UNI global union

THE CRISIS IN CARE

The urgent need for responsible investor action in nursing homes

CONTENTS

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INTRODUCTION:
THE SPOTLIGHT OF COVID-19

As with many areas of our societies and economies, COVID-19 exposed and exacerbated existing vulnerabilities in nursing homes. Long plagued with combined crises including under-funding and staffing shortages, nursing homes became the epicentre of the global pandemic. As of mid-October, estimates from 21 countries which had available data show that in countries where nursing home deaths were reported, on average 46% of COVID-19 deaths were care home residents.[1] Within many countries, the numbers of lives lost paint a bleak picture: In the United States, 68,000 COVID-19 deaths were of nursing home residents or staff – 40% of the country's total.[2] In Canada, long-term care homes accounted for more than 80% of COVID-19-related deaths, in Spain estimates count 63%, and in Australia 75%.[3]

This devastation has shone a spotlight on the underlying crises in the sector globally, as this briefing will explore. It also drives home the need for urgent action as we face a second wave of the pandemic in many countries. Moreover, it shows the need to address the root causes of the issues to prevent such a tragedy from occurring again in the future, and instead build a better system of eldercare to serve this fundamental social and economic need. Investors have a critical role to play across the sector, from exercising stewardship to improve the working conditions to tackling problems created through the pressures of excessive financialization.

NOTE:

This briefing focuses upon the issues in private for-profit nursing homes, although also draws upon research from some of the wider long-term care (LTC) sector. The LTC sector also includes other forms of care, including home care or informalized care. Nursing homes can also be referred to as residential or institutionalized care, or care homes.

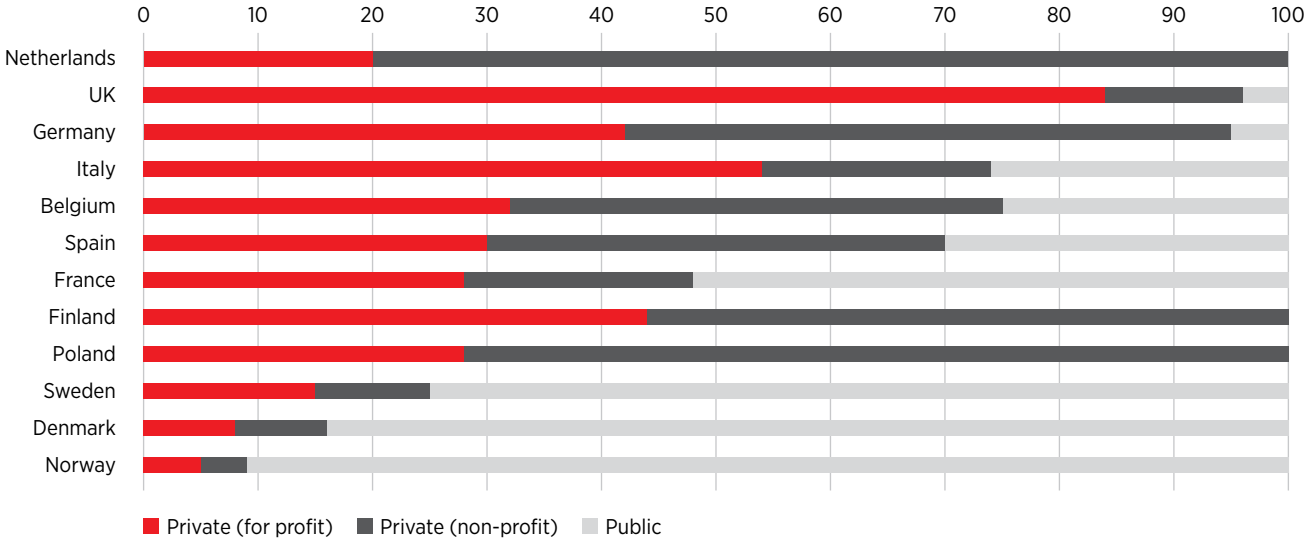
ABOUT THE NURSING HOME SECTOR

Demand for nursing homes is poised to grow globally, particularly with the demographic shifts in developed economies with a growing proportion of the elderly population and increasing lifespans. The number of people aged over 80 years will climb from over 57 million in 2016 to over 1.2 billion in 2050 in 37 OECD countries.[4]

Most countries are currently ill-prepared to meet this demand in several respects, most critically in funding and in the workforce, as discussed later in this brief. In three-quarters of OECD countries, growth in the number of long-term care workers has been outpaced by the growth in numbers of elderly people between 2011 and 2016.[5] The OECD found that the number of care workers will need to increase by 60% by 2040 or 13.5 million workers across the OECD to keep the current ratio of carers to elderly people.[6] At the same time, a European Commission study estimated that for EU member states "projections show that public long-term care expenditure in the EU is to increase from 1.6% to 2.7% of GDP, i.e. an increase of almost 70%, exerting constant pressure on public finances."[7]

While long-term care systems vary considerably across countries, there are trends of an increasing formalization of care and private nursing homes. Figure 1 below shows the extent of the private sector, both non and for profit across Europe.

FIGURE 1:
Percentage of public and private care home ownership in Europe based on data from Knight Frank[8]



While the private nursing home sector is extremely fragmented overall, both globally and domestically within many countries, some major for-profit chains stand out in this context. COVID-19 is likely to accelerate consolidation through mergers and acquisitions given the financial distress created by the pandemic for many nursing homes.[9]

Within Europe, Korian, Orpea and Domus VI have emerged as the largest pan-European nursing home firms and increasingly are expanding outside of Europe. Both Orpea and the Domus VI-backed Acalis have been pushing particularly into Latin America. In the UK, nearly one-fifth of the sector is taken up by the so-called big five operators (HC-One, Four Seasons, Barchester, Bupa and Care UK), however their market share is declining, falling from 16% in 2014 to 13% in 2019 as other mid-sized operators increase in size.[10]

Looking to North America, in the US, the Centers for Disease Control and Prevention (CDC) estimate nearly 70% of the nursing homes have for-profit ownership.[11] Since the 1990s, nursing home chains have had significant growth through acquisitions in the US, but the market still remains highly fragmented.[12] Some of the major US for-profit chains include Genesis, HCR Manorcare, Consulate Healthcare, Brookdale and the Ensign Group. In Canada, growth has varied by province, but in provinces such as Ontario, policy changes and public-private partnerships encouraged the rapid growth of for-profit chain providers since the 1990s. Major chains include Revera, Sienna, Extendicare and Chartwell.

