Care home versus home care?
Which direction for care services in Europe?
Eligibility for European Works Councils

by

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EXECUTIVE SUMMARY

The aim of this paper is to consider the eligibility of multinational companies working in the care sector for European Works Councils. It does this in the context of European and national policies impacting on care, particularly home care, and the strategies of multinational companies operating in this sector.

Long term care is a political issue for almost all Western European countries because the population is ageing. National governments are approaching the provision of care in different ways in some cases providing cash for care services, in others making it mandatory for individuals to be part of social insurance or private insurance schemes. In other countries older people are given a right to a basic package of care but no extra funding is made available to fund services. The way in which individuals can access long term care, whether through care allowances, vouchers, directly provided services, influences the way in which care services are organised, which impacts on care workers, often negatively. In Eastern/ Central Europe care services are in an early stage of development, with limited development of local not-for-profit services delivered in the community.

The for-profit sector is still trying to identify the most profitable strategies for care homes and home care. Several countries are experiencing a decline in care homes beds with an increase in home or domiciliary care. Private equity investors remain active in the care home sector but are also investing in home care companies.

The for-profit care home sector has been shown to deliver poor quality services in several countries. This has led to a questioning of whether outsourcing of care services is the best way of delivering care. The use of business models that depend on borrowing capital during a period of global financial crisis has undermined the profitability of the for-profit sector in the UK.

The extent of multinational care company expansion has not changed significantly since 2010. French care companies continue to acquire companies in neighbouring countries (Switzerland, Spain, Belgium and increasingly Germany) but are not owned by private equity investors although are starting to engage in joint ventures with property investors. Nordic care companies, with private equity investors, continue to operate in the Nordic region but with little expansion. Two companies in Sweden have been criticised for poor quality care, with one now being put up for sale.

Care home versus home care? Which direction for care services in Europe?

As a way of exploring the directions for multinational company involvement in care services in Europe this paper starts by examining some recent European Union policies towards care for older people, people with disabilities and childcare as well as major policy trends at national level. This builds on two previous reports for EPSU that considered European Works Council eligibility for multinational operating in the care sector.[1 2] These reports found that expansion of multinational companies was restricted to sub-regional expansion in Europe in Nordic countries and France/ Belgium/ Italy/ Spain and Germany. Many care companies provide care services and mental health services, allowing some diversification. By 2007 there were limited mergers and acquisitions but some signs of consolidation. Private equity ownership remained significant in 2010. This paper now outlines major developments in multinational company activities in care in Europe since 2012.

1 Trends in care policies

1.1 European level – social services

Over the next 40 years the proportion of the population over the age of 65 in the European Union will double, rising from 17% in 2005 to 30% in 2050 (European Foundation,2009) An expanding ageing population will bring demands for different types of care. There have already been extensive changes taking place in the financing of care and the support for carers, which affect the domestic demand for care from public, for-profit and not-for-profit providers. These changes have also led to the development of new occupations and roles in social care. They also provide opportunities for care companies to expand into larger markets although whether profits lie in care homes or home care is unclear at the moment.

Rights to social services

In 1996, the Turin Social Charter of the Council of Europe, which has been incorporated into the Lisbon Treaty adopted in 2009, agreed to establish a mandatory right to social services. In the 1st EU Convention (2000) and the draft European Constitution (2003), this mandatory right was abolished, as was the right to social assistance. The Charter of Fundamental Rights (2002) has a section on social security and social assistance, which recognises an entitlement to social security benefits and social services.

> "*The Union recognises and respects the entitlement to social security benefits and social services providing protection in cases such as maternity, illness, industrial accidents, dependency or old age, and in the case of loss of employment, in accordance with the rules laid down by Community law and national laws and practices.*" [3]

This indicates that although the demand for social care services in Europe will continue to expand with an ageing population, the rights to social services and social assistance cannot be assumed to be protected in future. The recognition of entitlement is a much weaker commitment to universal access than a right to social services. This is particularly important in the current context of austerity policies, which are affecting the level of funding and entitlement for social services and other public services.

Social Services of General Interest (SSGI)

An important issue is whether social services are protected from competition and the internal market laws in the EU. Access to social services will be affected if social services are considered a Service of General Interest (SGI) or a Service of General Economic Interest (SGEI). With the 2006 Communication on Social Services of General Interest (SSGI (COM(2006)177) this is

actually the case for basically all SSGI as they are being considered/classified as an economic activity/as being of economic nature according to the relevant ECJ rulings and based on a "functional approach" to SG(E)I. This has been subject to extensive political debate and the issue is still not resolved. The draft Services Directive (June 2004) *Services in the internal market COM(2004)* recommended that "*personal social services*" are considered a Service of General Economic Interest (SGI).[4] If this had been agreed then social care services would have been subject to competition law. The final version of the Services Directive, approved by the European Parliament, excluded both health and social care services.

The Protocol attached to the Treaty of Lisbon (October 2007) aims to clarify the approach to Services of General Interest. It also states that "*The Provisions of the treaties do not affect in any way the competence of member States to provide, commission and organise non-economics services of general interest*".[5] However, recent Communications, including COM(2007) 725 (22 November 2007) on "*Services of General Interest, including social services of general interest: a new European commitment*", suggest that social services can be considered both as an economic and a non-economic Service of General Interest.[6] This new Communication set out a strategy for social services, across the EU, and can be seen as indicative of the European Commission perspective. It proposed the development of a "*voluntary EU quality framework providing guidelines on the methodology to set, monitor and evaluate quality standard*", which was adopted by the Social Protection Committee on 8 October 2006. [7] It states that the EC will also "*promote the training of public authorities in the field of public procurement*". [8] This was announced in the 2nd Biennial Report on SSGI [9] and in "Buying Social", an EC Guide on Socially-Responsible Public Procurement issued on 28 January 2011.[10] This should serve as a single reference document for this type of training, in addition to the Interactive Information Service for questions on the applicability and application of community law on SGI. [11]

In 2011, the European Parliament's Employment and Social Affairs Committee (6 June 2011) adopted their report on social services of general interest (SSGI), presented by rapporteur Proinsias De Rossa. The report supported the modernisation of EU public procurement rules, called for the introduction of social criteria relating to the provision of services and called for a review of state aide rules applicable to SSGI. The report also called for the European Commission to recognise the non-market characteristics of SSGI, the role of local and regional authorities and the social provisions of the European treaties.[12] However the report did not address how to further shape the legal, policy and quality framework for SSGI at EU level in the context of the flagship initiatives of the EU 2020 strategy. It also continued to use the terms economic/ non-economic in relation to Services of General Economic/ Non-economic Interest whereas the terms not-for-profit/ for-profit would better reflect the reality of social services funding and delivery.

European Voluntary Quality framework for SSGI

The subsequent European Parliament resolution (5 July 2011) welcomed the European Voluntary Quality Framework (EVQF) and suggested that the EVQF principles could be used to '*help define service quality criteria for application to revised public procurement rules for tendering and contracts, including subcontracts*'. [13] The European Voluntary Quality Framework sets out quality principles which will define relationships between service providers and users and relationships between service providers, public authorities and other stakeholders.[14] Although these are drawn from the experience of local, regional and national providers of social services, the weakness of the European Voluntary Quality Framework is that it is a voluntary agreement with no specific targets that providers have to meet and no formal monitoring procedures. There are several additional issues that should be addressed within the European Voluntary Quality Framework. The employment potential of social services must be recognised as well as improving the quality of existing and newly created jobs. Pay levels and working conditions need to be protected. Measures need to be in place that counter recent trends in the downgrading of care work and the increasing precariousness of lower qualified and lower paid jobs. Training and professional development qualifications, decent work and pay conditions should be mandatory and could be

facilitated by the '*strengthening or development of social dialogue and collective bargaining in relation to social services, both within member states as at European level.* [15]

The European Voluntary Quality Framework contains provisions for the respect for workers' rights and with the quality of jobs but since its adoption the Social Protection Committee has not undertaken a structured follow up in view of its use or promotion. The EC has also not delivered on it's announcement to "*reinforce its commitment to promoting quality in the field of social services, and will use these achievements in this area as a model for other services of general interest*" (COM (2011) 900, p.3). [16]

Public Procurement

The impact of EU Public Procurement rules on the commissioning of social services is becoming more pronounced because of the drive to achieve the lowest costs.[17] Wider, more socially beneficial criteria, including on pay and working conditions, which are central to the delivery of high quality social services are not necessarily considered, although these would also contribute to wider EU goals. For example:

> *"In defining and implementing its policies and activities, the Union shall take into account requirements linked to the promotion of a high level of employment, the guarantee of adequate social protection, the fight against social exclusion, and a high level of education, training and protection of human health.'*(Article 5a) Lisbon Treaty [18]

In 2010, DG Markt launched an evaluation of the impact and effectiveness of EU procurement legislation and policy.[19] The two reasons for the evaluation were: '*to identify the scope for greater cost effectiveness to allow the delivery of public services at lowest cost and; to enhance the impact of public procurement for the support of other policy objectives*'. [20] The impact of the public procurement legislation shows that the focus has been on the lowest cost rather meeting wider policy objectives. The result of taking the lowest cost contracts often leads to a failure to deliver and the need to re-contract.

