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The privatisation and financialisation of social care in the UK

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Abstract

Even before the arrival of COVID-19, the care sector was already in long-term crisis, in large part due to insufficient funding, but the sector has also been under pressure from structural changes resulting from privatisation and financialisation.³ Social care is one of many elements of everyday life which, over the past few decades, have been repackaged to suit the needs of global capital. The process has transformed a social need into a financial issue which in turn translates into new social relations where narratives are constructed in terms of markets and efficiency. Care sector workers are treated as a financial overhead rather than integral to the quality of care provided. The financialisation of social care is an ongoing systemic process, which is accentuated in the increasingly challenging current global investment climate as investors seek alternatives to the low returns from traditional secure investments such as government bonds.

This paper is concerned with the tensions resulting in the private provision of social care services. Some of the larger care providers are owned by financial investors that have earned substantial profits via opaque corporate practices. Discussion in the paper shows that while social care offers relatively low risk and high return investment opportunities, structuring care services as a private sector endeavour risks major adverse social outcomes, potentially resulting in:

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³ Here the term is taken to refer to the increased penetration of financial institutions and the use of financial mechanisms to extract shareholder returns in the sector.

- Extensive transfers to the world's richest via the servicing of basic needs for some of society's most vulnerable people, financed by taxes and lifetimes' savings
- A two tier system of residential care where private providers seek to serve only self-funders
- Increasing strain on a largely female and minority ethnic un-unionised work force
- Increasing pressures on (largely female) informal carers that pick up the pieces of the failings in the care system

In the short term, the paper indicates that tighter regulation could reduce some of the inequitable practices of social care providers. However, the paper demonstrates that in the long term, tweaking the margins of regulation will not be sufficient to address the fundamental structural flaws underlying our current care system. Social care services are not competitive and the sector does not work as a conventional market. The analysis acknowledges the complexities of restructuring the care system and therefore offers both short and long term policy suggestions:

- Conditions for financial support to the sector in the wake of the COVID-19 pandemic should be imposed to curtail the current extractive practices of some care providers. Tighter regulation should promote socially responsible care provision, backed up with additional financial resources and long-term political commitment.
- Additional financial support is needed for local authorities to enable them to provide social care and reduce their reliance on private companies.
- Consideration should be given to innovative alternative provider models that draw on international examples of good practice.

The current structure of social care provision inevitably promotes inequality, while transparency and accountability are lacking. Moreover, the care system is increasingly moulded to suit the priorities of investors rather than social care needs. In the wake of the pandemic, more resources are urgently needed for social care but this is an opportunity for a radical rethink of the ways in which we support the most vulnerable in our society.

Keywords: Privatisation, financialisation, social care, UK.

JEL classification: D63, H75, I10, I38

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1 Introduction

This paper is concerned with the effects of the privatisation and financialisation of adult social care services, focusing on England, but with some reference to the other countries in the UK. Both residential and domiciliary care are mainly provided by private enterprises and there is an extensive range of provider types from small-scale family-run businesses to large companies that own chains of care providers, and provide thousands of beds. Social care is labour intensive, and care work has long been undervalued, with the mainly female workforce typically facing poor pay and working conditions.⁴ Currently over 60 per cent of care workers in England are paid less than the real Living Wage. The position is significantly worse for those working in the private sector.⁵ Since the early 2000s the increased involvement of financial investors in the sector has led to the creation of complex avenues for the extraction of shareholder returns which go beyond traditional means of generating profit, such as through high payments for rent, and borrowing from companies in the same corporate group. As a result, the relatively low risk and straightforward process of providing social care services has spawned an increasingly elaborate extractive international financial architecture.⁶

COVID-19 has had a devastating impact in the UK's care homes. By the end of May 2020 some 16,000 residents were confirmed or suspected to have died from Covid-19, amid outbreaks in 38 per cent of homes in England, and 59 per cent of those in Scotland.⁷ Research from the London School of Economics suggests that the real

⁴ See WBG briefing 'Social Care and Gender', March 2020 for further discussion, available at <https://wbg.org.uk/analysis/uk-policy-briefings/2019-wbg-briefing-social-care-and-gender/>, last accessed 1/7/20.

⁵ Resolution Foundation (2020) "What happens after the clapping finishes" The pay, terms and conditions we choose for our care workers" <https://www.resolutionfoundation.org/app/uploads/2020/04/Care-workers-spotlight.pdf>

⁶ Burns, D., L. Cowie, J. Early, P. Folkman, J. Froud, P. Hyde, S. Johal, I. Rees Jones, A. Killett, K. Williams (2016) "Where does the money go? Financialised chains and the crisis in residential care" CRESC Public Interest Report, Centre for Research on Socio-Cultural Change; ⁶ Horton, A. (2019). Financialization and non-disposable women: Real estate, debt and labour in UK care homes. *Environment and Planning A: Economy and Space*, 0(0) 1–16, DOI: 10.1177/0308518X19862580; Kotecha, V. (2019) "Plugging the leaks in the UK care home industry: Strategies for resolving the financial crisis in the residential and nursing home sector" Report for Centre for Health and the Public Interest, <https://chpi.org.uk/papers/reports/plugging-the-leaks-in-the-uk-care-home-industry/>.

⁷ 'UK coronavirus death toll passes 50,000, official figures show', <https://www.theguardian.com/world/2020/jun/02/uk-coronavirus-death-toll-nears-50000-latest-official-figures-show>; 'More than 16,000 people in UK care homes have died from coronavirus',

figure of COVID related deaths in care homes across the UK is significantly higher and that the death toll has reached over 22,000.⁸ One of the UK's biggest care home operators, HC-One had over 1,000 deaths in its facilities by July 2020.⁹ The company's accounts to October 2019 indicate that HC-One had 170 care homes in the UK with 8,400 residents suggesting that around 12 per cent of residents have died from the virus.

The pandemic has put the sector under immense strain, and many care homes are facing financial ruin as a result of falling levels of occupancy and rising costs. Many have called for government support. However, it is widely accepted that residential adult social care services were already in crisis at the start of 2020,¹⁰ significantly fragmented after three decades of privatisation and underfunded following ten years of cuts to local authority revenues in the wake of austerity. Rising staff costs due to minimum wage legislation, and staff shortages due to Brexit have added to the strain on care services.¹¹ But, the narrative of a sector deprived of funding misses some of the subtleties of the methods of profit extraction by private owners of care services. Simply providing more finance to a sector where the funds flow to offshore owners via opaque corporate structures has been described as akin to "pouring water into a leaky bucket".¹² More state funding will have limited long-term benefit without attention to the underlying business practices and structural deficiencies of the care sector.

<https://www.theguardian.com/world/2020/jun/16/more-than-16000-people-in-uk-care-homes-have-died-from-coronavirus>

⁸ 'Research estimates put 'real' care home COVID-19 death toll at over 22,000', <https://www.carehomeprofessional.com/research-estimates-put-real-care-home-covid-19-death-toll-at-over-22000/>; 'The ghosts of the care-home dead will come back to haunt this government', <https://www.theguardian.com/commentisfree/2020/jun/01/care-home-dead-government-systematic-ageism-uk-covid-19>

⁹ 'HC-One - COVID cases and loss of life', <https://www.hc-one.co.uk/Our-News/Corporate-News/HC-One-COVID-19-cases-and-loss-of-life.aspx>

¹⁰ See for example Age UK (2019) Briefing: Health and Care of Older People in England 2019, Age UK: London; Lightfoot, W., Heaven, W. and Henson Grič, J. (2019) 21st Century Social Care. What's wrong with social care and how we can fix it, Policy Exchange: London; Humphries, R., Thorlby, R., Holder, H., Hall, P., & Charles, A. (2016). Social care for older people. *The Kings Fund: Home truths*. London. Political Studies Association/ Commission on Care (2016) Towards a new deal for care and carers. Report of the PSA Commission on Care, 2016, Quilter-Pinner H (2019) *Ethical care: A bold reform agenda for adult social care*, IPPR;

¹¹ Resolution Foundation (2020) "What happens after the clapping finishes" The pay, terms and conditions we choose for our care workers"

<https://www.resolutionfoundation.org/app/uploads/2020/04/Care-workers-spotlight.pdf>

¹² Burns et al. (op.cit).

This paper reviews the changes in social care provision since the 1980s. The following section outlines trends in the structures of provision including the fragmentation of health and social care, the decline in local authority provision and an increase in domiciliary care rather than residential provision of care services. Increasing financial strain in the sector has led to a fall in provision which has led to greater pressure on informal carers. Section 3 focuses on the care sector workforce, which has been squeezed by profit-driven management practices and considers the implications of this. Section 4 then turns to the investors in social care and highlights the ways in which shareholder returns are generated with particular attention to debt and rental payments as mechanisms for revenue extraction. The final section sets out issues for consideration in moving forward in the sector.

The paper juxtaposes the increasing precarity of the low-paid workforce, where many are on zero-hour contracts, with the perspective of investors for whom investing in social care has been highly profitable. Even apparently loss-making operations have been able to pay millions of pounds in dividends to parent companies, some of which are located in tax havens. This structure of social care provision, which is funded by tax payers and the personal savings of individuals, inevitably promotes inequality, while transparency and accountability are lacking. Moreover, the care system is increasingly moulded to suit the priorities of investors rather than social care needs. In the wake of the pandemic, more resources are urgently needed for social care but this is an opportunity for a radical rethink of the ways in which we support the most vulnerable in our society.

2 Changing structures of social care provision

Care providers operate across different service types and range of needs. Some provide domiciliary care for adults with special needs as well as for the elderly. Many provide both residential and domiciliary services and some provide specialist medical services. In 2015 more than 350,000 older people in England used domiciliary home care services, 257,000 of which had their care paid for by their local authority. A further 76,300 younger people with learning disabilities, physical disabilities or mental health

problems were also estimated to be using publicly-funded home care.¹³ In the same year, there were over 460,000 residential care home beds, and around 87 per cent of these were for older people, with the remaining for people with learning disabilities and / or mental health conditions.¹⁴ Thus around 1.5 per cent of the population are accessing care services.

The boundaries between the provision of health and the provision of social care services are blurred. Local authorities have been responsible for social care since the creation of the NHS in 1948 but in subsequent decades successive Government Acts have altered the nature of the relationship between local government and the NHS.¹⁵ A number of factors have contributed to the fragmentation of relations between the NHS, local authorities and the care sector. In 1990 the NHS and Community Care Act shifted the role of local authorities to commissioning rather than providing social care. This paved the way for care services to be provided by the independent (i.e. private for-profit and not-for-profit (NFP)) sector. In 1997 responsibility for health policy was devolved to separate administrations in Wales, Scotland and Northern Ireland leading to increasing divergence of policy between the four countries.¹⁶ Within England the 2012 Health and Social Care Act has meant that different parts of the NHS and the care system are commissioned and funded separately and subject to different governance, accountability and regulatory regimes.¹⁷ As a consequence, today social care across the UK is provided by a diverse range of actors including government, local authorities, NFP and private-for-profit companies. Data from the Competition and Markets Authority show that, in residential care, for-profit providers account for 83 per cent of care home beds, the voluntary sector provides thirteen per cent on a not-for-profit basis and the remaining four per cent of care home beds are run by local government or the NHS.¹⁸ There are regional variations in types of ownership – in Scotland 58.6 per cent of care homes are private for profit, 27.1 per cent are not-for-

¹³ Bottery, S., L. Jefferson, L. Bennett, P. Hall, J. Cream, V. Dale, M. Honeyman, Y. Birks, K. Bloor, R. Murray (2018) Home care in England Views from commissioners and providers, Report for The Kings Fund, <https://www.kingsfund.org.uk/sites/default/files/2018-12/Home-care-in-England-report.pdf>

¹⁴ Naylor, A. and J. Magnussuon (2020) "Data that cares" Report for Future Care Capital, <https://futurecarecapital.org.uk/wp-content/uploads/2020/03/Data-that-cares-full-report-single.pdf>

¹⁵ Gorsky, M., Lock, K., & Hogarth, S. (2014). Public health and English local government: historical perspectives on the impact of 'returning home'. *Journal of Public Health*, 36(4), 546-551.

