Operating Environment for ORPEA and KORIAN

by

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The Public Services International Research Unit (PSIRU) investigates the impact of privatisation and liberalisation on public services, with a specific focus on water, energy, waste management, health and social care sectors. Other research topics include the function and structure of public services, the strategies of multinational companies and influence of international finance institutions on public services. PSIRU is based in the Business Faculty, University of Greenwich, London, UK. Researchers: Prof. Steve Thomas, Dr. Jane Lethbridge (Director), Dr. Emanuele Lobina, Prof. David Hall, Dr. Jeff Powell, Sandra Van Niekerk, Dr. Vera Weghmann, Dr. Yuliya Yurchenko

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This report was commissioned by EPSU to inform the project 'Building company networks and EWCs in health and social services' (Project VP/2016/003/0038) with a focus on the operating environment for ORPEA and KORIAN. It covers two main issues:

1. Demographic change and demand for long term care services;
2. Financing and regulation of long term care services.

It aims to provide background material which will help to understand the environment in which the two companies operate and how their interpretations of this environment inform their corporate strategies.

The information for this report has been gathered from a range of sources, including company annual and financial reports, academic research, commercial investment research and trade union research. The research has focused on the countries in which both ORPEA and KORIAN operate in: Austria, Belgium, Czech Republic, France, Germany, Italy, Poland, Spain and Switzerland.

1. Demographic changes and the demand for care services

Long term care (LTC) 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. Across Europe, several countries have adopted and implemented reforms in the provision of LTC 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 LTC 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.

Table 1: Spending on long term care as % of GDP (residential and home care)

Country	Population	Residential	Home care	Total
Austria	8.5 m	0.9	2.5	3.4
Belgium	11.2 m	1.3	3.3	4.6
Czech Republic	10.5 m	0.1	1.9	2.0
France	63.0 m	0.7	3.2	3.9
Germany	82.0 m	0.9	3.4	4.3
Italy	59.7 m	na	na	na
Poland	38.1 m	0.1	1.9	2.0
Spain	46.0 m	0.7	2.4	3.1
Switzerland	8.2 m	2.0	3.6	5.6

Source: OECD 2013; Verbeek-Oudijk , 2014 [1]

National expenditure on long term care for Austria, Belgium, France, Germany and Spain is between 3.1 and 4.6% of GDP (Table 1). The Czech Republic and Poland have a lower rate of 2.0 % GDP and Switzerland is higher at 5.6% GDP. How this expenditure is used can be divided into institutional and home care. More LTC is delivered as home care than residential care, which reflects a policy change from institutional to community/ home based LTC (Table 2). Table 3 shows that there are country variations in the numbers of LTC care beds available and many of these have not changed significantly in the last few years. Spain is an exception which has seen an increase of 3.7% in the number of LTC beds. Another factor which shapes the provision of LTC is the extent to which governments are responsible for funding and provision and whether families are expected to provide informal care. Table 3 shows that in Spain, Italy, Switzerland and Czech Republic the family has the main responsibility for LTC.

Table 2: Population aged 65 years and over receiving long term care (2011)

Country	Institutions	Home	Total
Czech Republic	2.2	10.9	13.1
Germany	3.9	7.8	11.7
France	4.3 (2010)	6.9 (2010)	11.2
Italy	No data	4.1	4.1
Poland	0.8	-	0.8
Spain	1.7	5.5	7.2

Source: OECD Health statistics 2013 and Who Cares in Europe p.18

Table 3: Long term care beds

Country	Long term care beds per 1,000 population aged 65 +	Annual change in number of LT care beds per 1,000 population aged 65+	Formal responsibility for LTC *
Austria	45.6	?	Government & family
Belgium	72.1	- 0.1	Government & family
Czech Republic	45.0	- 0.3	Mainly family
France	59.0	+ 0.2	Government & family
Germany	53.1	+0.3	Government & family
Italy	18.9	+ 0.5	Mainly family
Poland	na	Na	Mainly family
Spain	47.9	+ 3.7	Mainly family
Switzerland	67.6	-0.7	Mainly family

Source OECD Health statistics 2013 * Assessing the needs of care in European National – country reports

Formal responsibility for long term care has an influence on the potential market for LTC services. In countries where the family is the main provider of long term care there are more opportunities for the for-profit private sector, especially when the rate of female participation in the workforce has increased, making it more difficult for women to provide full-time informal care. In countries where there is a high level of family responsibility for LTC, levels of government expenditure and public provision are low, for example, Italy, Spain. The impact of austerity policies are affecting the scope of the public and not-for-profit sectors to provide services and beds, which again provides new opportunities for the for-profit private sector, although mainly targeting higher income groups.

