Institute for Public Policy Research

WHO CARES?

THE FINANCIALISATION OF ADULT SOCIAL CARE

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SUMMARY

Social care's reliance on private bed provision is growing. New data from IPPR – in partnership with Future Care Capital (FCC) – shows that 84 per cent of beds are now provided by the private sector up from an estimated 82 per cent in 2015. In total, 91 per cent of local authorities saw an increase of private provision during this period. Meanwhile, just 13 per cent of beds are provided by the voluntary sector and 3 per cent by the public sector – both stagnating as a share of total provision over time.

Larger providers – particularly those funded by private equity firms – are becoming more dominant. Nearly one-fifth of the sector is taken up by the big five providers, three of which are private equity funded. Such firms often rely on high levels of borrowing, complicated corporate structures and cost-cutting measures such as tax avoidance and low staff pay. As a result, this model can leave them unstable, with two of the big five providers – Southern Cross in 2011 and Four Seasons in 2019 – going into administration in recent years.

A growing reliance on private provision could mean lower quality care. There are a number of potential linkages between ownership and quality.

- Firstly, there is evidence that private providers have less training for staff, higher turnover and lower pay.
- Secondly, the private care market has proven volatile, with private equity owned businesses operating highly leveraged business models.
- Thirdly, the emergence of large private providers contrasts with evidence that small nursing and residential homes provide better care.

We need to be bold and arrest the growth of debt-fuelled private providers in social care. IPPR calls for a bold set of policy interventions to arrest the growth of debt-fuelled private social care provision and oversee the existing sector. This should include:

1. the creation of a powerful national financial care regulator – OfCare – to oversee the financial regulation of systemically important care providers
2. a new requirement that ensures all state-funded providers of care maintain a 'safe' level of reserves and demonstrate they are paying their fair share of tax in the UK
3. a commitment by government to build the 75,000 beds needed to by 2030 through borrowing worth £7.5 billion
4. the care for these homes should either be provided by the state or by innovative not-for-profit providers, building on the success of the 'Preston Model'.

INTRODUCTION

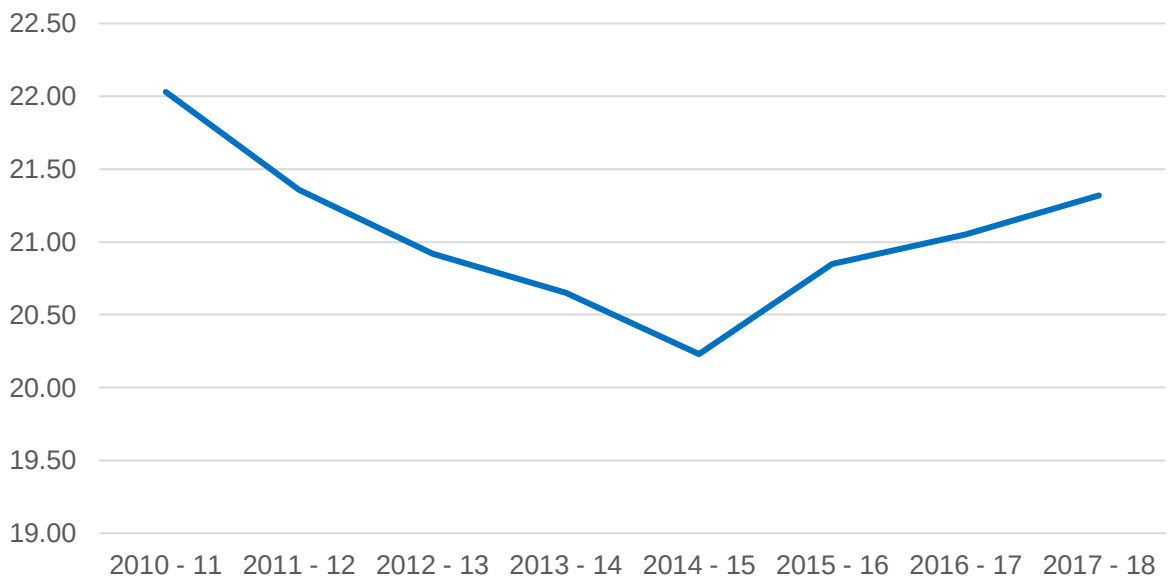
Earlier this year the social care provider, Four Seasons, went into administration after a protracted period of financial turmoil, putting the care of 16,000 of the most vulnerable people in the UK at risk. This is what the social care sector had been waiting for: ever since the demise of Southern Cross in 2011, then one of the biggest providers in the sector, experts have been predicting that more dominoes would fall.