¹⁶ Humphries, R. (2015). Integrated health and social care in England—Progress and prospects. *Health Policy*, 119(7), 856-859

¹⁷ Humphries, R. (op.cit).

¹⁸ Competition and Markets Authority, Care Homes Market Study, Final Report, 2017: 33.

profit providers, and local authority or Health Board provision accounts for 14.3 per cent.¹⁹

The disconnect between the health and social care sectors has led to the introduction of numerous policy initiatives and proposals since the 1970s and calls for better integration between the two sectors.²⁰ Nevertheless, there is no single definition for integrated care, and the integration of services can take place in various forms and at different levels. For example, services may be integrated at the level of a local or regional population, for a particular care or age group, or at an individual level, or indeed may involve more than one of these approaches.²¹ The National Audit Office (NAO) contends that:²²

Integration is about placing patients at the centre of the design and delivery of care with the aim of improving patient outcomes, satisfaction and value for money ... Integration aims to overcome organisational, professional, legal and regulatory boundaries within the health and social care sectors, to ensure that patients receive the most cost-effective care, when and where they need it.

In 2013 an independent commission, The Commission on the Future of Health and Social Care in England (Barker Commission) was set up by the Kings Fund to review the boundary between health and social care. The Commission's Interim Report identified three key areas that hindered better alignment between the NHS and social care systems in England. First, NHS care is free at the point of use while social care is means-tested. Second, the NHS is almost entirely tax-funded and operates within a ring-fenced budget while the social care budget is not ring-fenced and local authorities determine local spending. Finally, there is a lack of organisational alignment between the health and social care systems, largely as a result of the two services being

¹⁹ Pollock, A. and Harding-Edgar, L. (2020) Coronavirus Crisis: Underfunding, Restructuring, Privatisation and Fragmentation at the Heart of the Crisis in Holyrood and Westminster, 23rd April 2020, available at <https://www.scer.scot/database/ident-12745>

²⁰ Humphries, R. and Wenzel, J. (2015) Options for Integrated Commissioning: Beyond Barker, The Kings Fund: London, available at: file:///D:/Dell%20PC/Documents/WBG%20policy%20briefing/Integration/Options-integrated-commissioning-Kings-Fund-June-2015_0%20Humphries%202015.pdf, accessed 24/6/20.

²¹ Humphries and Wenzel, op.cit. 2015: 5.

²² National Audit Office (2017) Health and social care integration, Report. Available at: <https://www.nao.org.uk/report/health-and-social-care-integration/>, last accessed 24/6/20.

commissioned separately.²³ Although there is a general consensus on the need for single local commissioning arrangements of health and social care services, there is also widespread agreement on the need to avoid the extensive structural reorganisation of the system which would potentially be extremely disruptive for the provision of care. It is, however, worth noting that evidence supporting the claims that integration of health and social care always leads to better outcomes for patients is mixed, and that the 2017 NAO Report on Health and Social Care Integration did not find sufficient robust evidence to show that this was always the case. As the Report notes while there are some international examples of successful integration this has occurred in a context of different statutory, cultural and organisational environments.²⁴ Similarly, there is not sufficient evidence to show that integration would result in long-term financial benefits.²⁵

Nevertheless, over the past decade some attempts have been made to improve the integration of the social care sector and NHS. One example is the Better Care Fund (BCF) introduced by the Coalition Government in 2013, although in reality this did not involve new funds but instead involved the redeployment of funds from existing NHS services, resulting in caution over assessing the likely impacts. Indeed, the 2017 NAO Report argued that the BCF had not brought about any anticipated savings, but it remains integral to the government's long-term plan for the NHS.²⁶

In 2019 the publication of the NHS Long Term Plan²⁷ included proposals for the creation of Integrated Care Systems (ICS). These are partnerships that bring together providers and commissioners of NHS services across a geographical area with local authorities and other local partners, to collectively plan and integrate care to meet the needs of their population.²⁸ One of the most controversial aspects of the proposals has been the introduction of a contract that would formalise the partnerships within the ICS. This was initially known as an 'accountable care organisation contract' but later

²³ Humphries and Wenzel, op.cit. 2015: 8.

²⁴ NAO, op.cit, 2017: 7.

²⁵ NAO op.cit.

²⁶ 'Better Care Fund', <https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/>

²⁷ 'The NHS Long Term Plan', <file:///D:/Dell%20PC/Documents/WBG%20policy%20briefing/Integration/nhs-long-term-plan-version-1.2.pdf>

²⁸ 'Integrated Care Systems Explained', <https://www.kingsfund.org.uk/publications/integrated-care-systems-explained#what-are-ICs>

renamed the 'integrated care provider contract'. It would involve commissioners awarding a long-term contract to a single organisation to provide a wide range of health and care services to a defined population.²⁹ Critics have argued that this means that private companies could become responsible for commissioning and providing all care and that the plans also raise serious concerns around equity issues as well as questions of public accountability.³⁰ At present there are 14 ICS's in operation in England but future developments have been put on hold due to the COVID crisis.³¹

In residential care, local authority provision has shrunk dramatically as a result of government reforms. Between 1980 and 2018 the number of publicly provided local authority residential care beds fell by 88 per cent, from 141,719 to 17,100.³² In 1979 64 per cent of residential care and nursing home beds were provided either by local authorities or the NHS. Research by the Centre for Health and the Public Interest (CHPI) indicates that by 2012 the state's share had fallen to around 6 per cent (Figure 1).

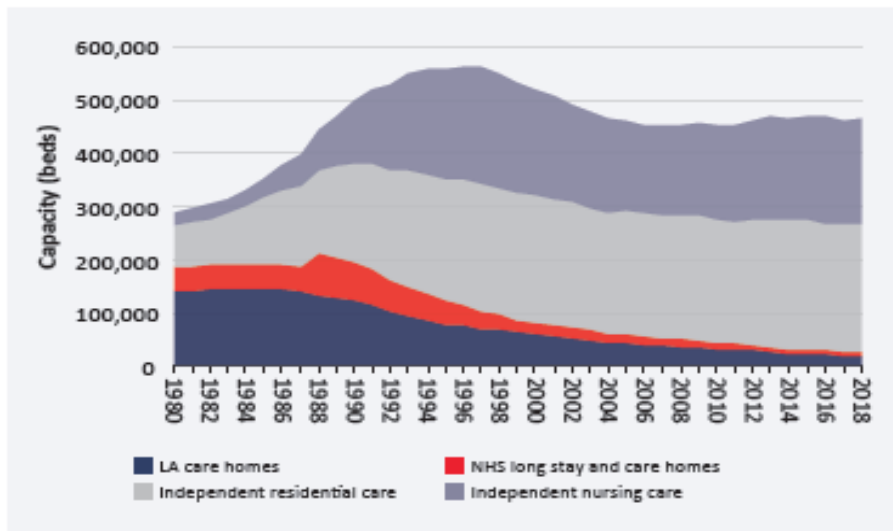
²⁹ 'Integrated Care Systems Explained', <https://www.kingsfund.org.uk/publications/integrated-care-systems-explained#what-are-ICSS>

³⁰ Pollock, A. M., & Roderick, P. (2018). Why we should be concerned about accountable care organisations in England's NHS. *BMJ*, 360; Hutchinson, C., Pollock, A., Richards, S. and Winyard, G. (2018) NHS England's consultation on the contracting arrangements for Integrated Care Providers, file:///D:/Dell%20PC/Documents/WBG%20policy%20briefing/Integration/AP_2018_Hutchinson_ICPCo nsultationResponse.pdf, last accessed 24/6/20.

³¹ 'Integrated Care Systems Explained', <https://www.kingsfund.org.uk/publications/integrated-care-systems-explained#what-are-ICSS>.

³² Kotecha, V. (2019) "Plugging the leaks in the UK care home industry: Strategies for resolving the financial crisis in the residential and nursing home sector" Report for Centre for Health and the Public Interest, <https://chpi.org.uk/papers/reports/plugging-the-leaks-in-the-uk-care-home-industry/>

Figure 1: UK capacity (beds) for older people (65+) in a residential setting by provider and care type³³

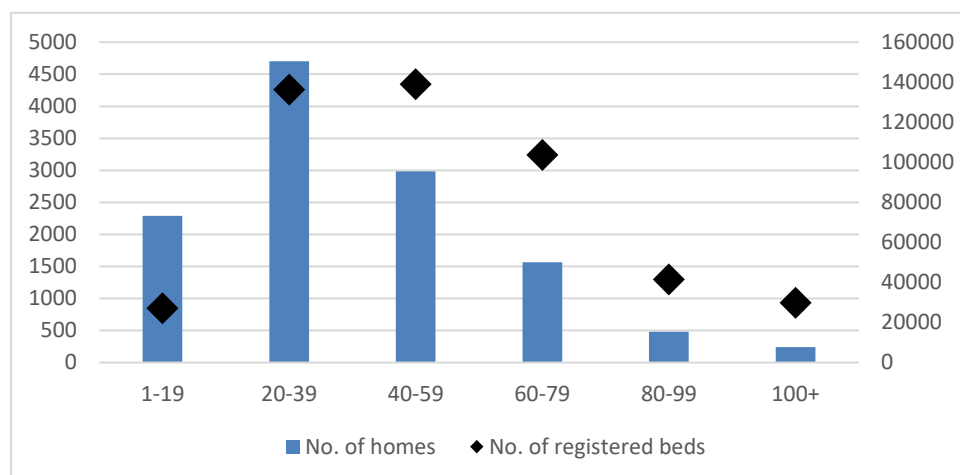


There are thousands of providers of adult social care and most operate on a small scale. Figure 2 shows the distribution of residential care homes and beds according to care home size. This shows that there are 2,290 homes that operate on the smallest scale (1-19 beds), accounting for 19 per cent of care homes but these provide just 6 per cent of beds in the UK (just over 27,000). Around 63 per cent of beds are concentrated in the smallest 80 per cent of care homes.

³³ Kotecha (op.cit).

Figure 2: Distribution of homes and registered beds according to care home size (UK)

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Overall, the provision of residential care has been declining. Between 2012 and 2019 bed numbers in England fell by 7,104 (1.5%) while the number of homes declined by 2,083 (11.7%) as providers of care homes have increased in size. Until the mid-1990s, most private care home operators were small family-owned firms owning one or two homes, often drawing on the owners’ medical experience. In the 1990s some entrepreneurial investors began to build up chains of residential care homes.³⁵ Hence, alongside the small-scale care providers, some large-scale operations have developed. Recently, however, the market structure has shifted with a slight decline in the share of the five biggest care home chains (see Section 4 for details of these) and an increase in the share of “mid-tier” operators (i.e. those with 1,500 to 3,000 beds).³⁶ The fall in supply of residential care has been taken up to some degree by an increase in domiciliary providers (Table 1).³⁷

³⁴ “COVID-19 in care homes: Latest intelligence from the frontline” Presentation for Health Investor, Julian Evans, Knight Frank, <https://www.ipevents.net/webinars/healthinvestor-webinars/COVID-19-in-care-homes-latest-intelligence-from-the-frontline/>

³⁵ Burns et al. (op.cit).

³⁶ ‘Market in minutes: elderly care homes’, https://www.savills.co.uk/research_articles/229130/291740-0/market-in-minutes--elderly-care-homes--q4-2019#:~:text=The%20largest%20five%20operators'%20market,more%20than%207%2C000%20beds%20each.

