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Failed Market Approaches to Long-Term Care

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Abstract

In countries where responsibility for long-term care of a growing elderly population has shifted significantly to the private sector, expectations of quality of service and standards of care are not being realised. This essay draws on prior research, analyses and case studies from Australia, Canada, the United Kingdom, France and the United States. Employment in long-term care has been growing but its largely female, often migrant, workforce has been subject to severe exploitation. High turnover and chronic staff shortages are exacerbated by low wages and excessive workloads, undermining the quality of care. Rather than funding improvements, private operators of long-term care regularly extract excessive revenues from public funding and private fees. This pattern is common across ownership types: private equity, private business, public company and large-scale not-for-profit. In almost all cases, private operators put business interests—profits or expansion—ahead of quality of care. Government regulation has been largely insufficient to maintain acceptable standards but some reform efforts are beginning to emerge. Greater worker participation and engagement with public-health systems and communities must be part of the solution, to ensure higher quality, address chronic staff shortages and build public support for adequate, fair and transparent public funding. Further reforms and future funding increases should prioritise direct public provision, to ensure adequate standards and reduce profit extraction by private operators.

Introduction

Long-term care has evolved in industrialised nations with smaller nuclear families and reduced ability to provide cross-generational care within the home. With longer life expectancy, elderly family members frequently require more intensive care.

With the possible exception of those on the highest incomes, there has never been a genuine 'market' for long-term care, where informed consumers choose from a range of options. Provision within communities may initially have been driven by local demand, but the funding and operation of those services have evolved in unplanned and largely unforeseen ways. In the countries analysed there has been a trend towards consolidation, particularly with for-profit operators, and away from services provided by government or local, non-profit or family-owned, single-facility providers.

Increased public funding and private fees have attracted significant investment, taking advantage of the shifting demographics and ageing population. Private investment has however gravitated towards serving high-income communities and those with the ability to pay significant fees. This leaves many communities lacking sufficient long-term care. The increasing complexity of medical needs and the poor integration of long-term care with public health services has made it more challenging for smaller providers to continue.

Public funding for long-term care operators typically increases when health needs are greater or more acute. Private providers are therefore not incentivised to spend money on rehabilitation and recuperation or indeed prevention: poorer health outcomes lead to, or sustain, higher funding. For example, more funding is generally provided for residents using a wheelchair or other supports. Encouraging residents to walk and exercise when possible is generally better for their health and wellbeing but rehabilitation consumes staff resources and potentially reduces funding. There are similar perverse incentives towards extensive use of pharmaceuticals, as over-medicating or sedating residents may reduce the staff

requirement while attracting greater funding.

Private operators tend in turn to create negative ‘externalities’ for public health systems. For example, the bed sores which are frequently a result of understaffing in long-term care often impose costs on acute healthcare outside the nursing home. Public funding can thus allow profits to be maximised, even at the expense of positive health outcomes and increased costs to health and social care overall.

With the increasing presence of larger for-profit operators, complex corporate structures have evolved which allow rents to be extracted from public funds. This frequently involves a separation between an operating company and a property company. In this OpCo/PropCo model, the operating company runs at a loss or with low margins, which justifies low staffing, low pay and demands for greater public funding and/or higher private fees. Simultaneously, the property company—generally with less regulation and lower requirements for transparency—makes significant profits from lease or rental payments from the operating company. In Australia, a similar model exists with large non-profits, where public funding for care is diverted to property and business expansion rather than provision.

Another device is to charge operating companies for other medical or non-medical services provided by related parties in the same corporate structure. These can be debt or mortgage payments related to property costs or the financing of acquisitions. They may also be management fees or fees for ancillary services, including prescriptions, physiotherapy and other specialised services, catering, laundry or other centralised purchases.

This extraction of profits by private operators is a drain on public funds. Conversely, without tighter regulation and transparency obligations increased funding is likely to be siphoned off as profit, rather than improving the quality of services through higher staffing and better pay and conditions attracting and maintaining a qualified, caring and motivated workforce.