Demand for nursing homes is poised to grow globally, particularly with the demographic shifts in developed economies with a growing proportion of the elderly population and increasing lifespans.

Australia is dominated by six major players: Bupa, Allity, Opal, Japara, Estia, and Regis. Of these, Japara, Estia and Regis are publicly listed companies, while Allity and Opal are private equity-backed. Bupa is a UK-headquartered multinational, which is privately owned.

Within this landscape, these companies often have complex and opaque structures, with multiple layers of corporate ownership and separate property companies or real estate investment trusts (REITs), which can be used to reduce taxes, litigation actions and regulatory oversight.[13]

Interrelatedly, private equity investments are surging in the sector, driven in part by the considerable real estate assets alongside the propositions of the demographic trends and stable revenues.[14] This took off in the US in early 2000s with acquisitions of major chains, and by 2010 private equity firms owned 40% of the biggest for-profit chains.[15] In the UK, three of the big five care operators are owned by private equity firms. The interest of private equity in the sector is posed to continue to expand further outside of the US and UK. Bain Capital, for example, recently won a USD $1.1 billion bid for the major Japanese nursing home provider Nichiigakkan.[16] Across Europe, private equity has been rapidly acquiring nursing homes. For example, EQT recently took a majority stake in the multinational French chain Colisée.[17] Tertianum, the largest Swiss chain, is owned by private equity firm Capvis AG, while Germany's second-largest chain Alloheim is owned by private equity firm Nordic Capital.[18] Ireland's largest nursing home operator Mowlam Healthcare is set to be taken over by a private equity fund. The role of private equity has had a significant impact on worsening conditions in the sector, as will be later explored.

THE ISSUES IN THE SECTOR

The COVID-19 pandemic did not strike a blank slate in nursing homes. The vulnerabilities of nursing homes to the contagion of the disease stemmed from long-standing problems in the sector – notably in the quality of care for residents, the working conditions, and financial sustainability. Among these interlinked issues, the pandemic's spotlight has illuminated the urgent need to address the poor working conditions to improve quality of care, and the role of financial actors in doing so. Figure 2 below illustrates a simplified interconnection of these factors, coming together to create the underlying crisis in care homes when the pandemic began.

FIGURE 2:
The interconnected crisis

As noted in Figure 2, even before the pandemic, the sector faced critical challenges in attracting and retaining sufficient workers to meet the needs for growth of the sector. The OECD has highlighted that this severe shortage of care workers globally stems largely due to the poor quality of jobs.[19] The following key issues in job quality have proved particularly critical in both the response to the COVID-19 pandemic and the long-term needs for workers, residents, and the sector's long-term needs.

Understaffing

Understaffing has been a persistent problem in the sector, often with inadequate staff-to-resident ratios. This fundamentally undermines the quality of care for residents, limiting residents' most basic levels of care or more advanced health support.

It is also both a cause and an outcome of poor working conditions. With the reputation and conditions of the industry, nursing home operators struggle to recruit and retain enough workers. This understaffing then creates more pressure on the existing workers, which creates a downward cycle as this pressure leads to further challenges in attracting and retaining workers and rising absenteeism. This in turn reinforces the understaffing.

This cycle stems from both the poor quality of jobs in the sector coupled with cost-cutting strategies, particularly in those nursing homes owned by private equity. An overwhelming majority of academic studies from the US have found that for-profit ownership and private-equity backing of nursing homes weaken facilities' staffing levels and overall quality of care compliance.[20] One study from New Jersey found that "private equity nursing homes provided each resident with only 3.59 risk-adjusted total nursing hours per day, less than all other ownership types and about 20 percent less than was provided at non-profit and public facilities.[21]

This follows a pattern of private equity strategies to reduce staffing. For example, a 2017 study of how a private equity takeover affected a nursing home chain found that the private equity chain "pursued a strategy of low staffing levels" by lowering total staffing hours per resident day, stripping the real estate, and extracting significantly higher operating margins.[22] A 2018 study of conditions at private equity-owned Arkansas facilities that were the subject of a lawsuit found that staffing levels were insufficient to meet residents' basic needs or to address their medical conditions resulting in "many quality of care problems, injuries, and deaths, as well as violations of their rights to human dignity."[23]

In the context of COVID-19, understaffing was found to significantly impact the contagion of the disease. For example, in Canada, where more than 80% of COVID-19 related deaths came from long-term care homes, understaffing played a critical role, according to academics and government officials including a report from the military which stepped into five failing care homes.[24] In Ontario, where much of this crisis played out, regulation and enforcement has been reportedly inadequate, with standards lowered for staffing ratios in the 1990s and little consequence for failing to meet even those reduced standards. One Chartwell home has reportedly been cited dozens of times in recent years for not maintaining adequate staffing.[25] Follow up-inspections often found that the Chartwell operators repeatedly "failed to comply" with regulations but there has been little consequence for them.[26]

