

**GLOBALIZATION AND THE U.K. MARKET IN  
LONG TERM CARE FOR OLDER PEOPLE**

A THESIS SUBMITTED FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

BY

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## ABSTRACT

The thesis aims to build on what is known about large and internationalized welfare firms, and to make a contribution to the debate about social policy and globalization, through an empirical and exploratory study of large and internationalized firms within the UK market in long term care for older people. The thesis utilizes two levels of analysis: a micro level analysis based on case studies of the three largest private providers of long term care in the UK; and a meso level analysis of the relationships between these firms and three other actors: the state and its agencies, staff and unions, and older people themselves. The findings of the thesis contradict deterministic claims concerning the loss of power by the state. The state is found to be the most powerful actor in the sector in terms of its ability to regulate the sector and influence its overall structure. In contrast, the relative weakness of unions and older people's organizations leads them to attempt to exert influence on private providers through the medium of the state. State policies, however, are likely to facilitate greater concentration and internationalization within the sector, an outcome which is in the long term interests of those firms which are already large and internationalized. The parallel processes of concentration and internationalization in the sector have significant implications for the delivery of care.

# CONTENTS

## **LIST OF ACRONYMS AND ABBREVIATIONS**

<b>INTRODUCTION</b>	<b>1</b>
<b>1) GLOBALIZATION, DETERMINISM AND LEVELS OF ANALYSIS</b>	<b>4</b>
INTRODUCTION	4
GLOBALIZATION, POLITICAL ECONOMY AND SOCIAL POLICY	5
LEVELS OF ANALYSIS	18
CONCLUSION	24
<b>2) THE INTERNATIONALIZATION AND REGULATION OF PRIVATELY PROVIDED WELFARE SERVICES</b>	<b>25</b>
INTRODUCTION	25
THE INTERNATIONALIZATION AND CONSOLIDATION OF PRIVATELY PROVIDED WELFARE SERVICES	25
The Growth of Trade and FDI in Services	25
The Internationalization of Privately Provided Welfare Services	29
The UK Market in Long Term Care	34
THE INTERNAL AND EXTERNAL REGULATION OF PRIVATE WELFARE PROVIDERS	40
Managerialism and the Welfare State	40
The External Regulation of Private Firms	42
Regulation and Quality	45
The Internal Regulation of Internationalized Firms	49
Company ‘Culture’ and Mergers and Acquisitions	52
CONCLUSION	55
<b>3) RESEARCH DESIGN AND METHODOLOGY</b>	<b>59</b>
INTRODUCTION	59
THE MICRO LEVEL ANALYSIS	61
THE MESO LEVEL ANALYSIS	65
METHODOLOGICAL QUESTIONS AND PROBLEMS	75
<b>4) FIRM LEVEL CASE STUDIES</b>	<b>84</b>
INTRODUCTION	84
COMPANY 1	85
1: Corporate History and Strategy	85
2: Internationalization	92
3: Quality Assurance and Organization	96
COMPANY 2	110
1: Corporate History and Strategy	110
2: Internationalization	112
3: Quality Assurance and Organization	125

COMPANY 3	132
1: Corporate History and Strategy	132
2: Internationalization	138
3: Quality Assurance and Organization	139
DISCUSSION AND CONCLUSION	143
<b>5) THE STATE AND REGULATION</b>	<b>148</b>
INTRODUCTION	148
ATTITUDES, PERCEPTIONS AND GOALS	149
FORM AND EXTENT OF ORGANIZATION	156
FIRM-SPECIFIC ASPECTS	177
DISCUSSION AND CONCLUSION	199
<b>6) STAFF AND UNIONS</b>	<b>204</b>
INTRODUCTION	204
ATTITUDES, PERCEPTIONS AND GOALS	205
FORM AND EXTENT OF ORGANIZATION	215
FIRM-SPECIFIC ASPECTS	232
DISCUSSION AND CONCLUSION	243
<b>7) RESIDENTS AND OLDER PEOPLE'S ORGANIZATIONS</b>	<b>248</b>
INTRODUCTION	248
ATTITUDES, PERCEPTIONS AND GOALS	249
FORM AND EXTENT OF ORGANIZATION	268
FIRM-SPECIFIC ASPECTS	273
DISCUSSION AND CONCLUSION	280
<b>8) CONCLUSIONS</b>	<b>285</b>
INTRODUCTION	285
IMPLICATIONS FOR THE GLOBALIZATION DEBATE	285
IMPLICATIONS FOR LONG TERM CARE IN THE U.K.	295
CONCLUSION	303
<b>APPENDIX 1: THE BARGAINING ARENA IN RUIGROK &amp; VAN TULDER'S MODEL</b>	
<b>APPENDIX 2: INTERVIEW RESPONDENTS</b>	
<b>APPENDIX 3: EXAMPLES OF INTERVIEW GUIDES</b>	
<b>APPENDIX 4: UNPUBLISHED DOCUMENTS</b>	
<b>BIBLIOGRAPHY</b>	

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## ACRONYMS AND ABBREVIATIONS

BIS	Bank for International Settlements
CCC	Continuing Care Conference
DSS	Department of Social Security
EMI	Elderly Mentally Infirm
EPSU	European Public Services Union
EU	European Union
FDI	Foreign Direct Investment
FIET	International Federation of Executive & Technical staff
FMI	Financial Management Initiative
GATS	General Agreement on Trade in Services
GATT	General Agreement on Tariffs and Trade
GMB	General, Municipal & Boilermakers' union
HA	Health Authority
HAI	Help Age International
HRC	Holiday Retirement Corp
IFA	International Federation on Ageing
IHA	Independent Healthcare Association
IIP	Investors In People
IMF	International Monetary Fund
INGO	International Non-Governmental Organization
IPE	International Political Economy
IR	International Relations
IT	Information Technology
LA	Local Authority
M&A	Mergers and Acquisitions
MAI	Multilateral Agreement on Investment
MNC	Multinational Corporation
MSF	Manufacturing, Services, Finance union
MNE	Multinational Enterprise
NCHA	National Care Homes Association
NCSC	National Care Standards Commission
NGO	Non-Governmental Organization
NHS	National Health Service
NME	National Medical Enterprises
NMW	National Minimum Wage
NPC	National Pensioners' Convention
NPM	New Public Management
NRS	National Required Standards
NSI	Next Steps Initiative
NVQ	National Vocational Qualification
OECD	Organization for Economic Cooperation & Development
OIG	Office of Inspector General (USA)
PFI	Private Finance Initiative
PPP	Private Patients' Plan
PPS	Prospective Payment System (USA)

PSI	Public Services International
PSPRU	Public Sector Privatization Research Unit
QA	Quality Assurance
RCLTC	Royal Commission on Long Term Care
RCN	Royal College of Nursing
REIT	Real Estate Investment Trust
RNHA	Registered Nursing Homes Association
SEIU	Service Employees' International Union
SIACS	States in Advanced Capitalist Societies
STG	Special Transitional Grant
TGWU	Transport & General Workers' Union
TNC	Transnational Corporation
TUC	Trades Union Congress
TUPE	Transfer of Undertakings (Protection of Employment)
UK	United Kingdom
UME	United Medical Enterprises
USA	United States of America
WTD	Working Time Directive
WTO	World Trade Organization

### **Journals and Corporate Authors**

AR	Annual Report
CCMN	Community Care Market News
L & B	Laing & Buisson

## INTRODUCTION

During the period of study during which this thesis was researched and written, the term 'globalization' has moved from relative obscurity to over-used buzzword. Fortunately, it has also become a serious topic of academic study in a wide variety of different disciplines, each of which has sought to investigate different aspects of the phenomenon and the implications of it for the particular concerns of that discipline. However, as Ruigrok & van Tulder (1995: 5) point out, there often seems to be few cross references between different debates and disciplines. Despite this, assumptions have sometimes been transported into one discipline from another without being sufficiently subjected to critical appraisal. This has often led to 'sweeping conclusions' based on acceptance of the claims of others. According to Ruigrok and van Tulder (*ibid*), 'members of the academic community sometimes forgot to put these claims to the same rigorous tests as they demanded from scholars from their own disciplines and debates'.

As will be discussed further in Chapter One, this charge of accepting assumptions at face value is one that can easily be made of some Social Policy accounts of globalization. In particular, such accounts have reflected a widespread view that changes in the world economy have placed severe restrictions on the social policies that can be pursued by governments. Assumptions about the nature of the contemporary world economy drawn, often uncritically, from Political Economy and associated disciplines have thus been used to present often simplistic and deterministic claims about the consequences for welfare provision and the social and economic policies which affect it. There is a rich tradition of analysing the welfare state from the perspective of Political Economy (O'Connor, 1973; Gough, 1979; Offe, 1984; Esping-Anderson, 1990). Yet much of the recent work on globalization within Social Policy has concentrated on the alleged effects upon welfare states, without taking sufficient account of debates within Political Economy which demonstrate the contested status of the idea.



This thesis takes an interdisciplinary approach from the start, integrating the Social Policy literature with that of Political Economy and associated disciplines. In doing so, it follows calls for interdisciplinarity from a number of academics in a cluster of disciplines concerned with globalization, including Social Policy, International Relations, International Political Economy and International Business (Deacon, 1997; Sally, 1996; Ruigrok & van Tulder, 1995; Dunning, 1993; Stopford & Strange, 1991).

Most Social Policy debates on globalization have usually been focused at a 'macro' level of analysis, that is, they attempt to assess the impact of changes in the world market generally on the social policies and reforms pursued by national governments. However, authors within the field of International Business have tended to focus on a 'micro' level analysis of international firms (Dunning, 1993), whilst some authors in International Political Economy have pioneered the study of bargaining relations between such firms and national governments (Stopford & Strange, 1991) or other actors (Ruigrok & van Tulder, 1995), what Ruigrok & van Tulder characterize as a 'meso' level of analysis.

This thesis aims to make a contribution to the study of globalization and social policy by incorporating some of these innovations from other disciplines. It focuses upon developments within one particular area of welfare, where private provision has become the norm in the UK - long term care for older people. It does this by combining two levels of analysis not often utilised within Social Policy. These are, firstly, a 'micro' level analysis based on case studies of the three largest firms operating within the UK long term care market, and secondly, a 'meso' level analysis of the relationships between such firms and three other key actors: the state and its agencies, the firms' staff and unions, and older people themselves.

The thesis has two principal aims. *Firstly*, it aims to build on what is known about large and internationalized welfare firms through an empirical and exploratory study of such firms within the UK market in long term care for older people. As well as having relevance for the globalization debate, this will have relevance for those involved in social work and health practice, who may deal daily with such firms but have little appreciation of the organizational and economic factors behind the delivery of care. So

that the results of the thesis should have the maximum relevance for the recipients of the service studied, there is an emphasis throughout on issues of quality. *Secondly*, the thesis aims to make a contribution to the debate within Social Policy concerning the perceived loss of power by the state and other domestic actors resulting from globalization.

Chapter One reviews the literature on globalization within Social Policy in the context of the Political Economy literature which has influenced it. Chapter One also reviews some approaches to the ‘level of analysis problem’, and its significance for the debate about globalization within Social Policy. This chapter also notes that the state may not be withdrawing from economic and social life, but rather changing the *form* of its intervention.

Chapter Two discusses issues relevant to the private provision and internationalization of welfare services. It notes that internationalization in services generally has increased in recent years, in line with growing internationalization in the wider world economy, and that the privatization of provision has increased the scope for internationalization in welfare services. This has been accompanied by a process of concentration in many sectors, including long term care. However, the increase in private provision of such services has led to a renewed emphasis on their regulation and on issues of quality. The chapter also discusses issues relevant to the internal functioning of large private providers, particularly those which may have a bearing on the quality of care, including processes of merger and acquisition.

Chapter Three outlines the research design of the thesis and discusses methodological issues. How the micro and meso levels of analysis were operationalized is explained in this chapter. Chapter Four discusses the results of the micro level analysis of the case study firms. Chapters Five, Six and Seven discuss the results of the meso level analyses of the relationships between these firms and the three other actors: state agencies, staff and unions, and older people respectively. The concluding chapter, Chapter Eight, discusses the implications of the research for both long term care in the UK, and for the debate about globalization.

# **CHAPTER ONE: GLOBALIZATION, DETERMINISM AND LEVELS OF ANALYSIS**

## **INTRODUCTION**

As indicated in the Introduction to this thesis, the idea of globalization has been adopted for study in a range of disciplines. In Social Policy, globalization has quickly become the new paradigm within which changes to welfare states are explained. ‘The emergence of a competitive global economy which has diminished national autonomy and community identity’ (BASW & University of Central Lancashire, 1999), is increasingly taken to be the causal force which is reshaping welfare.

In the first section of this chapter the debates which have surrounded globalization in the discipline of Social Policy are examined in the light of debates within Political Economy. In particular, deterministic claims concerning the loss of power by the state and other domestic actors are assessed. The section argues that such deterministic accounts of globalization are over-simplistic and open to challenge on a number of counts. Pursuing a theme which will be fundamental to the remainder of the thesis, it is argued that, despite significant changes to the world economy, the state retains its power. However, it will be argued that the *form* of state intervention may be changing, and that state intervention today may often take the form of regulation rather than direct provision. ‘Globalisation’ is thus regarded not as fully realized end point, but as a process which is actively shaped by a number of agents, including the state.

