PUBLIC SERVICES INTERNATIONAL RESEARCH UNIT (PSIRU), Business Faculty, University of Greenwich, UK

Final draft

Privatising our future: an overview of privatisation, marketisation and commercialisation of social services in Europe

February 2021

by
Jane Lethbridge
j.lethbridge@gre.ac.uk

A report commissioned by:

EPSU
EUROPEAN PUBLIC SERVICE UNION

Contents

Privatising our future: an overview of privatisation, marketisation and commercialisation of social services in Europe

This report has been commissioned to inform the future work of the EPSU Social Services Committee. The research objectives are:

1. To develop an overview of the extent of 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 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.

1.0 Social services and privatisation

1.1 Social services sector in Europe

In this report, the term social services is defined as: services for older people (often called long-term care), people with disabilities and Early Childhood Education and Care (ECEC), which include social work, social care and rehabilitation services. Services 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 existing social welfare systems. This has influenced the role that the public, for-profit and not-for-profit sectors play in social services provision. Although there have been different legislative changes, in European countries the responsibility for delivery of social services is now shared by public, private for-profit and private not-for-profit sectors. In Germany and the Netherlands almost all long-term care services are provided by the for-profit and not-for-profit sector. 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. Norway, Sweden and Slovenia have less than 20% of domiciliary care provided by the private, for-profit sector (Eurofound, 2017).

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

Although there have been some positive changes proposed for social services there has not been sufficient funding provided to properly implement these changes. In Austria, the asset contribution to residential care (*Pflegeregress*) was abolished in 2018 with the costs transferred to regional authorities. However, the amount that the Federal government has proposed transferring to cover the expected increases in demand for residential care is not considered adequate to cover the total costs. In Romania, central government made it compulsory for each community centre to have at least one social worker in public social services but no specific budget has been set aside to implement this measure. Even though there are inadequate funds available, local authorities are still responsible for social worker salaries (ESN, 2019).

Social services are often unevenly distributed geographically in a country leading to regional differences in provision. This may reflect population distribution but it can also reflect relative regional economic prosperity. This can be illustrated by the distribution of nursing home beds. In Sweden, 69% of nursing care home beds are concentrated in the southern part of the country, including Stockholm (Eurostat, 2020). For-profit companies are most active in the Stockholm region. 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/ most prosperous states and 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 an uneven regional distribution of services. This is reflected in company property strategies. Orpea has targeted the French regions of Île-de-France (Paris and west of the Paris region), Provence-Alpes- Côte d'Azur (Mediterranean coast), Aquitaine and Poitou-Charentes. In Belgium, most of ORPEA's clinics/ facilities are in Brussels and Flanders. In Spain, over 70% of ORPEA's facilities are in Madrid. In Italy, ORPEA 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 who are ORPEA's target market. Similar trends can be seen in the property strategy of Korian, a French multinational care company. In the UK, with a privatised system of social care provision, there are low rates of nursing care home beds in the East of England, North East England and South West of England, all predominantly rural areas and with lower rates of economic growth (Incisive Health, 2018).

Much long-term care is provided by informal carers, often because of the inadequacies of formal long term care services. In Poland, all long term care is provided by unpaid carers with families not receiving any support. In Ireland, there has been a recent expansion of informal carers, the majority of whom are women (ESN, 2019). In Belgium and Austria there is a notable lack of support for informal carers.

Support for informal/unpaid carers varies from country to country with some countries providing care allowances but 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 either employment or other interests, in order to secure a life of their own. In 2016, Scotland passed the Carers (Scotland) Act which set out the rights of carers and a Carers Charter. Carers have a right to an Adult Carer Support Plan or a Young Persons Carer Statement. A carer statement defines how much care is being provided, arrangements for future care planning, important 'personal outcomes' and support available locally (Scotland, 2016). Carers have the right to be involved in the planning of local services through either direct involvement or through a carer representative and to be involved 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 as health and social services are often funded by different government departments this makes integration of services difficult. There are also problems of a lack of understanding of which skills/ expertise/ competencies are present in each sector and how these could be better coordinated. More innovative ways of delivering services are being developed to meet the changing needs of services users, for example, in Portugal, 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 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 intellectual disabilities. For example, in Bosnia/Herzogovina, the move towards more community-based services is supported by a new administrative and legislative framework, which included 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 (public, for-profit and not-for-profit and occasionally cooperatives). However, this 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 home and residential services. This is continuing, with not-for-profit organisations often contracted directly by government to provide social services. The implications of not-for-profit organisations entering contractual relationships to deliver care are that the same pressure to measure the care being delivered can result in the loss of a more holistic approach to care provision.

1.2 Privatisation of social services

The term privatisation is defined as the change of ownership from public to private but during 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, land) are sold or transferred to private interests;
(2) **Financing**: when funding sources of public assets and service providers become private, for example, raising private capital instead of relying on public funding;
(3) **Management**: when private companies/ entities become responsible for managing and operating public assets and service providers;
(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. Although care homes require some capital investment, the growing demand for home care and other community-based services requires less investment although there are continuous labour costs. This has influenced the process of privatisation and has made the issues of management, production and provision more important. The framework which will be used to analyse the privatisation of social services covers*:*

- 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 public to for-profit and not-for-profit sectors. It is the nature of the contractual relationship which has an impact on how care is delivered. The voluntary/ religious sectors have provided care historically, as in Austria and Germany, but they were not necessarily involved in contracted care. The contracting of care involves them in the commodification of care through contract specifications.