Extensive academic evidence across several jurisdictions reinforces the link between lower staffing ratios and the contagion of COVID-19 and other infectious diseases. For example, in the UK, higher staff-to-resident ratios were associated with a lower risk of coronavirus infections, with a ten-percentage point increase in the bed-to-staff ratio associated with a 23% increase in infection.[27] They note that low staff-to-resident ratios along with lower occupancy rates "are likely to facilitate the implementation of infection control procedures such as isolating or cohorting infected residents, staff training, and regular environmental deep cleaning. When staff care for fewer residents, they also have a reduced likelihood of spreading infection between residents. Higher staff-to-resident ratios may also decrease reliance on agency staff who may spread infection between [long-term care facilities], and indicate better resourced [long-term care] facilities."[28]

US studies found a similar link, with a study finding that for every 20 minutes of additional registered nursing staffing time was associated with a 22% decrease in COVID-19 cases.[29] A University of Chicago study found similar significance for aides, concluding that "Having enough nurse aides to implement virus containment will be crucial if deaths are to be averted."[30]

Health and Safety

The pandemic has shone the spotlight on the health and safety deficiencies at nursing homes and the dire impact of these failings. The vulnerabilities of residents create an inherently high-risk environment for health and safety overall, not least contagious diseases. Many governments also fundamentally failed to act to prevent tragic consequences in nursing homes. But within this context, it is critical to recognize the failings of nursing home companies to manage their responsibilities to mitigate the clear risks of a health and safety crisis.

Nursing homes have long had a dismal record of health and safety performance for residents and workers. The US's CDC found that nursing home residents have an estimated 1 million to 3 million serious infections each year, and as many as 380,000 deaths attributable to them.[31] This is not isolated to the US. The OECD reports health care-associated infections were common across long-term care, with an average prevalence of 3.8% among residents in OECD countries in 2016-17.[32] Numerous exposés and legal actions worldwide, including high-profile cases such as Bupa in Australia,[33] and Golden Living in the US[34], documented horrendous conditions residents endured in nursing homes.

In addition to the pandemic, workers also bear a heavy health and safety toll with a high risk of infection, injuries and psychological distress. Across OECD countries, 15% of long-term care workers reported work-related health issues on average, compared to 12% of hospital-based workers. In the Netherlands, sickness absence in the sector is twice the national average. It ranks high in terms of the numbers of serious worker compensation claims, primarily because of muscular stress while handling objects and lifting or moving elderly people.[35]

The OECD further reports that: "Violence perpetrated by a resident or a resident's visitor is common in the sector, which may further contribute to mental and physical health risks at work. In the United States, a study showed that 48% of institution-based workers had been assaulted at least once in the last three months, 26% had been assaulted 1-2 times and 22% had been assaulted at least three times."[36] They note that this often goes unreported because of fears of losing their job or retaliation, closely intertwined with a lack of freedom of association and collective bargaining.

Lack of preparedness for the pandemic

The health and safety deficiencies are directly connected to the preparedness of nursing homes for the pandemic. In the US, for example, a recent report from the Government Accountability Office found that almost half of American nursing homes routinely violate infection-control standards, including those involving the isolation of sick residents.[37] A ProPublica investigation found that roughly 43% of such facilities did not have a legally-mandated emergency response plan at the start of this pandemic.[38] Last year, infection control was the largest single violation category in nursing-home inspections, according to the Centers for Medicare and Medicaid Services, with nearly 7,200 citations.[39] One of the most basic infection-control measures, hand hygiene, is reportedly one of the most cited health violations in nursing homes.

Again, this is not limited to the US. The New York Times reports only about a third of European nursing homes had infectious disease teams before the pandemic.[40] Most lacked in-house doctors and many had no arrangements with outside physicians to coordinate care.[41]

With this ill-preparedness, many nursing home operators then failed to manage the critical factors of personal, protective equipment (PPE), infection control protocols, and provision of sick pay to reduce the impact of the virus. A growing number of lawsuits have documented these deficiencies.[42] Once again, there is extensive evidence of these failings being amplified even further in private equity-backed nursing homes, as will be later explored.

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In many countries, high-profile reports revealed that nursing home workers were provided insufficient or poor-quality PPE. In some examples, the operators had even instructed staff in the beginning of the pandemic not to wear masks as it made patients uncomfortable, or to reuse PPE.[43]

Many firms also failed to adequately test, isolate and report ill patients. For example, a nurse employed at the private equity-backed Consulate reported that the head office had told staff that they were not allowed to test any patients with symptoms, and reportedly even intercepted testing kits. They instead required that "If local health recommends testing, send resident out to hospital."[44] At another US nursing home in Washington State, part of the Life Care Centers of America (LCCA), federal inspectors found that the facility had failed to proactively identify and manage ill residents and did not notify the state's Department of Health about the increasing rate of respiratory infection among residents, amongst other deficiencies. The centre could be fined more than $610,000 for its shortcomings and three "immediate jeopardy" issues related to the facility's COVID-19 response.

In countries where sick pay is not legally required, nursing homes' decision to provide sick pay is also a key factor in health outcomes. In the UK, for example, where statutory sick pay is very low, a study from the Office for National Statistics found that where sick pay was provided, there were lower levels of infections of residents.[45] Unfortunately reports indicate that some nursing homes not only did not provide financial support, but threatened staff if they could not work because of the need to self-isolate. At one Enlivant nursing home, employees alleged that after the first resident tested positive for COVID-19, staff were informed that: "There is no need to self-quarantine and per company policy anyone who chooses to do that will be considered self-termination."[46] Such practices create perverse incentives by encouraging workers to not get tested for COVID-19 or stay home when necessary, risking further contagion of the disease amongst both staff and residents.

Ensuring health and safety standards in this context is critically intertwined with the need for improvements in standards for workers. As the OECD notes: "Some of those safety failures could have been prevented with more investment in [the long-term care] workforce and infrastructure to ensure suitable levels of trained staff, with decent working conditions and prioritizing care quality and safety."[47]

Addressing workforce shortages

Improving health and safety is also a key component of attracting and retaining workers, even more so post-COVID-19, and thus can help correct the downward cycle of pressures on the sector. In the US alone, more than 700 nursing home staff have died from COVID-19,[48] a risk few are willing to take for the dismal pay and conditions.

