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Emerging Quasi-market of Home Care for Older People in Urban China: A Case Study in Shanghai

RESEARCH

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ABSTRACT

Context: China's reforms of long-term care stem from significant demographic and socio-economic changes since the 1980s. The growing involvement of the market in care provision for older people is a notable trend in its urban areas.

Objective: This study investigates how the marketisation process is shaping home care policy and practice in urban China.

Methods: Qualitative case study research was conducted in Shanghai. The data source includes interviews with 21 care provider representatives and 9 local government officials and follow-up consultations with 4 interviewees. Interview data were analysed thematically.

Findings: This article outlines three quasi-market models and power dynamics in Shanghai's home care sector, reflecting marketisation strategies and state-market relationships: the state-controlled model, the limited competition model, and the free market model. In Shanghai's home care market, heightened competition does not necessarily correlate with improved care quality, echoing international concerns such as disparities in access, care quality, and market concentration. These challenges extend beyond 'market failures' and increased risks to older people but also contradict the rhetoric of markets as being more responsive to consumers.

Limitations: The study only included Shanghai as the research site. It is an exploratory study that requires additional statistical data for future research.

Implications: This study underscores the influence of long-term care policy and local government characteristics on purchaser–provider relationships in commissioning and public procurement. The findings suggest that robust regulation and monitoring within the care market is crucial for mitigating associated risks and prioritising care quality during the development of the care market.

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INTRODUCTION

The concept of 'quasi-market' originated in the UK when the government started to introduce market-oriented reforms to the welfare state in the late 1980s. It referred to a market where competitive independent agencies replace monopolistic state providers (Le Grand, 1991; Le Grand & Bartlett, 1993). Hardy and Wistow (1998) explored the initial quasi-markets of domiciliary care in England, while Nyssens (2010) identified the prevalence of quasi-markets that have introduced market principles into public policies across Europe since the 1980s. Bode et al. (2011) have argued that quasi-markets involve a separation between the funder (the state) and the provider (various entities), with the aim of improving efficiency in home care provision.

The characteristics of quasi-markets observed in European welfare states over the past five decades are also emerging in the field of care for older people in China (Zhang, 2022). Since 2000, there has been a significant increase in the involvement of non-state care agencies, both private and not-for-profit, with many previously state-owned agencies being contracted out to for-profit and not-for-profit organisations (Qu et al., 2023). The role of the Chinese government in the field of care for older people has changed from a direct provider to a combination of funder, purchaser, and regulator. The current care market in urban China is a quasi-market rather than a conventional market. Following the Chinese central government's call for home care development (General Office of the State Council of China, 2006) and subsequent policies, local authorities started introducing regional policies to attract private capital for establishing social care organisations.

The Chinese government has implemented a range of strategies to bolster social service agencies operating in the care market. The Division of Social Security of the Ministry of Finance of China (DSS MFC, 2011) categorised the public procurement of social services into three ways: public financial support directed towards 'social service agencies' (*Mingban Gongzhu*), state-owned institutions with privately operated agencies (*Gongban Mingying*), and competitive procurement by the state within the market. Table 1 provides a summary of the diverse types of home care organisations, encompassing different commissioning methods, levels of state financial support, and relationships with the state.

With regard to the three key processes of the marketisation of care identified – contracting out care services, government financial support prompting older people and their families to purchase care services or employ care workers (e.g., 'cash for care' schemes in many European states (Woolham et al., 2017), or long-term care insurance in Japan and Germany (Bode et al., 2011)), and direct private funding by older people and their families (Shutes & Chiatti, 2012) – this paper focuses on the first two processes for quasi-market discussions and does not delve into the direct market activities of consumers (i.e., older people and their families).