- The personalisation of services aims to deliver services which meet the specific needs of the individual through funding given to the individual citizen/household to pay for

personal assistants to deliver care. Personalisation of services has been developed for people with disabilities and older people. This is a transfer of responsibility from public to the private individual household sphere.

All have implications for the way in which social services are organised and delivered. Social services are labour intensive services where the quality of the services is directly related to well-paid, trained and supported social services workers. However, the process of privatisation has made the workforce more widely exploited in order to extract higher levels of profit.

Corporatisation can be defined as the adoption of private sector/business models by the public sector so that 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 the work of 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 that providers have to compete to win contracts. Markets are often facilitated by the creation of internal markets in the public sector which introduce ways of costing and selling social services, turning services into commodities. Commodification of social services breaks down a social service into small component parts. For example, a home care service may be described as a series of tasks that 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 so allocating prices to services. Eventually this informs 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 quality of service the service user receives and the ability of the care worker to deliver a quality service. 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).

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

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

authorities in countries, such as Sweden, Denmark and the UK, but not always with the resources necessary for implementation. Consequently, measures to reduce costs through outsourcing and extend the diversity of providers were introduced, which the for-profit sector has taken advantage of. Although Sweden, Denmark and the Netherlands are the most well-known examples, decentralisation has also been introduced in some Central/Eastern European countries, Portugal and Spain, which have been trying to establish social services provision in the the last few decades.

In the UK and Sweden, specific policies were designed to increase competition and create markets for care. In many countries, for-profit institutions qualify for public funding, for example, Belgium, France, Germany, Greece, Ireland, Spain, Sweden (Spasova *et al*, 2018: 18). In Ireland, the for-profit sector has received funding from the government 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/nursing homes. The 2017 Eurofound report found that the for-profit sector provides more than 66% of the total care home places in Greece, the Netherlands, the UK (Scotland), Ireland, Spain, and Belgium. The for-profit sector has expanded over the last decade with often a contraction in public provision. The expansion of the for-profit sector has been most marked in the countries of Central and Eastern Europe (Table 1), where in Romania, Slovenia and Slovakia the for-profit sector expanded by over 23% during less than a decade. Only in Spain has there been an increase in public provision.

Table 1: Percentage of public: private care homes in six Central/Eastern European countries and Germany and Spain

Country	Year	Public: private	Year	Public: private	% increase of private sector
Czech Republic	2007	81%: 19%	2014	71%: 29%	10%
Croatia	2003	49%: 51%	2014	35%: 65%	14%
Lithuania	2003	65%: 32%: 3% (other)	2015	47%: 51%: 2%	19%
Romania	2008	66%: 34%	2014	43%: 57%	23%
Slovenia	2007	84%: 16%	2015	60%: 40%	24%
Slovakia	2005	76%: 24%	2013	45%: 55%	31%
Germany	2003	7%: 37%: 56%(NFP)	2015	5%: 42%: 53%	5%
Spain	2007	23%: 72%: 5% (other)	2015	28%: 71%: 0.5% (other)	-1%

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

The move 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.

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 countries have introduced new systems of long-term care insurance and co-payments. Germany introduced a system of long-term care insurance in 1995 which aimed to cover basic care costs not comprehensive costs, with families having to pay out of pocket or to 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. 64% of home care providers are for-profit providers (Nadash et al, 2018). In the Netherlands, there is a requirement that institutional care providers must be not-for-profit organisations, but the home care market has been opened to for-profit companies (Spasova *et al,* 2018).

Other countries use means testing as criteria for eligibility to social services. Funding of social services, especially 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, which leads to a focus on how to reduce costs.

Countries in Eastern and Central Europe (CEE) have gone through a different reform process with a greater focus on changing from public institutional care or de-institutionalisation to more community based social services. In Poland, Bulgaria and many other CEE countries, the public sector is still the main provider with for-profit provision expanding slowly. For-profit provision is 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 the main source of social services and still remains the dominant form of provision. In ECEC, the trends are slightly different in that the emphasis is on creating more community centres for young children.

Brennan *et al* (2012) looked at the impact of marketisation in Sweden, UK and Australia and 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 argue that marketisation includes 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 competitive tendering of large nursing homes and geographical areas of home care. In the UK, marketisation 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 the UK, an internal market was introduced in 1991 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 Sweden in 2009, the Act of 'Free Choice Systems' used incentives to make municipalities introduce consumer choice models in care for older people. However, there is a variation between municipalities in the extent of their use of for-profit providers, 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 but it also reflects a traditional distribution of social services which is concentrated in the south of Sweden, which is economically more prosperous.

