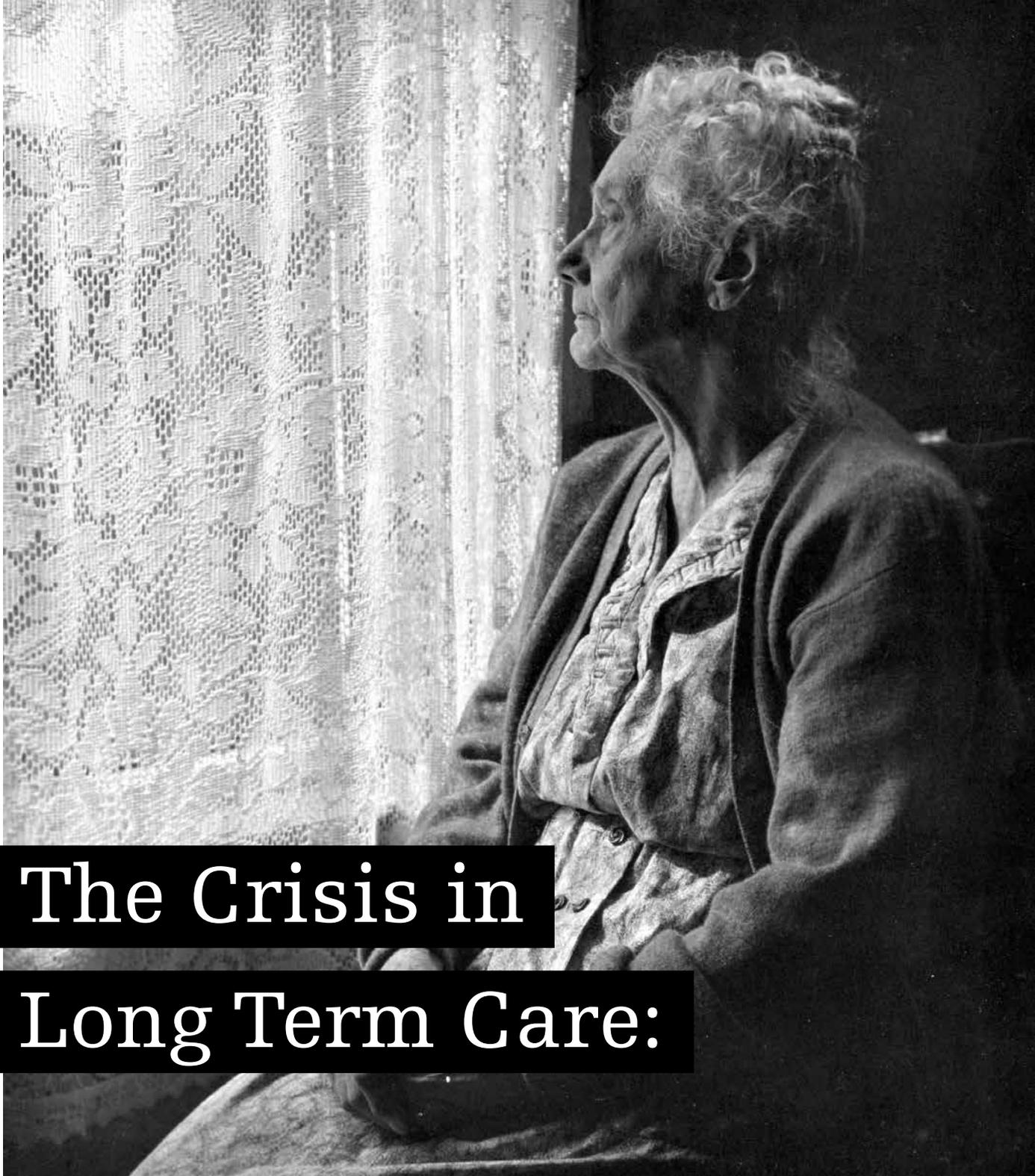




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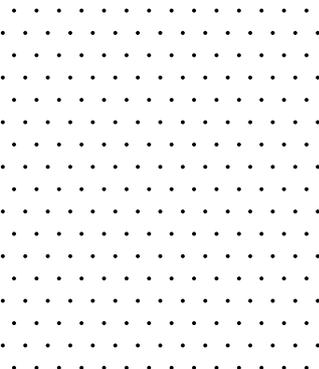
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The Crisis in

Long Term Care:

EFFECTS OF PRIVATE PROVISION



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A report for PSI prepared by Karol Florek, Independent Researcher
February 2022

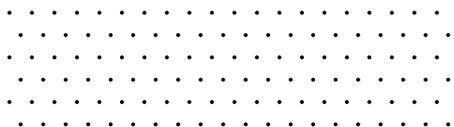
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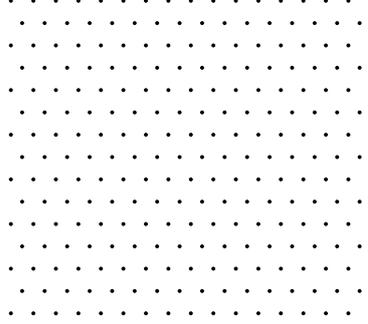
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* LTC: Long Term Care





Executive Summary

The COVID-19 pandemic has had a devastating impact on millions of long-term care (LTC) recipients and their families. For the purposes of this report LTC refers to care provided by an employee for a person in need of the care over an extended period, either in their own home or a residential facility and is usually partially or substantially subsidised by the state. It includes public, private and not for profit delivery. Especially in global north countries, nursing homes have been at the epicentre of the pandemic, experiencing very high proportions of deaths.

Within the first year of the pandemic, of the people who died from COVID-19 related causes, 4 out of 10 were nursing home residents, according to an analysis of 22 OECD countries. Millions of LTC workers have been infected, elevating the risk profile of care sector work. Working in a nursing home is now one of the most dangerous occupational categories. As care work is a highly feminised occupation, the impact of the crisis has disproportionately fallen on women. Excessive workloads, unsafe conditions, and psychological distress have pushed an unprecedented number of care workers to burn-out and leave the sector: a vicious cycle of understaffing, deterioration of conditions, and resignations.

This crisis is largely a result of established trends and existing inequalities, and the mounting deficiencies in the quality care provision arising for a sector increasingly run in the interests of private profit-making rather than society. Prior to the pandemic emergency, LTC was already beset by multiple crises stemming from the promotion of profit-making above patient care. The gap in unmet demand was growing in many countries, especially those with rapidly ageing populations. Understaffing was increasingly a problem, with poor retention a result of staff exploitation, low wages, curtailed trade union rights and poor working conditions. Deficiencies in care quality, especially pronounced in private nursing homes, were evident. Privatisation and COVID-19 have been described by academic experts as a “toxic cocktail” due to the alignment of high rates of infection and death with pre-existing structural risk factors. COVID-19 has dramatically exposed the existing vulnerabilities in the current model of LTC provision, rocketing the crisis in care into the public spotlight as well as prompting numerous investigations and official inquiries to identify weaknesses, assess failures and learn lessons.

At the time of this report’s publication, the world’s largest private nursing home multinational, the French company Orpéa, is the subject of a major

scandal in its home country. The French government has imposed a vast control operation to protect residents, while opposition parties have called for expropriation.¹ Extensive allegations of elder abuse, mistreated employees, accounting acrobatics, and squandered public money for financial gain at Orpéa were released in the book *Les Fossoyeurs* (The Gravediggers) by journalist Victor Castanet following three years of investigation, 250 interviews and testimonies of whistle-blowers.² Orpéa's stock price has plummeted, and the scandal has already claimed the CEO who was fired for alleged insider trading.³ These developments have significant implications not only in France, as Orpéa operates in 23 countries and is a major operator in Germany, Netherlands, Belgium, Spain, Portugal, Austria, Italy, Switzerland, Poland, Czech Republic, Slovenia and Ireland. It has also recently expanded to the Latin American region, and has operations in Brazil, Uruguay, Chile and Mexico.

PRIVATISATION, DISASTER CAPITALISM AND THE NEW COVID-CHARGED INVESTMENT BOOM

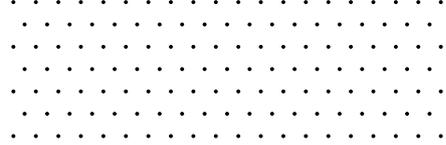
Over the last 30 years, the pursuit of neoliberal policies for market-driven expansion of the LTC sector has seen growing private investment, multinational expansion, and commercial consolidation. The demographic trend of an ageing population is especially advanced in much of the global north, with growing demand for care projected to continue to outpace supply. To close this growing gap, government policies have tended to move away from the concept of universal access to high quality care as a public good, instead incentivising private provision while driving down costs. While the pursuit of market solutions to care has been rationalised as a budgetary cost-saving measure, more than ever it is evident that the economic and social costs of reliance on private investment outweigh the benefits.