While these problems of low-quality care and profit extraction have been reported and recognised for decades in many markets, substantive changes have generally not followed. Indeed as for-profit operators have become increasingly dominant, so has their ability to capture regulators and lobby against meaningful reforms. Private operators have generally been able to resist or impede reforms to ensure public funds are spent to enhance the quality of care rather than enriching private interests.

There are however some recent positive indications that reforms could finally be imminent in several countries and that the trend towards a greater role for private providers could be waning. The devastating impact of the pandemic in for-profit care facilities dramatically exposed the underlying structural conditions across the sector. This raised awareness should be a catalyst for overdue reforms.

Unsurprisingly, in countries around the world public-sector facilities tended to manage the pandemic far better, with dramatically fewer preventable deaths. As public investment increases to address ageing populations, the failures of market approaches to providing long-term care must be acknowledged and inform future funding and planning decisions. The structural issues of excessive workloads, low pay and lack of training and career-advancement opportunities in the sector must be addressed to improve the quality of care.

Country case studies: United States

Private operators in long-term care and the influx of investment capital appear to have a longer history in the United States than in other 'markets'. In many cases, the US approach—and investment capital—has however been exported. Welltower, the third largest publicly traded Real Estate Investment Trust (REIT) in the US and the largest investor in long-term care and healthcare properties, has expanded into the Canadian and British markets. Formation Capital and Safanad, private-equity investors and long-term partners with a long record in the US, took over HC-One, the largest care-home operator in the United Kingdom.[1]

Formation Capital and its founders, including Arnold Whitman, have been at the heart of the US long-term care industry and have made a killing:

> The script, written by Arnold Whitman, is familiar: facilities saddled with debt, short-staffed and underpaid workers, residents left to rot, a lack of preparedness that looms large in a pandemic. Much of the tumult seen today is a by-product of the slash-and-burn strategy practiced by Formation and its imitators.[2]

While operators cry poverty and residents and staff suffer, Formation and other investors have extracted significant profits from US nursing homes and are rarely, if ever, held accountable. Consulate Health Care provides a recent and stark example. This long-term care company, which was controlled by Formation Capital, is the sixth largest nursing-home chain in the US and the largest in Florida. In 2020, it faced a quarter-billion-dollar judgment after being found to have 'systematically defrauded the government'.[3] Due to the complex corporate ownership structures, this record judgment against the chain is unlikely to have any direct financial impact on Formation or its investors. Consulate was alleged to have used 'a network of related businesses to shift assets and make a profit for their owners and investors', while nursing homes were 'designed to appear cash-strapped'.[4]

In September 2021, the $256 million judgment against Consulate was settled for a mere $4.5 million after entities in the corporate structure, controlled by Formation Capital, filed for bankruptcy.[5] Charlene Harrington, professor emerita at the University of California in San Francisco and a leading expert on the nursing-home industry, commented that the 'strategy has proven successful in protecting a billion-dollar company from taking even minimal financial and legal responsibility for poor care in its facilities'.[6]

Whitman led Formation Capital's 'growth and execution of over $8.5 billion in transactions' in senior housing and healthcare over the last two decades, according to its website.[7] He is described as a former

board member and chair emeritus of the National Investment Centre for Seniors Housing and Care, as well as a current board member of Genesis Healthcare and other companies and industry bodies.

