Privatising our future:

an overview of privatisation, marketisation and commercialisation of social services in Europe

A report by Public Services International Research Unit commissioned by EPSU
Privatising our future: an overview of privatisation, marketisation and commercialisation of social services in Europe

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This report has been commissioned to inform the future work of the European Federation of Public Service Unions (EPSU) Social Services Working Group. The research objectives are:

1. To develop an overview of the extent of the privatisation of social services across Europe on the basis of available studies at national and European level;
2. To review existing studies that compare public and private provision in relation to quality, accessibility, and affordability of services; and
3. To provide an overview of existing reports and surveys that reveal the impact of privatisation of social services on the pay and conditions of workers.
Contents
1 Social services and privatisation ................................................................. 4
   1.1 The social services sector in Europe ......................................................... 4
   1.2 Privatisation of social services .................................................................. 6
2 The extent of privatisation of social services across Europe ........................................ 8
   2.1 Privatisation – corporatisation, marketisation and outsourcing ....................... 8
   2.2 Expansion of the private, for-profit sector .................................................. 10
      Nordic region .............................................................................................. 11
      France ......................................................................................................... 12
      United Kingdom .......................................................................................... 13
   2.3 Social insurance and personalisation .......................................................... 14
3 Public and private provision – quality, accessibility and affordability of services .......................... 16
4 The impact of privatisation on pay and conditions ................................................... 19
   4.1 Overview of the for-profit sector .................................................................. 19
   4.2 Loss of control over the labour process ....................................................... 19
   4.3 Migrant workers ......................................................................................... 20
   4.4 Industrial relations ..................................................................................... 21
   4.5 Remunicipalisation .................................................................................... 22
5 Conclusion ....................................................................................................... 23
References ........................................................................................................ 24
1 Social services and privatisation

1.1 The social services sector in Europe

In this report, the term social services is used to describe: services for older people (often called long-term care), people with disabilities, and early childhood education and care (ECEC). It includes social work, social care and rehabilitation services which can be delivered at home, in the community, or as residential care.

Social services have evolved in different ways in each European country, partly determined by their existing social welfare systems. This has influenced the role the public, for-profit and not-for-profit sectors play in social services provision. Although there have been different legislative changes, the responsibility for the delivery of social services is now shared by the public, private for-profit, and private not-for-profit sectors across Europe. In Germany and the Netherlands, the for-profit and not-for-profit sector provide almost all long-term care services. In the Czech Republic, Finland, Greece, Norway, Romania, Slovenia and Sweden, less than 20% of residential care places are provided by the private, for-profit sector. Meanwhile, Norway, Sweden and Slovenia have less than 20% of their domiciliary care – care provided in the home – provided by the private, for-profit sector (Eurofound, 2017).

The 2019 review of social services in Europe by the European Social Network (ESN) found that ensuring quality, defined as capacity and coverage, is a challenge facing many countries. A lack of coordination between social, employment and healthcare services is impacting on the demand for social services in several countries. The review identified widespread difficulties in recruiting social services workers, with a high turnover of workers, low pay and poor working conditions. In ECEC it found financial problems, with limited budgets, in the Czech Republic, Germany and Ireland for example. The lack of a skilled workforce or recruitment problems limits access to ECEC facilities, with high fees restricting access in Poland, Slovakia and the UK (ESN, 2019). Long-term care services for older people and people with disabilities are facing increasing demands for care, especially those delivered at home, while increasing rates of dementia are stimulating a rise in demand for more specialised care (ESN, 2019).

Although there have been some positive proposals for change to social services, governments have not provided sufficient funding to properly implement these changes. In Austria, for example, the contribution from private wealth to residential care (Pflegeregress) was abolished in 2018 and the costs transferred to regional authorities. However, the amount the federal government proposed transferring to cover the expected increases in demand for residential care is not considered adequate to cover the total costs. In Romania, the central government made it compulsory for each community centre to have at least one social worker in public social services. However, it has not set aside a specific budget to implement this measure. Despite inadequate funding, local authorities are still responsible for social worker salaries (ESN, 2019).

Social services are often unevenly distributed geographically within a country, leading to regional differences in provision. This may reflect population distribution, but it can also reflect relative regional economic prosperity, as illustrated by the distribution of nursing home beds. In Sweden, for example, 69% of nursing home beds are concentrated in the southern part of the country, including Stockholm (Eurostat, 2020), where for-profit companies are most active. In Norway, there is a similar distribution, with beds concentrated around Oslo and the south of the country. In Germany, 57% of nursing home beds are in the four largest or most prosperous states, and similarly in Italy, 57% of nursing home beds are in three largest and most prosperous regions in the north (Eurostat, 2020). Regional disparities in the availability and quality of services are particularly acute in Croatia and Lithuania (ESN, 2019).
The for-profit sector contributes to this uneven regional distribution of services, which is reflected in company property strategies. For example, a French multi-national care company ORPEA has targeted the French regions of Île-de-France (Paris and west of Paris), Provence-Alpes-Côte d’Azur (Mediterranean coast), Aquitaine and Poitou-Charentes. In Belgium, most of its clinics and facilities are in Brussels and Flanders. In Spain, over 70% of ORPEA’s facilities are in Madrid and in Italy, it runs facilities in the northern part of the country. All these regions have good quality buildings and locations and a large proportion of high-income groups — ORPEA’s target market. Similar trends can be seen in the property strategy of another French multinational care company, Korian. In the UK, where there is a privatised system of social care provision, there are low rates of nursing home beds in the east of England, north east England and south west England. These are all predominantly rural areas with lower rates of economic growth (Incisive Health, 2018).

A lot of long-term care is provided by informal carers, often because of the lack of formal services. In Poland, all long-term care is provided by unpaid carers, with families receiving no support. There is also a notable lack of support for informal carers in Belgium and Austria, and there has been a recent increase in, mainly women, informal carers in Ireland (ESN, 2019). While support for informal or unpaid carers varies from country to country, with some providing care allowances, there is a growing awareness that carers do need additional support. This can be in the form of carers’ allowances, local carer centres, carers’ leave and other measures that allow carers to continue with employment or other interests in order to secure a life of their own.

In 2016, Scotland passed the Carers (Scotland) Act, which sets out the rights of carers, and a Carers Charter. Carers have a right to an adult carer support plan or a young person’s carer statement. A carer statement defines how much care is being provided, arrangements for future care planning, important “personal outcomes” and locally available support (Scotland, 2016). Carers have the right to be involved in the planning of local services, through direct involvement or a carer representative, and in the hospital discharge process of the person being carer for (Scotland, 2016).