There are more fundamental changes taking place in attitudes to care. People prefer to receive LTC in their own homes and are entering residential care at a later age and with higher levels of dependency. [2] This trend towards entering residential care at a later age and with higher rates of disability has implications for the type of services provided. In France, the average age of people entering residential care is now 89 compared to 82 in 1994. [3] The length of stay has also changed in the last twenty years with people staying for shorter periods. Alzheimer's disease is one of the most common reasons for entering residential care. This growing demand for more intensive care in residential facilities is found in many European countries.

Another factor that influences demand for type of long term care is the system of pricing of health care and different types of post-acute and rehabilitation services. The introduction of a system of pricing called 'diagnostic related groups' where a fee is paid for a medical intervention rather than a day of hospital treatment has resulted in medical and surgical

facilities moving patients as quickly as possible from a hospital/clinic bed to a post-acute or rehabilitation bed. In France, the cost of a day in a surgical or medical bed is between €500 - €800 per day. The cost of a rehabilitation bed is €120- €130/day.[4] The number of days spent in a surgical/medical bed is 4.7 days (private sector) and 5.7 (public sector) but over 31 days in a post-acute or rehabilitation facility. [5] With patients staying relatively short stays in surgical/medical beds, the demand for more complex care in post-acute and rehabilitation beds has increased. This also provides opportunities for the for-profit sector.

The reduction in the role of the public sector to directly provide adequate social care services over the last two decades provides an opportunity for the for-profit private sector but the conditions within which the private sector has to operate in relation to standards and regulation are also important. There are three main types care home market: licensed; free market and; outsourced. [6]

Table 4: Types of care home market

Type of market	Description	Countries
Licensed	Operators have to gain permission to build, open or operate new care homes	Belgium, France, Italy
Free market	Operators may develop care homes without permission from local/national government but there may be some restrictions	Germany, Spain and UK
Outsourced	Local authorities outsource care services to private companies for contracts 3-10 years	Finland, Norway and Sweden, UK

Source: Knight Frank, 2014 [7]

Table 5: Distribution of providers of long-term care services according to ownership

Country	Public		Private non-profit		For profit providers	
	Residential	Home care	Residential	Home care	Residential	Home care
Austria	55%	8%	24%	91%	21%	1%
Belgium Flanders Wallonia Brussels	 36% 26% (28%) 24%		 52% 21% (28%) 13%		 12% 52% (42%) 62%	
Czech Republic	59%		38%		3%	
France	23%	15%	55%	65%	22%	20%
Germany	5%	2%	55%	37%	49%	62%
Italy	30%		50%		20%	
Spain	23%		24%		53%	
Switzerland	30%		30%		40%	

Source: Rodrigues et al, 2012: 95 [8]

Although public sector provision is 50% or more in Austria and the Czech Republic, the for-profit private sector provides 40% or more in Germany, Switzerland and Belgium. Germany has 49% of residential beds provided by for-profit operators. In the Czech Republic the balance of public and for-profit beds extreme. The private for-profit sector is still relatively small.

2. Financing and regulation

How LTC is funded has an impact on business strategies and it is recognised that there are national and even regional differences in the way in which LTC is funded so that business models have to be flexible between countries and within countries. [9] To understand how these factors influence ORPEA and KORIAN the social care financing systems and systems of regulation in France, Germany, Italy, Belgium, Switzerland, Austria and the Czech Republic are set out below.

There are four main sources of LTC financing:

- Government national/ statutory health insurance;
- Care allowances from local authorities;
- Private LTC insurance;
- Out-of-pocket payments. [10]

Local authorities/ municipalities have a strong influence on the pricing of services, the quality standards for multi-occupancy rooms and minimum floor space and safety regulations.