Genesis Healthcare became the largest nursing-home operator in the US. In 2007, Formation Capital purchased Genesis for $2 billion and took the company private.[8] In 2011, Formation sold the real estate to Welltower's predecessor for $2.4 billion and listed the company in 2015.[9] In March 2021 Genesis, its share price having 'plummeted in recent years', delisted from the New York Stock Exchange.[10] Welltower then announced that to 'de-risk' its portfolio it was 'terminating $880 million in leases for 51 Genesis properties'.[11]

A detailed analysis examining data from 2005 to 2017 has shown that private-equity ownership of nursing homes in the US has had disastrous consequences:

- short-term resident mortality increased by 10 per cent;
- taxpayer funding per patient increased by 11 per cent;
- probability of application of antipsychotic drugs increased by 50 per cent, and
- management fees increased by 7.7 per cent, lease payments by 75 per cent and interest payments by 325 per cent linked to private-equity buyouts.[12]

Another recent study commented that the 'complex business structures used by many nursing home companies can obfuscate ownership' and 'allow owners to reap excessive profits while limiting financial transparency, primarily through use of related party services'.[13] This examination of private-equity ownership concludes that in 'an industry that provides care to some of the most vulnerable communities and receives hundreds of billions of dollars of government money each year, it is critical that private equity cannot be allowed to continue to siphon money out of nursing homes at the expense of patients and health care workers'.[14]

This record of providing low-quality services while extracting significant profits has been the subject of Senate investigations. In 2019, three

senators wrote to four private-equity firms which were major investors in the sector (Carlyle, Formation, Filmore Capital Partners and Warburg Pincus) regarding concerns over 'the declining quality of care in nursing homes'.[15] The letter said US nursing homes had 1.3 million residents in more than 15,000 facilities, of which 70 per cent were for-profit and over half part of large chains. It cited decades of research into links between private-equity ownership and declining quality of care.

In April 2022, BuzzFeed News released a disturbing investigation into BrightSpring Health Services, which owns 600 residential facilities serving people with severe intellectual or developmental disabilities.[16] The company was bought in 2019 by KKR, another large private-equity firm, for $1.3 billion. This prompted the same US senators to write to KKR about concerns that it put profits before patients, resulting in abuse and neglect and putting the lives of patients at risk.[17] The senators continued to articulate 'the long-standing problem of private equity's role in health care—which places short-term profit maximization above considerations for quality of care and patients'.

An August 2022 investigation of a takeover of a non-profit nursing home by a small private-equity firm exposed devasting results for workers, residents and their families.[18] A February 2023 investigation found that over seven years one nursing home had 'paid nearly $16 million in rent to its landlord—a company that was owned by the same investors'.[19] These owners profited to the tune of 'nearly $10 million, while residents injured themselves falling, developed bedsores, missed medications, and stewed in their urine and faeces because of a shortage of aides', according to New York authorities.[20]

These practices are so widespread that in his 2022 State of the Union address the president, Joe Biden, pledged: 'As Wall Street firms take over more nursing homes, quality in those homes has gone down and costs have gone up. That ends on my watch.'[21] Before the speech, the White House issued a fact sheet announcing a range of reforms to protect the elderly in nursing homes.[22] This cited studies on the links

between private-equity ownership and the quality of care, including research which showed that 'despite depriving residents of quality care, private equity-owned nursing homes actually led to an uptick in Medicare costs'.[23]

Biden proposed a gamut of measures to:

- ensure taxpayers' money supported nursing homes to provide safe, adequate and dignified care;
- enhance accountability and oversight;
- increase transparency;
- create pathways to well-paid union jobs, and
- ensure pandemic and emergency preparedness in nursing homes.

Advancing these reforms, in February 2023 the administration announced proposed rules to require greater public disclosure on the ownership and management of nursing-home investments by private-equity and property companies, including payments to related parties or third parties for services within homes.[24] This level of disclosure is essential and should be part of regulations in all jurisdictions. The secretary for health and human services, Xavier Becerra, said everyone knew the pandemic had 'graphically exposed some long-standing systemic challenges in our nation's nursing homes'. He went on: 'One of our greatest concerns is that quality seems to be going down in some nursing homes and the cost seems to be going up.'[25]

United Kingdom

As in the US, in the UK for-profit and private-equity owners have come to dominate residential long-term care and other formerly public social services.[26] Despite the National Health Service, long-term care has been largely separated from the public health system. And while long-term care regulation is organised under a single body in England, public funding comes largely from cash-strapped local authorities and increasingly from private fees.