The importance of integrating social services and health services is more widely recognised with some joint commissioning, but they are often funded by different government departments, making integration of services difficult. There is also a lack of understanding about which skills, expertise and competencies are present in each sector and how these could be better coordinated. There are examples of the development of more innovative ways of delivering services to meet the changing needs of services users. In Portugal, for example, there has been progress in deinstitutionalising people with mental health problems through the creation of a national network of integrated continuous care.

The move from institutional care to a more community-based model is also progressing slowly in several central and eastern European countries. This often involves not just the creation of a new service, but widespread institutional reforms and attempts to change wider social attitudes, especially towards people with mental health problems or learning disabilities. For example, in Bosnia-Herzegovina, the move towards more community-based services is supported by a new administrative and legislative framework. This includes the introduction of mental health care coverage by health insurance, the provision of mental health services, and changes within the community. These changes are supported by partnerships between the Swiss agency for development and cooperation, federal and local authorities, professional associations, accreditation agencies and patients’ associations (Placella, 2019).
Although there are signs of a growing consensus on the need for governments to play a key role in funding or facilitating the funding of long-term care, which is often decentralised to local government, this is usually to a range of different providers including public, for-profit, not-for-profit, and occasionally cooperatives. It rarely includes an expansion of provision by the public sector. The not-for-profit sector has a long history of providing social services in many countries, especially homecare and residential services, with not-for-profit organisations often contracted directly by government to provide social services. However, entering contractual relationships, with the need to measure the precise care being delivered, can result in the loss of a more holistic approach to providing care.

1.2 Privatisation of social services

Privatisation is defined as the change of ownership from public to private, but over the last twenty years of extensive public management reforms, the complexity of the privatisation process has become clearer. Mercille and Murphy (2017) define privatisation as a multi-dimensional process which takes place through changes in:

(1) **Ownership**: when public assets (including public companies, buildings, services and land) are sold or transferred to private interests;
(2) **Financing**: when the funding sources of public assets and service providers become private, including raising private capital instead of relying on public funding;
(3) **Management**: when private companies or entities become responsible for managing and operating public assets and service providers; and
(4) **Production and provision**: when private firms become responsible for the production or provision of a good or service, often via outsourcing by the public sector.

Social services provide a range of services to specific groups. Care homes require some capital investment, although the growing demand for homecare and other community-based services requires less investment. There are also continuous labour costs. This has influenced the process of privatisation and made the issues of management, production and provision more important.

The framework used to analyse the privatisation of social services in this report covers the following:

- **Corporatisation**, marketisation and outsourcing force public services to operate in a market environment and are accompanied by a reorganisation of the way in which services are provided and delivered. Outsourcing is the transfer of responsibility for managing and operating services from the public to the for-profit and not-for-profit sectors. It is the nature of the contractual relationship which has an impact on how care is delivered. Historically, the voluntary and religious sectors have provided care, as in Austria and Germany, but were not necessarily involved in contracted care. The contracting of care involves them in the commodification of care through contract specifications.

- **Personalisation** aims to deliver services which meet the specific needs of the individual through direct funding to pay for personal assistants to deliver care. It transfers responsibility from the public to the private individual or household sphere and has been developed for people with disabilities and older people.

Corporatisation can be defined as the adoption of private sector or business models by the public sector, where strategies, targets, regulation and more rigid inspection regimes become part of the process of public sector management. These new systems have a specific impact on public sector workers because they generate increased administration, data collection and inspections, which take time away from the delivery of services.
Marketisation is the process of creating markets so providers have to compete to win contracts. In the public sector, markets are often facilitated by the creation of internal markets which introduce ways of costing and selling social services, turning them into commodities.

Commodification breaks down a social service into small component parts. For example, a home care service may be described as a series of tasks the home care worker is expected to provide for the client. These task-focused ways of describing social services are initially used as a way of costing and allocating prices to services, but eventually they inform a system of competition with for-profit and not-for-profit providers. As the pressure is to reduce costs, the speed at which the tasks can be delivered becomes the focus of the work, rather, than the quality of service delivery. This affects the ability of the care worker to deliver a quality service to the user. It is part of a process of eroding a sense of responsibility for the care needs of an individual when the overriding goal is a return on investment (Horton, 2019).

These developments all have implications for the way in which social services are organised and delivered. Social services are labour intensive, with quality directly related to having well-paid, trained and supported social services workers. The process of privatisation has resulted in exploitation of the workforce in order to extract higher levels of profit.
2 The extent of privatisation of social services across Europe

2.1 Privatisation – corporatisation, marketisation and outsourcing

The health and social care sector is one of the fastest growing sectors in Europe, with increases in both economic and social value as well as the number of jobs created (EC, 2014). This needs to be understood in the context of a sector which has major recruitment and retention problems and an ageing workforce. This is the context in which the for-profit sector is gaining an increasing share of the social services market.

The privatisation of social services was part of wider changes in public sector provision of services for groups with specific care needs. As described above, corporatisation, marketisation and outsourcing all help to facilitate privatisation by changing the way in which care is assessed and costed, so it becomes a commodity to be bought and sold. At the same time, decentralisation, new systems of funding, social insurance for long-term care and the personalisation of care were also introduced, often using consumer choice as a rationale. These measures can now be seen to have contributed to privatisation by opening up opportunities for the for-profit sector to provide services.

Decentralisation has moved the responsibility for funding to local authorities, in countries such as Sweden, Denmark and the UK for example, but often without the resources necessary for implementation. Consequently, the for-profit sector has taken advantage of measures introduced to reduce costs through outsourcing and extending the diversity of providers. Although Sweden, Denmark and the Netherlands are the most well-known examples, decentralisation has also been introduced in some central and eastern European countries and in Portugal and Spain, which have been trying to establish social services provision over recent decades.

In the UK and Sweden, specific policies were designed to increase competition and create markets for care. In many countries, including Belgium, France, Germany, Greece, Ireland, Spain and Sweden, for-profit institutions qualify for public funding (Spasova et al, 2018: 18). In Ireland, the for-profit sector received government funding which increased from €3 million in 2006 to €176 million in 2019 (Mercille & O’Neill, 2019).

