The third sector and social care for older people in England: Towards an explanation of its contrasting contributions in residential care, domiciliary care and day care

Civil Society Working Paper 8

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March 2000

Abstract

This paper reviews the historical and recent development of the third sector in social care services for older people, and uses this as a springboard to develop a typology to capture in stylised form the diversity of providers within the sector. After reviewing a range of evidence concerning the nature of the third sector's relative contribution, three propositions are developed to explain why this balance varies so significantly between residential care, domiciliary care and day care. First, differences in the character of the regulatory regime, reflecting both the historical legacy of market development and different attributes of the services and their users; second, the nature of the demand for, and supply of, volunteers; and third, variations in the internal composition of the third sector. The last proposition underscores the importance of attending to internal variety within the third sector in understanding its contribution to the broader mixed economy of care.

Acknowledgements

This paper was written at the Personal Social Services Research Unit (PSSRU), London School of Economics, as a contribution to the CIRIEC project *Associations et Services aux Personnes Âgées*. An earlier English version appeared as PSSRU Discussion Paper 1525 (May 1999). A French version of this paper is forthcoming in J. Defourny, J. Laville et M. Nyssens (eds) *Service, Lien Social et Emploi*, Desclée de Brouwer, Paris. I would like to thank Jacques Defourny and Marthe Nyssens for helpful comments on an earlier draft. It has also benefited from numerous discussions with PSSRU colleagues Jules Forder and Martin Knapp, and co-re-searchers at the Nuffield Institute for Health, Brian Hardy, Patricia Ware and Gerald Wistow. The financial support of the Department of Health for the Mixed economy of Social Care (MEOC) programme, without which this work could not have been undertaken, is gratefully acknowledged.

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CONTENTS

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Introduction

This purpose of this paper is to describe and analyse the contribution of the third sector to the provision of social care for older people. The historical development of this field is outlined, and the development of recent policy reviewed in section 1. The implications of these trends for the *current* composition and scale of the third sector are drawn out in section 2.1. This not only describes some of the most important social care activities undertaken within the sector – residential care, care for people at home (domiciliary care) and day care – but sets out a typology to capture important differences in the orientation and resource characteristics of third sector organisations formed at different periods of historical time.

Section 2.2 of the paper then sets these organisations as a group in the context of the wider mixed economy in which they operate: that is, alongside the much larger private (for-profit) and public sectors. It isolates some common features that seem to cut across the different types of social care in which the third sector is involved, and distinguish it from other sectors. However, there also appear to be important differences in the nature of the third sector's relative contribution in each form of care. As a first step to accounting for these contrasts analytically, it is suggested in section 3 that sectoral choice can be understood as a two step process. First, the decision concerning how extensively to contract out is taken. Second, the balance between the private and third sectors must be determined. Three propositions are used to explain why this balance varies so significantly between residential care, domiciliary care and day care. First, differences in the character of the regulatory regime, reflecting both the historical legacy of market development and different attributes of the services and their users; second, the nature of the demand for, and supply of, volunteers; and third, variations in the internal composition of the third sector. The last proposition underscores the importance of attending to internal variety within the third sector in understanding its contribution to the broader mixed economy of care.

1 Historical development, and the impact of the welfare state

1.1 Before the twentieth century: dominant third sector, residual public sector

Up until the twentieth century and the consolidation of the modern Welfare State, when first the state and then the private (for-profit) sector have assumed central roles in the delivery of welfare for older people, voluntary organisations, comprising what would now be referred to as a voluntary or third sector were the primary conduits of formally organised care, supplementing the informal support provided by family, friends and neighbours. Large numbers of almshouses and local trusts for the relief of poverty were founded and run by members of *local state/church elites* from the late middle ages onwards[1] to house, and distribute cash, fuel or clothing to the "needy" or "poor" either born or residing in a particular village, parish or neighbourhood, many of whom were elderly people.

Not least because of the desire of the governing classes to keep down local taxation, the contribution of public authorities was strictly limited prior to the twentieth century. Under Poor Law doctrine, help from state resources was seen very much as a last resort for the "undeserving"; it was assumed that the needs of the "deserving" – people who were "not to blame" for their predicament, usually interpreted to include the vast majority of elderly people in need – would be met elsewhere. But in practice, the fortunes of vulnerable poor elderly people would have depended not only on their willingness to defer to and behave in ways approved of by their (potential) charitable benefactors, but where they happened to have been born or resided. Because the availability of assistance relied upon the *ability* of previous and current locale elites and the newly emerging social formations (see below) to give, it could hardly be consistently relied upon to match resources to needs – most obviously in the urban settings where more and more people were living as the industrial revolution gathered momentum. Furthermore, *willingness* to give remained highly variable, and nationally charitable giving and volunteering were unsystematic and uncoordinated despite the activities of the Charity Organisation Society (Lewis, 1995).

Anglican elite philanthropy and state resources did not, however, exhaust the historical scope of collective action. Friendly societies were one form of mutual association coming to prominence in the eighteenth century, which., with mixed success, developed as vehicles for the provision of life and health insurance in a spirit of sociability, primarily for people from lower socio-economic groups. Most visibly in the nineteenth century and at the start of the twentieth, in the context of fading Anglican hegemony and the assertion of a strong middle class identity and presence, denominations and occupational and professional

[1] Church elites' charitable impulses were officially guided by the doctrines of the Catholic church as interpreted by the Pope until the 1550s, when an independent Church of England assumed this role. Thereafter, the incumbent monarch was the supreme authority, with Protestantism (Anglicanism) finally mandated as the state religion in 1701 after a period in which the State religion oscillated between Catholicism and Protestantism.

groups proliferated. For these, the provision of social support and services for members, including people who had become older, was typically seen as core activities.

1.2 The early twentieth century: the take-off of state involvement

As the nineteenth century progressed, thinking about tax-funded public spending had started to change. The most important single rationale initially used to justify public expenditure was a "nation building" argument; investment in human capital was needed to allow England to compete more effectively both in foreign conflicts and in the international marketplace. It was primarily on these grounds that voluntary sector providers in the education and health fields were the first to benefit from significant injections of state funds (Taylor and Kendall, 1996).

This argument was obviously less easy to make in the sphere of personal social services, where the potential beneficiaries of state expenditures were, by definition, unlikely to be productive in the conventional economic sense or to take part in wars abroad! Rather, the decision to involve the state in this sphere, which was to come several decades later in the early twentieth century, flowed primarily from awareness of the range of limitations and failures of *laissez faire* in meeting need as described above. Evidence from social surveys and Commissions – initiated through voluntary action[2] – showed clearly for the first time the extent to which poverty and deprivation was experienced disproportionately by elderly people, and that the combination of residual state, charity and mutual aid left vast pockets of need unmet (Taylor and Kendall, 1996). Changes in thinking were also linked to the emergence of a less hostile attitude towards the state itself, connected with its democratisation, the shift in its orientation from a Confessional state to one recognising the claims of non-Anglicans as legitimate, and internal reforms within the state's infrastructure which enhanced its efficiency and expanded its capabilities (Kendall, 1996a, chapter 2).

The initial response to the failings of heavy reliance on voluntary action and a residual state was to examine ways in which the state could step in to rectify perceived deficiencies *without* undermining the existing contributions of the voluntary sector – which, as incumbent providers, wielded considerable political power and allegiance. Income maintenance was the first target area to directly affect elderly people, with 1908 legislation establishing a separate, means-tested state pension scheme, and then (from the mid-1920s) drawing the state and friendly societies into a working relationship, under which the latter administered state-initiated and organised contributory programs. Health and social care also began to involve state financial support on a wider scale, although here voluntary organisations remained dominant.

[2] It has been argued that the influence of social surveys on public policy in the nineteenth century was stronger in Britain than elsewhere in Europe or in the US – in part precisely because they were undertaken by philanthropists, and not initiated by the state (Mitchell, 1968, p.129).

While the new local government administrations were now increasingly responsible for running their own publicly owned hospitals and "public assistance institutions" (former Poor Law workhouses), the voluntary sector still provided the bulk of human service facilities financed with some state funds, but predominantly via a combination of private giving and subscriptions, and charges paid by users.