In the second section, the chapter moves on to a discussion of the ‘level of analysis problem’. It is pointed out that most Social Policy accounts of globalization have been pitched at the national, or macro, level of analysis. In contrast, this thesis combines findings from analyses pitched at two other levels: the micro (firm) level, and a meso

level concerned with interaction between core firms and other key actors. This discussion of the 'level of analysis' problem is resumed in Chapter Three.

## **GLOBALIZATION, POLITICAL ECONOMY AND SOCIAL POLICY**

In Political Economy (and International Political Economy in particular) it has been the massive growth of trade, foreign direct investment (FDI) and financial flows which have caught the attention of commentators in relation to globalization. Trade has been growing faster than output throughout the post-war period (Foreman-Peck, 1995: 288), but it was the realization that FDI had begun to grow at an even faster rate than trade in the 1980s which initiated the globalization debate. The primary vehicles for FDI are the Transnational Corporations (TNCs). The world's 37,000 TNCs directly employ about 73 million people, 20% of all employment in the industrialized countries. Their impact on indirect employment is just as huge, bringing the total number of workers dependent on TNCs to at least 40% of total employment in the industrialized countries (Ruigrok & van Tulder, 1995: 155). The role of TNCs is highly significant in both trade and FDI. Some 80% of US trade in 1992 was conducted by TNCs, which is not atypical for developed countries. For total US trade as much as a third was estimated to be intra-TNC trade, i.e. conducted within the boundaries of the company, involving transfers across borders between different parts of the same organization. As far as finance is concerned, even 'globalization sceptics' like Hirst & Thompson (1996) have accepted that there is a strong trend toward globalization. The most innovative changes here have come through the development of complex financial instruments such as derivatives. Technology has been a facilitator, as the exchange of shares and other financial instruments are increasingly recorded only on computer files, without the exchange of paper certificates. It is the volume, speed and price sensitivity of such exchanges which have dazzled commentators.

There are varying responses to these changes in the Social Policy literature. These can broadly be split into three types of response. Firstly, there are those accounts which argue that globalization is pushing all states in broadly the same direction, i.e. welfare retrenchment and the dominance of neo-liberal policies. Mishra (1999) is the

best example of this view, and his work will be discussed further below. Secondly, there are those accounts which argue that globalization is not the cause of contemporary changes in welfare states. This view has been advanced by Paul Pierson (1998), who argues that there are three endogenous causes of the current pressures being experienced by advanced welfare states which have nothing to do with globalization. These are firstly, the expansion of the service sector, which is less productive and therefore leads to slower overall growth; secondly, ‘the maturation of governmental commitments’, particularly pensions and health; and thirdly, population ageing. Despite these pressures, Pierson argues, the strength of support for welfare states in most countries makes their dismantling highly unlikely. The third type of response to globalization in the Social Policy literature are those accounts which argue that globalization is having an effect, but that this varies between different types of welfare state, which retain a degree of autonomy in terms of how they respond to external constraints. Esping-Anderson (1996a & b) is the best example of this view; his work will be discussed further below, especially in the second section of this chapter in relation to the level of analysis problem.

This thesis is primarily concerned with the first of these views, which will be referred to as the ‘deterministic’ view of globalization. This view, which also has many adherents within the wider political economy literature, encompasses the belief that globalization has stripped away the powers of the nation state (as well as of other domestic actors such as trades unions), leaving citizens vulnerable to the ravages of the world market. Ohmae even characterises the nation state as an ‘artefact of the eighteenth and nineteenth centuries’(1995: 129). Soedimoto, of the United Nations University of Tokyo, articulates well the widespread perception that today’s global market is beyond human control by likening it to the natural behaviour of the weather, rather than seeing it as a pattern of human relations:

In the process of interdependence, we have all become *vulnerable*. Our societies are permeable to decisions taken elsewhere in the world. The dynamics of interdependence might better be understood if we think of the globe not in terms of a map of nations but as a meteorological map, where

weather systems swirl independently of any national boundaries and low and high fronts create new climatic conditions far ahead of them.

(quoted in Campanella, 1995: 18, emphasis in original)

Internationalization is most often seen as ‘an exogenous development to which domestic actors must respond rather than the result of conscious policy choice.’ (Garrett, 1996: 83) In this view, even though policy liberalization invariably attends increases in trade and capital mobility, reductions in the relative prices of technology and transportation are seen as causally prior to changes in policy (ibid). Even if substantial state intervention is thought desirable it is not possible without paying high costs in terms of competitiveness (See Keohane & Milner, 1996). A consensus has thus emerged that, in order to attract investment, states must pursue an economic policy based on low taxation, restrained public borrowing and spending, low and stable inflation rates and a low wage, flexible labour market. The consequences for welfare involve both budget restraint and privatization.

This dominant, deterministic, thesis has become a new paradigm which accepts the inevitability of welfare retrenchment, what Held et al (1999: 31) call ‘political fatalism’. Mishra (1999: 6) sums up this view very well:

Put simply, by providing capital with an ‘exit’ option, globalization has strengthened the bargaining power of capital very considerably against government as well as labour... Thus money and investment capital can vote with their feet if they do not like government policies... Indeed globalization virtually sounds the death-knell of the classical social democratic strategy of full employment, high levels of public expenditure and progressive taxation.

Mishra (1999) advances seven propositions which encapsulate the ‘logic’ of globalization as he sees it. These are:

- 1) Globalization undermines the ability of national governments to pursue the objectives of full employment and economic growth through reflationary policies. ‘Keynesianism in one country’ ceases to be a viable option.

- 2) Globalization results in an increasing inequality in wages and working conditions through greater labour market flexibility, a differentiated 'post-Fordist' work-force and decentralized collective bargaining. Global competition and mobility of capital result in 'social dumping' and a downward shift in wages and working conditions.
- 3) Globalization exerts a downward pressure on systems of social protection and social expenditure by prioritizing the reduction of deficits and debt and the lowering of taxation as key objectives of state policy.
- 4) Globalization weakens the ideological underpinnings of social protection, especially that of a national minimum, by undermining national solidarity and legitimating inequality of rewards.
- 5) Globalization weakens the basis of social partnership and tripartism by shifting the balance of power away from labour and the state and towards capital.
- 6) Globalization constrains the policy options of nations by virtually excluding left-of-centre approaches. In this sense it spells the 'end of ideology' as far as welfare state policies are concerned.
- 7) The logic of globalization comes into conflict with the 'logic' of the national community and democratic politics. Social policy emerges as a major issue of contention between global capitalism and the democratic nation state.

With some qualifications, Mishra argues that there is a trend towards the realization of this logic, thus undermining existing welfare provision.

Whilst Mishra (1999) at least acknowledges the role of neo-liberal ideology in promoting contemporary globalization, George (1998: 34) claims that: 'It is a good example of structural forces overriding ideological influences.' George (1998: 30) offers the globalization thesis as 'the central explanatory notion' in approaching welfare developments in advanced industrial societies today. According to him, there are three main effects of globalization on welfare developments. First, the cheaper labour costs of South East Asian Newly Industrializing Countries (NICs) is enabling them to increase their share of world trade at the expense of the West. Second, these lower labour costs are encouraging firms to transfer some of their production to developing countries, putting pressure on advanced industrial countries to lower their own labour costs in order to compete. Third, globalization has resulted in the mobility of capital, but not of labour, making it easier for multinational companies to frustrate

the taxation policies and other demands of national governments. This gives capital the upper hand and undermines the forces which have traditionally defended state welfare. The result is that 'governments are no longer total masters in their own countries and welfare developments are, to some extent, at the mercy of globalizing influences.' (1998: 31) According to George (1998: 34), it is only within these new hostile conditions that national factors influencing welfare can be understood.

A more sophisticated view argues that states can at least actively shape policy in the area of education and labour market efficiency, and thus increase national competitiveness (see Jordan, 1998, and Holden, 1999, for critiques of such policies). According to Reich (1991), it is the workers *within* countries who now must compete with each other, since competitiveness no longer depends on the success of nationally owned corporations (which have outgrown their national bases) but on value added by workers within states. Equipping workers with the skills with which to compete in the global marketplace is seen as the main task of national governments. It is only through education, and the application of new technology which such education allows for, that the value added by routine workers in both the shrinking manufacturing sector and the service sector can be enhanced. This is a view shared by Tony Blair, who has pledged to 'accept globalization and work with it'. According to Blair, the 'driving force of economic change today is globalization' which has created a world order 'where capital and technology are mobile...(and) people are our key resource' (Speech to the Keidenran, Tokyo, 5.1.96, quoted in Froud et al, 1996: 133).

This is ultimately the view of Esping-Anderson (1996a: 4). Whilst his work at least emphasizes the differing types of welfare state adaptation, he nevertheless starts from the proposition that, 'integration in the world today almost automatically implies open economies', further noting that, 'openness is said to sharply restrict nations' capacity to autonomously design their own political economy.' His argument is illustrated in relation to the two very different welfare states of Australia and Sweden (See also Stephens, 1996 and Castles, 1996). Australia could pursue a model of welfare based on job security, full employment and high wages only as long as it adhered to protectionist measures - the price it paid was lagging growth. Sweden could balance full employment with its famously generous welfare state only so long as governments



could control domestic credit and investments, and as long as the ‘labour market partners’ could guarantee wage moderation consensually. Following liberalization in the early 1980s, Sweden suffered heavy capital leakage abroad. At the same time, its tradition of centralized national social pacts eroded. Enhanced openness in both Australia and Sweden has thus compelled governments of both left and right to cut back social expenditure (Hirst & Thompson, 1999: 167, offer a different interpretation of the Swedish crisis). Yet policies based on liberalization tend to produce greater inequalities, and in democracies this compels governments to rely on persuasion or compensatory social guarantees to gain the consent of their populations. Esping-Anderson’s conclusion (1996b: 256) is that a strategy based on education and training can be the basis of a ‘positive-sum solution’ which avoids the ‘trade-off between jobs and equality’. ‘Lifelong learning’ and ‘social investment’ strategies can eliminate the surplus of unskilled workers and ensure that inferior low-paid jobs do not become life cycle traps but merely stop gaps or first entry jobs.

Whilst Esping-Anderson emphasizes the differences between welfare states, he shares with the deterministic thesis the assumption that exogenous developments in the world market have placed constraints on states which push them in a particular direction. Yet such assumptions have been questioned for a variety of reasons. First, the extent of globalization may be exaggerated in such accounts. In Political Economy, there has been much debate about the extent of FDI and its significance, with ‘sceptics’ such as Hirst & Thompson (1996 & 1999) and Ruigrok & van Tulder (1995) pointing out that the overwhelming majority of TNCs continue to be nationally based rather than genuinely ‘footloose’. So, although around 40 of the world’s largest 100 firms generate at least half of their sales abroad, this is mainly through exports: less than 20 maintain at least half of their production facilities abroad. The executive boards of the top firms are overwhelmingly national in their composition. Many firms appear to have internationalized their finances when measured in terms of the number of foreign stock exchanges on which they have listed shares, yet when this is measured in terms of the percentage of the firms’ total shares it is minimal (Ruigrok & van Tulder, 1995: 156). Where firms have operations in more than one country, but a clear national base, it is therefore more accurate to call these ‘internationalized’ rather than ‘globalized’ firms,

or 'multinational' corporations (MNCs) rather than 'transnational' corporations (TNCs).

Nevertheless, it is clear that there is a growing trend towards the internationalization of investment. Ruigrok & van Tulder (1995: 149) themselves quote figures which show that between 1983 and 1988, FDI rose by more than 20% annually, four times faster than international trade. Hirst & Thompson (1996: 51) also note that during the 1980s, FDI overtook trade as 'the dominant factor driving the world economy'. As Held et al (1999: 282) point out, the pre-eminence of MNCs in world output, trade, investment and technology transfer is unprecedented. Even where MNCs have a clear national base, their interest is in global profitability and competition above all.

So although the extent of economic globalization may be exaggerated, the evidence suggests there is in fact a trend towards greater integration. The comprehensive work undertaken by Held et al (1999: 427) concludes that when viewed in historical terms, contemporary patterns of globalization across a range of 'domains' are unprecedented, not just in quantitative terms but also qualitatively in terms of their organizational forms. Whereas sceptics such as Hirst & Thompson (1996 and 1999) argue that contemporary patterns of internationalization are essentially no different to the pre-1914 period of the Gold Standard, Held et al (1999: 425) point out that the pre-1914 period was characterized primarily by divided imperial systems. Contemporary globalization, on the other hand, is characterized by global flows and networks between independent nation states, 'overlaid by multilateral, regional and global systems of regulation and governance'. Growing integration therefore means that globalization is best seen as a *process*, rather than a fully realized end point (Held et al, 1999: 27; Perraton et al, 1997). This process, however, is not pre-determined or teleological, but is reflexive and contested: 'globalization today reflects the varied and self-conscious political or economic projects of national elites and transnational social forces pursuing often conflicting visions of world order' (Held et al, 1999: 430).

However, despite the terminology of 'globalization', many authors have pointed out that the majority of FDI flows have come from and gone to other industrialized countries (Ruigrok & van Tulder, 1995; Hirst & Thompson, 1996 & 1999). Moreover,

most of this investment is also regionally based. So the world economy is actually bound together by threads of investment between the three dominant economies of the USA, Europe (of which Germany is the core) and Japan - what Ohmae (1990: 6) calls the 'Interlinked Economy' of the 'Triad'. Each of the three major powers of the Triad is dominant in the poorer economies which are geographically closest to it. Thus, the USA dominates in Latin America, the EU dominates in central and Eastern Europe, as well as Africa, and Japan dominates in the Newly Industrializing Countries (NICs) of East Asia. These regions may centre around formal trading blocs such as the EU and NAFTA, or may be more informal, as in Japan's dominance of the East Asian economies (Ruigrok & van Tulder, 1995: 198). Held et al (1999: 270), however, argue that high levels of transregional flows mean that contemporary globalization and regionalization are mutually reinforcing. Hirst & Thompson (1996: 63) point out that there is more 'cross-fertilization' between regions in terms of FDI than in terms of trade, a fact which mirrors the general growth in importance of FDI.