The OECD reports that: "Good workplace safety not only improves the health of [long-term care] workers but also decreases their intention to leave. Prior work shows that in Sweden work-related exhaustion is one of the strongest predictors of low workplace satisfaction among home-based and institution-based workers. In the United States, people reporting that they worked in a less safe environment, in institutions, were almost twice as likely to consider leaving their job in the next two years, compared to those working in a good safety climate."[49] They report for instance, a 10% increase in turnover was associated with an increase in mortality among nursing home care residents and a decrease in the quality of care measured by the physical environment and infection control, among other factors.[50]

Wages and Contracts

The extremely low wages and prevalence of precarious contracts in the sector add another piece to the interconnected crisis in the sector, both in the long-term and in the pandemic's immediate threats.

Across Europe, the OECD reports that "[Long-term care] workers earn much less than those working at hospitals in similar occupations. The median wage for long-term care workers across European countries was EUR 9 per hour, compared to EUR 14 per hour for hospital workers in broadly similar occupations. There are also more career promotion prospects in hospitals than in the [long-term care] sector."[51] For example, in the United Kingdom, the Low Pay Commission has flagged social care as a sector of concern in terms of compliance with the national minimum wage.

The OECD also reported that: "Non-standard employment, including part-time and temporary work, is common in the sector. Almost half (45%) of [long-term care] workers in OECD countries work part-time, over twice the share in the economy as a whole. Temporary employment is frequent: almost one in five [long-term care] workers have a temporary contract, compared to just over one in ten in hospitals."[52] This share reaches 30% or more in Poland and Spain.[53] In France, for example, one-third of institution-based long-term care workers were temporary agency workers.[54] In England, the share of zero-hours contracts in the sector is high compared to the average in the economy, representing a quarter of the entire workforce in the sector.[55]

The combination of low-wages and precariousness has been tied to the spread of the coronavirus, with nursing home workers often needing to work multiple jobs at multiple homes in order to earn enough to make a living. In the US, for example, analysts have found poorly paid staff members working two or more nursing home jobs may be significant contributors to the contagion of COVID-19. A study by the National Bureau of Economic Research, for example, traced connections between nursing homes using geolocation data and found that the typical nursing home has, on average, staff connections with 15 other facilities, concluding that "eliminating staff linkages between nursing homes" could reduce coronavirus infections in nursing homes by 44%.[56]

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The US CDC found that at one of the earliest outbreaks in a nursing home: "Limitations in effective infection control and prevention and staff members working in multiple facilities contributed to intra- and interfacility spread."[57] The New York Times reports that "Many staff members are not employed full time even though they essentially do two full-time jobs a day, sometimes 14-hour-long stretches separated by a break of just one or two hours. Most get paid close to minimum wage and do not get sick leave."[58] David Grabowski, a professor of health care policy at Harvard Medical School, concluded: "We don't value this work force, and if we paid them a full-time position or a living wage, they wouldn't have to do all this moonlighting across facilities."[59]

In Canada, sector experts point to the same issue taking place, contributing to the spread of COVID-19 in nursing homes. In Ontario, the government even stepped in to ban staff working at multiple care homes.[60]

The UK's Office for National Statistics found similar correlations. They reported that care homes where staff regularly work elsewhere increase the odds of infection of staff. They also found that care homes using bank or agency nurses or carers most days or every day are more likely to have cases in residents and in staff.[61]

Beyond the pandemic, the low wages and insecure work are a major obstacle to attracting and retaining the workforce needed to keep pace with the growth of the sector. The OECD found that low wages "present a challenge for staff retention, especially because there are few opportunities for pay progression."[62] On the other hand, they report that "There is evidence that wage increases in LTC have led to employment of more workers, longer job tenure and lower turnover. When higher wages have led to an increase in skilled workers, they have contributed to more consumer value than they cost."[63] Insecure work has also been found to increase turnover rates. For example, in the UK turnover rates were nearly 28% higher for workers on zero-hour contracts, with a 31.8% turnover rate for those on zero-hour contracts compared to 24.9% for those not.[64]

It is crucial however to recognize that raising wages alone will not fully solve these issues in care. As the OECD notes: "Wage increases that are not matched by increases in resources lead to increased workload and duties."[65] Ensuring the rise of wages alongside improving wider conditions is a critical role for collective bargaining.

A US study found the presence of a health care worker union was associated with a 30% lower mortality rate from COVID-19 among nursing home residents.

Freedom of association and collective bargaining

Social dialogue with trade unions, underpinned by respect for freedom of association and collective bargaining, is an integral component to addressing the poor conditions discussed. During the pandemic, trade unions have been found to be a key differentiator in the COVID-19 impacts at nursing homes. A study focusing on New York State found that among 355 nursing homes in New York State, the presence of a health care worker union was associated with a 30% lower mortality rate from COVID-19 among nursing home residents.[66] They also found that unions were associated with a 42% relative decrease in COVID-19 infection rates among nursing home residents.[67] These findings were robust to adjustment for a range of covariates and specification checks for bias from missing data.