As many traditional industries continue to decline, global investors have increasingly pivoted toward the care sector, with nursing home real estate in particular functioning as a lucrative sink for financial capital. The transformation of LTC into an investment product is widely seen as attractive for investors for offering low-risk and high returns, thanks in large part

to government funding, rising unmet demand, and a lack of regulation on the quality of care provision. Despite the devastation that COVID-19 has meant for care recipients, their families and the workers who care for them, there has been little in the way of accountability for those who profit from the industry. In fact, the sector is currently experiencing a boom due to an influx of capital, with a new wave of private-equity takeovers and consolidations.

This report explores these privatisation trends within the LTC sector, focusing on residential care nursing homes. Key conclusions include:

- The privatisation of LTC is a multi-dimensional process; overt transfer of service provision from public provision to private ownership is only the most obvious aspect. The lines between different forms of ownership are often blurred as reforms to financing and regulation encourage commercialisation of services, corporatisation, marketisation, outsourcing, personalisation, and transfer of responsibility from public to private individuals.
- The dominant market-based model for LTC has seen incredibly uneven growth and geographic inequality, both on an international scale, as well as within countries. The developers of nursing home real estate are not guided by concerns of unmet care needs, but rather the promises of highest profitability.
- LTC is highly dependent on government financing as a source of revenue. Profit-making in the sector is understated, and clashes with public perceptions of thin profit margins due to chronic underfunding, especially in light of austerity policies. Yet a number of investigations have shown that hidden extraction of profits occurs through hierarchies of ownership and business models designed to transform government subsidies and resident fees into other sources of income, including lease agreements, management fees, interest payments to owners, and related-party transactions. The role of rental income from nursing homes as lucrative real estate assets is especially critical, often in conjunction with complex multinational company structures to facilitate tax evasion.



- LTC is often seen as under-resourced, yet there is no shortage of private investment flooding into the sector. Nursing homes were a booming industry prior to the pandemic, with extremely high profitability on the eve of the pandemic; in some countries, rates of return for investors in private LTC have been reported to be several times higher than the average for other industries.
- The COVID-19 pandemic has turbo-charged an investment boom, seeing a new wave of market consolidation in private LTC and the transfer of non-profit nursing homes into private ownership; in both Europe and the United States, private investment in nursing homes surged during the pandemic, largely on the back of a real estate boom and fed by investor expectations that privatisation and austerity measures will continue.

THE FAILURES OF FOR-PROFIT CARE BEFORE AND DURING THE PANDEMIC

A significant volume of empirical research has been built over the last few decades documenting the structural deficiencies of commercialised care systems – and in particular, the deficit of quality provision within for-profit nursing homes. This evidence has mounted substantially since the onset of the pandemic, with studies linking poor outcomes with features that define profit-making models.

The current disaster is a consequence of the neoliberal project built over the last several decades to turn care into a profit-making opportunity. Key conclusions within this report include:

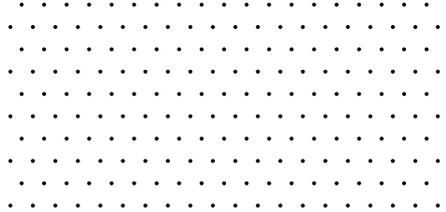
- For-profit providers engage in a variety of strategies to maximise revenues including targeting wealthier demographics, charging out of pocket fees, introducing additional hidden fees and in many cases shifting the responsibilities for care back to families. In a labour-intensive sector where conditions of work are the most important determinant of care quality, for-profit providers also engage a number of strategies to minimise costs, mostly focused on reduction of labour. Such methods include short-staffing, contracting out, wage suppression, erosion of conditions,

undertraining, attacks on trade union rights, and the transferal of responsibilities onto families and informal carers.

- For decades prior to the pandemic, research has accumulated that shows that ownership of LTC has a significant impact on the quality of care and life expectancies of nursing home residents. A key difference that emerges from many studies comparing for-profit, non-profit and public facilities is the adequacy of staffing. Key indicators of quality – hospitalisations and mortality – have been documented to be significantly worse in for-profit facilities in the US, UK and Canada. Perverse financial incentives have been found to encourage for-profit providers to limit the care and treatment that could prevent hospitalisation, instead transferring responsibilities back on to healthcare systems.
- Evidence drawn from various studies undertaken during the COVID-19 pandemic shows link between the for-profit ownership status of nursing homes and worse outcomes compared to public and non-profit facilities, in some cases with dramatic differences in the number of deaths; this evidence exists for the United States, Canada, United Kingdom and Australia. Studies also show a link between higher risks of outbreaks, infections and deaths and the physical characteristics of nursing home facilities built to be larger and more crowded; other factors relate to labour conditions - understaffed facilities, the employment of staff on insecure contracts, the lack of access to sick pay, the deployment of staff across multiple facilities, a lack of cohorting or isolation between infected and uninfected patients within facilities, and a lack of a trade union presence in the workplace.

CHANGING THE NARRATIVE ON CARE

Quality LTC is a matter of life and death; it is an essential service that is too important to leave in the hands of those whose primary motivation is the extraction of profit. Quality of care relies on well paid, trained and supported workers – which the profit motive inevitably undermines. A new model of care is urgently needed which prioritises caring for people.



Unions organising these LTC workers have sometimes been led by employers to demand more funding. But without rebuilding the social organisation of care based on fundamental reform to the model, the risk is that extra resources will be captured by privatised and financialised corporations and not find their way to better patient care and to the workers needed to provide it.

PSI is advocating for a radical new approach to care, highlighting the need to urgently rethink care in our society, to integrate transforming gender roles in the organisation of quality, universal and public care service systems, while also denouncing and opposing the privatisation, commodification and financialisation of the sector. Fixing the care crisis requires a shift away from notions of a 'care economy' towards that of the social organisation of care.⁴ The Care Manifesto released on 1 October 2021 calls for a global movement to rebuild the social organisation of care based on five key concepts (the 5R's):

- Recognise the social and economic value of care work (paid or not) and the human right to care.
- Reward and remunerate care work with equal pay for work of equal value, decent pensions, dignified working conditions and comprehensive social protection.
- Reduce the burden of unpaid care work on women.
- Redistribute care work within households, among all workers, eliminating the sexual division of labour and between households and State.
- Reclaim the public nature of care services and restore the duty and the primary responsibility of the State to provide public care services and develop care systems that transform gender relations and women's lives - including by financing State's capacity to invest through fair and progressive taxation and ensuring internationally equal taxing rights of nation States.⁵

The conclusion of this report outlines some potential strategies for resisting and reversing privatisation and reforming the sector to improve the quality of care and the associated workforce crisis. Key points include:

- **Investment in the Care Workforce:** The COVID-19 pandemic has reinforced public awareness of care work as essential yet undervalued. The problem of low wages, poor conditions, and high-risk work is now well-acknowledged in policy as a recruitment and retention problem posing a key barrier to developing the sector to ensure both current and future care needs are met. For example, the OECD identifies a 36% pay gap in the median wage between LTC workers and hospital workers in equivalent occupations across Europe. Without substantial investment into the care workforce, the crisis of understaffing will only continue to worsen to the detriment of all society. Reforms to ensure that care work is no longer synonymous with low-paid work are long overdue. Working conditions must improve, including a focus on healthy and safe work. Care occupations must be professionalised through adequate training and upskilling.
- **Staff-to-patient ratios:** Despite irrefutable evidence that understaffing is a core problem in the sector, very few countries have implemented staff to bed ratios in LTC. This is critical to quality of care, workforce retention, and responding to the pandemic. As the current situation is leading to increasing workforce shortages, care needs can only be met through implementing minimum ratios that reduce workloads and improve working conditions.
- **Regulation for Higher Standards:** There is an urgent need to improve regulatory mechanisms, including labour inspectorates, and to enforce higher standards in LTC. The right to quality care needs to be legislated in many countries. Governments must create mechanisms to take over private care providers which fail to meet

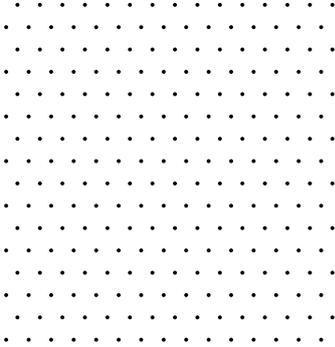


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basic standards. The lack of integration between the LTC and public healthcare sectors has figured significantly in political debate in many countries especially where the pandemic response saw hospital care prioritised while LTC was neglected. On its own, however, bureaucratic integration without addressing the structural problems will not be sufficient.