More specifically, the evaluation submissions raised several issues that illustrated the lack of 'joined-up' policy making at EU level which results in public procurement rules overriding wider social benefits, such as social cohesion, gender equality, sustainable development and social dialogue. The EU Commission has failed to recognise that financially quantifiable costs are not always a sound basis for making a procurement award because contracts often go over budget and what appeared as the lowest cost are unable to be delivered because costs were unrealistic. The lack of recognition by the EC that public procurement should be used to improve social cohesion was reflected in the way in which economic and internal market rights are prioritised over social and labour rights.[21] Several opportunities to implement wider EU social policy had been missed in the public procurement process. Gender equality could be improved by making service providers adopt equal pay policies. In the same way, public procurement could be an instrument to promote employment opportunities for people excluded by the labour market. If EU member states were encouraged to ratify ILO Convention 94 on labour clauses in public contracts and other ILO standards and conventions that promote working and trade union rights, this would make the public procurement process part of the implementation process for these ILO standards and conventions. The narrow interpretation of the '*most advantageous tender for the contracting authority'* together with the current economic and financial austerity measures results in cost cutting through the lower levels of staffing, reduced staff costs and poorer service quality. [22]

Although a wide range of criticisms were made in the evaluation submissions they do not appear to have had a significant influence on the proposed Directive on Public Procurement. This again focuses on the lowest price/ lowest cost and the '*most economically advantageous tender*' (MEAT) and raises serious concerns about sustainability and quality concerns in relation to qualified and experienced staff. A more comprehensive concept of the '*most economically advantageous tender*' is needed. There are no social externalities included in life cycle costing, which continue to be narrowly interpreted. More details are needed about the specific process of production or service provision, which should include social production characteristics. There should be

opportunities to continually refine and develop new ways of defining the production process or service provision process. Labels and certification schemes could help commissioning authorities to introduce sustainable development into public procurement. Once again, social and environmental interests should be integrated into these schemes and citizen organisations should be able to contribute to the development of labels/ certification. The proposed governance arrangements which propose a single national oversight body are welcome but will also require the development of indicators as well as linking the oversight/ regulation bodies with research organisations that could provide access to best practice and evidence based policies and recommendations. A wide range of social partners should be involved in this process. [23]

Personal and household services

In June 2012, the European Commission (EC) published a consultation document (Staff Working Document) on '*Exploiting the employment potential of the personal and household services*', which accompanied the Communication 'Towards a Job Rich Recovery'. Although the focus is on employment growth, this document defines 'personal and household services' as covering child care, long term care for older people and people with disabilities. It defined services as including cleaning, remedial classes, home repairs, gardening, ICT support, thus effectively mixing home care services (part of health and social care) and wider household services. This reflects some confusion in the overall approach of the consultation document.

The document makes a series of recommendations that would be important for improving the pay and working conditions of work that is often part of an unregulated market, predominantly performed by women. It recommends regularising work that is currently done by undocumented migrant workers and moving work in personal and household services away from the informal economy so that workers have access to employment rights and benefits/ entitlements. However it fails to address a series of issues which relate to the funding, organisation and regulation of 'personal and household services'.

Although the aim of increasing the number of jobs is important at a time of rising unemployment, the paper does not place the funding of personal and household services within the context of stronger public finances. Although the aim of making the work of personal and household services, which is predominantly done by women, recognised as paid work is important, the mixing of home care service activities and wider household activities has the potential to undermine the need for specific training for social care work. The mix of these two activities (personal and household services) within the context of self-employment of women will also not contribute to strengthening the position of these workers in the labour force but will lead to marginalisation. Although the use of use of voucher schemes as a tool for employment creation has potential this would have to be placed in the context of health and social policies and the effects of organisation, financing and quality of personal & household services. This consultation paper shows some confusion in future EU policy for services delivered at home and does not place personal and household services in any coherent long term care strategy.[24]

Although the aim of increasing the number of jobs is important at a time of rising unemployment, the paper does not place the funding of personal and household services within the context of improving public services and increasing public funding. Although the aim of making the work of personal and household services, which is predominantly done by women, recognised as paid work is important, the mixing of home care service activities and wider household activities has the potential to undermine the need for specific training for social care work. The mix of these two activities (personal and household services) within the context of self-employment of women will also not contribute to strengthening the position of these workers in the labour force but will lead to marginalisation and an increase in less-protected forms and contracts of employment, in terms of labour law and coverage by all branches of social security and protection

Although the use of voucher schemes as a tool for employment creation has potential this would have to be placed in the context of health and social policies and the effects of organisation,

financing and quality of personal & household services. This consultation paper shows some confusion in future EU policy for services delivered at home and does not place personal and household services in any coherent long term care strategy.[25]

1.2 National policies – care for older people

Care services for older people across Europe are diverse and range from institutional care to home care, with some significant changes taking place over the past two decades. There is a growing demand for services to be delivered at home, moving away from institutional care. The health and social care sector is one of the fastest growing in Europe with increases in both economic and social value as well as the percentage of jobs created. [26]

Across Europe, several countries have adopted and implemented reforms in the provision of care services for older people, which, in some cases, have resulted in a shift from public to for-profit and not-for-profit providers of services. National policies, for the financing of care, have a strong influence on the type of care services provided by the for-profit and not-for-profit sectors. Although services are still funded by taxation in many countries, some countries have introduced new systems of long term care insurance and co-payments. Other countries use means testing as criteria for eligibility. Funding of long term care is a major political issue in many countries. For countries that have introduced new funding arrangements, there is concern about the long term financial sustainability of services.

The expansion of home care services is also related to the new systems where money is paid directly to service users so that they can purchase their own personal care services. Older people and people with disabilities, in some countries, are being given cash benefits which means money from public funding to purchase the services that they require. Austria, Germany, France, Belgium, Spain, Greece, UK, Denmark and Finland have introduced these types of arrangements for people needing care. Norway, Sweden, Netherlands and Portugal do not have this provision and deliver care services directly.

With an increase in individually assessed care packages, there is a rising demand for care services delivered at home. In the UK, the Community Care Direct Payment Act has led to increased home care provision. The introduction of personalised budgets for people with disabilities and older people has led to an individual receiving a cash payment rather than receive a service have led to the growth of a new type of carer called '*personal assistants*'. A personal assistant can be employed directly by the budget holder, by a social care budget holder (micro-employer) or be employed by a for-profit or not-for-profit agency. It has led to the growth of an unregulated workforce. [27]

In France, a major reform to the French system of long term care took place in 2002 with the introduction of the *Allocation personnalisee e l'autonomie* (APA) which provides cash for the care of frail elderly. There is a mix of public and private provision and services are delivered at home or in a residential setting. In Austria, a care allowance for people with long term care needs was introduced in 1993. The introduction of a care allowance has led to the development of a fragmented system of care services with different providers, different form of provision and different regulations in relation to access and finance. [28]

In 1988, Italy introduced a companion payment or needs based allowance, which is a universal benefit, funded through central government taxation and not means tested. It is used to pay for private services or to pay a relative. Since its introduction, there has been an increase in the proportion of over 65s who receive it. In 1991 5.0% claimed the allowance. By 2008, the proportion has risen to 9.5%. The expansion is also caused by the slow growth in institutional residential care. [29]

In Denmark, changes in the home help services have taken place since the late 1970s, characterised by the introduction of 24 hour care which involved both home help workers and home nurses.[30] New national legislation, which was designed to eliminate the black market in domestic services, now allocates subsidies for home service or housekeeping activities. [31] Private firms, with as few as two people, can register to receive these subsidies.