1.3 1945 to 1976: State consolidation, third sector displacements and continuities

The social legislation that followed in the aftermath of World War Two dramatically altered this institutional landscape. Enthusiasm for the capabilities and potential of the state was at a high ebb across society as a whole following its wartime achievements. With a new socialist government with roots in the Labour movement, ideologically committed to the consolidation of a state-run Welfare State as a way of pursuing both efficiency and distributional goals, an unstoppable momentum was created to bring all core social insurance functions, together with health care, into full state ownership and control. As a mainstay for meeting social need, charity and mutual aid were variously dismissed as riven with what were later to be theorised as "voluntary failures" (Salamon, 1987). In spite of these limitations, however, it was widely argued that such organisations, as well as commercial (for-profit) providers, should still have an extremely important supplementary role as an "extension ladder" to the (aspired to) universalistic services directly controlled by the state in a free society (Webb and Webb, 1912; Beveridge, 1948; see Kendall and Knapp, 1996, chapter 1).

From the late 1940s onwards, the voluntary sector's contribution to both income maintenance and health care was therefore to be dwarfed by that of the state: both these human services were, with a small number of exceptions, fully nationalised (brought fully under central state ownership and control). *Personal social services* was treated differently, however. These were made the responsibility of local rather than central government under the post war settlement, and voluntary providers, for the time being, remained at the core of service delivery. As with other human service fields, the *intention* was certainly to expand the ambit of (local) state controlled provision. But social care services were a relatively low spending priority in the years after the war, and so initially investment in this area was relatively limited. Moreover, new legislation specifically empowered local authorities to meet the needs of their elderly populations not only through building up their own residential and community services, but also by funding voluntary organisations to do so. For example, much of the residential care provided by traditional charities, including the Anglican and Catholic sisterhoods and the Salvation Army, was applauded as exemplary (Kendall and Knapp, 1996, pp. 212-214). In the non-residential care field, an example of the voluntary sector's resilience would include its position as the principal provider of day care provision at least up until the late 1970s (Carter, 1981; see discussion below for modern definitions of different forms of care).

Third sector social care and housing for elderly people was also given added impetus from within the sector between the 1940s and the 1970s with the formation of new national specialist voluntary organisations and federations, such as Age Concern, Help the Aged and the Abbeyfield Society. These were distinguishable from existing providers by their founding orientation towards elderly people in general, of all religious and occupational backgrounds.

Both types of organisations sometimes received public finance, but as more public funding was made available in the climate of "welfare optimism" that set in during the 1960s (George, 1996), local authorities in general tended to develop care services on behalf of their electorates by expanding directly run public services, rather than through providing financial support for independent suppliers. This course of action generated relatively little resistance. Professionals and volunteers in the voluntary sector, as much as the community in general, tended to welcome this development as wholly consistent with what was essentially at the time an uncontested, expansionary Welfare State project (Pierson, 1998).

In this context, they tended to see their roles, as local authorities saw them: increasingly as essentially pioneers, supplementers and niche market specialists rather than core or mainstream providers. Voluntary organisations and the volunteers they mobilised were recognised as key ingredients, particularly in non-residential services where the activities of many were thought of as consistent with the encouragement of independent living[3] and community development (Seebohm, 1968; Barclay, 1982; Brenton, 1985). Yet the vast bulk (well over 90 per cent) of the expenditure on non-residential services of the Social Service Departments (SSDs), newly created within local authorities, was deployed to fund an expansion of locally owned services.

1.4 1976 to 1989: State and third sector plateau, private residential care grows

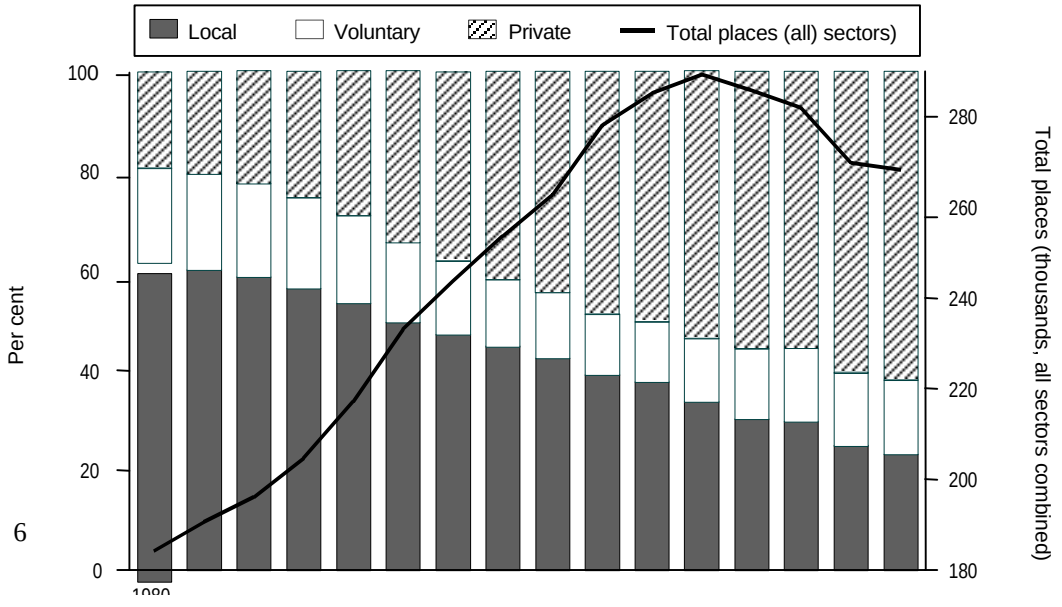
Local authorities' own expenditure on residential care services fell dramatically from the mid 1970s to the late 1980s in response to constraints on their funding from central government – a change in the latter's generosity which arose in a climate of "welfare pessimism" induced by a range of well documented political and economic factors of relevance to the UK and other countries (George, 1996). There was also within-budget reallocation of funds from residential to non-residential care in line with a further increase in the desire to favour "community care" options (Evandrou et al, 1990, p. 218).

[3] At least from the 1960s onwards, greater policy emphasis was also being given to community based options for elderly people in response to their own preferences, professional opinions, voluntary groups' lobbying efforts, and considerations of cost (Tinker, 1992).

However, aggregate public expenditure on residential services provided independently was to continue to expand outside the confines of politically controlled local-central government negotiated settlements via another source not designed for that purpose: central government's social security system. Through this route, relatively generous cash payments were available to elderly people satisfying a means test and entering residential care, regardless of whether this form of care was appropriate (Audit Commission, 1986; Griffiths, 1988). During the 1980s, these state resources effectively acted as de facto "vouchers". These payments were *not* sector-specific, so elderly people were able to choose between private and voluntary sector residential care – provided, of course, these suppliers were there in the first place.

In fact, it was the private, for-profit sector, and not the third sector, which responded decisively to the phenomenal surge in publicly-funded demand that developed on the back of these funds' availability. Figure 1 shows the rather dramatic increase in provision of residential care, and the transformation of market shares that resulted from 1980 onwards. This was, however, not the equity-fuelled growth of multiple home owning corporations, whose relative responsiveness has been emphasised by US commentators (Hansmann, 1981; Goodspeed and Kenyon, 1993). While very little is known about the private sector that was operating at a low level prior to the 1980s, we know that from this point onward growth involved an extraordinary proliferation of small businesses whose owner-managers were predominantly previously trained and employed in the public sector. Most of these health and social care professionals were content to run just one or two homes, and saw the establishment and running of their own private homes as a way of combining three goals: a desire to exercise more independence and control than had been possible in their previous jobs; a wish to meet the needs of elderly people, in part through the exercise of their professional skills; and the achievement of a reasonable level of surplus or profit (Kendall and Forder, 1997). The latter appeared possible both to providers, and to any external funders from whom resources might be sought – usually family, friends or the local bank – at least in part because central government's social security system had effectively underwritten elderly people's demands.

Fig 1: Percentage by sector and total residential places for elderly and younger physically handicapped people



In the meantime, aggregate third sector residential provision grew only marginally, and thus accounted for a dwindling market share as the market expanded. Although it is hard to identify patterns because data on the third sector cannot be disaggregated, most religious, professional and occupational charities were probably relatively unresponsive to the changing conditions, and seem to have declined in absolute terms in the context of typically dwindling membership. This appears to have been offset by some growth in the scale of national specialist provision, and also by the emergence on the scene of what might be referred to as new, non-profit social entrepreneurship.

