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Long-term care: from public responsibility to private good

Abstract
The neo-liberal assault on the welfare state has not always been direct. The acknowledged popularity of the UK NHS has resulted in governments using covert means to undermine its core principles, namely universality and equity. Long-term care with its vulnerable client base is an important example of how care has become a private responsibility with little or no debate or discussion. Using the social security regulations, the Conservative government of the early 1980s pump-primed with public funds the massive expansion of private nursing and residential care, to the extent that the past 20 years has witnessed the evolution of a significant new economic market sector. This article charts the trajectory and structure of the market in long-term care provision, from its 'cottage industry' beginnings to increasing dominance by generic, often publicly-quoted multinational corporations. It shows how the privatization of funding was accompanied by transferring responsibility for payment of care from central government to local authorities in 1993, and how the introduction of eligibility criteria and the shrinking of public provision has made care a private and personal responsibility. Government is now encouraging companies to diversify into higher-cost specialist areas such as diagnostics, acute psychiatric care and acute hospital and intermediate care, with long-term care increasingly seen as a lower profit 'core' industrial package predicated on basic services and casualized, low wage labour. The commodification of the care process is now being extended to other parts of the NHS and has serious implications for the health and well-being of the whole population and not just for the most frail and vulnerable.

Key words: decentralization, long-term care, markets, means-testing and charging, privatization

Introduction

Long-term care for frail elderly people, the chronically ill and the physically and mentally disabled has been almost completely eliminated from NHS and local authority provision. It is now largely under the control of the for-profit private sector. It is also generally appreciated that this radical change in the way a large and growing proportion of society's most vulnerable and dependent members are treated belongs to a wider, transnational drive, strongly endorsed by the World Bank, the OECD and other agencies, to 'downsize' state services of all kinds and to open them up to the operation of the markets (Price et al., 1999). Less well understood, however, is the specific process by which this has been achieved, the character of the new long-term care market and industry that has emerged as a result. Also less understood are the implications both for long-term care and for the possible privatization of further parts of the NHS.

This article describes the way long-term care was made into a market sector and the features and dynamics of the long-term care industry, including the emerging impact on it of global forces. It concludes by examining what such developments imply for the 477,000 people currently in long-term care in the UK (Laing and Buisson, 2000), and asks what light the story of the privatization of long-term care sheds on the conditions for privatizing other parts of the public sector that are vital to people's well-being and the subjecting of those services to the logic of profitability.

Given the entrenched public nature and general popularity of health care provision in the UK, its penetration and erosion has been necessarily ad hoc and fragmented. It was most easily begun in the long-term care sector where the last 20 years has witnessed the emergence of a significant new economic sector—with generic companies aimed explicitly at nursing and residential care, increasingly in purpose-built accommodation, followed by corporate consolidation and acquisition, flotation on the stock exchange, diversification into specialist niche markets (particularly the broad range of psychiatric care) and the adoption of US health care practices that separate commercial ownership from commercial operation through sale and leaseback arrangements.

Community care—a symbolic consensus

From 1946 to 1979 responsibility for funding and providing long-term care was shared by two public sector agencies. The NHS, funded through central taxation, provided care in long-stay and day hospitals and through domiciliary community health services, while local authorities, funded through central and local taxation, provided, through their social services departments, residential care and community-based home care services such as home helps and meals on wheels. All services provided by the NHS were free at the point of delivery but local authorities had discretionary powers to charge for services and means-test their users. Until the 1980s few chose to do so (Pollock, 1995; Macfarlane and Pollock, 1998).

Within this general framework, however, long-term care and community care have long been areas of rhetorical flourish, conceptual uncertainty and inconsistent resource allocation. Politicians, from the outset sensitive to the unpopularity of the image of 'water towers and chimney stacks' associated with asylums and institutional care, used the term 'community care' so frequently in the period 1948 to 1979 that in the public imagination it was thought of as having already been achieved (Walker, 1997). But in reality huge public resources remained committed to the public perpetuation of residential care, including substantial capital investment in buildings. The presence of a powerful residential care lobby, the symbolic importance of institutions and an ongoing concern regarding hospital costs, all added to an inflexibility of approach (Bernard and Phillips, 1998). Indeed, the major 1962 report *Health and Welfare* revealed that local authority preparations for expansion of community care were non-existent (Ministry of Health, 1963: 46). Rather, their plans showed that staff numbers in residential institutions were due to increase at nearly twice the rate of home helps between 1962 and 1972.

> Subsequent official statements and policies similarly failed to provide any sustained attempt to define and measure the need for community care, nor did they set policy goals and then relate those goals to the scale of need and the allocation of resources. In other words there was a complete lack of planning for the development of community care services.
>
> (Walker, 1997: 180)

Yet the very lack of conceptual, statutory and financial substance attaching to the idea of 'care in the community' helped to sustain a symbolic consensus in this area, while sufficient resources were never transferred from institutional to community care to enable any of the political promises to be achieved. Residential care continued to consume the bulk of local authority personal social service (PSS) budgets over the whole of the period. But by remaining largely in the realm of symbolism the consensus was vulnerable to attack, a vulnerability compounded by the politically weak position of the elderly, the mentally infirm and the physically disabled.