The for-profit sector is expanding provision, particularly in residential and nursing homes. A 2017 Eurofound report on care homes for older people found the for-profit sector provides more than 66% of the total number of care home places in Greece, the Netherlands, Scotland, Ireland, Spain and Belgium. The for-profit sector has expanded over the last decade, often at the same time as public provision has contracted. This has been most marked in central and eastern Europe (Table 1), where in Romania, Slovenia and Slovakia it expanded by over 23% in less than a decade. Only in Spain has there been an increase in public provision.

The movement of social services companies from national markets to European or global markets has been uneven. Although the demand for services for older people is expected to continue to expand, the growing demand for home-based services means that people enter residential care at higher levels of dependency. This has implications for the services that can be provided at home and those needed in residential settings. There are a wide range of services which could provide support for older people which are not just home based but can be delivered in community centres. These include domiciliary care and day care to provide support and reduce isolation, intergenerational projects to develop interaction between older and younger people, emergency care digital services, and different forms of education, art and music therapy.
Table 1: Percentage of public: private care homes in six central and eastern European countries, Germany and Spain

<table>
<thead>
<tr>
<th>Country</th>
<th>Public: private</th>
<th>Public: private</th>
<th>Percentage point change in share of private sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>Czech Republic</td>
<td>81%: 19% (2007)</td>
<td>71%: 29% (2014)</td>
<td>10pp</td>
</tr>
<tr>
<td>Croatia</td>
<td>49%: 51% (2003)</td>
<td>35%: 65% (2014)</td>
<td>14pp</td>
</tr>
<tr>
<td>Lithuania</td>
<td>65%: 32%: 3% (other) (2003)</td>
<td>47%: 51%: 2% (other) (2015)</td>
<td>19pp</td>
</tr>
<tr>
<td>Romania</td>
<td>66%: 34% (2008)</td>
<td>43%: 57% (2014)</td>
<td>23pp</td>
</tr>
<tr>
<td>Slovenia</td>
<td>84%: 16% (2007)</td>
<td>60%: 40% (2015)</td>
<td>24pp</td>
</tr>
<tr>
<td>Slovakia</td>
<td>76%: 24% (2005)</td>
<td>45%: 55% (2013)</td>
<td>31pp</td>
</tr>
<tr>
<td>Germany</td>
<td>7%: 37%: 56%(not-for-profit) (2003)</td>
<td>5%: 42%: 53% (not-for-profit) (2015)</td>
<td>5pp</td>
</tr>
<tr>
<td>Spain</td>
<td>23%: 72%: 5% (other) (2007)</td>
<td>28%: 71%: 0.5% (other) (2015)</td>
<td>-1pp</td>
</tr>
</tbody>
</table>

Source: Adapted from Eurofound (2017): 51-52

National policies for the financing of long-term 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 have introduced new systems of long-term care insurance and co-payments. Germany, for example, introduced such an insurance system in 1995. This aimed to cover basic, rather than comprehensive, care costs, with families having to pay out of their own pocket or claim means-tested eligible expenses (Nadash et al, 2018). Although prices are regulated, the system does encourage competition between for-profit and not-for-profit providers based on quality and reputation. Nearly two-thirds (64%) of home care providers are for-profit (Nadash et al, 2018). In the Netherlands, there is a requirement that institutional care providers must be not-for-profit organisations, but the homecare market has been opened up to for-profit companies (Spasova et al, 2018).

Other countries use means testing as criteria for eligibility to social services. For those that have introduced new funding arrangements, there is concern about the long-term financial sustainability of services, leading to a focus on how to reduce costs. The funding of social services, especially long-term care, is a major political issue in many countries.

Countries in eastern and central Europe have gone through a different reform process with a greater focus on changing from public institutional care, or deinstitutionalisation, to more community-based social services. In many of these countries, including Poland and Bulgaria, the public sector is still the main provider, with for-profit provision expanding slowly and only accessible to higher income groups. In Spain, Portugal and Greece, a publicly funded social services sector has only been established since the 1980s. Family care was previously the main source of social services and remains the dominant form of provision. In ECEC, the trends are slightly different, with the emphasis on creating more community centres for young children.

Brennan et al (2012) looked at the impact of marketisation in Sweden, the UK and Australia. They found that the arguments for marketisation focused on the need for individual choice in care for older people and childcare, and how this depended on more provider competition and user co-payments. They define marketisation as including contracting out service delivery, financing users to buy services, setting up social insurance schemes to cover the costs of long-term care, and providing cash or tax
concessions to employ carers at home. In Sweden, marketisation started with the competitive tendering of large nursing homes and geographical areas of home care. In the UK, it was seen as a way of giving citizens access to consumer choice, empowerment and flexibility. The rights of service users and carers were promoted as consumer empowerment rather than citizen rights.

In 1991, the UK introduced an internal market to local government, with a requirement for local authorities to outsource 85% of their social services. Similar legislation in Sweden, the Local Government Act (1991), facilitated municipalities to outsource some services, including care for older people, to for-profit and non-profit organisations (Brennan et al, 2012:381). In 2009, the Swedish Act of “Free Choice Systems” used incentives to force municipalities to introduce consumer choice models in care for older people. However, the extent of municipalities’ use of for-profit providers varies, with Stockholm having high levels but many rural areas having much lower levels. This reflects the interests of the for-profit sector in providing services in urban areas as well as the traditional distribution of social services, which is concentrated in the economically more prosperous south of Sweden.

Swedish law also encourages “freedom of choice” in childcare, although the for-profit sector plays a much smaller role than it does in care for older people. However, higher income groups are using for-profit provision with the potential to undermine social solidarity. A study of the marketisation of early years care in Iceland illustrates how the creation of charter schools introduced a deregulation of the for-profit sector, an increase in the size of schools, and the outsourcing of the management of publicly funded schools and presents a long-term threat to public provision (Dýrfjörð & Rós Magnúsdóttir, 2016).

This pattern of opening up public social services to for-profit and not-for-profit providers, under the guise of providing more choice, can be seen in many countries. A study of the marketisation of care for older people in Switzerland provides a more detailed picture of the processes that have contributed to marketisation (Schwiter et al, 2018). A market was introduced to the health care sector making reimbursements much stricter and affecting nursing homes and domestic care agencies. Nursing homes had to raise their fees because they could not cover all their previous medical costs. Domestic care services covered by public health insurance had to introduce a strict time-control system for workers to justify each minute spent. This resulted in domestic care workers spending less time providing care. Although households in Switzerland have traditionally contributed to care costs at a much higher level than in other European countries, the restrictions on payments caused by the medical care reforms created a new market for care services. Private care agencies started to provide live-in care workers to deliver care and personal household services (Schwiter et al, 2018).