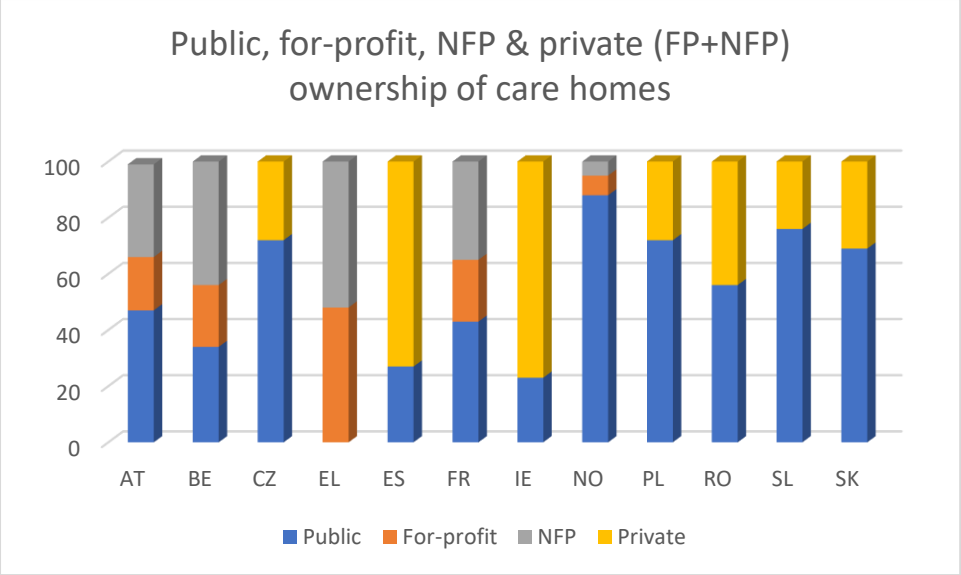
Although Sweden has had legislation in place to encourage 'freedom of choice' in childcare, the for-profit sector plays a much smaller role but with a similar local variation to care for older people. However, higher income groups are using for-profit provision with the potential to undermine a social solidarity. A study of the marketisation of early years care in Iceland illustrates how the creation of charter schools introduced a de-regulation of the for-profit sector, an increase in the size of schools and the outsourcing of the management of publicly funded schools (Dýrfjörð & Rós Magnúsdóttir, 2016). This provides a long-term threat to public provision. 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 provided 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 this affected nursing homes and domestic care agencies. Nursing homes had to raise their fees because of an inability to cover all their previous medical costs. Domestic care services covered by public health insurance had to introduce a strict time control system for workers so that they could justify each minute spent so domestic care workers spent 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 who provide care and personal household services (Schwiter *et al*, 2018).

2.2 Expansion of private, for-profit sector

Although European countries show different levels of participation by the public, for-profit and not-for-profit sectors, the presence of for-profit companies has increased in many countries.

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



Source: Adapted from Eurofound, 2017: 51-2

During the last twenty years there has been an expansion of multinational care companies in some countries, which are the result of for-profit companies expanding outside their domestic market. Although this has, until recently, been limited to regional groups of countries, for example, the Nordic region and continental Europe, but there are signs that this is expanding either through multinational company expansion or through increased investments by private equity companies in companies working in the social services sector (Lethbridge, 2019).

Existing multi-national companies (MNC) have become involved in social services in several ways. Many multinational social care companies own a mix of care homes as well as some clinical services, usually mental health services. Facilities management MNCs have become involved in the delivery of homecare services, for example, ISS, Sodexho. Some companies, not always involved directly in care, provide luxury retirement apartments with a range of services. The services may cover care but also include recreational activities for people on higher incomes (ESN*, 2019).*

Even through there is a wide variation between countries in terms of public and private for-profit provision, most countries are experiencing 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 childcare and early childhood education and care (ECEC) there is a much stronger public provision with over 50% provided directly by the public sector (EC, 2011).

The way in which these companies have expanded has 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 making it difficult to identify actual owners and ultimate accountability. All companies were involved in a wide range of social services from social care, pre-schools, child protection and patient hotels, which are considered a good investment because of continued demand for these services. Social services for-profit expansion will be examined in terms of the expansion of Nordic companies, French companies and UK companies which deliver a range of social services.

Nordic region

Table 2: Ownership, number of employees and expansion of Nordic Companies delivering social services

Companies	Ownership	Numbers employed	Countries
Norlandia Care	Adolfsen Group/ Norlandia Healthcare Group	9,700 Care group 3,000	Norway, Sweden, Germany, the Netherlands, Poland - Preschools Norway, Sweden & Finland - Patient hotels Norway & Sweden– Elderly care
Attendo	Nordstjerman AB (PE), Swedbank Robur Fonder, Didner & George Fonder (Investment bank)	Total number of workers 25,000 = 16,499 FTE equivalents Sweden 8012 Finland 7662 Norway 511 Denmark 314	Denmark Finland Norway Sweden
Vardaga/ Ambea = Stendi	Ambea is subsidiary of Acto SCA Luxembourg) and bought Aleris 2019 ACTR Holding AB and ACTOR SCA are controlled by KKR and Triton (50.1%) total number of shares and votes in Ambea. Triton and KKR first invested in 2010, buying from 3i.	26,000	Sweden Denmark Norway
Forenade Care	Subsidiary of Forenede A/S a facilities management company	3,000	Denmark and Sweden – care

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

Table 2 shows that there are several companies active across the Nordic region.
Nordic companies expanded initially into Denmark, Finland, Norway and Sweden. Only Attendo has expanded out of the Nordic region into the Netherlands and Poland.
The multinational care companies involved in Norway and Sweden overlap. All are owned by one or more private equity investors. This type of ownership has expanded since 2005.
Norlandia is privately owned by the Adolfsen Family and a private equity company. Attendo is publicly traded but also had some private equity shareholders. Aleris was bought by Vardage/Ambea in 2019. Forenade Care is a subsidiary of a facilities management company, Forenede A/S.