³⁷ CQC (2019) The State of Care Report. The Care Quality Commission https://www.cqc.org.uk/sites/default/files/20191015b_stateofcare1819_fullreport.pdf

Table 1: Numbers of care homes and domiciliary care agencies in England³⁸

	April 2014	April 2019
Residential homes	12,665	11,333
Nursing homes	4,699	4,413
Domiciliary care agencies	7,728	9,528

To some extent the declining numbers of providers are related to falling profitability. The sector is financed by a combination of public funding from local authorities for social care and from the NHS for medical services as well as private payments from individuals. The amount paid by the local authority is means-tested and there is no support for individuals with assets worth more than £23,250 in England and Northern Ireland.³⁹ The amount paid by local authorities varies across regions and may be supplemented by NHS resources for medical conditions.⁴⁰ Most care homes serve a mix of self-funders and local authority-funded residents and charge a higher rate to the former with the average differential around £236 per week, so self-funding residents cross-subsidise those funded by local authorities.⁴¹ In the UK in 2018, £7.4bn of residential care funding came from local authorities or NHS and £7.7bn from self-funders. The share of sector funding from private individuals increased from 45 per cent in 2008 to 51 per cent in 2018. Moreover, where new homes are being constructed these are aimed at self-funders.⁴²

Care sector finances have been squeezed by a rise in staffing costs and a drop in government funding for social care from 2010 which limited the fees paid by local authority-funded residents.⁴³ Upward pressures on staff costs are due to increases in the National Living Wage (NLW), pension auto enrolment, and a shortage of labour due to Brexit and fewer student nurses. Increases in local authority fees have failed to

³⁸ CQC (2019) The State of Care Report. The Care Quality Commission
https://www.cqc.org.uk/sites/default/files/20191015b_stateofcare1819_fullreport.pdf

³⁹ The cap for support in Scotland is £28,500 and in Wales, £50,000.

⁴⁰ 'Local authority care rates', <https://nationalcareassociation.org.uk/news-events/news/local-authority-care-rates>

⁴¹ Competition and Markets Authority (op.cit) p39.

⁴² 'Care homes for the elderly: where are we now?', <https://www.grantthornton.co.uk/globalassets/1.-member-firms/united-kingdom/pdf/documents/care-homes-for-the-elderly-where-are-we-now.pdf>

⁴³ "We don't get paid for empty beds": the crisis facing UK care home operators', <https://www.ft.com/content/410afc04-206b-46c7-90fe-764f2109e734>

keep up with rising costs.⁴⁴ Although spending on social care has increased since 2016/7, in real terms spending has still been cut by £0.5 billion since 2010/11. Furthermore, this does not take into account rising demand. Spending per head of the adult population has fallen by £49 – or 17.5 per cent – from £539 in 2010/11. Given that it is the older population that is growing most rapidly – particularly the oldest who are most likely to need care – the picture for people aged over 65 is likely to be even more acute.⁴⁵ These financial pressures have affected the market for residential care. In 2018, a number of care homes were up for sale, hoping to take advantage of a growing appetite for real estate-backed healthcare assets, particularly from infrastructure funds.⁴⁶ However, interest began to wane in part due to uncertainty caused by Brexit. A number of anticipated sales fell through.⁴⁷

Table 2 shows that thousands were affected by the closure of facilities or cancellation of contracts before the pandemic. This has been an upward trend since 2016. This disruption is a threat to the provider market as a whole. A particular concern is that significant regional inequalities have been reinforced, with changes in nursing home bed numbers ranging from a 44 per cent rise in one local authority to a 58 per cent reduction in another between April 2016 and 2018.⁴⁸

Table 2: Councils with providers that have closed, ceased trading or handed back contracts within previous six months to June 2019 (out of survey of 150 councils in England)⁴⁹

	Closed or ceased trading		Handed back contracts	
	No. of councils	Predicted no. of people affected	No. of councils	Predicted no. of people affected
Home care	72	7,019	38	3,464
Residential/Nursing care	52	1,173	12	310

⁴⁴ 'Market oversight update', https://www.cqc.org.uk/sites/default/files/CM061907_Item7_marketoversight_presentation.pdf

⁴⁵ Age UK, 2019: 21

⁴⁶ 'Care home group Barchester put up for sale', <https://www.ft.com/content/4e755d04-890d-11e8-bf9e-8771d5404543>

⁴⁷ 'Macquarie drops £2.5bn care home deal over Brexit concerns', <https://www.ft.com/content/4b58ac0c-a261-11e9-a282-2df48f366f7d>

⁴⁸ Age UK, 2019: 35.

⁴⁹ ADASS (2019) ADASS Budget Survey, Report by Association of Directors of Adult Social Services, <https://www.adass.org.uk/media/7973/no-embargo-adass-budget-survey-report.pdf>

Declining service provision has resulted in extensive informal care.⁵⁰ The ONS estimates that the number of people receiving some level of informal care from family, friends or others is approximately 2.1 million. The number of unpaid carers in England increased from 5.9 million to 7.6 million from 2001 to 2018.⁵¹

Inadequate funding from local authorities has led to immense strain on social care but this is only part of the reason for the emerging crisis in the sector. Also relevant are the structural shifts resulting from privatisation and financialisation. As the following section highlights, the pursuit of profit in social care creates downwards pressure on wages and working conditions. However, as we discuss below, these poor working conditions often persist alongside high returns for investors. In addition, the financial activities of some care providers can contribute to weaknesses in the system of care provision. The resulting structures are inequitable and put vulnerable people at risk.

3 Care sector workers

The lack of value placed on care work by society is widely acknowledged,⁵² and research has highlighted how these accepted norms around the importance of care work are used to justify low wages paid to predominantly female care workers. Indeed, many employers in the care sector consider acceptance of poor wages as a significant, and almost a prerequisite, element of working in the sector. Where workers challenge the poor levels of pay this is often seen by employers as evidence of an individual's unsuitability for the work.⁵³

⁵⁰ See WBG briefing 'Social Care and Gender', March 2020 for further discussion, available at <https://wbg.org.uk/analysis/uk-policy-briefings/2019-wbg-briefing-social-care-and-gender/>, last accessed 1/7/20.

⁵¹ 'Care deserts: the impact of a dysfunctional market in adult social care provision', <https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/care--support/care-deserts---age-uk-report.pdf>

⁵² See WBG briefing 'Social Care & Gender', March 2020.

⁵³ Hussein, S. (2017). "We don't do it for the money"... The scale and reasons of poverty-pay among frontline long-term care workers in England. *Health & social care in the community*, 25(6), 1817-1826., p. 1821.

Within the adult care sector, the majority of jobs are split between residential⁵⁴ and domiciliary⁵⁵ employers (just over 40 per cent each), two per cent of jobs are in day care services and 13 per cent are community based.⁵⁶ Available data on care sector workers do not always differentiate between those working in residential or domiciliary care; therefore, data included here refer to the sector as a whole unless specifically stated. Data from the United Kingdom Homecare Association (UKHCA) show that the domiciliary care sector in England has an estimated workforce of 520,000. Around 505,000 of these roles were within the private-for-profit and NFP sector, with 19,000 in local authorities.⁵⁷

Across the social care sector in the UK the gender composition of the workforce is relatively consistent. In England 82 per cent of workers are female and the average age of workers in the sector is 43 years old, with a quarter of employees aged over 55.⁵⁸ Similarly, in Scotland the gender composition of the social care sector workforce is 83 per cent female (with women workers over 50 accounting for 45 per cent of care workers) and 17 per cent male.⁵⁹ In England, Black, Asian and Minority Ethnic (BAME) workers made up 21 per cent of the adult social care workforce, whereas BAME people are 14 per cent of the population of England.⁶⁰ Although gender does not vary significantly between most job roles, more men are likely to be in senior management (34 per cent) and support and outreach roles (25 per cent) compared to other frontline roles.⁶¹ The ethnic profile of the workforce varies considerably across England, with the most diverse workforce in London (67 per cent BAME) and the least diverse

⁵⁴ The service types included in this category are care homes with nursing, care-only homes and Shared Lives services. <https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/Size-of-the-adult-social-care-sector/Size-and-Structure-2019.pdf>

⁵⁵ Domiciliary care involves a wide range of services including supported living services, domestic services and home help, meals on wheels as well as nursing agencies (<https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/Size-of-the-adult-social-care-sector/Size-and-Structure-2019.pdf>).

⁵⁶ Day and community based services includes a wide range of services, such as carers' support services, the organisation of short breaks and respite care, community support and outreach services, disability adaptations and assistive technology services, occupational and employment-related services and information and advice services (<https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/Size-of-the-adult-social-care-sector/Size-and-Structure-2019.pdf>); State of adult social care sector and workforce in England, 2018 p.21.

⁵⁷ <https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/Size-of-the-adult-social-care-sector/Size-and-Structure-2019.pdf>

⁵⁸ State of adult social care sector and workforce in England, 2018.

⁵⁹ Fairwork Convention (2019) Fair Work in Scotland's Social Care Sector 2019.

⁶⁰ State of adult social care sector and workforce in England, 2018, p.60.

⁶¹ State of adult social care sector and workforce in England, 2018, p57.

workforce in the North East (four per cent). In general, these proportions reflect the composition of local populations in each area⁶² although in London the BAME population is over-represented in the care sector workforce given that the overall BAME population in the city is only around 32 per cent.⁶³ Only a small percentage of people with BAME backgrounds were employed in management roles in the care sector – 14 per cent as registered managers and 17 per cent as senior managers. In terms of other professions within the care sector, registered nurses had the highest proportion of people with a BAME background (38 per cent), whereas occupational therapists had the lowest (10 per cent).⁶⁴

Analysis from the Institute for Public Policy Research (IPPR) using Labour Force Survey data shows that 7.1 per cent of the total workforce in the care sector as a whole in England is made up of EU nationals, and non-EU nationals constitute 9.5 per cent of the workforce. EU nationals represent 7.8 per cent of all care workers in England.⁶⁵ In London the provision of social care is particularly dependent on migrant workers – only 37 per cent of the adult social care sector workforce in London is UK born, with 12 per cent being from the EU and 51 per cent being non-EU migrants.⁶⁶ In the early 2010s the top three countries of origin of migrant workers in the care sector were the Philippines, India and Poland.⁶⁷ Research has also found that a growing number of migrant men are moving into frontline care work, particularly within the private sector. Moreover, migrant men were more likely to work with more ‘challenging’ service user groups when compared to British men, and migrant women were also over-represented with some of these users’ groups. For example, 12.7 per cent of migrant men worked with older people with dementia compared to only 6.9 per cent of British men, and 2.1 per cent worked with adults detained or being cared for under the Mental

⁶² State of adult social care sector and workforce in England, 2018, p.60.

⁶³ <https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/regional-ethnic-diversity/latest#areas-of-england-and-wales-by-ethnicity>, last accessed 25/6/20.

⁶⁴ State of adult social care sector and workforce in England, 2018, p.61.

⁶⁵ While it has not been possible to locate detailed data for the domiciliary care sector the Skills for Care’s National Minimum Data Set shows that 65.4% of all careworkers in the domiciliary care sector in England are British citizens (UKHCA (2019) An overview of the UK Homecare Market., available at: <https://www.ukhca.co.uk/downloads.aspx?ID=611#bk1>, last accessed 25/6/20.

⁶⁶ Dromey J and Hochlaf D (2018) *Fair care: A workforce strategy for social care*, IPPR. <http://www.ippr.org/research/publications/fair-care>. P. 14.

⁶⁷ Hussein, S., Stevens, M., & Manthorpe, J. (2013). Migrants’ motivations to work in the care sector: experiences from England within the context of EU enlargement. *European Journal of Ageing*, 10(2), 101-109.