2.2 Expansion of the private, for-profit sector

Although there are different levels of participation by the public, for-profit and not-for-profit sectors across Europe, the presence of for-profit companies has increased in many countries.

Over the last twenty years, there has been an expansion of multinational care companies in some countries as for-profit companies expand outside their domestic market. This has until recently been limited to regional groups of countries, including the Nordic region and continental Europe – France in particular. However, there are signs of increasing multinational company (MNC) expansion and private equity investment in companies working in the social services sector (Lethbridge, 2019).

Existing MNCs have become involved in social services in a number of ways. Many multinational social care companies own a mix of care homes and clinical services, usually mental health services. Facilities management MNCs, such as ISS and Sodexho, have also become involved in the delivery of homecare
services. Other companies, not always involved directly in care, provide luxury retirement apartments with a range of services. These may include care as well as recreational activities for people on higher incomes (ESN, 2019).

**Figure 1: Public, for profit (FP), not-for-profit (NFP) and private ownership of care homes**

Even though there is a wide variation between countries in terms of public and private for-profit provision, most countries are seeing an expansion of for-profit care homes. A Eurofound (2017) report found that private care homes were less likely to provide specialist medical access, although this can also be influenced by legislation. For ECEC, there is much stronger public provision, with over 50% provided directly by the public sector (EC, 2011).

The way in which multinational care companies have expanded often started with the acquisition of companies in neighbouring countries. As well as having complex ownership structures, these care chains have had regular changes in ownership, with individual and corporate owners, subsidiaries, holding companies, and other companies taking control. This makes it difficult to identify actual owners and ultimate accountability. Most companies were involved in a wide range of social services, from social care, pre-schools, child protection and patient hotels.

The expansion of for-profit social services is examined by looking at Nordic, French and UK companies delivering a range of social services.

**Nordic region**

Table 2 shows there are several companies active across the Nordic region, with multinational care companies involved in Norway and Sweden overlapping. All are owned by one or more private equity investors, with this type of ownership expanding since 2005: Norlandia is privately owned by the Adolfsen Family and a private equity company; Attendo is publicly traded but also has some private equity shareholders; Vardage/Ambea bought Aleris in 2019; and Forenade Care is a subsidiary of a facilities management company Forenede A/S.
Table 2: Leading Nordic companies delivering social services

<table>
<thead>
<tr>
<th>Companies</th>
<th>Ownership</th>
<th>Numbers employed</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norlandia Care</td>
<td>Adolfsen Group/Norlandia Healthcare Group (NHG)</td>
<td>9,700</td>
<td>Norway, Finland, Sweden, Germany, Netherlands, Poland</td>
</tr>
<tr>
<td>Attendo</td>
<td>Nordstjerman AB (PE), Swedbank Robur Fonder, Didner &amp; George Fonder (investment bank)</td>
<td>25,000</td>
<td>Denmark, Finland, Norway, Sweden</td>
</tr>
<tr>
<td>Ambea</td>
<td>Largest shareholder is Triton (25.1%) through ACTR Holding AB and ACTOR SCA</td>
<td>26,000</td>
<td>Sweden, Denmark, Norway</td>
</tr>
<tr>
<td>Forenade Care</td>
<td>Subsidiary of Forenede A/S (facilities management)</td>
<td>3,000</td>
<td>Denmark and Sweden</td>
</tr>
</tbody>
</table>

Source: Adapted from Harrington et al, 2017; NHG Annual Report, 2018; Attendo Annual Report 2018; Websites Stendi, Forenade A/S

France

Since 2005, four of the largest French multinational care companies have expanded into many European countries, with some investment also in China and Latin America. Over the last 10 years, their investors have gradually changed, often from founder investors to global investment companies or pension funds. The expansion of these French companies is having an impact on European social services, either by taking over existing national for-profit companies or by moving into countries with small for-profit sectors and building new facilities. They are leading the privatisation of social services, either through contracts to provide services for the public sector or by providing social care services for those able to pay. Accurate assessment of the funding and regulatory environment influences the success of company expansion strategies (Lethbridge, 2019), which will increasingly be mediated by the priorities of global investors.

Table 3: Leading French companies delivering social services

<table>
<thead>
<tr>
<th>Companies</th>
<th>Ownership (% share capital)</th>
<th>Numbers employed</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORPEA</td>
<td>CPPIB 14.5%; FFP Invest (controlled by Peugeot Family group) 5.0%; Sofina SA (Belgian holding company) 2.0%</td>
<td>54,000</td>
<td>Austria, Belgium, Czech Republic, France, Germany, Ireland, Italy, Poland, Slovenia, Spain, Switzerland (Also: Mexico, China)</td>
</tr>
<tr>
<td>Korian</td>
<td>Predica (Credit Agricole Assurances) 24.3%; Malakoff Humanis (7.7)</td>
<td>56,000</td>
<td>France, Belgium, Germany, Italy, Netherlands, Spain</td>
</tr>
<tr>
<td>Domus VI</td>
<td>Acquired by ICG Europe VI in July 2017 with co-investment by ICG Enterprise. Intermediate Capital Group (ICG) and Sagesse Retraite Santé acquired a majority stake</td>
<td>37,000</td>
<td>France, 14,000; Spain, 22,000; Portugal, 300; (Also: Chile, Uruguay, Colombia = 1000 employees)</td>
</tr>
<tr>
<td>Colisée</td>
<td>IK Investment Partners (2017) Groupe Teycheney 30% (founder) Management 6%</td>
<td>16,000</td>
<td>France: Colisée; Belgium: Armonea; Spain: Saleta and STS; Italy: Isenior</td>
</tr>
</tbody>
</table>

Sources: Lethbridge, 2018 : Korian Annual Results, 2019; Orpea, 2019; Websites Domus VI and Colisée
United Kingdom

In the UK, there are five large care companies – Four Seasons, BUPA care homes, HC-ONE, Barchester Healthcare and Care UK/Social Care Investment. BUPA is a not-for-profit company and provides care services internationally. Although the other four care companies do not deliver care services outside the UK, their investors are global investment and private equity companies. The privatisation of social care after 1991 led to the growth of for-profit care homes, many of which were small or medium-sized enterprises. Increasingly, the market is now dominated by a group of larger for-profit companies, controlled by private equity investors.