France

Since 2005, four of the largest French multinational care companies have expanded into many European countries. All have expanded from providing care and psychiatric services in France to care services for older people across Europe, with several moving into China and Latin

America. Over the last 10 years, there have been gradual changes in their investors, often changing from founder investors to global investment companies or pension funds. The expansion of these French companies is having an impact on European social services by either taking over existing national for-profit companies or moving into countries with small for-profit sectors and building new facilities. These companies are leading the privatisation of social services either by being contracted to provide services for the public sector or 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: Ownership, number of employees and expansion of French companies delivering social services

Companies	Ownership (% share capital)	Number of workers	Countries
ORPEA	CPPIB 14.5% FFP (controlled by Peugeot Family group) Invest 5.0% SofinaSA (Belgian holding company) 2.0% Free float 78.4% Treasury shares 0.1% 2004 First international expansion Ist private operator in France	54,000	Europe: Austria France Belgium Czech Republic Italy Germany Ireland Poland Spain Slovenia Switzerland International: Mexico China
Korian	Predica (Credit Agricole Assuances) 24.3% Malakoff Humanis Group (7.7) Free float 67.9 Treasury 0.1? 2007 1st international expansion 2nd Private operator in France	56,000	France, Belgium, Germany, Italy 2020 recent acquisitions: The Netherlands (Aedificia- real estate health) Spain – 2,000 beds
Domus VI	Acquired by ICG Europe VI in July 2017 with co-investment by ICG Enterprise Intermediate Capital Group (ICG) and Sagesse Retraite Santé, an investment fund controlled by Yves Journel acquired a majority stake in the DomusVi group from PAI Partners. 2014 First international expansion 3rd private operator in France	37,000	France, 14,000 Spain, 22,000 Portugal, 300 Chile, Uruguay, Colombia =1000 employees No China presence in 2019
Colisée	IK Investment Partners (2017) Groupe Teycheney 30% (founder) Management 6% 2014 First International expansion	16,000	France: Colisée Belgium: Armonea Spain: Saleta and STS Italy: Isenior China.

	4th private operator in France		Colisée offers home services with the teams from Onela. https://www.onela.com/decouvrir-onela/

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

United Kingdom/Ireland

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 but increasingly the market is dominated by a group of larger for-profit companies, controlled by private equity investors.

Table 4: Ownership of UK companies delivering social services

Companies	Ownership	Numbers employed	Countries
Four Seasons Healthcare	**H/2 Capital Partners**	**20,000**	**UK**
BUPA Care Homes	**BUPA**	**5,735**	**UK, Poland, Chile**
HC-One Ltd	**Dr. Chai Patel**	**14,000**	**UK**
Barchester Healthcare	**Dermot Desmond, JP McManus and John Magnier**	**17,000 (39% staff turnover)**	**UK**
Care UK and Social Care Investment Ltd	**Bridgepoint**	**15,148**	**UK**

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, which is the poor quality of services and the process of financialisation which takes ownership away from the geographical location of social services to the centre of investment/ finance. This makes decision making 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 problems of the business models used to generate growth. In England, in 2010, the failure of the largest care provider, Southern Cross, due to high level of debt had already showed the vulnerability of depending on the private sector, as well as companies' use of debt to cover property acquisitions. In 2015, Care UK and Bridgepoint established Silver Sea Holdings to build, oversee and rent care homes for Care UK (Harrington *et al*, 2017). The company is registered in Luxembourg. In a similar way to care companies in the Nordic region, the complex ownership structures make it difficult

to identify owners. **In 2019, Four Seasons was declared insolvent and was sold to H/2 Capital Partners, a private equity company (Financial Times, 2019). Large companies buy and sell chains of care homes regularly, creating uncertainty and a failure to plan for the long-term.**

Recent reports have examined some of the motivations behind investments in this sector. Many of the residents are paid for by local authorities. 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). This is a high level of return and as many care places are funded by local authorities, they are directly contributing to such a high level of private return for a public service. The social care sector is a low risk sector because the nature of the activity changes little and so lower levels of return should be required for companies providing care services. The expected high rate of return by private providers has had an impact on the debates about the future of social services. Extra funding is presented as the solution and private providers lobby governments to try and secure this (Burns *et al*, 2016).

In 2017, Opus Restructuring, a social-care analyst, in research commissioned by the BBC 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 contribute 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. The cost of the growing demand for social services in an ageing population is a major political issue. Countries have approached this issue in different ways, partly influenced by the existing system of social welfare. Some countries introduced new social insurance schemes which citizens pay into and subsequently become eligible for social care. Germany and the Netherlands introduced systems of social insurance which have resulted in an expansion of for-profit and not-for-profit providers.

There is a growing demand for social services to be delivered in the home/ 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, UK all have some form of cash allowance for long term care. In countries where payment of the allowance is specifically for the payment of home/ 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 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. The percentage of older people and people with disabilities claiming the allowance has increased, resulting in

increased provision of home care both the quality of care and quality of jobs is highly variable. Women workers from Italy or from neighbouring countries often have little or no training, work long hours and develop occupational health problems such as back injuries and stress (Ferre et al, 2014).