In Germany, a reform of long term care insurance was introduced in 1994, which established a social long term care insurance (LTCI) and a mandatory private LTC covering the whole population. All insurance products are capped so there are private co-payments and means tested assistance, especially for nursing home care. LTCI beneficiaries can choose between home care (in kind or cash), day and night care and nursing care. All providers, not-for-profit, for-profit and public, must have a contract with LTCI funds. [32]

Many social care systems depend on unpaid carers in the family to provide different levels of care, from a few hours a week to full time care to older relatives. The majority of carers are women. Carers have often been recognised for the first time in new social care legislation. The UK introduced an 'attendance allowances' as payment for carers who previously would have provided unpaid, informal care. Ireland has also introduced a Carer's Allowance.

Although the system of community care provision is still evolving in countries of Central and Eastern Europe, there is some tradition of care related payments. In Hungary, payments are made to informal carers at a level of the basic minimum pension. The Czech Republic has just introduced a care allowance. Social care services are financed through tax based services with social assistance. [33]

A report commissioned by EPSU (2010) presented the results of a survey of health and social care workers in 8 European countries. In the majority of European countries, care workers for older people are low paid, even though their jobs are emotionally and physically demanding. Care work is often considered a low status career. The workforce is predominantly female with 80% of employees in the health and social care sectors in Europe are women. [34] Pay is traditionally higher in public sector services than in private and not for profit services. Improving wages in this sector would help to reduce the gender pay gap. Recent research into the impact of austerity policies on public sector jobs has shown that women are being affected particularly strongly. [35] [36]

Changes in the way that care is funded have also led to the expansion of types of care worker.[37] As well as care workers employed by the public, for-profit/ not-for-profit sectors, there are 'independent' formal carers, who are registered with an employment agency, for short term placements. Job security and wages are often inadequate. A third category, called '*personal assistant*' carers, are recruited by the care recipient or recipient's family, and may be permanent, short term or live-in. Once again, the pay and terms and conditions of '*personal assistants*' are often poor.[38]

Care for older people is beginning to be recognised as an important policy issue at national and European level but there a lack of clarity about how it should be funded and delivered. The use of public procurement processes in the social services sector is making collective bargaining more difficult. In Austria, as a result of the public procurement process and the role of the state in the payment of social services, the state is only willing to pay for the cheapest wages. This restricts the capacity of the social partners (employers/ employees) to negotiate. In Scotland, the absence of a regulatory framework for public procurement, combined with cuts to budgets makes negotiations between public sector employers and trade unions problematic.[39]

The social services sector is directly affected by the austerity programmes that have been introduced in response to the financial crisis in Europe. In both Germany and the Netherlands, budget cuts contribute to making negotiations about collective agreements difficult to resolve. In

Ireland, social partners are disaffected with the existing collective agreement. In Spain, new labour reforms are threatening the existence of national collective bargaining agreements with a possible move towards company level collective bargaining. [40]

Care / long term care for older people is faced with major problems in securing a sustainable workforce. Although the health and social care sector is fast growing in terms of social and economic value and in terms of job creation, the long term future of the workforce is unclear with an ageing, low paid, mainly female workforce that has high rates of turnover.

The impact of caring responsibilities for parents/ family members, not just children, on the mainly female workforce will require flexible working conditions in the same way that child-care is part of a strategy to increase female participation of the workforce. However the EU 'personal and household services' consultation paper does not fully address these issues within any recognised policy framework. This will be required to secure a workforce for the care of older people. This has an impact not just on governments but also on for-profit and not-for profit providers of services.

1.3 Child care

The European Union recognised the need to improved access to childcare as part of its European Employment Strategy to expand the percentage of women in the workforce. The Barcelona European Council targets aimed to provide, by 2010, childcare services for 90% of children between three years of age and the mandatory school age, and for 33% of children under three years of age.[41]The EU focus on child care provision is also related to falling birth-rates and the recognition that good quality child care is a factor in determining decisions about family size and in achieving a sustainable work-life balance.[42]

A recent EC Communication (2011) on 'Early Childhood Education and Care (ECEC): providing all our children with the best start for the world of tomorrow' outlines the argument for the value of early childhood learning which has social, economic and educational impacts. It is presented as helping parents balance family responsibilities with employment and also helping disadvantaged groups. High quality early childhood education is considered as contributing to helping two Europe 2020 targets – reducing early school leaving and helping to lift people from poverty and social exclusion. The emphasis is on the quality of early childhood education rather than just on the quantity of childcare/ pre-primary places. [43]

In outlining how early childhood and care should be funded, this Communication argues that '*market based services have the potential to limit public expenditure and allow greater choice and control for parent: however this should not be allowed to restrict the availabilty of high quality services for all*' (p21)[44]. This is a new development in EU child care policy in that previously the pressure to provide child care services focused on quantity but there is a growing awareness that the quality of services is also important. There is even some recognition that market based solutions may not always be effective in securing high quality services. However the argument of ECEC raises questions about the influence of EU policy on the national level policies for early years education. It is beginning to promote childcare policies not just as a way of expanding women's participation in the labour force but as part of a social inclusion strategy.

There are wide variations between levels of child-care provision in EU countries, which are influenced by the period in which child care provision has expanded. Countries in the Nordic region established a state system of childcare by the 1980s. The UK has been developing a much more mixed system since the 1990s. The largest investments have been in pre-school age care. Except in Denmark and Sweden, pre-school age care is more developed than care for 0-3 year olds, which is more likely to be small scale, informal [45] and more often delivered by the for-profit / not-for-profit sector.[46] In Germany, there are large regional variations in percentages of children in child care services, ranging from 49% in Saxon-Anhalt to 6% in Bavaria. There is a lack of child

care services in many rural areas, in West Germany and in many poor/ disadvantaged areas although there is a growing demand for services but a shortage of qualified workers.[47] In some Eastern and Central European countries the provision of child care services has decreased. [48]

Informal care continues to be the dominant form of care. Changes in types of funding are having an influence on the types of care worker. Workers involved in childcare services that are part of the educational sector are generally better qualified and better paid than child care workers for the younger 0-3 year age group. The separation of responsibility for child care services for these two age groups between education and welfare departments has also made it more difficult for workers to move between different services.

In all countries, the child care workforce is predominantly female. Although child care services have often been developed as a way of increasing the participation of women in the labour market, the child care sector remains gender segregated. Low pay and poor working conditions in many countries has led to high rates of staff turnover and problems in recruitment. Migrant workers also work in many areas of child care services, particularly unregulated services

The impact of the EC Communication on Early Childhood Education and Care may start to impact on the training of workers in this sector. The low pay and low status of child care workers is being addressed, mainly through the provision of training. One of the most common initiatives is to provide access for child care workers to access higher level training or to make stronger links between vocational training and higher/ tertiary education. Several countries are integrating training for childcare and educational workers.

2 Multinational company trends

Multi-national companies are involved in care services in several ways. A group of French multinational care companies own a mix of care homes as well as some clinical services, most usually mental health services in countries bordering France. Facilities management MNCs are increasingly becoming involved in the delivery of homecare services, for example, Sodexho. Some companies, not always involved directly in care, provide retirement apartments with a range of services (assisted care) which may include care as well as recreational activities for people on higher incomes.

The for-profit sector is becoming increasingly involved in care provision but there is uncertainty about the future of these types of investments in some countries. There are examples of care homes operating in national markets going bankrupt (Austria/ Germany/UK) and also scandals about the poor quality of care delivered (Sweden/ Germany/ UK). This is partly because the business model for many care homes, until the financial crisis of 2008/9, was based on a sale / leaseback arrangement, which gave companies greater flexibility to respond to the changes in demand for places but without large-scale property investments. (Appendix 1 provides a case study of the UK failure of social care privatisation.) However after the crisis, borrowing capital became more expensive and the austerity measures introduced by national governments have put pressure on the payments that governments, as funders of individual care places, will pay. In Germany and France, government funding and regulation for care homes have become more rigorous and the effect on for-profit care homes companies is unclear.

Nordic care companies continue to benefit from the outsourcing of care services at municipal level, and operate within a regional market. However, Sweden reported a decline in care home places but an increase in domiciliary services in 2011. [49]There are examples of private equity companies investing in domiciliary services and the three largest home care companies in Sweden all have private equity investors (Humana (ArganCapital) [50]; Frosunda (HG Capital)[51]; and Olivia

(Procuritas)[52]. There are signs that some private equity investors are sensitive to the criticisms of the quality of care. Attendo has been put up for sale by its owners IK Investment Partners.