In the UK, private-equity firms own three of the largest care-home operators and there is limited oversight of financial structures, which reach stunning complexity.[27] As in the US, there are ample examples of private equity taking over operations and

reducing the quality of care and creating artificial losses while shifting profits offshore. Despite a record of failure and collapse, the long-term-care sector is a major and growing business.

Recent studies in the UK have also demonstrated that when investment firms take over care homes there is a significant decline in the quality of care and an emphasis on cutting costs to extract profit.[28] In a recent hearing at Westminster on care homes, Ros Altmann, a Conservative member of the House of Lords, said: 'I don't have a problem with offshore companies that make profits if they offer good services … I do have a problem if those companies are taking advantage of some of the most vulnerable people in our society without oversight, without controls.'[29]

As mentioned, HC-One is the largest care-home operator in the UK. As Covid-19 ravaged its UK care homes, the company demanded and received an additional £18.9 million in government payments while it continued to siphon millions in tax-free profits to the Cayman Islands.[30] HC-One and other large operators wield enormous power and influence over public policy and the lives of thousands of vulnerable people and front-line care workers. HC-One may provide the clearest possible example of the need for greater transparency and accountability across the entire UK care sector. The operator's overseas owners appear to have prioritised extracting profit—underpinned by public funding and private payments from residents—over the care of elderly and vulnerable users.[31]

In 2020, in the midst of the global pandemic while thousands of residents were dying, HC-One's offshore owners managed to pay themselves, via related parties, £4.8 million in dividends, £17.7 million in interest payments and £24.7 million in lease payments and had payments of £162.5 million owed to related parties, primarily due within a year.[32] The HC-One exposé generated substantial media coverage and outrage over poor conditions and high profits with limited regulation and oversight.[33] No significant reforms have however been implemented in the UK care sector, despite overwhelming evidence of the need

for them, as well as greater transparency.

An earlier analysis of three UK care-home chains controlled by a Canadian public pension fund via its ownership of Revera, Canada's second largest operator, found a similar pattern.[34] These 60 homes were much more reliant on fees, yet despite charging residents more than £225 million in 2019 no profits were reported in the UK. The homes were owned via shell companies in the secrecy jurisdictions of Jersey, Guernsey and Luxembourg and rents paid to related parties shifted profits offshore and tax-free. Meanwhile, reports to shareholders in the US REIT Welltower, a joint-venture partner, indicated $84.8 million in net operating income coming from these care homes in 2019. In contrast, the UK operating companies reported combined losses of $12.6 million.[35]

A February 2023 report from CICTAR, Extracting Profits Through Care Home Real Estate: The Billion-Pound Property Speculation Fuelling Britain's Care Crisis, analysed how investment in care-home property pulled substantial profits out of the sector.[36] The report assessed the returns from property investment and development to the private-equity owner of Care UK, one of the top four UK operators.

CICTAR found that under sale-and-leaseback arrangements, including within the same corporate groups, an estimated £1.3 billion of rent per year—£24.8 million a week or £8,000 per bed per year—was being paid to private landlords, with margins as high as 80 per cent. This profit extracted could improve staffing and quality of care, rather than further enriching wealthy investors. The report recommended reforms to require greater transparency on property costs in care homes.

A Guardian editorial covering the CICTAR report complained that in the UK debates about improving social care began and ended with funding: 'Cuts to local authority budgets have squeezed the sector. But providing more funding without addressing the financial gymnastics that underpin many large care companies would be like putting water into a leaky bucket. Rising rents may force care home operators to find

other ways of reducing costs by cutting staffing levels.'[37]

The Guardian noted that in 2021, when the chair of the Commons select committee on health and social care, Jeremy Hunt, had been presented with evidence (from CICTAR's HC-One report) of excessive profit extraction by care homes demanding more funding from cash-strapped local authorities, he had described this as the 'unacceptable face of capitalism'. Hunt was now finance minister and the editorial concluded: 'He is in a position to fix this—and he should do so.'[38]

The UK experience of profit extraction through property ownership and development appears to be a pattern in all markets were private for-profit ownership and operation has become increasingly prevalent. Healthcare and care-home property investment is growing across Europe, with two Belgian REITs reporting substantial margins on European care-home investments.[39] A forthcoming CICTAR report will address the excessive profit margins, which can be 80-90 per cent, of European REITs with growing care-home investments and the possible impact of rent or lease payments on the quality of care.

