%)	232 (23%)	176 (30%)	241 (25%)
Southeast		81 (12%)	42 (15%)	125 (12%)	57 (10%)	89 (9%)
Southwest		52 (8%)	28 (10%)	85 (8%)	30 (5%)	116 (12%)
West Midlands		75 (11%)	26 (9%)	173 (17%)	98 (17%)	240 (24%)
Yorkshire and The Humber		125 (19%)	17 (6%)	68 (7%)	48 (8%)	85 (9%)

Data are n, n (%), or n/N (%) unless otherwise specified. The sample sizes used to calculate the profit margins only apply to the subset of Companies House accounts that exclude small or microcompanies. The profit margins of third sector homes are financial surplus, which cannot be distributed to shareholders. See appendix (p 9) for missing data. NA=not available. *Chain size is the average number of locations (homes) owned by the same ultimate owner.

Table 1: Descriptive statistics of children's homes in Government Office Regions in England between 2014 and 2023

manually verified (see appendix p 7 for the exact classification procedure). Individual-owned homes are those in which 50% or more of the immediate shareholders, or shareholders of a holding company, are individuals. Corporate-owned homes are homes with a corporate chain in which no investment company is involved at any level.

We also descriptively analysed the children's homes inspection ratings, age, and size. Inspection ratings are given following an Ofsted inspection. We converted the ratings into a 1–4 score (1 being inadequate and 4 being outstanding). The age of the children's home was calculated as the amount of time passed from when it was registered with Ofsted until Jan 1, 2024. The size of the home was measured as the number of registered places, which is likely to slightly exaggerate actual capacity because most children's homes operate at around 70% occupancy.[23]

We tested the regional provision of children's homes according to three main exposures: the number of children in residential care, the area need for homes, and regional house prices. Some of our exposure data on

children's locations were retrieved through a Freedom of Information (FOI) request (appendix p 11) to the UK Department for Education.

We first measured market response according to the number of children in residential care that an area is responsible for, including children located inside and outside the area (appendix p 3). We operationalised area need via the measure of net loss of children. Through a FOI request, we obtained each Local Authority's net loss of children in residential care between 2014 and 2024. This metric was calculated as the number of children placed by a Local Authority in out-of-area homes, minus the number of children placed within the Authority by other Local Authorities. We interpreted a high net loss (more children placed outside the area than received from elsewhere) as indicative of an undersupply of provision, suggesting a high level of area need. Conversely, a net gain (receiving more children than placed outside) suggests a relative oversupply. A spatial representation of this measure is provided in the appendix (pp 14–15). Importantly, this metric is a raw and relative measure of need that is not necessarily representative of the suitability of local places to the needs of the area.

We created a dataset structured in a hierarchical nature, with children's homes clustered within Local Authorities. Our raw data are longitudinal and we aggregated values into averages at the Local Authority level over time for analysis. We present a full list of variables, data sources, descriptive statistics, and definitions in the appendix (pp 3–12). A description of missing data is also available in the appendix (pp 9–10). The manuscript is reported in accordance with STROBE guidance (appendix pp 25–28).

Analysis

We conducted a four-stage analysis. First, we descriptively analysed the patterns of children's home provision according to our ownership categories to map the development of different forms of ownership. We analysed the average size, inspection rating, and age of homes by ownership category.

Second, we conducted an observed-to-expected ratio analysis of the number of children's homes. We ran a bivariate regression between the number of children in children's homes and the number of places available in the Local Authority area to create an expected average ratio of places to children. This model is bivariate and can therefore calculate a simple prediction of the expected number of local places based solely on the number of children in care. We then plotted the observed number of places in open children's homes against the expected values, given the area's number of children in children's homes in 2023. Exact Poisson distribution probabilities are used for 95·0% and 99·8% funnel limits to identify outliers.[24]