The privatization of long-term care

The general popularity of the NHS posed a problem for the Conservative project of privatizing this element of the public sector, but the weakness of the position of long-term care offered an opening solution. Early notification of a radical break with the past was given in 1979 in the government's first White Paper on public expenditure, which saw 'the ending of protected status for personal social services spending, the abandonment of the coordination and monitoring of local service provision, and increasing reliance on non-statutory forms of welfare' (Walker, 1997: 182).

As a result, NHS funding for long-term care was cut and a dramatic programme of 'bed closures' for long-term care was undertaken, while local authority bed provision stopped expanding. Since 1979, nearly 300,000 NHS beds in England have closed, including acute, mental illness and geriatric beds, and beds for people with learning disabilities (Department of Health, 1998).

Simultaneously, public expenditure was re-routed away from direct provision to private sector providers through the social security budget. Paradoxically, the voluntary sector played a significant role. Finding its main source of income from cash-strapped local authorities dwindling (in 1974 local authorities paid for almost 60 percent of voluntary sector residents in England; by 1983 the figure was 34 percent; Laing and Buisson, 1988: 21), voluntary organizations started to look for alternative sources of money. They found it in the social security system. In response to pressure orchestrated by voluntary associations, local DSS offices started to pay (the then) supplementary benefits to people who were unable to pay their own fees, and

for whom local authorities were unwilling to foot the bill. The practice became so widespread that policy was formalized in 1983, when in effect the government set up a voucher system for public funding of private and voluntary care homes, i.e. people could choose—or have chosen for them—private nursing or residential care, and have the fees paid from the government's social security budget. Although voluntary organizations initiated the campaign for new sources of public funding, 'the principal beneficiaries have been private providers, and there is no doubt that the availability of supplementary benefits fueled the rapid expansion of private residential care' (Laing and Buisson, 1988: 22).

The option to claim supplementary benefit (later called Income Support) was not available to residents in local authority Part III homes or NHS institutions, or for community services delivered to people in their own homes. This led local and health authorities to encourage people to opt for private care subsidized by the social security budget (Tinker et al., 1994; Pollock, 1995). In 1979 there were some 11,000 recipients of Income Support in private and voluntary nursing and residential homes at an annual cost of £10m. By February 1993, immediately prior to the implementation of the 1990 NHS and Community Care Act, the number of recipients had reached 281,200 at an annual cost to the DSS of £2.6bn (Laing and Buisson, 1994) (see Table 1). When the act was formally implemented in April 1993 those receiving such payments continued to be entitled to them under 'preserved right' status.

The for-profit private sector rapidly moved into a dominant market position (Tables 2 and 3; Figure 1). In 1979 the independent sector—both for-profit and voluntary—had 33 percent of the long-

Table 1 Comparison of payments for long-term care in 1979, 1991 and 1999

	Numbers	*Average payments/week* £	*Annualized expenditure* £(m)
1979	11,000	18	10
1991	231,000	156	1872
1999	477,000	347	8600

Source: Laing and Buisson, 1999.

Table 2 Market value by sector (£m) 1988–2000

	Private sector			*Voluntary sector*			*Public sector*			*All*
	Res.	*Nurse*	*All*	*Res.*	*Nurse*	*All*	*Res.*	*Nurse*	*All*	
1988	971	763	1734	326	107	433	976	1368	2344	4511
1992	1664	2274	3939	459	205	659	1104	1505	2609	7207
1996	1968	3077	5044	701	295	996	1130	1250	2380	8420
1998	2103	3219	5322	715	341	1057	963	1092	2054	8433
2000	2347	3248	5597	764	367	1131	890	997	1886	8614

Source: Laing and Buisson, 2000.

Table 3 1998 Long-term care market

	Places	*£(m)*
Private sector	371,000	5597
Voluntary sector	73,000	1131
Public sector	93,400	1886
NHS long-stay geriatric	20,400	594
NHS elderly mentally ill	12,300	358
NHS younger physically disabled	1500	44
Local authority elderly/younger physically disabled	59,200	890
Total	538,300	8614

Source: Laing and Buisson, 2000.

term care market. Of places in residential care homes, 16 percent were in the for-profit sector, with 20 percent in the voluntary sector. Nursing home figures did not differentiate between for-profit and voluntary sectors until 1987. However, voluntary and for-profit nursing home places only accounted for 19.8 percent of total long-term care places in 1979 (Laing and Buisson, 1991). By April 2000 (the most recent date for which figures are available), of the 538,300 places available for long-term care of the elderly and physically disabled across all sectors, 371,000 (69 percent) were in the for-profit sector, with 73,000 (14 percent) in the voluntary not-for-profit sector.

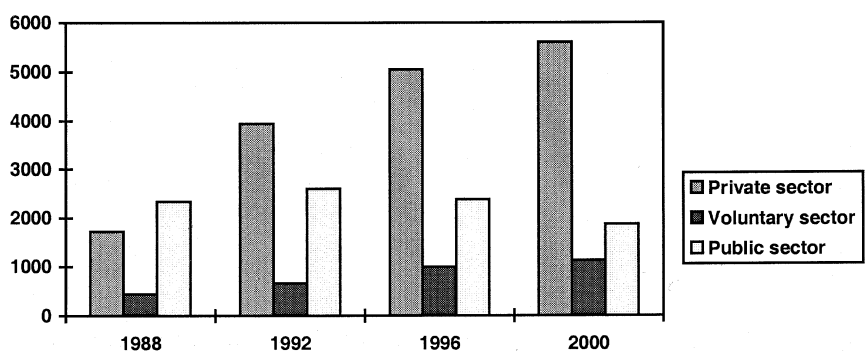

Figure 1 Market value by sector (£m) 1988–2000

Only 93,400 (17 percent) remained in the public sector (Laing and Buisson, 2000).