Private equity continues to invest in care services. Several nordic multinational care companies have private equity investors. The recent patterns of investment by HG Capital show that care continues to be a priority investment in Europe (Table1).

Table 1: HG Capital care investments 2006-2011

Year of acquisition	Company	Activity	Country
2006	Voyage Group	Homes for people with learning disabilities and in 2011 (5,507 workers)	UK
2008	Casa Reha	Care homes	Germany
2010	Frosunda	Personal assistants for people with disabilities (also psychiatry & school 'business') (3,700 workers)	Sweden
2011	Mainio Vive	27 care homes (1,150 workers)	Finland

Sources: http://www.hgcapital.com/; http://www.worksmart.org.uk/

There are examples of home/ domiciliary care companies being bought up by private equity investors in Spain. [53] The case of Sacyr Vallehermono, a Spanish construction, infrastructure and property group, also illustrates how home care and care homes are becoming part of a portfolio of activities for companies operating in different sectors. Valoriza is the services group of Sacyr Vallehermono which operates in cleaning, facilities management and in social care through Valoriza Servicios Socio Sanitarios (VSS). VSS is a joint venture between Valoriza and the Spanish state-owned holding company, SEPI. Valoriza owns 52% . VSS provides both home care services to older people as well as managing nursing homes. In 2011, VSS won several contracts with regional and provincial government for home care.[54]

The use of Real Estate Investment Trusts (REITS) to invest in health and social care continues slowly. Confinimmo, one of the largest REITs in Belgium has health care investments in Belgium and France which include nursing homes, psychiatric care and rehabilitation clinics. [55] [56] An analysis of Confinimmo's health / care home investments in France show that both Korian and Medica France run care homes are owned by Confinimmo. [57] In November 2011, Confinimmo signed a joint venture agreement with ORPEA, the French care company, which would be managed by ORPEA. Their first clinic acquisition was in April 2012.[58] The joint venture is governed by French law in which Cofinimmo holds a 51% stake and the ORPEA Group 49%. Cofinea I SAS receives tax benefits through the *Société d'Investissement Immobilier Cotée* (SIIC) regime or French listed real estate investment company.[59]

The not-for-profit sector is also a major provider of care in residential and home settings. Charitable organisations, such as the Red Cross, Caritas or Diakonie, are major providers of care in many European countries. Not-for-profit organisations have not had a long tradition of unionised staff because they have often depended on volunteers for much of their labour force. This has led to low pay and poor working conditions. [60] However, increasingly not-for-profit providers now employ staff and professionals in many social services, including care for older people, for people with disabilities and childcare. [61]

As major providers of care in more than one country in Europe, some not-for-profit organisations should also be assessed as eligible for a European Works Council. However, there are several reasons why their eligibility for EWC may not be fully realised. In the case of the International Red Cross, it is an organisation that operates multi-nationally but is relatively small, whereas country

Red Cross societies are larger but nationally organised. Many not-for-profit organisations operate as umbrella organisations at a national/ federal level but do not employ large numbers of staff directly. Staff who deliver services are more often employed by regional or local branches, which operate as independent legal entities.

3 Multinational care companies - European and wider international presence

Company	European presence	International presence	Number of workers (2012)
Aleris (formerly CarePartner)	Sweden, Denmark, Norway	-	6,300
Ambea (formerly Carema)	Sweden, Norway, Finland	-	10,300
Attendo	Sweden, Norway, Denmark,	-	12,000
BUPA Care Homes	UK, Spain	Australia, New Zealand	26,950 (UK) 17,466 (Spain) 5,000
Korian (formerly Medidep)	France, Belgium, Italy, Germany	-	15,000
Medica France	France, Italy	-	8,500
Norlandia	Sweden, Norway, Denmark, Finland	-	2,450
Orpea	France, Italy, Spain , Belgium, Switzerland	-	23,000

Non-EWC eligible

Company	European presence	International presence	Number of workers
Domus VI Dolcea (Groupe DVD)	France	Canada	4,000

Significant acquisitions and sales of subsidiaries 2005 - 2012

Company	Buying	Selling	Year	
Aleris	Sodermalms nursing homes 2011 Bollnas Hospital 2011 Proxima 2011	ISS sold shares in Aleris to EQT	2005 2011	
Ambea	Sold by 3i to KKR/Triton		2010	
BC Partners	Medica France		2006	Floated on stock exchange
Attendo	MedOne		2007	2012 for sale
BUPA	Sanitas Residenciales	BUPA Corporate child care services to The Family Care Company BUPA Scandinavia (Insurance closed) 2011	2007	

Domus VI	Sedna, Canada Merged with Dolcea (2010)		2007 2010	
Korian	Segesta, Italy Phönix, Germany		2006 2007	
Medica France				
Orpea	Arteride, Spain 2011 Joint venture with Confinimmo (REIT) Belgium 2011		2011	

4 European Works Councils

The European Works Councils (EWC) Directive, initially adopted in 1994,[62] aims to improve the right of workers to information and consultation in trans-national companies. It requires transnational companies to establish information and consultation agreements covering their entire European workforce, if they have not already done so. The content of these agreements is largely left to negotiation between management and employee representatives, but minimum requirements where management refuses to negotiate include the requirement of annual reports to the EWC on the company's business prospects, and the right to be informed about exceptional circumstances affecting employees' interests, such as closure or collective redundancy.

The EWC directive applies to companies, [63] or groups of companies[64], with

- at least 1000[65] employees across the member states, [66]*and*
- at least 150 employees in each of two or more distinct member states.

These employment criteria represent a lower bound – *companies meeting them are obliged to establish a EWC*, but companies which do not meet them may nonetheless choose to establish one voluntarily. In a number of instances companies have chosen to do so, whether it be for purposes of labour relations, prestige in order to demonstrate Europe-wide coverage, or, in the case of UK during its opt out, in the expectation of the future introduction of a legal obligation.

The directive was revised in 2008 following an agreement on amendments by the European social partners (ETUC and employers). On 23 April 2009 a revised directive on European Works Councils (EWCs) was adopted 2009/38/EC. This has to be transposed into national legislation by June 2011. The thresholds were not changed.

The most important changes in the recast directive 2009/38/EC relate to:
- Inclusion of a definition of information
- Improvement of the definition of consultation
- Inclusion of a definition of transnationality and clarification of the transnational competence of EWCs
- Link between various levels of employee information and consultation
- Employers' obligation to provide EWC members with training
- Facilities provided to the SNB, such as pre and post meetings, the presence of experts – including trade union members- in the negotiation meetings
- Obligation to inform the European social partners of negotiations (= recognition of the role of the European social partners)

- Mandate for the employee reps in the EWC to collectively represent the employees and obligation for the management to provide the EWC with means necessary to perform this function (www. http://www.worker-participation.eu/European-Works-Councils/Recast-2009)

5 Companies with European Works Councils (or eligible)

5.1 Company name: ALERIS

Box 47134,
SE-10074 Stockholm
Tel: 08 690 55 00
www.alerisgroup.com

Total number of employees: 6,300 (2012)

EWC: NO – ELIGIBLE

Subsidiaries:

Aleris AB Katrinebergsbacken 35 A Box 471 34 100 74 Stockholm SWEDEN Tel. + 48 8 690 55 00 Fax.08-690 59 91 E-mail: info@aleris.se	Aleris AS FrederikStangsgt 11-13 0264 Oslo NORWAY Tel. + 47 22 54 10 00 E-mail: info@aleris.no	Aleris Bernhard Bangs Alle 39 DK-2000 Frederiksberg DENMARK Tel. + 45 38 17 17 70 Fax. + 45 38 11 13 1 E-ail: info@aleris.dk

Company activities and strategy

Aleris operates specialist care centres, surgical units, local hospitals, senior care homes, nursing homes, home services, rehabilitation centres, foster homes, psychiatric residential homes, radiology centres, clinical tests laboratories, medical test centres and audiology centres. The company is active in Sweden, Norway and Denmark. [67]

In February 2005, ISS announced that it was setting up a joint venture with the EQT III fund to take over the activities of ISS Health Care, fully owned by ISS. The joint venture would also take over 100% of CarePartner AB, which was 49% owned by ISS and 51% owned by management. ISS took over the 51% of CarePartner AB from management prior to the sale of the combined activities to the joint venture.[68]

ISS then sold its health care operations to the newly formed joint-venture, now named Aleris Holding AB, owned by EQT III Limited, ISS and Aleris's management. In June 2005, ISS sold its interest in Aleris to EQT III Limited. The sale of Health Care resulted in a non-taxable gain DKK 237 million. [69] The EQT investment group was founded in 1994, by Investor AB, Scandinavia's largest industrial holding group. It is part of the Wallenberg group. [70] In July 2010, Investor AB increased its share of Aleris to 97%, buying from the EQT Investment Group. Aleris management own the remaining 3% shares.[71]

In 2011 Aleris bought a Swedish home care company, Södermalms assisted living AB with 400 employees.[72] The company also bought at Bollnäs hospital, which runs emergency services, on 1 April 2012 as well as healthcare company Proxima.