The standard narrative is that this fragility is the result of funding cuts. The problem, providers argue, is that local authorities are simply not paying providers enough for care. This argument is not without merit. Social care has experienced swingeing cuts over the last decade (figure 1), despite growing levels of need, and this has undoubtedly put pressure on local authorities' ability to pay higher fees for residential care.

Figure 1

Adult social care funding has fallen by £700m since 2010

Adult social care spending (£bn) 2010-18



Source: Bottery et al (2019)

But this is only half the story. Funding alone cannot explain the failure of care providers like Southern Cross and Four Seasons. For that, we need to recognise the role that the ownership and business models of these kinds of big residential care providers have played in the growing instability of the care home sector. This is the story of how deregulation in the financial sector, sometimes referred to as financialisation, has transformed not only our economy but also our public services.

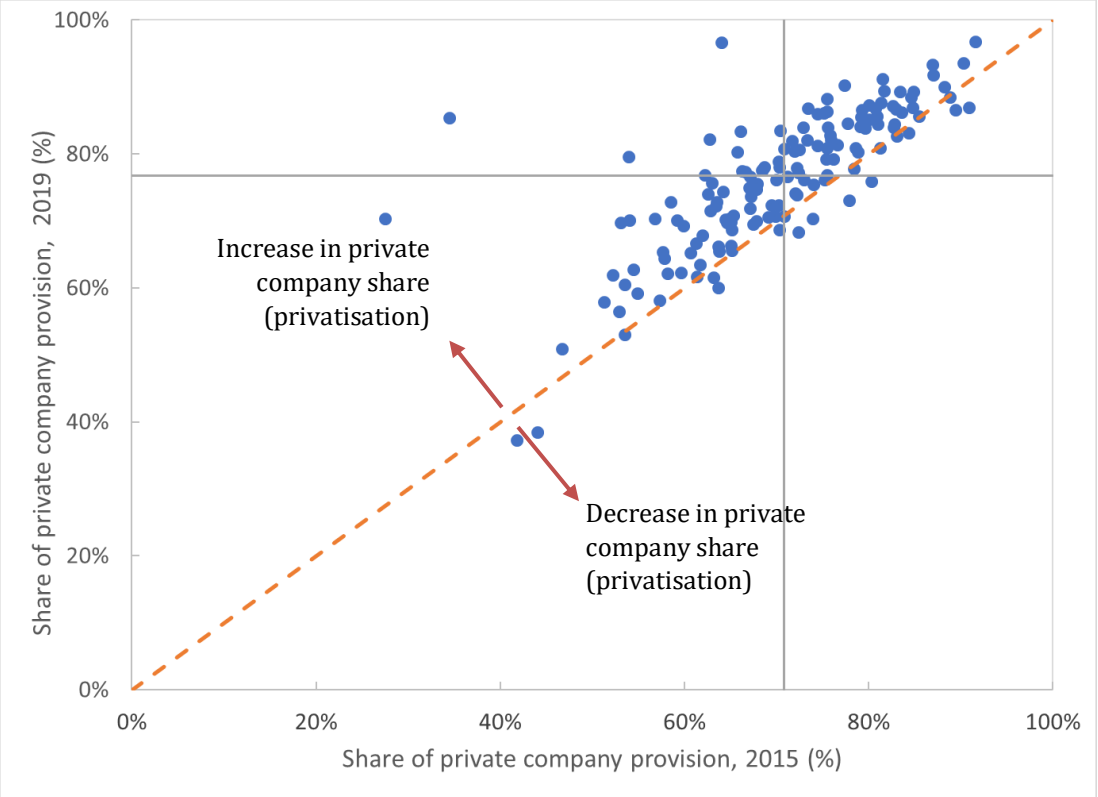
Notably, since the 1970s, when the majority of care was provided by the state, provision in England has inexorably shifted towards the independent sector, dominated by for-profit providers (figure 2). New analysis by Future Care Capital shows that this process is still happening: in 2019, 84 per cent of beds are provided by the private sector – up from an

estimated 82 per cent in 2015[1] – and just 13 per cent and 3 per cent by the voluntary and public sector respectively (FCC forthcoming, 2019).