The fact that the majority of FDI flows go to other industrialized countries casts doubt on the claim that unemployment in the industrialized countries is a result of TNCs seeking cheaper labour in less developed countries. The availability of low wages is only one of the reasons motivating TNCs to invest abroad. They may also seek developed infrastructure or more skilled labour. Alternatively, foreign investment may be the extension of an export strategy designed to penetrate overseas markets. This may require the firm to become an 'insider' in order to get past trade barriers or overcome the uncertainty of exchange rate movements (Ruigrok & van Tulder, 1995: 179). Most importantly, however, the firm will be seeking investment opportunities that are not open to it at home. As Chapter Two indicates, overseas provision of some services has to take the form of FDI rather than trade, since they are consumed at the time of production. In so far as any area of the 'Third World' has benefited substantially from the increase in FDI flows, it is China, to which all areas of the Triad have exported large amounts of capital. Meanwhile, a few East Asian NICs, such as South Korea, are becoming significant as a *source* of FDI. As Hirst & Thompson (1996: 69) put it, global inequalities 'are dramatic, remain stubborn to change and indeed have grown since the 1970s.' (see also Hoogvelt, 1997)

The evidence therefore suggests that there is a significant trend towards greater internationalization in the world economy, although this falls short of the claims of some globalization theorists. However, this need not lead us to the conclusion that the state has become powerless. In fact, the state itself has been a powerful *agent* of change. This is an argument advanced most forcefully by Weiss (1997, 1998). She argues (1998: 204) that, 'states may at times be facilitators (even perhaps perpetrators) rather than mere victims of so-called "globalization".' She presents evidence that states such as Japan, Singapore, Korea and Taiwan are increasingly acting as 'catalysts' for the internationalization strategies of corporate actors. This involves offering incentives to finance overseas investment, to promote technology alliances between national and foreign firms, and to encourage regional relocation of production networks. For example, the Japanese Ministry of International Trade and Industry (MITI) has for a number of years sought to manage trade imbalances with the United States by assisting companies to localize production offshore. In countries such as Vietnam, Cambodia and Laos, 'MITI has been centrally involved in the selection and planning of model cities as free-trade zones which will serve as incubators for the transition to a market economy' (1998: 205). Thus internationalization is, 'a key strategy of the Japanese bureaucracy, implemented through agencies such as MITI' (1998: 204).

Neo-liberal states such as Britain can also be seen to have acted to facilitate globalization. Dominelli & Hoogvelt (1996: 48) argue that in Britain the central government has played a crucial role in 'transmitting the global market discipline throughout the economy'. This has been possible because even today the state has direct control over 40% of GDP. Thus privatization has seen huge transfers of money from the public sector to the private sector in the form of subsidies and tax cuts to business, and has created an infrastructure for the private sector to trade with through various forms of contracting out.

Weiss (1998: 190) points out that, 'globalists tend to exaggerate state powers in the past to in order to claim feebleness in the present'. Furthermore, there is a wide variety of state responses to current economic conditions; at least two nation states, Germany and Japan, have pursued extensive Keynesian policies of the type that are regarded as 'impossible' in countries such as Britain (1998: 191). The most important

point, however, is that rather than withdrawing, states may be changing the *form* of their intervention. Weiss (1998: 196) refers to this as state ‘adaptivity’. State capacity may appear to have been weakened by the loss of effectiveness of particular macro-economic *policy instruments*. However, strong states will adapt to use whichever tools permit them to pursue their strategic goals. States such as Japan have pursued their goals through industrial policy, which by its very nature must be creative and adaptive. In contrast, the willingness and capacity of states to play such a role, ‘are not widely institutionalized outside East Asia in contemporary capitalism, and are more and more *ideologically* constrained in the European setting’ (1998: 201, emphasis in the original). However, Weiss (1998: 195) argues ‘that nation states will matter more rather than less and, by implication, that this will advance rather than retard development of the world economy.’

Similarly, Held et al (1999: 431) argue that, ‘different historical forms of globalization may be associated with quite different state forms’. Contemporary globalization may even, therefore, dramatically expand the scope for state initiatives (Held et al, 1999: 437). According to Held et al (1999: 440) states in advanced capitalist societies (SIACS),

are undergoing a profound transformation as their powers, roles and functions are rearticulated, reconstituted and re-embedded at the intersection of globalizing and regionalizing networks and systems. The metaphors of the loss, diminution or erosion of state power can misrepresent this reconfiguration or transformation... For while globalization is engendering a reconfiguration of state-market relations in the economic domain, SIACS and multilateral agencies are deeply implicated in that very process.

According to Taylor-Gooby (1997: 186), ‘government is becoming more rather than less significant’, although the increased use of the private sector in welfare shifts the emphasis of state intervention to regulation rather than provision. The issue of regulation will be pursued in some depth in the next chapter.

Furthermore, the distribution of power between states is profoundly unequal. Keohane & Milner (1996) point out that it is the world's most powerful states, and the international institutions which they control, which have helped to shape changes in internationalization. They provide ample evidence of how during the 1980s intense political pressure was exerted by the advanced capitalist countries on developing countries to open their economies: international financial institutions such as the IMF and World Bank intensified their emphasis on conditionality (primarily through 'structural adjustment programs'); the GATT codes of the Tokyo round moved away from unconditional 'most-favoured-nation' treatment towards demands for reciprocity from developing countries; and the USA pressed hard for liberalization of foreign investment regulations, and for the protection of intellectual property. As Keohane & Milner (1996: 24) put it: 'As always in the world economy, power mattered.'

Where powerful states *do* come under pressure from changes in the world market, they may respond through supranational institutions like the EU or intergovernmental agreements like the Basel Accords of 1988 which set international standards for global finance (Hirst & Thompson, 1996: 134. See also Coleman & Porter, 1994). As Held et al (1999: 430) point out: 'Globalization is far from being simply "out of control" and is, on the contrary, the object of new forms of multilateral regulation and multilayered governance.' Deacon (1997) has argued for the possibility of supranational social policy in the form of regulation, redistribution and provision at a global level. This could include a 'Tobin Tax' on short term capital flows, which could reduce the level of global speculation and provide revenue for development purposes (see ul Haq et al, 1996). Furthermore, Deacon shows that international organizations such as the IMF and the World Bank are not monolithic, but contain within them potentially more progressive as well as neo-liberal wings. Even Mishra (1999; 1998) has suggested the feasibility of setting up a system of global social standards. These could be linked to the economic standards achieved by different nations, and thereby 'help overcome the vexed problem of developed societies demanding a level of social protection and labour standards from less developed societies, which appears arbitrary and which the latter can ill afford to provide.'(1998: 487-488)

Just as states may cooperate at the international level to regulate the world market and economic competition between themselves, so citizens also may organize internationally to form social movements which transcend borders (Waterman, 1998; Held et al, 1999: 371). According to 'The Economist' (11.12.99), 'citizens' groups are increasingly powerful at the corporate, national and international level'. The web site of one group (Global Solidarity, <http://www.utexas.edu/ftp/student/subtex/.web/Groups/crossborder/gstrategy.html>) claims that workers' organizations are:

formulating new strategies and tactics to coordinate activities, share resources and establish common bonds in order to bargain more effectively with the multinational corporations. The same advanced communications technologies that allow multinational corporations to globalize their operations also create the potential for increased international cooperation amongst labor organizations.

Beck (1999), despite a fairly crude view of globalization, argues that: 'The age of globality should bring... a new beginning, through the growth of transnational states such as the European Union, the development of international law, the rise of trade unions and consumer groups that cut across national boundaries...'. The protesters who disrupted the meeting of the World Trade Organization (WTO) in Seattle in December 1999 represented a diverse, and often incoherent, alliance of different interests. They nevertheless succeeded in creating a public debate about the future direction of the world's most powerful governments' policies towards the world economy.

In order to assess the claim that welfare spending inhibits the competitiveness of nations, Pfaller, Gough & Therborn (1991) carried out a comparative study of five advanced capitalist countries (the USA, the UK, Germany, France and Sweden). In his section on the UK, Gough found that neglect of the public sector may actually harm economic competitiveness (Pfaller, Gough & Therborn, 1991: 149). This is because neglect of investment in human capital may lead to skills shortages, and therefore wage inflation, despite high levels of unemployment; and because the rundown of physical infrastructure (e.g. public transport in SE England) is not conducive to business. The

study found that there has been a general trend towards containing public expenditure in the five countries, except where it is associated with an ‘investment function’ (ibid: 274). This is consistent with some aspects of the new thinking on welfare discussed above. Yet Pfaller et al (1991: 280) show that economic changes diminished the effectiveness of the old welfare state arrangements even without any budget cuts, through unemployment in France, Germany and Britain, and growing low wage employment in the USA. Concern about economic competitiveness prevented ‘remedial action’, but changes in welfare may be seen as the result of the economic slowdown which began in the 1970s as much as of globalization (see also Paul Pierson, 1998, discussed above). Preoccupation with the tax burden imposed by welfare spending arose first in a period of slow economic growth, and preceded the current debate on globalization (see O’Connor, 1973; Bacon & Eltis, 1976).

Thus, we must also take account of the powerful legitimating role that ideas like globalization may play (Burnham, 1997; Weiss, 1998: 193). As Moran & Wood (1996: 140) put it: ‘Constructing external constraints... allows particular national elites to present their policy preferences as the more or less unavoidable consequence of forces over which nationally organized institutions can have little or no control.’

### **LEVELS OF ANALYSIS**

We have seen that deterministic accounts of globalization and its relationship to social policy are open to many criticisms. However, as indicated above, there are also some more sophisticated accounts which recognise national specificities and the mediating effects of different levels of policy-making in determining how states adapt to external pressures. Wilding, for example, emphasises the importance of domestic politics (1997: 422), although he concludes that national social policies ‘will be much more globally and regionally influenced and patterned than in the past.’(ibid: 426) Comparative approaches have been particularly good at recognising the importance of national institutions:



One of the most powerful conclusions in comparative research is that political and institutional mechanisms of interest representation and political consensus building matter tremendously in terms of managing welfare, employment and growth objectives.

(Esping Anderson, 1996a; 6)

Thus, whilst post-war Western welfare states addressed similar objectives, they differed in terms of how they pursued these. Similarly, as these same welfare states seek to adapt to the changing conditions associated with globalization, they do so very differently (see also Weiss, 1998, 1997; Keohane & Milner, 1996: 14; Held et al, 1999: 13; Hirst & Thompson, 1999: 163-190). As Esping-Anderson (1996b; 258) points out: 'Each of these welfare state responses combines benefits and costs in a way which is hardly Pareto optimal.'

Thus in acknowledging the specificity of national history and culture we may conclude that the influence of globalization has to work its way through several 'layers' of national institutions and practices, leading to different results in different countries. Yet this still assumes a one way flow from the world market 'downwards' through the different levels (each having its own mediating effect), finally ending at the delivery of actual welfare services 'on the ground'. The chain of causation is not seen as being able to work in the opposite direction. One way of attempting to deal with this problem is to utilise the concept of 'structuration'. Structuration has been theorised and popularised by Giddens (1981; 1984), and involves a 'two-way' conception of agency and structure where each impacts on the other. As Held et al (1999: 27) put it: 'globalization is akin to a process of "structuration" in so far as it is a product of both the individual actions of, and the cumulative interactions between, countless agencies and institutions across the globe'. Utilised in this context, structuration could acknowledge the potential for national institutions and practices to modify the working of the world economy, i.e. for the chain of causation to work 'upwards' as well as 'downwards'. A good example of this is the way in which decisions taken by some governments on financial liberalization (Thatcher's being the obvious example) encouraged others to do the same to remain competitive. Thus decisions taken by conscious agents produce a new structure (in this case an open world financial

market), which is difficult to reverse - actors are constrained by past decisions (Cerny, 1990 & 1996).

This acknowledgement of different levels of policy making and activity is related to the 'level of analysis problem'. This was identified in the discipline of International Relations (IR) by Singer (1961). He argued that in IR, as in any science, 'the observer may choose to focus upon the parts or upon the whole, upon the components or upon the system' (1961: 77). This means we may 'choose between the flowers or the garden, the rocks or the quarry, the trees or the forest, the houses or the neighborhood, the cars or the traffic jam, the delinquents or the gang' and so on (ibid). The complexity and significance of these level of analysis decisions are indicated by the long-standing controversies between, for example, social psychology and sociology or micro- and macro-economics. According to Singer, in IR, authors had:

roamed up and down the ladder of organizational complexity with remarkable abandon, focusing upon the total system, international organizations, regions, coalitions, extra-national associations, nations, domestic pressure groups, social classes, elites, and individuals as the needs of the moment required. And though most of us have tended to settle upon the nation as our most comfortable resting place, we have retained our propensity for vertical drift, failing to appreciate the value of a stable point of focus. (1961: 78)

We may switch between levels of analysis, but must explicitly recognise that this is what we are doing.