The Chinese government employs two main marketisation strategies, as outlined in Table 1: contracting out care schemes to the market and allocating financial resources to social service agencies (DSS MFC, 2011). Firstly, the state engages in the practice of contracting out care schemes to the market, encompassing two distinct approaches. In the former, local authorities sell existing public institutions to the private sector, and the private providers acquire ownership and operational control of the institution. Conversely, the latter approach entails contracting out the daily operation and management of services, with the state or the community retaining ownership. Secondly, the government extends financial support to care providers, which includes both independent agencies and public–private joint ownership

MARKETISATION THEMES	POLICY STRATEGIES	AGENCY OWNERSHIP	FUNDING SOURCE
1. Contracting out and commissioning care services	1a. Care services project commissioning	Private – Institution established with private funding or sold to the private provider	Public procurement of care services.
	1b. Contracting out the operation and management of existing public care organisations	State/public	Public procurement of care services
2. Financial support to social service agencies	2a. Joint venture	Public and Private joint ownership	• Public funding for the public section within care agencies; • Private funding for the private section; • Government subsidies for the private section.
	2b. Joint investments for the establishment and operation of agencies	Public and Private Joint ownership	• The state provides assets and in some cases, partial funding; • Private funding.
	2c. Private investments with public support	Private	• Private funding; • Government subsidies.

Table 1 The marketisation strategies and categories of home care providers.

agencies, through a range of subsidies. These subsidies are often contingent on factors such as the number of beds or the frequency of service delivery provided by care providers, both public and private, and vary significantly by region (Hu et al., 2020). Additionally, financial support mechanisms encompass reductions in utility expenses (e.g., water and electricity) and tax reductions (Shanghai Municipal Government, 2016).

In this context, despite the absence of national statistics, it is widely recognised that the state plays a significant role as a key funding provider for various categories of home care agencies operating throughout China (Yang et al., 2016). Leveraging its capacity for mass purchases of care services using public funding, the government ensures its continued status as a pivotal source of financial backing for the diverse array of care agencies functioning within the home care sector.

Alongside their support for care providers, local authorities in urban China also provide financial support to older people, facilitating their access to home care services. This financial aid comes in both cash and non-cash forms (Feng et al., 2020). While many local authorities only offered non-cash support, some, such as Shanghai, also applied in-cash benefits for older people (Lei et al., 2022). Non-cash support is commonly provided through care service vouchers (Hu et al., 2020), often distributed based on the number of hours of home care based on needs assessments of older people. For instance, in Shanghai, a prevalent form of non-cash support involves the allocation of care service vouchers, which may also take the form of direct assignment of care workers without the necessity of physical vouchers (Zhang, 2018).

Despite the introduction and expansion of supportive policies aimed at older residents in urban China, the current state-funded home care coverage and allocated service hours (e.g., 20 or 25 hours per month, which is less than 1.5 h every other day for those with high-level needs) remain insufficient, with notable regional disparities in the eligibility criteria and the level of financial support provided by local authorities. The group of older people eligible for local authority-funded home care services represents only a small fraction of the overall population in need of external financial support to access such care – specifically, only 10% of the participants in Hu et al. (2020)'s multi-city study, which included a sample of 3247 older people.

DSS MFC (2011) acknowledges that the development level of the market and the regulatory approaches adopted by local governments contribute to the emergence of diverse and complex relationship models within the realm of public procurement for social services. Establishing regulatory frameworks is important in response to marketisation, to ensure healthy competition, empower consumer choice, and safeguard the rights of involved stakeholders, including service users and care workers (Pavolini & Vanci, 2008). In the development of the home care market in China, central and local governments gradually take on responsibilities for setting standards, regulations, and monitoring behaviours in the market. For instance, Ningbo's municipal government implemented local regulations in 2008 to standardise basic requirements for various home care services, while the Xuanwu District of Nanjing established an independent home care assessment centre in the same year. Despite these efforts, there is a lack of formal regulations and practical rules for social care in China (Zhang, 2022).

Given the experimental nature of marketisation policies in China and the accountabilities of making and implementing local care policies and schemes by local authorities, there are significant differences between regions and areas, evident in residential care (Jia et al., 2018) as well as community-based and home care (Zhang, 2022). However, there is a lack of evidence regarding the relationship between the state and the market at the local level, as well as the rationale and outcomes of different marketisation strategies across regions. This study aimed to address this gap by investigating how the marketisation process is shaping home care policy and practice in urban China, using Shanghai as a case study. The objectives were to explore the experiences and viewpoints of care providers and local government officials on the state-market power dynamic, the reasons for adopting different contracting out and marketisation strategies, and the different models of marketisation in Shanghai.