Figure 2

Private provision as a share of residential beds has increased in 91% of local areas since 2015

Share of beds run by private companies, 2015-19



Source: FCC (forthcoming 2019)

In most cases these private providers are small, local entrepreneurs. But as property values rocketed, the sector also attracted a number of much bigger providers – some of which are funded by private equity – who (in the good times at least) saw the care sector as a way to get rich fast. However, as the boom became a bust 2007/08, these business models have begun to falter. This suggests that in order to really deliver high quality and sustainable care we will need to grapple this issue. Put more simply: more funding is *necessary but not sufficient* to transform the sector.

Instead, we must ask:

- what is financialisation and how has it changed ownerships?
- what do these business models imply for the quality, stability and efficiency of care in the sector?
- what reform is needed over the coming decades in order to secure high-quality care for all in the future?

[1] Note this is an estimate because of changes in the way this information is collected.

WHAT IS FINANCIALISATION?

Financialisation is a process involving the increasing role of financial motives, financial markets, financial actors and financial institutions in the operation of the domestic and international economies'. Over the past century and a half, the UK's finance sector (measured by gross value added (GVA)) has grown at double the rate of the rest of the economy. By 2009, finance and insurance activities accounted for nearly 10 per cent of total economic output. But the growth of finance sector GVA has been dwarfed by the growth of banks' assets – by 2008, banks held assets worth five times as much as the output of the entire British economy.

This process began in earnest in the 1980s when Margaret Thatcher's Conservative government introduced a programme of financial liberalisation that significantly impacted the trajectory of the British economy. Controls on capital mobility and exchange controls were removed, both of which served to increase the amount that banks were able to lend. Building societies were de-mutualised and began to compete with traditional banks. As a result, household debt increased from 80 per cent of households' disposable incomes to 145 per cent in 2007.

Most of this debt took the form of mortgage lending, and as the amount of credit being directed into property increased faster than the housing stock, house prices increased substantially. Newly deregulated and internationalised banks took this mortgage debt and packaged it up into securities – like mortgage-backed securities and collateralised debt obligations – that could be traded on financial markets. Capital flowed into those countries with the highest levels of mortgage lending – primarily the US and the UK – and their finance and real estate sectors, and the debt-fuelled asset price inflation that resulted led to a boom in the City.

As well as deregulating commercial banking, Thatcher also deregulated investment banking. In 1986, the Big Bang resulted from a series of changes to the London Stock Exchange including the introduction of rapid, digital trading, and the entry of foreign firms into the City. Institutional investors and asset managers, who control large pools of capital derived from savings and profits, came to dominate the City – and these investors rigidly enforced the ideology of shareholder value. They encouraged firms to scrimp on long-term investment and wages, and instead spend huge sums of money on dividends payments, share buybacks and mergers and acquisitions.

Bank lending to corporations also increased over this period, growing from 25 per cent GDP in 1979 to 101 per cent GDP in 2008. Many corporations used relatively inexpensive debt to boost their share prices, rather than investing in fixed capital. The combination of the growing prominence of shareholder value ideology and rising corporate debt has led to a set of deep-rooted problems with British corporations. Some – like the outsourcing giant Carillion – became highly leveraged and extremely unstable as a result of financialisation.

Rather than stepping in to arrest these trends, the state itself has become beholden to the interests of the finance sector. Rising tax revenues from the booming finance sector encouraged policymakers to pursue a 'light-touch' approach to financial regulation, which exacerbated the impact of the financial crisis in the UK. Institutional investors also came to gain sway over state policy through their ownership of sovereign bonds, resulting in rising pressure on governments to implement 'market friendly' policies that will encourage investors to hold their government debt.

In the UK, perhaps the most significant manifestation of this logic was the growth of outsourcing and private finance. As investors' power over state policy has grown, states have relied on private corporations to provide public services through outsourcing and have used private financing to have investors undertake spending on the states' behalf. The social care sector has become one of the main areas where finance has come to shape public service delivery. This manifests in a number of ways.

Firstly, social care providers – and in particular the large private equity-backed providers (figure 3) – are increasingly involved in real estate markets through their ownership of large amounts of land. In the last 40 years experts estimate that over £30 billion of capital costs have been invested in the care sector (LaingBuisson 2014). This is, to some degree, inherent in the model of residential care. However, increasingly providers have entered and stayed in the market not because of their specialism in care, but because of the benefits of the debt-fuelled real estate boom.