Table 4: Leading UK companies delivering social services

<table>
<thead>
<tr>
<th>Companies</th>
<th>Ownership</th>
<th>Numbers employed</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Four Seasons Healthcare</td>
<td>H/2 Capital Partners</td>
<td>20,000</td>
<td>UK</td>
</tr>
<tr>
<td>BUPA Care Homes</td>
<td>BUPA</td>
<td>5,735</td>
<td>UK, Poland, Chile</td>
</tr>
<tr>
<td>HC-One Ltd</td>
<td>Dr. Chai Patel</td>
<td>14,000</td>
<td>UK</td>
</tr>
<tr>
<td>Barchester Healthcare</td>
<td>Dermot Desmond, JP McManus and John Magnier</td>
<td>17,000</td>
<td>UK</td>
</tr>
<tr>
<td>Care UK and Social Care Investment Ltd</td>
<td>Bridgepoint</td>
<td>15,148</td>
<td>UK</td>
</tr>
</tbody>
</table>

Sources: Harrington et al, 2017; Lethbridge, 2018; BUPA, 2019; Barchester Healthcare; Bridgepoint, 2019/20; HC-One Ltd; and Four Seasons Healthcare

The UK has the highest rate of privatisation of social services, with over 75% of services delivered by the for-profit sector. The concentration of the for-profit sector has started to show some of the effects of privatisation. These include poor-quality services and the process of financialisation. This takes ownership away from the geographical location of social services and moves it to the centre of investment or finance and means decision making is remote from the services being delivered.

As well as reports of poor-quality services, the experience of privatised care services in England shows the risks of depending on for-profit sector providers and the business models used to generate growth. In 2010, the failure of the largest care provider, Southern Cross, due to its high level of debt clearly demonstrated the vulnerability of depending on the private sector. It also highlighted companies’ use of debt to cover property acquisitions. In 2015, Care UK and Bridgepoint established Silver Sea Holdings, a company registered in Luxembourg, to build, oversee and rent care homes for Care UK (Harrington et al, 2017). In a similar way to care companies in the Nordic region, the complex ownership structures make it difficult to identify ownership. In 2019, Four Seasons was declared insolvent and sold to the H/2 Capital Partners private equity company (Financial Times, 2019). Large companies regularly buy and sell chains of care homes, creating uncertainty and a failure to plan for the long-term.

Recent reports have examined some of the motivations behind investment in this sector. The Centre for Research on Socio-Cultural Change (CRESC) found that private providers expect a 12% rate of return on investment (Burns et al, 2016). As many care places are funded by local authorities, they are directly contributing to this high level of private return for a public service. Yet the social care sector is low risk, because the nature of the activity changes little, so lower levels of return should be required for companies providing care services. The expected high rate of return by private providers is also
influencing the debate about the future of social services. Extra funding is presented as the solution and private providers lobby governments to try to secure this (Burns et al, 2016).

In 2017, BBC-commissioned research by social care analyst Opus Restructuring found that the UK’s: “Four largest care home operators - HC-One, Four Seasons Health Care, Barchester Healthcare and Care UK — have racked up debts of £40,000 a bed, meaning their annual interest charges alone absorb eight weeks of average fees paid by local authorities on behalf of residents” (BBC, 2017).

This shows the precarity of the larger providers in the care sector and the use of debt to maintain their businesses. Local authority payments are contributing to maintaining this business model.

2.3 Social insurance and personalisation

The demand for social services for older people and people with disabilities is increasing across Europe and the cost of this growing demand in an ageing population is a major political issue. Countries have approached this issue in different ways, partly influenced by their existing systems of social welfare. Some countries have introduced new social insurance schemes which citizens pay into and subsequently become eligible for social care. Germany and the Netherlands have introduced systems of social insurance which have resulted in an expansion of for-profit and not-for-profit providers.

There is growing demand for long-term care to be delivered in the home or household in a more personalised way than social services were traditionally delivered. Many countries have introduced a system of care allowances which care recipients, or their families, can use to buy personalised care. Austria, Belgium, Denmark, Finland, France, Germany, Italy, Netherlands, Norway, Poland, Slovenia, Sweden and the UK all have some form of cash allowance for long-term care. In countries where the allowance is specifically for the payment of home or personal assistants or domestic workers, for example Spain, France, the Netherlands and the UK, this has led to the growth of poorly-paid jobs with little security.

In 1993, Austria introduced a care allowance for people with long-term care needs. This quickly led to the development of a fragmented system of care services with different providers, different forms of provision, and different regulations controlling access and finance (Schiffbaenker and Kraimer, 2003). By 2016, around five per cent of the Austrian population, or 455,354 people, and around 18% of the over 60s population received the care allowance, which is paid at seven different levels according to the amount of care needed. Live-in 24-hour homecare is provided by private assistants, with around 62,500 recruited from central and eastern European countries. Extensive regional variations in care remain (Bachner et al, 2018).

In Denmark, changes to home help services have been taking place since the late 1970s, characterised by the introduction of 24-hour care provided by home help workers and community nurses. National legislation, the “Free Choice” reform (2003), was designed to eliminate the illegal market in domestic services by allocating subsidies for home service or housekeeping activities. Private firms, with as few as two people, can register to receive these subsidies (Lewinter, 2004). The Consolidation Act of Social Services (2007) which was fully implemented in 2010, gave local authorities the option of arranging services by providing a user with a service certificate. This allows a person to employ their own personal helper. The helper can be an individual or provided by a company and private providers have to meet quality standards and sometimes price requirements (OECD, 2011). This has not led to an expansion of for-profit homecare providers because municipalities provide adequate public homecare services and set prices and quality standards for tendering procedures for homecare providers. The for-profit sector provides extra services which municipalities are unable to provide (Winkelman et al, 2014).
Although the system of community care provision is still evolving in central and eastern Europe, there is some use of personal care-related payments. In Hungary, payments are made to informal carers at the same level as the basic minimum pension. In 2009, the Czech Republic introduced a care allowance which increased the amount of home-based care. Social care services are financed through tax-based services with social assistance (Osterle, 2010, Alexa et al, 2015). In the Czech Republic, Latvia and Slovenia, the right to and the amount of the cash benefit depends on the level of care dependency while in Croatia, Hungary and Slovakia, it is only for people with severe disabilities. (Spasova et al, 2018).