This was often expressed in the context of consortia or other mixed organisational forms initiated at the interstices of a variety of tiers and fields of the central and local state: the harsh fiscal climate alluded to above was experienced unevenly in publicly funded services, and not all fields suffered the retrenchment experienced by SSDs. Creative packaging of service options could exploit money from adjacent budgets, where service responsibilities were blurred, problematic or perceived to be shared for social care ends. In particular, public expenditure on health care remained buoyant, and non-profit housing was enjoying a major period of growth under the impetus of central government supply side financial support, which was only available to third sector organisations. A significant segment of the limited expansion of third sector residential care activity that took place in the 1980s and early 1990s involved joint mobilisation of funds from these central government budgets (Morton, 1990; Kendall and Knapp, 1996, chapter 5). A much more limited parallel seems to have taken place outside residential care: some existing and new providers were able to access health budgets for home care schemes, and many took advantage of the funds that were becoming available in the 1980s from central government's job creation and training programmes. But unlike housing, the latter funds were available to the private sector as well as the third sector. Moreover, also in contrast to health and housing budgets, from the late 1980s onwards, training budgets were cut back and the level of funds reaching the third sector fell dramatically (see Kendall and Knapp, 1996, pp. 143-146).

As far as local spending is concerned, we know that the overwhelming bulk continued to be retained in-house to develop their own service portfolios. For example, in 1990-91 just three per cent of local authority expenditure on non-residential services for older people was allocated externally, almost entirely to the third rather than the private sector (Wistow et al, 1994, chapter 3). SSDs' direct financial support for the former tended to be general grant aid or in support of day care.[4] However, much of the voluntary sector's

[4] The existence of other forms of indirect financial and non-financial support should also be mentioned, including tax breaks and in-kind support of various kinds.

activities, and any provision made available by the private sector at this time, appears to have been carried out entirely independent of state support, and certainly did not achieve the high visibility of residential care.

1.5 The mid to late 1990s: "Enabling" and encouragement for the "independent sector"

While the Thatcher years (1979-1990) witnessed *de facto* changes in the structure of residential care supply – presided over, rather than deliberately engineered, by central government – the 1990s witnessed extensive, purposeful policy reform. Under John Major's premiership (1990-1997), the *1990 National Health Service and Community Care Act*, with full implementation from 1993 onwards, has had far-reaching implications for all providers of social care, and introduced the most sweeping legislative reforms in the field since the 1940s. In particular, the intent of the Act (Wistow et al, 1994) was to:

- Encourage an alteration in the balance of care from institutional to community care, discouraging long-term hospital provision and residential and nursing home placements;
- Engineer a move away from supply-led towards needs-led decisions and service arrangements;
- Enhance the role of both the private and voluntary sectors through the deployment of contractual and quasi-contractual agreements, and through the creation of "not-for-profit" providers to manage floated off services formerly directly run by local authorities; and
- Move much more responsibility for community care decision-making and funding to local authorities, and away from central government (the National Health Service and the Department of Social Security), from whom funds were transferred in annual tranches.

To encourage contracting out, central government introduced high powered financial incentives via two main routes. First, local authorities were required to spend at least 85 per cent of transferred funds on the "independent sector", or future finance would be withheld. Second, a "Choice Direction" was introduced, under which local authorities were required by law to allow elderly people for whom they have responsibility to attend the home of their choice – regardless of sector – within certain limits of cost and suitability. Again, failure to comply with this requirement would theoretically result in local authorities suffering considerable financial penalties.

A range of influences lay behind the shifts in financial and service delivery responsibilities, but three seem particularly important. First, the New Right central government's enthusiasm for markets and consumer-led services; second, its rather indiscriminate ideological prejudice against all forms of local direct service provision; and third, a desire to locate political blame for apparent "underspending" and scandals involving client neglect or abuse at the door of local government (see Klein, 1995, for a discussion of the concept of decentralisation of blame in the context of the National Health Service). There was certainly some resistance from within the third sector and outside it by those who saw the reforms as a "stalking horse" for withdrawal by the state from core welfare state financial responsibilities (Lawrence, 1983), or regarded the

(further) involvement of private sector providers as inherently incompatible with care processes and user welfare.

However, most observers did accept that there were real problems with existing services (particularly in-house services), and contracting out was but one strand of the wider package which we have seen also emphasised sensitivity to users' needs, and prioritised the pursuit of independent living as a core value. Moreover, during the 1980s, there was a steady build up of evidence from academic research and official reports that the *status quo* involved extensive unmet or inappropriately met needs, and ineffective use of resources (Baldock and Ungerson, 1993).

In particular, there were a range of "perverse [financial] incentives" built into the system favouring the use of residential and institutional care, when non-residential services often appeared to be both cheaper and more compatible with user welfare. The most obvious were the social security payments we have described, but others resulted from territorial or boundary disputes between the various components of central and local government. In as much as the reforms sought to alter this situation to secure more appropriate use of taxpayers' money, thereby increasing the likelihood of enabling more elderly people to live independent lives at home, their intent was broadly welcomed.

2 Personal social services for elderly people in the 1990s: evidence on the relative scope and contributions of voluntary organisations

2.1 The internal structure of voluntary sector supply

In 1995, third sector social service organisations were employing 185,000 full time equivalent paid employees and 221,000 full time equivalent volunteers (Kendall and Almond, 1999).[5]
The historical record is suggestive of the massive variety that lies beneath these headline figures, but also implies the existence of identifiable broad classes of organisation reflecting the historical circumstances of foundation. While all organisations tend to change and adapt over time, they continue to bear the imprint of their origins (Stinchcombe, 1965). Moreover, in the case of charities in particular, the objectives for which they were originally founded are institutionalised, acting as a duality of enabling guides to

[5] These figure relate to all client groups, of which services for older people comprise one segment. The third sector is also extremely active in services for children and families, people with learning disabilities, people with physical and sensory disabilities, and youth development. (The latter category is not normally thought of as part of "social services" in the UK, but as falling within the education field: it is included here because that is how social services has been defined for cross national comparative purposes in the most exhaustive classification building effort to date: see Salamon and Anheier, 1997).

appropriate action, and (legally sanctioned) constitutional barriers to change.[6] In other words, provision may be distinctly layered in terms of purpose, resourcing and structure in a pattern that tends to reflect historical legacies, and it is important to find some way of capturing this diversity. It may be helpful to start with the typology of Smith and Lipsky (1993) developed in the US. Based upon empirical research in four health authority areas, Mocroft and Thomason (1993) have argued for the utility of Smith and Lipsky (1993)'s distinctions in England for personal social services in general. Box 1 tentatively extends this by incorporating two new categories, national specialists and providers created as "not-for-profit trusts" formed as a direct response to the 1990 Act, with the particular history of provision for elderly people in England we have outlined in mind.

Box 1: Major types of voluntary organisations providing social care for elderly people*

- Generalist social service agencies with services for elderly people operating alongside services for other people in need. Typically with pre World War II origins, these tend to be either directly or indirectly connected to religious denominations or based around occupational, trade or professional groupings with a wide variety of structures. Mixed funding, often including substantial income earned on historically inherited assets and accumulated financial reserves.
- Specialist providers for elderly people, typically founded from around World War II onwards, and often with federal structures. Mixed funding, with much variety between local affiliates.
- New social entrepreneurship organisations founded and/or expanded from the 1960s onwards, but most extensively in the 1980s, in direct response to the availability of public funds, particularly for community care, training and housing programmes. These may or may not specialise in providing care for elderly people, can develop national structures from typically local or regional origins, and often remain heavily reliant on public funding and user contributions.
- Community and self-help groups not covered in the above categories. Mixed funding.
- Not-for-profit trusts operating homes formerly run directly by local authorities from whom they have been "floated off". Typically funded almost entirely by direct authority funding and user contributions**

* The focus here is on service provision, so we have not included the growing range of groups oriented entirely towards advocacy and campaigning, such as pensioners' fora: see various chapters in Bernard and Phillips (1998) for more details.

** Arguably, these are not sufficiently independent from the public sector to quality as part of "the voluntary sector". (Kendall and Knapp, 1995). However, these are included here since data upon them is not separable from data on the other provider types in the aggregated statistical data presented below, so accounting for trends in those data must be inclusive. See section 3 for further discussion.