The study points to the reasons for this outcome, finding that "nursing homes with labor unions had greater access to PPE and lower COVID-19 infection rates—two important mechanisms that may link unions to lower COVID-19 mortality rates."[68] They report: "Specifically, unions were associated with a 13.8% relative increase in access to N95 respirators and a 7.3% relative increase in access to eye shields."[69]

They state that official guidelines now recommend the use of this PPE, as well as universal testing in facilities with confirmed COVID-19 infections. However, they note that "equipment and test shortages, as well as challenges with implementing infection control plans, have limited the adoption of these recommendations."[70] They conclude that trade unions representing health care workers perform several functions that may reduce transmission of COVID-19:

> "Unions generally demand high staff-to-patient ratios, paid sick leave, and higher wage and benefit levels that reduce staff turnover. They educate workers about their health and safety rights, work to ensure that such rights are enforced, demand that employers mitigate known hazards, and give workers a collective voice that can improve communication with employers. In the specific context of the COVID-19 pandemic in New York, labor unions advocated for access to PPE and new infection control policies. Health care worker unions have been shown to improve the occupational safety of health care workers and, in some cases, overall patient outcomes."[71]

Unions in nursing homes also played these critical roles in pushing for robust standards in many other countries. In Australia, the UWU ensured workers – including casual staff - are provided paid COVID-19 leave at nursing home chains Bupa and Brightwater.[72] In New Zealand E tū has called on the New Zealand government to introduce mandatory minimum staff-to-resident ratios in private nursing care homes.[73]

In Torun, Poland, nursing home workers have organized to secure deliveries of PPE, hazard pay for those working with COVID-19 patients, and pay rises so that pay now meets the minimum wage.[74] In the UK, the GMB won full COVID-19 sick pay for the 27,000 workers at HC-One.[75] In Ireland, the union SIPTU arranged a protocol for workers across their health and social care services to work safely in private nursing homes, helping ease staffing shortages.[76] In Spain, the CCOO tried to work with management at a Vitalia nursing home to implement the needed health and safety precautions, and alerting the government labour inspectorate when such actions were not taken.[77] When both the company and government failed to intervene, the CCOO ultimately called for an indefinite strike to ensure necessary measures are taken for resident and staff safety.[78]

> Collective bargaining is needed to ensure long-term care workers receive proper training and have improved working conditions.

These roles trade unions played during the pandemic illuminate their importance in addressing the many other long-standing issues in the sector's working conditions. For health and safety more widely, the OECD highlights the instrumental role of worker representatives in creating a culture of health in the workplace. They also highlight that "collective bargaining is needed to ensure long-term care workers receive proper training and have improved working conditions,"[79] which as discussed are closely intertwined with health and safety outcomes.

They note however that the lack of collective bargaining coverage holds back progress for the sector. They report that: "Collective bargaining can be used to improve working conditions and wages in the sector. The extent of unionisation levels and social dialogue is uneven across and within countries in the [long-term care] sector, limiting its reach."[80] In particular, they cite obstacles to ensuring training and equal standards for temporary or agency workers without trade union representation. On the other hand, they note the improvements secured in Austria through trade union negotiations: "In Austria, collective bargaining in long-term care led to the approval of improved working conditions: more vacation and free weekends were negotiated in the collective agreement, along with compulsory supervision in the care sector."[81]

Spotlight: Orpea and freedom of association and collective bargaining

The publicly listed French nursing home chain Orpea has grown to be Europe's largest private nursing home provider and is expanding rapidly outside Europe into Latin America and China. In several ways, Orpea illuminates these key issues in care.

Orpea has a record of cutting costs, including through under-staffing and anti-union behaviour, with a direct impact on the quality of resident care. Exposés have highlighted these intersecting issues in cases such as in France[82] and Switzerland.[83] The company's dismissals of union leaders led to court rulings against their behaviour in Germany[84] and ongoing court cases in Poland.[85] In France in 2014, the CGT even filed a complaint against the company for spying on the union through infiltration.[86]

In Madrid, Orpea stands out for sanctions from the Ministry of Social Policies for poor practices, including often understaffing. Of all the 140 penalties issued, more than a third (58) were directed against one Orpea centre.[87] In total, within Madrid alone Orpea had to pay 64 fines worth more than €500,000 between 2015 and 2020, according to media analysis of government data.[88]

COVID-19 elevated these long-standing issues into a critical health and safety risk. Orpea reported 475 COVID-19-related deaths, despite stating that because of their presence in China they were aware early of the risks.[89] In Belgium, workers went on strike over understaffing and lack of supplies.[90] In Spain, the company is facing legal actions from families who lost loved ones in their nursing homes,[91] and media scrutiny such as the powerful story of an 89-year-old resident who left his Orpea nursing home over the fear of losing his life to COVID-19.[92]

Even as a publicly listed company, Orpea also demonstrates a disconnect between the purpose of nursing homes and the sector's financialization. Its business model and annual reporting focus on acquisitions and real estate assets rather than providing care services. As noted in one critique: "Orpea is explicit about its business model: acquire high-value land, hold onto it as prices climb, then sell to cash in, leasing back the care homes if they are profitable enough."[93]

PRESSURES FROM FINANCIALIZATION

As highlighted throughout this brief, pressures from excessive financialization have underpinned many of these interconnected sector issues. As noted earlier in the brief, private equity investments in particular have been well-evidenced to amplify all the documented problems of the sector. But the example of Orpea demonstrates that these issues are by no means limited to only private equity-held nursing homes.

As with the other factors, this came to the fore during the COVID-19 pandemic. A study from Americans for Financial Reform (AFR) focusing on New Jersey found that 58.8% of private equity nursing home residents contracted COVID-19, 24.5% higher than the state-wide nursing home average and 57% higher than at public facilities.[94] They also found that the coronavirus fatality rate was 10.2% higher at private equity facilities than the state-wide average and higher than at non-profit and for-profit facilities.[95] They note that the share of private equity resident cases is 25% higher than its share of residents and the share of deaths is 33% higher.[96] Private equity ownership of the sector came into scrutiny as COVID-19 hit nursing homes in many countries – particularly the US, Canada, and the UK.