In IR, the two most commonly used levels of analysis were the international system, usually conceived as a system of nation states, and the level of the individual nation states themselves. Both of these levels have their own strengths and weaknesses. Thus, the systemic (international) level of analysis allows for comprehensive study of 'international relations in the whole' (1961: 80), although it tends to 'lead the observer into a position which exaggerates the impact of the system upon the national actors and, conversely, discounts the impact of the actors on the system.' (ibid) It also requires the postulation of 'a high degree of uniformity in the foreign policy

operational codes of our national actors'. This is a similar criticism to that which has been made above of the more deterministic accounts of globalization in Social Policy. The national state level of analysis, on the other hand, allows for differentiation among the actors in the system, but may lead to an exaggeration of the differences between them.

The comparative approach often favoured in Social Policy has usually been pitched at the national level. This involves comparing the social policies of countries (and often types of social policy 'regime' - see Esping-Anderson, 1990) and changes in them to detect common trends and differences (Esping-Anderson, 1996a&b). This work has done much to advance our understanding of broad shifts within social policy and the impact upon them of existing national institutions and practices. However, there may sometimes be only a conceptual link between globalization and the observed changes, which could perhaps be explained at least in part with reference to some other paradigm, such as the influence of ideology (a particularly important factor following the collapse of the Soviet Union). As discussed above, determinism may be avoided at this level by approaches which recognise the mediating role of national institutions and practices, the existence of influences other than globalization on welfare state change, and the ability of states themselves to influence the globalization process. Yet little work has been done on globalization and social policy which is pitched at other levels of analysis. Deacon (1997) is one exception to this, having argued for a shift to 'global social policy' analysis through a focus on supranational and transnational institutions.

The level of analysis problem has been addressed in relation to accounts of NHS reform in Britain by Mohan (1996). He notes that such accounts have been pitched at three levels: the macro, the meso and the micro. In Mohan's categorisation, 'macro-level' accounts see welfare states as converging on a common set of solutions, as in the grip of forces beyond their control, and/or as grappling with common dilemmas which leave them with very little scope for manoeuvre, just as the crude version of the globalization thesis does. However, such accounts concentrate on trends which are contextual influences, and must be, 'complemented, at a lower level of generality, by discussion of the ways in which these trends are mediated.' (ibid: 682) For Mohan, 'meso-level' accounts are pitched at the level of national state policies which may arise

from the distinctive character of governments' ideological predispositions and political strategies. However, the strategies pursued by these governments 'have had effects on the character of discourse in the welfare state, and on the construction of a constituency with a vested interest in the reforms (e.g. those with private healthcare; GP fundholders, and their patients; owners of health-related businesses).'(ibid: 686) 'Micro-level' accounts thus focus on the processes operating either internally within the NHS or within British society. The way these issues are worked out varies between different sectors of the welfare state, but they nevertheless 'are structured by and, in their turn, recursively structure the operation of state policies.'(ibid: 691) So, for example, the parameters within which welfare pluralism operated were set by the state, but the welfare system was becoming more plural partly because of the involvement of multi-national healthcare and ancillary-service corporations, attracted to Britain by the liberal operating environment (see Mohan, 1991).

According to Mohan, all of these three levels of analysis offer important insights into the nature of change in the NHS, but none of them is alone sufficient. He thus concludes that a degree of 'eclecticism' is required if a comprehensive account of the NHS reforms is to be constructed.

Ruigrok & van Tulder (1995) tackle the level of analysis problem in relation to accounts of industrial restructuring in the world economy. They begin their book with an evaluation of post-Fordist debates at four levels of analysis. The 'meta-level' is analysed by the 'neo-Schumpeterian' school, which is concerned with the concept of 'long waves' of technological innovation. This school is technologically determinist and underestimates the role of governments in affecting change. The 'macro-level' (in this account, that which is concerned with state policy) is analysed by the regulationist school and the Amsterdam school, which is concerned with issues such as the new 'political hegemony' of neo-liberalism. However, macro analyses are too general and fail to analyse developments in the production process (crucial to a 'post-Fordist' paradigm). 'Micro' analyses of post-Fordism have concentrated on perceived improvements for workers in the labour process at the firm level, taking Japanese models as exemplars. However, they have overlooked the more negative aspects of

changes in management, and have ignored the potential side effects of these changes on third parties such as subcontractors.

For Ruigrok & van Tulder (1995), 'meso-level' analyses are those which have concentrated on the developments of networks of cooperating firms as an alternative to the existing model of markets vs. hierarchies. So whereas previously firms may have chosen to 'make' inputs within a large firm hierarchy rather than 'buy' them in the market (generally to cut down on transaction costs), they can now choose to 'cooperate' through a network. Ruigrok and Van Tulder (1995) conclude that a meso level of analysis is the most appropriate for studying industrial restructuring. However, they argue that post-Fordist writers have failed to analyse relations within the network, and possible shifts in the balance of power within it. Furthermore, they have not analysed the working conditions within these firms or acknowledged the importance of institutional and political forces (1995: 32). Ruigrok and Van Tulder (1995) thus suggest their own conceptual framework, based around a meso-level analysis of 'industrial complexes'. An industrial complex (1995:7) is a bargaining arena made up of six actors:

- 1) the *core firm* , which is 'the spider in the industrial web';
- 2) its *supplying firms* , which may or may not be owned by the core firm;
- 3) its *dealers and distributors* , which may also be owned by the core firm;
- 4) its *workers* , who may or may not be represented by a union;
- 5) its *financiers* , which may consist of banks or pension funds, e.g.;
- 6) its local, regional and national (and even supranational) home and host *governments*.

Each core firm will have a series of bargaining relationships with each of the other actors in its industrial complex (see Appendix One).

Ruigrok & van Tulder (1995) therefore provide a framework for the meso level analysis of the relationships between internationalized firms and a range of other actors (including the state) which is distinct from those approaches based on macro level analyses of the interaction of nation states with the world market in general. This is an

important and innovative approach which, when modified and applied to social policy, allows for a detailed analysis of the way relevant actors inter-relate in the delivery of a particular service. Resting as it does upon the concept of a 'core' firm at the heart of an 'industrial complex', such an approach is particularly suited to an area of welfare where provision is undertaken by private companies. Private provision of welfare in the UK has advanced furthest in long term care, as is discussed in the next chapter. Hence, the three largest private providers of long term care were chosen as the focus of this study. Using an adapted version of Ruigrok & van Tulder's model, the relationship of these firms with other key actors could be analysed. These other key actors were the state and its agencies, staff and unions, and older people and their organizations. How Ruigrok & van Tulder's model was adapted for this thesis is discussed in detail in Chapter Three.

Here, however, it can be noted that this meso level of analysis is centred on the relationships between *organizations*, or more correctly between collective actors with varying degrees of organizational capacity. Agency is conceived of primarily at the level of the organizations themselves, rather than at the level of entire classes, or of individuals, for example. The strength of such an approach, as already argued, is the scope it affords for a detailed analysis of relationships between key organizational actors within a particular sector, including the state. As with other levels of analysis, however, its strength is also its weakness, in that it entails a 'trade-off' with other levels of analysis. It therefore precludes consideration of interactions at other levels, whether these be the interaction of the nation state with the world market in general (as in the macro level of analysis), or the interaction of individuals within organizations. This weakness is remedied to some extent in this thesis through the inclusion of micro level case studies of the chosen firms, involving analysis of their internal organization and strategies. The importance of these issues of organization and strategy as they apply to internationalized welfare firms, and the relationship between them and the issue of the *external* regulation of private welfare providers, are discussed in the next chapter.

## CONCLUSION

This chapter has argued that deterministic accounts of globalization and its relationship to social policy are over-simplistic and open to challenge on a number of counts. Following from this assessment, some preliminary conclusions can be reached. Firstly, globalization is best regarded as a *process*, rather than a fully realised end point or an objective force. Secondly, this process may be seen as being shaped by a number of active agents, including both nation states and multinational corporations. Thirdly, globalization may not necessarily be leading to a reduction of state intervention in economic and social affairs in advanced capitalist societies, but to changing forms of state intervention, often involving greater regulation rather than direct provision. The issue of regulation will be pursued further in the next chapter.

This chapter has also discussed the ‘level of analysis problem’, pointing out that most Social Policy accounts of globalization have been pitched at the national, or macro, level of analysis. This thesis aims to make a contribution to the globalization debate within Social Policy by focusing upon the area of welfare delivery in the UK where private provision has gone furthest, that of long term care for older people. In focusing on private providers of a welfare service, the thesis will be able to combine findings from two levels of analysis not often utilised in Social Policy. Thus, a micro level analysis of the three largest private providers of long term care in the UK is conducted as the basis for the subsequent meso level analysis of the relationships between these firms and other key actors. This approach allows for an exploratory and empirical enquiry into a welfare service which is experiencing a process of internationalization, as well as making a contribution to the debate concerning the perceived loss of power and autonomy by the state (and other domestic actors). Issues relating to research design and methodology are discussed in Chapter Three. Issues relevant to the private provision, and growing internationalization, of welfare services are discussed in the next chapter.

## **CHAPTER TWO: THE INTERNATIONALIZATION AND REGULATION OF PRIVATELY PROVIDED WELFARE SERVICES**

### **INTRODUCTION**

This chapter discusses issues relating to the private provision, internationalization and regulation of welfare services, focusing particularly on the long term care market in the UK. In doing so it sets out the key themes which inform the research questions detailed in Chapter Three, and which are therefore central to the remainder of the thesis. The first section begins with a discussion of the growing internationalization of services generally, before moving on to discuss issues specific to the internationalization of welfare services. The second section deals with issues relevant to both the internal and external regulation of large private welfare providers. This section develops in some depth the observation made in Chapter One, that the form of state intervention may be shifting away from direct provision towards regulation.

### **THE INTERNATIONALIZATION AND CONSOLIDATION OF PRIVATELY PROVIDED WELFARE SERVICES**

#### **THE GROWTH OF TRADE AND FDI IN SERVICES**

Most writing on multinational corporations has been concerned with manufacturing industry (Enderwick, 1989a). This is not surprising, since the majority of the world's largest firms are manufacturing based. However, changes in the structure of the advanced capitalist economies have brought about a profound shift away from manufacturing and towards services. The reasons for this shift are the focus of much debate, and cannot be fully discussed here (see Daniels, 1993: 13-23; and Allen & Massey, 1988; Gough, 1979). Nevertheless, the extent of the shift is evidenced by the



fact that services now account for 78 % of employment in the British economy ('The Economist': 1999).

Whilst not all countries have experienced this shift to the same extent as Britain, the growing importance of services in the world economy has been reflected in the trade figures, which show that 20% of world trade is now in services (Hoekman & Primo Braga, 1997: 285). The USA is by far the biggest exporter of services, with \$233.6 billion worth in 1998, 18.1% of the world total ('The Economist', 8.5.99). Britain comes second with \$99.5 billion worth, or 7.7% of the total. This is an important indicator of the reliance of the British economy on services, since it ranks only fifth in the league table of goods exporters, with a 5.1% share. Both Britain and the USA run large service-trade surpluses, but even larger goods-trade deficits. The growing importance of services is also reflected in the FDI figures, which show that FDI has been growing fastest in services (Stopford & Strange, 1991: 87, Hirst & Thompson, 1996). The Invest in Britain Bureau (IBB, 1998) confirms the growing importance to Britain of inward services FDI. It notes how in the past the service sector has been 'considered less capable of delivering a product across national boundaries' (1998: 20). Today, however, advances in communications technology and the growing use of outsourcing has changed this.

The distinction between trade and FDI is less clear cut in services than in manufacturing. This is because cross-border sales of services often have to take the form of FDI, since many services require physical proximity to the consumer, because they are consumed as they are produced (Hoekman & Primo Braga, 1997: 286). So, for example, where a doctor travels overseas to carry out an operation, this may be regarded as trade. But where a healthcare company wishes to deliver its services abroad on a more regular basis, it must invest in setting up or running its own hospital. The company could grant a licence to a third party to deliver the service, but this may result in loss of control over the knowledge contained in such delivery, the quality, the price, or all of these things (Daniels, 1994: 89). Evidence from the USA, therefore, suggests that service firms prefer overseas production to exporting from their home base. Over 80% of total foreign sales by US service industries were derived from overseas affiliates. The same trend was apparent for sales of services by foreign firms

in the US (Daniels, 1994: 89). The subtleties of the difference between trade and FDI in services have been occupying the WTO, during and since negotiations over the General Agreement on Trade in Services (GATS) (Hoekman & Primo Braga, 1997: 302; see Chapter Five).

Yet Dunning (1993: 256) notes that: 'Compared with the large volume of publications on the global strategy of goods producing companies, there has been very little research done on the strategy of service MNEs.' Stopford & Strange (1991) argue that in large part the growth of services FDI has been caused by demand derived from earlier investors. Thus, just as many component suppliers to the automobile industry expanded abroad to provide worldwide supply to their large customers, so many service firms, such as banks, accountants and advertising agencies, have done the same. The growth of tourism has spurred equivalent developments in the hotel and leisure-related sectors. A key influence on the decision of the US firm Hospital Corporation of America to invest in Southampton was the presence in the area of other multinationals with large company-paid private health insurance schemes (Mohan, 1991: 857). Both Erramilli & Rao (1990) and Enderwick (1989a), however, have pointed out that service firms may be 'market seeking' as well as 'client following'. Many examples, including most hospital services, retailing and news agencies, do not fit the 'client following' pattern (Enderwick, 1989a: 33).