Cross cutting this diversity in terms of history, organisational structure and resourcing are the different types of social care provided. Residential care in old people's homes *financially* dominates the voluntary sector's activities, with payments in support of these paid-labour-intensive services accounting for over four-fifths of the sector's total operating revenue (Kendall and Knapp, 1996). With the shifting of responsibility for public funds *within* the public sector described in the previous section, publicly-funded providers are becoming increasingly reliant on *local* authority contracts as compared to all other sources of state finance, and contracting-out has led to greater overall dependence on public funding at the sector wide level (Kendall and Almond, 1999). Private earned income is also important, while private giving is

[6] Of course, charities can change the means by which they pursue their purposes, and ultimately change the latter to a limited extent in accordance with the cy-pres principle of charity law (Kendall and Knapp, 1996, chapter 2). However, the point is that they are relatively restricted in comparison with other (independent) organisations, which do not face such significant legal or constitutional barriers to change.

estimated to have accounted for only a relatively small proportion of the revenue used to support this form of care (see Kendall, 1996b, for more details).

As has been the case historically, the voluntary sector is also heavily involved in providing non-residential care, and private giving tends to be a relatively more important source of revenue in support of these activities. In the UK, the official (contested) labels most often used to describe the main varieties of non-residential care are domiciliary services, day care services, and social/luncheon clubs. The former are those services which seek to promote the welfare of elderly people while in their own homes, including welfare-relevant domestic tasks which would otherwise not be undertaken, such as the delivery of meals, and the provision of home help (including cleaning, laundering, shopping and cooking). The aim of the latter two modes of provision is also client well being, but this time the provision is through a day centre, club or based within a residential home.

Day care can be distinguished from social/luncheon club activity by its involvement of staff recognised explicitly as "care givers", and through its operation for at least four hours each day (Brearley and Mandelstam, 1992). Social contact and companionship, recreation and the provision of meals are the main activities undertaken in both settings (as well as transporting elderly people to their day centre or club in the first place).

While non-residential care appears relatively small in *financial* terms, accounting for non-financial resources alters this picture significantly. *Volunteering* in particular seems relatively limited in residential care settings across all provider sectors (Local Government Management Board and Central Council for Education and Training in Social Work, 1997b; Netten et al 1999, p. 92), and most volunteers – many of them elderly themselves[7] –are active outside old people's homes.

Popular activities undertaken by volunteers (often alongside paid staff) include the care, quasi-care and support tasks referred to above, particularly in day care and other contexts where extensive social interaction is possible. Fundraising and participating on committees (Davis Smith, 1998), and the provision of advice and counselling, are other important activities. The simple provision of companionship may be a particularly important benefit to elderly people from the involvement of volunteers (Waddington

[7]There is both evidence from econometric analyses of national survey data, and from a local context to support this proposition. Knapp et al (1995, pp. 18-19) report that, ceteris paribus, while the probability of volunteering across all fields of activities increases up to the age of 43 and decreases thereafter, the "turning point" for volunteering on behalf of elderly people occurs much later at 54 years, and higher yet, at 68 years, for visiting sick and elderly people. Anecdotally, Pearce (1993, p. 101) reports that a survey of Age Concern volunteers found that in the South East of England "many of the management committee and many of the [other] volunteers were themselves over 60 years".

and Henwood, 1996), and this clearly cuts across and interweaves with the various care and support activities we have described.

2.2 The English third sector in comparative perspective

As will be apparent from section 1, third sector activities co-exist with service provision in the public and private (for-profit) sectors. Indeed, if measured purely in terms of overall financial or paid human resource terms (which we have seen does not reflect the major contribution of volunteers), this sector is very much ranked third behind the private (for-profit) and public sectors. This is both in aggregate for personal social services across all client groups, and specifically in care for elderly people.[8] Moreover, table 1 underlines that compared to other countries, the voluntary sector's role in residential care services in England is peculiarly limited.

Table 1: English Residential care provision in international comparative context: Proportion of residents in residential care (all client groups) by sector, 1990

Country	Voluntary	For-profit	Public	Total	Ranking*
Italy**	78.9	(very small)	18.1	97.0	1
Germany	60.3	13.3	26.4	100.0	1
France	54.9	4.0	41.1	100.0	1
Japan	43.0	1.0	56.0	100.0	2
Austria***	21.6	2.0	76.4	100.0	2
United States	19.0	77.0	3.0	100.0	2
Hungary	2.9	0.0	97.1	100.0	2
England	14.5	46.5	39.0	100.0	3

Source: All data from Salamon, Anheier, Sokolowski and Associates, 1996 with the exception of Italy and Austria, from 6 and Kendall (1997).
* Ranking of relative contribution of voluntary sector
** Status of 3% of residential care homes not known
*** Data relate to "retirement homes" and refer to the total number of places available (rather than proportion of residents)

Unfortunately, as far as non-residential care is concerned, reliable recent data is available only for those services funded by local authorities, in England and from 1992 onwards. As our discussion in the preceding section suggests the picture, is, therefore, partial, since many third sector services are supplied *without* local authority funding. Much care is provided without any recourse to public funds, but relies on

[8] A recent attempt to estimate paid employment in personal social services across all three sectors estimated that, out of a total of 931,000 workers in 1995, just under half (49.8%) were working in the private sector; around a third (33.8%) were directly employed by local authorities; and just 16% were employed by third sector agencies (Local Government Management Board and Central Council for Education and Training in Social Work, 1997a). Note, however, that this overall figure conceals very large variations by client group. For example, in many of the individual services provided for people with physical or sensory disabilities, the third sector ranks ahead of the private sector, and in some cases the public sector.

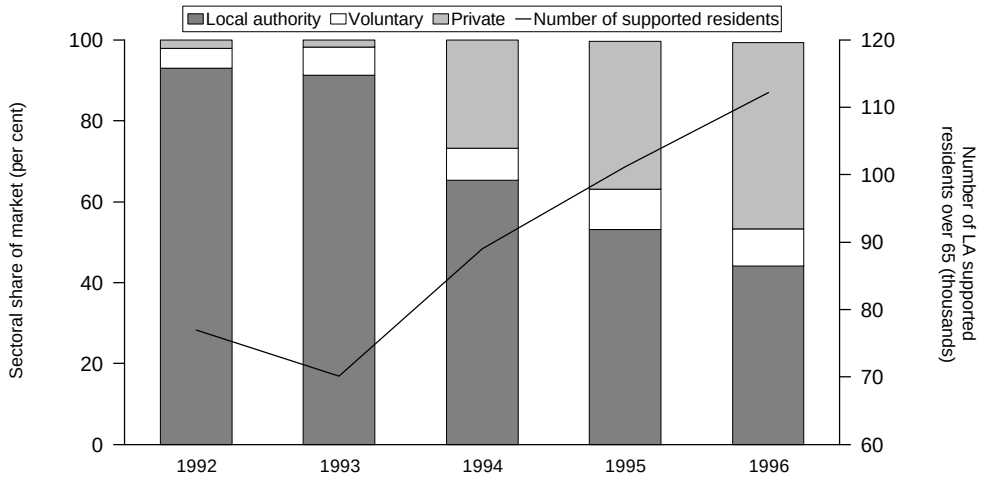
user charges, private giving, or involves no financial exchange. This would be the case, for example, with much of the low level, low visibility care and quasi-care support for people at home provided by denominational charities and many of the local groups affiliated to national specialist charities. These important activities are not treated directly in the analysis that follows.

Figures 2 and 3 show how changing levels of local authority funded activities (in England) only are split between the three formal sectors in the case of domiciliary and day care respectively; and figure 4 provides directly comparable data for residential care.[9] Four stylised facts emerge from this data:

- Albeit from different starting points, across all forms of care, the public sector share of local authority funded activity has contracted in absolute and relative terms, opening up a wider space for independent provision;
- In *residential* care, after a long period of relative decline (1970-1990), during which it provided an almost unchanged number of places in a rapidly expanding overall market, the third sector's market share appears to have begun to recover (figures 1 and 2). Most activity, however, has continued to be undertaken under private sector auspices.
- In *local authority funded domiciliary* care, the third sector's contribution is relatively rather small, and lags far behind the contribution of the other sectors (figure 3). The growth of independent sector activity has emerged within the private sector, dominated by small businesses owned and managed by entrepreneurs with similar attributes to those operating in residential care.
- In *local authority funded day care*, the third sector has retained its strong position in recent years, and this is the only field of the three in which it ranks ahead of the private sector, and approaches the scale of in-house services (figure 4).