Table 2.Revenues and EBITDA SEK m

	2009 (SEK million)	2010 SEK Million
Net sales	3,882	4,120
EBITDA	332	296
Net debt	1,624	1,980

Source: 2011 AlerisAnnual report

5.2 Company name: AMBEA

Owner: In April 2010, Triton and Kohlberg Kravis Roberts & Co (KKR) acquired Ambea, the company which owned both Carema (a Swedish healthcare and care company), and Mehiläinen, a Finnish health care company. Ambea is now owned by a Luxembourg holding company, called Actor SCA, which was set up in 2010.[73]

Ambea/ Carema Vretenvägen 13 Box 1565 171 29 Solna, Sweden Tel: +46 (0) 8-578 700 00 Fax: +46 (0) 8-578 700 01 www.ambea.com **Mehiläinen** North Hesperiankatu 17 C, 00260 Helsinki, Finland Tel: +358 (0) 10 4140 112 www.mehilainen.fi	**Actor SCA** 26, rue Edward Steichen Luxembourg, 2540 Luxembourg

Total number of employees: Carema 8,000 employees (after sale of Carema healthcare in December 2012) Mehiläinen 5.000 employees (including 2,500 doctors)

Company outline and strategy

The healthcare company Carema, founded in 1996, developed primary care, specialist healthcare services, care services and health staffing activities until 2005, when 3i (and Government of Singapore Investment Corporation) invested in a buyout of Carema. In 2006, Carema bought Mehiläinen, the largest healthcare provider in Finland for €160 million. [74] These two companies became subsidiaries of a newly formed parent company called Ambea in 2007. They remained as separate brands. Between 2005 and 2009, Ambea bought over 20 healthcare businesses which covered primary care, specialist healthcare services, care services and healthcare staffing services. Mehiläinen continues to operate in Finland. Carema ran services mainly in Sweden with one clinic in Norway (specialising in physical activity and rehabilitation).

In 2010, 3i (75.01% ownership), the Government of Singapore Investment Corporation (15.94% ownership) and Carema management sold Ambea to Triton and KKR, both private equity funds. [75] KKR is a US private equity fund which also owns part of the HCA company, which operates in the US, UK and Switzerland. Since 2010, Ambea has been owned by a holding company called Actor SCA, based in Luxembourg. No Annual report has been published since 2009.

In 2011, Carema faced strong criticism about the standards of care services delivered in its Carema homes. A 90 year old woman died of starvation in a care home where she had been living for three years.[76] There were several other cases reported about the poor quality of care received in Carema care homes and as a

result Stockholm City terminated its contract with Carema.[77] More than 150 complaints were made about Carema to the National Board of Health and Welfare.[78] In November 2012, further complaints were reported about treatment and quality of care for older people in a Carema nursing home. There was a reduction in the number of municipal/ government contracts that Carema won after the criticisms of Carema nursing care in 2011.

In 2012, Ambea sold Carema healthcare (providing healthcare services in Sweden) to Capio, arguing that this would enable Carema to concentrate on improving its care services. In December 2012, Carema reported that its health staffing services (Rent-a-Doctor and Rent-a-Nurse) had won contracts in Norway to supply public sector health care staff.[79]

5.3 Company name: ATTENDO AB

Owner: IK Investment Partners

Attendo AB
Attendo 2006
Vendevägen 85B,
182 91 Danderyd
Tel: 08-5862 5200
www.attendo.se

Total number of employees: 15,500 (12,000 in Sweden, Denmark, and Norway; 3,500 in Finland)

EWC: NO – ELIGIBLE

Company activities and strategy

Attendo is the leading care company which provides care for older people and disabled people on behalf of local authorities in Sweden, Denmark, Norway and Finland. It provides services in the following sectors: homecare, assisted living, nursing home, primary care, medical staffing.Attendois based in Danderyd, Sweden, where the company won Sweden's first outsourced home care contract in 1988.

In February 2005,the British private equity funds management company Bridgepoint Europe II, belonging to British Bridgepoint Capital Group Limited, bought a majority holding in the Swedish care services provider Attendo AB. [80]Announcing its acquisition of Attendo AB in 2005, Bridgepoint Capital said that it "*intends to be an active owner, using its extensive industry knowledge and capital resources to offer the necessary support to management and the business*".[81]In 2005-6, Bridgepoint Capital merged two divisions of Attendo (systems and response systems) with Tunstall, a company specialising in telecare, which Bridgepoint Capital had also acquired. Bridgepoint Capital then sold the remaining nursing care division of Attendo to IndustriKapital, a Swedish private equity group. This sale was completed in January 2007.[82]

Since then, IndustriKapital has changed its name to IK Investment Partners. It owns 68% of the shares in Attendo. The remaining 32% of the shares is owned by Varma, Intermediate Capital Group and Attendo employees (www.attendo.se). In 2007 Attendo AB bought MedOne, a Finnish company that provides medical staff and delivers primary care, specialist care, dental care and elder care in Finland.78% of the shares is owned by IK Investment Partners. The remaining 22% of the shares is owned by Varma, ICG, Attendo's board of directors, Attendo's management team and employees.[83]IK Investment Partners does not own any other specific care or health care companies but other health care investments include private dental care and mobility aids.

In 2011, Attendocare homes were the subject of criticism in Sweden with accusations of ill-treatment of older people. [84] In 2012, IK Investment Partners announced that Attendo was for sale.[85]

Table 4: Revenues and operating profits

MSEK	2005	2006	2007	2008	2009	2010	2011	
Revenues	2 395,6	2 857,6	3 491,5	4 940,5	6 108,0	6 552,6	**7,289**	
Operating profit	140,3	223,8	267,6	302,6	426,7	508,3	**555.0**	

Source: http://www.attendo.com/en/start/Financial-information/Ownership-Structure/http://attendo.com/en/start/Financial-information/Financial-Overview/

5.4 Company name: BUPA

Owner:
BUPA
BUPA House
Bloomsbury Way
London WC1A 2BA
www.bupa.com

EWC: NO but ELIGIBLE

Total employees: 52,000 (worldwide)

Table 5: Major European subsidiaries

Company	Ownership	Country	contact	Website	Employees
Sanitas – Spain	100%	Spain	c/via Augusta 13-15, 28042 Madrid Tel: + 902 10 24 00	www.sanitas.es	5,285
BUPA UK Insurance	100%	UK	BUPA House Bloomsbury Way London WC1A 2BA	www.bupa.com	15,466 (2011)
BUPA Care Services Ltd	100%	UK			

Company outline and strategy

Care services have been BUPA's largest area of expansion since the mid-1990s. This sector has continued to grow, with increased acquisitions, not just in the UK but in Spain, Australia and New Zealand.

BUPA's major European subsidiary is Sanitas, a Spanish health insurer and healthcare provider, which was incorporated into BUPA in 1989. In 2007, the Sanitas group acquired Sanitas Residencial, BUPA Group's Spanish care home provider, bought the Euroresidencias' care home and day centre portfolio from the Spanish company SaaremaInversiones. This made Sanitas, the second largest provider of long term care in Spain.

In July 2007, BUPA sold its corporate childcare services to Emergency Child and Home Care. The new company will be called The Family Care Company and will offer its clients emergency child and elder care; out of school care; on-site creche and nursery management; childcare search and selection services, and advice lines for employers and their employees. Previously, The Family Care Company concentrated on providing back-up and emergency childcare and elder care predominantly through a website service. BUPA employees have transferred to the new company. [86]

In 2010, BUPA employed 52,000 employees worldwide. Sanitas employed 5,295. Over 17,000 employees work for BUPA Care Service in the UK.