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 form of provision and different regulations in relation to access and finance (Schiffbaenker and Kraimer, 2003). By 2016, around 5% of the Austrian population or 455,354 people and approximately 18% of the population aged 60 years and older received the care allowance, which is paid in seven different levels according to amount of care needed. Live-in 24-hour home care is provided by private assistants, about 62,500 recruited from countries in CEE. There are still extensive regional variations in care (Bachner *et al,* 2018).

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. National legislation, the Free Choice reform (2003) was designed to eliminate the black 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 an option to arrange services by providing a user with a service certificate, which allows a person to employ his/her own personal helper among individual persons and companies. Private providers have to meet quality standards and sometime price requirements (OECD, 2011). This has not led to an expansion of for-profit home care providers because municipalities provide adequate public homecare services and set prices and quality standards for tendering procedures for home care 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 countries of Central and Eastern Europe, there is some use of personal care related payments. In Hungary, payments are made to informal carers at a level of 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. In Croatia, Hungary and Slovakia, it is only for people with severe disabilities. In Slovenia and Slovakia the use of the allowance is not determined (Spasova *et al*, 2018).

The introduction of care allowance schemes can be seen as part of a privatisation of care provision to the household level which has been met either by members of the household being paid an allowance for care work or the recruitment of low paid, precarious workers who are often migrant workers. 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 predominantly the main form of long-term care in many countries.

3.0 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 through increasing the amount of work by reducing the number of workers or by increasing the hours worked/ holidays taken and generally intensifying the labour process.

The social services sector shows how the market has failed to deliver a public service, whether effectively, efficiently or equitably. The use of market mechanisms in England, specifically the purchasing and providing of care services from private providers, has resulted in a crisis of funding because shareholders and investors expect high rates of return. A growing demand for care services and austerity policies, which have affected local authorities particularly acutely, has led to further pressure on existing services, with local authorities often reducing the services they can afford to commission. An increased number of citizens are self-paying for care services or not receiving care services that they need to live independently. There has been an increase in inequalities among service users. Promoting consumerism has resulted in higher income groups being able to manoeuvre 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. Several studies have found that there is no difference between the public and private sector in terms of efficiency and effectiveness. Marczak and Wistow (2016) found little evidence that prices were reduced and when there is a reduction in prices, this was often accompanied by a decrease in quality of care.

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

In terms of quality of staff, in France, excessive workloads result in a high turnover of staff, with resulting labour shortages. In Austria, low staff-to-resident ratios worsen conditions of work in nursing and residential homes. In many countries, for example, Belgium, Sweden, France, Slovenia, 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 does not happen in social services. There are a number of social services which have been taken back in-house because of failure of private sector to provide services which are sensitive to the needs of the users (Denmark, Sweden, 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 the elderly and disabled. 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) made 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 that there is no evidence to show that increased competition has resulted in reduction in costs or increased efficiency. The rationale for marketisation and the expansion of for-profit provision was supposed to provide people with greater choice which would lead to their empowerment. In the United Kingdom, 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). Sometimes there was a lack of information and advice and often a lack of support to individuals in 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 efficiency 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) argued that these two concepts have to be considered together. They identify two models of residential care: a person-centred approach where 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 of care. Budget reductions results in reductions in numbers of workers, longer working hours, and work intensification and directly affect the quality of care. However, in a nursing home 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 pay and hours worked deteriorated, the workers were still consulted, were allowed to work flexibly and still maintained some control over their work.

In contrast, the 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 reduced maintenance of the facilities. Workers were unable to give voice to their concerns. The research examined 12 residential homes. Seven homes had a person-centred approach and five had a custodial approach and were both for-profit and not-for-profit ownership (Burns *et al*, 2016). This study shows that job quality and care quality have to be considered together. Job quality impacts on care quality.

There are limited 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 the quality of care was improved even more when a range of care workers were employed, for example, 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).

There is a need for more research into how to measure the quality, accessibility and affordability of social services. Staff-client ratios are one way of assessing the likelihood of a higher quality service. Increased training and worker support as well as 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 client and social

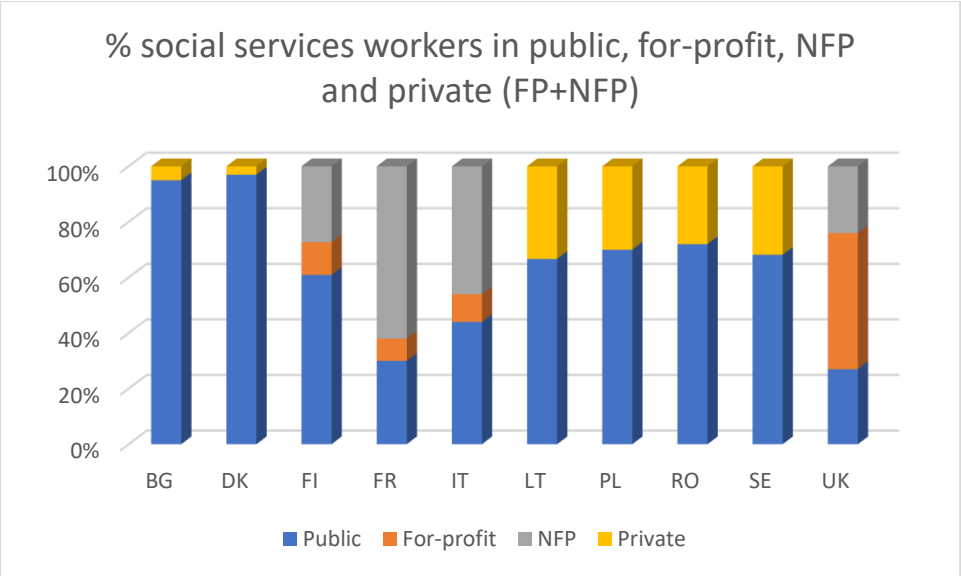
services worker rather than consumer surveys are needed. The introduction of marketisation and corporatisation was based on a limited evidence base. The failure to recognise that social services are highly labour-intensive services where quality is directly related to the quality of the workforce led to the creation of systems and structures where the interests of for-profit providers are paramount.