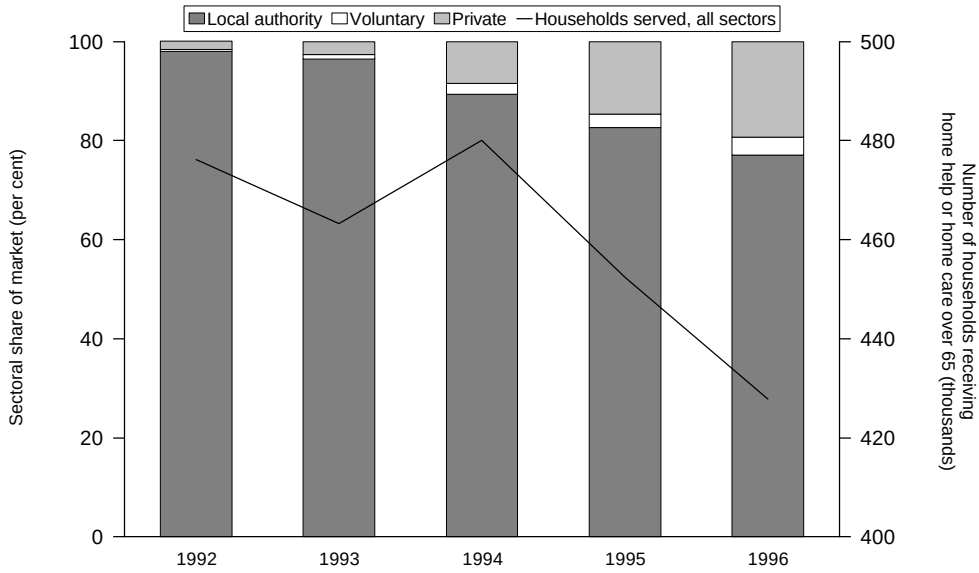
Fig. 2: Local authority funded residential care for elderly people, 1992-1996: supported resident numbers

[9] That is, unlike figure 1, it focuses on elderly people *only*, funded by local authority payments *only*, over the period 1992-1996.



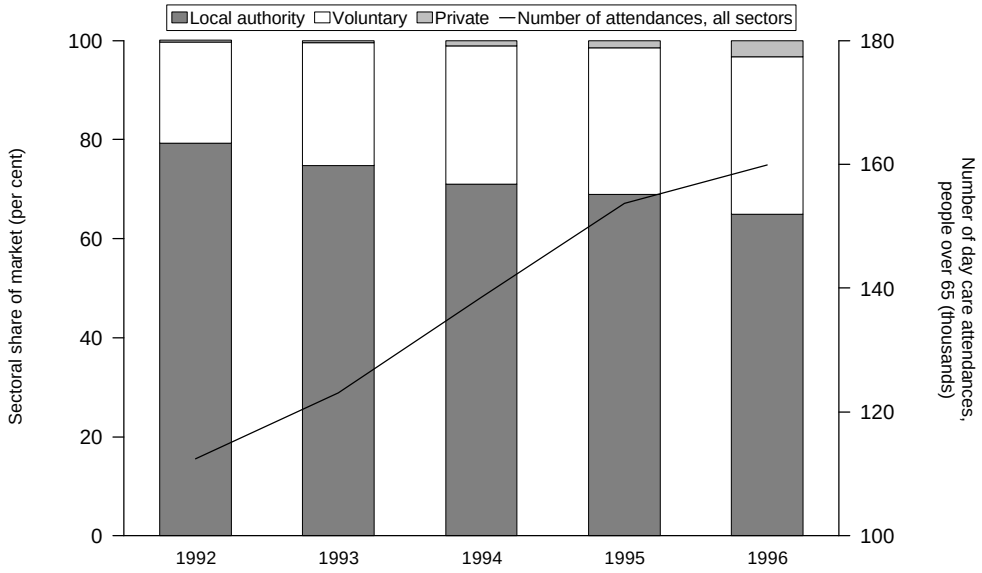
Source: Adapted from data in DH StatisticalBulletins and Department of Health (1997).
Note: Separate figures for elderly people are not available for 1992 and 1993, as in these years published figures for local authority elderly people and adults with physical disabilities are conflated.The figures for elderly people only for 1992 and 1993 have therefore been estimated by subtracting from the conflated totals estimates foradults with physical disabilities (calculated by projecting backwardssectoral trends for later years for this client group).

Fig. 3: Local authority funded domiciliary care for elderly people, 1992-1996: households served



Source: Data from DH Statistical Bulletin 1997/8.

Fig. 4: Local authority funded day care for elderly people, 1992-1996: average number of attendances



Source: Data from DH Statistical Bulletins 1994/5 and 1997/8.

In the remainder of section 2, we review the most important sources of empirical evidence on the *relative* contribution of third sector providers in each form of care. This body of evidence, in combination with the aforementioned stylised facts, will form the basis for three theoretical propositions set out in section 3.

2.3 Shared features of the third sector's relative contributions across different forms of social care

There are perhaps three major generalisations that can be made which hold across different forms of care about sectoral difference. First, on average voluntary sector providers have been operating much longer than other providers. This reflects the historical rootedness of many voluntary establishments and organisations as described in the opening section. This strong voluntary sector track record, together with the extent to which it operates under a non-distribution constraint and a number of other factors to which we return below, have traditionally fuelled a belief amongst local authority purchasers that providers in the voluntary sector are in general more trustworthy than private organisations. This has mattered because purchasers have sought to secure "high quality" services as a key objective. Because this attribute defies "definition, measurement and monitoring", decision makers "have to rely on informal information, status, trust and reputation as a basis for assessing it" (Mannion and Smith, 1998). However, this sectoral trust

differential now seems to be eroding, or at least can no longer be taken for granted – a theme developed in section 3 below.

Second, the average dependency of elderly people is typically relatively low in the third sector. There have been significantly lower levels of resident dependency in voluntary than private residential homes for some time (Townsend, 1962), although since the early 1990s these levels have more or less converged (Darton, 1998; Netten et al, 1999). However, this latter trend seems to be driven significantly by the inclusion of "not-for-profit trusts", whose inclusion in the third sector is problematic (see box 1, and section 3 below). In domiciliary and day care, the less extensive evidence that does exist (our own unpublished research, and Knapp and Missiakoulis, 1982, respectively) suggests that average dependency is also lower in the third sector in those cases.

Finally, recent sectoral analysis of data collected in the most important and extensive labour force survey in the UK suggests that average wages for paid staff, and the likelihood of avoiding low paid vary by sector. Wages are significantly higher in the third sector than the private sector – although this data covers all social services, and is not limited to older people, so is not strictly comparable with other findings reported here (see Almond and Kendall, 2000a, 2000b).

2.4 Variations in the nature of the third sector's contributions in different forms of care

There are three key ways in which the third sector's contribution has been shown to differ from that of other sectors, varying with the type of care. First, third sector care agencies provide a qualitatively different service, but the way in which this difference is apparent varies according to the type of care. For example, in residential care, evidence from the 1980s shows that there were greater opportunities for recreation, leisure and visiting in voluntary homes than in private homes after controlling for the differences in dependency referred to above (Kavanagh and Knapp, 1997). There are also differences between the private and third sector in admissions policy and client selection: Third sector homes are significantly more likely to restrict admissions to clients from particular professional, ethnic or religious backgrounds, leading to a different environment or ethos for elderly people in those homes (Wistow et al, 1995).

Outside residential care, in contrast, in the case of (local authority funded) domiciliary care, voluntary providers appear to be considerably *less* likely to offer diverse services, most noticeably day sitting, night sitting, night sleeping and live-in services, than their counterparts in the private sector (Nuffield Institute for Health and PSSRU and LSE, 1997). Similarly, in day care, Carter's (1981) study found that the

voluntary sector was providing more limited physical treatment for users, this time in comparison to public sector provision (cited in Knapp and Missiakoulis, 1982, p. 342).