Third, we ran multilevel, multinomial regression models to estimate how area-level conditions predict children's home ownership. These models allowed us to estimate the effect of between-Local Authority variance on children's home characteristics while accounting for the hierarchical nature of the data, with children's homes nested within Local Authorities. We used a Bayesian hierarchical model because it accommodates hierarchical data structures and offers flexibility and efficiency in converging with complex multinomial models.[25] We applied weakly informative priors because our hypotheses on the likelihood of homes responding to need are two-tailed: we think it is equally likely that commerical providers respond better or worse than other providers to care need (see appendix p 13 for positionality statement). We normalised all variables to enable these priors. Priors were not updated during the research but we present sensitivity checks, varying the range of our priors and diagnostics, in the appendix (pp 21–23).[26] We presented our results visually by transforming the ORs into predicted probabilities. No corrections for multiple comparisons or multiplicity were applied to these analyses and credible intervals should be interpreted as exploratory.

Fourth, we analysed the descriptive number of new children's homes opening by ownership type, according to area need. This descriptive analysis tested whether the commercial market responded to need by opening homes where they were needed. Analyses were all conducted in R (version 4.5.1). Ethics approval was not required for this study, there was no protocol published, and a positionality statement is available in the appendix (p 14).

We did a range of sensitivity checks on our regression models, including systematic adjustments to variables and model specifications. We also controlled for political party affiliations in our model and compared the characteristics of included and excluded children's homes. We changed the reference category in our
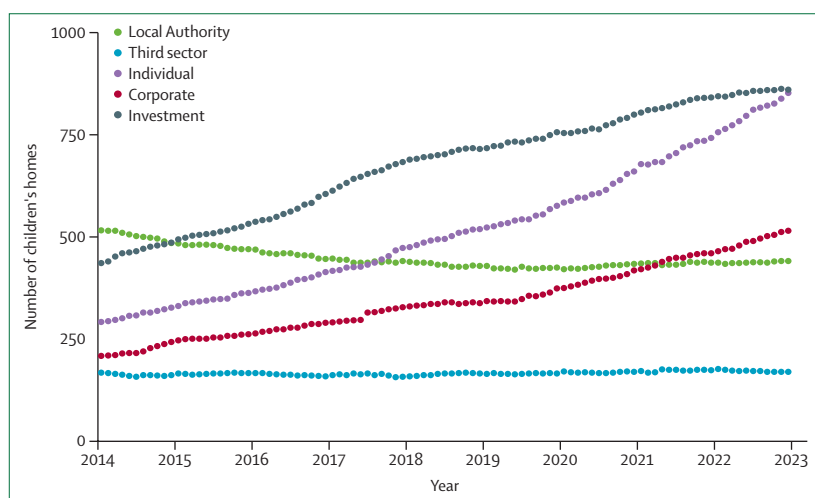

Figure 1: The rise of commercial ownership in children's social care
Number of children's homes in England operating between 2014 and 2023 by ownership type. Data on children's homes from Ofsted.[20] Data on ownership of children's homes from FAME.[21]

multinomial model to test for differences between different for-profit models.

Findings

Our data include 4356 unique children's homes that operated in England between 2014 and 2023. Of these, 1014 can be linked to ownership by an investment company, 594 to a corporate firm, 1034 to family or individual ownership, 286 to third-sector charity ownership, 682 to Local Authority ownership, and the remaining 746 were either unlinked for-profit because they opened after 2023 or closed before 2018, or had more complex ownership types (table 1; appendix p 8). We found that the most common type of children's home ownership for most of the 10-year period was investment or private equity ownership. In the past 10 years, the number of for-profit homes has more than doubled (from 903 in 2014, to 2247 in 2023) and there has been a decrease or plateau in the number of third sector (from 167 in 2014, to 164 in 2023) and publicly owned homes (from 510 in 2014, to 450 in 2023; figure 1).