4.0 Privatisation and pay and conditions of workers

4.1 Overview of for-profit sector

An examination of the proportion of social services workers employed in the public, for-profit and not-for profit shows how the growth of the for-profit sector is taking place in many countries across Europe. This reflects the growth in for-profit ownership of care homes and the expansion of care MNCs across Europe. The United Kingdom (49%) has the largest for-profit sector employment but Sweden (25%), Finland (18%) Romania and Latvia are smaller but expanding for-profit sector employment (Eurofound, 2017: Lethbridge, 2019).

Figure 2: % social services workers in public, for-profit, NFP and private (FP+NFP)



Source: PESSIS + Lethbridge, 2019

4.2 Loss of control over 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 services 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 home care.

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 that the emphasis on the minutes spent with the client meant that travel time, training and supervision were squeezed out of paid

work time. These activities then became part of unpaid work, which then affect 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 services care workers and maximise their productivity, in a narrow sense, of delivering care tasks but it does this by taking out the relational aspects of care which are crucial for quality care.

This is reflected in another study of the changes in domiciliary care which showed how the use of care plans and rotas determine the labour process but other qualitative elements of care work, for example, talking to clients, are squeezed out. Health care tasks are increasing 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 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 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 larger 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 care homes to rigorous scrutiny, nor does it look critically on 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 own 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 migrant workers 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 just by predominance of either household care or formal care services.

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 high levels of undocumented migrants and an underground economy rather than cash for care programmes. In Italy, there are both cash for care programmes coupled with high levels of migrant labour and an underground economy. In countries with larger public services, for example, the Netherlands, France, Sweden and Norway, this results in migrant labour 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 both by 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 are affecting their economic security as care workers. In Austria, child benefits are provided to residents even if their children live in another country. This can provide an extra source of income for migrant workers. Recent changes in the benefits system will make these child benefits linked 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 the migrant workers. Schwiter *et al* (2018) found that these employment brokers perceived themselves as operating in a social market which provided a social good. They argue that the work is not necessarily 24 hours a day but is more likely to be 5-6 hours with the worker spending time with their client. They also portray the care workers as long-term commuters or short-term migrants who will return to their own country. This is used to justify low salaries. This model continues to support a highly gendered and racialized model of care. It 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/firm level bargaining, for example, in Central and Eastern Europe, Spain, England (Lethbridge, 2019). Privatisation tends to fragment collective bargaining systems down to individual companies. The drive to increase profits is driven through a reduction in labour costs.

Even before the introduction of austerity policies, there was pressure on workers through low wages, reductions in sick pay and bank holiday pay, which resulted in higher levels of accidents and ill-health. The reduction in expenditures on basic equipment makes the work more difficult. However, Horton (2019) found in a series of interviews with care workers that they maintained their own values that included more responsibility for residents and their colleagues. The companies which these care workers were employed by were subject to regular takeovers and 'buy-outs', which resulted in reduced employment terms. However, workers accepted these terms because of their commitment to the home and its residents. As a result, workers take on extra shifts and work long, 70 hour weeks. Horton argues that this continued commitment by care workers is a form of resistance and actually places limits on the extent of financialisation (Horton, 2019:11).

The labour intensive nature of care work means that it is difficult to reduce labour costs to below 60% of company revenues. Larger care companies can experience a 'diseconomy of scale' when communication problems, falling care standards and increased organisational complexity. These findings are also reflected in a survey of workers in Orpea, a French multi-national care company which is expanding rapidly across Europe. The survey of some of the ORPEA's workforce showed that there was a high level of dissatisfaction with pay and working conditions and that this was affecting staff morale. Although ORPEA showed positive growth of revenues, profits and dividends in recent years, there was growing evidence that the development of a professional human resource management, building a strong industrial relations culture with trade unions and creating open information and consultation structures are not developing at the same rate. The labour disputes in Germany and France in 2018 reflected this. Combined with the decentralized nature of running the businesses following take-overs this has created conflicts which will affect the company negatively in future (Lethbridge, 2018).

Since, 2017, ORPEA has shown a 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 setup a last in-person meeting in the middle of the pandemic, with the accompanying risks for the health and safety of delegates. The company refused to have the meeting on-line (EPSU,2020).

Pay is often lower in the for-profit sector. In Germany, pay is lower in for-profit homes but there is now a minimum wage agreement for care assistants. In Austria, pay is higher in public residential homes than in private for-profit ones although there are collective bargaining agreements which cover both sectors. In Norway, if a worker changes from the public to private, although legally s/he should be paid the same, for-profit companies may re-organise work and reject the collective agreement, which results in lower pay. In Ireland, there is little difference in pay but benefits e.g. pension and maternity pay, are higher in the public sector. In Sweden, pay for assistant nurses is lower in the private for-profit sector. In the UK, workers in 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. But, the type of provider is a mediating factor. Private, for-profit providers and homes managed by national chains were least likely to distribute the benefits of quality commissioning through improved employment standards.