Figure 3

The five largest providers which provide nearly one-fifth of total beds are dominated by private equity ownership

Market share and ownership model of the largest care providers (brands) by beds

Rank	Organisation	Total homes	Total beds	Registered beds as % of all for-profit homes	Cumulative total market share	Ownership
1	HC-One Limited	271	16,266	5.1%	5.1%	Private equity
2	Four Seasons	214	11,856	3.7%	8.9%	Private equity
3	Barchester Healthcare	165	10,559	3.3%	12.2%	Public company with ultimate shareholder register in Jersey
4	Care UK	111	7,462	2.4%	14.6%	Private equity
5	BUPA Group	118	6,972	2.2%	16.8%	Provident Association (for profit division)

Source: Future Care Capital (forthcoming 2019) and Burns et al (2016)[2]

Secondly, as a result, providers rely significantly on banks and financial markets for funding. In the decade since the financial crisis, with interest rates very low, many providers have become heavily indebted, using this to borrow on the basis of limited equity in order to

[2] Organisations have been identified based on the 'brand' identifier in the CQC data. Brands may comprise multiple companies.

expand by buying up smaller residential care providers. For example, when Three Delta bought Four Seasons in 2006 (before it sold on to Terra Firma in 2012), 80 per cent of the £1.4 billion cost was funded by debt (Burns et al 2016). When Four Seasons went under earlier this year it had £500 million of debt which was costing £50 million to service each year (Rowland 2019). Under these models the cost of servicing this debt is usually passed onto consumers in higher fees.

Thirdly, these close relationships between financial interests and social care providers have reshaped corporate governance in the sector. In particular, it has created a strong incentive for companies to focus on maximising shareholder value rather than focussing on delivering public services and taxpayer value. This is often achieved by reducing costs. Some of these methods are fairly standard, albeit still damaging to society, such as putting a downward pressure on wages, while others are not, such as tax avoidance.

Fourthly, at the heart of this change has been the emergence of astonishingly complex corporate structures, with individual corporations often comprised of multiple different subsidiaries – many offshore – used to minimise tax liabilities. These are used to drive cost savings and profit increases. For example, Barchester Healthcare is a subsidiary of Grove Ltd, which is registered as a public company in the Bailiwick of Jersey. Meanwhile, Care UK has reduced its tax liability by shifting from equity to debt finance (which has risen from 33 per cent of its capital to 85 per cent in a decade). This is estimated to have saved them £25 million a year in tax (Rowland 2019).

WHY DOES IT MATTER?

Combined, these trends have completely changed the way the social care market works. This may be tolerable if it had delivered value for the taxpayer and for those who need social care. But the evidence is far from clear that this is the case. The case for outsourcing care – in particular to larger private equity backed providers – broadly appears to rest on two core claims.

1. Private providers – and the market – will result in better quality social care.
2. These reforms would enable care to be delivered more efficiently.

With three decades of experience since the start of this transformation we should have a growing evidence base with which to test these claims. However, the truth is that – as a result of poor data availability – unpicking the drivers of quality and efficiency in the market is challenging. Simply mapping the quality metrics that are available onto ownership model data does not show a clear correlation. But the more in-depth research that does exist throws significant doubt on the claims that private provision – including large private equity backed corporations – has delivered ‘more for less’.

There are mixed results on the link between ownership model, competition and quality. However, on balance, studies from both the UK and the USA, find a negative correlation, meaning for-profit providers and areas with higher levels of competition, deliver lower quality care (Forder and Allan 2011; Rosenau and Linder 2003; Devereaux et al 2009). For example, a systematic review and meta-analysis published in the BMJ found that of 82 studies published between 1965 and 2003, around half found that not-for-profit providers delivered worse care, compared to just three which found favourable results for private providers (Devereaux et al 2009).