METHODS

This study applied a qualitative case study approach to explore the different care market models implemented by district local authorities in Shanghai, a rapidly ageing city in China. As of 2023, Shanghai has an older population of 4,244,000 people aged 65 or over, accounting for 28.2% of its population (Shanghai Civil Affairs Bureau, 2023). The case study approach enables a comprehensive understanding from multiple perspectives with contextualised information (Lewis & Nicholls, 2014; Lune & Berg, 2017). Shanghai's prominent position at the forefront of Chinese modernisation and economic development, driven by marketisation reforms and the opening up policies over recent decades (Wang et al., 2017; White III, 2015, Wong et al., 2016), makes it an ideal subject for this topic.

During the fieldwork from February to May 2016, semi-structured qualitative interviews were conducted with a total of 30 participants who have first-hand knowledge of the home care market in Shanghai with an interpretative approach based on the exploratory research question. The participants consisted of care provider representatives

(*n* = 21) and local government officials (*n* = 9). The care provider representatives held various roles, including agency owners or senior managers (*n* = 9), marketing managers (*n* = 3), care managers in charge of arranging care schedules and managing frontline care workers (*n* = 7), and care managers who also worked as frontline care workers while holding managerial roles (*n* = 2). Nine government representatives were recruited from four sub-districts in Shanghai, specifically two in Pudong District, one in Yangpu District, and one in Huangpu District. These interviewees included those who held roles at the sub-district governments or the Civil Affairs Bureau (*n* = 5) and community officials (*n* = 4). Their active involvement in policy implementation, monitoring, inspection, and their deep insights into care demands and frontline feedback were integral to this study.

In addition to these initial interviews, it's worth noting that in December 2018, four of these participants (two government officials and two care provider representatives) were invited to and actively participated in follow-up consultations and workshops. This follow-up engagement was particularly helpful in providing updated insights.

Shanghai has been at the forefront of care policy reforms in China, serving as a vital experiment site for marketisation strategies and models since 2000 (Zhang, 2022). The insights gained from Shanghai's pioneering care market experience have influenced the roll-out of trial models in other cities. The COVID-19 pandemic prompted central and local governments to prioritize safety and health protection in recent years (2020–2023). However, the commitment to developing the care market and home care services for older people remains evident in China's State Council (2022) guidelines for the next stage of care system development. Therefore, the experiences and viewpoints of frontline stakeholders in Shanghai, from this exploratory study, continue to be relevant and offer insights into the home care market policies, practices and research in Shanghai and across China, especially as the development of the care market regains prominence on the agenda in the post-COVID era.

Thematic analysis was applied to analyse the interview data, guided by Braun and Clarke (2006, 2019) framework, which encompasses decisions on 'inductive or deductive', 'semantic or interpretative', and 'realist or constructionist' approaches. This study investigated the underlying ideas interpretatively, considering sociocultural and structural contexts from the constructionist perspective. These decisions align with the analysis levels of the case study approach (Creswell, 2014): interpreting themes, categories and patterns at the interpretation level; examining data and theme meanings structurally; and reflecting on the marketisation process. NVivo was used to code and facilitate the analysis. This study obtained ethical approval from the Research Ethics Committee (REC) of School for Policy Studies, University of Bristol. Written consent was obtained from all participants. Each interview was audio-recorded and transcribed verbatim. To ensure confidentiality, pseudonymised codes have been used to replace names of individuals, organisations and places. The length of interviews ranged from 35 minutes to 90 minutes. Interviews were transcribed verbatim and checked for accuracy in Chinese while extracts for quotations were translated into English.

RESULTS

This paper identifies different marketisation models based on variations in contracting-out strategies, financial support methods, the power dynamics within the care market, and their impact on state-market relations. Drawing insights from the fieldwork, this section outlines three marketisation models: the state-controlled model, the limited competition model, and the free market model.