In the case of social care for older people or people with disabilities, some systems of social insurance, which cover the costs of long-term care, provide an allowance which enables an older or disabled person to pay for the cost of a carer. This has created a poorly paid workforce which is often trans-national 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 musculo-skeletal problems and stress.

In 2018, 24 care workers started to sue Aleris for recognition of labour rights. Aleris was taken over by Ambea in January 2019. The merged company is known as Stendi, which is now the largest social care provider in Norway, Sweden and Denmark. The workers were forced by the company to be self-employed and called 'consultants' which removes any rights to sick pay, holiday pay or 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, which showed that the legal definition of the term 'employment' was unclear (Eurofound, 2019).

4.5 Re-municipalisation

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.

In Spain, in the municipality of Albolote, care services for people with disabilities had been directly managed by the municipality for many years but a conservative government privatised

the service by issuing a management contract to a private company. In 2015, with a change of municipal leadership, the city council took back control of this service and employed 27 workers and one coordinator to deliver the service for 108 citizens (TNI, 2020).

4.6 Recruitment and retention

In almost every European country, the social services sector has problems in recruiting and retaining workers because of the growing demand for services, the lack of status of care work pay and poor terms and conditions as well as lack of training and continuous professional development.

An OECD (2020) report highlighted policies to improve pay and working conditions, workers' autonomy and occupational health. Social dialogue plays a key role in these changes. Improving prevention to strengthen the health and well-being of older people will also play a key role in maintaining the independence of older people. Effective collaboration with other health workers is important (OECD, 2020). Overall, the sector needs to become more professionalised.

EPSU (2020) in a position statement developed with the Social Employers, representing social services not-for-profit management, emphasized the importance of management taking a constructive role in the development of a positive workplace culture, where management and workers collaborate and respect each other. Issues such as national or local pay, working time, job security and career progress, contract quality, job quality, introduction of new technologies and staff ratios and workforce qualifications can all be addressed through collective bargaining at local, national, regional and/or sectoral levels. National and local authorities responsible for funding social services should ensure that pay and working conditions are protected (EPSU/Social Employers, 2020).

An ILO (2018) report argued that public policy has a crucial role to play in influencing the level of employment, pay, working conditions and status of care workers. Migration and labour policies have a strong impact on the working conditions and the way in which care workers are treated. Public provision of care services tends to improve working conditions but 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 which contributes to the professionalisation of care work.

5.0 Conclusion

Social services are a labour-intensive sector with care homes as the main form of infrastructure. Many social services are delivered in the home or household. Marketization and the corporatisation of the health and social services sector have played a key role in preparing social services for privatisation. The decentralisation of services to municipalities and the rhetoric of choice in social services prepared countries for a new way of delivering social services. The impact of these changes is still being felt in many countries. In addition, there is a growing demand for social services which places 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 what is important 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, home care workers has been met in many countries by migrant workers, working on short term or commuting arrangements, migrant workers are also employed by public sector agencies and private companies.

There is a need for more research into what public and private provision in relation to quality accessibility and affordability of social services. 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, for example, worker-client/resident ratios, sickness rates 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 from the services.

The labour-intensive nature of social services dictates that if private companies are to generate regular dividends and high returns for investors then 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.

Jane Lethbridge
31 January 2021

References

Alexa J, Rečka L, Votápková J, van Ginneken E, Spranger A, Wittenbecher F (2015) Czech Republic: Health system review, 2015 Health Systems in Transition 17(1):1–165.

Attendo (2019) Annual Report

Bachner F, Bobek J, Habimana K, Ladurner J, Lepuschütz L, Ostermann H, Rainer L, Schmidt A E, Zuba M, Quentin W, Winkelmann J. (2018) Austria: Health system review. Health Systems in Transition, 2018; 20(3): 1 – 256

Bolton S. and Wibberley B. (2013) Domiciliary Care: The Formal and Informal Labour Process Sociology 48(4) 682–697

Braanen B. (2019) *Dramaet i rettssal 383* Klassenkampen 7 February 2019 https://www.klassekampen.no/article/20190207/ARTICLE/190209974?fbclid=IwAR2pjCuwNmCe4HM-ojhTzDC0F34GVl4ws9X0MgfHGRQxrTqvGPveeJk1oOM

Brennan et al (2012) The marketisation of care: Rationales and consequences in Nordic and liberal care regimes Journal of European Social Policy 22(4): 377-391

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

Burns D. Hyde P. and Killett A.M. (2016) How financial cutbacks affect the quality of jobs and care for the elderly ILR Review 69(4): 991-1016

Care Home Professional (2017) HC One sell recently acquired BUPA care home http://www.carehomeprofessional.com/hc-one-sell-recently-acquired-bupa-care-home/

Comondore V., Devereaux P. Zhou Q. et al (2009) Quality of care in for-profit and not-for-profit nursing homes: systematic review and meta-analysis British Medical Journal 339: b2732

Costa-Font J. (2010) Devolution, diversity and welfare reform: Long term care in the 'Latin Rim' Social Policy & Administration 44(4):481-494

Da Roit B. and Weicht B. (2013) Migrant care work and care, migration and employment regimes: a fuzzy set analysis Journal of European Social Policy 23(5): 469-486 https://doi.org/10.1177/0958928713499175