Enderwick (1989a) shows that there are a number of important differences between manufacturing and service MNCs, in terms of both structure and strategy. Such differences are important because they, 'could raise unexpected issues for a policy framework heavily orientated to extractive and manufacturing multinationals' (1989a: 31). Enderwick (1989a: 30) argues that, 'the relatively recent take-off in service-sector FDI implies that these firms may not have yet reached the multinational maturity characteristic of many manufacturing enterprises.' Service sector MNCs tend to be smaller than their manufacturing counterparts and display greater product specialisation. Whilst economies of scale in purchasing may be important, they are less so in production, since consumption of services must often take place at the same time as production, so that concentration of production in one place and dependence on mass distribution is not viable. According to Enderwick (1989a: 32): 'The

comparatively late take-off and considerable cross-investment in services suggests that acquisition may be a preferred form of entry for many firms.’ Analysis of inward investment in the USA confirms this. A strategy of acquisition allows rapid entry into a market and ‘the achievement of a critical mass which may be considerable in industries characterised by multiple outlets’.

As Daniels (1993: 3) points out, however, services are diverse and consequently difficult to classify. Firms delivering health or social care, for example, are very different to financial services firms or IT firms. One way of dealing with this problem of heterogeneity is to carry out industry-specific studies (Enderwick, 1989a). In his table of illustrations of ‘OLI advantages’ (ownership, location and internalization advantages) relevant to multinationals in particular industries, for medical services Dunning (1993, 276) mentions experience with advanced / specialised medicine, modern management practices and supportive role of government under ownership (competitive) advantages; the fact that consumers have to travel to the place of production under location advantages; and quality control under internalization advantages (coordinating the advantages of an ‘hierarchical’ rather than market route of exchanging intermediate services). The issue of quality control is discussed later in this chapter, but it is worth noting here the potential importance of branding and corporate identity to service firms in which quality is a key consideration (see also Enderwick, 1989a: 24). Lower costs as a result of economies of scale may give multinational service firms the resources to provide quality and consistency, which can be branded, thus helping them to retain or extend their competitive advantage (Daniels, 1993: 45-60).

The characteristics of both home and host countries are important in influencing the investment decisions of MNCs. For example, Dunning (1993) found that language and culture scored high among factors identified by service firms as affecting location. However, ‘non-tariff barriers’, especially the regulatory environment of host countries, are also a major factor influencing the way in which markets are serviced by foreign-owned firms (Stopford & Strange, 1991; Dunning, 1993; Enderwick, 1989b). Stopford & Strange (1991) argue that regulatory barriers have been an especially important obstacle to the full development of internationally traded services. Dunning (1993:

260) is of the opinion that, in general, governments have adopted more controls on trade and investment in services than in goods. However, these tend to vary considerably between countries, and are more common in developing countries. In economically advanced countries, government decisions about investments are less likely to be ad hoc, and more likely to be bound by rules and international agreements. States in advanced economies, therefore, will usually have committed themselves to accept foreign investment unless it *contravenes* particular rules. But as Daniels points out (1993: 67), trade in services is heavily influenced by government regulations intended to enforce standards in particular industries.

### THE INTERNATIONALIZATION OF PRIVATELY PROVIDED WELFARE SERVICES

The internationalization of services has combined with government policies of privatization over the last two decades to produce a new phenomenon whereby 'public' services are being increasingly provided by internationalized firms. One of the key reasons for the relative shift in industrialized economies away from manufacturing and towards services was the expansion of the welfare state in the post-World War Two period. This is indicated by the large growth of employment in social services (broadly defined) during this period (Daniels, 1993: 9). This itself relates to the growth of public expenditure. As Gough (1979: 78) puts it, the twentieth century, and the post-war period in particular, saw 'public expenditure rising as a share of GDP, and social expenditure rising as a share of public expenditure'. Privatization therefore promotes internationalization because: 'With rare exceptions, government-owned service organizations do not compete globally.' (Porter, 1990: 247) In the context of the current process of globalization, privatized services thus move from a protected existence into an internationally competitive market. International companies now run public services in a range of different countries and continents where privatization has taken place, providing services from water and electricity to catering and cleaning. For example, the school meals in Bromley, the water in Newcastle and the refuse collection in Bristol, were all run in 1996 by subsidiaries of Lyonnaise des Eaux, which also ran

the water and sewage of Buenos Aires and was the biggest road builder in the Czech Republic (PSPRU, 1996: 1).

Privatization, or more usually contracting out, of welfare services has gone furthest in the USA, where private healthcare has long been more entrenched than in most of Europe. In Britain, there have been significant changes in the delivery of health care, although the ideological preferences of Conservative governments since 1979 did not lead to outright privatization. However, the scope for the development of private care has increased considerably. By 1989, spending on private acute health care already amounted to over £700 million per annum, with another estimated £1 billion spent on private nursing homes and residential care, and around 30% of the NHS budget paid to suppliers of goods and services (Mohan, 1991: 853). As Mohan (*ibid*) points out, these sums support various activities which cross the boundary between the service sector and manufacturing, and which employ people in a wide range of occupations. Yet even before the NHS was set up, there was little commercialism in British healthcare - private health services were provided largely on a voluntary subscription or charitable basis. For thirty years after the creation of the NHS the private sector remained small, although there were 'occasional hospital takeovers by US corporations' (Mohan, 1991: 854).

This situation began to change in 1976, when the Labour government attempted to separate private practice from the NHS (Papadakis & Taylor-Gooby, 1987: 43; Mohan, 1991: 854). There was concern at this time that private healthcare was not abolished altogether, for this would mean losing revenue from rich overseas patients attracted to Britain by its specialised medical expertise. At the same time, the government's National Enterprise Board established United Medical Enterprises (UME) through a merger between two smaller companies. This was to operate as a hospital developer and supplier, primarily in the Middle East, exploiting Britain's competitive advantage in health care provision and management derived from the experience of the DHSS (Mohan, 1991: 854; Griffith & Rayner, 1985: 41). At that time, UME was not permitted to enter the British market, leaving instead US based multinationals as those best placed to invest in new hospitals there. These corporations had access to capital which the non-profit sector in Britain did not, allowing them to

finance hospital acquisition and construction. Mohan (1991) traces the introduction of commercial provision in ancillary services to this period also, since Conservative interest in this after 1979 dated from a desire to loosen the grip of trade unions in the public sector, which had grown during the 1970s (see also Papadakis & Taylor-Gooby, 1987: 49). In contrast, the pharmaceutical companies which supply the NHS have always been in private hands, and have grown to be huge international players (Held et al, 1999: 266; Moran & Wood, 1996: 135; Wood Mackenzie, 1999 & 2000).

As with other public services, therefore, private provision in health has been accompanied by internationalization. Mohan (1991: 855) argues that the main source of opportunities for internationalized companies in the health sector has been 'state policies regarding the regulation and provision of welfare', which have provided a greater space for the operation of the commercial sector in Britain than in Europe. In addition, state policies elsewhere have 'forced multinational organizations to seek new investment opportunities' (Mohan, 1991: 855), such as in the US where federal restrictions on healthcare expenditures were one reason behind decisions to invest in various European states in the 1980s.

Enderwick (1989a: 21) argues that the consolidation of corporate hospital chains in the US market facilitated, 'the application of modern management methods, the achievement of huge purchasing economies and the development of arrangements with commercial insurance companies which have yielded financial and policy-formulation strengths'. This then provided a basis for overseas expansion. By 1988, commercial hospitals in the UK accounted for 55% of all beds in independent hospitals, compared with 29% in 1979, whilst 22% of all independent hospital beds were US owned (Mohan, 1991: 857). The strategy of US corporations in the UK at this time was based on expansion through acquisition of existing businesses as much as on new-build (Griffith & Rayner, 1985: 33 & 44) - a trend which is being repeated within the long-term care market today.

In the mid-1970s, independent health care in Britain was fragmented, based on small organizations and run on a largely charitable basis. The largest British organization, (the Company 1 affiliated) Nuffield Hospitals, with thirty facilities, was a non-profit

body, with prices held low and any surpluses invested in new hospitals. Foreign-owned hospitals have typically been large and have concentrated on high technology medicine and surgery, where domestic firms have been reluctant to compete due to the scale of investment involved and its attendant risk.

However, 'non-profit' organizations enjoyed some advantages, as explained by Oliver Rowell, Nuffield's General Manager at that time:

[Nuffield] generates a surplus every year but one major difference... [from] a commercial company like American Medical International, Hospital Corporation of America and United Medical Enterprises, etc. is that they have to make a profit to satisfy shareholders and bankers, [but Nuffield] makes a surplus that is totally recycled into itself and used totally to expand and improve its service to private patients.(cited in Griffith & Rayner, 1985: 34)

Furthermore, 'non-profit' organizations do not have to pay corporation tax (Griffith & Rayner, 1985: 15).

However, commercial companies have the advantage of being able to borrow in order to fund expansion. Mohan (1991: 857) claims that British financial institutions were initially reluctant to back private health care because of political uncertainties, whereas US corporations, with access to Wall Street, had enormous financial advantages. US multinationals consolidated their position further by a marketing strategy aimed at the luxury end of the market. Furthermore, they developed a strategy whereby the largest proportion of fees was charged for 'ancillary' services, rather than beds, allowing them to remain profitable even when occupancy rates were low (Griffith & Rayner, 1985: 38). The success of these American firms reflects the longer tradition of privately provided health care in the USA, and indeed Michael Porter's table (1990: 255) estimating patterns of competitive advantage in service industries for different countries shows the USA in a leading position in healthcare services. However, multinationals remain vulnerable to market conditions, and foreign subsidiaries are vulnerable when the fortunes of the parent company change. For example, during 1989

American Medical International had to sell off its UK operations, and Hospital Corporation of America's hospitals were acquired by Company 1 (Mohan, 1991: 859).

The problems experienced by American multinationals were exacerbated by the British recession of the early 1990s. Their partial withdrawal from the British market opened the way for the entry of European conglomerates (May & Brunson, 1999: 286; Mohan, 1991: 859). The French Generale des Eaux, for example, acquired a small British hospital chain in 1990. According to a spokesman from the company, the initial acquisition reflected the fact that the UK market for private healthcare had become 'uniquely liberal' in Europe ('Daily Telegraph', quoted in Mohan, 1991: 859). By 1996 Generale des Eaux's other UK operations included water companies, refuse collection services, waste to energy plants, housing management, financial administration, road and bridge building, car parks, cable television, mobile phones and was bidding for a railway franchise (PSPRU, 1996: 3).

Some of the American multinationals have also diversified into other areas. American Medical International, for example, moved into private psychiatry, a head injuries treatment centre, and the treatment of drug addiction, partly in response to the reduced profitability of the acute hospital sector (Mohan, 1991: 857). By the beginning of the 1990s, multinationals were also seeking greater collaboration with the NHS, for example through partnerships in jointly financed capital projects. Collaboration with other kinds of multinationals has also been positively encouraged by the introduction of the Private Finance Initiative (PFI), which has been adopted by the New Labour government after its introduction by the Conservatives. Tarmac, for example, the UK's largest civil engineering and building contractor, has been closely involved with the Private Finance Initiative, building the first PFI hospital and the first PFI prison. Tarmac has operations or offices in thirty countries, with 25% of its 24,000 employees based overseas (<http://www.tarmac.co.uk>). As with other kinds of public services, multinational activity in health care ancillary services has often taken the form of acquisitions of domestic firms, notably in laundry, catering and contract cleaning (PSPRU, 1996).



Mohan (1991: 864) points out that considered from the standpoint of market share and geographical coverage, the impact of multinationals in health care may appear to be limited, and in some ways this is true of the long term care sector considered below. However, the *qualitative* impact on the way services are delivered is of much greater importance, since multinationals are leaders in terms of innovation, whether in terms of marketing methods and budgeting techniques, as in the hospital sector, or in terms of new methods of work organization, as in ancillary services. Held et al (1999: ch.5) make a very similar point in relation to MNCs generally in the world economy. Mohan (1991: 863) argues that multinationals may lead experiments with changes to the labour process due to their scale and management expertise. This may lead to a deskilling and devaluation of such work comparable to similar developments in manufacturing. Furthermore, the process of concentration which the multinationals have led has raised the possibility that some operators may achieve a de facto monopoly in certain areas. Both these issues - of concentration, and of labour process and control - will be discussed later in this chapter, and are key concerns of the thesis.

Given privatization policies across the world, and the increasing globalization of economic activity, the involvement of such internationalized firms is likely to attain greater significance in the future, with more people dependent on them for both work and welfare services. The most fundamental shift towards private provision in the UK in recent years has come in the area of long-term care (May & Brunsdon, 1999: 287). This is the focus of this thesis, and will be discussed next.

### THE UK MARKET IN LONG TERM CARE

Demand for the private provision of residential and nursing care for the elderly in the UK has two main determinants: demographic trends and the actions of the state. The state influences demand for long term care because local authorities (and until recently the DSS) pay for the largest single share of it. The extent of private provision is also affected by the extent of public supply. As Laing & Buisson (hereafter L&B) put it: 'It is those areas where the marginal cost of choosing private over public treatment is low

and where there is a significant public sector supply constraint that private sector demand and supply has flourished most.’ (1997: A140)

Both purchasing by public agencies and the constraint of public sector supply are the direct result of policies introduced by Conservative governments, although, as Bradshaw (1988) points out, the effects of these were not always intentional. Until the 1980s, delivery of care was divided up between the NHS and local authorities in a way which is reflected today in the regulatory regime: the NHS provided nursing care; local authorities provided residential and home care services. Such provision was largely free at the point of use, since local authorities rarely used their discretionary powers to levy charges. The growing awareness of the problems of institutionalization (Ebrahim et al, 1993: 199) and the move towards community care from the 1960s onwards led to the closure of many NHS and local authority institutions. According to Harrington and Pollock (1998: 1806) when this trend extended to older people in the 1980s it led to ‘reinstitutionalisation in the private sector’.