Health Act (MHA) (2007) compared to less than 1 per cent of British men.⁶⁸ Migrant workers were also more highly qualified than British workers suggesting a de-skilling of the migrant workforce.⁶⁹

In England the majority of care workers (78 per cent) are employed in the private care sector and seven per cent of jobs are located in local authorities. Although the sector regulator in England, the Care Quality Commission (CQC) does not differentiate between private for profit and not-for-profit (NFP) providers, within the private sector it is estimated that approximately 75 per cent of the jobs for private sector employers were in 'private-for-profit' establishments and 25 per cent were in NFP establishments.⁷⁰ While it is not easy to get a clear picture of differing terms and conditions for workers between the local authority, NHS and private sector some evidence points to better conditions and opportunities for staff employed in the NHS and local authority sector, at least in England. According to the IPPR the use of zero-hours contracts, which do not guarantee workers a minimum number of hours, is higher in the social care than any other sector.⁷¹ Using Labour Force Survey data, the IPPR has shown that 6.1 per cent of workers in residential care and 9.7 per cent of care workers are on a zero-hours contract, compared to 2.3 per cent of employees across the whole economy. However, the real prevalence of zero-hours contracts is likely to be far higher, particularly for those working in domiciliary care services where in England 58 per cent of care workers and 52 per cent of registered nurses were recorded with this contract type.⁷² Moreover, the IPPR found that care workers employed by private providers in England are over three times more likely to be on zero-hours contracts than those employed by local authorities (34.8 per cent compared to 10.1 per cent).⁷³ Within the domiciliary care sector there is also evidence that private sector managers use the lack of any guaranteed hours as a means of increasing staff compliance with a changing mix of users and rotas. If people are not

⁶⁸ Hussein, S., & Christensen, K. (2017). Migration, gender and low-paid work: on migrant men's entry dynamics into the feminised social care work in the UK. *Journal of Ethnic and Migration Studies*, 43(5), 749-765., p755.

⁶⁹ Hussein, S., & Christensen, K. (op.cit)

⁷⁰ State of adult social care sector and workforce in England, 2018, p.20

⁷¹ Dromey J and Hochlaf D (op.cit), p.10.

⁷² State of adult social care sector and workforce in England, 2018, p.61

⁷³ Dromey J and Hochlaf,2018: 10.

sufficiently flexible, they are not offered as many hours.⁷⁴ As a result, domiciliary care workers can end up working extended and fragmented hours which potentially include unsocial hours as well as unpaid hours in between shifts which cannot be used effectively for other activities or for other employers.⁷⁵ In Wales some progress has been made towards eliminating zero-hours contracts for domiciliary care workers as well as limiting 'call-clipping' where home visits are cut short because care workers do not have sufficient time to travel between visits. In April 2018 the Welsh Government issued legislation compelling employers to offer the choice of guaranteed hours after three months of employment or remain on a zero hours contract should they wish to do so.⁷⁶ The legislation also requires care providers to ensure that allocated travel time is clearly set out to avoid call-clipping⁷⁷

Recruitment and retention, particularly of frontline care workers and especially nurses, are a major challenge within the sector although there is some regional variation. Reports suggest that the difficulties in recruiting nurses are most acute in Northern Ireland, and in certain rural areas of Scotland.⁷⁸ Figures from England suggest that the number of registered nursing jobs in adult social care has reduced by 18 per cent since 2012. In Scotland in 2020, 52 per cent of private-for-profit care homes had nursing vacancies compared to 15 per cent in the NFP sector.⁷⁹ In England registered nurses in social care had a relatively high turnover rate (32.4 per cent) over a twelve month period (2017-18), equivalent to around 11,500 leavers, compared to other regulated professions in the care sector such as occupational therapists and social workers. It is worth noting though that in the main, registered nurses are employed in the private sector whereas occupational therapists and social workers are primarily employed by local authorities. The turnover rate over twelve months is particularly high for those working in domiciliary care. In 2017/18 the turnover rate of care workers

⁷⁴ Rubery, J., Grimshaw, D., Hebson, G., & Ugarte, S. M. (2015). "It's All About Time": Time as contested terrain in the management and experience of domiciliary care work in England. *Human Resource Management*, 54(5), 753-772., p.761.

⁷⁵ Rubery, J., Grimshaw, D., Hebson, G., & Ugarte, S. M. (op.cit), p758.

⁷⁶ Curb on zero-hour care worker contracts and 'call clipping', <https://www.bbc.co.uk/news/uk-wales-politics-43606992>, last accessed 25/6/20.

⁷⁷ 'Welsh government cracks down on zero-hours contracts in homecare', <https://www.unison.org.uk/news/2018/04/welsh-government-cracks-zero-hour-contracts-homecare/>

⁷⁸ Care homes market study,2017, 4.62

⁷⁹ Commonweal Policy (2020) The predictable crisis: why COVID-19 has hit Scotland's Care homes so hard., p.18.

within domiciliary care providers was 42.3 per cent.⁸⁰ However, care workers on zero-hours contracts were more likely to have a higher turnover rate compared to those not on a zero-hours contract (31.4 per cent compared to 27.4). This was shown to have a greater influence on those working in residential care compared to those in domiciliary care (in which zero-hours contracts are more prevalent).⁸¹ Competition from other low paid sectors has been cited as an explanatory factor in relation to high turnover of staff, particularly domiciliary care workers. Alternative jobs such as supermarkets can offer higher wages and predictability as well as other advantages such as not having to travel from house to house in bad weather and fewer risks in terms of threats to safety and well-being that care workers endure.⁸²

The extent of low pay in the care sector highlights the need for the national living wage to be raised to the level of the real living wage. Data from the IPPR show that, despite the introduction of the national living wage in 2016, half of care workers in England are still paid below the real living wage. Moreover, their analysis found significant differences in pay between care workers in the private sector where the median hourly pay was just £7.76 compared to those working in local authorities where hourly pay rates were £9.80.⁸³ Although the introduction of the national living wage meant that wages for the lower paid care workers increased by just under seven per cent, the increases for those above the wage floor were far smaller.⁸⁴ In effect the result has been that some senior care workers might earn just an average of £0.81p an hour more than a junior care worker but have considerable responsibility in terms of managing shifts, handing over to new staff and administering medication.⁸⁵

The lack of integration with the NHS has had a significant impact on recruitment and retention in the care sector as employment terms and conditions are more favourable in the NHS. This is particularly evident around training and career progression. Nurses and occupational therapists in particular often favour working in the NHS because there is a clear structure for promotion and career progression which is generally

⁸⁰ State of adult social care sector and workforce in England, 2018, p.35.

⁸¹ State of adult social care sector and workforce in England, 2018, p.41.

⁸² Jefferson, L., Bennett, L., Hall, P., Cream, J., Dale, V., Honeyman, M., & Murray, R. (2018). Home care in England. Views from commissioners and providers. *The King's Fund: London*.

⁸³ Dromey J and Hochlaf, (op.cit) ,p.8.

⁸⁴ Dromey J and Hochlaf, (op.cit), p8

⁸⁵ Moriarty, J., Manthorpe, J. and Harris, J. (2018) Recruitment and Retention in Adult Social Care Services, Social Care Workforce Research Unit, The Policy Institute, Kings College, London. , p. 10

missing from the care sector. While newly qualified professionals may opt to start off in the care sector and gain experience, many prefer to then move into the NHS because of the longer-term opportunities.⁸⁶ Yet as a report from the Resolution Foundation recently argued, there is little incentive for care providers to invest in training and benefits for care workers. They argue that funding pressures and uncertainties within care markets have led to low-investment employer strategies, and high labour turnover means providers fear losing the benefit of any investments they do make before they have enough return. For care workers themselves, becoming more qualified rarely leads to any increase in pay or autonomy so there is also little incentive to invest in their own skills.⁸⁷ Although the 2013 Cavendish Review sought to address the lack of common training standards across the care sector, little real progress has been made. In England a Care Certificate was introduced that could be completed within 12 weeks of an individual starting work. However, the certificate is not mandatory nor enforced by a regulator, and concerns have been raised about quality assurance, portability and suitability and only a small proportion of care workers have registered for the training. Given that many care workers report having to carry out the training unpaid in their own time this is perhaps not surprising. Moreover, significant differences exist between private sector providers where around 56 per cent of care workers have no relevant social care qualifications compared to around 19 per cent of local authority providers.⁸⁸ Nevertheless, care workers in domiciliary care services were more likely to have engaged with the training required for the Care Certificate than those in residential care – in 2017/8 75 per cent of domiciliary care workers had either completed all or part of the certificate or were in the process of completing the training.⁸⁹

There are also other ways in which care workers in the private sector are disadvantaged compared to those in the NHS. One significant barrier to recruitment for rural care homes and domiciliary services is the issue of transport as many care workers do not own cars. Within the private sector domiciliary care workers are rarely paid for travel time between visits (though sometimes exceptions are made in rural

⁸⁶ Moriarty et al. (op.cit).

⁸⁷ Gardiner, J. and Hussein, S. (2015) *As if we cared. The costs and benefits of a living wage for social care workers*, The Resolution Foundation., p. 35.

⁸⁸ Dromey J and Hochlaf, (op.cit) p.11.

⁸⁹ *State of adult social care sector and workforce in England, 2018*,p.77.

areas) and workers are often expected to cover transport costs out of their wages.⁹⁰ Moreover, private sector care workers are rarely given support should they wish to purchase their own car and it is a personal choice as to whether or not they may choose to take out a loan to buy a car, yet in contrast some care workers within the NHS are offered the opportunity to obtain a lease car which makes transportation more affordable and also leads to improved wellbeing for workers which contributes to staff retention.⁹¹ The lack of value placed on care workers in the private sector is clearly expressed in research which found that some private sector employers believed that their staff receive a range of 'non-monetary rewards' which compensated for low wages despite the fact that the majority of these rewards were items that employers were legally responsible for providing, including essential items such as uniforms and locker keys.⁹²

These conditions have an impact on care standards. Staffing levels and training, together with a supportive working environment are major determinants of care quality.⁹³ These poor working conditions sit alongside high payments to shareholders and directors. For example, in 2018, the highest paid director at Care UK received remuneration of £0.9m. In the same year, the company paid wages salaries for staff working in nursing care and support as well as management and administration an average of £21k. Directors are all male, senior managers are 63 per cent male, while 'other employees' are 80 per cent female.⁹⁴

The data presented here clearly illustrate that the care sector is underpinned by a low-paid, feminised and racialised workforce. It is this pervasive devaluing of care work and care workers that not only formed the background to privatization but has since enabled investment funds to take a significant stake in the sector and redirect

⁹⁰ Rubery, J., Grimshaw, D., Hebson, G., & Ugarte, S. M. op.cit).

⁹¹ Moriarty et al., 2018: 16

⁹² Hussein, op.cit. 2017.

⁹³ Dromey J and Hochlaf D (2018) *Fair care: A workforce strategy for social care*, IPPR.

<http://www.ippr.org/>

[research/publications/fair-care.p](http://www.ippr.org/research/publications/fair-care.p)

10;

and

see

https://www.cqc.org.uk/sites/default/files/20170703_ASC_end_of_programme_FINAL2.pdf

⁹⁴ These figures are from the consolidated accounts which includes Care UK's accounts for residential care services and health services. Residential care accounted for 47% of Care UK's revenue in 2018, CareUK Health & Social Care Holdings Ltd Annual Report and Financial Statements 30 September 2018

resources from labour to financial actors.⁹⁵ These financial actors are examined in greater detail in the following sections.

4 The financialisation of social care

Social care has attracted the attention of global financial capital, and services have in some cases been structured in ways that allow the scarce public resources and individuals' savings, which fund the sector, to be extracted to shareholders, across residential and domiciliary care. Such practices have created an additional vulnerability in the sector. In one high profile case the company Southern Cross went into administration in 2011 (Box 1). Another service provider, Castlebeck, went into administration in March 2013.⁹⁶ It was owned by private equity group Lydian Capital Partners LP based in Jersey.⁹⁷ The company closed following a BBC programme showing physical abuse and neglect in one of their care homes, Winterbourne View.⁹⁸ The company was highly indebted with borrowings of around £448m.

⁹⁵ Horton, (op.cit).