In the UK, as elsewhere, private for-profit care homes faced a huge increase in preventable deaths due to the Covid-19 pandemic. Some deaths were inevitable but the underlying, pre-existing problems of low staffing and low-quality care dramatically exacerbated the situation. Yet, as identified with HC-One, a recent study found that the UK's biggest care-home chains saw profits jump by an average of 18 per cent during the pandemic.[40]

As a further indication of the profits available from the UK's struggling care homes, in February 2022 the global investment vehicle of the UK's second richest family made its first investment in the sector. Reuben Brothers entered into a joint venture with Welltower to take over Avery Healthcare. David Reuben Jr said that the 'investment in Avery Healthcare will be an exciting addition to our portfolio of real estate and operating companies, as we arrive at the precipice of unprecedented growth of the UK seniors population'.[41]

A CICTAR briefing from July 2022, 'Lifting the lid on offshore care home landlords', found that offshore companies owned 82 of the 706 care homes in England run by one of the four largest operators (HC-One, Four Seasons, Barchester and Care UK).[42] Seventy-five of these offshore companies were based in the secrecy jurisdictions of Jersey or the Isle of Man.[43] Separate from this offshore ownership of care homes, Cindat, a largely Chinese state-owned investment group, owned 64 properties, of which 44 were owned via Jersey and the Cayman Islands.[44]

The New Statesman reported: 'Care home residents and families are paying high fees to companies whose rents may be disappearing offshore rather than staying within the UK economy. This raises questions about who owns our care homes, and how profits from social care could be being siphoned offshore.'[45]

While the need for reforms is widely acknowledged in the UK, little progress has been made. Comments by Labour's shadow health and care secretary last September however provide some cause for optimism.

Ahead of his party's conference, Wes Streeting pledged 'to kick out the financial "sharks" that have taken over the nation's care homes and reverse declining standards at our elderly facilities'.[46] He committed Labour to establishing a National Care Service and would start by 'guaranteeing carers' proper pay and training'. Investors in the sector, he said, were 'able to waste millions of pounds of taxpayer money on tax avoidance and on servicing debt. It's a complete injustice for families who rely on care and we're not going to put up with it.'

Australia

Scandals in Australia's residential 'aged care' sector led the previous government to hold a two-year 'royal commission'.[47] The intensive investigation, following several previous inquiries, exposed a system characterised by widespread 'neglect', the title of the commission's interim report. While there are examples of private-equity and publicly owned nursing-home operators prioritising profits over care, Australia also offers examples of large non-profits following similar models,[48] prioritising property

development, acquisitions and growth over adequate staffing and care.[49]

A report in May 2018 detailed the financial and tax practices of the largest for-profit aged-care companies.[50] At the time, Bupa, a large UK mutual with a significant presence in Britain's care homes, was the largest for-profit operator in Australia. It subsequently reached a settlement worth 157 million Australian dollars with the Australian Taxation Office over prior tax avoidance.[51]

Bupa has faced allegations of poor-quality care and tax avoidance in the UK and Spain as well. A large number of its Australian aged-care facilities have repeatedly failed to meet basic standards, but the global insurance and care giant has continued to operate in Australia and win further government contracts.[52]