The introduction of care allowance schemes can be seen as part of the privatisation of care provision at household level, with members of the household paid an allowance for care work or low paid, precarious, and often migrant, workers recruited. The majority of paid and informal carers are women. The introduction of care allowances has formalised a system of informal household care, although informal care is still the predominant form of long-term care in many countries.
3 Public and private provision – quality, accessibility and affordability of services

The provision of social services is a labour-intensive sector where the quality of the service is directly related to the quality of the labour force. Companies make profits by reducing labour costs. They do this by reducing the number of workers and increasing the amount of work or by increasing the hours worked and reducing the holidays taken and generally intensifying the labour process.

The social services sector shows how the market has failed to deliver an effective, efficient or equitable public service. The use of market mechanisms in England, specifically the purchasing and providing of care services from private providers, has resulted in a funding crisis because shareholders and investors expect high rates of return. A combination of the growing demand for care services and austerity policies, which have affected local authorities particularly acutely, has led to further pressure on existing services, with councils often reducing the services they can afford to commission. An increasing number of citizens are self-paying for care services or are not receiving the care they need to live independently and there has also been an increase in inequalities among service users. Promoting consumerism has resulted in higher income groups being able to navigate the system more effectively than those with more limited resources and lower levels of education.

A Eurofound (2017) report on long-term care homes examined different aspects of efficiency and effectiveness and reported that several studies found no difference between the public and private sector. Marczak and Wistow (2016) found little evidence that prices were reduced, and where there was a reduction in prices, it was often accompanied by a decrease in the quality of care.

In terms of affordability, the 2017 Eurofound survey found that costs are a barrier to accessing long-term provision even where some residential services are contracted by the public sector. In many countries, private residential fees are more expensive in for-profit care homes and prices have increased since the 2008 financial crisis.

In terms of quality of staff, excessive workloads have resulted in high turnover, with resulting labour shortages in France. In Austria, low staff-to-resident ratios have worsened conditions of work in nursing and residential homes, and in countries including Belgium, Sweden, France, Slovenia and Estonia, the for-profit sector has lower staff: resident ratios (Eurofound, 2017).

The rationale for privatisation was to increase efficiency, but there is growing evidence that this has not happened in social services. A number of social services have been taken back in-house after the failure of the private sector to provide services that are sensitive to the needs of the users in Denmark, Sweden and the UK (Eurofound, 2017).

A comprehensive study of the impact of privatisation on all forms of social services in Sweden could find no evidence of improvements in efficiency or quality. The study covered all major welfare areas: preschool, school, individual and family care, health and medical care, labour market policy, and care of older and disabled people. It concluded that:

“there is a remarkable lack of knowledge of the effects of competition in the Swedish welfare sector. On the basis of existing research, it is not possible to find any proof that the reform of the public sector has entailed the large quality and efficiency gains that were desired”

(Hartman, 2011).

Iparaguirre and Ma (2014) carried out a study of efficiency in the provision of social care for older people which used a measure of efficiency based on the production of a welfare framework and self-reported quality of life of recipients. They found that, when controlling for a wide range of
environmental variables, “more stringent eligibility criteria and higher assessment costs are negatively associated with efficiency in provision of social services” (Iparaguirre and Ma, 2014).

Brennan et al (2012) found no evidence to show that increased competition has resulted in reduced costs or increased efficiency. The rationale for marketisation and the expansion of for-profit provision was supposed to provide people with greater choice that would lead to their empowerment. In the UK there is evidence to show that greater choice, as seen through the introduction of personal budgets managed by individuals, is actually a hindrance to improved provision, particularly among older people (National Audit Office, 2011). There was sometimes a lack of information and advice, and often a lack of support, for individuals employing their own carers. In Sweden, differences between levels of education influence the extent to which people can exercise their choice in finding services (Brennan et al, 2014).

In England, the creation of a market in social care has not resulted in lower prices, the balancing of supply and demand, or the creation of more efficient and effective services, which are the arguments used to justify marketisation.

Job quality and care quality are often seen as separate issues but Burns et al (2016) argue that these two concepts must be considered together. They identify two models of residential care: a person-centred approach where the residents’ needs and interests influence how care is delivered; and a custodial approach where residents are assumed to be unable to determine how they would like to receive care and so are seen as passive recipients. The research examined 12 for-profit and not-for-profit residential homes: seven with a person-centred approach and five with a custodial approach (Burns et al, 2016).

Budget reductions cut the number of workers, increased working hours and work intensification, and directly affected the quality of care. However, in nursing homes with a person-centred approach, care workers tried to shield the residents by reorganising work practices and routines. They worked through meal breaks, worked longer hours for no pay, and arranged to share information. Although their pay and conditions deteriorated, the workers were still consulted, allowed to work flexibly, and still maintained some control over their work.

In contrast, in homes with a custodial approach, workers focused on physical care and excluded other forms of care. Management focus was on financial cuts rather than maintenance of care, and on reducing maintenance of the facilities. Workers were unable to voice their concerns. The study shows that job quality and care quality have to be considered together as job quality impacts on care quality. There are a limited number of studies of efficiency, effectiveness and quality of care. In a US study, higher nursing staff levels were found to influence the quality of care, but this was improved even more when a range of care workers were employed, including administrative staff and social services workers (Bowblis and Roberts, 2018). An older study, again in the US, showed that staffing ratios were lower in for-profit facilities than in non-profit facilities (Comondore et al, 2009).

More research into how to measure the quality, accessibility and affordability of social services is needed. Staff-client ratios are one way of assessing the likelihood of a higher quality service, while increased training and worker support and adhering to rigorous occupational health and safety standards also contribute to the delivery of a quality service. More publicly agreed ways of assessing the quality of the relationship between the client and social services worker, rather than consumer surveys, are also needed. The introduction of marketisation and corporatisation was based on limited evidence and failed to recognise that social services are highly labour-intensive services, where quality
of care is directly related to the quality of the workforce. It has led to the creation of systems and structures where the interests of for-profit providers are paramount.
4 The impact of privatisation on pay and conditions

4.1 Overview of the for-profit sector
An examination of the proportion of social services workers employed in the public, for-profit and not-for-profit sectors shows the for-profit sector is growing in many countries across Europe. This reflects the growth in for-profit ownership of care homes and the expansion of multinational care companies across Europe. The UK has the largest percentage of for-profit sector employment (49%), while Sweden (25%), Finland (18%) Romania and Latvia have smaller but expanding for-profit sector employment (Eurofound, 2017: Lethbridge, 2019).