The controversy of private equity in the sector is not new to the pandemic. High-profile bankruptcies from Four Seasons in the UK to ManorCare in the US raised fundamental questions on the role of private equity in long-term care. Many media reports examined the rise of deficiencies after private equity takeovers, such as a New York Times investigation on the industry[97] and a Washington Post report on the deterioration of standards before ManorCare's bankruptcy.[98] Moreover, academic studies have evidenced the long record of private equity takeovers driving lower resident care quality. The report from AFR summarises key studies:

> "A 2014 Journal of Health Care Finance study found that private equity delivered lower quality care than other for-profits, which deliver poorer care than non-profit nursing homes.[99] It found that private equity-owned nursing homes had 29 percent fewer registered nursing hours per patient, 9 percent more pressure sores and 21 percent more deficiencies than for-profit homes.[100] A 2020 study by researchers from the University of Pennsylvania, New York University, and the University of Chicago found "robust evidence of declines in patient health and compliance with care standards."[101] The longitudinal study of private equity nursing home takeovers found that buyouts led to declines in quality ratings by federal authorities, reduced per patient per day staffing ratios driven by "cuts to 'front line' caregivers," and higher hospital readmission rates.[102] Private equity purchases led to a 6.5 percent decline in quality ratings, a 4.0 percent decline in patient health outcome ratings, and other reductions in quality the researchers conclude results in "economically and statistically significant declines across multiple dimensions of quality at nursing homes following [private equity] buyouts."[103]

The practices that drive these deteriorating standards at its core can be attributed to a misalignment of purpose. As noted in the 2020 study from University of Pennsylvania, New York University and the University of Chicago: "In the nursing home setting, it appears that high powered profit maximizing incentives can lead firms to renege on implicit contracts to provide high quality care, creating value for the firms at the expense of patients."[104]

In practice, this takes various forms but often entails increasing debts for the nursing homes. A common practice particularly under private equity ownership in both the US and the UK is splitting nursing homes into real estate partnerships which own the nursing homes and the operating businesses, which run the individual nursing homes. The real estate companies own the nursing homes and rent them back to the operating businesses, which can be profitable for the owners of the real estate assets, but a Harvard study found these practices led to "significantly decreasing liquidity" and increasing debt for the nursing home operators.[105] Moreover, the operating nursing home can also be required to purchase services and supplies from companies affiliated with the owner of the firm, which again can further reflect a conflict of interest and ultimately incur further debts.[106]

In the UK for example, a report from the Centre for Health and the Public Interest found that "The collapse of the care home provider, Southern Cross, was in part due to unaffordable rents."[107] They note that seven of the 18 large for-profit providers in the UK spend between 15% and 32% of their revenue on rent payments.[108] They also calculate that the five large UK for-profit private equity-backed providers have borrowed £35,072 for each care bed they own, and pay interest costs of £102 per bed per week.[109] Those for-profit firms not backed by private equity still have significant debts, borrowing £21,546 for each care bed they own, and pay interest costs of £14 per bed per week.[110]

In addition to jeopardizing the financial stability of the nursing home companies, these practices also can insulate the owners of the firms from the liability and fines that can come from poor practices, reducing the pressure for improving standards. It can also serve as a means of minimizing tax obligations. Moreover, these complex structures limit transparency, creating extremely opaque chains of ownership and further shielding from accountability.

It is worth noting that this comes in the context that in many countries nursing homes were traditionally and to varying degrees still are also provided by the public sector. In many countries long-term care is also still largely funded by the public sector, raising further implications for needs of transparency and alignment of financial management with the public interest.

Spotlight on HC-One: Over-financialization

HC-One is the largest provider of elderly care in the UK, with 272 nursing homes across the UK and 16,306 beds and 27,000 staff. The company has an extremely opaque structure. Their financial accounts indicate that their "immediate parent" is Jersey-based Libra Intermediate, while their "ultimate parent" is a Cayman Islands-based entity called FC Skyfall LP. Analysis has found 62 companies under FC Skyfall, which along with 17 more companies, are registered in the Cayman Islands, known for secrecy and as a tax haven.[111]

The company is owned by a consortium of private equity investors including Formation Capital, Safanad, and Court Cavendish, a management company run by the founder of HC-One, Chai Patel.[112] It has previously changed hands of investors three times in less than a decade, each time becoming further indebted.[113]

Within this complex structure, media reports exposed problematic over-financialization. Analysis from investigative journalists in Scotland for example found that HC-One is often split into operating companies and property companies, allowing the property company to charge the operating company high rent. Registries in Scotland showed that HC-One rents six of its care homes from HCP UK Investments (Jersey) Limited.[114] HCP UK Investments is largely owned by the Chinese Ministry of Finance through the Cindat investment fund and China Cinda bank, and the property investor Omega Healthcare.[115] As well as renting care homes from HCP, HC-One also rents 23 Scottish care homes from its own sister company, FC Skyfall IOM Properties Limited.[116] For one care home, they report that: "Land registry records show that HC-One's property company pays an independent company £76,500 a year to lease Redmill Nursing Home in West Lothian. The property company then sub-leases the building to HC-One's care company for £293,000 a year."[117]

Other investigative analysis of their accounts also showed that the company payed out £5.43 million over two years in "transaction and management fees" from a firm called FC Skyfall Holdings SVP, which is 10.7% owned by founder Patel and his family, to Court Vavendish Ltd, 90% owned by Patel and his family.[118] They report that recent accounts show the company "reported pre-tax profit of £1.95m with £6m paid to shareholders in dividends and an £809,000 pay package handed to its highest paid executive, up from £469,000 the previous year."[119]

These practices positioned HC-One precariously for the coronavirus crisis. HC-One had COVID-19 outbreaks in about two-thirds of its 238 care homes and had more than COVID-19 related 1,000 deaths.[120] The company warned in April 2020 that it is at risk of breaching the terms on loans worth more than £265 million, due to the reduced occupancy and needs for extra funding for PPE and higher staff costs.[121]

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In Scotland, in a care home where 10 residents died, regulators threatened to strip the home of their licence to operate after finding serious shortcomings in their management.[122] The reports included residents lying in urine and faeces.[123] Ultimately, the home is now being purchased by the UK's National Health Service (NHS).[124] They are also facing a potential legal action from Leigh Day on behalf of families who lost loved ones at the site.[125]

Despite this, progress has come in HC-One's practices due to the presence of unions in the company. In May 2020, the trade union GMB successfully negotiated to ensure HC-One provides all their workforce COVID-19 sick pay.[126] Prior to this most workers in UK care homes only receive the statutory sick pay (SSP) of £95 per week.