How is social care/ long term care (LTC) funded in different countries?

Table 6 shows that there are many different ways in which care/ medical expenses, accommodation, meals and residential services are financed. Care and medical expenses are most likely to be covered by state financing at either national, regional or local levels. State authorities have a strong influence on setting of prices. Accommodation, meals and residential services are more likely to be paid for by the resident or family but there may be some control over prices. However, from a care company perspective, there is more scope to increase income from the accommodation, meals and residential services.

Table 6: Financing of LTC in key countries

Country	Care & medical expenses	Accommodation, meals, residential services
Austria	Paid for by Dependency Insurance	Paid by resident Low income residents may have support from social support system
Belgium	Medical care allowance is financed from national health insurance based on number of	Paid by resident Prices are set by federal government

	residents and level of dependency	
Czech Republic	Dependency flat rate financed by Dependency Insurance	Paid by residents and families
France	Personal Autonomy Allowance (ACA) assessed according to dependency and resources Care services fee funded by national health system Prices are fixed by French Social Security system	Paid by re resident (or local authority if 'social security support' Prices controlled by Finance Ministry
Germany	Paid by dependency section of national health insurance system – allowance depends on level of dependency and region Tariff are based on day fees which are negotiated with Social Security or Retirement funds	Paid by resident/ family
Italy	Residents either given a voucher giving access to a facility or the facility is given a care allocation Pricing is determined regionally.	
Poland		
Spain	Paid by resident	Paid by resident
Switzerland	Medical allowance covers 30% of day rate which is based on level of dependency Fees can be changed without government permission	Paid for by resident

Source: Robertson *et al*, 2014; Orpea, 2017

Closely linked to the systems of financing are the systems of inspections in clinics and nursing homes.

Table 8: Systems of inspection in clinics

Country	**System of inspection**
Austria	Annual control by health authorities
Belgium	Quality controls by supervisory authorities?
Czech Republic	New quality system on recently introduced
France	Compulsory external assessment procedure carried by independent public authority *Haute Autorite de Sante* HAS
Germany	Compulsory certification processes to meet standards validated by *Bundersarbeitsgermeinshaft fur Rehabiliation* – this has to be redone every 3 years. Annual intermediary visits are also required.

Italy	External assessment procedure for all facilities, clinics by approved inspection agency, regional health services or an independent public authority
Spain	
Switzerland	No specific requirements but clinics have chosen to be certified using ISO 9001:2008

Source: Orpea,2017: 28 [11]

Table 9: Systems of inspection in nursing homes

Country	System of inspection
Austria	Annual control by government authorities
Belgium	Quality controls by supervisory authorities
Czech Republic	New quality system on recently introduced
France	Every 5 years, nursing homes have a self-assessment and every 7 years an external assessment is done
Germany	Annual inspections by medical services of health insurance funds including a sample of 9 residents, 3 from each level of dependency
Italy	External assessment procedure for all facilities, clinics. For nursing homes the assessment is carried out by the regional health agency
Spain	AENOR, International certification body (certified by Health ministry), carried out multi-site certification audit
Switzerland	Care documentation audited by insurers

Source: Orpea,2017: 28 [12]

Inspection systems for clinics are more rigorous than for nursing homes. These can be seen as a barrier to entry into the LTC market in Europe. All countries that ORPEA and KORIAN have operations in have some system of inspection or regulation for nursing homes. The main difference is whether there is self-assessment, as in the case of France, or whether the inspection is mandatory and done by government, insurers or an external quality agency.

Research into the impact of regulation on the quality of care has shown that the more prescriptive systems of regulation are often used in systems of increased privatisation of social care. They do not necessarily result in better quality care or better working conditions. Instead highly prescriptive regulation results in reactive work organisation. Many organisations often interpret rules about who should be included/ counted as a member of staff very loosely so that more highly qualified workers are not recruited. [13] This is relevant to the discussion in the Orpea report which deals with ratios of care workers and residents.

Setting fees

For profit companies are primarily interested in generating profits. How they set fees for their services has an important bearing on their ability to generate profits. As seen in the earlier section on financing of long term care, social care is funded from several sources in almost every European country. Medical services and care services are often determined and paid for by government. Companies have to exploit the opportunities to charge fees in areas which are not controlled by government, most often accommodation and extra services.