THE STATE-CONTROLLED MODEL: CASE STUDY EXAMPLE IN SUB-DISTRICT R

This paper categorises sub-district cases that designate a single, pre-determined agency as the exclusive supplier with minimal competition involved as the state-controlled model. For example, in sub-district R of Huangpu District, the local government took the initiative to establish a care agency called 'Happy Home' in 2008 by providing state-owned facilities. As shown in Table 2, the sub-district R government not only helped establish 'Happy

AGENCY – (PSEUDONYMISED NAME)	CONTRACTING OUT METHODS	PROPERTY OWNERSHIP	FUNDING SOURCE	POWER RELATION	SERVICE COVERAGE
Happy Home	1. Public investment and private provision (*gongban minying*) 2. Project commissioning	Public	1. Local government provides the estate; the majority of establishment costs; public purchasing. 2. Private: small-scale investment for agency establishment; operation costs.	1. Strong state control; 2. Low competition	One sub-district

Table 2 The pattern of care agency 'Happy Home' in sub-district R.

Home' but also exclusively outsourced all state-paid care schemes to this particular provider. Both the day care centre and administrative offices of 'Happy Home' remained under the ownership of the local government and have been operated by the same agency since its inception. 'Happy Home' exclusively served residents of sub-district R and did not extend its services to other jurisdictions. The close working relationship between the sub-district R government and 'Happy Home' is evident in various facets, from managerial coordination to daily communications. Community officials who participated in this study revealed that they consistently referred residents seeking care services, such as daycare or live-in care workers, directly to 'Happy Home' as the preferred provider. This strong connection between the local government and 'Happy Home' played a significant role in shaping the dynamics of the care market within the region.

In the state-controlled model, local governments directly assign care service contracts and resources to selected agencies, which are mandated to strictly adhere to the local government's directives. This model marks a departure from the traditional state provision of care, where public or state-owned agencies monopolised care services. Instead, social service agencies now engage in limited competition. The day-to-day aspects of care provision, including operations and recruitment of care workers, are managed by the care providers. This arrangement was believed to improve the state's efficiency in other areas, like regulation and finance. Government officials and care providers involved in the state-controlled model emphasised their focus on efficiency and care quality in the quasi-market system compared to the previous public provision.

In sub-district R, the government plays a prominent role in both contracting out and care provision. Some government officials argued that care recipients benefit from the state-controlled model due to high-level government oversight of service quality and delivery. However, there was consensus that this strong government control hindered the growth of the care market, as the decision-making process lacks transparency, resembling a 'black box' with projects awarded to a single provider without open competition. Contracting out without open competition may lead to insider dealing and corruption. Qing, an executive of a care agency, suggested that this resembles in-house commissioning rather than true contracting 'out.'

Additionally, under full state control, care providers gained resources but faced administrative burdens and local government restrictions. For instance, agencies couldn't serve privately paying customers without local government approval. Expanding care services to other areas, like neighbouring sub-districts, was rarely feasible without local government consent.

Based on insights from the interviews, the rationale behind the state-controlled model revolves around the benefits of stringent government oversight and monitoring of care providers' activities. For example, a sub-district R official underscored that the key factors driving the selection of this care agency were concerns for public welfare and the preservation of local government influence in the care sector:

> We [Sub-district R] were a pioneer in applying the contracting out strategy in Shanghai [...] When deciding to support to establish the agency and to purchase services from it, we had several concerns. On one hand, we preferred to support an organisation who really cares about our residents' welfare [...] On the other hand, we want to make our sub-district as a top case in Shanghai. We do not trust strangers outside of the public system because there are many providers who only take the job for money instead of good will.
>
> Hao, a government official at the sub-district level

'Happy Home' had garnered recognition from the Shanghai Municipal Government as a prominent care agency. More specifically, government officials in sub-district R and managers in 'Happy Home' indicated that the agency had earned an esteemed reputation in Shanghai for the quality of its services, receiving positive feedback from both older people and other local residents. The interview data further underline the effectiveness of cooperation between the local government and this social service agency, with interviewees involved in this case expressing a sense of pride in their decision-making and performance.

Inevitably, the efficacy of the state-controlled model primarily relies on the motivations and capacities of the local government. Sub-district R government aimed to set up an outstanding example in Shanghai, by exerting high control over 'Happy Home' to ensure strict compliance with their instructions. Nevertheless, the lack of transparency and openness complicates the assessment of government officials' true motivations. There are risks underlying this model. For instance, interviewees indicated that government officials might prioritise personal or local interests over enhancing care provision and providing sufficient financial support to older people.