⁹⁶ 'Castlebeck sold to fellow care provider, saving 850 jobs', <https://www.communitycare.co.uk/2013/09/05/castlebeck-sold-to-fellow-care-provider-saving-850-jobs/>

⁹⁷ CB Care Accounts 2010

⁹⁸ 'Castlebeck care homes go into administration following abuse scandal', <https://www.bbc.co.uk/news/uk-21674695>

Box 1: The collapse of Southern Cross

In 2011, Southern Cross was the UK's biggest care home provider. The chain expanded rapidly under the ownership of private equity investors, Blackstone, who bought it in 2004 and set up a "sale and leaseback" (see below) where ownership of the care home properties was set up under a separate company from the operations of the care services. The property company, NHP, was initially also owned by Blackstone but was then sold in 2006 for £1.1bn to a fund backed by the Qatar Investment Authority. After the sale, Southern Cross ran into difficulties for a number of reasons. Rents were higher than those paid by rival companies in part due to the, upwards only, annual rent increases of around 2.5 per cent that were agreed.⁹⁹ The company faced higher interest on debts as it no longer owned properties on which loans could be secured.¹⁰⁰ Eventually, the onset of the financial crisis in 2008 led to falling occupancy rates and a freeze in council payments so that Southern Cross could no longer afford the lease payments. Cost-cutting led to poor care standards so that the company was closed in 2011. The company's financial structure was linked to poor care and ultimately the deaths of five residents. The financial strategy put vulnerable people at risk.¹⁰¹ Meanwhile, the property sale was lucrative for Blackstone. The Southern Cross homes were taken over by other care home companies, with 241 taken over by the newly-established HC-One which was owned by the landlords, NHP.¹⁰²

In part to address this vulnerability resulting from financial engineering, the 2014 Care Act imposed new statutory duties on local authorities to support the development, functioning and sustainability of markets for social care services. This included market shaping and contingency planning should a provider fail either financially or in terms of quality. The Act established a new "Market Oversight" role requiring the CQC to

⁹⁹ 'Southern Cross's incurably flawed business model let down the vulnerable',

<https://www.theguardian.com/business/2011/jul/16/southern-cross-incurable-sick-business-model>

¹⁰⁰ IPC (2014) "The stability of the care market and market oversight in England" Institute of Public Care, Oxford Brookes University, <https://www.cqc.org.uk/sites/default/files/201402-market-stability-report.pdf>

¹⁰¹ Bayliss, K. (2016) "The financialisation of health in England: Lessons from the water sector", Fessud Working Paper No. 131, http://fessud.eu/wp-content/uploads/2015/03/Financilisation_Health_England_WorkingPaper131.pdf

¹⁰² 'Care provider NHP examines options', <https://www.ft.com/content/a7e06a62-ddac-11e2-892b-00144feab7de>

assess the financial stability of certain providers which, because of their size, concentration or specialism, would be difficult to replace were they to fail.¹⁰³ The CQC has no powers to prevent provider failure but is just required to provide notification to authorities to aid contingency planning in the event of a likely cessation of services in order to minimise avoidable uncertainty for vulnerable people.¹⁰⁴

This section reviews the financial practices of the largest care providers. Annex A lists the 63 care providers on the CQC Market Oversight list in May 2020 and provides details of their ownerships based on a review of company accounts. These companies account for around 25 per cent of the adult social care market in England.¹⁰⁵ They cover a range of services and geographical locations and provide a representative overview of the principal providers of social care, encompassing services for elderly as well as other adult services such as support for individuals with learning disabilities and mental illness. This section also draws on a report for the Centre for Health and the Public Interest (CHPI)¹⁰⁶ which provides a forensic analysis of the accounts of the 26 largest care home providers in the UK which account for 31 per cent of all registered beds. The CHPI Report groups these into not-for-profit (NFP) (eight providers, 24,964 beds); for-profit private equity (five providers, 36,755 beds) and for-profit not private equity (13 providers, 55,530 beds).

Some companies in Annex A have a unique ownership status in the group. Caretech is the only company listed on the London Stock Exchange.¹⁰⁷ Welltower Inc is listed on the New York Stock Exchange. In the UK (and elsewhere) it operates a Real Estate Investment Trust (REIT)¹⁰⁸ which owns nursing and care home buildings. Prestige Nursing is owned by Sodexo from France and Clece Care Services, by a Spanish private company. BUPA is an international health company, registered in the UK providing health insurance, dental and medical services as well as care homes. While technically it is NFP as it is limited by guarantee, in many ways it operates as a private

¹⁰³ 'Market oversight of adult social care', <https://www.cqc.org.uk/guidance-providers/market-oversight-corporate-providers/market-oversight-adult-social-care>

¹⁰⁴ https://www.cqc.org.uk/sites/default/files/CM061907_Item7_marketoversight_presentation.pdf

¹⁰⁵ CQC (2019) The State of Care Report. The Care Quality Commission
https://www.cqc.org.uk/sites/default/files/20191015b_stateofcare1819_fullreport.pdf

¹⁰⁶ Kotecha, V. (op.cit).

¹⁰⁷ The two brothers that set up the company became millionaires when the company was floated in 2005, <https://www.theguardian.com/business/2005/sep/19/8>

¹⁰⁸ <https://welltower.com/investors/press-release-details/?id=23531>

company with high payments to directors and complex group structures.¹⁰⁹ The Priory, the UK’s largest provider of mental health services, is owned by US-listed firm Acadia Healthcare Co. Inc, via a chain of intermediate holding companies including some registered in the Cayman Islands.

Seven in Annex A are owned by parent companies listed in tax havens some of which are private equity investors, and a further five are owned by private equity investors that are not registered offshore.¹¹⁰ Private equity firms typically invest funds on behalf of investors but the funds are managed by the private equity partnership so this is the party that might exercise some kind of shareholder control in the company. Care UK, for example, is majority-owned (78.2 per cent) by a collection of seven private equity funds termed the “BEIV Fund” that are managed by private equity firm Bridgepoint.¹¹¹ For 20 of the CQC Market Oversight companies, the owner or controller is a private individual or family. A further 20 providers have some form of charitable status, as a community organisation or registered society, if not as a registered charity. For five companies, the identity of the owner or controlling party was not possible to establish from a review of the accounts or wider internet search.

Included in the list in Annex A are the country’s largest providers of residential care. Table 3 lists the number of care homes and beds provided by the five biggest chains in the sector. The data are just for England but these companies also operate in the rest of the UK. The number of beds provided by these five companies has fallen since 2015 but their market share is unchanged at 12 per cent of the total beds in the sector.¹¹²

Table 3: The five largest care home chains in England¹¹³

	2015	2019
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¹⁰⁹ Total remuneration of BUPA’s highest paid director came to £2.461m in 2019, BUPA Annual Report

¹¹⁰ Private equity ownership means that a company is owned privately rather than listed on the LSE. Typically though, the term applies to specific private equity fund managers that manage investment portfolios on behalf of investors for a management fee.

¹¹¹ ‘Bridgepoint: about us’, <http://www.bridgepoint.eu/en/about-us/>

¹¹² However, this is a moving target. Care homes are bought and sold often so that the ownership portfolio is difficult to pin down. In 2017, HC-One bought 110 homes from Bupa but then some have subsequently been sold on. According to real estate company, Savills, HC-One operated 22,000 beds in October 2019 but HC-One’s accounts indicate that the company had 170 care homes in the UK with 8,400 residents.

¹¹³ Naylor, A. and J. Magnussuon (2020) “Data that cares” Report for Future Care Capital

	Total homes	Total beds	Total homes	Total beds
Four Seasons Group	317	17,432	271	16,266
BUPA Group	222	16,541	214	11,856
Barchester Healthcare	222	10,669	165	10,559
HC-One Ltd	150	7,756	111	7,462
Care UK	107	6,806	118	6,972
Total	1,018	59,204	879	53,115
Share of total beds/homes (%)	6	13	6	12

Notwithstanding the recent financial pressures outlined above, in a global climate of low yields in many sectors, the UK care sector is attractive to international capital for several reasons. It offers predictable and secure returns from an ageing population. The services provided are medically necessary, often funded by the state. While the sector is depicted as a “market”, barriers to entry are high when it comes to operating at scale and clients tend not to move to alternative providers. Yet the continued existence of numerous small enterprises in a fragmented sector offers opportunities for operations to grow. Private equity investors in particular aim to restructure business to sell them on for a profit, and in part this is achieved by buying up small providers (known as ‘bolt-ons’). In addition the connection with real estate offers additional security, with scope for profits through rent and capital gains. Real Estate Investment Trusts (REITS) such as Welltower and Target Healthcare REIT, lease care home properties to the operating companies at high returns (see below). These are described as high-yielding, “hands off” investments similar to student accommodation.¹¹⁴ Notably, however, it is not just residential but also domiciliary services that have attracted financial investors as social care has been reimagined in terms of a revenue stream and a financial asset.

Investors receive returns on their investments in different ways. The most obvious is with the payment of dividends. Some companies have reported losses but still paid

¹¹⁴ ‘Why the UK care home market is worth investing in?’, <https://www.onetouchinvestment.co.uk/news/care-home-investment/uk-care-home-market-worth-investing/>

dividends. HC-One paid £48.5m in dividends in 2017/2018 despite declaring a loss every year except one since it was founded in 2011 out of the collapse of Southern Cross.¹¹⁵ Avery Healthcare Group declared losses of £5.9m in 2019 and £10.9m in 2018 yet paid dividends of £3m and £2.7m in the respective years.¹¹⁶

Kotecha¹¹⁷ finds that small and medium companies make far higher profits than the biggest 26 providers. But this does not necessarily mean the shareholders of the big companies are not generating returns on their investments. As Burns et al point out:

The declared profit of operating subsidiaries in financialised chains is not a hard indicator of surplus in one year accrued after necessary expenses. Rather, it is the malleable result of manoeuvring over several years to reduce tax, extract cash and rearrange obligations with an eye to exit.¹¹⁸

Companies have adopted various strategies to boost outflows (or “leakage” as termed by Kotecha) to investors in ways that are unrelated to productivity. Some care providers are embedded in extensive complicated networks of corporate companies, with funds flowing between firms so that it is difficult to trace where profits might end up. A number of companies in Annex A have set up their parent company, or other companies in the group structure, in an off-shore jurisdiction where the company avoids both tax and scrutiny. Smaller care home chains that do not feature in the Annex such as Orchard Care Homes and Ideal Care Homes also are connected to offshore locations (Guernsey and the Cayman Islands, respectively).¹¹⁹

With complex corporate structures, profits can be hidden in different ways such as interest on intergroup loans, rent paid to a separate company owned by the same shareholder and management fees paid to other group companies. These inter-

¹¹⁵ ‘Care home group paid £48.5m in dividends while warning of cuts’, <https://www.ft.com/content/c0e37072-7243-11e9-bf5c-6eeb837566c5>

¹¹⁶ Avery Healthcare Group Ltd Annual Report and Financial Statements for year ended 31 March 2019

¹¹⁷ Kotecha (op.cit).

¹¹⁸ Burns et al. (op.cit). p.24..

¹¹⁹ Orchard Care Homes was controlled by Alchemy Special Opportunities Fund III LP, registered in Guernsey, Orchard Care Homes.com Holdings Ltd Directors’ Report and Financial Statements for 18 month period ending 30 September 2018. In April 2019 Ideal Care Homes was sold to Warwick European Opportunities Fund II Ltd. The ultimate owner of the purchaser of Ideal Care Homes is unknown but Companies House lists as a “person with significant control” over Ideal Carehomes Topco Ltd Warwick European Opportunities Fund Li (Gp) Ltd which is registered in the Cayman Islands, <https://beta.companieshouse.gov.uk/company/11900154/persons-with-significant-control>¹¹⁹

company payments appear to lower the profitability of the operation but can boost shareholder returns. Some of the extraction methods that are unrelated to productivity are explored below.

4.1 Debt

Some care providers are heavily indebted. In part, these debts are related to the buying and selling of investments in “leveraged buyouts”. Refinancing can mean that part of the cost to the investor of buying the care homes then sits with the care home chain itself. Debt levels are highest in private equity owned care home chains.¹²⁰ Burns et al¹²¹ document how the Four Seasons care home chain after 1999 had serial changes in ownership where at each change-over the seller made a profit from the buyer who loaded the business with more debt. Funds flow back and forth across an impenetrable web of companies owned by the same shareholders.