Descriptive analysis showed that individually owned private children's homes receive the poorest inspection ratings (table 1). For closures, Local Authority (232 [34%] of 682) and third sector (122 [43%] of 286) homes were approximately twice as likely to have closed than homes from individual (158 [15%] of 1034), corporate (75 [13%] of 594), and investment (162 [16%] of 1014)

providers. Local Authority-owned homes had, on average, been open the longest (mean 165 [IQR 78–242] months vs 141 [61–218] months for third sector, 91 [31–126] months for individual, 106 [41–154] months for corporate, and 112 [57–150] months for investment-owned homes), with marginally better mean quality inspection ratings than other types. Investment-owned homes operated in much larger chains (mean 98 [IQR 24–131]) than other ownership types (Local Authority 8 [5–12], third sector 6 [2–12], individual 4 [1–5], and corporate 15 [4–22]). When looking at the registration dates of homes across Local Authorities from 1996 to 2023, newer homes are, on average, smaller and have lower inspection ratings (appendix p 16).

Figure 2 displays the observed-to-expected ratio of the number of places in children's homes in each Local Authority. Based on a simple ratio between children and places, it shows that some areas had more than 3 times the expected number of children's home places (a ratio over 3·0), while many other areas had less than half the number of expected places (a ratio under 0·5). The areas with more places than expected are typically more rural, in the north of England, and often neighbouring a city. The areas with fewer than expected places are often city regions. One notable exception is Redbridge, which had many places in children's homes (109) compared with the average number of children it houses in children's homes (17), which is very different from most other
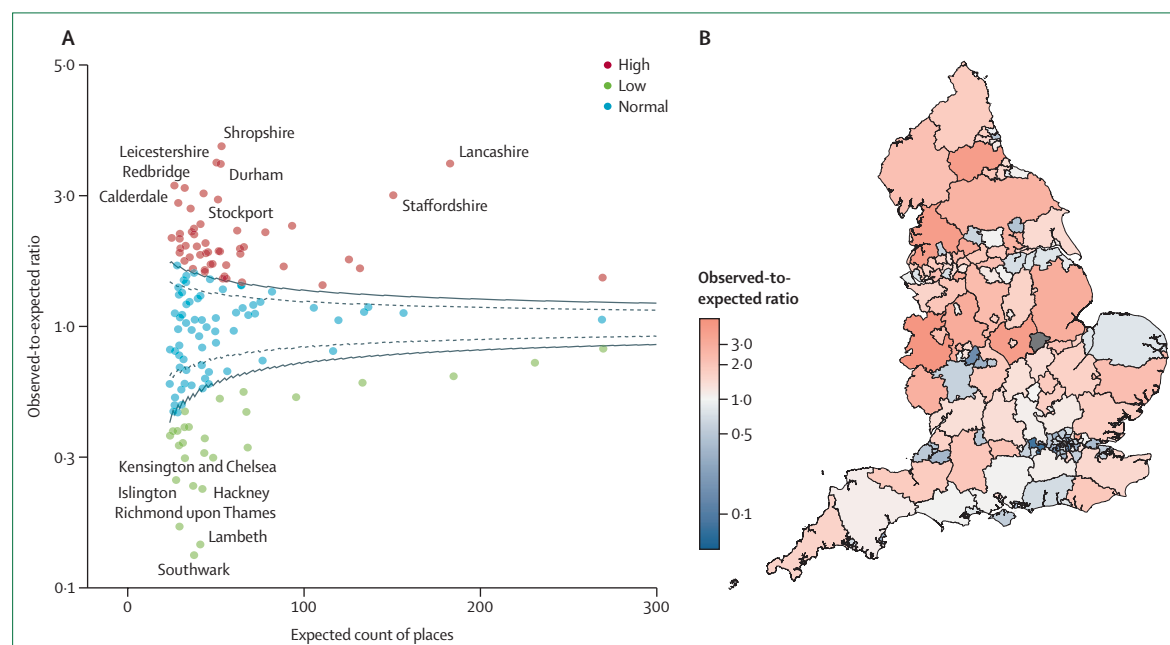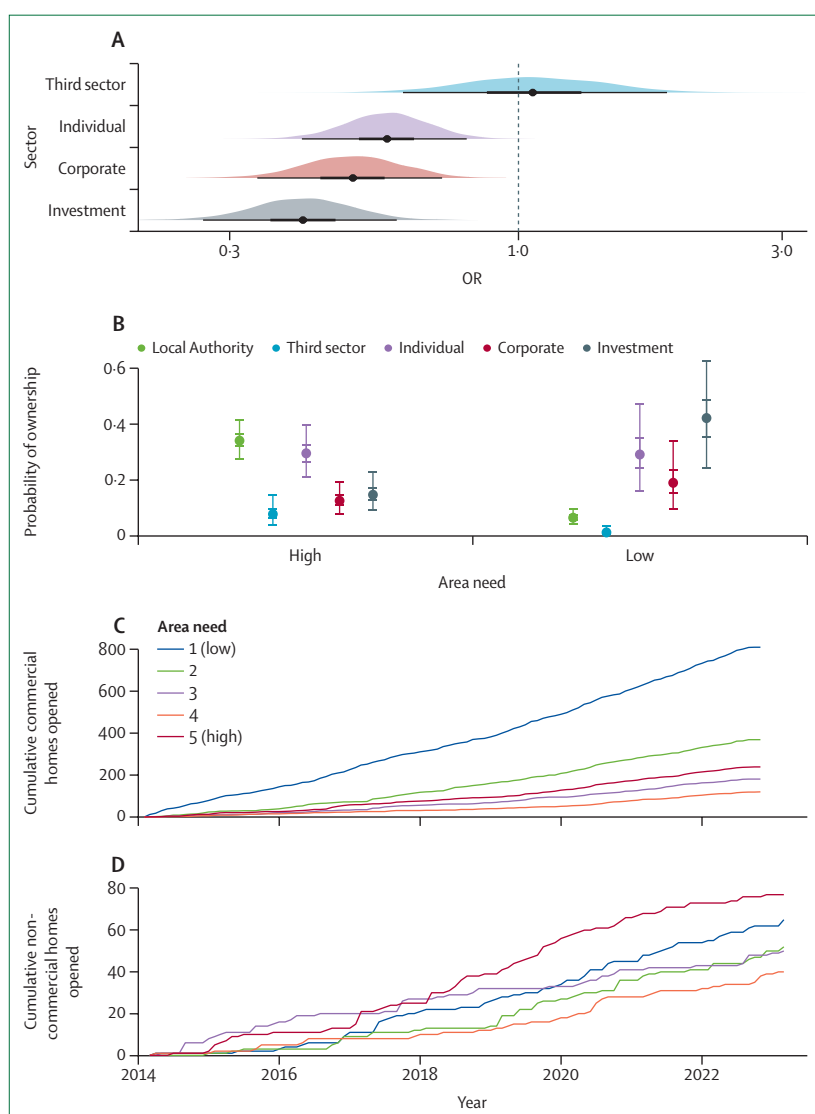