Figure 2: Percentage of social services workers in public, for-profit, not-for-profit (NFP) and private sector social services

![Percentage of social services workers in public, for-profit, NFP and private sector social services](image)

Source: PESSIS + Lethbridge, 2019

4.2 Loss of control over the labour process
One of the results of corporatisation and marketisation is a loss of control by social services workers over the labour process. The pressure to reduce costs is felt most intensively by social care workers, resulting in reduced pay, longer working hours, and increased occupational safety and health risks. This can be seen in the way in which work is organised in care homes and in the use of electronic monitoring in homecare.

Moore and Hayes (2017), in a study of zero-hours contracts in the home care sector and the use of electronic monitoring on paid and unpaid labour, found the emphasis on the minutes spent with the client meant travel time, training and supervision were squeezed out of paid work time. These activities then became part of unpaid work and affected the personal time of the care worker. Electronic monitoring shows how the use of digital technology can make the measurement of time with the client much more precise and so take out “unproductive work”. In the context of local authority austerity policies which aim to reduce costs, this has been used to control the work of social care workers and maximise their productivity, in the narrow sense of delivering care tasks. However, it does this by taking out the relational aspects that are crucial for quality care.
This is reflected in another study of the changes in domiciliary care. This showed how the use of care plans and rotas determine the labour process, but squeeze out other qualitative elements of care work, such as talking to clients. Health care tasks are increasingly expected to be done as part of domiciliary care, which again intensifies the labour process (Bolton & Wibberley, 2013). Although the integration of health and social care is a generally positive development, care workers need additional training, better pay, increased staffing levels and more time to spend with users.

Horton (2019) presented an analysis of how the financialisation of care is impacting on care workers in nursing homes in the UK. The use of debt financing and the sale and lease-back models used by private equity owners of care homes has made the sector more insecure. The indebtedness takes away resources from wages, new infrastructure, and other care services. The demands of investors have placed greater pressure on workers through higher workloads, the imposition of targets, and a reduction in the number of workers. Although local authorities contract care homes, the system of regulation is relatively “light touch” and does not expose them to rigorous scrutiny, nor does it look critically at the way in which care workers are treated.

4.3 Migrant workers
One impact of privatisation has been an increased use of migrant labour. Workers leave their home countries, which then experience a loss of care workers, creating further problems of recruitment and retention. The increase in personal care workers, paid for by care allowances, has facilitated low-paid and insecure care work in households (Spasova et al, 2018).

Da Roit and Weicht (2013) explored the relationship between different arrangements for funding systems for care, migration and employment regimes. In Germany, Austria, Italy and Spain, migrant workers are employed as individual care workers in the household. In the Netherlands, Sweden, Norway and the UK, they are more likely to be employed in formal care services. In France, migrant workers do not form a significant part of either the household or formal care workforce. The differences cannot be explained simply by the predominance of either household care or formal care services.

Instead, Da Roit and Weicht argue, that Germany and Austria use high levels of migrant labour because of underdeveloped formal care services and uncontrolled “cash for care” programmes. In Spain, high levels of migrant labour in the social services sector is related to the high levels of undocumented migrants and an underground economy, rather than cash for care programmes. In Italy, there are cash for care programmes coupled with high levels of migrant labour and an underground economy. In countries with larger public services, such as the Netherlands, France, Sweden and Norway, migrant labour is working in the formal economy, but in the UK the large private sector employs high levels of migrant workers Different arrangements for care delivery are mediated by both existing employment situations and different arrangements for care funding (Da Roit and Weight, 2013).

There are examples of how changes to the rights of migrant workers affect their economic security as care workers. In Austria, child benefits are provided to residents even if their children live in another country, which can provide an extra source of income for migrant workers. Recent changes in the benefits system will link these child benefits to the cost of living in the child’s country, not Austria, and will lead to a loss of income for migrant care workers (ESN,2019).

Household care work is a particularly precarious type of work, with little oversight or control over the work process. In Switzerland, recruitment agencies operate as brokers and employers for migrant workers. Schwiter et al (2018) found that these employment brokers perceived themselves as operating in a social market which provide a social good. They argue that the work is not necessarily
24-hours a day but is more likely to involve the worker spending five to six hours with their client. They also portray the care workers as long-term commuters or short-term migrants who will return to their home country and use this to justify low salaries. This model continues to support a highly gendered and racialised model of care and shows how the impact of public management reforms and cost cutting led to a further privatisation of household care in Switzerland (Schwiter et al, 2018).

4.4 Industrial relations
The impact of privatisation on collective bargaining and social dialogue has been a reduction in national, sectoral level collective bargaining and an increase in company or firm level bargaining in countries in central and eastern Europe, Spain and England for example (Lethbridge, 2019). Privatisation tends to fragment collective bargaining systems down to individual companies. Increased profits are driven by a reduction in labour costs. Even before the introduction of austerity policies, there was pressure on workers through low wages and reductions in bank holiday and sick pay, which resulted in higher levels of accidents and ill-health. The reduction in expenditure on basic equipment makes the work more difficult.

The labour-intensive nature of care work means it is difficult to reduce labour costs to below 60% of company revenues. Larger care companies can experience a “diseconomy of scale” with communication problems, falling care standards and increased organisational complexity.

These findings are also reflected in a survey of workers in French multi-national care company ORPEA, which is expanding rapidly across Europe. The survey of some of ORPEA’s workforce showed there was a high level of dissatisfaction with pay and working conditions affecting staff morale. Although ORPEA has showed positive growth in revenues, profits and dividends over recent years, there was growing evidence that developing a professional human resource management, building a strong industrial relations culture with the trade unions, and creating open information and consultation structures were not progressing at the same rate. Labour disputes in Germany and France in 2018 reflected this. Combined with the decentralised nature of running the businesses following take-overs, this created conflicts which will affect the company negatively in the future (Lethbridge, 2018).

Since 2017, ORPEA has shown a distinct lack of interest in establishing a European Works Council (EWC) and has blocked any constructive dialogue between management and unions, instead creating an atmosphere of distrust. Typical of ORPEA’s management approach was the attempt to set up an in-person meeting in the middle of the Covid-19 pandemic, with the accompanying risks for the health and safety of participants. The company refused to hold the meeting on-line (EPSU, 2020).