High debt levels lead to high interest payments and these are tax deductible. Kotecha calculates that the eight largest NFP providers of residential care pay interest costs of £19 per bed per week compared with £14 for the 13 large for-profit providers. Meanwhile the five private equity-owned providers pay interest costs that amount to £102 per bed per week. This is equivalent to 16 per cent of the weighted average weekly fee of £622 for residential care and 12 per cent of the equivalent fee for nursing care at £856 per week. The biggest four care home providers pay around £239m a year on interest on their debts and this is ultimately financed by tax payers and individual payments by residents.¹²² There is no intrinsic reason why care homes should be so indebted. High debts are only a feature of a small proportion of providers. In a study by Opus and Company Watch of a sample of 6158 care home operators, over 80 per cent had no borrowings at all.¹²³

Shareholder returns are boosted further where the debt is owed to a related company or to shareholders, especially if this is at high rates of interest. Finding from the

¹²⁰ Kotecha, V. (op.cit).

¹²¹ Burns et al., (o.,cit).

¹²² Plimmer, G. (2020) “‘We don’t get paid for empty beds’: The crisis facing UK care homes” Financial Times.

¹²³ Opus (2016) “Residential Care Home Finances 2014 – 2016”. Report by: Opus Restructuring Llp and Company Watch, <http://www.opusllp.com/wp-content/uploads/2016/11/DOC-161114-NRH-care-home-finances-report-final-as-PDF.pdf>

Paradise Papers show how private equity owners, Terra Firma, hoped to make vast profit from buying the Four Seasons company in 2012 and the company was made to borrow £220m from subsidiaries of the private equity owners at 15 per cent interest a year on a compound basis over ten years. By 2022 when it was due to be repaid, the care home chain would have owed its controlling shareholder four times the original sum. The debt was later written off because of financial struggles at Four Seasons.¹²⁴

It is not just residential care but some domiciliary and other support providers that are also heavily indebted. City and County which is owned by private equity firm Graphite Capital Partners has liabilities over £180m including shareholder loans, some of which are at 10 per cent interest. Voyage Care raised £272m on the bond market in 2013 in order to refinance existing debt. In their 2019 company accounts, Voyage Care has debts of £491m and finance costs for the year of £38m.¹²⁵ The company's accounts indicate that shareholder loans at 10 per cent interest have accrued interest in the region of £100m. Alina Care Holdings, the parent of Alina Homecare paid interest of £1.6m in 2019 which contributed to its post-tax loss of £2.2m. The company's loans and borrowings consist mainly of £11.6m at interest rate of 10.3 per cent to the controlling party Bridges Fund Management Ltd.¹²⁶

4.2 Rent

A large number of small- to medium-sized residential care companies are family run or charitable organisations operating with one to three properties which they own outright so they pay little or no rent. Larger NFP providers often have low rent costs because they own their properties.¹²⁷ However, property-related costs can generate substantial shareholder returns.

A number of residential care providers have separated the ownership of the property from the providing of services into separate companies under a “sale and leaseback”

¹²⁴ ['Private equity firm made struggling care home operator take costly loan'](https://www.theguardian.com/news/2017/nov/08/private-equity-terra-firma-care-home-four-seasons-loan), <https://www.theguardian.com/news/2017/nov/08/private-equity-terra-firma-care-home-four-seasons-loan>

¹²⁵ ['Voyage Care acquires Fox Elms Care'](https://healthcarebusiness.co.uk/voyage-care-acquires-fox-elms-care/), <https://healthcarebusiness.co.uk/voyage-care-acquires-fox-elms-care/>

¹²⁶ Alina Care Holdings Ltd Annual Report and Consolidated Financial Statements for the Year Ended 30 April 2019.

¹²⁷ Kotecha (op.cit).

arrangement. The operating company pays rent to the property company. Kotecha found that under these arrangements, care home chains paid much higher levels of rent (£14.32 out of every £100 spent compared with £2.34 for the eight large NFP providers studied).

The property company may then be sold to a new investor, and this releases cash for further expansion, or retained under the control of the same shareholders. And there are additional advantages if the property owner is registered in a tax haven. During 2018, Care UK paid rent of £5.2m to Silver Sea Holdings Ltd, a company apparently based in Luxembourg¹²⁸ and owned by the same parent private equity shareholder, Bridgepoint. Silver Sea was established to build and own residential care home property.¹²⁹ But these transactions are difficult to trace with intercompany transfers via offshore jurisdictions. The accounts for Barchester Healthcare Ltd show that the company leased properties from Limecay Ltd which is “owned by common controlling shareholders of Grove Ltd”, the Jersey-based parent company of Barchester. The accounts show leasing costs of £116m, accounting for 20 per cent of operating costs. The Limecay accounts indicate that the company generated £102m in rental income from properties leased to Grove Ltd. Limecay Ltd is owned by Limecay International, a company registered in the British Virgin Islands.¹³⁰ In this way, lease and rental costs can be used to move profits to wherever the investor chooses.

The sector has attracted the interest of property developers and REITs. These are described by the Financial Times as “a closed-ended company which trades on public markets, providing tax efficient investment exposure to property assets”.¹³¹ UK REITs have become one of the best performing UK assets over the past decade.¹³² These

¹²⁸ <https://opencorporates.com/companies/lu/B155153>

¹²⁹ CareUK Health & Social Care Holdings Ltd Annual Report and Financial Statements 30 September 2018

¹³⁰ Limecay Ltd Annual Report and Financial Statements for Year Ended 31 December 2018.

¹³¹ ‘How to solve a problem like liquidity: REITs and the UK property sector’, <https://www.ftadviser.com/property/2019/10/01/how-to-solve-a-problem-like-liquidity-reits-and-the-uk-property-sector/#:~:text=They%20have%20become%20one%20of,property%20sector%20returned%206.2%25%20annualised.>

¹³² ‘How to solve a problem like liquidity: REITs and the UK property sector’, <https://www.ftadviser.com/property/2019/10/01/how-to-solve-a-problem-like-liquidity-reits-and-the-uk-property-sector/#:~:text=They%20have%20become%20one%20of,property%20sector%20returned%206.2%25%20annualised.>

are attracted to the secure rental incomes generated in the care home sector. US-based Welltower REIT is described as one of the biggest investors in the UK care home market.¹³³ It has a 10 per cent stake in care home provider, Avery Healthcare Group. Another REIT, Target Healthcare, is a publicly listed company that specialises in purpose built care homes. It operates 63 properties with 24 tenants and 4,094 residents and contractual rent of £32.2m. The company reports an annualised total return 12 per cent with trading performance boosted by “upwards-only rent reviews”.¹³⁴ Despite COVID-19 the company declared a 1.5 per cent rise in its third interim dividend in April 2020.¹³⁵

A further dimension to the financialisation of care homes and the increasing involvement of REITs is the re-formatting of care into large-scale hotel-style homes with 60+ beds. This operating model operates on lower costs due to economies of scale.¹³⁶ New investment is often directed towards self-funded residents, targeting wealthy areas and leaving poorer ones with local authority funding. The North East has by far the lowest proportion of self-funders (18 per cent) and the South East has the highest.¹³⁷ Care homes serving mainly local authority-funded residents are not considered economically viable.¹³⁸ With greater attention to the revenue stream generated by care home residents, the result is likely to be a two-tier system with “care deserts” emerging in some parts of the country.¹³⁹

4.3 “Multiple arbitrage”

In private equity this term refers to the practice by which investors generate returns without having to make any operational interventions in the business which they own. The concept relies on the fact that the asset will be sold in the future rather than being

¹³³ ‘Welltower among US investors in Barchester, report’,

<https://www.carehomeprofessional.com/welltower-among-us-investors-interested-barchester-report/>

¹³⁴ Target Healthcare REIT Annual Report and Financial Statements 2019

¹³⁵ ‘Care home trust keeps dividend on target as Covid infects under 5% of residents’

<https://www.theaic.co.uk/aic/news/citywire-news/care-home-trust-keeps-dividend-on-target-as-covid-infects-under-5-of>

¹³⁶ Burns et al. (op.cit).

¹³⁷ ‘Care deserts: the impact of a dysfunctional market in adult social care provision’,

<https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/care--support/care-deserts---age-uk-report.pdf>

¹³⁸ Competition and Markets Authority, Care Homes Market Study, Final Report, 2017.

¹³⁹ <https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/care--support/care-deserts---age-uk-report.pdf>

held with the intention of raising investor returns by improving profitability. In social care a core example of this is that of increasing the business size. Where the future sale price of a company is likely to be based on a multiple of its earnings, the larger the company, the larger the absolute value of the sale margin.¹⁴⁰ Investors can make a profit just by increasing the size of the company. The debt-financed expansion of operations was a theme in the accounts of many of the companies in Annex A. Companies and segments of operations are changing hands frequently. When in 2014 private equity investor Duke Street bought Voyage Care, which provides services for people with learning disabilities and complex needs, part of the rationale was, “a high likelihood of multiple arbitrage” which was expected to enhance already attractive investor returns.¹⁴¹ This was a feature in the profits made from Southern Cross where Blackstone paid around six times EBITDA (earnings before interest, tax, depreciation and amortisation) for care homes bought in 2004 and sold them for nine times in 2006.¹⁴²

Hence social care providers or segments are frequently bought and sold as ownerships are moved around different investment portfolios. Small providers are bought by larger ones and portfolios reconfigured to boost shareholder earnings. The CQC notes considerable “churn” in the domiciliary care market with around 500 agencies registering and 400 de-registering.¹⁴³ Duke Street had already owned Voyage Care from 2004 to 2006 during which time it carried out four acquisitions¹⁴⁴ and then sold to the company to HcCapital before buying it back eight years later. Despite its debts and losses Voyage Care continued to buy up small care providers such as the purchase of Fox Elms Community Care Ltd, a supported living provider for 35 people in Gloucestershire for £5.8m in 2019.¹⁴⁵

¹⁴⁰ ‘Multiple arbitrage: a primer’, <https://www.businessinsider.com/multiple-arbitrage-a-primer-2011-11?r=US&IR=T#:~:text=Multiple%20arbitrage%20is%20a%20tool,single%20synergy%20or%20cost%20cut.&text=It%20is%20primarily%20a%20tool,also%20used%20by%20strategic%20buyers>.

¹⁴¹ The UK’s leading provider of specialist care for people with learning disabilities’, <https://www.dukestreet.com/our-portfolio/voyage.html>

¹⁴² Burns et al. (op.cit).

¹⁴³ CQC (2017) The State of health care and adult social care in England 2016/17. Report by the Care Quality Commission. https://www.cqc.org.uk/sites/default/files/20171123_stateofcare1617_report.pdf

¹⁴⁴ ‘Paragon passes from Duke St to Hgcapital’, <https://www.buyoutsinsider.com/paragon-passes-from-duke-st-to-hgcapital/>

¹⁴⁵ ‘Voyage Care acquires Fox Elms Care’, <https://healthcarebusiness.co.uk/voyage-care-acquires-fox-elms-care/>

Care providers are moved around private equity owners with each seeking to make a mark up before selling it on. Such operations are not costless and often require specialist financial and legal services. For example, the 2013 bond issue by Voyage Care was underwritten by JP Morgan, Goldman Sachs and Lloyds and Voyage Care was advised by Rothschild.¹⁴⁶

4.4 *Issues arising*

The above highlights some of the methods used by shareholders to extract revenue in ways that go beyond increasing profitability. Investors can also profit from payments of fees to shareholders. For example, during 2018, management charges of £0.1m were paid by Care UK to Bridgepoint.¹⁴⁷ Court Cavendish a company owned by Dr Chai Patel, the founder of HC-One, has received £25m in management fees from the company.¹⁴⁸ Voyage Care paid £600k in consultancy fees to its private equity owners in 2018.¹⁴⁹

While these activities by investors may increase their returns, there is no clear impact on quality of care in part as a result of the monitoring of the CQC. There is no clear distinction between care quality in large financialised or small companies with examples in both categories of the best and worst of care performance. Financialised chains are not uniformly poor performers but they are also not the best.¹⁵⁰ There is however some indication that private for profit residential care providers deliver a lower quality of care than is delivered by the voluntary and state sector. Naylor and Magnusson analyse data from the CQC and find that the private sector tends to be rated as lower quality than public and NFP providers and that smaller care homes tend to be rated as better quality than larger ones.¹⁵¹ While 84 per cent of care homes run by local authorities were rated good or outstanding, this compared with just 77 per

¹⁴⁶ 'Voyage Care raise £272m on bond market',

<http://www.healthinvestor.co.uk/ShowArticle.aspx?ID=2651>

¹⁴⁷ CareUK Health & Social Care Holdings Ltd Annual Report and Financial Statements 30 September 2018

¹⁴⁸ 'Care home group paid £48.5m in dividends while warning of cuts'

<https://www.ft.com/content/c0e37072-7243-11e9-bf5c-6eeb837566c5>

¹⁴⁹ Voyage Care HoldCo Annual Report and Financial statements for year ended 31 March 2019

¹⁵⁰ Burns et al. (op.cit).