In April 2000 the private sector accounted for £5.6bn out of a total of £8.6bn spent on long-term care. On the other hand, the vast majority of private sector care recipients—70 percent—are state financed: 53 percent are local authority funded, 11.5 percent receive Income Support under 'preserved rights' and 5 percent are NHS funded (Laing and Buisson, 2000). The remaining 30 percent of private care recipients find the costs of care from private funds, from third party top-ups, usually from relatives, or from the sale of assets, most commonly their homes.

The structure of the private sector market

In 1983 a host of new entrants came into the long-term care marketplace. By 1987, six main categories of individual and corporate provider could be identified: (1) traditional owner/managers—either new entrants with training in a caring profession, predominantly nursing, or those involved in a career change (usually as a result of redundancy, early retirement, etc.); (2) colonizer chains—over time some of these cottage industries were transformed into 'colonizer chains' by business people seeking new areas of investment. Such ventures included 'new start-ups' backed by the government-subsidized Business Expansion Scheme (BES). An example of this is Takare which for a period was the largest care home market operator; (3) hotel and leisure interests—companies with subsidiaries in gambling and brewing, such as Stakis and Boddington; (4) construction and property groups such as McCartney Stone; (5) private for-profit health care groups including UK and US corporations such as Community Hospitals and Westminster Health Care (initially a subsidiary of the US healthcare corporation NME); (6) private not-for-profit health care groups including BUPA, Nuffield Hospitals and GM Healthcare.

From the first, industry analysts saw the last two categories of corporate providers as representing 'an entirely different class of proprietor with potential for generating fundamental market changes' (Laing and Buisson, 1985: 6). Such companies, with their extensive financial and management resources, could enter into the care home market on a regional or national scale and, with their well-developed managing, marketing and training skills, could develop 'facility chains'

with a corporate reputation for quality and consistency. Their potential for innovative marketing, combined with considerable investment reserves, would also allow them to take a longer-term view so that they could respond to, and indeed determine, market developments.

By 1993 many of these advantages had begun to be consolidated, with linked trends toward specialization and toward flotation of generic long-term care providers on the stock exchange (Laing and Buisson, 1994), while the big public companies with leisure and property interests that had initially staked a place in the industry withdrew (including Kunick, Stakis and Buckingham International). The new corporate providers started to develop large, purpose-built accommodation aimed particularly at the more lucrative nursing home (as opposed to purely residential home) market. The industry had become clearly defined, so that care home operation was now the core business of all quoted long-term care companies.

1993—The end of the gravy train?

The 1990 NHS and Community Care Act, implemented in April 1993, capped the social security budget by devolving responsibility for funding long-term care from central government to local authorities. It also required local authorities to assess needs and financial eligibility for long-stay residential and nursing home care. Local authorities continue to have discretionary powers to impose charges on community-based and residential services for individuals with assets in excess of £16,000.

To 'ease' the transition from central government to local authority funding (and to soften the potential impact on the private providers), the government introduced a Special Transition Grant (STG) for local authorities in addition to the allocations for Personal Social Services (PSS) in their normal Block Grants. The STG was a grant ring-fenced solely for spending on community care, but 85 percent of this money had to be spent on private sector providers, effectively preventing local authorities from reverting to providing long-term care directly in-house, and making alternative provision in the community virtually impossible. Although the Labour government, elected in 1997, abandoned the 85 percent rule for the financial year 1998/99, by this time its task had been accomplished. 'Contracting out is now sufficiently well established in local authority culture and procedures

not to need protection through budgetary ring fencing' (Laing and Buisson, 1998: 104).

Financial support for private sector long-term care after 1993 also came in the form of a means-tested Residential Care Allowance from the DSS, based on the rental value of sheltered housing in place of housing benefit which low-income claimants would be entitled to; residents in local authority Part III homes cannot claim this benefit. Local authorities can then recoup this allowance from the resident—currently £61.30 and £68.20 in London—as well as his or her state pension minus their personal allowance (Edwards and Kenny, 1997). In a climate of public sector financial austerity this arrangement acts as a very strong additional incentive to place people in private care. It also acts as a disincentive to implementing 'packages' of *non*-residential care (Kenny and Edwards, 1996), which might often be considerably cheaper as well as strongly preferred by the people concerned.

However by 1998 the impact of the switch to limited local authority funding had begun to be felt. While the STG increased government funding on social services by 63 percent overall for the five years from 1992/3 to 1997/8, during this same period the basic component of central government grants to local authorities attributable to PSS, excluding the STG, increased by only 8.5 percent in cash terms (Edwards and Kenny, 1997). Taking inflation into account, the real value of PSS SSAs has actually decreased by over 6 percent annually in spite of increasing demand. Since 1993 local authorities in England have taken on the support of an extra 111,500 people in care homes (Edwards and Kenny, 1997), 17 percent higher than the previous year. By 1996 the number of residents supported in residential and nursing homes represented 25 per thousand population aged 65 and over.