THE RELEVANCE FOR INVESTORS

Improving the standards in the nursing home industry is highly relevant to investors from a range of perspectives, including human rights responsibilities, commitments to gender and racial diversity, and a clear-cut business case.

Human rights

As the briefing has touched upon, the human rights at risk from the poor practices in nursing homes are stark and multi-fold. Ultimately with COVID-19, the lives of both residents and staff are at risk. Alongside this, the sector has documented human rights concerns with health and safety, living wages, and freedom of association and collective bargaining.

Under the OECD Guidelines for Multinational Enterprises, investors with minority shareholdings in companies that cause or contribute to adverse human rights impacts have a responsibility to prevent or mitigate those adverse impacts using investment stewardship tools.

The OECD guidance also notes that in some situations investors, such as private equity investors or others with a significant degree of control in a company, may be considered "contributing" to these impacts rather than being "directly linked" and so may be responsible for remediation. They cite: "These situations could arise where investors wield significant managerial control over a company, for example, in certain General Partnerships."[127]

With the momentum for mandatory human rights due diligence requirements across a number of jurisdictions, including at the EU level, these responsibilities may become codified into a legal requirement for investors' own due diligence.

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Diversity commitments

Many investors have committed to action to address racial and gender disparities, based on a human rights or financial perspective. On average across OECD countries, women represent more than 90% of the long-term care workforce.[128] With the dismally low wages in the sector, raising wages would be an impactful way to address societal gender pay gaps.

There is also a disproportionate impact of the poor conditions of the sector along racial lines, amplified even further during the pandemic. In the US, for example, a recent study found that: "63% of nursing homes with a relatively high share of Black residents reported one or more COVID-19 death, higher than the share reported by nursing homes with a lower share of Black residents (40%). Similarly, 55% of nursing homes with a relatively high share of Hispanic residents reported COVID-19 deaths, higher than the share reported by nursing homes with a lower share of Hispanic residents (44%)."[129] A New York Times analysis found a similar pattern, reporting that nursing homes with a significant percentage of Black or Latino residents had double the prevalence of COVID-19 as homes where that is not the case.[130]

Staff facing these risks also are also disproportionately people of colour, with 48% of the US long-term care workforce being non-white.[131] Outside the US, the sector is also often dominated by migrant workers. The OECD reports that on average, foreign-born workers represent over 20% of OECD countries' long-term care workforce. These workers face additional risks from the vulnerability of their status as a migrant worker.

With this disproportionate impact of the poor conditions of the sector on women and people of colour, nursing homes are highly relevant for investors seeking to act on commitments to addressing gender or racial disparities.

The business case

Improving standards in nursing homes, including specifically working conditions, has a clear-cut business case. The sector is people-centred, depending on workers to deliver the purpose of the business to deliver quality care for residents. Failing to do so harms corporate reputations which can create challenges attracting residents, and ultimately can also create legal risks.

High-profile bankruptcies from HCR ManorCare in the US to Southern Cross in the UK, following patterns of deteriorating standards, have illuminated the financial risks in the sector long before COVID-19. But the pandemic has heightened these risks further. Share prices tanked for nursing home operators and the Real Estate Investment Trusts (REITs) in the sector in the early days of the pandemic. Shares of Brookdale Senior Living, for example, fell from more than $8 in mid-February, as the pandemic was taking hold in the US, to just under $3 in early May.[132] A REIT Ventas had it share prices cut in half — from $62.40 to $29.04.[133] Although these share prices have recovered somewhat, a second-wave could risk another drop.

Nursing homes and analysts have reported dire financial forecasts following the pandemic. Occupancy rates have already dropped – from loss of lives of residents and the reputational impact on the industry. The Guardian reports that "one network with normal occupancy of 92% fell to 70%. Another said its normal occupancy of almost 90% dropped to 79%."[134] A UK analysis from Knight Frank predicted a plunge in the demand for care homes by the end of 2021 that would leave 180,000 beds empty.[135]

Legal risks

Nursing home chains also face significant legal risks from the poor management of the pandemic. Many chains are facing legal actions including lawsuits in Canada[136] and the US,[137] lawsuits and potential criminal investigations in Spain and Italy,[138] and potentially an action on behalf of families of victims HC-One in the UK from Leigh Day.[139]

Many chains are also facing government fines for failing to meet standards. One LCCA facility in the US for example is facing up to $610,000 in fines for its shortcomings in response to the pandemic. Another firm was fined $220,000, and inspectors warned that the fine could keep growing until the problems are remedied.[140] In Madrid, the city has collected €3.8 million from 152 sanctions and 140 penalties on nursing homes over the past five years.[141] More widely, the prosecutor's office in Spain has at least 160 criminal investigations open with long-term care homes over COVID-19, and 211 civil proceedings.[142] This pattern of sanctions holds true across many other countries.

> High-profile bankruptcies... illuminated the financial risks in the sector long before COVID-19. But the pandemic has heightened these risks further.

From this, nursing homes are facing more and more regulatory scrutiny. During COVID-19, regulators have stepped in and even taken over operations of care homes or stripped some of their licences. In Ireland, for example, authorities had taken over running a care home due to its deficiencies, and now are seeking to fully close the facility.[143] Although long-term care is a necessity, the model of large nursing homes has been fundamentally called into question, creating a risk for licence to operate. In particular private equity investors are facing increasing regulatory scrutiny. For example, US Senator Elizabeth Warren along with Senator Sherrod Brown and Member of Congress Mark Pocan sent letters to four private equity firms over their involvement in nursing homes.[144]

Moreover, the contagion of COVID-19 in nursing homes demonstrates a risk to the wider economy from the lapse in standards in nursing homes, impacting investors' wider portfolios. This is a risk for both the immediate recovery from COVID-19, but also presents a risk from future pandemics if conditions are not improved.