Simultaneously, within the state-controlled model, care providers lack independence and negotiation power with local governments. For example, 'Happy Home' managers sought to expand the service list by adding additional home care services, like bathing, based on older people's care needs and their confidence in the agency's ability to provide relevant care. However, the sub-district government rejected the proposal, expressing

concerns about the risk management of such services. The pursuit of greater independence for care agencies within the state-controlled model contradicts the initial intentions of government officials who opted for this approach. However, it is important to recognise that local governments' preferences and choices regarding marketisation models are not fixed and may potentially shift to alternative patterns at different stages.

THE LIMITED COMPETITION MODEL: CASE STUDY EXAMPLE FROM SUB-DISTRICT Z

The limited competition model is exemplified by the case of sub-district Z in Pudong District. In this sub-district, state-paid home care schemes were commissioned to three care agencies: one community agency and two independent social service agencies. As detailed in Table 3, the community agency operated separately from the government but was subject to direct oversight by the sub-district Z government in terms of its operations, including staff recruitment, service allocation, and management. The two social service agencies, 'Warm Heart Care' and 'Healthy Support', operated independently. 'Warm Heart Care', established locally in 2000 with private funding, provided services to people of all age groups within sub-district Z. 'Healthy Support', founded in 2012 with private funding and state subsidies, provided community- and home-based care to older people. Both of these social service agencies began taking on care service projects commissioned by sub-district Z in 2013.

In this model, local governments select a few providers to compete for home care contracts, allowing for comparison and evaluation. Decision-making regarding the commissioning of contracts is subject to alterations based on performance evaluations. This approach grants care providers a degree of autonomy greater than that in the state-controlled model. However, it remains state-driven as officials retain the power to choose providers based on personal preferences. For example, some local governments prefer to involve multiple local agencies for competition, while others may allocate home care projects across various categories of care agencies, including small local, large for-profit chains, and public organisations. The criteria and process of how the local government selects providers are not open to bidding groups, lacking transparency, as management-level government officials set the criteria and parameters for contracting out.

In contrast to the state-controlled model, where a single agency is under full government control, the limited competition model allows multiple agencies to compete for care projects. However, the interaction between sub-district governments and care providers is primarily state-driven, while local authorities maintain a predominant influence over these care agencies. The contracting out procedure lacks explicit regulation through legal or formal rules, resulting in instances of government officials intervening in the bidding process. For example, a sub-district government official said, 'I sometimes need to modify bidding reports for agencies and teach them to design their organisations and service plans'. Care providers always accepted their guidance unquestioningly. In general, management teams of care agencies in the early stage of the development process have less experience in the field of care for older people than government officials who have held management-level roles in the welfare sector for years. The influence of these experienced government officials can significantly impact the operations of newly established agencies.

In the sub-district Z case, the local government initiated the establishment of the Community Home Care Service Centre in 2003 with the primary objective of generating employment opportunities for people who had been unemployed or 'laid off'. All staff, including care workers and managers, were part of the mid-age group who re-entered the job market after experiencing layoffs during state-owned enterprise reforms in the 1990s. The provision of home care services to low-income older residents was regarded as a positive 'spill-over' effect, offering additional community benefits. Over time, the number and scope of care recipients gradually expanded.

AGENCY – (PSEUDONYMISED NAME)	CONTRACTING OUT METHODS	PROPERTY OWNERSHIP	FUNDING SOURCE	POWER RELATION	SERVICE COVERAGE
Community Home Care Service Centre	N/A	Public	Direct allocation by the state	Strong state control	One sub-district
Warm Heart Care	Project commissioning	Private	1. Private investment and operation; 2. Public funding and subsidies for state-paid services.	1. State control over projects; 2. Mid-level competition	Four sub-districts
Healthy Support	1. Private establishment with public support (*minjian gongzhu*) 2. Project commissioning	Private	1. Private establishment with government subsidies; 2. Public funding and subsidies for state-paid services.	1. State control over projects; 2. Mid-level competition	Six sub-districts

Table 3 The different patterns of care agencies in sub-district Z.