One consequence has been the tightening of eligibility criteria for access to, particularly, nursing home care, and increased rationing of services targeted at those at greatest risk, with accessibility to continuing care services often dependent on where people live rather than on defined needs. An increasing number of local authorities have moved away from 'flat' fees based on national DSS rates, setting up their own rates and 'dependency bands' in accordance with local market conditions (*Community Care Market News {CCMN}*, July 1998). There is also growing realization that as the elderly are the largest user group of both health and local authority services, they are

bearing the brunt of the changes and restrictions in service delivery (Edwards and Kenny, 1997). For many the growing practice of inappropriate discharge into nursing homes represents a 'form of abuse' (quoted in Edwards and Kenny, 1997: 7), with the bulk of placements chosen largely as a result of the ready availability and/or oversupply of care homes.

The market response to policy changes

Many analysts have viewed the change of statutory responsibility from central to local government as a serious threat to the viability of this new long-term care market, citing reduced company profit margins, depressed occupancy rates and the capping by local authorities of fee levels (see Table 4).

Certainly by the late 1990s the rate of new registrations fell sharply from 440 in 1996 to 181 in 1999, mainly in nursing homes. Only 39 new nursing homes were registered for the first time in 1999 compared with 85 in 1998 and 126 in 1997 and the peak of 618 in 1989/90 (Laing and Buisson, 1999). Much of this reduction took place within the for-profit 'major provider' sector (i.e. companies with three or more homes) which accounted for only 29 percent of newly registered bed capacity in 1999, compared with 33 percent the previous year and 39 percent in 1997—a drop from 7840 in 1996 to 1857 new beds in 1999 (Laing and Buisson, 2000). However the drop in nursing home registration has been almost exactly offset by a sharp acceleration in the trend towards 'dual registration' of care homes, i.e. homes registered as both nursing and residential care homes—with a 79 percent increase in for-profit dual registered homes witnessed in the years 1997–9, bringing the total to 1900 homes with 89,000 places by the end of 1999 (Laing and Buisson, 2000). The impetus for this has been that with tightened eligibility criteria for nursing care, dual registration allows operators at least to gain access to the much larger pool of local authority residential care placements.

A rising trend in closure rates can also be identified, with 215 nursing homes closing in 1999 and 141 the previous year, compared with 41 in 1993. Indeed, by 1998 the attrition rate for nursing homes was greater than that of residential homes—the first time this has

Table 4 Margins as a percentage of operating revenue by sector providers 1997–99

Care providers	*Other operating costs %*			*Operating profit %*			*Profit before tax %*		
	1997	*1998*	*1999*	*1997*	*1998*	*1999*	*1997*	*1998*	*1999*
Publicly quoted or subsidiary of publicly quoted	24.6	20.6	20.7	21.3	23.2	19.7	39.8	7.8	9.7
Subsidiary of non UK owned company	12.8	13.5	18.1	39.7	34.7	29.0	46.8	6.7	−54.0
Private company	21.9	23.2	23.8	22.6	21.6	20.2	6.4	6.8	0.8
Provident association subsidiary	16.6	23.4	26.5	30.6	23.5	14.8	−2.8	7.0	2.4
Charity	11.7	10.2	12.7	3.5	3.2	3.5	4.7	5.9	4.0
Care providers total	16.5	17.6	19.5	12.9	14.2	12.2	7.0	6.5	2.7

Source: Fitzhugh, 2000–01.

occurred since Laing and Buisson began collecting data on the sector (Laing and Buisson, 2000). Contributory factors include the willingness and need of the 'cottage industry' individual owner/manager to survive, in spite of lower margins; the reluctance of lenders to foreclose on bad loans; and the fact that the capital value of a nursing home is typically still greatly in excess of the property's value in alternative forms of use (Laing and Buisson, 1999).

In effect, by the late 1990s the long-term care industry was restructuring following its initial government-driven expansion. In the process, several tendencies characteristic of any comparable market could be observed.

Consolidation and acquisition

The number of for-profit major providers fell from 295 in 1996 to 285 by 1998, with quoted companies falling from 11 to six in the same period. By July 1999 with the sales of Westminster Health Care (see later) to Canterbury Healthcare, and CrestaCare to the privately-owned Carat Secre, this latter figure had dropped to four. As already noted, with the exit of quoted brewing, hotel and property interests in 1997, care home operation is now the core business of all the quoted companies except for Regency Care Homes.

Other major acquisitions also took place throughout the period 1997 to 1999. The most prominent was the purchase by BUPA of Goldsborough Healthcare, Community Hospitals and then the Care First group. Care First had itself been formed in 1996 by a merger between Court Cavendish and Takare, the latter being then the largest operator in the sector. Exceler Healthcare, a subsidiary of the US-owned Sun Healthcare Group, bought out Apta Healthcare and Ashbourne and formed a group which has continued to trade under the Ashbourne name (MSI Databrief, 1999). Craegmoor and the Highfield Group also expanded their portfolios to in excess of 3000 beds, the latter buying 38 homes from the Vaux Group, the last of the brewing interests in the long-term care sector (see Tables 5 and 6).

The market share of for-profit major providers in nursing home places grew in 1999 (43.3 percent) after a slight fall in 1997 (36.9 percent). Newly registered nursing homes are typically larger than average, due to major operator activities where the 60 new registrations

Table 5 The top 10 major companies by the number of beds operated (*CCMN*, December/January 2001)

Company	*No. of homes*	*No. of beds*
BUPA	232	16,574
Ashbourne	145	8326
Idun Healthcare	120	6231
Westminster Health Care	91	5897
Four Seasons Healthcare	113	5780
Craegmoor	181	4696
Southern Cross	70	4117
Highfield Group	69	3600
ANS	46	3164
Ultima Holdings	61	3144

averaged 55 beds in 1997, compared with a 30-bed average for operators not classified as major. Nursing home closures are also concentrated among homes at the lower end of the market (Laing and Buisson, 2000).