Figure 2: **Observed-to-expected ratios of places in children's homes in England from 2014 to 2023**
The observed-to-expected ratio is the number of children in children's homes and the number of places available in each Local Authority. (A) Funnel plot of observed-to-expected ratios of Local Authority-owned children's homes. Dashed lines are 95% CI and solid lines are 99·8% limits (standard Poisson limits). Expected count of places calculated from a Bayesian Poisson model. The model assumes that all areas need the same number of places per child. For a London-specific map and a funnel plot including the outlier of Birmingham (because Birmingham is the largest Local Authority, the number of children in care is too high to plot on the x-axis and maintain figure clarity), see the appendix (pp 29–30). Names have been added next to points on the funnel plot that have extreme values for substantial interpretation of where has over and undersupply. (B) The observed-to-expected ratio mapped across England.

	Model 1 (N=3540)		Model 2 (N=3610)	
	OR of predictor: house price	Probability posterior >1	OR of predictor: net loss	Probability posterior >1
Third sector	1·30 (0·12; 1·08–1·54)	1·00	1·09 (0·32; 0·60–1·87)	0·57
Individual	1·01 (0·07; 0·87–1·15)	0·52	0·58 (0·11; 0·40–0·82)	0·00
Corporate	0·96 (0·09; 0·87–1·14)	0·32	0·51 (0·10; 0·34–0·72)	0·00
Investment	0·75 (0·08; 0·60–0·90)	1·00	0·42 (0·09; 0·27–0·61)	0·00

Data are posterior mean (posterior SD; 95% CrI). Model 1 shows the relationship between area house price and children's home ownership; model 2 shows the relationship between area need (measured as net loss) and children's home ownership. For both models, the table shows the OR given an increase in one standard deviation change of the predictor. Local Authority-owned children's homes are the reference. The models control for whether children's homes were open or closed and the total number of children in children's homes in each area. CrI=credible interval. OR=odds ratio.

Table 2: Analysis from Bayesian hierarchical multinomial regression models predicting ownership of children's homes in England from 2014 to 2023

Figure 3: **Relationship between area need and children's home ownership in regions of England between 2014 and 2023**

Net loss is the number of children placed by a Local Authority in out-of-area homes, minus the number of children placed within the Authority by other Local Authorities. Data were obtained through a Freedom of Information request to the UK Department for Education. (A) OR of ownership by area need. Local Authority ownership is the reference. The half-eye plot shows the posterior distribution, the thick lines represent 50% CrI, and the thin lines represent 95% CrI. (B) Predicted probability of ownership by area need, with number of children fixed to the average and closure status set to open. High need is defined as a net loss of 1·5 SD above the mean. Low need is defined as a net loss of 1–5 SD below the mean. The thick lines represent 50% CrI and the thin lines represent 95% CrI. (C) Commercial homes (individual, corporate, and investment ownership) opened by area need (net loss, quintile). (D) Non-commercial homes (Local Authority and third sector ownership) opened by area need (net loss, quintile). CrI=credible interval. OR=odds ratio.

London and city boroughs (for a London-specific map see the appendix [p 29]).

Our multilevel models (table 2) show relationships between area characteristics and children's home ownership types. For-profit providers disproportionately operate in lower-need areas (figure 3), with investment firms particularly concentrated in regions with lower property values. Area need negatively predicts the likelihood of children's homes having individual, corporate, or investment ownership compared with Local Authority ownership. An SD increase of 1 in area need reduces the ORs of all commercial ownership compared with Local Authority ownership. This relationship is strongest for investment-owned homes (OR 0·42 [95% credible interval [CrI] 0·27–0·60]), followed by corporate-owned (0·51 [0·34–0·72]) and individual-owned homes (0·58 [0·40–0·82]).

Investment-owned homes are more likely to operate in areas with lower house prices; an SD increase of 1 in house prices reduces the odds of investment ownership (OR 0·745 [95% CrI 0·60–0·90]). House price was not strongly related to the other ownership types and these results are robust to specification type. See the appendix (pp 13–21) for a suite of regression specifications varying the analytical model, variable structure, and covariates, including controlling for council political control, as well as for the relationship between our two predictors of house price and area need (p 28).

Figure 3 visualises the relationship between area need and ownership calculated on the models in table 2. The posterior distribution of model 2 (net loss; figure 3A) shows that homes with non-commercial ownership are more likely to operate in areas with higher need for provision compared with homes with commercial ownership. This finding is also shown in absolute probabilities (figure 3B) and shows that in areas of high need, the most likely ownership type is Local Authority, despite there being less of these homes overall.

The cumulative number of new children's homes opening since 2014 is also broken down by ownership type and area need (figure 3C, 3D) and shows that

commercial providers consistently opened new children's homes where need was lowest. Conversely, non-commercial homes opened more frequently in areas with the greatest need for provision. We present the same visualisation for house prices in the appendix (p 16), which shows that it is predominantly investment-owned homes that locate into the areas with lowest house prices. The patterns of opening remain consistent if we change the house price and area need quintiles to be calculated at the start of the period in 2014, rather than as an average over time (appendix p 23).