Pay is often lower in the for-profit sector. In Germany, pay is lower in for-profit homes although there is now a minimum wage agreement for care assistants. In Austria, pay is higher in public residential homes than in private for-profit homes, although there are collective bargaining agreements which cover both sectors. In Norway if a worker moves from the public to the private sector, legally they should be paid the same rate. However, for-profit companies may re-organise work and reject the collective agreement, resulting in lower pay. In Ireland there is little difference in pay, but benefits such as pensions and maternity pay are higher in the public sector. In Sweden, pay for assistant nurses is lower in the private for-profit sector and in the UK, workers in the private for-profit sector are on lower pay (Eurofound, 2017).

Grimshaw, Rubery and Ugarte (2015) found that improving the quality of the commissioning process, as measured by higher fees and partnership working, has a positive influence on pay levels and human resource practices. They suggested that improving local authority contracting could improve employment standards, although the type of provider is a mediating factor. Private, for-profit
providers and homes managed by national chains were the least likely to distribute the benefits of quality commissioning through improved employment standards.

In the case of social care for older people and people with disabilities, some systems of social insurance, which cover the costs of long-term care, provide an allowance to pay for the cost of a carer. This has created a poorly paid workforce which is often transnational and migrates for short and long periods to provide care to older people or people with disabilities in a household setting. This has had an impact on the way in which these workers are recruited, paid and organised, and results in high levels of illegal employment. In Sweden, 72% of personal assistants are in the private for-profit or not-for-profit sectors. Workers often receive little training and suffer from health and safety problems including musculo-skeletal disorders and stress.

In 2018, 24 care workers in Norway started to sue Aleris for recognition of labour rights. Aleris was taken over by Ambea in January 2019 and the merged company is known as Stendi the largest social care provider in Norway, Sweden and Denmark. The company forced the workers to be self-employed and called them “consultants”, removing their rights to sick pay, holiday pay and pension contributions. The employer does not have to pay employer contributions to the government (Braanen, 2019). The court found that 12 out of the 24 care workers were employees, demonstrating that the legal definition of the term “employment” was unclear (Eurofound, 2019).

4.5 Remunicipalisation
The poor quality of social services provided by companies has led to several municipalities returning to in-house management of social services. Norlandia Care was involved in nursing overtime and staffing issues in Norwegian care homes in 2011. In Sweden, scandals about understaffing and poor care provided by Ambea in 2011 led to the company being rebranded as Vardaga (eldercare) and Nytida (disability services). In 2015, the city governments of Oslo and Bergen decided not to renew management contracts with these for-profit companies. Public provision of care services tends to improve working conditions, while unregulated private care work creates poor working conditions. The role of unions and systems of social dialogue have a positive influence on working conditions, influencing pay, status and training and contributing to the professionalisation of care work.
5 Conclusion

Social services are a labour-intensive sector, with care homes the main form of infrastructure and many services also delivered in the home or household. The marketisation and corporatisation of the health and social services sector has played a key role in preparing social services for privatisation. The decentralisation of services to municipalities and the rhetoric of choice prepared countries for a new way of delivering social services. The impact of these changes is still being felt in many countries. In addition, the growing demand for social services has put pressure on existing budgets in a time of austerity.

As a labour-intensive sector, the main source of profit is generated by reducing labour costs. This has been done through the commodification of care services and their transformation into a series of tasks without any relational exchanges. This takes away an important element in the quality delivery of social services, the relationship between client and care worker. The use of digital technology has given the employer or commissioner more control over the worker by timing the delivery of care.

The introduction of care allowances to clients or households has created a demand for low-paid care workers, based in households with little control over their work or the wider labour process. Although the demand for personal, homecare workers has been met in many countries by migrant workers working on short-term or longer-term commuting arrangements, migrant workers are also employed by public sector agencies and private companies.

There is growing evidence that the claims of privatisation and ability of the private sector to be more efficient have not been met. Instead, there are a growing number of indicators, including worker to client or resident ratios and sickness and turnover rates, that are better in the public sector and contribute to quality services. The effects of austerity are being felt by service users who find it increasingly difficult to access services because they are either unable to pay for user fees or are excluded altogether.

The labour-intensive nature of social services dictates that if private companies are to generate regular dividends and high returns for investors this can only take place with reduced labour costs. As the quality of social services depends on workers who are well-paid, trained, supported, and able to work in a safe environment, the profit motive undermines the basis of high-quality social services.
References

- Braanen B. (2019) Dramaet i rettssal 383 Klassenkampen 7 February 2019 https://www.klassekampen.no/article/20190207/ARTICLE/190209974?fbclid=IwAR2pjCuwmCe4HM-olh7zDCOF34GVl4ws9X0MgfHGRQxTqvGPveeJk1oOM
- Burns D et al. (2016) Where does the money go? Financialised chains and the crisis in residential care Centre for Research on Socio-Cultural Change (CRESP) University of Manchester
- EPSU (2020) EPSU Executive Committee stands for ORPEA workers’ rights to information and consultation 65th Meeting of the EPSU Executive Committee - 24-25 November 2020
- Eurofound (2017) Care homes for older Europeans: Public, for-profit and non-profit providers Dublin: Eurofound
- European Commission (2014) Health and social services from an employment and economic perspective EU Employment and Social Situation Quarterly Review December 2014
• Eurostat (2020) Long term care beds in nursing and residential care facilities by NUTS 2 regions
  https://ec.europa.eu/eurostat/web/products-datasets/-/hlthRs_bdns
• Financial Times (2018) Britain’s biggest care home business for sale https://www.ft.com/content/8e4de9a8-5c0f-11e8-ad91-e01af256df68
• Financial Times (2019) Four Seasons to be taken over by H2 Capital Partners 11 September 2019 https://www.ft.com/content/eab8c4c4-d49a-11e9-8367-807ebd53ab77
• Harrington et al (2017) Marketization in Long-term care a cross country comparison large for profit nursing home chains Health Services Insights 1: 1-23
• Horton A. (2019) Financialization and non-disposable women: Real estate, debt and labour in UK care homes EPA: Economy and Space pp1-16
• Lethbridge J. (2018) ORPEA in the long-term care sector: company strategy and working conditions Brussels: EPSU
• Lethbridge J. (2018) Korian in the long-term care sector: company strategy and working conditions Brussels: EPSU
• Lethbridge J. (2018) Operating Environment for ORPEA and KORIAN Brussels: EPSU
• Orpea (2019) Annual Report