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Should we take Mum to market? Quality and funding in the Care Home sector

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Key points:

- Private equity investment occurs in social care.
- There is increasing evidence that this has negative effects on quality.
- Equal access to care and maintaining quality levels is vital.
- We recommend increasing information available to consumers and ensuring the sound financial base of potential new owners of large chains.

Older-age residential and nursing care has evolved from charitable initiatives to a professional and still indispensable part of the health and social care system (1). In England, as in many other countries, it has become increasingly marketised; most care homes are privately owned (for-profit), often in larger

corporate chains. Many of these chains are being taken over and financed by Private Equity (PE) firms, whose principle purpose is getting a high yield for their investors (2). This has led to concerns about where the money that pays for social care goes (3, 4). PE generally aims to exploit larger scales and streamline processes, and while cutting costs also try to gain higher revenues. This could have potential implications for the quality of services. We therefore welcome the empirical investigation undertaken by Patwardhan et al to assess if PE influences the care quality of care homes in England (5).

The authors hypothesise that PE-backed care homes are probably more focused on short term profits, instead of building a sound reputation, and therefore will have lower quality of care, evidenced, for example, by a disinvestment in quantity and quality of staff.

Quality is currently measured using a rating system by the Care Quality Commission (CQC, the national regulator of health and adult social care), which is guided by the "*Mum Test"*, i.e. if a care home is good enough for your Mum (6). Using a snapshot of CQC data from January 2020 for all 10,803 care homes for older people and those living with dementia in England, Patwardhan et al compare CQC quality ratings for homes with alternative ownership types. Identifying 649 PE-backed homes from five chains listed in a contemporaneous think-tank report (7), they separate care homes into four groups: PE chain, non-PE chain, independent for-profit and not-for-profit (homes run by charities, local authorities and the NHS). From their results the authors conclude that the lower quality of for-profit care homes is driven by PE homes and independent for-profit care homes. Their finding for PE investment is in line with the international literature cited in the paper.

The findings are largely confirmed through analysis of the ratings for the five key lines of enquiry, asking if the care home is 'Safe', 'Effective', 'Caring', 'Responsive to people's needs' and 'Well-led'. The authors also include a number of sensitivity checks to confirm their findings and note the limitations to their work. These limitations include the lack of resident level data on needs and socio-economic characteristics and PE chain identification. These could be important in influencing results. For example, Barchester Healthcare, included as a non-PE chain in this analysis but which uses many of the finance strategies common to PE chains (8), is aimed at the higher quality end of the market, with a majority of self-funding residents. However, a lack of resident-level data is an issue common to analyses of this type for England, although with hope that this may change (9). Better data would allow for further research to assess the effect of PE on resident outcomes.

Patwardhan et al have provided initial quantitative evidence on the quality effect of PE in the English care homes market. If PE is here to stay, what can be done to a) ensure access to (good quality) care

and b) increase information to help Mum and her relatives make the right choice as to which care home to choose?

There will always be a mismatch between market forces on the one hand and ensuring equal access to good quality care for all (10). PE investment necessarily takes advantage of market forces to the extreme and there are risks to these strategies (11). This suggests that PE will have little concern for lack of access to care if a care home is deemed unprofitable. The generally short term outlook of this *modus operandi* does not fit with local authorities' need for a longer term perspective on 'market shaping' local provision (12). Further, closure of a care home will create (unwanted) movement of residents, which usually have negative repercussions and therefore have to be carefully managed (13).

The collapse of Southern Cross in 2011, then the largest care home provider in the UK (14), ultimately led to the CQC being given the duty of assessing the financial sustainability of 'difficult to replace' providers (15). This *"Market Oversight"* is to be used to notify local authorities that have a legal responsibility of temporarily ensuring continuing care of all those that would be impacted by a cessation of services. Given market forces are still at large in the care homes market, we therefore recommend better assessment of the financial base of potential buyers of large chains of care homes to ensure better continuity of care. Wider thought would be required on what this would entail, but could, for example, include setting a ceiling level of debt allowed for potential leveraged buyouts or minimum capital levels to improve financial sustainability.

Ensuring a sound financial base of large chains may also help to maintain care quality. Yet, Mum and her relatives still require clearer information on PE and care quality to make informed decisions on choice of care provider. This could help to further mitigate any negative effects of PE-backed ownership. Currently, an interested party can use the CQC website to find out about the provider of a care home, past registration details and reports on inspections. However, it is not overtly clear if the owner is part of a PE corporate chain, and it is difficult to understand why changes in registration have taken place. There is also a lack of information for consumers on examples of what good quality looks like. For example, there is no clear guide as to what a good quality level of staffing would look like, based on needs and number of residents.

Better information on providers' ownership structure would also improve data quality for future research and allow more regular monitoring of the relationship between ownership and quality. In the absence of nationally mandated information, here Patwardhan et al have made novel use of external sources linked to CQC data, to provide strong empirical evidence that in English care homes, PE investment is associated with lower care quality.

Private equity investment is involved in the provision of social care and we need to continue to monitor what impact this will have on care home residents. Overall, improved regulation and information is required to protect Mum from the potential negative effects of the marketisation of residential and nursing care.

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