Private sector provision of long term care in Britain increased rapidly when the Conservative government used an amendment to the Social Security Act to allow residents entering private sector homes to claim board and lodging to pay homes for their care. Residents being cared for in the public sector could not use this provision, so local authorities encouraged residents to opt for the private sector, which allowed the release of income through the closure and sale of public facilities (Harrington & Pollock, 1998: 1806). However, according to Bradshaw (1988: 177): ‘The growth of social security funding for private care arose largely because its availability was made more explicit in the 1980 reforms of supplementary benefit’, rather than because the government desired it. Other factors combined with this to produce a huge growth in social security spending on long term care: demographic factors, the closure of state institutions, financial pressure on local social services departments, and the emergence of ‘a new entrepreneurial class who make their living in private residential care’ (Bradshaw, 1988: 176). Although most of those entering into the private provision of long-term care were small businesses, some of the American multinationals discussed above began to turn their attention towards the market (Griffith & Rayner, 1985: 47). As the social security budget spiralled, concern was expressed about costs, as well as

that expenditure was being skewed towards nursing and residential care rather than community based services.

The government's response was the NHS and Community Care Act (1990), which was implemented on 1 April 1993, and which made local authorities responsible for purchasing care packages from providers. Local authorities received an annual increment of funds from the Government known as the Special Transitional Grant (STG), which included a transfer element intended to replace the amount which would otherwise have been spent by the Department of Social Security on new residents in residential care and nursing homes. A condition was attached to the STG stipulating the proportion of the grant which must be spent on independent sector services. In order to fulfill this the authority had to demonstrate that overall community care spending on the independent care sector had increased by an amount equivalent to at least 85% of the transfer element of the grant each year (Edwards & Kenny, 1997: 11). Through this means, LAs were compelled to expand public subsidy for private sector care. This condition has since been relaxed and finally replaced with the Labour government's 'Best Value' system. The independent sector accounted for nearly 69% of the residential and nursing home budget in 1996/7, compared with 63% in 1995/6 and 54% in 1994/5 (Edwards & Kenny, 1997: 12). In November 1998, an estimated 111,000 or 29% of independent sector care home residents were self-payers (L&B, 1999-2000: 211).

L&B (1997: A144) predict that underlying demand for care services will continue to expand over the coming years, as the proportion of older people in the population grows. This is because rates of disability and dependence escalate rapidly with increasing age. Demand for care services is also affected by the numbers of people prepared to provide informal care for family members. An estimated 1,400,000 currently devote 20 hours or more to such care. If all the informal care provided for elderly and disabled people were valued at £7.00 per hour (based on local authority pay rates) the cost would have been £42 billion per year at April 1996, dwarfing the £11.6 billion spent on formal long term care for the elderly (L&B, 1997: A144).

In 1999 there were approximately 13,000 residential homes for older people, 11,600 of which were in the independent sector. There were approximately 4,600 independent nursing homes, catering mainly for older people (DoH, 1999b, regulatory impact statement, 2.6 & 5.2). The independent sector provided 88% of all residential and nursing care home places in 1998, compared to 82% in 1994 (DoH, 1998a). However, 1999 showed the third annual decrease in capacity across the sector, and the sixth year in succession in which capacity growth fell short of what would be expected from demographic pressure (L&B, 1999-2000: 163). Nevertheless, private sector capacity continued to expand at the expense of public sector capacity. Dual registered places in the independent sector increased from 8% in 1994 to 18% in 1998 (DoH, 1998a). The increase resulted from the re-registration of many nursing homes as dual registered homes, which in turn is a reflection of budgetary pressures on local authorities, many of which adopted a policy of placing people wherever possible in (less expensive) residential care rather than in nursing care (L&B, 1997: A147).

According to L&B (1997: A149): 'The 1980s era of rapid expansion in private care capacity, fuelled by open ended income support funding, has clearly come to an end with the transfer of state funding to cash limited local authority budgets in April 1993.' Despite consistently falling occupancy rates since 1993 (Laing, 1999), in 1997 L&B (1997: A149) thought there was still scope for an expansion of private sector provision, given continuing demographic pressure, the decline of public sector provision, and the lack of hostility towards the market on the part of the New Labour government. However, occupancy rates continued to fall. In March 1999 these stood at 85.7% for private nursing homes and 87.1% for private residential homes (L&B, 1999-2000: 182). The main reason for this has been the failure of local authority funding to keep pace with demographic pressure.

Wistow et al (1996: 90) note that in the early 1990s attitudes of local authorities towards the private sector, 'reflected a relatively crude, knee jerk reaction against what was often seen as inappropriate commercialization of social care.' However, their research shows that very few private providers of residential care were motivated primarily by profit maximization. Nevertheless, this research was geared towards *residential* care where the vast majority of providers are *small* owners. As Wistow et

al (1996: 111) make clear, the homes with most noticeable market awareness and commercial orientation tended to be private sector, relatively large, part of a multi-home organization, of intermediate age, and purchased rather than inherited. Most homes began operating during the early and mid-1980s, 'presumably partly fuelled by the availability of social security funding.' (1996: 183)

Corporate penetration is greater in nursing than in residential care. Corporate providers concentrate on nursing care partly because homes are typically larger than in residential care. They therefore afford some economies of scale (L&B, 1999-2000: 176), despite the observation by Enderwick (1989a), discussed earlier in this chapter, that service firms make less use of economies of scale in production (as opposed to purchasing). Between 1988, when L&B started maintaining records, and 1997, major providers more than doubled their share of the for-profit care home market (L&B, 1997: A186). L&B's definition of 'major provider' includes all organizations with three or more homes. Yet there has clearly been a process of consolidation within the corporate care home sector (L&B, 1997: A186). For the first time in 1996 the number of for-profit major providers fell slightly. More significantly, the number of UK stock market quoted companies fell sharply as a result of mergers and acquisitions (M&As) during 1996 and 1997 (ibid). During calendar year 1998, the for-profit major providers' share of the entire for-profit care home sector rose by 3% to 29.7%, which, according to L&B (1999-2000: 176), represented 'a quickening of the pace of corporatisation'. At the end of 1998, there were 288 for-profit major providers (CCMN, March 1999). However, the ten largest operators owned or leased 13.8% of total UK for-profit capacity, whilst the three largest owned or leased 7.9% (L&B, 1999-2000: 176).

Walker & Golding (1997) saw the largest firms involved in M&A activity in the sector as having, 'the appearance of chess grandmasters operating an intricate offensive, or defensive, strategy prior to striking at the heart of their opponents.' US operators had entered the UK market as a result of their perception that there were better opportunities abroad than at home, 'since to a large extent UK dynamics are simply following the pattern already seen in the US' (ibid). The extent to which concentration in the UK market has been accompanied by internationalization is one of

the key research questions tackled by this thesis, which are discussed in the next chapter.

This process of concentration in the industry appears to be reinforced by the problems experienced by the smaller homes in the current tight financial climate. Andrews & Phillips (1998: 10) found that in Devon, where their study was focused, smaller homes were experiencing the most severe financial problems. In 1994, for example, 70% of the homes operating at or below their margins of profitability were registered for fifteen beds or fewer. Many proprietors were disillusioned with working in the residential sector, and over one third of home owners stated they would sell their business if it were possible. Smaller homes are not necessarily owned by small *companies*, but on the whole this is the case, partly because large companies have engaged in some new build in order to take advantage of economies of scale. According to Bartlett & Burnip (1999: 10), in the process of improving quality in care homes, 'the loss of good smaller homes along the way seems inevitable'. As Andrews & Phillips (1998: 10) point out: 'Ironically, it is the smaller homes, being less "institutional", which sit best with the philosophy of care in the community.'

In addition to the pressures upon existing small providers, financial barriers to entry have risen for small providers, as average home sizes have increased, and as lending institutions have operated stricter lending policies in contrast to the expansion period of the 1980s (L&B, 1999-2000: 178). Investment in the private care sector involves highly capital-intensive investment in property, but sale and leaseback offers a mechanism whereby care home operation can be separated from property investment. Corporate providers have, therefore, increasingly made use of sale and leaseback as a way of funding expansion. This has brought a number of Real Estate Investment Trusts (REITs), including many US based ones such as Omega Worldwide (CCMN, April 1998), into the market. However, the increasing recourse to sale and leaseback has prompted much debate within the industry following the financial difficulties experienced by some companies. These have included Tamaris, as well as Advantage Care and Grampian Care, both of which went into receivership in 1999 (CCMN, October 1999).

## THE INTERNAL AND EXTERNAL REGULATION OF PRIVATE WELFARE PROVIDERS

### MANAGERIALISM AND THE WELFARE STATE

As we saw in the previous section, there has been a significant shift towards the private provision of some welfare services in recent years. Yet despite this, many such services have remained 'in house'. However, even these services have been affected by the 'logic' of the private sector. The health service 'internal market' has seen hospitals become semi-independent trusts, which are supposed to follow the efficiency maximising logic of private firms within a (internal) competitive market. Even where quasi-markets have not been introduced, public agencies of all kinds have been required to account for their efficiency through a range of measurable performance criteria. Many commentators have noticed how this has tended to shift power away from professionals and towards a new elite of managers (Clarke et al, 1994).

Under the paradigm of the 'New Public Management' (NPM), this managerialism has been linked by some to globalization, and other PhD work is proceeding on this particular topic (See Barnes, K., 1997). NPM is usually linked to globalization via the concept of Cerny's 'competition state'. Cerny (1990) sees a new emphasis on economic competition between states as emerging from growing transnational 'interpenetration', which undermines state welfare provision and the Keynesian demand management that supported it. NPM is therefore seen by some as an aspect of this competition, as states try to maximise efficiency within those services which remain in public hands (Hood, 1995).

Cousins (1988: 222) has also argued that in the NHS, even where in-house tenders won contracts for ancillary services, 'although labour is still not conducted for a profit, the labour process is organized as if it were'. Dominelli & Hoogvelt (1996: 56) make a similar point when they argue that the reorganization of social work training around

core competences (usually in the form of NVQs) 'is in keeping with the strategies which have been developed by multinational firms'. Competences make tasks 'more amenable to quality control and quality assurance mechanisms', something discussed later in this section. According to Dominelli (1997: 20), competences are Taylorist in approach and 'provide a means through which employers can control both the labour process and their employees by reining in independent thought processes and deliberations.'

Dominelli (1997: 15) argues that globalization has promoted, 'the penetration of market discipline into welfare provisions in order to release capital for accumulation and investment in various sectors of the economy, primarily by individual private entrepreneurs and financial corporations who operate on a world-wide scale'. According to her (1991: 15):

This has led to the emergence of the global market principle at the heart of the welfare state, the spread of the conditions necessary for flexible accumulation within it, the introduction of just-in-time production techniques into public sector activities, and the internationalisation of the national welfare state by the incorporation of non-national and multinational firms as key providers of services. As a result, global competition sets the parameters within which the quasi-market of the welfare state is compelled to operate.

According to Dominelli (1997: 15), The Financial Management Initiative (FMI) of 1982 laid the foundations for drawing the welfare state into the marketplace and 'transforming caring relations into exchange relations'. It did this by introducing business management techniques into welfare provisions, particularly health and education. FMI was succeeded by the Next Steps Initiative (NSI) in 1988. In services for older people, the basic tenets of NSI were explicated through the Griffiths Report (1988), 'which demanded that business methods be properly introduced into social work to improve the productivity of its practitioners and increase customer choice' (Dominelli, 1997: 16). According to Dominelli, the FMI, NSI and PFI between them laid the groundwork for managerialist control of the public sector workforce, and the challenging of professional autonomy.



## THE EXTERNAL REGULATION OF PRIVATE FIRMS

The imposition of managerialism, and the adoption of assessment by measurable performance criteria, in the welfare state has led to a culture change in public services. This has reacted back onto the private sector through a new concern with measurable quality indicators by commissioning agencies, and increased regulation. Private providers are thus tied into a field of 'dispersed' state power (Clarke, 2000: 212). Hence, some of the methods for the external regulation of private providers identified by Dominelli (1997: 18) include contract specification, the setting of measurable performance targets, specifying and costing input and output measures and establishing monitoring and reporting mechanisms. According to Dominelli (1997: 18), it is for this reason that Total Quality Management (TQM) and British Standards (BS) 'have found their way into social work practice and its lexicon'. The British Standard BS 5750 was originally written with manufacturing industry in mind, but in 1987 it acquired an international equivalent, ISO9000, and in 1991 an additional part to the standard, ISO9002, was introduced for services (BSI, 1994; Pollitt, 1996: 104). The essential idea behind BS 5750 / ISO 9002 is that the processes by which goods or services are produced and delivered should be very clearly specified. The standards lay heavy emphasis on documentation, and require subscribing organizations to identify 'control documents' such as manuals.