Discussion

Our study shows that the commercialisation of children's social care in England has contributed to a sufficiency crisis with profound indirect health consequences. When Local Authorities have inadequate placement options, at-risk children are increasingly placed in unregistered accommodation without regulatory safeguards, which is comparable to placing patients requiring medical treatment in unregulated health-care facilities.[27] Scarcity of places also forces children into out-of-area placements, severing family and social connections needed for successful community reintegration. Those with the most placement disruptions—often those with the greatest needs—are placed furthest from home.[28] In addition, such displacement hinders authorities' abilities to monitor children's progress.

Our findings demonstrate that commercial providers are less likely to open and operate in areas of high need. Instead, these homes cluster where operational costs are lowest. Public and third sector providers, which now account for the smallest market segment, are the most likely to open homes in areas where services are most needed. From 2014 to 2023, all types of for-profit provision were more likely to open and operate in low-need areas than high-need areas, but investment-owned facilities had the strongest negative relationship with area need. The choice to locate in low-need areas is potentially a lucrative strategy, with children placed out-of-area being 2·5 times more likely to enter private provision than those within their area.[28]

These harms are invisible when looking at quality ratings alone, which suggests that current regulatory frameworks are inadequate to ensure and maintain geographical equity in sufficiency. Our findings could mean that the profit motive is fundamentally misaligned with ensuring care availability where it is most needed, or that commercial providers are not sufficiently incentivised to operate in high-need areas. Either way, it reveals a system either inherently unsuited to commercial interests, or too poorly resourced to effectively regulate private sector behaviour.

This study contributes to the commercial determinants of health literature by extending its scope beyond harmful commodities to include the governance and spatial organisation of care provision. In the case of children's social care, we show how profit incentives shape provider behaviour in ways that produce geographical dislocation and, in turn, structural health inequities. Strategic location decisions that prioritise economic performance over population needs exacerbate sufficiency issues and create harmful pathways for children already at risk. As many health and care systems around the world adopt commercial models, public health research must monitor these changes and interrogate how structural logics of profit redistribute risk and entrench inequity under the guise of neutrality and efficiency.

There are some limitations to consider with our study. First, it is not possible to observe how a counterfactual market without commercial entities would have developed. Some relationships identified in this study could also have been influenced by residual confounding. For example, we found a relationship between average area house price and children's home ownership, but we cannot verify if this represents operating costs or another confounding variable. Although we took several steps to verify and systematically check our categorisation of children's homes, the data might contain errors because some steps involved matching names, for which some companies could be miscategorised. For-profit homes that closed before 2018 were generally removed from the analysis because they had no company name reported, meaning we could not categorise their ownership and our sample is likely biased towards underestimating the number of closures for this provider type (appendix pp 9–11). Furthermore, our measure of area need is imprecise because it excludes the 9% of children for whom distance from home is unknown or unrecorded, which is an important aspect of the care system that requires further research.[29] Our measure of area need is also a relative geographical measure and cannot easily establish whether the whole system requires more, or fewer, children's homes. This question requires further research that includes the experiences of children, analysis of individual-level data, and demographic breakdowns. Equally, we did not capture other forms of care provision, such as fostering and adoption, which have important impacts on area need. Part of our conceptualisation of sufficiency is an assumption that it is, on average, better for children to receive care locally. This understanding is widely shared within the sector, although some children might benefit from care delivered further from home, something this study cannot account for. Finally, we have not analysed spatiotemporal effects to examine how regional clustering and spillovers function and how boroughs use each other's homes.

Conclusion

Commercial entities increasingly deliver health and care services. Our analysis finds that the profit-motivated owners of children's homes operating in care markets are, counter to some theoretical expectations, less responsive to population need than children's homes with non-commercial and public ownership.

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