Consequently, the community agency could no longer adequately address the increasing care demands within the sub-district. In response, the sub-district government decided to outsource a portion of the home care projects to social service agencies. Prior to publicly releasing bidding information for home care projects on the district-level platform, the sub-district Z government did market research about home care providers within their district. Two local agencies, 'Warm Heart Care' and 'Healthy Support', were identified and invited to discuss their bidding proposals with local government officials before the formal bidding process. These two agencies essentially functioned as default options for contracting out, rendering the bidding process more of a procedural confirmation of their selections.

Despite the pre-selection of agencies, government officials aimed to stimulate competition among them intentionally. Subsequent to the commissioning process, the sub-district Z government conducts regular inspections of the home care services delivered by these agencies. The renewal of annual contracts is contingent upon their satisfactory performance in each period. The allocation balance between the two agencies is adjusted based on their prior-year performance, fostering peer pressure and competition within this model. Government officials in sub-district Z explained their choice of this model was a lack of trust in 'private' agencies and concerns of potential disputes arising from for-profit motives, especially in the absence of comprehensive regulations.

> We keep talking about cutting administrative departments and giving power to the market, but we are not able to achieve it now. [...] First, we dare not delegate to social organisations. We do not trust them, because they are always profit-driven. We are afraid that we will not be able to effectively regulate or restrict the market once giving out too much power. Second, the state needs more time to set up regulations and laws to prevent potential problems.
>
> Zhan, a government official at the sub-district level

THE FREE MARKET MODEL: CASE STUDY EXAMPLE FROM LARGE FOR-PROFIT HOME CARE AGENCIES

The free-market model is characterised by open competition within a bidding framework. Interview data reveals an increasing adoption of this model in various Shanghai jurisdictions. Sub-district governments have established dedicated offices to manage public procurement, including care services for older people, while district governments oversee public bidding websites. Ideally, government officials with connections to service providers are expected not to interfere in the commissioning process.

Unlike state-controlled or limited competition models, where there is a preference for supporting local agencies and direct oversight, district-level central bidding departments tend to prioritise efficiency more. Consequently, large for-profit home care agencies are experiencing notable growth within the open and competitive bidding system. For example, 'Loving Care', a large for-profit home care agency founded in 2008, achieved financial stability only in 2011 when the Pudong District government initiated an open bidding process for 30 home care projects. Upon securing care scheme commissions from multiple local jurisdictions simultaneously, 'Loving Care' expanded its reach and influence across Shanghai.

This section sheds light on the characteristics of care providers more dominant in the free market model, focussing on three large for-profit home care agencies included in this study (see Table 4).

AGENCY – (PSEUDONYMISED NAME)	CONTRACTING OUT METHODS	PROPERTY OWNERSHIP	FUNDING SOURCE	POWER RELATION	SERVICE COVERAGE
Loving Care	1. Private establishment with public support 2. Project commissioning	Private	1. State subsidies; 2. Public purchasing; 3. Direct purchasing.	1. State influences over projects; 2. High competition	Five districts in Shanghai
Harmony Family	1. Joint establishment and joint funding 2. Project commissioning	Public and Private	1. State provides estates and funding; 2. Private investment; 3. Public purchasing 4. Direct purchasing.	1. State influences over projects; 2. High competition	Four districts in Shanghai
Oak House Care	Project commissioning	Private	1. Public purchasing 2. Direct purchasing	1. State influences over projects; 2. High competition	Six districts in Shanghai; many projects in Beijing

Table 4 The patterns of three large for-profit care agencies in Shanghai.

Fieldwork data reveals that owners and managers of large for-profit home care agencies possess greater negotiation experience with government officials, as opposed to adhering solely to administrative instructions. To ensure accountability, the district-level 'Social Organisation Service Centre' engages a third-party entity to assess the performance of care agencies and furnish bi-annual or quarterly inspection reports to local governments. Furthermore, government officials at the sub-district and community levels maintain ongoing communication with care agencies, addressing emerging requests from local governments or service users and promptly addressing issues that may arise, such as complaints.

Despite the relatively higher degree of independence care providers have in the free market model, the majority of owners and managers of large for-profit agencies still rely heavily on policy and financial support from the government. The interviewees indicated a preference among care providers to operate within a quasi-market environment characterised by reasonable state interference and regulation, rather than within an entirely open and unregulated market.