Table 7 shows how Orpea's daily fees are made up of three types of costing: care and medical expenses; dependency and; accommodation, meals and residential services. Fees for care and medical services are more likely to be paid by government or social insurance, which can be seen as a reliable source of income although the company then has less scope to change the level of fees. Accommodation is most often paid for by the individual/families so prices have to reflect their ability to pay but the company can decide on their own charges in many cases. Related food and accommodation services and additional services are also a source of potential income for the company.

Table 7: Percentage contribution of different forms of funding in nursing homes by country for ORPEA and KORIAN in France

Country	Care & medical expenses	Dependency	Accommodation, meals, residential services	Average day price €
Austria	20% LTC	40% personal care	40%	
Belgium	40%		69%	
Czech Republic	20% Long term care	15% personal care	65%	
France	**Korian 26% /Orpea 20%**	10%	**Korian 64% Orpea 70%**	
Germany	50%		15% rent 35% food/services	
Spain	20%	80%		
Italy	45%		55%	
Switzerland	28%	18%	54%	

Source: Korian Registration Document 2017 Orpea Registration document 2017

To illustrate how the three different types of costings are used by ORPEA and KORIAN to set their daily rates, the case of France will be used to show that the two companies have a slightly different approach to pricing. This information has been drawn from the 2017 Registration documents for ORPEA and KORIAN, which aim to explain to investors how the company develops its services and the potential for profits.

Table 8: Korian - Services and capacity for extra charges

	Payments from	**Korian's additional services**
Medical/paramedical care **26% of Group revenues**	Tariff is composed of three rates Care rate set by the RHA (ARS) – Funds salaries of care givers, state reg nurses, physios..and waste… Care rates are not charged to the residents but are paid directly to the facility by the NHI in a single payment that depends on the amount of medical care paid by the facility. Treatment rate is adjusted annually.	offer premium hotel and catering services ….tailored to the needs of the elderly p.11
		Residents' rooms –adapted to needs of people with disabilities and residents may obtain additional services e.g. cleaning, laundering, telephone and television
		Also rooms for relaxing, hairdressing, beauty treatments, newspaper kiosks and spaces reserved for leisure activities as music, reading and cooking Also other activities organised to prevent isolation and provide mental stimulation
Dependency rates	Set by the local Departmental council accounts for 10% of the Korian's nursing home revenues. It covers assistance and monitoring services necessary for everyday tasks unrelated to medical care. It covers a portion of these services e.g. salaries of hospital cleaning and maintenance workers, certified care givers and expenses linked to incontinence and accommodation supplies, maintenance products, laundry and depreciation of dependency care equipment	
Accommodation	64% of group LTC nursing homes in France Accommodation rates are set by local Departmental council Residents may also be eligible for means tested benefits e.g Residence contract, housing allowance, PIA or tax allowance. Paid directly by resident	Following services may be provided for an additional charge in addition to basic rent: Catering services Leisure and social activities External services e.g. hairdresser, beautician Assisted living facilities

		Apartments – a la carte services – available to ensure a secure and appropriate living environment for each resident

Source: Korian 2017 Registration document

Korian's analysis of how it can generate income from the provision of additional services shows that the Accommodation rates provide most opportunities for income generation(64%) although there is some scope in medical/ paramedical care. This is in contrast to Orpea where medical/paramedical services only generate 20% of its income but accommodation services generate 70%. This is measured through their daily rates.

3. Conclusion

This analysis of the factors that influence the corporate strategies of ORPEA and KORIAN shows that the ageing population is an important factor which will create a constant demand for long term care services. However, the nature of government funding and regulations make expansion of a long term care business more difficult. Each country has its own set of regulations and systems of accreditation and different levels of provision by public, for-profit and not-for profit providers. Companies have to achieve a balance between securing an income for medical and care services which are funded directly by government and the scope for providing services whose prices are not capped by government. Both ORPEA and KORIAN are aiming at providing services for medium to high income groups so that they can afford extra services. The costs of labour are the most basic costs which are more difficult to reduce. The individual country reports show how the two companies limit the number of workers as part of their wider corporate strategies.

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