Blue Care, controlled by the Uniting Church and the biggest aged-care operator in Queensland, provides an example of a large non-profit. It is part of Uniting Care Queensland, which also runs private hospitals and other services and is the largest private employer in the state. In the 2021 fiscal year, UCQ had total gross income of over $1.7 billion, including $662.3 million in government grants, and held nearly $2.3 billion in assets.[53] Despite increasing revenue and stable operating income from aged-care services, Blue Care has continued to cry poverty, cut staffing levels and demand more government funding to remedy poor-quality care.[54]

Despite already enjoying high government support and not facing any decline in revenue or layoffs due to the pandemic, Blue Care was the largest recipient of the federal government's JobKeeper programme[55] designed to support employers and workers facing associated job losses. In the second year of receiving JobKeeper payments, totalling nearly $160 million, total compensation for key management personnel rose to $7.3 million while front-line workers went on strike seeking wage increases matching inflation.[56]

Tens of millions in payments from UCQ's heavily subsidised operations in Queensland flow to the church itself every year. These included $5.3 million over two years to settle charges for child sexual abuse.[57]

Likewise, Anglicare, controlled by the Anglican diocese of Sydney and one of the largest non-profit aged-care operators in New South Wales, spent millions in aged-care funding on settlements for the church's historic abuse incidents, while cutting staffing and demanding higher government support.[58]

Two recent transactions provide further evidence of the financialisation of large, non-profit aged-care operators in Australia. In 2022, the Little Company of Mary Health Care, a Catholic operator better known as Calvary, paid $380 million to takeover the formerly publicly listed Japara.[59] While Japara's record on care was troubling, its top shareholders made a killing in the sector.

Bolton Clarke is now the largest non-profit aged-care operator in Australia after it paid $700 million to purchase Allity, a private-equity-owned company with a chequered history of care. The non-profit charity also has a $700 million 'development pipeline' and has invested in nursing homes in China among other for-profit subsidiaries.[60]

The New York Times has revealed large US non-profit hospital systems similarly abandoning their missions to game public funding and prioritise profits over patient care.[61] In 2021, the chief executive of one of the largest US non-profit hospital systems told an industry publication that 'nonprofit health care' was 'a misnomer.' Rather, he said: 'It is tax-exempt health care. It still makes profits.'[62]

These examples from Australia and the US make it clear that non-profit healthcare operators are not inherently better than for-profit counterparts. In health systems designed with a market or profit-based approach, industry practices, which put profits over patients, converge.

The previous Australian federal government failed to implement any significant reforms following the two-year royal commission. Before the May 2022 election, however, the opposition made aged-care reform a priority and in government Labor has passed significant legislation. Details on implementation of these reforms were imminent at time of writing.

In February this year the government's Fair Work Commission announced that all aged-care workers would receive an immediate 15 per cent pay rise from the end of June. [63] The commission recognised that the workforce had been historically undervalued, due to gender discrimination, and that the low pay was contributing to staff shortages. The government is expected to fund the increase in full after initially proposing to phase it in over two years.

Labor's key commitments for aged-care reform were to:

- require a registered nurse on site at all aged-care facilities at all times,
- mandate minimum standards for care for every resident per day,
- increase pay for aged-care workers,
- improve food for residents with mandatory nutrition standards and
- ensure federal funding goes to care by requiring operators to report publicly how this money is spent.[64]

Legislation introduced after the change of government aimed to improve transparency in the aged-care system, with 'measures to monitor the costs associated with aged care, placing greater responsibility on providers to be transparent and fair'. [65] The plan aimed to 'stop the rorting [misappropriation] of Home Care fees' and ensure money was directed to users—'not the bottom line of providers'.[66]

While these are a promising effort to address a disturbing situation, it remains to be seen whether the largely privatised Australian aged-care system can be reformed to provide higher standards and better use of government funds. In Victoria—the only state to have a large number (179) of publicly run facilities, with mandated staffing ratios—state-run aged-care homes suffered hardly any deaths during the pandemic, while private for-profit and non-profit facilities had very high death rates.[67]