Spotlight: Revera and legal risks

Revera is a Canada-based chain of nursing homes, which operates more than 500 properties across Canada, the United States and the United Kingdom.[145] They have approximately 50,000 employees and more than 55,000 residents globally.[146] They own, invest in, or manage the following brands: Revera (Canada), Groupe Sélection (Quebec, Canada), Sunrise Senior Living (US, UK, and Canada), Gracewell Healthcare (UK), Signature (UK), Cogir (Quebec, Canada), and Avera (UK). Revera is a wholly-owned subsidiary of the Public Sector Pension Investment Board (PSP), which invests funds for the pension plans of the Canadian federal public service, the Canadian Forces, the Royal Canadian Mounted Police and the Reserve Force.[147]

As with the other major long-term care providers in Canada, particularly the publicly listed chains of Sienna, Extendicare and Chartwell, Revera has long had a history of deficiencies and public scrutiny. They have also faced ongoing legal risks with lawsuits filed, including multimillion-dollar class action suits that were filed against Revera, Extendicare and Sienna in 2018.[148]

When COVID-19 struck, Revera and the other for-profit operators again hit the headlines over concerns of mismanagement of the disease. In Ontario, where nursing home deaths made up two-thirds of all COVID-19-related deaths in the province, research from SEIU Healthcare found that for-profit homes had 7.2 deaths per bed during the pandemic, in contrast to 4.5 deaths per bed at non-profits, and 2.4 deaths per bed at those owned by the municipal governments.[149] Media reports noted Revera had 230 deaths in their nursing homes in Ontario, the second-highest number of any chain, following only Sienna, which had 295 deaths.[150] Outside Ontario, Revera also owns many of the nursing homes with the highest death tolls.[151] Unions across many of Revera's sites have been calling on the company to increase staffing levels, found to a be a key contributor to the contagion of COVID-19.[152]

Following this, Revera has faced significant legal risks. A CAD $100 million class action lawsuit was filed against Revera and now additionally Sienna Senior Living in Ontario, alleging negligence and breach of contract.[153] Another CAD $25-million class-action lawsuit has been filed against Revera over its operation of the McKenzie Towne Continuing Care Centre in Calgary, where COVID-19 killed 21 residents and infected 63 others as well as 44 employees.[154] These come amongst many other legal actions against Revera specifically and the other operators in the Canadian long-term care sector. In Ontario alone, The Ontario Health Coalition has found at least 21 legal actions relating to conditions in the province's long-term care homes.[155]

The tragic impact of COVID-19 on Canadian nursing homes has also sparked a public debate about the role of a for-profit model in the sector. In Ontario, the military published a scathing report on conditions in five care homes - none of which are owned by Revera. Prime Minister Justin Trudeau called the findings "extremely troubling."[156] Ontario Premier Doug Ford reportedly responded to the question of whether the province will take over long-term care and integrate it into the system: "The system is broken and everything is on the table. I'll do whatever it takes. If that's what it takes, that's what we will do."[157] The PSP has also faced pressure over its investment in Revera. Media exposés highlighted their role,[158] and the public sector union Public Service Alliance of Canada called on them to end their ownership of the chain as a material risk to plan members.[159]

Operational risks

Beyond the pandemic, operationally, the looming crisis of workforce shortages risks holding back the growth of the sector to meet the demographic needs. As the briefing noted earlier, the OECD found that the number of care workers will need to increase by 60% by 2040 or 13.5 million workers across the OECD to keep the current ratio of carers to elderly people.[160] But the sector is struggling to attract and retain workers due to the poor quality of jobs.

Turnover is already creating operational challenges. The OECD reports high turnover issues. In the US, they note, 13% of long term care workers are entrants, while 21% were leaving the sector.[161] In Germany, on average only 68% of long-term care workers in a given year keep participating the following year.[162] In the United Kingdom, the mean turnover rate among care workers between 2008 and 2010 was 23%.[163] In France, it was estimated that 60,000 positions went unfilled in 2019.[164] This turnover generates costs, through requiring hiring replacement staff with associated recruitment and training costs. This briefing notes the need for improving conditions to address this central operational issue.

THE ROLE FOR INVESTORS

The nursing homes sector carries extremely high risks for investors. Investors must consider the sector an urgent priority for action within the COVID-19 pandemic, but also look to address the long-term issues in the sector of: quality of resident care, working conditions, and financial sustainability.

Fully addressing this crisis will require the involvement of all the actors in the sector, including governments alongside the private sector. This intersection of actors cannot be an excuse for inaction. Investors, in particular, have an important role to play to kickstart progress and set best practices. **Without investor impetus across the sector, individual nursing homes will be unable to break the downward cycle of pressures.**

Moreover, from the evidence presented in this briefing it is clear that any strategy for the industry must centre on improving the conditions for workers. The poor working conditions are a central problem in themselves, and also underpin the other critical issues of the sector, not least quality of care for residents. Improving these working conditions is highly dependent on ensuring respect for the rights of freedom of association and collective bargaining, as shown through academic evidence from their central role in the pandemic response and the myriad of examples of unions driving progress on key standards.

Investors must urgently recognize nursing homes as a high-risk industry, particularly regarding labour practices, within their risk management processes. As such, they must also act on this risk including through their stewardship activities.

To be effective, these activities must seek to address the issues for workers outlined in this brief, including:

- **understaffing,**
- **health and safety,**
- **wages and precarious work, and**
- **freedom of association and collective bargaining.**

Over-financialization is also critical for all types of investors to recognize, and even more so for private equity investors themselves and investors such as pension funds invested in private equity.

UNI will be working with investors to raise standards for the industry, including convening investors to develop best practices. We welcome the involvement of interested parties in this.

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