- **Reforms to public financing of care:** Austerity policies must be reversed and the LTC sector adequately funded. However, it is insufficient to simply increase government funding without ensuring there are measures in place that direct this funding towards care workers, not further

subsidising additional profits. Public financing must be reformed to be accountable and transparent. There is a need to remove barriers such as ‘competition policy’ frameworks that bind governments to provide equal subsidies to commercial and non-commercial operators. There is a need for governments to develop mechanisms that ensure any increased public funding is directed to wage increases for care workers, to make public funding contingent on collective bargaining tied to such wage increases, to curtail rent-seeking behaviour of the LTC property sector, and to utilise direct state investment into developing publicly-owned and operated LTC.



Section One

The Privatisation of Care

/// *[Privatization] is sometimes attained not by outright sales but by deliberately allowing services to run down, by erecting barriers to access, by withholding information and by making receiving benefits so difficult and demeaning that the public has little alternative but to turn to the private sector.” David Macarov, What the Market Does to People: Privatization, Globalization and Poverty ⁶*

“Privatization is the process of moving away from... not only public delivery and payment for health services but also a commitment to shared responsibility, democratic decision-making, and the idea that the public sector operates according to a logic of service to all.” Pat & Hugh Armstrong, The Privatization of Care: The Case of Nursing Homes ⁷

Experts who study privatisation have long pointed out that it is a multidimensional process.⁸ Privatisation encompasses more than the overt transfer of provision of services from the public to private entities, and relates to the processes of corporatisation, marketisation, outsourcing, personalisation, and transferal of responsibility from public to private individuals.⁹ In the case of long-term care (LTC), privatisation is closely linked

to commercialisation of services and the shifting of government-funded services away from public provision toward private operators.¹⁰

The LTC sector is complex; systems vary considerably between countries. Demographic and social trends determine the demand for care, yet the functioning of the sector is largely determined by government policies toward social services. This includes funding, regulation, and the integration of care services with broader health and welfare systems. Government policies toward LTC are highly interconnected with broader economic and social policies, and especially decisions that affect health care, ageing, pensions and social security, labour force participation especially of women, and support given to unpaid carers. Significantly, the sector is highly feminised; formal care systems are built on foundations of the ‘invisible’ labour predominantly carried out by women without pay.¹¹

Although the mix of public and private funding varies considerably from country to country, public financing of care is a major precondition to sustaining modern LTC systems. The outsourcing of provision – where public financing is mobilised by the state and



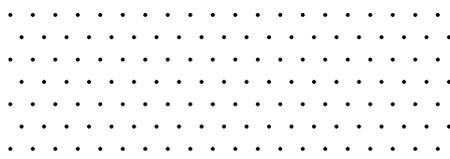
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distributed to service providers rather than carried out directly by the state – is the dominant feature of this model. Analysis of OECD data carried out by Investigate Europe shows that €218bn of state funds goes to care home operators each year, with a further €65bn paid in out-of-pocket fees by residents and families.¹² This second figure however is very likely a substantial underestimate, as it only captures data from some countries, excludes informal care and various associated costs borne by care recipients and families.

LTC has grown immensely over the past three decades and is projected to expand considerably into the foreseeable future; however, this continues to be an uneven process, highly dependent not only

on ageing population trends but also the degree to which the sector is financed. The global inequalities in terms of access to LTC are stark. Even just within the EU-27, the ratio of LTC workers per 100 people aged 65+ ranges from 12.4 in Sweden to just 0.1 in Greece.¹³

Since the early 1990s, expansion of the LTC sector has been strongly shaped by neoliberal market-orientated reforms. However, private ownership of nursing homes is not a new phenomenon. In many countries, ownership was long held by churches, not-for-profits and individual private operators making little or no profit. Unlike many other forms of privatisation - for example, the sale of publicly-owned utility companies - in most cases, the defining



characteristics of privatisation of LTC did not involve substantial transfers of public assets to the private sector. Instead, they typically involved removal of regulatory barriers to profit-making, the introduction of market-based funding mechanisms to realign public financing of the sector as subsidies that can be complemented with private payment, and the encouragement offered by the state to operators to consolidate into corporate chains.¹⁴ Such reforms have been pursued deliberately to encourage the entry of private investment capital and, in doing so, commodified care and created a financialised investment product.

The ownership mix of residential LTC varies considerably between countries (see **table 1**). For the purposes of international comparisons, a distinction between public and private provision is typically made, with the latter often separated between for-profit and non-profit providers. England, Korea, and the United States are examples of countries where private for-profit providers are dominant, whereas Australia and Portugal stand out as countries where non-profit providers are dominant. Canada has a more even mix between for-profits, non-profits, and public facilities. Nordic countries retain a predominantly publicly-provided

	Private		Public
	For-profit	Non-profit	
Korea	99.5%		0.5%
England	86%	14%	10%
United States	70%	23%	7%
Switzerland	71%		29%
Canada	44%	30%	27%
Australia	30%	60%	10%
Sweden	20%		80%
Denmark	14%		86%
Norway	10%		90%

Table 1: Private vs public, for-profit and non-profit in selected countries. Table compiled from data in: <https://agedcare.royalcommission.gov.au/sites/default/files/2020-01/research-paper-2-review-international-systems-long-term-care.pdf>

residential LTC sector. However, even in the Nordic countries, marketisation reforms have seen a trend towards private financing, with a growing share of for-profit providers.¹⁵

The ongoing privatisation trend in LTC can be tracked through the changing proportion of private

provision as a share of total provision. For example, an analysis by Jane Lethbridge from PSIRU focused on Central and Eastern Europe shows a substantial shift towards private provision in seven out of eight countries during the 2000s and 2010s (see **table 2**).¹⁶

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

Table 2: Percentage of public: private care homes in six central and eastern European countries, Germany and Spain

Privatisation of LTC blurs the line between different forms of ownership. Policies that promote marketisation not only facilitate a move away from direct public delivery of services, but also affect the remaining public and non-profit services. Outsourcing is a common manifestation of cost-containment applied to public services and the move away from public financing to private payments by families and individuals, especially contracting-out ancillary services such as cleaning, catering, laundry to private agencies. This also leads to the promotion of for-profit managerial practices within the remaining not-for-profit and public services, including outsourcing management functions. Finally, there is a 'privatisation of decision making' with an erosion of democratic control, loss of accountability and loss of regulatory oversight, on the grounds of encouraging competition.¹⁷

STATE-SUBSIDISED PROFIT-EXTRACTION AT THE EXPENSE OF WORKERS, CARE RECIPIENTS AND THEIR FAMILIES

The for-profit ownership category in LTC does not comprise a single business model. Businesses range across a spectrum from independent owner-operated facilities to small and medium groups to very large national and multinational chains. Some ownership structures are simple and transparent, others are made up of multiple layers of owners and related parties, extending into webs of subsidiaries and secretive offshore accounts. LTC operating companies can own assets – that is, the properties in which they operate – or they can lease them from another party, transferring a substantial proportion of revenue to real estate investors. They can also be heavily debt-financed, diverting significant amounts of their revenue to creditors in the form of interest payments. In the case of many large for-profit providers, these interests tend to be related; a common corporate strategy is to structure a company in a way that creates artificial divisions between the operational, property and finance