Canada

As mentioned, the Canadian government's pension plan for federal workers, PSP, directly owns Revera, the second largest care-home operator in Canada with significant investments in the US and UK. Yet the evidence of poor-quality care,

thousands of preventable deaths in Canada and tax avoidance in the UK suggests this public-sector fund behaves like a private-equity firm, not the long-term, responsible investor it claims to be.[68] Unions in Canada, representing both federal workers whose money is invested and frontline care workers, along with healthcare advocates, have been demanding the government make Revera public and take full control of its operations.[69]

In addition, PSP, the Canada Pension Plan Investment Board (CPPIB, the default government pension fund for all Canadians) and the Caisse de dépôt et placement du Québec (CDPQ) are major investors in publicly listed and large private carehome operators in Europe, discussed below.

In May 2022, Canadians for Tax Fairness released a report about the financial practices of the largest forprofit operators in Ontario, including Revera. Despite being government-owned, as a private company the information publicly available on Revera is limited. The other three companies, Chartwell, Extendicare and Sienna, are publicly listed. Chartwell is structured as an REIT. The report estimated that if forprofit facilities had the same lower death rate during the pandemic as municipally owned and operated facilities, more than 1,400 fewer residents would have died in 2020.[70]

The report also estimated that forprofit long-term care corporations had diverted almost four billion Canadian dollars in public funding away from improving care for residents and towards increasing profits over the previous decade.[71] In 2019 alone, it was estimated that $440 million in unrestricted core public funding for long-term care had been diverted to this end.[72] The report said that while corporations 'reap profits from this public funding', very little returned to the public purse. While Revera has a record of using secrecy jurisdictions when it comes to its overseas care-home investments, the three largest publicly listed operators were found to have paid an average effective tax rate of only 4.5 per cent over the last decade.[73]

As in other countries, in Canada publicly owned (municipal) care homes had significantly better

outcomes throughout the pandemic and in maintaining higher quality care standards overall than for-profit counterparts. There are continuing calls to integrate long-term care into the public health system and bring all for-profit care homes back under public control.

France and Europe

The French for-profit care sector has been rocked by scandal and crisis since the publication of Victor Castanet's Les Fossoyeurs (The Gravediggers) in January 2022.[74] The book, based on years of research, exposed a pattern of poor-quality care at Orpea, listed on the Paris stock exchange and the largest care-home operator in Europe. Orpea's largest shareholder, with two board seats and more than 22 per cent of voting rights, was Canada's CPPIB.[75] With a fall in stock value of over 90 per cent and the company on the verge of collapse, a restructuring left a coalition of new investors—led by the Caisse des dépôts et consignations, controlled by the French government—in majority ownership and control of Orpea's board.[76]

The intent of Orpea's new management and investors is to invest more heavily in staff and reduce profit margins from 25 to 20 per cent. Whether this is sufficient to achieve 'an ethical, virtuous and quality business model that meets the major challenges of supporting the fragile people', as claimed by the new chief executive, remains to be seen.[77]

Korian, another French publicly listed European care-home company and the largest in France, has also been rocked by scandals. Leaked internal documents revealed a company strategy to keep spending to under €4.50 per resident per day to maximise profits. PSP, the Canadian pension fund which owns Revera, remains a significant shareholder in Korian.[78] As with Orpea, Canadian workers have taken a huge hit to their retirement savings with their pension-fund investment in Korian, while European care workers and residents have suffered from efforts to extract excessive profit from care.

Quebec's CDPQ has invested alongside EQT Private Equity in Colisée, a private for-profit care home operator which is the fourth largest in Europe. Colisée is headquartered in

Paris and operates more than 270 care homes in France, Belgium, Spain and Italy.[79] The outcome of this investment for the retirement of workers in Quebec and the treatment of care workers and residents across Europe remains to be seen.