Table 6: Revenues by segment (£ million)

Revenues	2010	Operating Profit	2011	Operating profit
International markets (insurance) Australia, Latin America, Hong Kong, Thailand, India, Arabia	3,394.0	208.5	3,874.3	283.4
Europe & North America Health & Wellbeing, Sanitas, Health Dialog, Cromwell Hospital, BUPA Scandinavia	2,999.5	116.4	2,933.7	141.7
Care Services – UK, Australia, New Zealand, Sanitas Residential, Home Healthcare	1,182.9	139.7	1,203.7	146.7
Consolidated total revenues	7,576		8,018	

Source: BUPA Annual Report 2011

BUPA Care Services in the UK reported a fall in revenues of care services which was due to fall in occupancy caused by a decline in public funding, a slowdown in self-financed admissions and high winter mortality rates. [87]

5.5 Company name: KORIAN

32 rue Guersant
75017 Paris
France
Tel : +33 1 55 37 52 00
Fax: +33 1 55 37 52 16
www.groupe-korian.com

Total number of employees: 15,000

EWC: NO – ELIGIBLE

Subsidiaries:

Italy	Germany
Segesta Group	**Phonix Group**

Company activities and strategy

Founded in France in 1992, Medidep expanded between 1998 and 2002 by acquiring 142 homes in France and 3 homes in Belgium. By 2004, 94 centres were in operation with 50,000 people using the services.

In 2003, with the retirement of the founder, Pierre Austruy, there was a change in ownership. ORPEA, another leading French care company, became a major shareholder (29%) with Fidelity Investments owning 5% of shares.In 2006, Medidep and Suren merged to form a new company, Korian. [88] The same year, Korian bought Segesta, the second largest private care operator in Italy. [89]In August 2007, Korian signed an agreement to acquire a 92.5% stake in the Phönix group, Germany, with the remaining interest held by the management team. Phönix, with corporate headquarters in Bavaria, operates nearly 3,000 beds in medical retirement homes.[90]

In 2012, Korianwas active in France, Italy and Germany. Its shareholders included:

- Batipart : 23.8 %
- Prédica : 31.0 %
- ACM Vie : 10.4 %
- Malakoff-Médéric: 13.3 %
- MASCF: 10.4 %
- Public : 10.8 %

Table 7: Revenues and EBITDA 2007-11

€m	2007	2008	2009	2010	2011
Revenues	608.7	781.3	850.6	922.9	1014.8
EBITDA	79.7	93.5	94.3	109.0	122.7

Source: Korian Annual Report 2008, 2009, 2010, 2011

5.6 Company name: MEDICA GROUP

39 rue Gouverneur General Eboue
Issy Les Moulineaux
France
Tel : 33 01 41 09 95 20,
Fax : 33 01 45 95 51 80
http://www.groupemedica.com/

Number of employees: 8,000

EWC: NO – ELIGIBLE

Strategy and activities

Medica Group runs 201 nursing homes and clinics with 15,395 beds in 2012, an increase of almost double the number of beds since 2010. The company moved into the Italian market in 2005, when it bought a majority share in Aetas, an Italian care company with 11 nursing homes and 741 beds. In 2006, it bought a further four homes in Lombardy and Piedmont.[91]

In 2010, Medica's net debt was €365 and this had increased to €433 million by 2011. Of this net debt, property debt was €141 million with total property assets of € 387 million.

Bridgepoint Capital and Alpinvest, bought 70% of Medica France from Caisse de Depots, a Quebec fund manager for public and private pension funds, in 2003, [92] but sold it in 2006 to BC Partners for €750m.[93] BC Partners floated Medica France in February 2010. It is now known as Medica Group.

Ownership (2012)
Monroe in Batipart Group 9.5%
Predica (Life insurance) 11.3%
Covea Group (claims management) 21.4%
Free float 54.4%

Table 8: Revenues and EBITDA

€m	2008	2009	2010	2011
Revenues	448.8	480.7	539	632.1
EBITDA	78.3	84.6	95	108

Source: Medica Group Financial Report 2009 and 2011

Table 9: Revenue by sector

	2011	2010
France long term care	391.1	334.6
France post acute& psychiatric	162.4	144.2
Italy	778.8	60.0
Total	632.1	538.9

Source: Medica Annual Report 2011

5.7 Company name: Norlandia Care

Owner: The Adolfson Group

Address
Rådhusgt 23,
0158 Oslo
Norway
Tel.: +47 21 42 30 00
Fax:+47 21 42 30 01
www.adolfsen.com

Number of employees: 2,450 (2011)

EWC eligible

Table 12: Revenues 2006-2010

	2006	2007	2008	2009	2010	2011
Revenues	272	351	465	578	615	1,217
EBITDA	18	24	24	41		

Source: Norlandia Annual Report, 2009, 2010

Table 11: Revenues by country

NOKm	**Norway**	**Sweden**	**Total**
Revenues	**368 (64%)**	**210 (36%)**	**578 (100%)**

EBITDA	26 (63%)	15 (37%)	41 (100%)

Source: Norlandia Annual Report, 2009

Table 12: Revenue by enterprise

Total revenue (NOK)	Patient hotels	Nursing homes	Childcare
1,217m	127m	476m	614m
100%	10%	40%	50%

Source: www.norlandia.no

Company activities and strategy

Norlandia Care was established in 1997 with a joint venture between Norlandia Hotels and Resorts and BoendeFornyelseoch Service AB. Originally running care centres (Children and older people), nursing homes (older people and people with disabilities) and patient hotels in Norway and Sweden, it sold its care centre business in Sweden in 2009. In 2010, Norlandia Care ran nursing homes, patient hotels and home care services for young people. It provided services to the public sector as well as providing private care services directly to patients. Almost 64% of revenues come from Norway.[94]A patient hotel is run as a hotel where a patient stays when receiving healthcare treatment from a nearly hospital. Several county councils in Norway and Sweden have contracts with Norlandia for patient hotel services.

In 2007, Norlandia acquired a majority stakes in Achima, a temporary staffing agency providing healthcare personnel to Norwegian and Swedish public and private healthcare institutions. It sold Achima in 2009 after a decision to focus on core business areas of nursing homes, patient hotels and home care.[95] However in 2010, it sold out its home care business to focus more on care homes.[96]

In 2011, Norlandia Care was accused of not paying a number of Swedish nurses around 700 hours of owed overtime pay, beginning in 2008, as well as allowing illegal double shifts and employees staying in patient rooms.[97] In August 2012, the company reported that strikes had occurred in some of its nursing homes as a result of failed negotiations with the trade unions.[98]

In 2012, Norlandia merged with ACEA, a company running childcare in Norway, following the FSN Capital's sale of its 45% stake in the Norlandia group and 50% of ACEA to the Adolfsen family.[99][100]ACEA was set up by Kristian and Roger Adolfsen who established the Norlandia Care Group in 1997 and the ACEA Group in 2008.[101]

5.8 Company name: ORPEA

Groupe ORPEA /CLINEA
1-3, rue Bellini
92800 PUTEAUX Cedex
France
Tél.: 01 47 75 78 07
www.orpea.com

Subsidiaries

Grupo care C/ Monte Esquinza 30 7° Izquierda 28010 Madrid	La Matairie Avenue de Bois-Bougy Nyon CH-1290 Switzerland	Residence Winston Churchill Clinique Longchamp Brussels	Residencesde Ancône (Region de Marches) and NizzaMontferrato (Piedmont)

Tel. 91 426 09 52 - Fax 91 391 57 38 www.grupocare.com www.grupocare.es	Tel : 41-(0)22 363 2020	Belgium	

Employees: 23,000

EWC: NO – ELIGIBLE

Company activities and strategy

Orpea is the largest private sector provider of social care in France. It provides two types of services: care services and psychiatric services. Since 2004, ORPEA has expanded into Spain, Belgium, and Switzerland.

Table 10: Revenues, EBITDA and % beds by country (2011)

Country	Revenues	EBITDA	Beds % (2011)
France	1,094	202	50
Spain	30.5	1.8	30
Belgium	76.5	9.7	14
Italy	26.8	1.9	5
Swizerland	14.8	2.9	1
Total	1,234.1	218	

Source: ORPEA Annual report 2011

Property is considered a strategic asset for the group.