Second, there is a major difference in the use of unpaid labour: as already noted, volunteering is not evenly distributed across the different forms of care. Case study and anecdotal evidence suggest that volunteer supply is heavily concentrated in day care, in large part because this is the context in which volunteers can mutually network and interact (Gaskin et al, 1993; Ware, 1997).[10]

A third major difference is that the third sector's relative cost, and the causes thereof, vary according to the form of care, as well as its scale. Most recently, PSSRU research has demonstrated that in residential care, other things being equal (most importantly having controlled for differences in user dependency), residential care prices are lower in the third sector than in the private sector (Forder and Netten, 1999). Why is this the case? Third sector homes receive relatively little input from volunteers in residential care: in both voluntary and private sectors, paid staff are the dominant human resource. Private giving, the most obvious source of financial subsidy, appears to be a relatively unimportant source of income for them (Kendall, 1996b). Adding to the puzzle is the observation that rates of pay, in what is a labour-intensive field of activity, tend to be *higher* in the third sector than the private sector.

Price differences instead seem to reflect other factors. On average, current profit or surplus margins are lower in the third sector. This in part seems to reflect a tendency for operators in this sector to place relatively less weight on financial goals than private sector providers, either because they are receiving other compensatory benefits, or because a sense of duty, commitment or sacrifice is coming into play (Wistow et al, 1996, chapter 7). However, this effect should not be overstated: evidence on motivations, at least at the management level, suggest remarkably little difference in the priorities between the private and third sectors.

More important seems to be the different abilities providers have in each sector to sustain their operations in spite of low (and often negative) current surpluses or mark-ups because of their historically inherited structures and resources, as already distilled in the typology in section 2.1. The implications at the third sector wide level (i.e. aggregating the situations of the range of provider types set out in box 1) are set out in box 2. Their structural inheritance presents them with more extensive *opportunities* than private providers to keep prices relatively low. A further, final factor to emerge from the evidence is the third

[10] The importance of social interaction as a motive to volunteer is not confined to older people. A recent reanalysis of a major survey of volunteering in the UK concluded that "the social adjustment motivations (the social aims of volunteering such as the desire to meet people and male friends) are more important

sector's greater tendency to mobilise externally provided care for its residents, so that costs are not borne directly, and therefore do not have to be factored into pricing. If the costs are born by the same *organisation*, which runs both the care home *and* provides or pays for the external care but does not pass the cost onto purchasers, then we have the cross subsidisation referred to in box 2; otherwise we have "cost shunting" or at least cost avoidance.

Box 2: Structural reasons why the third sector may be positioned to charge lower prices in residential care

- Access to income earned from endowments or surpluses accumulated over time. The fact that these funds tend to be more widely available in the third sector (and particularly generalists) ultimately reflects their relatively longer track record in combination with the legal constraint that surpluses generated have to be retained for internal organisational purposes.
- Exploitation of the greater potential for cross-activity (and in the case of generalists, cross client group) cross subsidy available to third sector organisations, and the achievement of economies of scope (Chandler, 1994). These factors are corollaries of their tendency to be multiple-field (and/or multiple client group) operators.
- The achievement of within-field economies of scale following from their tendency to be larger organisations.

Outside residential care the evidence base is more limited. But in the case of day care, a thorough evaluation of the third sector's relative cost effectiveness have been made, albeit in comparison with the public sector only (Knapp and Missiakoulis, 1982). This study found that, after controlling for all relevant cost related factors, voluntary sector day care providers were more cost effective than their public sector counterparts, but that this effect was conditional on the relatively small size of the former's facilities. The cost functions suggested that voluntary sector facilities would quickly lose this advantage if run at high attendance levels, and the authors attributed the relative efficiency of small scale voluntary sector provision to their comparative advantage in access to regular volunteers. This, it is argued, occurs both because their relative lack of formality and proportionately lower burden of management and care makes them relatively attractive environments in which to volunteer, and also because of limits to volunteer availability.

Finally, a rather different picture again emerges if attention is focussed on (local authority funded) domiciliary care. In this case, we find that, ceteris paribus, third sector providers' charges are significantly *higher* than those in the private sector (see Nuffield Institute for Health and PSSRU at LSE, 1997). Building on the foregoing discussion, we can speculate that in this case any advantages in terms of net benefits from volunteer contributions and managers' pro-social motivations (on which sector specific analysis has yet to be done) are outweighed by other effects. In particular, the factors listed in box 2, which seem to drive the third sector's low pricing in residential care may be absent, or working in the opposite direction in the case of domiciliary care. Why may this be the case? Most importantly, the extent to which the different provider types set out in box 1 are represented seems to differ[11] as far as local authority funded

than other motivations (such as altruism or skills acquisition) in determining the regularity of commitment to volunteer" (Knapp et al, 1995, pp. 29-30).

[11] "*Seems* to differ", because national data does not distinguish between types of providers within the third sector. This assertion is based loosely on impressions gained from a comparison of the types of organisations involved in residential and domiciliary care funded by local authorities.

home care is concerned. As a proportion of all activities, "national specialist" affiliated organisations appear to be relatively more active, and other types, including what we have referred to as generalists and social entrepreneurs, relatively less prevalent.[12] If the ability to access funding from endowments and surpluses accumulated over time, and to cross subsidise from other sources of funds (including adjacent public budgets) and activities is an important driver of low prices in residential care, then their absence will help to explain the relatively high prices in the case of home care. A relatively high proportion of providers in home care, especially national specialists, seem not to be positioned to take advantage of cross subsidy, economies of scope and scale, or reserves accumulated over time. Second, it is possible, of course, that those generalist and social entrepreneur type organisations which *are* so advantaged and *are* involved in home care services are simply choosing not to use their resources to subsidise the prices charged to local authorities. Indeed, it is conceivable that they may actually be offsetting operating deficits in other forms of care with operating surpluses generated in domiciliary care, although there is no evidence to substantiate this.

However, it should also be recognised that there are conceptual problems with price comparisons in domiciliary care. It is difficult to measure a shadow "price" paid by purchasers for services, when some of domiciliary services are provided under grant arrangements; and partly because third sector services often appear to be very different from their private sector counterparts. It may therefore be more appropriate to regard much third sector provision as not just providing a qualitatively different service, but as operating in a completely separate market (Forder et al, 1998). A good example is those third sector organisations which primarily provide support for carers for older people, which have no real equivalent in the public or private sectors, and account for a significant proportion of local authority funded third sector activities.

3 Analysis

Primarily since the early 1980s, a number of general theoretical perspectives have been developed to explain the relative scope of the third sector (Kendall and Knapp, 1996, pp. 11-15; see also articles in *VOLUNTAS*, 9, 3). The conventional, falsificationist way to analyse the size and character of the third sector in care for older people would be to directly test these hypotheses against empirical data which had been collected for that purpose. Unfortunately, this is not possible on the basis of available evidence, including that reviewed in the previous section.

[12] This is not to say that providers other than national specialists are not active at all in local authority funded domiciliary care. They are. Rather, the point is that they seem to be *relatively* less active than in residential care. Moreover, to repeat a point made earlier, they often provide services to people at home without financial support for this purpose from local authorities: in sections 2.2 and 3, we are only focusing on local authority funded care.

However, it is legitimate to contribute to theory *building* by suggesting propositions which seem to follow from the logic and evidence thus far – even if we are not positioned to test hypotheses directly. We can start by making the assumption that the balance between the sectors that we observed in figures 1-4 can be understood, to a significant extent, as the outcome not predominantly of tradition, habit, ritual or dogma, but of reflexive and reflective, cost-conscious choice.[13] It is then analytically useful to think of two steps to decision making. First, the balance between the public sector and all other provision is established. Second, how the funds available for external contracting are to be allocated between the third sector and the private sector is considered, taking into account the significant variation in relative contribution according to the type of care in question.

3.1 Choosing between the public sector and external provision

The major shift away from public provided to contracted out provision shown in figures one to four can be understood at three levels. First, it was simply the necessary response of purchasers wishing to preserve their budgets, and hence the services for which they were responsible, in the face of the new legal and policy environment created and imposed by central government. Not to have channelled funds to external services in line with the requirements of the latter would have involved incurring major financial penalties, and involved a failure to maximise available resources because of the conditions described in section 1.5 above. Second, at a less immediate level, this begs the questions of *why* central government, for its part, brought about this new legal and policy context. The answer is also to be found above, where it was argued that this move was made in response to a number of developments, both in research and in the political stream.