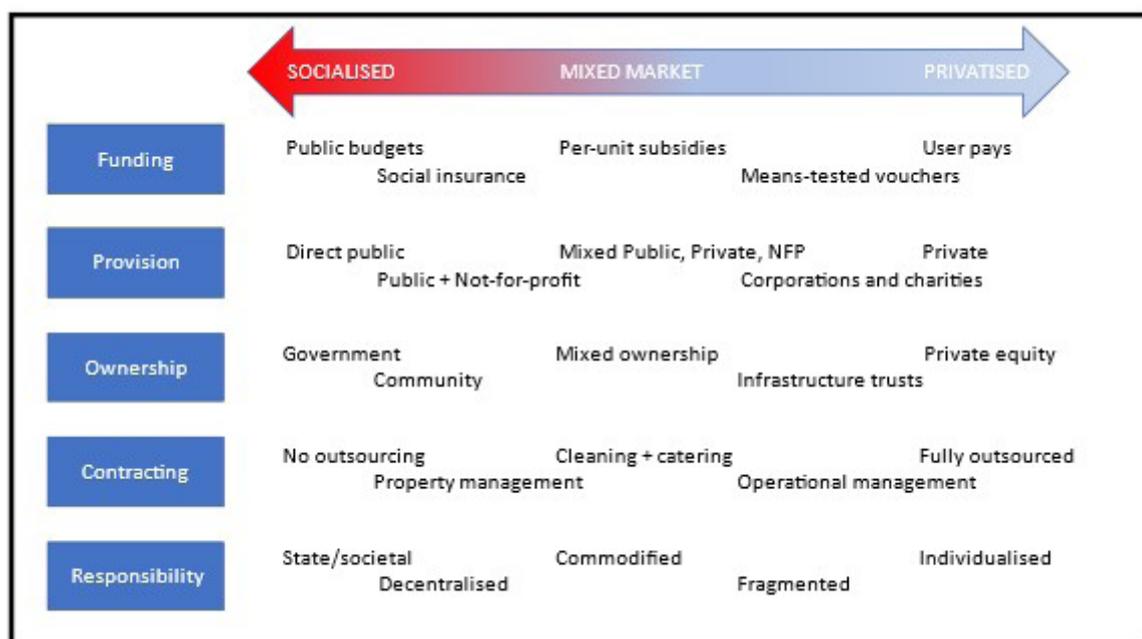


Figure 1: Privatisation of LTC by function

components, allowing a transfer of artificially high rents and interest payments to related companies, which are often based offshore in tax havens, while operating companies are structured to have low or even negative assets.¹⁸ Independent owners of nursing home real estate and lenders of money can also step outside their role as silent partners to exert considerable influence on the managerial decisions of a licensed operator. For all these reasons, determining the underlying ownership of nursing homes is not always straightforward.

Beneath the ideology of ‘deregulation’ and ‘competitive markets’ so often espoused by proponents of privatisation of social services is a bleak reality that the fortunes of some of the largest corporate players in LTC are built on nepotistic ties with powerful political actors. In his explosive investigation, Victor Castanet interviewed a former Orpéa executive who reveals that during the time of heady expansion in the 2000s and 2010s, ‘Orpéa had succeeded in establishing relations right up to the top of the State... We had the Minister of Health [Xavier Bertrand] at the time in our pocket’. The functions of this relationship involved financing, authorisation and risk-insurance, thanks to a close relationship between Orpéa’s founder and the former Health Minister in the Sarkozy government: ‘When there was really no other solution, Marian called on Bertrand... even more than with the authorisations, Bertrand helped us to get financed’. Xavier Bertrand remains an influential right-wing politician and currently serves as the President of the Regional Council of Hauts-de-France.¹⁹

Over the past few years, a considerable amount of investigative work carried out by researchers affiliated with CRESC²⁰, PSIRU²¹, CICTAR²², CHPI²³ and Investigate Europe²⁴ among others, has gone into understanding how profits are extracted from the LTC sector. The key conclusion drawn from this work is that profit-making in the sector is understated. The evidence that significant profits are made in the sector clashes with perceptions of nursing homes as chronically underfunded, especially in light of austerity policies. A typical narrative promoted by both for-profit and non-profit LTC operators is that margins are thin, and that staff cannot be paid decent wages, additional staff cannot be hired, and the quality of care cannot be improved in the absence of additional funding without making providers unviable. Although government funding is an important factor – it is usually the core revenue base for operators, whose profits derive primarily from public subsidies – at the same time, cost-containment policies can also serve to further privatisation: private providers often gain from increasing the shift of funding to out-of-pocket fees and outsourcing of various LTC functions by public authorities to private providers. Furthermore, an absence of investment by governments into the construction of nursing home properties also creates a prime opportunity for real estate developers and investors to profit from rent-seeking. While it is true that in some areas of the sector profit are slim, the extent to which profits can be extracted from LTC is determined by

not only the extent of public subsidies flowing to private operators, but also the scale and structure of the companies and the position of owners within hierarchies of ownership.

A boom in private investment: Whereas LTC is often framed as under-resourced, there is no shortage of private investment flooding into the sector. Systemic reforms that have commodified LTC and transitioned it into a market environment have been immensely successful on this measure: they have created one of the most profitable sectors of the economy for investors, attracting a growing pool of investment capital. Private investors in nursing homes receive returns that outperform most traditional industries. Significantly, it has become increasingly evident that real estate rather than service provision is the core investment attraction.²⁵ The LTC sector has been particularly lucrative for real estate investment trusts (REITs), multinational care companies that have invested into real estate, and private equity firms. For financial capital, the attractiveness of the sector relative to other investment products is due to the low-risk, high-return profile of nursing homes. This is underpinned by an expectation for rising real estate asset values, further privatisation, increases to public subsidies, and the expectation of rising demand in the foreseeable future.²⁶ Alarming, this expectation that the profitability of LTC is guaranteed long-term has only intensified during the COVID-19 pandemic.²⁷ The ongoing COVID-charged investment boom and the implications for trade unions will be further explored later in the report.

Uneven growth: privatisation favours a development model which concentrates services geographically within areas that promise the highest profitability – both current and projected. This means targeting users who can afford to pay out-of-pocket fees but also targeting locations for development where property values are expected to grow. Consequently, private nursing homes tend to be developed in the wealthiest urban centres, often excluding regions where dependency rates are highest and the need for LTC is unmet. The uneven development trend is evident across Europe. For example, 57% of nursing home beds in Germany are located in four of the largest and wealthiest states. Similarly, in Italy, 57% of beds are located in the three largest and wealthiest northern regions. Likewise in Sweden and Norway, where nursing home beds are concentrated in the capital cities in the southern part of the country.²⁸ In many countries, in regions that lack access to formal LTC, families are often forced by a lack of state support to resort to other models of care such as the employment of migrant live-in care workers.²⁹

Maximising revenues: A key enabler of profit-extraction from LTC is a steady revenue pipeline that is at least partially state-subsidised. Although for-profit LTC facilities also exist in the absence of state funding, as is the case in some Eastern European countries and most countries in the global south, the sector is small where business opportunities are limited to the wealthiest demographics that can afford to cover a full out-of-pocket fee. Private players in the for-profit LTC sector aim to maximise revenue from all sources; this can involve lobbying states for additional funding as well as charging additional user-fees where this is possible. In most countries where this is the case, there is usually a significant price differential evident. For example, the average daily price for a for-profit nursing home in Flanders, Belgium was EUR 64.66 compared to EUR 56.27 in a public facility.³⁰ At the same time, for-profit operators also engage in cost-shifting strategies to transfer responsibility from the institution to the care recipients' families for various miscellaneous expenses. This can involve minor or substantial additional hidden fees that would otherwise be part of the standard package (examples may include access to activities, laundry detergent, even transport for medical care).³¹

Minimising costs: Due to limited options for reducing costs in a highly labour-intensive sector, key cost-minimisation strategies that are pursued occur at the expense of care workers to the detriment of the quality of care, undermining the capacity of workers to do their jobs, dangerously compromising the quality of care, reducing the quality of life of residents, and sometimes falling below formal minimum regulatory requirements (where they exist). This typically involves the managerial strategies to reduce staffing costs to the minimum through measures such as:

- Short staffing: the most common measure pursued by for-profit operators to lower labour costs, particularly in the absence of regulatory requirements, is to reduce the ratio of staff to patients; this can occur at the level of registered nurses or personal carers or both.
- Contracting out: occurs both in terms of the core personal carers, but often also ancillary services such as food, laundry, and cleaning. Shifting away from permanent employment towards temporary and agency work.
- Wage suppression: Whereas corporate chains tend to reward their executives and senior managers with large pay packages and bonuses,

they rely on low-paid frontline workers who often work for minimum wages.

- Erosion of conditions: This can include the introduction of monitoring of workers to time activities, as well as saving on health and safety, for example through undersupplying of protective equipment.
- Undertraining: Recruitment of personnel without adequate training or failing to provide progression.
- Attacks on trade union rights: A number of large corporate LTC companies have engaged in union-busting campaigns.
- Transferal of care responsibility: one consequence of lean-staffing LTC facilities is a shift of care responsibility back on to individuals. Family members, and in some cases informal carers contracted by families, occupy a significant share of routine care tasks in LTC facilities in countries as diverse as Canada,³² Germany, Poland, and Peru.