Integration

The financial pressures of reduced real local authority fee levels have pushed corporate providers in two directions—some towards larger, integrated healthcare groups, others to major investment funds which 'break them up' into their constituent parts (Taylor, 1997). BUPA leads the integrationist camp, building the UK's largest nursing home business to complement its medical insurance and hospital activities. A similar direction has been taken by companies like Care UK and Craegmoor through focusing on more lucrative specialist areas such as intensive care and head injury units, homes for people with acute psychiatric needs or challenging behaviour, and young people with dementia. For example a recent report on one provider, Tamaris, indicated that;

Table 6 The top 10 long-term care providers ranked by 1999 operating profit

Rank	*LTC Provider*	*Category*	*1998 (£000)*	*1999 (£000)*
1	Westminster Health Care	2	32,184	31,654
2	Care First Health Care	4	35,892	28,491
3	Anchor Trust	5	18,570	18,966
4	ANS	2	8239	9882
5	Care UK	1	8787	9792
6	BUPA Nursing Homes	4	15,297	5888
7	Care First Care Homes	4	7709	4375
8	Trinity Care	1	3058	3960
9	B&M Care Group	2	3130	2850
10	Barchester Health Care	2	1812	2806

Categories: (1) Publicly quoted company; (2) Private company; (3) Subsidiary of non-UK-owned company; (4) Provident association subsidiary; (5) Charity/not-for-profit
Source: Fitzhugh, 2000/01).

> [A]t the year end including new developments, occupancy rates in these purchased Quality Care Homes, had risen more than 3 percent and the improvement had continued into the current year to around 86 percent. What is more the revenue base has also benefited from a change in the product mix. In several homes, recognition of local funding difficulties and over supply has also led to a change of product and enlargement of the catchment areas of homes. For example one home is now catering for persons with alcohol problems and another has reopened this month for persons with learning difficulties.
>
> (*CCMN*, June 1998: 57)

In 1998 fees for intensive care units are as high as £495 per day and for head injury clients over £400 per day. 24-hour nursed care is typically costed at between £750 and £975 per week (*CCMN*, March 1998; *Healthcare Market News*, February 1998). Such niche marketing, it should be noted, represents a potent trend of creeping privatization of the hitherto sacrosanct 'core' of 'clinical' NHS and local authority provision. It also demonstrates the ability of major companies to pursue continuous improvements in methods, products and service delivery

systems, becoming increasingly adept at responding to, and influencing, fluctuations in market demand.

Sale and leaseback

The care home business has been characterized as a cross between a property investment and a specialized service (Laing and Buisson, 1995). Direct investment finance for large-scale commercial property is highly particularized, long-term and reliant on regular rental reviews and capital appreciation of land values. Large lot sizes, illiquidity and high transaction and management costs deter many investors seeking short-term returns (Ball et al., 1998). Similarly, capital investment can be overly tied up in owning the 'bricks and mortar' rather than in actual operation of the care services themselves.

To circumvent this the sector has begun to adopt sale and leaseback strategies pioneered in the US which effectively separate ownership and operation. A care home company can now sell its properties to a specialized investment fund/property company which then leases back the property to the care home company. For the vendor immediate capital is freed for further acquisitions and/or payment of debt, while, for the purchaser, prime assets are acquired which by definition provide a good covenant, the term of investment is long thereby reducing exposure to early repayment, and the rate of return after amortization is normally relatively high. The attraction to bondholders is that revenue streams from care home rentals can be structured in such a way as to offer a very safe investment 'guaranteed' or underwritten by government funding (Laing and Buisson, 1998). Such moves have also increasingly allowed the use of indirect property investment vehicles such as securitized debt to finance care home development, and the introduction of specialized Real Estate Investment Trusts (REITs) which provide investors with low entry cost access to the property market.

The development of such facilities is reflected in the surge of growth in the care home investment fund sector. The quoted company, Nursing Home Properties (NHP), which specializes in the purchase of long-leasehold interests in purpose-built care homes, invested some £200m in buying 106 care homes (with 5584 beds) in the yearly period to September 1998 (*CCMN*, December/January 1999). By March 2000 the group's investment amounted to £667m in 378 homes, incorporating 18,918 beds, and leased to 25 tenants

(*CCMN*, July 2000). Hamilton Finance, which manages funds for MEPC (the UK's third largest property group) and the United Bank of Kuwait, re-entered the market in January 1998 with at least £100m of new money to be placed on behalf of property investors; Principal Healthcare, a subsidiary of the US REIT Omega Investors Inc., raised £150m through the Eurosterling market to refinance its bank borrowings (*CCMN*, December/January 1998); while Westminster Healthcare has entered into partnership with a US REIT, Holiday Retirement Corporation and Bankers Trust, in a new vehicle called Atlantic Healthcare Finance which intends to build up a £200m care home portfolio in the UK over the next three years.