¹⁵¹ Naylor, A. and J. Magnusson (2020) "Data that cares" Report for Future Care Capital, <https://futurecarecapital.org.uk/wp-content/uploads/2020/03/Data-that-cares-full-report-single.pdf>; and https://www.cqc.org.uk/sites/default/files/20170703_ASC_end_of_programme_FINAL2.pdf

cent of for-profit homes, according to a LaingBuisson analysis of regulatory reports cited in the Financial Times.¹⁵²

While quality may not be directly affected, the extractive practices of investors create vulnerabilities in the sector. Highly-indebted care home chains have only a small buffer to deal with any changes in financial flows. Firms are highly vulnerable to downturns in occupancy or fee rates. In 2016, Four Seasons had 13 per cent of the debt across the residential care sector, compared to only five per cent of its beds. When the owner, Terra Firma Capital Partners, failed to meet a £27m interest payment in December 2017, control was reported to be passed to H/2 Capital Partners, a US hedge fund which owns much of the chain's £730m debt and will acquire around 185 of the group's freehold sites.¹⁵³ Sale and leaseback obviously brings risks into operations that would not be there if a single company both owned the properties and provided the care services. Orchard Care Homes carried out a sale and leaseback in 2007. In 2018 it was reported that four of their homes went into administration after failing to agree lease terms with landlords.¹⁵⁴ The 2011 collapse of Southern Cross was in large part due to an increase to its annual rent bill and a cut in fees paid by local authorities.¹⁵⁵

For the first four years of the operation of the CQC market oversight scheme, no intervention was required by the Commission. However, since 2018, the oversight function has been operated twice. The CQC takes this as an indicator of increasing fragility in the market.¹⁵⁶ Naylor and Magnusson¹⁵⁷ report a growing incidence of provider failure. In November 2018 the CQC warned local authorities with regard to the company Allied Healthcare, which had been providing homecare for around 13,500 elderly and disabled people across 150 local authorities as well as out-of-hours GP services for the NHS. The company was owned by German private equity

¹⁵² 'Private equity and Britain's care home crisis', <https://www.ft.com/content/952317a6-36c1-11ea-a6d3-9a26f8c3cba4>

¹⁵³ Horton, A. (op.cit); <https://www.ft.com/content/eab8c4c4-d49a-11e9-8367-807ebd53ab77>

¹⁵⁴ 'Former Orchard care homes go into administration', <https://www.carehomeprofessional.com/exclusive-former-orchard-care-homes-go-administration/#:~:text=Four%20care%20homes%20have%20gone,failed%20to%20agree%20lease%20terms.>

¹⁵⁵ 'Care home group paid £48.5m in dividends while warning of cuts' <https://www.ft.com/content/c0e37072-7243-11e9-bf5c-6eeb837566c5>

¹⁵⁶ CQC (2019) The State of Care Report. The Care Quality Commission https://www.cqc.org.uk/sites/default/files/20191015b_stateofcare1819_fullreport.pdf

¹⁵⁷ Naylor, A. and J. Magnusson (op.cit)

company Aurelius. The CQC was concerned that the company had failed to provide adequate assurance that it would have sufficient funding to operate beyond the expiration of its line of credit.¹⁵⁸ In December 2018, the company was taken over by Health Care Resourcing Group.¹⁵⁹

CQC has also intervened in a single local authority in connection with Orchard Care Homes.¹⁶⁰ There are also unofficial reports of a third intervention by the CQC. In 2019 Advinia became England's 10th biggest care home operator overnight after borrowing £59m to buy 22 homes from Bupa. According to a document leaked to The Guardian, the CQC has alerted local authorities to the potential failure of the company in light of their lack of cooperation with a regulatory enquiry into its finances and the non-provision of information to the CQC.¹⁶¹ Following the collapse of Southern Cross and Castlebeck, unions called for government action to stop debt-laden companies from taking over residential care homes due to the risks to vulnerable residents.¹⁶² However the intervention from the CQC is only to warn the local authorities of the need for contingency plans. There is nothing to prevent firms from creating debt-laden structures and the investors may emerge relatively unscathed in the event of a corporate failure. Moreover, the effects of such practices have implications beyond the failure of a company. These opaque structures that funnel tax payer and individually financed service fees to, often unknown, shareholders have major implications for transparency and accountability as well as inequality.

¹⁵⁸ 'Local authorities braced for collapse of care provider Allied Healthcare', <https://www.ft.com/content/1e3cad5e-e1b9-11e8-a6e5-792428919cee>

¹⁵⁹ <https://crg.uk.com/uncategorized/media-statement-allied-healthcare-acquisition-crg-continuation-services/>; see also 'British care home group saved by last ditch sale', <https://www.ft.com/content/6717cdc8-f498-11e8-9623-d7f9881e729f>

¹⁶⁰ https://www.cqc.org.uk/sites/default/files/CM032006_Item6_marketoversight_presentation.pdf

¹⁶¹ 'One of UK's biggest care home operators investigated over finances' <https://www.theguardian.com/society/2019/oct/06/care-home-firm-advinia-investigated-amid-fears-over-its-finances>

5 Final reflections and policy implications

COVID-19 has been devastating for the care sector which was already vulnerable. The £3.2bn of pandemic emergency funds is insufficient¹⁶³ and local authorities are concerned that providers of both residential and domiciliary care will fail. Most local authorities in England have offered some kind of financial support to providers.¹⁶⁴ But even pre-COVID only 35 per cent of England's Directors of Adult Social Services were fully confident that their budgets were sufficient to meet their statutory duties.¹⁶⁵ By June 2020, this already low figure had fallen to just four percent.¹⁶⁶ Furthermore, some providers are warning that they are at risk of collapse. HC-One has seen resident numbers plummet and anticipates an occupancy level of just 70 per cent by July 2020. A letter from the company's Chief Financial Officer to local authorities and care commissioners in April 2020, called on commissioners to guarantee HC-One's income at the equivalent of 90 per cent occupancy. They also set out other avenues they are exploring including "payment deferrals with stakeholders such as HMRC, landlords and lenders".¹⁶⁷ There is a real risk that the care sector will be unable to meet the needs of the most vulnerable.¹⁶⁸ But more is needed than simply increased funding. Some companies have diverted substantial volumes of revenue to shareholders and investors via opaque means and left care providers heavily indebted in ways that create additional financial vulnerability. Meanwhile care workers have been at the frontline of the pandemic, often without adequate protective equipment and with significantly higher mortality rates than the rest of the population.¹⁶⁹ Such practices inevitably risk a deterioration of care quality. Social care services have become tools

¹⁶³ 'Tory councils warn coronavirus second wave could bankrupt local authorities', <https://www.theguardian.com/society/2020/jun/17/conservative-councils-warn-covid-19-second-wave-could-lead-to-bankruptcies>

¹⁶⁴ ADASS (2020) Coronavirus Survey, Report by ADASS, Association of Directors of Adult Social Services, <https://www.adass.org.uk/media/7967/adass-coronavirus-survey-report-2020-no-embargo.pdf>

¹⁶⁵ ADASS (2019) ADASS Budget Survey, Report by Association of Directors of Adult Social Services, https://www.adass.org.uk/media/7295/adass-budget-survey-report-2019_final.pdf

¹⁶⁶ ADASS (2020) ADASS Budget Survey, Report by Association of Directors of Adult Social Services, <https://www.adass.org.uk/media/7973/no-embargo-adass-budget-survey-report.pdf>

¹⁶⁷ 'HC-One letter to local authorities', <https://www.hc-one.co.uk/Our-News/Corporate-News/HC-One-letter-to-Local-Authorities-%E2%80%93-29th-April-20.aspx>

¹⁶⁸ 'Legacy of political neglect had left social care fatally exposed before the outbreak began', <https://www.health.org.uk/news-and-comment/news/legacy-of-political-neglect-had-left-social-care-fatally-exposed>

¹⁶⁹ 'Social care workers at increased risk of death from coronavirus, ONS finds', <https://www.theguardian.com/world/2020/jun/26/social-care-workers-increased-risk-death-coronavirus>

to facilitate extraction of funds. Simply spending more is not sufficient to fix this dysfunctional care system.

The need to reform the social care sector is clear and has been widely debated over the past two decades including a range of government White and Green Papers and consultations. There have been 12 consultation and policy papers as well as five independent commissions on social care since 1998.¹⁷⁰ With the spotlight on social care in the wake of the pandemic, this is an opportunity to introduce reforms that will promote not only a financially sustainable but also an equitable system for caring for the vulnerable in society. Clearly a substantial increase in funding is urgently needed but ultimately, the sector needs to be reconfigured to fully meet all social needs, with a well-trained and -resourced workforce. However, we are mindful that such wholesale restructuring is not without cost and raises additional challenges. Hence, we set out some short- and long-term policy implications below.

1. **Conditions for financial support** – The government is in a position to insist that additional support for care providers is contingent on certain conditions being met that will curtail the opaque and inequitable practices of some care providers. These could include the following:
 - **On-shore ownership** – A number of EU countries including Scotland, Wales and other EU member states such as France and Denmark have blocked companies based in tax havens from accessing coronavirus bailout funds.¹⁷¹ Similar restrictions should be placed on care providers.
 - **Transparency** – Full disclosure of corporate structures and financing for the past five years should be required. This could include the details of inter-company loans, inter-company payments for services, identity of shareholders. The aim would be to establish a clear pathway of financial flows to establish where the user fees and taxpayer funds end up and what the users are paying for.
 - **Working conditions** – Companies need to commit to putting a stop to paying workers less than the National Living Wage. While an immediate

¹⁷⁰ 'Private equity and Britain's care home crisis', <https://www.ft.com/content/952317a6-36c1-11ea-a6d3-9a26f8c3cba4>

¹⁷¹ 'Scotland bans Covid-19 support to firms based in tax havens', <https://www.theguardian.com/politics/2020/may/21/scotland-bans-covid-19-support-firms-tax-havens>

increase in wages is difficult in the context of falling revenue, companies need to show clear pathways by which they will ensure that care workers will be paid fairly.

- **Care quality** – Bailout support should be limited to care providers with a CQC rating of Good or Outstanding.

2. **Regulation for socially responsible care** – the 2014 Care Act introduced requirements for the CQC to alert local authorities if they had concerns regarding the financial sustainability of care providers. This should be tightened so that rather than just dealing with the fall out, these corporate practices are prevented and the companies themselves can be penalised. Furthermore, regulation needs to be extended to include a requirement that care providers are socially as well as financially responsible, in addition to existing care quality requirements. Some Local Authorities have signed up to UNISON’s ‘Ethical Care Charter’ but financial resources and on-going political commitment are needed to ensure its long-term effectiveness.¹⁷² Performance indicators for socially responsible care would include:

- Responsible gearing levels (i.e. ratio of debt to equity, based on average sector performance)
- Specific ratio of directors’ to workers’ pay
- Ban on zero-hours contracts
- Career pathways for care workers such as ‘Care First’¹⁷³

3. **Support for local authorities** to provide residential and domiciliary services. Some local authorities are moving to greater involvement in care provisioning rather than simply commissioning care. Hertfordshire County Council, for example, owns care homes that are leased to NFP care provider company Quantum Care. The council is constructing a new care home due to become operational in 2021¹⁷⁴ and has tendered for the care provider. The council has

¹⁷² Moore, S. (undated) ‘An Evaluation of UNISONs Ethical Care Charter’, Work, Employment and Research Unit, University of Greenwich, available at <https://www.unison.org.uk/content/uploads/2017/06/ethicalcarecharterEDITFINAL.pdf>., accessed 1/7/20.