In theory such mechanisms aim to assure the purchaser that the provider has the mechanisms in place to guarantee the delivery of quality products. However, they have been criticised for making no allowance for the fact that service organizations are different from organizations producing physical goods, and may require different techniques to take account of them (Dominelli, 1997: 18; Pollitt, 1996: 105). Furthermore, the user of the service is not involved in the specification of the services provided, and is thus constructed as a passive recipient of what others think is best for them. General issues of quality measurement in health related services will be discussed in the next sub-section, and the internal forms of organization used by large and internationalized firms to facilitate quality and other goals in the sub-section following

that. Here we discuss issues relating to the external regulation of firms, particularly those providing long term care.

Le Grand & Robinson (1984; see also Le Grand et al 1992) identify three possible forms of state economic and social activity: provision, tax/subsidy and regulation. It has already been seen that the shift away from direct state provision has involved an increase in state subsidy to private providers. However, in an advanced capitalist economy a shift to private provision is also likely to lead to the state increasing its regulatory role, since the threat to standards of care posed by inadequately regulated profit-seeking would be generally unacceptable. As Papadakis & Taylor-Gooby (1987: 56) argue, privatization paradoxically necessitates 'even more intervention in order to issue standardised guidelines'. All of the privatized utilities in Britain are currently regulated by an agency specially set up for that purpose (see Bishop et al, 1995). In residential and nursing care, the expansion of private provision in the 1980s encouraged a trend towards 'an insistence on higher standards through the regulatory system' (Day & Klein, 1987). However, this regulatory system was divided between individual health authorities which had responsibility for the regulation of private hospitals and nursing homes, and individual local authorities which had responsibility for the regulation of residential homes.

This drive towards greater regulation can be seen in a number of countries, where it has been reinforced by scandals and by the perception of low standards among private providers. Dartington & Denham (1991: 78) note that arguments for privatization of continuing care in the UK claimed that this would improve standards of care whilst reducing the financial burden on the NHS. It was implied that privatization would mean de-institutionalization and better care and efficiency, especially since the public sector applies standards to the private sector which it would not often apply to itself. However, American experiences in the 1980s have involved scandals in private nursing homes, half of which provided their care in life-threatening situations in at least one aspect (ibid). The perception of low standards, and fraudulent behaviour (Inman & Sone, 1997), among American firms has raised concern in Britain since, as discussed above, US firms have been entering the British market. In Australia, stories of mistreatment and neglect in private nursing homes in the late 1970s and early 1980s led

eventually to a new regulatory system being introduced in 1987 (Braithwaite et al, 1993: 2). The imposition of higher standards through state regulation may have played an important role in increasing the appeal of private care in Britain (Papadakis & Taylor-Gooby, 1987: 64).

Mintzberg (1991: 390) sees regulation as only one possible tool for the control of organizations by outside interests. At best, according to Mintzberg, regulation sets minimum and usually crude standards of acceptable behaviour. When it works 'it does not make any firm socially responsible so much as stop some from being grossly irresponsible.' (1991: 395) Furthermore, because it is inflexible, regulation tends to be applied slowly and conservatively, usually lagging behind public sentiment. It often does not work because of difficulties in enforcement. The regulators may have limited resources and information compared to the industries they are supposed to regulate. Yet Mintzberg quotes Theodore Levitt's argument (Levitt, 1968) that business has fought every piece of proposed regulatory or social legislation throughout this century, from the Child Labor Acts on up. However, there are, according to Mintzberg, obvious places for regulation, especially where the industry creates tangible 'externalities' such as pollution. Likewise, regulation may have a place where competition encourages the unscrupulous to pull all firms down to a base level of behaviour.

In the literature on corporate strategy, however, Pfeffer (1991: 383) identifies regulation as one of a number of options open to *managers* of corporations, who, he argues, are seeking to reduce uncertainty and interdependence. Uncertainty arises from the unpredictable actions of competitors, as well as from noncompetitive interdependence with suppliers, creditors, government agencies, and customers. According to Pfeffer, regulation most frequently benefits the regulated industry, since regulation reduces competition and uncertainty and may allow prices to rise. In contrast to Levitt (1968), Pfeffer (1991: 387) argues that regulation has frequently been sought by the regulated industry. However, firms have no assurance that regulatory authority will not be used against their interests, and it is very hard to repeal once enacted.

One approach suggests that regulation is created for the public benefit, but is subsequently 'captured' by the firms subject to regulation. Braithwaite et al (1993: 52) found that capture was not a particularly useful concept for understanding nursing home regulation. However, they saw a need for 'constant reinvigoration' of the regulatory program to guard against Marver Bernstein's (1955) notion that regulatory agencies go through a 'life cycle', that sees public interest progressively subordinated to the interests of the regulated industry. Braithwaite et al (1993: 52) found evidence that, over time, inspectors who gave tougher ratings were more likely to leave the job than those that gave easier ratings. Those who left complained of lack of departmental support to take tough action against recalcitrant nursing homes. How the regulatory authorities are organized is also a key issue. According to Dartington & Denham (1991: 78), many of the problems associated with poor standards of care in US homes in the 1980s arose because 'the responsibility for financing the parameters of care and proving quality, while preventing and punishing fraud and abuse, were fragmented between agencies at all levels.' In the UK, regulation is currently divided between a multiplicity of local and health authorities, an issue discussed in some depth in Chapter Five.

However, where MNCs are involved, they may make use of 'regulatory arbitrage' (taking advantage of differences in national regulations) (Sally, 1996: 68). Furthermore, it is argued that MNCs tend to have greater expertise, intelligence of non-market environments, access to political elites, and skills in the exercise of influence and negotiation, compared to smaller national firms without international production networks (Sally, *ibid*). Thus, as Ruigrok & van Tulder (1995) and Stopford & Strange (1991) emphasise, MNCs are likely to engage in bargaining over regulation and other issues with state (and other) actors.

## REGULATION AND QUALITY

We have discussed above the issues relating to the external regulation of private firms. This has involved a concern with measurable criteria. This section discusses the types of criteria which may be used in measuring quality.

Attempts to set quality standards for care home residents have made a distinction between structure, process and outcome (see Donabedian, 1966). Braithwaite et al (1993: 9) give some useful examples of these which illustrate the differences between them. *Structural* standards are concerned with inputs. Examples are a requirement that certain numbers of square metres of space be available per resident, that buildings have sprinkler systems and that a registered nurse be on duty at all times. *Process* standards are defined in terms of the good professional or organizational practices thought necessary to deliver quality care. Examples are requirements for the regular repositioning of residents to prevent bed sores, or accounting standards which specify procedures for the management of residents' finances. *Outcome* standards are concerned with the outcomes that are considered desirable for residents. These were usually defined in medical terms, but today outcomes also include concepts such as 'quality of life'. As already indicated, systems such as ISO 9002 are concerned with process.

Haywood (1991) argues that the NHS has been preoccupied with structure and process considerations at the expense of outcomes, reflecting a service-led approach. In contrast, the development of appropriate indicators for the measurement of outcomes requires a concentration on patients' preferences and rights. Discussing a Health Services Management Centre exercise for registration and inspection officers, which requires them to judge services against the standards they would apply to themselves, Haywood (1991: 20) notes: 'The outcome remains challenging for most registration officers since comparisons of existing practice (NHS and private) with things that are valued for themselves produce a significant deficit.'

Twining (1991), however, notes that the more successful we are in raising standards of care, the more difficult it becomes to demonstrate that what we are doing is effective. Once we have taken care of basic bodily needs, the measurement of standards becomes more problematic. Thus today, according to Twining (1991: 47), the 'ultimate aim of nearly all care for older people is quality rather than quantity of life.' Any definition of quality of life must include the subjective element of the degree of satisfaction or dissatisfaction felt by individuals about various aspects of their lives.

‘Thus it can only ever be this perception, and the factors influencing this, which we can hope to measure.’ (Twining, 1997: 49) These factors are: physical environment; physical health; social interaction; mental health; and personal and past history. Social interaction is particularly important since studies of older people in hospital have shown that the greatest causes of dissatisfaction tend to be with interpersonal rather than physical aspects of the environment. Personality and past history, being rooted in the past, may not seem to be amenable to change, but have a significant impact on how individuals adjust to different settings.

The Burgner Report (1996: 38, 4.3.7) on regulation of the social services argued that input measures cannot be replaced as the central basis for statutory regulation, but that they should increasingly be used in conjunction with outcomes. This reflects the current American system, where the emphasis is on moving towards an outcome orientation, but with the regulatory process mandating both structures and processes seen as necessary to achieve these outcomes. However, it is different to the Australian system, where since the federal government took over most of the responsibility for the regulation of nursing homes in 1987, the emphasis has been much more radically outcome oriented (Braithwaite et al, 1993). The Australian philosophy is based on the conviction that outcomes are what counts, but that ‘there are few, if any, well established truths about which inputs consistently result in improved outcomes’ (Braithwaite et al, 1993: 10). It is argued, therefore, that input regulation runs the risk that regulators will set in concrete requirements that make residents worse off.

According to Braithwaite (1993), in the US, where the expansion of private provision of long term care took place far earlier than in the UK, input regulation encouraged the development of a ‘disciplinary’ culture within nursing homes. The structure of the US nursing home industry in the immediate post-war period was very similar to that of the UK in terms of being composed of mainly small providers running small homes (Braithwaite, 1993: 19). During the 1970s, however, tough regulatory measures concentrating on structural input standards were introduced. The effect of these was to lead to the development of large chains running large homes which could meet the standards but still be profitable by utilising economies of scale. Provision by large chains running large homes, where ‘management control became increasingly remote

from actual care giving' (Braithwaite, 1993: 21), led to disciplinary practices towards residents, such as high levels of restraint. Input regulation therefore led to 'ritualism', i.e., 'going along with institutionalized means for achieving regulatory goals while not attaining the goals themselves' (Braithwaite, 1993: 11). According to Braithwaite (1993: 20): 'Nursing homes owned by some of the largest chains became dispiriting places - regimented, standardized, institutionalized, relying heavily on restraint to maintain order, and devoid of a warm, homelike atmosphere.'

There are some arguments in favour of input regulation, however. One is that when business people are making major capital investments, they like certainty (Braithwaite et al, 1993: 10). For example, they like to be able to ask regulators how they should build a new wing to meet their requirements, and they don't like being told that it does not result in adequate outcomes once it has been built. Input measures also provide clear guidance to managers who may not be well trained. There are some areas in which there is little dispute about the need for clear guidance, such as fire prevention. It is also argued that inputs, such as the number of beds per room, can be easily counted, and therefore enforced.

Objective outcome indicators, like the number of pressure sores, may also be easy to count, and in the US has provided a strong basis for comparisons between homes, particularly over the incidence of physical restraint. In contrast, Twining (1991: 65) points out that there are several dimensions to subjective outcomes such as quality of life, and these are difficult to measure. He does however, suggest ways in which this might be done. It is worth doing because, as Dartington and Denham (1991: 69) argue: 'Home is what you own - psychologically if not literally.' Thus, psychological ownership is especially important for those who are increasingly in need of physical support and for whom the therapeutic task is to maintain their sense of identity and worth as people. They should be able to make as many decisions for themselves as possible, and be consulted in decisions made for them. Braithwaite et al (1993: 13) similarly argue that 'the key to delivering an outcome orientation is a resident centred process'. Whilst recognising the problems presented by high dependency levels, Braithwaite et al (1993: 14) argue that: 'It is simply not true, as some of the critics

have suggested, that a resident centred process cannot work well where levels of disability are high.’

It has been seen, therefore, that quality systems may make use of structure, process or outcome measurements, or a combination of these. Increasingly there is a recognition that structure and process indicators should not dominate over outcome measures when monitoring quality. However, when discussing the issue of quality, it is necessary to consider not only the arrangements for *external* regulation of providers, but what kind of *internal* systems might be used by such providers.

### THE INTERNAL REGULATION OF INTERNATIONALIZED FIRMS

We have discussed so far in this section how the advent of managerialism in welfare services, together with public concern about standards, has encouraged a new emphasis on the regulation of private providers and demonstrable quality measures. Yet little detailed work has been done on how private providers of welfare (as opposed to manufacturing MNCs) actually organize themselves.

Mintzberg (1979) identifies five main types of corporate organization: the simple structure, the machine bureaucracy, the professional bureaucracy, the divisionalized form, and the adhocracy. Each of these has a ‘prime coordinating mechanism’. In a professional bureaucracy, for example, coordination is through standardization of *skills*, and training and indoctrination. This results from the specialized knowledge of professionals, leaving them relatively autonomous in the work process once they have graduated through the relevant training (1979: 349). A health care firm might therefore be assumed to operate in this way. However, this would be mitigated in firms providing care for older people, which tend to rely to a fairly large extent on relatively low-skilled, low-paid workers (see Chapter Six). A firm employing low-skilled workers is more likely to resemble a machine bureaucracy, which concentrates on standardizing the work *process* in classic Taylorist fashion. Furthermore, according to Mintzberg (1979: 380), multinational firms tend to be organized as divisionalized forms. This is because successful operation in diverse markets requires the firm to be



divided into a set of quasi-autonomous entities held together by a central administrative structure or headquarters. Thus, the vast majority of the Fortune 500 are organized in this way.

Divisionalized forms rely on standardization of (financial and profit-oriented) *outputs* as their prime coordinating mechanism. This is because the divisionalized form enhances the power of middle line managers, who control the day to day running of each division, but who must be held to account by headquarters. Quantitative performance control systems are thus a key design parameter of this type of organization. According to Mintzberg (1979: 424), this reliance on performance criteria is both its chief source of economic efficiency and the basis for one of its most serious social consequences:

The Divisionalized Form requires that headquarters control the divisions primarily by quantitative performance criteria, and that typically means financial ones - profit, sales growth, return on investment, and the like. The problem is that these performance measures become virtual obsessions, driving out goals that cannot be measured - product quality, pride in work, customers well served, an environment protected or beautified. In effect, the economic goals drive out the social ones... As a result, the control system of the Divisionalized Form drives it to act, at best, socially unresponsively, at worst, socially irresponsibly.