> The state ought to guide the expression of care needs of older people in the market, operate trials, and boost the consumption.
>
> Le, executive of a care agency

The interview data reveals an intriguing competition dynamic in the home care contract sector. Many care providers acknowledge that certain care service schemes may not yield immediate profits. Nevertheless, a significant number of care agencies actively participate in bidding processes with the aim of expanding service coverage and positioning themselves for potential future profits and influence. For some providers, this approach is viewed as an investment strategy, driven by optimistic projections of eventual profitability. Conversely, others perceive this as vicious competition initiated by larger agencies with substantial resources, with the intention of eliminating smaller agencies that lack the financial backing to shoulder the risk of offering services without immediate returns.

> Agencies try to grab a larger share of the care market to expand their coverage, but they consider less about what to do in care delivery [...] The share in the market is connected to the influence level in the care industry. Currently, there are no generalised standards in the care for older people sector. The influence level will surely be important in making regulations, training, and every aspect of the development of this field.
>
> Zhan, a government official at the sub-district level

The fieldwork data highlights Pudong District as one of the local governments with a keen interest in adopting the free market model as a pioneer in Shanghai's care market development since 2010s. This transition partially shifted commissioning and oversight authority from sub-district governments to the district-level 'Social Organisation Service Centre'. This separation of responsibilities between the demand side (sub-district governments) and the contracting and monitoring side (district-level bidding platform) has facilitated the standardisation of the commissioning process.

> In our sub-district, the commissioning of projects for public services are all organised by one office in Pudong District government, the Social Organisation Service Centre. This office gathers our requirements for each welfare project; advertises and contacts social service agencies; and posts bidding information on the central District platform.
>
> Wei, a government official at the sub-district level
>
> Most large-scale care schemes are posted on the bidding platform [...] Usually, social service agencies first hear the information about contracting out of agencies or projects. Then, providers get involved in the bidding. We compete with proposals based on the institutional capacity, advantages, and the suitability to projects.
>
> Fu, executive of a care agency

The central bidding platform was not mandatory, allowing sub-district governments the option to independently contract home care service projects, like the limited competition model. Nevertheless, there is a growing trend of sub-district governments opting to use the central bidding platform.

Interviewees shared mixed feedback on the free market model. Some praised the model for its transparency and reduced local-level distractions, while others expressed concerns about the increasing trend of large for-profit providers winning bids in the free market model, which they believed exacerbated inequality in the care market and failed to correlate to better care quality or outcomes for older people.

> The quantity of care service is increasing, but the quality remains very low [...] The increasing percentage of contracting out to large for-profit

companies makes an unequal environment for smaller agencies. While large companies may boast professional staff for report writing, this doesn't necessarily translate to better practice [...] This dynamic put smaller agencies at disadvantaged in the competition.

Yue, executive of a care agency

DISCUSSIONS

The findings of this study shed light on the growing home care market in Shanghai, where diverse care providers coexist as the government contracts out care schemes. The characteristics of a quasi-market, as proposed by Le Grand (1991) and Le Grand and Bartlett (1993), align with the marketisation processes observed in Shanghai's long-term care sector. The state-dominated long-term care provision in urban China is transitioning into a quasi-market structure. In this context, providers, whether not-for-profit or for-profit, engage in competition for public contracts. Older people access care services through vouchers, subsidies, or self-funded means. Additionally, in some instances, agents, such as community officials, act as representatives for older people within the care market.

Drawing from empirical data, this study identifies three distinct quasi-market models in Shanghai (see Table 5). Each model is shaped by different contracting out strategies, methods of financial support, power dynamics in the care market, and how it influences the state-market relations in turn. The findings resonate with international discussions that the application of different marketisation strategies and models are path-dependent (Bode et al., 2011; Williams & Brennan, 2012). The in-depth examination of Shanghai's quasi-market in home care for older people has implications not only for other regions within China, especially given Shanghai is the forefront experiment site for care policies and schemes in China, but also for international studies, particularly in East Asian societies where the state plays a substantial role in long-term care provision (Kurimoto & Kumakura, 2016; Zhang, 2023).