Dýrfjörð K. and Magnúsdóttir B.R. (2016) Privatization of early childhood education in Iceland Research in Comparative and International Education 11(1): 80-97

EPSU/ Social Employers (2020) Joint Position Paper Recruitment and Retention in European Social Services – state of play, ways forward and the role of European social dialogue Brussels: EPSU/Social Employers https://www.epsu.org/sites/default/files/article/files/Joint%20EPSU_FESE%20Position%20Paper_Recruitment%20and%20Retention%20in%20Social%20Services.pdf

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

Eurofound (2019) Social partners debate court case on employment relationship of care workers Norway latest developments in working life Q3 (2019) https://www.eurofound.europa.eu/publications/article/2019/norway-latest-developments-in-working-life-q3-2019

European Commission (2011) Study of Social Services of General Interest Brussels: European Commission

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/-/hlth_rs_bdsns

European Social Network (ESN) (2019) Connecting Social Services in Europe https://crm.esn-eu.org/sites/default/files/publications/European%20Semester_Interactive.pdf

Ferré F, de Belvis AG, Valerio L, Longhi S, Lazzari A, Fattore G, Ricciardi W, Maresso A. Italy: Health System Review. Italy Health Systems in Transition, 2014, 16(4):1–168.

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 H/2 Capital Partners 11 September 2019 https://www.ft.com/content/eab8c4c4-d49a-11e9-8367-807ebd53ab77

Grimshaw D. Rubery J. and Ugarte S. M. (2015) Does better quality contracting improve pay and HR practices? Evidence from for-profit and voluntary sector providers of adult care services in England Journal of Industrial Relations 57(4) 502–525

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

Hartman, Laura (ed.) (2011) *Konkurrensens konsekvenser. Vad händer med svensk välfärd?* [The Consequences of Competition. What is happening to Swedish Welfare?] SNS - Centre for Business and Policy Studies http://www.sns.se/artikel/consequences-competition-what-happening-swedish-welfare

Horton A. (2019) Financialization and non-disposable women: Real estate, debt and labour in UK care homes EPA: Economy and Space pp1-16

Incisive Health (2018/9) Care deserts: the impact of a dysfunctional market in social care provision, London https://www.incisivehealth.com/wp-content/uploads/2019/05/care-deserts-age-uk-report.pdf

International Labour Organization (ILO) (2018) Care Work and Care Jobs for the future of decent work Geneva: International Labour Organization

Iparraguirre J.L. & Ma R. (2014) Efficiency in the provision of social care for older people. A three-stage Data Envelopment Analysis using self-reported quality of like Socio-Economic Planning Sciences 49:33-46

Korian (2019) Annual Results 2019 https://www.korian.com/sites/default/files/documents/27.02.2020%20Annual%20results_PR_EN_FOR%20RELEASE_2.pdf

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

Lethbridge J. (2019) Final European Report for PESSIS + Brussels: EASPD/PESSIS +

Lewinter M. (2004) Developments in home help for elderly people in Denmark: the changing concept of home and institution International Journal of Social Welfare 13:89-96

Mercille J. and Murphy E. (2017) What is privatization? A political economy framework Environment and Planning A 49(5): 1040–1059

Mercille J. & O'Neill N. (2019) The growth of private home care providers in Europe: the case of Ireland. Social Policy Administration 2019:1-16

Moore S. and Hayes L. (2017) Taking worker productivity to a new level? Electronic Monitoring in homecare – the (re)production of unpaid labour New Technology, Work and Employment https://doi.org/10.1111/ntwe.12087

Nadash P. Doty P. and van Schwanenflugel M. (2018) The German Long-Term Care Insurance Program: Evolution and Recent Developments The Gerontologist 58(3): 588–597

OECD (2011) Help Wanted? Providing and Paying for Long-Term Care Paris, \www.oecd.org/health/longtermcare and www.oecd.org/health/longtermcare/helpwanted

Orpea (2019) Annual Report

Österle A. (2010) Long term care in Central and South-East Europe: Challenges and perspectives in addressing the 'New' social risk Social Policy & Administration 44(4):461-480

Placella E. (2019) Supporting community-based care and deinstitutionalisation of mental health services in Eastern Europe: good practices from Bosnia and Herzogovina BJPSYCH International 16(1): 9-11

Schiffbaenker M. and Kraimer H. (2003) A new Austrian care system? Theoretical approaches Institute of Technology and Regional Policy InTeReg Working Paper No.07-2003

Schwiter K. *et al* (2018) Neoliberal austerity and the marketisation of elderly care Social & Cultural Geography 19(3): 379-399 https://doi.org/10.1080/14649365.2015.1059473

Spasova, S., Baeten, R., Coster, S., Ghailani, D., Peña-Casas, R. and Vanhercke, B. (2018). Challenges in long-term care in Europe. A study of national policies, European Social Policy Network (ESPN), Brussels: European Commission.

Scottish Parliament (2016) The Carers (Scotland) Act 2016 https://www.legislation.gov.uk/asp/2016/9/contents/enacted

Winkelman J. Rodrigues R. Leichsenring K. (2014) To Make or to Buy Long-term Care II: Lessons from Quasi-markets in Europe Policy Brief 2014 Vienna: European Centre for Social Welfare Policy and Research