	2011	2010
Net financial debt:	€1,619 (31 December 2011)	€1,483
Property debt	80%	82%
Operating debt	20%	18%

Sources: Orpea Annual report 2010, 2011

In 2011, Orpea entered into a joint venture with Confinimmo, a Belgian based REIT (real estate investment trust) and in April 2012, they bought a nursing home in France. ORPEA will manage the services.

The company has expanded in Belgium, Spain and Italy. Orpea considers that the "*European care sector remains very fragmented at European level*". [102] The company has identified these three countries as having similar characteristics to France: a regulatory and supervisory system; similar demographic trends; and a fragmented sector. [103] In 2011, Orpea bought Artevide, a Spanish chain of care homes.

In 2011, ORPEA is still a third-owned by its founders, the Mariam family.[104] Shareholders are

- Marian family : 32,5%
- Sempre : 17,3%
- Public : 50,2%

Table 11: Revenues and operating profit

€m	2005	2006	2007	2008	2009	2010	2011
Revenues	309.6	414.9	544.6	702.3	848.3	964.	1,234
Operating	74.8	60.6	72.4	95.0	115.5	172	218

profit	(included profit from sale of Medidep stake					(EBITDA	(EBITDA)

Source: ORPEA Full year results www.orpea.com

5.9 Company Name: SeneCura

Management: A-1060 Vienna, Capistrangasse 05/01/54 Tel: +43 (0) 1 585 61 59-0 Fax: +43 (0) 1 585 61 59-19 e-mail: office@senecura.at	**Office Dornbirn:** A-6850 Dornbirn, Färbergasse 15 Telephone +43 (0) 5572 558 77 Fax +43 (0) 5572 558 77-6 e-mail: dornbirn@senecura.a

Number of employees: 3,000

EWC eligible: Yes?

Company activities and strategy

Senecure is an Austrian company that has 49 nursing homes in Austria and 15 assisted living units in Switzerland. In 2012, it is opening care homes in the Czech Republic.

5.10 Company Name: Sodexho

Owner: Sodexho Group
Address
255 quai de la Bataille de Stalingrad
92130 Issy-les-Moulineaux
FRANCE
Tel : +33 01 30 85 75 00
www.sodexho.com

EWC: YES

Employees: 391,000 (2011)

Table 13: Regional revenues and workforce

Region	Revenues % (2010)	Revenues (2011)	Employees (2011)	Employees (2011)
North America	39%	37%	32%	124,919
Europe (Continental)	45%	36%	26%	102,166
UK & Ireland		8%	9%	34,918
Rest of world	16%	19%	33%	129,145
Total				391,000

Table 14: Sectoral sales and employees

Sector	Employees (2010)	% sales	Employees (2011)	% Employees	% sales (2011)
Corporate	152,767	34.5	143,095	37%	31%
Defence	14,848	3.3	13,693	4%	4%
Justice	3,222	1.6	3,956	1%	2%
Remote sites	32,055	7.2	39,112	10%	8%
Healthcare	60,055	20	61,964	16%	20%
Seniors	12,468	6.2	13,204	3%	6%
Education	90,438	22.5	93,566	24%	22%
Sports & leisure	n/a		8,183	2%	3%
Motivation Solutions	n/a	4%	3,575	1%	4%
Personal & home services	n/a		1,955	0.5%	
Group HQ & shared structures	n/a		5,865	1.5%	
	379,137		391,000	100%	

Company activities and strategy

The Sodexho Group works in the following sectors: business and industry, defence, justice/ prison services, healthcare, education, older people as well as in remote sites. It also manages voucher and card schemes. Healthcare is one of its largest sectors.

In the healthcare sector, Sodexho provides a range of services, often described as multi-service, to hospitals and to older people's care homes. These services may include, catering, cleaning, housekeeping, building maintenance and management of paramedical staff. Services delivered within the health care sector provide 20% of total revenue.[105] Sodexho is continuing to develop partnerships with public and private sector organisations in order to deliver services. In the UK it is involved in several PFI project both as an operator and as an investor.

Although health, education and seniors sectors percentage of sales remains unchanged between 2010-2011, there are signs that the contribution of corporate services to sales fell in this period from 24.5% to 31%. There are also changes in the distribution of the workforce between regions, with an increase in the numbers of workers in 'the rest of the world'.

In 2009, Sodexho created a new division for 'Personal and Home services', which covers a range of services delivered to people's homes. They include childcare; tutoring and adult education; concierge services; senior care. Sodexho has several contracts with local authorities in the UK to deliver meals to older people in their homes. As an indication of its expansion into home care, Sodexho bought Comfort Keepers, a home care services provider for older people in North America in 2009. Comfort Keepers is run as a franchise organisation and as well as delivering services in North America also has branches in Ireland, Singapore, Portugal, UK, New Zealand and Australia. In Ireland, Comfortkeepers recently (2012) won a large State contract for home care services. It provides services for the Health Services Executive and for individuals.[106] Sodexho in Ireland already has schools, catering and other site service delivery.

In 2011, Sodexho lost several contracts in the UK, for example, King's College Hospital did not renew its outsourced contracts. Sodexho reported that it had been affected by public sector clients delaying decision making in 2011. [107]

Table 15: Sodexho Revenues and operating profits (€billion)

Year	2011	2010	2009	2008
Revenue	€16 billion	15.5bn	€14.6bn	€13.6bm
Operating profit	€853	€771	€746	€690

Source: Sodexho Annual Report 2011

NON EWC eligible companies

Companies and organisations that are not yet eligible for EWC, but are active in more than one country globally, are set out below. A French care company, Domus VI, after merging with Dolcéa / GDP Vendôme became the largest care home company in France called Groupe DVD. It runs services in France and Canada/ Quebec.

The International Federation of the Red Cross and Red Crescent Societies and International Committee of the Red Cross are included to illustrate the potential of charitable / humanitarian organisations for eligibility for EWCs.

5.11 Company name: DomusViDolcea GROUPE DVD

DomusViDolcéa
7 Avenue de l'Opéra
75001 PARIS
Website: www.domusvi.com

Number of employees : 7,000 (France and Canada (Quebec))

Company activities and strategy

Founded in 1983, Domus VI became independent after the French health care company, Generale de Sante, sold its care homes, through a management buyout in 2003, supported by Barclays Management Capital.[108]AscaideDomusViviendi provided home care in France and specialised in the care of older people. In 2007, Domus VI bought SanteSegna, a Canadian social care company, which was originally owned by Generale de Sante, which sold its Canadian subsidiary, Générale de Services Santé N.A., in 2003. After the sale in 2003, the company was renamed SanteSegna. Three subsidiaries were taken over by Domus VI:

- Groupe Champlain Inc. (www.groupechamplain.qc.ca)
- Villa Medica Inc. (www.villamedica.ca)
- Accès Services Santé GSS Inc. (www.acces-services-sante.ca)

In 2010, Domus VI merged with Dolcéa / GDP Vendôme, a French care company, so forming the largest French care company called DomusViDolcea (Groupe DVD). The new company has kept its Canadian subsidiary SanteSegna. In 2011,Groupe DVD opened a new department of Nursing at Home which provides nursing care and general services to encourage people to stay at home (especially people with dementia).[109]In 2011, Groupe DVD entered into a joint venture agreement with Gecimed, a French REIT investor in health care properties (part of Gecina REIT), to sell 26

care homes but continue to manage the care services.[110] This is a similar arrangement to the ORPEA/ Confinimmo joint venture.

5.12 Company Name: Red Cross

Address:

International Committee of the Red Cross (ICRC)	International Federation of Red Cross and Red Crescent Societies
19 avenue de la Paix CH 1202 Geneva Fax: ++ 41 (22) 733 20 57 Phone: ++ 41 (22) 734 60 01	P.O. Box 372 CH-1211 Geneva 19 Switzerland Telephone: +41 22 730 42 22 Fax: +41 22 733 03 95

Number of employees: ICRC - 1,400 + 800 (hq)
IFRC - Europe -

The International Committee of the Red Cross (ICRC)
The International Committee of the Red Cross (ICRC) is an "impartial, neutral and independent organization whose exclusively humanitarian mission is to protect the lives and dignity of victims of armed conflict and other situations of violence and to provide them with assistance". It aims to reduce suffering by promoting and strengthening humanitarian law and universal humanitarian principles.ICRC employs more than 1,400 people, both specialized staff and delegates, on missions for the ICRC worldwide, with 11,000 local employees providing backup and support. About 800 staff work at the Geneva headquarters (ICRC, 2012).