In the realm of contracting out and public procurement for social services, the anticipation of an equitable contractual arrangement between purchasers and providers is often challenged by unique characteristics of local governments, such as management style, policy priorities, and personal preferences at the administrative level. These attributes can influence the choices made in contracting out, procurement, and regulatory processes. DSS MFC (2011) indicated that the public procurement process involves two distinct entities: the purchaser and the provider, who ideally should maintain an equal contractual relationship. However, in practice, government entities often hold a dominant role.

Open bidding and increased competition do not necessarily lead to better care quality and benefits for older people, as identified in other care regimes in Bach-Mortensen and Barlow (2021)'s systematic review. Similarly, 'market failures' are inherent in long-term care markets across welfare states (Fernández et al., 2009; Forder et al., 1996; Lewis & West, 2014). Internationally, discussions on the limitations of marketisation of care often revolve around issues such as disparities in access and provision (Brennan et al., 2012), concerns about care quality (Glendinning, 2012; Lewis & West, 2014) and care relationships (Hardy & Wistow, 1998; Lewis & West, 2014), increased burdens on families (Lewis & West, 2014), market concentration with a trend towards fewer large providers (Glasby et al., 2019).

It is also important to acknowledge that these issues are not solely attributed to market failures, but are also influenced by the policy and technical aspects of commissioning, care arrangements and business strategies, where cost-efficiency is prioritised over care quality (Bach-Mortensen & Barlow, 2021). In their pursuit of cost reduction and profit maximisation, providers often diverge from the ideal market rhetoric of responsiveness to individual consumer needs. These challenges underline the necessity for policymakers to carefully assess risks within the care market, such as the potential closure of large for-profit care providers (Glasby et al., 2019). Importantly, the findings of this study indicate that these risks have prompted recognition among some care providers and government officials in China of the crucial role of state regulation and monitoring within

MODELS	COMPETITION	STATE CONTROL	GOVERNMENT PRIORITIES	CONTRACTING OUT METHODS	COMMONLY INVOLVED PROVIDERS
State-controlled model	Low	High	Local preferences	Pre-determined one agency	Local agencies
Limited competition model	Medium	Medium	Comparisons and combined considerations	Several chosen agencies	Diverse types of agencies
Free market model	High	Low	Efficiency	Open bidding	large for-profit agencies

Table 5 Three models of the quasi-market in Shanghai.

the market, irrespective of the quasi-market model they employ or operate under.

While this paper primarily examines government commissioning and financing support to illustrate key processes of the marketisation of care in Shanghai's home care market, it does not delve into market activities of consumers (i.e., older people and their families) or the outcomes (e.g., impacts on care quality). Consequently, this calls for research to investigate the outcomes and impacts of the marketisation of care, particularly focusing on care quality, relationships, and impacts on older people and their families with different quasi-market models.

In the context of increasing discussions on quasi-care markets in long-term care across the world (Bode et al., 2011; Green et al., 2022), the dynamics of quasi-market models and marketisation processes in China provide valuable insights for the broader discourse on care marketisation in diverse settings, with an emphasis on the call for attention to the consequences of marketisation, government monitoring, and care quality.

CONCLUSION

This study provides insights into the evolving care market in Shanghai, illustrating its shift from state-dominated care provision to a quasi-market structure. Nonetheless, it's essential to acknowledge that this research was conducted in 2016–2018, preceding significant recent events such as the COVID-19 pandemic and subsequent policy changes, which may require further examination of its relevance and implications in the current context. It identifies three quasi-market models, each shaped by distinct contracting strategies, financial support mechanisms, and power dynamics. Despite the presence of open bidding and increased competition, it highlights the risks of 'market failures' in the care market, echoing international concerns regarding disparities in access, care quality, and increased burdens on older people and their families. The findings emphasise the critical role of robust regulation and monitoring to mitigate associated risks and prioritise care quality. Furthermore, this study underscores the importance of conducting further research to examine the outcomes and impacts of marketisation, particularly focusing on care quality, relationships, and the impacts on older people and their families. It also contributes to policy and research discussions in the international context of growing care markets.

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COMPETING INTERESTS

The author has no competing interests to declare.

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