A third factor to be taken into account has been more internal: attitudinal change at the local authority level. First, these have become aware of the research evidence on the extent of the inadequacies of public sector dominated *status quo ante* referred to above, and many have both contributed to and responded to the changing political climate itself. Second, the impact of learning-by-doing at the local authority level should not be overlooked. Purchasers have re-evaluated contracting out in the light of experience, and significant numbers who were initially hostile to it in principle, and adopted it initially only with great resignation, have increasingly accepted its utility as a pragmatic tool. As we have reported in unpublished research elsewhere, based on an extensive programme of interviews of time with a representative sample of purchasers, there has been a steady increase in the proportion of local authorities holding the view that the process is "neither inherently inappropriate nor disadvantageous in the planning and delivery of social care". By 1996 the "absolute horror" of enabling and developing a mixed economy uncovered in a

[13] The assumption that local level decision making is increasingly informed and reflective rather than dogmatic or habitual, seems to be have become *increasingly* appropriate during the 1990s: see the remarks on shifting local authority attitudes below, and also see Kendall and Knapp (2000).

significant number of cases had virtually disappeared. Rationales for continuing to retain any public sector services at all included these services' role as contingency in the case of independent provider business failures; a wish to avoid destabilising local markets; an exemplar of good practice; and to preserve sectoral choice, partly in response to lobbying by older people and their relatives (Wistow et al, 1996, p. 24).

3.2 Choosing between the private sector and the third sector

Three propositions try to capture why the balance between these sectors varies with the type of care in question.

> ***Proposition 1: Different regulatory regimes, reflecting both differences in historical legacies of sectoral development and differences in the technical character of services, are important determinants of the relative strength of demand for third sector as opposed to private sector care.***

Over the period 1992 to 1996, local authorities seeking to fund external services were operating in very different regulatory contexts in each of the three forms of care. This matters as far as explaining the third sector's relative contribution is concerned because it suggests that the breadth of choice in institutional options for responding to informational difficulties varies systematically by service area. Based on the premise that purchasers see trustworthiness as a necessary characteristic of providers of care (cf section 1), it follows that it is important to know what range of mechanisms or institutions are available for securing it, or at least safeguarding against its abuse.

In residential care, the menu has been most extensive, with two options not available in other forms of care. Most obviously, only residential care is subject to national regulation. These regulations, enforced through regular visits to homes, are primarily concerned with measures of home structure and input rather than the final welfare outcomes with which purchasers are ultimately concerned. They therefore provide some guarantee of minimum standards not systematically available in other forms of care, and frustrate very crude attempts to cut corners on easy-to-measure aspects of quality of care. However, in their current form they hardly constitute a mechanism for cultivating trust, but rather offer a way of substituting for it.

The second option significantly available only in residential care reflects its particular history: in section 1.4, we noted how many providers were established in the 1980s, and by the 1990s had had an opportunity to establish reputations for themselves as trustworthy. Local authorities who had traditionally or dogmatically associated the private sector with opportunism, in this case, now had track records to draw upon to justify or refute their beliefs. In fact, part of what happened in the early 1990s can be read precisely as a revision of these very perspectives. It is true that local authorities had little choice but to contract with the private sector in the context of financial pressures to switch from public sector provision (see above) and highly restricted third sector supply (see below). But it does appear that an increasing awareness of

many private sector providers' good reputations, in turn predicated on their professional backgrounds and record in caring for people in their homes, has seen a systematic transformation of purchaser attitudes.

Reputation clearly has the *potential* to come into play in domiciliary and day care by a similar process, as markets develop, but it would be too early to claim this was relevant during 1992-1996 when markets outside residential care were widely thought of as being "immature". However, there are also important differences stemming from the nature of the care processes themselves which seem to be relevant. Domiciliary care appears to be relatively amenable to contractual control in the sense that discrete payments can, if desired, be linked fairly easily to discrete, time limited episodes of clearly delimited care tasks with individual clients. In contrast, because it involves much more unpredictability in demand and involves more fluid and amorphous interactions, day care is much harder to parcel and demarcate. As a result, financial support is much more likely to come in the form of grants or block contracts, rather than on a fee per client basis. There is therefore more scope for opportunism because it is comparatively difficult to gauge what has been achieved. In other words, it would be relatively easy for providers to underperform without this coming to the attention of a public purchaser.

A final way in which the regulatory repertoire varies according to the form of care is through the possibilities for stakeholder involvement that they present. One of the ways in which purchasers can seek to increase the likelihood that services are delivered on a trustworthy basis is to allow them to be controlled directly by their beneficiaries, who, because they have a direct interest, have every reason to safeguard quality. However, the feasibility of this option varies, as elaborated under proposition 2 below, because the scope for the involvement of elderly-volunteer-beneficiaries varies with the type of care, with extensive participation really only feasible in day care. Moreover, in day care, it could also be comparatively easy to monitor volunteers' activities, because they are undertaken in the same time at the same place.

Table 2: Comparing regulatory regimes and technical features by type of care

	Residential care	**Domicilary care**	**Day care**
INHERITED REGIME FEATURES			
National regulation present	✓	×	×
Private sector market mature, and hence scope for private reputation effects to erode traditional suspicion	✓	×	×
TECHNICAL LIMITS			
Spot contracting perceived to be feasible?	✓	✓	×
Limited scope for extensive stakeholder control?	✓	×*	××

*Primarily paid stakeholders in carers' organisations submarket only.

Table 2 summarises the discussion of proposition one: the logic of the argument is that the more factors present (registered by a tick), the wider the regulatory repertoire, the greater the possibilities for private

sector providers to penetrate the market, and therefore the less robust the third sector claim to an a priori trust advantage.

Proposition 2: Different patterns of volunteer involvement are important determinants of the relative strength of supply of third sector care.

Four inter-related findings from the empirical literature seem particularly relevant in understanding volunteer decision making in this field:

- The most important motive for regular and committed volunteering is "social adjustment" or networking motives – the desire to meet people and make friends – rather than altruism or skills acquisition (these are not irrelevant, but simply not dominant);
- Volunteers typically prefer to work in support of less dependent people;
- Volunteers usually prefer to work in environments in which the scope for social interaction is greatest; and
- Many, or even most, volunteers are themselves older people.

Given the evidence reviewed in section 2.2, the first three factors help to explain the observed concentration of the supply of volunteers in day care, its limited contribution in domiciliary care, and its minor role in residential care. However, willingness to supply is not sufficient to determine the actual scope of formal volunteering (volunteering through agencies): this also depends upon organisations' demand for volunteers, and public purchasers' perceptions as to their appropriateness. How does this vary between forms of care? This seems to mirror the supply side pattern: to the extent that these forms of care are professionalised to different degrees, we can expect different perceptions from the demand side regarding the extent to which volunteer involvement is regarded as appropriate or feasible. Residential care is the most professionalised form of care: the view that trained specialist staff are required in this situation has increasingly been spelt out in national regulations following the 1984 Registered Homes Act. While it is possible that trained volunteers could meet the necessary conditions, there is an implicit assumption that to guarantee "professional standards", care staff should be both trained *and* paid.[14]

In contrast, in community care, as noted in section 1, since the 1960s volunteering has not only been tolerated but strongly encouraged. Moreover, it seems possible to argue that this has been particularly the case in day care, where large numbers of local authorities fund centres staffed and run by older people themselves on behalf of their peers (point four above) are commonplace. In comparison, public purchasers seem to exhibit an ambivalent attitude towards volunteer involvement in domiciliary care: the increasingly

[14] A recent review of the regulations that apply to residential and nursing care stated that "volunteers must never be used as substitutes for staff who are part of the home's paid employed staff establishment" (Department of Health, 1999, p. 43).

dominant view is that reliance on volunteers is now an inappropriate way to provide services to people in their own homes.[15]

Table 3 brings together the arguments concerning how the availability of volunteers and regime attributes are linked to different forms of care. Ceteris paribus, we would expect that as we move from the north west to the south east corner of the schema, we observe conditions increasingly favourable to a large third sector presence. Or equivalently, as we move in the opposite direction, the possibilities for involving private sector operators broaden.

Table 3: Variation in breadth of regulatory repertoire and volunteer participation by type of care

Breadth of Regulatory repertoire	**Volunteer Participation: net outcome of demand and supply effects**		
	Very limited	**Some**	**Extensive**
High	Residential care		
Medium		Domicilary care	
Low			Day care

However, this picture does not adequately account for the empirical picture we sketched out in section 2. In particular, we observe that the third sector's contribution to publicly funded domiciliary care is less significant than its contribution to residential care. A final proposition, which necessitates that we take into account variation in the internal composition of the third sector by field, and are explicit about price and cost factors stemming from structural differences (cf Box 2), is necessary to explain this situation:

Proposition 3: The internal composition of the third sector differs between the different forms of publicly funded care, and this has important implications for the relative size of the third sector in each form of care. This happens in two distinctive ways.