Richard Ellert, Chief Executive of NHP, considers that the UK care home sale and leaseback market is fast becoming an established property investment sector in its own right, growing at an estimated £300m per annum (Ellert, 1998), and since 1995 nearly 25 percent of all purpose-built care home beds have been financed by sale and leaseback. The operational side of the equation has been taken up by companies such as Southern Cross, Trinity Care and Tamaris. Tamaris, for example, in the yearly period to March 1998 revealed an 87 percent increase in turnover, reflecting the expansion of its portfolio from 2004 to 5339 beds and a 100 percent increase in home operating profit (*CCMN*, June 1998).[1]

An illustration of the trends: Westminster Health Care

Westminster Health Care (WHC) illustrates these trends. It has increased its market share by diversifying into higher value services such as learning disabilities, medium secure units for mentally ill offenders and a diagnostics division providing specialist radiology services. It has also set up a REIT with Atlantic Healthcare Finance, a US REIT with a US$800m capitalization value, with the aim of penetrating the sale and leaseback market in the UK. Its purchase and sale of several properties has also now meant that the proportion of single rooms with en suite facilities in its portfolio has risen to more than 90 percent, more than twice the industry average. Occupancy rates within its nursing home sector remain high at 91 percent, although a squeeze on its profit margins has been felt due to a shortage of highly trained permanent staff as increasing numbers leave the sector through poor pay and terms of employment, and hence a

greater reliance on more expensive agency staff (*CCMN*, August/September, 1998). Nursing homes themselves represent a decreasing proportion of the group's turnover and operating profit, being 72 percent and 69 percent respectively last year compared with 80 percent and 79 percent in 1996/7 (*CCMN*, August/September 1998), and the trend is expected to continue. Moreover, local authority 'only' funded clients comprise less than one-third of average levels, with the self-pay ratio up from 25 percent to 35 percent. This functional flexibility of the company accounts for its continuing ability to sustain high levels of growth.

Implications for care

Townsend (1964) launched a fierce critique of long-term residential care in this country. He went on to consider the effect on the elderly of other social constructs including retirement policies, the legitimation of low income through state pensions and the custodial and impersonal forms of institutional and residential care (Townsend, 1981). The forms of dependency engendered by these constructs appear to have been, it can be argued, sustained, indeed deepened, by the creation of a private market in long-term care over the past two decades. Not only are the elderly faced with public acquiescence and moral and imaginative failure regarding alternative models of care, but the active pursuit of private capital accumulation by and within institutional forms conflates significant aspects of vulnerability for an already dependent group.

It is clear that continuity of care does not sit well with the relatively high rates of home closures, and the management and other changes characteristic of an industry in constant search of new avenues of profitability. The focus alters, with commitment to service a by-product, at best, and subject to constant changes in market capitalization values, share speculation and short-termism. A *CCMN* editorial commented that 'one city analyst with a strong following among institutions thinks all the shares in the care home sector are a strong buy'. Maybe so, since many of them in the next few months will offer short-term trading opportunities, but *CCMN* took the view that 'there are only 2 or 3 [companies] in the sector who have established management credentials for serious medium-term investment' (*CCMN*, December/January 1997). Of the three companies in

the running, Quality Care Homes no longer exists, WHC was sold to Canterbury Health Care, and Care UK placed itself on the market in 1998. There were no takers.

Recipients of care within the private sector increasingly become vectors of market forces, the bearers (or sufferers) of this interplay of demand and supply for a commodified set of services. Niche marketing and the emphasis on subspecialization could mean that the care home sector becomes peripheral if residential fee levels and profitability drop—a poor relation to the more profitable 'sub-acute' specialties, a ponderous but demographically predictable 'mass' underwritten by state subsidy. One of the positive features identified by some local authorities of the shift to corporate provided care was that there was an increased probability of small sub-standard homes being forced out of the market (Kenny, 1997); but the basic care typically provided by such homes is not what the large corporate providers see as 'high value added'. With companies such as CrestaCare increasing their receipt from specialties to almost 60 percent of turnover, the danger is that residential care standards will suffer.

The effect of the National Minimum Wage, the Working Time Directive, and the pressures on costs of qualified staff arising from demographic trends, may also impinge on staff hours per resident that companies are willing to provide. If the US is anything to go by, companies are not slow to adjust. Sun Healthcare Group (SHG), one of the largest US nursing home operators (and the holding company of UK-based Ashbourne Group plc which itself operates 149 homes and 8367 beds nationwide), saw its shares fall more than 60 percent at the beginning of 1999—primarily due to the imposition of tighter reimbursement policies by Medicare, the US government health programme for the elderly, which is attempting to curb excessive charges made by private companies for long-term care. Such companies as SHG and Tenet anticipate reducing operating costs through staff redundancies, reducing time spent with patients and using lower-paid professionals to deliver the care (High Yield Report, 1998). Indeed the company has already fired 7490 employees, including 36 percent of rehabilitation workers (*CCMN*, February 1999). One must assume that Ashbourne homes could be subject to similar 'savings'.

On top of the problems pointed out by Townsend (1981), private care can mean that a sector is expropriated, exploited and then left to

suffer. For example, in the case of Tamaris mentioned earlier, the question must be asked as to what happened to the former residential or nursing home residents after the change of product and enlargement of the catchment areas of the homes.