The strategies of maximising revenue and minimising costs outlined above are evident in the case of the recent controversy concerning Orpéa; although its facilities charge exceptionally high fees (up to six times higher than the average), Victor Castanet's investigation reveals a logic of 'making its establishments as profitable as possible by forcing the teams to limit costs'. Crucially, the term 'gravediggers' that forms the title of his book is not directed at care workers, but rather those from whom it is a 'lucrative business'. Long response times, poor hygiene, patients left in their excrement for hours, and the failure to deliver timely medical care are a consequence of understaffing, making use of many temporary workers, stressed staff, and the rationing of meals and hygiene supplies.³³ In a separate investigation, research by Investigate Europe has found systemic falsification of hundreds of employment records Orpéa, in order to allow temporary workers to replace who never existed.³⁴ The consequence of such business practices is clear: compromised quality of care, leading to preventable deaths of residents.

The private LTC business model functions at the expense of workers, care recipients, and their families, sustained through expenditure of public funds that tend to flow to where the profits are being generated rather than where the funds are needed. There is a confluence of risk-factors associated with

lower quality care in for-profit facilities, with a link to understaffing. While this has been evident for some time, privatisation and COVID-19 have been described by academic experts as a "toxic cocktail" as all these structural risk-factors have aligned with high infection and death rates during the COVID-19 pandemic.³⁵ The next section will examine in detail this substantial evidence base for how the features of a private LTC model align with poorer quality care.

DEFICIENCIES OF FOR-PROFIT LTC FACILITIES BEFORE THE COVID-19 PANDEMIC

A large number of studies carried out over previous decades show that ownership of long-term care has a substantial impact on the quality of care.³⁶ Much of this evidence is based on data collected by regulatory authorities in the United States and Canada and the United Kingdom. Both prior to and during the COVID-19 pandemic, there has been a scarcity of these large-scale empirical studies outside of these three countries. For example, a rapid literature review published in May 2021 assessed 18 studies that were available at the time, of which 14 were from the US, 3 from Canada, and only one small study from the European Union (France).³⁷ The reasons for this gap are largely due to the availability of data; where it is not routinely collected by regulatory authorities, it is much harder for researchers to do statistical analysis using large-scale databases like those that exist in the US, Canada, and the UK. Nonetheless, despite these limitations, the available evidence allows for general conclusions to be drawn about for-profit LTC that are relevant beyond the context of individual countries.

Conditions for workers, and in particular the adequacy of staffing, have consistently emerged as a key difference between for-profit, non-profit and public long-term care facilities.³⁸ Studies show a significant difference in staffing on a per resident basis, and with for-profit chains in particular having the fewest nursing hours.³⁹ These differences can be very substantial, for example, one Canadian study from 2010 showed public facilities provided 61 more minutes of staffing per resident per day compared to for-profit facilities.⁴⁰ On the eve of the pandemic, private LTC facilities in Ontario were providing just 2.63 hours daily of direct care per resident, well below recommended minimum of 4.1 hours.

The academic literature that compares care quality across different LTC ownership types usually focuses on two key indicators: the risk of hospitalisations

and mortality. Since the quality of care has a strong impact on the degree to which patients are hospitalised, the higher the staffing, in terms of both personal carers and registered nurses, the lower the rate of hospitalisations.⁴¹ A substantial proportion of hospitalisations are preventable if adequate care and treatment is received within the nursing home.⁴² One study carried out among nursing home residents in Georgia, United States, found that up to 67% of hospitalisations were potentially avoidable;⁴³ an earlier study of nursing home residents in California found 45% of hospital admissions were inappropriate.⁴⁴ Provider characteristics, rather than patient factors, have been found to explain nearly half of all hospitalisations in the United States.⁴⁵

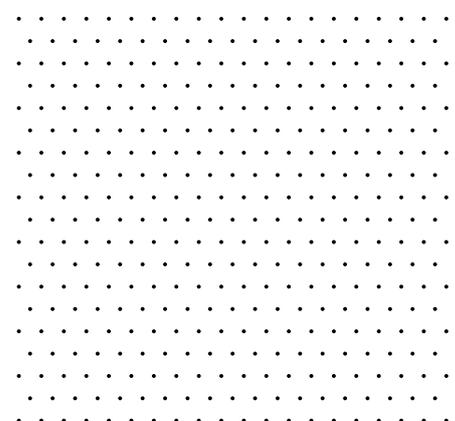
For-profit nursing homes in the United States and Canada have been found to be much more likely to hospitalise their residents, and to experience higher death rates, compared to public and not-for-profit facilities. One study found that residents of non-profit facilities were 3.1% less likely to be hospitalised within 90 days.⁴⁶ A study of long-term care facilities in Ontario, Canada carried out in 2015 similarly found that for-profits had significantly higher morbidity and hospitalisations compared with non-profits. Residents of for-profit LTC had a 16% higher death rate within 6 months of admission, and 33% more likely to be hospitalised.⁴⁷

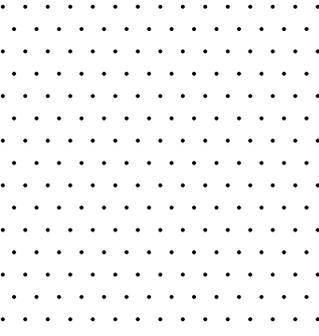
Perverse financial incentives lead providers to favour hospitalisation of nursing home residents rather than avoiding these hospitalisations in the first place. Aside from the avoidable detrimental impacts on health and the lives of residents, there is also an efficiency argument in regard to the use of public funds and the resources of health systems. An inefficient use of public funds is to subsidise profits of providers delivering inadequate quality care, and then provide additional funds to health systems to resolve health complications that could have been avoided.⁴⁸

In Australia, the Royal Commission into Aged Care Quality and Safety Evidence examined evidence that one out of three residents in aged care facilities receive substandard care and one in seven suffer abuse. Residents in for-profit aged care facilities were four times as likely to be hospitalised for malnutrition compared with residents in government-operated facilities.⁴⁹ A research report prepared for the Royal Commission found that residential aged care facilities operated by government providers had the highest proportion of facilities ranked in the highest-quality category (24%), followed by not-for-profits (13%) and for-profits (4%). The report also

found a strong correlation between larger facilities and diminishing quality – whereas 41% of facilities with 1-15 places were in the highest quality category, only 2% of facilities with 121-200 places and 0% of facilities with over 200 places were ranked as high quality.⁵⁰

Significant variations in the quality of care also occur among for-profit providers. Private-equity owned LTC companies have been found to experience the worst outcomes relative to other types of for-profit ownership. A 2021 National Bureau of Economic Research study looked at buyouts of nursing homes between 2000 and 2017 in the United States alongside data on the quality of care. It found that there were sharp and immediate declines in patient outcomes in private LTC facilities following their acquisition by private equity firms. Private-equity owned nursing homes increased the short-term mortality of patients by 10%, reduced nursing assistant hours per patient by 3%, and cost taxpayers 11% more per patient for additional healthcare required as a result of poor quality care. The study authors conclude that private-equity ownership leads to a ‘systematic shift in operating costs away from patient care’.⁵¹ Although focused on the US, this finding should be very concerning in Europe, where 13 out of 28 largest corporate LTC companies are owned by private equity firms.⁵² This includes the third-largest company, DomusVi, which operates in France, Spain, Portugal, Ireland, and the Netherlands.⁵³





Section Two -

From crisis

to catastrophe -

THE PANDEMIC AND FOR-PROFIT LTC

Dozens of studies have been conducted since the start of the pandemic that show a relationship between COVID-19 cases/deaths and for-profit ownership status of LTC facilities. As was the case prior to the pandemic, most of this research is based on retrospective analysis of routinely collected data from regulatory authorities. The key findings of three of the largest studies are summarised below:

- United States: An early study based on data from 9,395 nursing homes during the initial stages of the pandemic (up to 11 May 2020) found that for-profit ownership increased the probability of any case by 7% whereas government ownership reduced the probability by 16%. The same study found, however, that the most significant variables related to the size of the facility and its location.⁵⁴
- Canada: A study of all 623 LTC facilities in Ontario, Canada found that in the period up to 20 May 2020, for-profit nursing homes had nearly double the odds of an outbreak, and 78% more resident deaths compared with non-profit homes.⁵⁵
- United Kingdom: A study based on phone surveys of 5126 nursing home managers in England (out of the total 9081) found that for-profit status was associated with a 19% increase in the odds of infection among both residents and staff.⁵⁶

- Australia: Although relative to most of the world Australia has had a low number of COVID-19 deaths, as of November 2021 there had been 691 COVID-19 deaths in aged care facilities, a very high proportion (71%) of the country's total COVID-19 deaths. For-profit aged care facilities in the state of Victoria accounted for 82% of all deaths in the state during the second wave of the pandemic. There were no deaths reported in government-operated facilities, which account for 10% of the sector. Thousands of COVID-19 cases were reported among nursing home staff in for-profit facilities compared to just five cases in state-operated facilities.⁵⁷

A substantial amount of research links for-profit status of nursing homes to negative outcomes for nursing home residents. In most studies, this comparison is made between for-profit and not-for-profit ownership status of providers. Yet, as evidence from Ontario (Canada) shows, government-run nursing homes performed better than both for-profit and non-profits homes in COVID-19 outbreak management. Although ownership type did not affect the risk of an outbreak occurring in the first place, where outbreaks occurred, death rates in government-run nursing homes were the lowest at 1.6%, compared to non-profits at 4.5% and for-profits at 6.5%.⁵⁸

A key observation from these studies is that the relationship between LTC ownership and outcomes is mediated by the underlying characteristics of care homes. This relates to physical factors (size and



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design of facilities), organisational and workforce factors (staff to bed ratios, work conditions, training, permanency of employment, access to PPE, and testing), and contextual factors (rates of infections in local community around the nursing home).⁵⁹ These characteristics can correlate with ownership status but can also be difficult to untangle as separate factors.