¹⁷³ PSA Commission on Care, 2016: 42.

¹⁷⁴ <https://www.hertfordshire.gov.uk/about-the-council/news/press-releases/building-a-future-for-hertfordshire-new-nursing-home-for-wormley-in-2021.aspx>

contracts to buy 50 per cent of the beds at the local authority rate so they are guaranteed access to affordable services and have a significant stake in the market. The investment is financed by borrowing from the Public Works Loan Board.¹⁷⁵ In 2019, the Government raised interest on rates on new loans by 1 per centage point in 2019 to discourage a dramatic increase in borrowing for investment in commercial activity from 2016, making the typical rate for a loan 2.8 per cent instead of 1.8 per cent¹⁷⁶ but this is still considerably less than some of the interest rates paid by private service providers. Further research is needed to establish additional measures that will support local authorities to provide social care and reduce their reliance on private companies.

4. **Develop alternative provider types** to the current care system in the UK which is split between health and social care and, within the latter, split between domiciliary and residential care. In practice, care needs do not always fit easily into such bounded categories and more research is needed to identify alternative models of care provision. Within the UK there are some examples of alternative practice. One such case is the Buurtzorg model, a nurse-led approach developed in the Netherlands and applied in a number of different settings including the UK which integrates health and social care into one service.¹⁷⁷ The model consists of small self-managed teams with a maximum of 12 nurses that provide coordinated domiciliary care for a specific catchment area of around 40-60 patients living in their own homes. More research is needed to explore innovative approaches to meeting social care needs.

Social care is one of many elements of everyday life which have been repackaged to suit the needs of global capital, alongside, for example, housing, pensions and student loans. The process transforms a social need into a financial issue which in turn translates into new social relations where narratives are constructed in terms of

¹⁷⁵ Personal Communication with Director of Hertfordshire Adult Care Services

¹⁷⁶ 'Hike in PWLB rate will cost councils £70m a year', [https://www.localgov.co.uk/Hike-in-PWLB-rate-will-cost-councils-70m-a-year/48314#:~:text=The%201%25%20increase%20to%20the,town%20hall%20chiefs%20have%20warned.&text=The%20Local%20Government%20Association%20\(LGA,put%20capital%20schemes%20at%20risk](https://www.localgov.co.uk/Hike-in-PWLB-rate-will-cost-councils-70m-a-year/48314#:~:text=The%201%25%20increase%20to%20the,town%20hall%20chiefs%20have%20warned.&text=The%20Local%20Government%20Association%20(LGA,put%20capital%20schemes%20at%20risk).

¹⁷⁷ Maybin, J., Honeyman, M., Williams, E. and Perks-Baker, S. (2019) A review of the West Suffolk Buurtzorg test-and-learn in 2017–18, The Kings Fund. <file:///D:/Dell%20PC/Documents/WBG%20policy%20briefing/Future%20of%20care/Review-West-Suffolk-Buurtzorg-test-learn-2019%20Maybin%20et%20al.pdf>, last accessed 6/6/20.

markets and efficiency. Care sector workers are treated as a financial overhead rather than integral to the quality of care provided. The financialisation of social care is an ongoing systemic process, which is accentuated in the increasingly challenging current global investment climate with, for example, low returns from traditional secure investments such as government bonds. Even during the pandemic, private equity firm Westbridge acquired a company providing specialist care services in June 2020.¹⁷⁸

While social care offers relatively low risk and high return investment opportunities, as the above discussion shows, structuring care services as a private sector endeavour risks major adverse social outcomes, resulting in:

- Extensive transfers to the world's richest via the servicing of basic needs for some of society's most vulnerable people, financed by taxes and lifetimes' savings
- A two-tier system of residential care where private providers seek to serve only self-funders
- Increasing strain on a largely female and minority ethnic un-unionised work force
- Increasing pressures on (largely female) informal carers that pick up the pieces of the failings in the care system

The COVID pandemic not only reveals and exacerbates these inequalities but has also exposed a lack of understanding of social care itself. The paper demonstrates that in the long term, tweaking the margins of regulation will not be sufficient to address the fundamental structural flaws underlying our current care system. Indeed the paper provides clear evidence to support existing calls for a radical reassessment of what care is for, how it should be financed and provided.¹⁷⁹ Many are now questioning this privatised and financialised model of social care. For example, in June 2020 Conservative peer and former pensions minister, Ros Altmann, called for a

¹⁷⁸ "WestBridge invests £9.6m in Bespoke Health & Social Care"
<https://www.westbridge.co.uk/news/2020/06/24/westbridge-invests-9.6m-in-bespoke-health-and-social-care/>

¹⁷⁹ 'Calls for national care service as crisis leaves homes in critical state'
<https://www.theguardian.com/society/2020/jun/28/calls-for-national-care-service-as-crisis-leaves-homes-in-critical-state>

renationalising of care homes.¹⁸⁰ The Women's Budget Group is one of a growing number of actors calling for the establishment of a National Care Service that provides care free at the point of delivery and has equal standing to the NHS and is funded from general taxation at the national level to avoid the entrenchment of regional inequalities.¹⁸¹ Such a radical restructuring is vital to ensure that the needs of the most vulnerable can be fully met in a socially equitable fashion.

¹⁸⁰ Altmann, R. (2020) 'The lesson of the Covid-19 care homes tragedy: renationalising is no longer taboo', <https://www.theguardian.com/commentisfree/2020/jul/06/covid-19-care-homes-tragedy-renationalise-crisis>

¹⁸¹ WBG, (op.cit): 7.

Annex A: CQC Market Oversight list, company ownership

	CQC list name	Type of care	Ownership type	Controlling party / ultimate parent
1	CareTech	Residential	Listed company, UK	CareTech Holdings plc
2	Welltower	Residential	Listed company, USA	Welltower Inc
3	Acadia (trading as The Priory in the UK)	Residential and non-residential	Listed company, USA	Acadia Healthcare Co. Inc, via Cayman Islands
4	Prestige Nursing	Non-residential	Listed company, Paris	Sodexo Holdings Ltd
5	Clece Care Services	Non-residential	Privately owned by Spanish company	Clece S.A.
6	BUPA	Residential and non-residential	NFP	British United Provident Association Ltd - Co. No. 432511
7	Akari Care Ltd	Residential	Offshore private equity	CSP IV (Cayman 2) LP, Cayman Islands
8	Four Seasons	Residential	Offshore private equity	Terra Firma Holdings Ltd, Guernsey
9	Galaxy Group (trading as Achieve Together)	Residential	Offshore private equity	AMP Capital Investors (European Infrastructure No 5) S.a.r.l, Luxembourg
10	HC-One	Residential and non-residential	Offshore private equity	FC Skyfall LP, Cayman Islands
11	Barchester Healthcare	Residential	Offshore privately owned	Barchester Holdco, Jersey
12	Excelcare	Residential and non-residential	Offshore privately owned	Excel Portfolios Ltd, Jersey
13	Lifeways	Non-residential and Residential	Offshore privately owned	Listrac Holdings Ltd, Jersey
14	Alina Homecare	Non-residential	Private equity	Bridges Fund Management Ltd

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15	Care UK	Residential and non-residential	Private equity	Bridgepoint
16	City and County Healthcare	Non-residential	Private equity	Graphite Capital Partners VIII
17	MiHomescare	Non-residential	Private equity	Apposite Healthcare II GP LLP
18	Voyage	Residential and non-residential	Private equity	Majority owned by investors where investments are managed by Duke Street LLP and Partners Group AG but the directors do not consider there to be an ultimate controlling party
19	Agincare Group Ltd	Non-residential	Privately owned	Derek Luckhurst
20	AMG Consultancy Services Ltd	Non-residential	Privately owned	Mr and Mrs JR and SW Trippet
21	Avery Healthcare Group Ltd	Residential	Privately owned	JMB Strowbridge and Welltower (above) (via Xanadu Investments Ltd
22	Caring Homes Healthcare Group Ltd (trading as Caring Homes Consensus)	Residential and non-residential	Privately owned	Paul Jeffery
23	Cera Care Ltd	Non-residential	Privately owned	Marek Sacha
24	Country Court Care Homes Ltd	Residential	Privately owned	The Kachra brothers
25	Countrywide Care Homes Ltd	Residential	Privately owned	Phil Borgan - see Maria Mallaband
26	Grosvenor Health and Social Care Ltd	Non-residential	Privately owned	Ravi Bains (see www.ravibains.co.uk , although accounts say 'no controlling party')
27	Hales Group Ltd	Non-residential	Privately owned	Nigel Wray

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28	HCRG Health Care Resourcing Group Ltd, trading as CRG Homecare Ltd, previously Castlerock Recruitment Group	Non-residential	Privately owned	Ian Munro via Ijmh Ltd
29	Hill Care Ltd	Residential	Privately owned	JA and A Hill
30	Larchwood Group	Residential	Privately owned	Anthony Stein
31	Maria Mallaband Care Group	Residential	Privately owned	Phil Burgan - see Countrywide
32	Midshires Care Ltd	Non-residential	Privately owned	Lee Family
33	Minster Care Group	Residential	Privately owned	Company account list preference shareholders which include family trusts and companies of Mahesh Patel
34	Premier Care Ltd	Non-residential	Privately owned	Directors – JPA and MAB Regan and D McGuinn
35	PrimeLife Ltd	Residential	Privately owned	Peter Alexander Van Herrewege
36	Radis Community Care	Non-residential	Privately owned	SR Patel and D R Patel & family members
37	Runwood Homes Ltd	Residential	Privately owned	Gordon Sanders
38	Select Healthcare Group	Residential	Privately owned	Mr B Bernard, Mr D Bernard and Mr Cooke
39	Anchor Hanover Group	Residential and non-residential	Community benefit society	
40	Accord Housing Association	Non-residential	Housing association	
41	Affinity Trust	Non-residential and Residential	Registered Charity	

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42	Alternative Futures Group	Non-residential	Registered Charity	
43	Brandon Trust	Non-residential	Registered Charity	
44	Choice Support	Non-residential	Registered Charity	
45	Community Integrated Care	Non-residential	Registered Charity	
46	Greensleeves	Residential	Registered Charity	
47	HF Trust	Non-residential and Residential	Registered Charity	
48	Leonard Cheshire	Residential and non-residential	Registered Charity	
49	Methodist Homes	Residential and non-residential	Registered Charity	
50	Orders of St John Care Trust	Residential and non-residential	Registered Charity	
51	Royal Mencap Society	Non-residential and Residential	Registered Charity	
52	Sanctuary Care	Residential and non-residential	Registered Charity	
53	Thera	Non-residential and Residential	Registered Charity	
54	Turning Point	Non-residential and Residential	Registered Charity	
55	United Response	Non-residential and Residential	Registered Charity	

Annex A: CQC Market Oversight list, company ownership

56	Creative Support	Non-residential	Registered society	
57	Dimensions	Non-residential and Residential	Registered society	
58	Housing 21	Non-residential and Residential	Registered society	
59	Advinia Healthcare	Residential	Privately owned	Unknown (Paraman Trust stated but no details on this)
60	Shaw Healthcare	Residential	Privately owned	Unknown
61	Westminster Homecare	Non-residential	Privately owned	Unknown
62	Healthcare Homes Group Ltd	Residential and non-residential	Privately owned	Unknown
63	Bondcare (London)	Residential	Privately owned	Unknown