The profit from core residential and nursing home care depends heavily on the use of casualized, non-union labour, with its corollaries of low wages, minimum guaranteed hours and the absence of sick pay or training opportunities. Indeed in 1996 care home assistants were among the 10 lowest paid occupations in Britain (Garner, 1998), with average rates for care assistants and support staff found to be below £4.00 per hour; three-quarters of those earning below this figure are women (Garner, 1998). A survey of 178 homes by *Pay & Workforce Research* (*PWR*), prior to the introduction of the national minimum wage, found that if the minimum were set at £3.20, 38 percent of homes would be affected as they paid staff less than this. If the level were set at £3.70 'major problems will begin, and many employers will respond by consolidating enhancements and allowances into basic pay rates' (*PWR*, quoted in *CCMN*, August/September 1997: 96). The eventual figure decided on—£3.60 per hour—'could add £90m to the costs of private and voluntary care homes in the UK according to an analysis of wage rates for care assistants and other low paid hourly employees' (*CCMN*, June 1998: 49), and the additional costs are expected to fall most heavily in the North of England where up to two-thirds of unqualified employees are paid below £3.60 per hour. A 1998 Unison survey further revealed the endemic nature of low pay and poor or non-existent employment benefits in the sector. The overwhelming majority, 84 percent, of employers relied on state subsidies to provide sick pay when employees were absent; 35 percent of employers did not pay overtime; while only 6.3 percent offered manual grades a pension scheme (Hall et al., 1998). Such terms necessarily affect the quality and conditions of care, promoting high staff turnover, indifference of care staff towards their employers and resultant ambiguity towards their charges. Similarly, poor pay and inadequate pension provision cannot hope to attract qualified staff, a large and growing number of whom are leaving the sector (*CCMN*, August/September 1998).

Private capital itself can always regroup if profits dwindle below an acceptable level and seek other ways of gaining access to an increasingly perforated NHS. The decision in April 1999 by WHC to sell its

entire share capital to a new company, Canterbury Healthcare, was met with considerable surprise among sector analysts, especially given WHC's ability to outperform the market. *CCMN* asked why the original founders of WHC, Pat Carter and Martin Bradford, decided to leave the sector:

> The reality is that their sale was not planned, and they probably thought that if a bid did come, they themselves would swiftly move to make a rival bid in a form that would be described as a management buyout. What has actually now occurred is the price that was put on the table has persuaded the original team that it might be better to take the money and invest elsewhere.
>
> (*CCMN*, April 1999: 2)

Recipients of long-term residential and nursing home care do not, however, have such flexibility.

As mentioned earlier, the growing permeability of state services is part of a global trend, and is not simply peculiar to the UK. Such a trend points to an emphasis on the market-driven character of reorganization, with state intervention increasingly concentrated upon the productive sphere, with even welfare provision being geared less towards the needs of clients and users than towards improving the general level of export-oriented industrial competitiveness. The recomposition of welfare along discretionary, means-tested and minimalist lines is combined with an often contradictory attempt to open such spheres to capital accumulation, with the role of the state only that of purchaser and, at times, a regulator of services. Such drives are increasingly homogenous. In the developed North, for example, the concern with the structural competitiveness of supranational bodies such as the European Community goes well beyond management of international monetary relations, foreign investment and trade. The emphasis is also highly geared towards the rearticulation of political capacities; in particular, reining in levels of public spending and welfare provision (Jessop, 1992). Similarly the *1993 World Development Report: Investing in Health*, designed by the World Bank primarily for low- to middle- income and formerly socialist countries, reinforced the neo-liberal canon of the privatization of health care to turn it into a terrain for capital accumulation (Laurell and Arellano, 1996). The commodification of long-term care

in the UK must be seen within such a context, one that as yet privileges the neo-liberal response.

Conclusion

Government policies show no enthusiasm for returning to public provision or accountability, or to the principle of collective risk pooling through social insurance.

> New Labour poses no fundamental threat to the private care home sector . . . there is nothing to suggest that the government wishes to roll back the dominant position that the private sector now occupies in the provision and supply of care services. Ministerial speeches emphasise the aim of achieving best value in state purchasing of community care regardless of delivery by private, public or voluntary sector providers.
>
> (Laing and Buisson, 1998: 2)

There is also no sign of the playing field being levelled. Local authorities and primary care trusts continue to have a strong incentive to keep placing residents within the independent sector. Similarly, local authority capital expenditure rules have not been relaxed, so there is no means of upgrading the remainder of their own Part III stock of residential or nursing homes to the standards that have been put forward in the 1998 White Paper on regulation. The Best Value imperative was strongly reiterated by the Health Minister Paul Boateng at a conference in April 1998 on interagency collaboration, when he said that 'the days when a local authority could get away with an approach to residential care which was always to prefer their own provision before that of the private sector are dead and gone and will not be tolerated' (quoted in *CCMN*, May 1998: 30). Indeed if a local authority 'seeks persistently to undermine the private sector, that local authority will answer for it' (Boateng, in *CCMN*, May 1998).

The government has rejected its opportunity to make an official commitment to free, comprehensive long-term care as recommended by the Royal Commission on Long Term Care, 1999, and care will continue to be predicated on publicly unaccountable private provision where shareholders take priority. The neoliberal ideologies of New Labour's 'Third Way' are in full swing and the poor, old and vulnerable will bear the consequences of this severing of the 1948 social contract.

Note

1. Since this article was drafted, NHP has experienced financial meltdown. Three of its main tenants, Advantage Healthcare, Grampian Homes and Westwood Homes went into receivership in 1999/2000, while a fourth, Tamaris, ceased to operate; its Chief Executive was forced to retire; and the annual accounts revealed that the company had swung from an £18m profit to a £13.7m loss 'on the back of soaring interest costs and a raft of charges related to bad debts, tenant funding problems, property value write-downs and abortive merger costs' (Lea, 2001).