The understaffing of for-profit LTC was exposed during the COVID-19 pandemic. A study for Ontario Canada found that for-profit LTC employed 17% fewer staff than non-profit and publicly-owned homes during the first wave of the pandemic. At the same time, however, they received some \$138.5 million in COVID relief funding while paying out \$171 million in dividends to shareholders during the first three quarters of 2020.⁶⁰ In Belgium, commercial nursing homes employ 33 staff per 100 residents, compared to 39 in non-profit and 43 in public.⁶¹ In the UK, a major study by Shallcross et al. concluded that a

confluence of factors related to understaffing and poor conditions endemic to privatised LTC shaped the risk of COVID-19 across the sector: “Odds of infection and/or outbreaks were reduced in LTCFs that paid sickness pay, cohorted staff, did not employ agency staff and had higher staff to resident ratios. Higher odds of infection and outbreaks were identified in facilities with more admissions, lower cleaning frequency, poor compliance with isolation and ‘for profit’ status.”

Table 3 summarises the key findings drawn from a sample of studies surveyed for this report:

Risk factor	Key findings	Country / period
Larger nursing homes	Facilities with 70+ beds had 1.8 times greater rates of infection versus those with 35 or fewer beds. ⁶²	United Kingdom March-June 2020
	For every 10-bed increase, the probability of an outbreak increased by 0.9%. ⁶³	United States March-May 2020
Crowded nursing homes	Confirmed infections were 2.5 times higher in facilities with 0.85-1 resident per room versus those with 0.7 to 0.85 residents per room. ⁶⁴	United Kingdom March-June 2020
Understaffed nursing homes	A 10% increase in bed to staff ratio was associated with 23% increase in infection. ⁶⁵	United Kingdom March-June 2020
	Each one unit increase in the staff to bed ratio was associated with reduced odds of infection in residents and staff. ⁶⁶	England March-June 2020
	Nursing staff shortages, measured both in terms of total hours per resident and registered nurse hours per resident, were associated with higher COVID-19 cases. ⁶⁷	United States Jan-June 2020
Reliance on temporary, casual and agency staff in nursing homes	Care homes that employed temporary agency staff every day or on most days were found to have odds of infection 1.88 times higher among staff and 1.58 times higher among residents, compared to care homes not using temporary agency staff at all. ⁶⁸	England May-June 2020
Transfer of staff between multiple nursing home facilities	The odds of infections among staff were found to be 2.4 times higher in care homes where staff regularly worked elsewhere, compared to care homes where staff never worked elsewhere. ⁶⁹	England May-June 2020
	49 percent of nursing home resident cases were attributed to shared staff transmitting the virus across multiple nursing homes. ⁷⁰	United States March-May 2020
Lack of cohorting	In nursing homes without cohorting, where staff cared for both infected and uninfected residents, the odds of infection were 1.3 times higher in residents and 1.2 times higher in staff. The risk of outbreaks occurring was 2.5 times higher. ⁷¹	England March-June 2020
Lack of sick pay	Care homes where staff received sick pay were 0.87 times less likely to have infections among residents. ⁷²	England May-June 2020
For-profit ownership of nursing homes	For-profit nursing homes were found to have nearly double the odds of an outbreak, and 78% more resident deaths compared with non-profit homes. ⁷³	Canada March-May 2020
	The risk of infection in residents and staff was 19% higher in nursing homes that were for-profit compared to not-for-profit. ⁷⁴	England March-June
Lack of trade union presence	Nursing homes with a trade union presence were found to have 30% lower COVID-19 deaths among residents compared to non-unionised facilities. ⁷⁵	United States March-May 2020

Table 3: COVID-19 risk-factors in LTC: Summary of key findings of selected studies

THE IMPORTANCE OF LTC HAS NEVER BEEN CLEARER

As the Pan-European Commission on Health and Sustainable Development concluded in September 2021, “The avoidable deaths of so many people living in residential facilities will, for many families, be remembered as a defining characteristic of the pandemic. For too long, social care has been the poor relation of the health system. Few governments have put in place systems to fund it adequately, despite clear warnings from demographers about ageing populations.”⁷⁶

The experience of the COVID-19 pandemic is closely linked to failure of LTC systems. An analysis of data from 22 countries carried by the International Long-Term Care Policy Network found that as of January 2021, COVID-19 related deaths among long-term care residents were estimated to be 41% of the total.⁷⁷ In the early stages of the pandemic, one study found that long-term care residents across 12 OECD countries had an average 24.2-fold higher rate of death compared to older persons living in the community.⁷⁸

The impact of COVID-19 on LTC has ranged considerably between countries. In the United States, a total of 137,126 COVID-19 deaths among nursing home residents have been reported at the end of September 2021. In addition, 2,084 care workers have died.⁷⁹ In Europe, Belgium saw one of the highest proportions of deaths, where 9.4% of all nursing home residents died due to COVID-19 as of January 2021.⁸⁰ Although there is a significant correlation between high deaths in the general population and high deaths among care home residents, in all countries the pandemic has exposed the weaknesses of LTC. As seen in the evidence above, privatisation has had an immense impact on the risk factors that made LTC structurally vulnerable to the pandemic event.

WORKFORCE SHORTAGES: A DETERIORATING SITUATION

As detailed above, the level of staffing in LTC has consistently been reported in academic literature as the key difference between for-profit, non-profit, and public facilities that determines quality outcomes, such as hospitalisations and mortality. As numerous studies demonstrate, understaffing has been a key risk factor for the rate of COVID-19 infections and deaths in nursing homes.

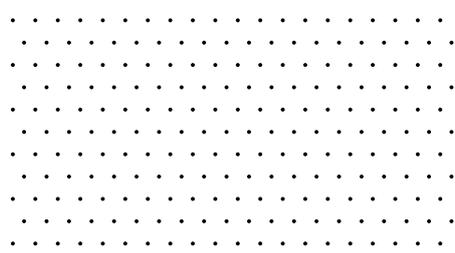
The issue of understaffing experienced daily by a large proportion of care workers is not a new problem; it is a structural problem which has beset the sector for more than a decade. Despite countless official reports and workforce strategies that have aimed to address workforce recruitment and retention, the gap between available workforce and the demand for care has only grown. For the whole of Europe, the ratio of long-term care workers per 100 people aged 65+ fell from 4.2 to 3.8 between 2011 and 2016.⁸¹

The pandemic has resulted in significant deterioration of existing workforce shortages, affecting especially nursing homes. In both the EU and the US, since the start of the pandemic, nursing home workers withdrew from their jobs in the hundreds of thousands. This is a catastrophic trend that can only be addressed through significant improvements to wages and conditions for all workers in the sector. Recent data for Europe shows that the workforce is not only failing to grow sufficiently to meet demand, but it is undergoing a sharp contraction on an unprecedented scale. In the EU, residential care lost 421,000 workers between 2019 and 2020, a fall of 9.5%.⁸² A similar trend is evident in the United States, which saw nursing homes lose 380,000 workers between February 2020 and July 2021, a fall of over 11%.⁸³ This trend is clearly complex, it is uneven across different regions, states and countries and requires further exploration. Key factors include:

A deterioration of already intolerable workforce conditions during the pandemic, that includes excessive workloads, unsafe conditions, and psychological distress, pushed an unprecedented numbers of care workers to burn-out and leave the sector; a vicious cycle of understaffing, deterioration of conditions, and exits.