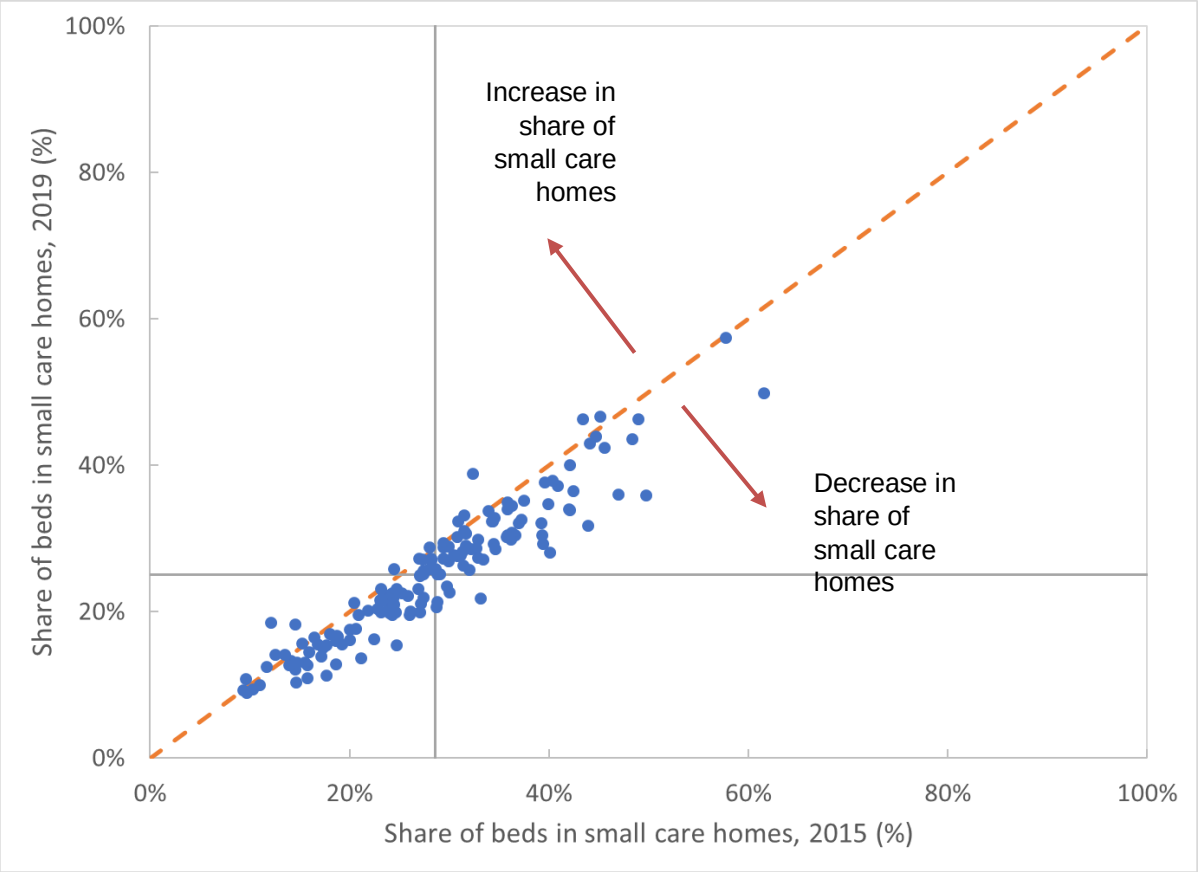
The evidence suggests that there are three potential causal links between ownership model, competition and quality.

- *Workforce* – There is strong evidence that private providers have lower levels of staffing, higher staff turnover, lower rates of pay and lower levels of training (Dromey and Hochlaf 2018). Numerous studies, including one by the Care Quality Commission (CQC 2017), have highlighted the link between the quantity and quality of the workforce and the quality of social care provision (Eaton 2000; UNISON 2018).
- *Instability* – The care market has grown increasingly volatile, with three-quarters of local councils experiencing provider closure, up from two-thirds the year before (ADASS 2019). There is evidence that provider closure can result in higher levels of resident distress and mortality (Hallewell et al 1994).[3] This is particularly problematic with the big providers who supply up to 30 per cent of the beds in some areas.
- *Size* – There is a link between the size of a provider and quality of provision. 89 per cent of both small nursing and residential homes are rated as good or outstanding by the CQC, compared with just 65 per cent and 72 per cent of large nursing and residential homes respectively (CQC 2017). This has particular implications given that FCC analysis shows that larger homes – including those owned by private equity backed providers – make up a growing share of the market (figure 4).

Figure 4

There has been a decline in small care home providers in 91% of local areas since 2015

Share of beds provided by small care home, 2015-19



Source: Future Care Capital (forthcoming 2019)

[3] Though others argue that contestability and market exit can also improve quality

The evidence on greater efficiency is also mixed. A number of studies find that higher levels of competition result in a downward pressure on price (Forder and Allan 2011). However, many of these studies also show that this is achieved by 'cutting corners' (e.g. paying lower staff wages, offloading more complex cases to the NHS etc) and is therefore at the expense of quality. This is particularly true for local authority funded beds where competition is based on price not on quality (eg providers minimise price subject to meeting minimum CQC standards) (ibid).

Meanwhile, the entrance of private equity backed private providers into the sector was also seen as a more efficient way of transforming the ageing residential care home estate. This helped overcome the historical inability of local authorities to borrow to invest, and ensured that central government could keep capital costs off the balance sheet. However, in hindsight this looks foolish: government can borrow at lower rates than the private sector and does not require the same return on capital as private providers do.