3a Assume observed publicly funded external supply reflects public purchasing decisions which are to a significant degree responsive to the price or fee charged by suppliers. The third sector's willingness and ability to supply care at a sustainable price depends not just on volunteer contributions and providers' motivations, but on a range of structural resource factors. These structural resource factors differ systematically within the third sector between types of providers. Because the internal balance between different types of providers within the third sector also varies according to the (publicly funded) type of care, the third sector's overall supply of care at a sustainable price also varies according to the type of care.

The proposition stated above is deliberately formulated in very general terms, as the aim is to state a hypothesis which is as theoretically as widely drawn as possible. In the context of the particular features of

[15] Based upon a combination of telephone interviews with 19 local authorities and in depth field work with 6 others, Ware reports that "Many local authorities saw little opportunity for volunteering in the mainstream of service provision for home support and suggested that the development of NVQ [National Vocational Qualification] requirements together with Health and Safety policies meant that volunteers were inappopriate… however, there are a number of home support schemes in the case study authorities where volunteers were a key feature. There were also voluntary organisations with volunteer management operating under contractual funding" (Ware, 1997, p. 219).

social care in England, it is being suggested both that cost is a relevant factor; and that the composition of the third sector in residential care means that it is better positioned on average to sustain relatively low prices here than in the domiciliary care case. This builds jointly on the evidence concerning costs and pricing that we have reviewed, and the observation that it *seems* to be the case[16] that the balance as between providers differs significantly between residential care and domiciliary care funded by local authorities. Providers who are better positioned to take advantage of historically accumulated surpluses and endowments benefit from buoyant adjacent budgets, reap economies of scale and scope, and tend to be *relatively* more active in residential care than in domiciliary care.

3b Public purchasers have also actively created hybrid or quasi-third sector supply as an additional type of provider. The financial incentives to do this have varied significantly between different types of care, and public purchasers have responded accordingly.

Finally, the extent to which the third sector is relatively larger in residential care than propositions 1 and 2 would lead us to anticipate also seems to reflect the disproportionate creation of not-for-profit trusts for delivering that type of care. The care provided by these organisations is *included* as part of the third sector in figures 1 and 2. If these hybrids were treated as part of the public sector, as many would argue would be appropriate because they lack autonomy from public authorities and voluntarism in financial or human resource terms, then the apparent size of the third sector would fall significantly. Indeed, it seems likely that most or all of its apparent growth between 1992 and 1996 would evaporate.

If we *do* wish to treat these entities as part of the third sector (and we are in a sense forced to, because the data cannot be disaggregated), their disproportionate creation in residential care can ultimately be understood as a response to economic cost pressures strongly felt there but largely irrelevant to other forms of care. First, creating "arm's length trusts" allowed public purchasers to evade Treasury [central government] spending limits and secure new capital, an imperative predominantly relevant to physical capital-intensive residential care.

Second, by reconstituting their own homes in this way, public purchasers could qualify the residents of that home for demand side subsidies (from the social security budget) for which they would otherwise not have been eligible. The quasi-third sector legal form, rather than for-profit status, was attractive because it allowed purchasers to retain some measure of control over the running of the home, and avoid what were thought to be undesirable European regulations assumed (wrongly, as it ultimately transpired) not to apply to this type of legal structure on the grounds that they were not "commercial" undertakings (Wistow et al, 1994; Laing and Buisson, 1996, p. A208).

[16] See footnote 11 *supra*

4 Conclusion

This chapter has described the historical and recent evolution of the third sector in the delivery of care services for elderly people, and built upon this to tease out what makes these services different from the care provided by the private and public sectors.

While quantitatively small, the third sector is clearly of considerable importance in the mixed economy of welfare in a qualitative sense, with its involvement bringing advantages and disadvantages to the system in which it operates. On the positive side, it has traditionally been seen (justifiably or not) as relatively trustworthy by local public purchasers; its existence has clearly expanded choice at least for those elderly people who meet its varied admissions criteria, offering an alternative peer group mix and ethos; it has apparently charged relatively low prices in some contexts, and enabled some cost savings to be achieved by public purchasers. It has also provided institutional expression for a range of motivations and behaviours for both managers and volunteers.

More negatively and in many ways the other side of the same coin, at least some voluntary provision appears to be socially exclusive, relatively costly in some contexts beyond certain bounds of scale, and perhaps in some cases only in a position to achieve any apparent cost advantages through "cost shunting" to other providers.

In section 3, an attempt was made to build upon a rather disparate body of evidence to suggest some of the factors which may help to explain why we see such a marked difference in the scale of the third sector's involvement in different types of care. It was suggested that three aspects seem to be particularly important in seeking to understand these differences: variation in the regulatory regime; the contribution of volunteers; and differences in the internal composition of the third sector, particularly as between publicly funded residential care and care for people at home.

Because of the nature of the evidence base, this paper necessarily focused primarily on developing a comparative analysis *within* England between different forms of care, but we finish with some more outward looking comments. The patchy evidence that is available suggests that the English voluntary sector probably plays a relatively minor role in *quantitative* terms in the delivery of social care services for elderly people in comparison with other parts of Europe and many other Northern developed countries.

We can speculate that this has much to do with the pro-market conditions that prevailed in recent years, including the New Right ideological climate and the concomitant lack of institutional barriers to profit making in the care field. As we have seen, in the English case, this was, first almost accidentally and then

purposefully driven by central government policy, in a country where the latter exploited its centralised power to set the agenda.

This contrasts sharply with the value-driven hostility to combining private financial gain and social services that prevails in many other countries, and which is given most obvious expression politically in central European social democratic and labour movement thinking (for example, see Badelt, 1997). Moreover, even if a more sympathetic view towards the for-profit sector is promoted by governing political parties, it is unclear that other countries would have been able to affect such rapid policy change in the absence of a relatively highly centralised command and control structure equivalent to that which is at the disposal of British central government (Kendall and Knapp, 1996; see Klein, 1997 for a statement of this argument as applied to UK health care reform from a comparative perspective).

The election of Tony Blair's New Labour administration in 1997 – the first time a government not pursuing New Right priorities has been in power since Mrs Thatcher assumed the premiership in 1979 – has yet to make its mark on social care systems, and the place of the third sector within them. While putatively adapting a more European policy style – most obviously, by reversing the UK opt-out from the 1989 Social Policy Agreement governing workers' conditions, social partnership, and putting social exclusion onto the agenda – the impression to date as far as policy orientation towards independent sector providers has generally been one of broad continuity rather than change. This has been confirmed in a recent White Paper, whose most significant departure from the *status quo ante* for our purposes is probably the suggestion that the time has come for more extensive regulation of residential care (Department of Health, 1999), and the introduction of regulations for domiciliary care at a national level. By the logic of the argument presented in section 3, this could ultimately make conditions more amenable to private sector operations. However, in the short-term in the residential care case, it seems set to disproportionately impact upon private sector supply. Many small businesses seem set to be poorly positioned to handle the costs of compliance associated with physical infrastructure requirements (Department of Health, 1999, Part III; Netten et al, 1999).

The view that social care is inherently incompatible with private financial gain, while still current amongst some elements of the British left and the trade union movement, has made way at the level of central government and most of local government for the argument that what matters in a very tight fiscal environment[17] is "best value" – regardless of private, third or public sector delivery. Under this view there is scope for further regulation of social care to protect vulnerable users from exploitation, but little or no hostility to the profit motive *per se*.

[17] The New Labour government has kept within the public spending limits of the previous Conservative administration.

One sense in which the government *has* moved in a more European direction has been in its acceptance of a minimum wage as a legitimate means of tackling the "social exclusion" of low paid people.[18] As noted in the review in section 2, fewer third sector organisations have paid their employees low wages, so this policy's implementation in April has more limited implications for these agencies than for their private sector counterparts. In this sense at least, the third sector has had less to worry about than the private sector in social care.

[18] Social exclusion is a (deliberately) elastic and ambiguous concept (see Atkinson and Hills, 1998), but important aspects of most accounts are labour market issues. Many would agree that not only unemployed people, but those in the labour market but on very low rates of pay – particularly if their jobs are insecure – are also in some sense "socially excluded".

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