Compounding this is the ageing profile of the nursing home workforce, many of whom are nearing retirement age. In the EU, the proportion of care workers aged over 50 increased from 28% in 2008 to 38% in 2019 due to a long-term failure to recruit younger workers.⁸⁴

Available evidence shows care work to be one of the most dangerous occupations during the pandemic, with one of the highest death rates of all occupations, and significantly higher than nurses and other health workers.⁸⁵ In some countries, very large proportions of the workforce have been infected with COVID-19. For the United States, CMS data reports 650,161 confirmed COVID-19 cases among workers in nursing homes – approximately 1 in 5 of all



workers – as well as 2,084 deaths among workers.⁸⁶ In Germany, for example, the rate of infection among residential care workers was six times higher than the average for the population as a whole. About 70% of nursing homes in Germany experienced staff shortages, and working hours increased by an average of one hour per shift.⁸⁷

There is likely to be a significant but as yet unknown proportion of care workers who are experiencing long-Covid symptoms and unable to return to work. According to recent evidence, as many as 1 in 3 people are diagnosed with at least one long Covid symptom three to six months after infection.⁸⁸

THE COVID-CHARGED INVESTMENT BOOM

Prior to the pandemic, it was evident that private investment was booming in long-term care, which was generating high returns for investors. Some notable examples:

The Corporate Europe Observatory noted that investor-orientated outlooks produced on the eve of the pandemic emphasised the profitability of the long-term care real estate sector, with some returns as high as 25-35% reported.⁸⁹

In Belgium, rent payments are high, and real-estate groups expect a return of at least 6%.⁹⁰

Australian private aged care companies are reported to have the world's highest rate of return on investment. A quarter of companies have a return four times higher than the most profitable companies elsewhere in the world, with a return on equity that is 10 percentage points higher than the average for stock-market listed companies. The funding model allows companies to invest in real estate, collect bonds from residents, and then charge themselves rent that is ultimately funded by government (80% of funding for aged care is directly from government).⁹¹

The Plugging the Leaks report, a detailed forensic investigation carried out in 2019 into the finances of 830 care home companies in the United Kingdom, found that 10% of all income that flows to the sector

– £1.5 billion – is distributed to owners of capital. This investigation is significant for looking beyond raw profits to identifying various forms of 'leakage' in the sector taking the form of rent, dividends, interest payments, director fees. The proportion leaking out was found to be much higher among the largest 18 for-profit care home providers (15%) compared with small and medium size companies (7%).⁹²

Larger companies are positioned to organise finances using complex corporate structures that allow for profits to be hidden in the form of management fees, lease agreements, interest payments to owners, and related-party transactions. Splitting of care home businesses into operating and property companies has allowed some companies to extract profits in the form of rent, to operate with negative assets and minimise potential liabilities, while the property ownership is often based in other jurisdictions. While a steady income is generated from bed occupancy, companies that own the real estate generate rental income, and speculate on the property values. The model encourages private investors to invest in the real estate, build larger nursing homes and aim their product at the most profitable parts of the market, in particular wealthier demographics who can afford to pay out-of-pocket fees.

Remarkably, during the pandemic, the disaster has allowed 'well-heeled and often well-cloaked private investors' to accelerate take-over of the industry, leading to increasing market consolidation in private LTC as well as transfer of non-profit nursing homes into private ownership.⁹³ Given the systemic failures of privatised LTC systems, one might expect the pandemic to have negative consequences for large private investors. There is plenty of evidence that the commercial viability of many individual private LTC operators has been severely affected due to falling occupancy levels, higher operating costs, higher risks (including reputational risks), and uncertainty about the future. The very visible and distressing catastrophe of mass deaths in nursing homes – and especially the higher share of deaths in private nursing homes – should be enough to make investors reluctant to bank on profiting from care in the future. Yet there is an investment boom. On the one hand,

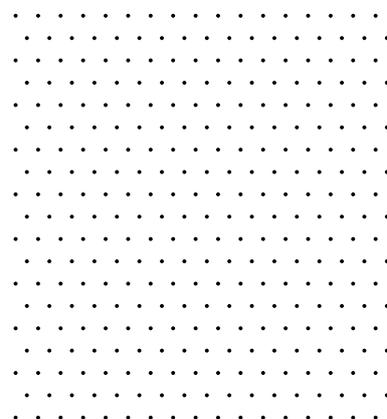
there is a ‘tough operating environment caused by COVID-19’ where many independent operators face bankruptcy. On the other hand, investors are prepared to pay very high prices for acquisitions, in what is being promoted by the real estate industry as a ‘sellers market’.⁹⁴

In the United States, a boom of private equity acquisitions is in progress as both private and non-profit facilities are being bought out and consolidated in fewer hands. Public companies are being bought out and delisted, ownership transferred to a more secretive group of owners. Investors are prepared to pay considerable amounts. For example, in August 2021, the publicly-listed LTC company Diversicare Healthcare Services operating 61 nursing homes and a total of 7,250 beds was acquired for 256% of its stock value.⁹⁵ The new owner, retirement assets manager Ephram “Mordy” Lahasky, owns a complex and opaque web of companies which makes the extent of his ownership unclear. He has been embroiled in legal disputes, accused of falsifying staff records and at least one of his nursing homes has been placed into receivership. In July 2021, he attempted to buy a company that holds 1/6 of nursing home bed capacity in the state of Vermont (with his wife formally listed as the would-be owner). The acquisition business model adopted by Lahasky has not gone unnoticed in local media. It is a model of ‘scoop up distressed homes during the pandemic, even as residents and staff have grappled with brutal COVID-19 outbreaks’.⁹⁶

A similar COVID-charged investment boom for nursing homes is occurring in Europe. In 2020, investment in nursing homes rose to a record of 3.6% of all European investment volume from an average of 2.3% in previous years.⁹⁷ Europe’s largest long-term care multinational, Orpea, reported growth during the pandemic, with increased revenue and profitability. It is no coincidence that Orpea is not just the largest private operator of nursing homes in Europe, but also Europe’s largest owner of nursing home real estate, with assets valued at over €7.4 billion. During the pandemic, Orpea was able to grow this property portfolio by 23%, accumulating an additional €1.4 billion of property between 31 December 2019 and 30 June 2021.⁹⁸ As a recent market outlook from

Frank Knight makes clear, despite ‘headwinds’ due to the impact of COVID-19 – presumably mass deaths making some investors nervous about perceived long-term risks – investors are assured that the outlook remains ‘remarkably buoyant’ due to rising demand and growing cost pressure at both central and local government level, which inevitably ‘will lead to further privatisation across many markets, creating a larger pool of real estate investment opportunities’.⁹⁹

The quote above reveals that investors expect that the privatisation trend of LTC is not over, that further austerity measures will see an investment boom for nursing homes. Above all, the crisis represents an investment opportunity for the owners of LTC property assets. Strategies to reverse the toxic trend of privatisation need to focus on attacking the perverse financial incentives and reforming funding systems to ensure that public money intended for care is spent on care, and not used to subsidise additional yields for real estate investors. However, a strategic approach cannot be solely focused on the operators – it needs to take on LTC real estate, as this constitutes the key sink of investment capital into the sector and is the key area where profits are being accumulated.



Section Three :

Fixing the care crisis:

SOLUTIONS AND STRATEGIES TO HALT AND REVERSE PRIVATISATION

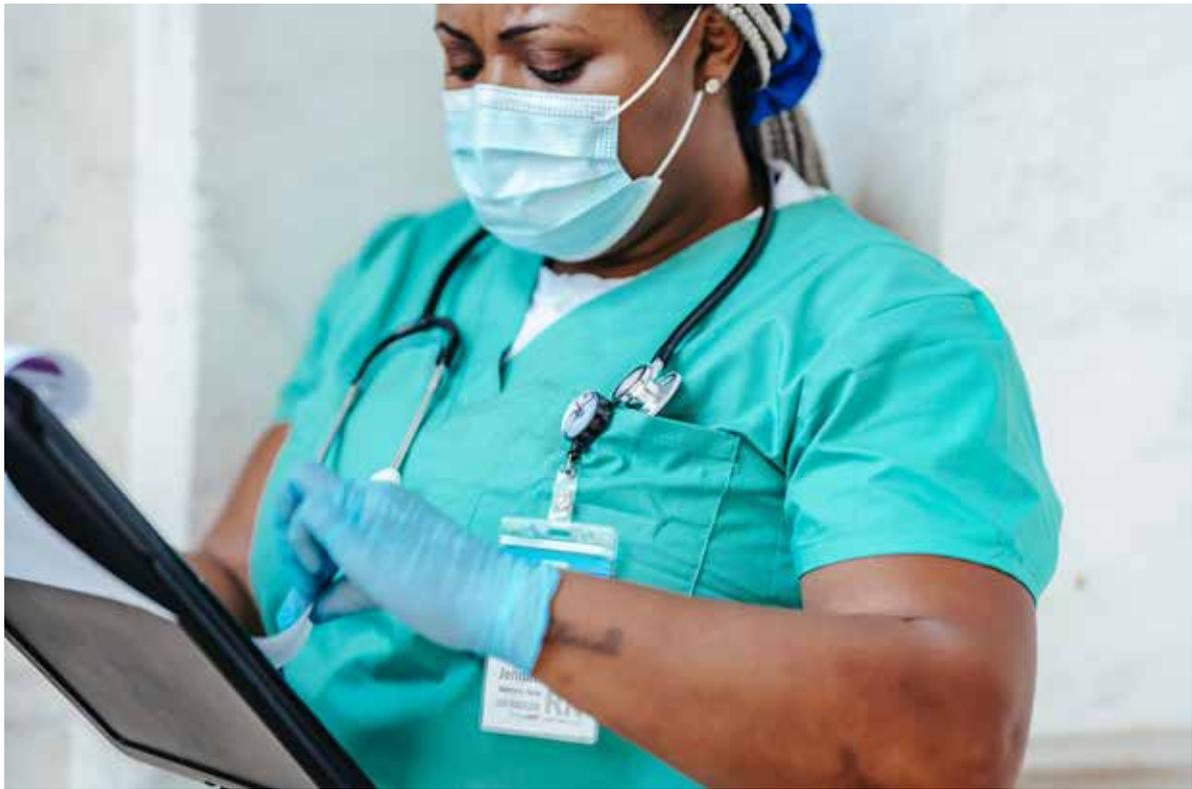
INVESTMENT IN THE CARE WORKFORCE

The worsening crisis of understaffing in LTC cannot be reversed without significant investment into the care workforce. This issue will become increasingly critical as older aged care workers retire, and fewer younger workers are prepared to enter into the sector with low pay and terrible conditions. The OECD notes that the median wage for long-term care workers is just EUR 9 per hour, compared to EUR 14 per hour for hospital workers in equivalent occupations.¹⁰⁰ Care work is essential to functioning societies, and yet care jobs are difficult, risky and poorly rewarded. The continued reliance on exploiting migrant workers is both morally wrong and will not address the causes of the crisis. The goal must be to make these jobs attractive, safe and fulfilling. The problem is not new, and solutions are evident. Over the past decade, chronic shortfalls in recruitment and retention due to low pay and poor conditions have confronted policy makers as a key barrier to the development of LTC: growing demand for care has consistently outpaced the number of workers prepared to make care work their career. The situation has markedly deteriorated since the onset of the COVID-19 pandemic, exposing the inadequacy of safe working conditions, and compounding existing workforce shortages arising from low pay and poor working conditions.

To retain existing workers and attract new care workers, reforms must focus on the following priorities:

- Care work must no longer be synonymous with low-paid work. Pay levels need to increase substantially across the whole sector; as a minimum, the level of pay needs to rise to parity with workers at comparable levels of responsibility, skills and qualifications in the rest of the healthcare system.
- Working conditions in the sector must be conducive and not detrimental to quality care; a safe and secure work environment must be ensured, including access to PPE, safe workloads, regular hours, and security of employment.
- Care work must be professionalised through access to adequate training; it should be aimed at both upskilling the existing workforce and attracting the millions of new workers to the sector who are needed.

There is an important role for trade union participation, to facilitate collective bargaining, unionisation, and strengthened social dialogue at both the peak level and within workplaces. Improving



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the representation of workers in decision making processes should also include the presence of staff on company boards, and the introduction of whistleblower protections. Special attention must be given to ensure the rights of migrant workers are protected and they are free to organise.

Expert institutions such as the WHO should be consulted and invited into the processes of improving and developing new workforce standards.

STAFF-TO-PATIENT RATIOS

For many years, trade unions have campaigned for the introduction of minimum staff to patient ratios in LTC. This is an issue that is widely and deeply felt by care workers worldwide. The evidence is irrefutable and the core problem of workforce retention, its link to poor conditions and low wages, is now uncontroversial in policy discussions at national and international levels.

While understaffing is a sector-wide problem, it nonetheless disproportionately affects for-profit providers. As this report has outlined, understaffing is closely aligned with poor quality outcomes and recognised as a key risk factor for COVID-19 infections and death. Despite decades of talk about

the need to attract more workers to the sector in order to cope with current future demands for care, the problem has been getting worse. The pandemic has blown a large hole in the retention crisis, resulting in a catastrophic exodus of up to a million care workers.

In light of this, it is critical to keep up pressure for the introduction of staff-to-patient ratios, despite the fact that there are chronic shortages of available workers to fill vacant positions. It is only with significant improvement to work conditions that shortages can be resolved.

REGULATION FOR HIGHER STANDARDS

The experience of a nursing home sector devastated by the pandemic has led to a general consensus that the LTC sector is poorly regulated and poorly integrated with many national public healthcare systems. The start of the pandemic saw bureaucratic inertia and the decisions of governments that led to a situation where capacity of hospitals was prioritised at the cost of neglecting LTC. This observation features extensively in various official 'lessons learned' post-mortems and investigations that reflect on failures in light of high COVID-19 death tolls among nursing home residents. There are ongoing political

EFFECTS OF PRIVATE PROVISION

debates concerning proposed solutions for better integration of LTC with public healthcare systems.

Bureaucratic reorganisation of LTC to bring it under public healthcare systems is not sufficient on its own to solve underlying structural problems and regulatory issues; there need to be ways to bring outsourced services into public ownership, and to remove for-profit entities from being eligible for procurement. Technocratic administrative reorganisation will not resolve the underlying problems plaguing the sector – especially in relation to workforce retention, pay and conditions.

There is an urgent need for governments to improve quality monitoring and enforcement of standards in LTC, including through better resourcing of regulatory bodies and labour inspectorates.

The right to quality care is lacking in many countries and needs to be established on a legislative level. Such legislation must be framed in terms of patient care objectives and not viewed primarily through the lens of market-driven competition.

Governments must create mechanisms to take over private care facilities where operators consistently fail to meet standards, or in an emergency crisis situation as seen during the COVID-19 pandemic. The case of Orpéa in France demonstrates that such mechanisms as both necessary and to require political resolve to be established.

REFORMS TO PUBLIC FINANCING OF CARE

The LTC sector has suffered from decades of austerity and cost-containment measures, which have on the one hand been incredibly beneficial to investors by creating new opportunities for privatisation, while on the other have created a public perception that the sector lacks money and the solution is for greater public funding. Both direct and indirect profits that are extracted from the sector. Increasing funding on its own is not enough; funding systems must be reformed to make operators' access to public funds contingent on care provision, not to reward poor quality.

Public financing must be made accountable and transparent; LTC must be unambiguously excised from all so-called 'competition policy' and legal frameworks that prescribe that private businesses receive equal subsidies to those given to publicly

owned and non-profit entities. At the level of national legal frameworks, financing of LTC is current subject in many countries to such competitive frameworks. In the case of EU legislation, LTC needs to be unambiguously exempted from being subject to European internal market and competition policy (state aid rules) and defined within the category of 'services of general economic interest (SGEI)'.

As a minimum, any funding increases must contain safeguards that prevent their redirection towards subsidising further profits. Possible measures include:

- Direct public funding of wage increases for all LTC workers: rather than subsidising providers and expecting this to trickle to more staffing or wage increases, states could become responsible for directly paying staff.
- Make all public funding to providers conditional on collective bargaining tied to wage increases (Germany offers an imperfect example of such a reform, as it contains loopholes that allow employers to undercut union agreements)
- Curtail rent-seeking behaviour in the sector – real estate, not care provision, is the main game for many investors into private LTC; property leases are a key point of profit extraction. As LTC infrastructure is a strategic asset it should not be left to the whims of private developers and financial speculators to extract publicly-subsidised profits from building and owning such assets. The toxic pandemic-driven investment boom is ultimately sustained by political decisions and could be curtailed. Effective measures could include introducing eligibility criteria for the property ownership of nursing homes (such as making off-shore ownership of nursing home properties illegal), capping maximum rents that can be charged, and introducing steep taxes on the owners of property assets that serve essential functions.
- Direct state investment to publicly-owned and operated LTC – to reverse privatisation, states should take over from private investors wherever possible, as owners of assets, as buyers of failing or collapsed companies, creating conditions that promote publicly owned (and where viable, high-quality non-profit) operators in the sector. Governments need to be prepared to step-in to takeover operators such as Orpea, including their property assets.

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