The truth is that for too long we have let profits come before people. Finance has crept into every aspect of our society on the back of big promises about quality and efficiency. But it has failed to deliver, often putting the most vulnerable members of society at risk. It is time to call this out: care not cash must be at the heart of our adult social care system in the future. Turning this around will take time – and require bold reform as well as more funding – but this effort will be rewarded by a more stable, higher quality and more humane social care system.

WHAT SHOULD WE DO ABOUT IT?

Some commentators have flirted with the idea of nationalisation of private provision in the social care sector as a solution. But this seems practically challenging. Firstly, it would be exceedingly complex: there are over 24,000 registered providers in England. Secondly, it would be very costly (assuming private providers were properly compensated): experts suggest that the private sector has provided up to £30 billion of investment in the last four decades (LaingBuisson 2014).

However, there is no doubt that we need radical reform to put care back at the heart of our social care system. The status quo cannot be allowed to continue. Instead, we propose a two-stage process.

1. A radical increase in financial regulation of residential care providers to improve sustainability and public value for money

Under the Care Act 2014, local authorities have a statutory duty to support the development, functioning and sustainability of markets for social care services. This includes a market oversight function, which involves actions to monitor the performance and finances of social care providers – particularly larger providers – in order to predict and prevent (or manage) provider failure and the associated consequences for older people.

However, our research suggests that as a result of both the complexity of larger private equity-owned care providers, and also the capacity and capabilities of local authorities, this is an unrealistic expectation. Furthermore, given that these larger providers are nationally rather than locally run, it seems unlikely that individual local authorities would be able to meaningfully engage with and shape their financial and delivery decisions.

We therefore argue that the financial regulation of systemically important care providers should be primarily undertaken at the national level. As it stands both the CQC and the CMA

have some national role in financial regulation in the sector, but their relative roles, powers and capabilities to perform this function are unclear. Instead, **we recommend the creation of a powerful national financial care regulator – OfCare – to perform this function**. This should sit within CQC and build on their existing Market Oversight function.

In addition, we recommend that **the government should require all state funded providers of care to maintain a certain 'safe' level of reserves** to ensure financial stability and to **demonstrate they are paying their fair share of tax in the UK**. In order to monitor this – and the wider financial sustainability of the sector – **government should also mandate that all state funded contracts are subject to use of open-book accounting**. This will allow OfCare and local authorities to properly perform their market oversight function.

2. A commitment by the state to shifting care back into public or voluntary sector ownership in the 2020s

While it is unrealistic – and potentially undesirable – to begin the wholesale nationalisation of existing residential care providers, we have more choice about what happens with regards to future expansions of supply. Research by Grant Thornton shows that if current supply trends continue, as a result of an ageing population, the sector will be short by 75,000 residential care beds by 2030 (Grant Thornton 2018). **Government should put in place a strategy to reduce this gap through measures to shift care into the community**. But regardless we face a challenge going forward.

We recommend that government should commit to filling the gap between demand and supply itself by borrowing the £7.5 billion necessary to build these homes.[4] Given the state can borrow at record low levels this would be significantly cheaper than allowing the private sector to do it. Further savings could be achieved by building these on existing government land. Moreover, in doing this the government could ensure supply maps more completely onto need – addressing the issue of so-called 'care deserts' – something which the market is currently failing to do.

We recommend that either **the state provides the care within these homes itself – either through the local authority or the NHS – or it could promote the 'Preston Model' (Lockey and Glover 2019) and commission innovative providers to do so instead**. This would allow new models of care such as co-operatives and social enterprises to flourish, many of whom are currently locked out of the residential care market because of the prohibitively high capital costs associated with the sector.

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[4] Grant Thornton estimate the build cost for a modern care home runs at around £100,000 per bed, not including the cost of land.

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CORRIGENDUM

This briefing paper was amended to reflect a clarification on pages 2 and 6. The original paper incorrectly recorded Sunrise Senior Living as the fourth largest care provider in the sector as a result of duplicate entries in the CQC dataset (page 6). When corrected Care UK becomes the fourth largest and BUPA, a provident association, becomes the fifth largest care providers in the market. The market share held by the five largest providers remains the same. This means three out of the five largest care home providers are private equity backed rather than four as originally stated (page 2). The original report also incorrectly listed Sunrise Senior Living as private equity funded instead of jointly owned by a pensions investment board and real estate investment trust. These amendments have no material impact on the conclusions of the report.