References

Ball, M., Lizieri, C. and Macgregor, B. D. (1998) *The Economics of Commercial Property Markets*. London: Routledge.

Bernard, M. and Phillips, J. (1998) *The Social Policy of Old Age—Moving into the 21st Century*. London: Centre for Policy on Aging (CPA).

Department of Health (1998) *NHS Hospital Activity Statistics: England 1987–88 to 1997–98 Statistical Bulletin 1998/31*. Westerby, Department of Health.

Edwards, P. and Kenny, D. (1997) *Community Care Trends: The Impact of Funding on Local Authorities*. London: Local Government Management Board (LGMB).

Ellert, R. (1998) 'The UK Sale and Leaseback Market—Another Year of Exceptional Growth', *Fitzhugh Directory of Independent Healthcare and Long Term Care 1998/99* A23–A25. London: Healthcare Information Services.

Ellison, N. and Pierson, C. (1998) *Developments in British Social Policy*. London: Macmillan.

Fitzhugh, W. (1998/9) *Fitzhugh Directory of Independent Healthcare and Long Term Care 1998/99*. London: Healthcare Information Services.

Fitzhugh, W. (1999/00) *Fitzhugh Directory of Independent Healthcare and Long Term Care 1999/00*. London: Healthcare Information Services.

Fitzhugh, W. (2000/01) *Fitzhugh Directory of Independent Healthcare and Long Term Care 2000/01*. London: Healthcare Information Services.

Garner, H. (1998) *Undervalued Work, Underpaid Women: Women's Employment in Care Homes*. London: Fawcett.

Hall, D., Hallam, J., Jaffe, M. and Meech, C. (1998) *Care Homes and the Minimum Wage*. PSPRU Briefing 6. London: Public Services Privatization Research Unit.

High Yield Report (1998) 'Healthcare companies bond prices remain stable despite low quarterly results', *American Banker* 9(43): 1.

Jessop, B. (1992) *From the Keynesian Welfare to the Schumpeterian Workfare State*. Lancaster Regionalism Group Working Papers 45: Lancaster University.

Kenny, D. (1997) *Influencing the Market: Negotiating Fees with Independent Nursing Homes*. London: Local Government Association.

Kenny, D. and Edwards, P. (1996) *Community Care Trends: The Impact of Funding on Local Authorities*. London: LGMB.

Kenny, D. Edwards, P. and Stanton, R. (1994) *From Social Security to Community Care: The Impact of the Transfer of Funding on Local Authorities*. Luton: LGMB.

Laing and Buisson (1985) *Care of Elderly People Market Survey*. London: Laing and Buisson Publications.

Laing and Buisson (1988) *Care of Elderly People Market Survey*. London: Laing and Buisson Publications.

Laing and Buisson (1991) *Care of Elderly People Market Survey*. London: Laing and Buisson Publications.

Laing and Buisson (1994) *Care of Elderly People Market Survey*. London: Laing and Buisson Publications.

Laing and Buisson (1995) *Care of Elderly People Market Survey*. London: Laing and Buisson Publications.

Laing and Buisson (1998) *Care of Elderly People Market Survey*. London: Laing and Buisson Publications.

Laing and Buisson (1999) *Care of Elderly People Market Survey*. London: Laing and Buisson Publications.

Laing and Buisson (2000) *Care of Elderly People Market Survey*. London: Laing and Buisson Publications.

Laurell, A. C. and Arellano, O. L. (1996) 'Market Commodities and Poor Relief: The World Bank Proposal for Health', *International Journal of Health Services* 26(1): 1–18.

Lea, R. (2001) 'NHP Hurt as £14m Loss Hits Home', *Evening Standard* 25 January.

Macfarlane, A. and Pollock, A. (1998) 'Statistics and the Privatisation of the NHS and Social Services', in D. Darling and S. Simpson (eds) *Statistics in Society*. London: Arnold.

MSI Databrief (1999) *Nursing and Residential Homes and Sheltered Housing*. Chester: MSI.

Ministry of Health (1963) *Health and Welfare: the Development of Community Care*. London: HMSO.

Pollock, A. (1995) 'The Creeping Privatisation of Community Care', *Health Matters* 20: 9–11.

Price, D., Pollock, A. M. and Shaoul, J. (1999) 'How the World Trade Organisation Is Shaping Domestic Policies in Health Care', *The Lancet* 354: 1889–92.

Royal Commission on Long Term Care (1999) *With Respect to Old Age* (Cm4192-1). London: The Stationery Office.
Taylor, R. (1997) 'Adapt or Die—the Keynote to Survival', *The Times* 25 November 1997: 27.
Tinker, A., MacCreadie, L., Wright, F. and Salvage, A. (1994) *The Care of Frail Elderly People in the United Kingdom*. London: HMSO.
Townsend, P. (1964) *The Last Refuge*. London: Routledge and Kegan Paul.
Townsend, P. (1981) 'The Structured Dependency of the Elderly: A Creation of Social Policy in the Twentieth Century', *Aging & Society* 1: 1–28.
Walker, A. (1997) 'Community Care: Past, Present and Future', in S. Iliffe and J. Munro (eds) *Healthy Choices, Future Options for the NHS*. London: Lawrence and Wishart.

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