A February 2022 report on Orpea, produced by CICTAR in collaboration with the two largest French union federations, confirmed that the corporation's focus on growth, adding a new bed every hour on average in recent years, had been at the expense of quality care.[80] The report found that care-home revenues, based significantly on public funding, had been used 'to finance the debt-fuelled expansion of a vast European property portfolio'. And it went on: 'This portfolio has been purchased and sold through a complex maze of corporate structures from Luxembourg to the British Virgin Islands, largely hidden from the company's own shareholders and the public.'[81] Across Europe, rental payments and debt from acquisitions were pushed down to the facility level, so there was less money to finance adequate staffing and care.[82]

Following CICTAR's report, an exposé by Investigate Europe beginning in May 2022 found that Orpea had relied on a secret Luxembourg company called Lipany, used by several senior managers to cover up lavish commission payments.[83] Lipany's parallel holding and its network of more than 40 subsidiaries had been used for over a decade to shift millions of euro for the personal benefit of key Orpea executives, involving dozens of Orpea care homes across Europe.[84]

The new chief executive said the new management team had taken 'an active approach to transparency, particularly financial transparency'. He recognised that the 'malfeasance and ethical misconduct, combined with the excessive real estate and international development undertaken by the previous management team', had 'seriously affected' the company's financial situation.[85]

Unfortunately, the situation with Orpea—although egregious—is common in the operations of for-profit care-home operators across Europe and around the world. While Orpea's global expansion may have been halted, other public and private

for-profit care operators continue to expand into Latin America and China. A forthcoming CICTAR report will critically examine the growing role of REITs in owning care homes across Europe and whether profit margins above 80 per cent are taking crucial funding away from staffing and quality care.

In recognition of the problems in private care across Europe, the European Commission has proposed a Council of the EU recommendation on long-term care in which it stresses the need for a regulatory framework.[86] While the draft recommendation would not put any limits on profit-making, it does call for stricter controls and quality mechanisms to prevent abuse of public funds. The crucial question remains as to whether investor expectations of high returns can be aligned with the needs of care-home residents and workers to improve quality of care and reverse the declining standards associated with private investment.

Conclusions

The growing trend towards a greater role for for-profit operators within publicly funded long-term care must be reversed. Where for-profit operators already have a significant share of the market there is an urgent need for stronger and more independent regulation and far greater transparency and accountability. Over time options for returning long-term care to the public sector should be considered. As public investments will increase to care for ageing populations, there is a strong case for direct public provision to reduce overall costs and improve quality.

Regardless of public or private operation, there must be a stronger union presence in long-term care. Workers need to able to stand up for their rights and protect their ability as front-line workers to provide high-quality care and dignity to elderly residents. Without union protection workers are likely to be fired, have hours reduced or face other forms of retribution from employers for reporting problems and failures to provide quality care. Higher staffing, an appropriate training and skill mix and maintaining continuing relationships with residents are the most important factors to improve care. Increasing and protecting the

ability of workers to speak out on these issues will lead to significant enhancements.

Care facilities also need to be rendered accountable to residents, family members and local communities. All care homes must be required to implement meaningful and regular consultation with community oversight. Communities should have input into, and a voice in approving, changes in ownership and/or management of care homes.

As demand grows with an ageing population, expansion of in-home care should also be considered, as both desirable and associated with lower costs. But this must not follow the for-profit residential-care path, rather being maintained as a public service. The US provides interesting models of in-home care through public authorities, at county or state level, where those receiving services have the ability to hire and fire carers but these are employed through a public authority which maintains standards and conditions.[87] Washington state, where a branch of the Service Employees International Union represents more than 45,000 long-term-care workers, may provide one of the best examples.[88]

Allowing private operators to extract profits from long-term care is an inefficient use of public funding and has not produced desirable results. It has benefited investors at the expense of residents, workers and public-sector budgets.

This global trend must be reversed to improve outcomes and ensure that public monies are spent as intended—and that care meets community expectations and upholds the human rights and dignity of the elderly and front-line care workers. There is meanwhile a generational opportunity to turn around the legacy of gender discrimination in a predominately female workforce and transform the growing sector into one with millions of new rewarding jobs with long-term career prospects.

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