International Federation of Red Cross and Red Crescent Societies
The International Federation of Red Cross and Red Crescent Societies is the "world's largest humanitarian organization, providing assistance without discrimination as to nationality, race, religious beliefs, class or political opinions"(IFRC, 2010). The International Federation consists of 186 member Red Cross and Red Crescent societies, a Secretariat in Geneva and more than 60 delegations around the world. The Red Crescent is used in place of the Red Cross in many Islamic countries. IFRC works on four core areas: promoting humanitarian values, disaster response, disaster preparedness, and health and community care.

In Europe, national Red Cross societies are becoming major providers of health and social care services. The table below shows the number of employees by national society as well as the number of volunteers involved in health and social care activities.

Table 16: European Red Cross Societies - employment by country

Country	Numbers of employees	Numbers of volunteers
Austria	4,900	46,300
Belgium	2,134	24,000
Britain	1,637 fulltime and 1,087 part time	35,000
Bulgaria	300	13 136 (5592 youth and 7617 adults)
Czech Republic	195 staff (160 at local branches and 32 at headquarters)	8,000
Denmark	126 at HQ (65 women and 44 men), 17 part-time support staff (17 women)	15,000
Estonia	43	300 youth 200 adult

Finland	1,088 - 114 at HQ (70 % women), 104 in districts and 870 in the institutions (blood transfusion service, emergency shelters for youth, ambulances and other professional institutions within the Finnish RC)	45,000 (60-70 % women):
France	16,270	60,000
Germany	82,000	400,000
Greece	593 at national HQ, 95 at provincial level (the majority are women)	3,000 at national HQ, 5,059 in the branches and committees (the majority are women)
Hungary	530	30,000
Ireland	16	2,879
Italy	2,958 (353 at HQ, 2,605 in branches)	190,000
Latvia	24	1,469
Lithuania	60	2,319
Luxembourg	536 (100 men, 436 women)	2,000
Malta	4	60
Netherlands	303 (160 at national HQ (72 men, 88 women), 143 (35 men and 108 women) district/branches	34,000
Poland	600 staff also 1,110 " PLRC nurses".	290,000
Portugal	218 at HQ and 498 in the branches and chapters	5,000
Slovakia	114	130,000
Slovenia	100	209,070
Spain	8,654	142,333
Sweden	530 paid employees, 150 of them at headquarters (65% women)	40,000

Source: http://www.redcross-eu.net (statistics unchanged 2012)

As many national Red Cross societies are becoming major providers of health and social care services in Europe, it is useful to look at the experience of other countries, which have the Red Cross as a major service provider. In the United States, the American Red Cross is the major supplier of blood. It has been accused of poor quality standards because of a failure to screen potential donors, failure to test for syphilis, and failure to eliminate poor quality or contaminated blood. As a result it was fined by the Food and Drug Administration (FDA).[111]

Although the blood industry has a very large turnover, the American Red Cross has been trying to reduce its labour costs by reducing pay and replacing staff on low pay rates and more limited healthcare and pension benefits. With increasingly poor working conditions caused by understaffing, 14 hour working days, low morale and high turnover, American Red Cross workers went on strike in June 2010. [112]

Since 2010, the American Red Cross has continued to be involved in a series of labour disputes. In 2011, HPAE (Health Professional & Allied Employees) tried to negotiate a contract that covered blood safety, staffing and scheduling but Red Cross rejected the proposals meanwhile demanding that union members waive their right to bargain over health care and retirement issues. [113]

6 Conclusion

Europe has an ageing population and consequently a growing demand for care services, particularly services delivered at home. The role of the EU in shaping care policies is increasing. With child care, there are clear policy directions but for long-term care the directions are less clear although the influence of the EU public procurement legislation is considerable.

The for-profit sector is still trying to identify the most profitable strategies for care homes and for home care. Several countries are experiencing a decline in care homes beds with an increase in home or domiciliary care. Private equity investors remain active in the care home sector but are also investing in home care companies.

The for-profit care home sector has been shown to deliver poor quality services in several countries. This has led to a questioning of whether outsourcing of care services is the best way of delivering care. The use of business models that depend on borrowing capital during a period of global financial crisis has undermined the profitability of the for-profit sector in the UK.

The extent of multinational care company expansion has not changed significantly since 2010. French care companies continue to acquire companies in neighbouring countries (Switzerland, Spain, Belgium and increasingly Germany) but are not owned by private equity investors although are starting to engage in joint ventures with property investors. Nordic care companies, with private equity investors, continue to operate in the Nordic region but with little expansion. Two companies in Sweden have been criticised for poor quality care, with one now being put up for sale.

There is some expansion of for-profit companies investing in homecare. Sodexho, as a global multinational company, has established a 'personal and home services' division, which is delivering different types of home care on a small scale. This can be seen as a sign of testing the market for services delivered in the home.

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6.1 APPENDIX A: Privatisation of social care in the UK: an example of market failure

In the UK, the NHS and Community Care Act (1990) promoted subcontracting from local authorities to private providers by separating local authority purchasing and provider functions. Initially, this led to an expansion of the private social care residential sector and a transfer of provision from local authorities to private residential homes. Between 1997 and 2002, the percentage of beds in local authority staffed homes fell from 24% to 14%. The overall number of people in either local authority, private or non-profit staffed residential or nursing care home rose from 236,335 in 1997 to 259,490 in 2002. By 2009, about 4% of older people lived in care or residential homes. About two thirds were funded by local authorities and a third were privately funded. [114] In the last five years there has been a move towards personalisation of budgets where the individual is given cash to purchase their own services

Private providers of care services often started as small businesses in the early 1990s, which could respond to user needs, but have been taken over by larger companies, which results in management being further away from the services being delivered. Large, private sector care providers are often publicly limited companies that have to work to generate annual dividends for shareholders. In recent years, private equity investors have bought social care companies, as part of long term investments. This has made the companies subject to the investment strategies of private equity funds, which are focused on a high rate of return for the investor rather than the needs of users.

By 2010, residential care provision for older people was dominated by four companies, which are also involved in provision of mental health services and services for people with learning disabilities. The public sector is the main purchaser of services. Except for one non-profit company, these large providers of residential care all adopted a business model which was based on the 'sale and leaseback' of residential properties. This involved using cheap credit to purchase residential homes, selling them and then leasing them back for use. This was considered a flexible solution to the problem of property ownership, if the market for residential homes started to contract. The success of this model was based on access to cheap credit and a growing demand for residential care.

The financial crisis of 2008 started to undermine this business model. Credit became more expensive and more difficult to access. By 2010, with cuts in local authority budgets, the demand for places in residential care homes was decreasing. Local authorities were also trying to reduce the price of residential care. This can be described as a market contraction. Care companies had to renegotiate their access to credit and the rents paid for the leased back care homes. By 2011, one major private provider declared itself bankrupt after failing to negotiate reduction in rent payments. Other providers have to renegotiate debt arrangements in 2012. The largest company, Four Seasons, was due to renegotiate its debt in 2012 but was taken over by the private equity company, Terra Firma, in July 2012, which has reduced and rescheduled its debt.[115]

This experience shows how vulnerable social care services are when provision is dominated by the private sector. The aim of the private sector is to maximise profits. For private equity investors, their aim is to maximise their investment. The combination of these goals results in companies taking financial risks which do not consider the needs of people using their care services. The TUC Commission on Vulnerable Employment (2008) found that care services, which had been privatised over the previous decade, showed how the terms and conditions of workers had deteriorated.[116]

Decisions about residential homes are made far away from the communities in which they are based. With the failure of at least one company, the local authorities that have commissioned

services from this company are ultimately responsible for finding alternative care services. This is the result of a failure of the privatisation of social care services. Direct local authority provision of residential care services is very limited and so local authorities will be unable to provide their own services. They will continue to be dependent on the private sector.

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[64] A group of companies (undertakings) includes a controlling company and any companies it controls ("exerts a dominant influence over"), whether by virtue of ownership, financial participation or the governing rules of the controlled company.

[65]Based on the average number of employees, including part-time employees, employed during the previous two years calculated according to national legislation and/or practice.*http://europa.eu.int/comm/employment_social/soc-dial/labour/directive9445/9445euen.htm*

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