Although there is evidence that some MNCs have turned towards more flexible forms of organization, and that there is a diversity of these, (Bartlett & Ghoshal, 1998 and 1987; Held et al, 1999: 268), Coates et al (1993: 7) and Stopford & Strange (1991: 150) confirm that MNCs measure the worth of any particular investment by the rate of return on that investment.

The implications of this for welfare organizations, where quality of service is all important, are profound. According to Griffith & Rayner (1985: 38), the American healthcare corporations operating in Britain in the early 1980s were managed according to company guidelines set at head office, but with some latitude allowed.

This meant that managers had some discretion, but that their personal progress within the organization depended on financial results. Gene Burleson, the chief executive officer of American Medical International, said that: ‘Progress against budget is reviewed daily, weekly and monthly by the hospital director working with his department managers. Deviations from budget are dealt with by agreeing plans for corrective action. However, all managers within AMI are aware they are responsible for meeting their budgets and that failure to do so may result in ... *de-selection*.’(cited in Griffith & Rayner, 1985: 38; emphasis in original) According to David Bromberg, a spokesperson for American hospital corporations in 1983, ‘As a service becomes unprofitable, there is greater danger that quality may be sacrificed’ (Cited in Griffith & Rayner, 1985: 51).

Mintzberg (1979) argues that the divisionalized form encourages firms to grow ever larger as managers seek to expand their power and profitability. Paradoxically, this also encourages the concentration of power *outside* the firm, as unions and government agencies seek to match that of the corporation. Yet according to Mintzberg (1979: 288): ‘The greater the external control of the organization, the more centralized and formalized its structure.’ This is because the two most effective means to control an organization from the outside are (1)to hold its most powerful decision makers responsible for its actions, and (2)to impose clearly defined standards on it. ‘The first centralizes the structure; the second formalizes it.’(ibid: 289) There thus appears to be a symbiotic relationship between state and firm, the actions of each encouraging a concentration and formalization of the power of the other.

In firms providing welfare, the imposition of standards through the regulatory system is likely to result in a formalization of the firm’s structure through its adoption of internal quality assurance (QA) systems, which will operate simultaneously with financial criteria. As already discussed, quality systems such as ISO 9002 are based on controlling the labour *process*, in the manner of Mintzberg’s ‘machine bureaucracy’. In a competitive market, the firm is likely to seek to standardize the quality of its ‘product’ in any case, in order to be able to sell it. This relates to the issue of branding. The chief officer of the American healthcare firm Humana Corporation, for example, once declared that the wanted to provide a product as uniform as a McDonald’s

hamburger (Griffith & Rayner, 1985: 37). Large firms thus have incentives to impose internal quality systems, and the capacity to do so through their formalized structures.

It may also be the case that large and internationalized firms are able to deliver higher quality care as a result of economies of scale, access to more resources or a wider knowledge base. Dunning & McQueen (1981: 203) argue that economies of scale, managerial and organizational expertise, a high level of training and the provision of detailed instruction manuals are amongst the factors which give a competitive edge to multinationals involved in the hotel industry, which has a number of things in common with long term care, although in other ways it is very different (for a discussion of the 'hotel approach' to long term care, see Bland, 1999).

Overlapping with these issues of formal organization is that of 'culture' within the firm. This will be discussed next.

### COMPANY 'CULTURE' AND MERGERS AND ACQUISITIONS

'Culture' within a firm may seem like an intangible notion, but it is important to the functioning of the firm, and may have been nurtured over many years. Johnson & Scholes (1993; 60) argue that: 'It is clear in examining decision processes that experience carries an important influence. Managers draw heavily on frames of reference which are built up over time and which are especially important at a collective organisational level.' Johnson & Scholes (1993: 162) see the core of an organization's culture as residing in its 'paradigm', which is composed of values, beliefs and assumptions. Values may be easy to identify in an organization, as they are often written down as statements about the organization's mission, objectives or strategies. However, they tend to be vague, such as 'service to the community'. Beliefs are more specific, and are also issues which people in the organization can 'surface' and talk about, such as a belief that professional staff should not have their professional actions appraised by managers. Assumptions are seen as the 'real' core of an organization's culture: 'They are the aspects of organizational life which are *taken for granted* and which people find difficult to identify and explain.' (Johnson & Scholes,

1993: 162, emphasis in original.) Culture is related to organizational structure because the latter preserves the core beliefs of the organization. Furthermore: 'The way in which responsibility and authority are distributed within the organizational structure is also an important part of the culture' (ibid: 167).

This issue of culture is relevant to the long-term care industry because, as with health care ancillary services and many other privatized services (PSPRU, 1996), a process of expansion through mergers and acquisitions (M&As) has been particularly marked in the UK Community Care market (see above). According to Johnson and Scholes (1993: 234) a compelling reason to develop by acquisition is the speed with which it allows the company to enter new product market areas. Johnson and Scholes (ibid) also point out that international developments are often pursued through acquisition (or joint development) in order to gain market knowledge quickly. Additionally, there may be reasons of cost efficiency which make acquisition desirable, perhaps arising from the fact that an established company may already be a long way down the 'experience curve', and may have achieved efficiencies which would be difficult to match quickly by internal development. According to Johnson and Scholes (ibid), in public services cost efficiency is usually the stated reason for merging units and/or rationalizing provision. Consolidation can bring benefits from economies of scale involving cuts in administration costs and savings from additional buying power of consumable items and utility costs. Although M&As often lead to staff cuts, consolidation may also assist retention of staff and increase potential for bringing on board skilled middle managers and professionals. In the long term care market, a particular reason for acquisition is the expense of new-build.

However, Johnson & Scholes (1993: 234) point out that: 'The overriding problem with acquisition lies in the ability to integrate the new company into the activities of the old. This often centres around difficulties of cultural fit.' The problem of cultural fit has been well illustrated in the recent spate of mergers in the world economy more generally. In 1998 there were \$2.4 trillion worth of mergers worldwide, a 50% increase on 1997, itself a record year ('The Economist', 9.1.99). A quarter of these involved cross-border mergers. 1999 saw a huge increase in M&A activity between pharmaceutical and biotechnology firms (Wood Mackenzie, 1999 & 2000). Much of

the inward investment in the UK in particular has taken the form of M&As. Foreign spending on acquisitions in the UK rose by 36% in 1997, while the US saw a fall of 16% (IBB, 1998: 8). In absolute terms, the amount spent in the US by foreign investors was only 13% higher than that in the UK, despite the much larger size of the US economy.

Yet most studies have shown that two of every three deals has not worked. According to 'The Economist' (9.1.99): 'The only winners are the shareholders of the acquired firm, who sell their company for more than it is really worth.' However, as 'The Economist' (9.1.99) puts it, 'People never fit together as easily as flow charts.' This applies to top management as much as to other staff - the drug merger of Glaxo Wellcome and SmithKline Beecham collapsed 'when neither boss was prepared to play second fiddle'. According to 'The Economist' (9.1.99), two things make culture clashes harder to manage today; one is the growing importance of intangible assets (i.e. skilled staff who can 'walk out of the door' and important relationships with customers and suppliers built up over time), the other is the rise in cross-border mergers. For example, the link between Sweden's Pharmacia and America's Upjohn in 1995 was supposed to be driven by cost-cutting and matching drug portfolios, but time was wasted on 'American' practices like banning alcohol at lunch. In addition, Pharmacia had not integrated an earlier Italian acquisition. The new company started with 'power bases' at Stockholm, Milan and Michigan, but after a failed attempt to make everybody report to a new office near London, the firm moved to New Jersey and appointed a new boss.

According to 'The Economist' (9.1.99), there are three 'ominous signs' about the recent merger boom. First, firms may be better at negotiating the deal than at integrating their acquisitions, especially in America. The services conglomerate Cendant, for example, ended up with two bosses and two different accounting centres: neither side really knew what the other was doing. This problem of integration has been confirmed by a Bank for International Settlements (BIS) study (BIS, 1999), which showed that bank profitability had fallen in twelve countries despite a wave of consolidation. The BIS found that acquirers had 'systematically' underestimated organizational problems. Second, many deals are rushed - Cendant did twelve big

deals in four years. Third, mergers have often become a strategy in their own right. For example, most American bank deals have been done in the name of cost-cutting, yet research has shown that merged banks had generally cut costs more slowly than those that had not merged. Mergers may therefore distract managers' attention from tackling the real problems. As well as the problem of wrecking 'carefully nurtured corporate cultures' ('The Economist', 9.1.99), there are problems such as linking distribution systems or settling legal disputes. In particular, many mergers have found it difficult to mesh information technology together. For example, Aetna, an insurer, bought US Healthcare, a health maintenance organization, partly for its computer systems, which could sift out the 'best' doctors. However, the two firms had big problems combining their 'back offices'.

It is clear, therefore, that M & As may be problematic. A study of the large firms that are developing in the long term care sector, where M & A activity has been widespread, must therefore investigate the impact of M & As on such firms' internal organization and culture.

## **CONCLUSION**

This chapter has discussed a number of important issues. It has surveyed the growing internationalization of services, and the way in which the internationalization of welfare and other public services has been facilitated by privatization. Although little is known about internationalized welfare firms, it was noted that there may be a number of important differences between manufacturing and service MNCs, in terms of both structure and strategy. Like other large firms, service firms are likely to make use of economies of scale. These may primarily be in purchasing, rather than production (provision), since consumption of services must generally take place at the same time as production, making the concentration of production in one place and dependence on mass distribution impossible. However, providers of long term care have made use of some economies of scale in production, through the use of large, purpose-built, homes. Furthermore, Mohan's analysis of the expansion of internationalized firms in the UK hospital market in the 1980s (1991) indicates that they may have had a qualitative

impact on the way services are provided, through their innovative role in work organization for example; whilst Dunning & McQueen's analysis of the hotel industry (1981) indicates that multinationals may also have competitive advantages arising from managerial and organizational expertise, and training and instruction manuals. Whilst services are diverse, and consequently difficult to classify, strategies of internationalization may be either 'client following' or 'market seeking'.

In long term care, the introduction of the 'mixed economy of care' has allowed significant penetration of delivery by large private companies. The long term care market has been experiencing a process of M & A, reflecting trends in the world economy more generally. Entry to a foreign market may take the form of mergers or acquisitions because they allow the firm to gain market knowledge quickly. This is confirmed by Mohan's research (1991) which showed that US hospital corporations often entered the UK market via these means. However, M & A can be a disruptive process, since the new firm is faced with the problem of integrating previously independent companies into a single coherent entity. Such problems often revolve around the issue of 'cultural fit', i.e. the difficulty of cohering companies with sometimes very different practices based on their own specific set of values, beliefs and assumptions.

This chapter also discussed the growing concern with state regulation in long term care resulting from increasing private provision. It was argued that growing managerialism within the welfare state, influenced to a large extent by practices in the private sector, has reacted back onto private providers. As more provision has been transferred to the private sector, there has been a growing concern with the need to find external forms of control. This is consistent with the observation made in Chapter 1, that rather than the state losing power it may be changing the *form* of its intervention, in this case from direct provision to subsidy and regulation. However, it was noted that the monitoring of quality is not a straightforward process; the type of quality criteria utilized may have an impact on the outcomes for residents, depending on how the regulatory system interacts with providers, the nature of those providers, and the overall structure of the market. Braithwaite (1993), for example, has shown that in the US after the 1970s the introduction of tough structural input standards

encouraged the development of large companies which met the standards by developing large homes which could take advantage of economies of scale. These organizations ultimately engaged in 'ritualism', i.e., 'going along with institutionalized means for achieving regulatory goals while not attaining the goals themselves' (Braithwaite, 1993: 11).

Also relevant to this issue of regulation were issues relating to the *internal* organization of large and internationalized firms. Based on Mintzberg's typology (1979), three types of organization were identified as potentially being relevant to large private providers of long term care. These were: firstly, the 'professional bureaucracy' in which coordination takes place through the standardization of *skills* and training and indoctrination; secondly, the 'machine bureaucracy' in which coordination takes place through standardizing the work *process* in classic 'Taylorist' fashion; and thirdly, the 'divisionalized form' which is relevant to MNCs and results from their need to control their quasi-autonomous national divisions from a central headquarters. The divisionalized form relies on the standardization of financial *outputs*, or profitability criteria. This emphasis on profitability criteria was identified as a potential source of concern where firms are providing welfare services. However, the incentive for firms to ensure minimum standards of care through their own internal quality assurance mechanisms was also acknowledged. These incentives relate to the need for the firm to compete on quality as well as price if market share is to be gained, and this relates in turn to the issue of 'branding'. The firm must also meet the requirements of external regulators, and doing so is an important part of maintaining its brand image. As Mintzberg (1979: 289) notes, the attempt to control the firm through external regulation tends to encourage even greater centralization and formalization of the firms' internal structure. There is, therefore, potentially a 'symbiotic' relationship between state and firm, with the actions of each encouraging a concentration and formalization of the power of the other.

This chapter has identified a number of issues and concepts which are important for studying the development of internationalized welfare firms, and have particular relevance to the UK market in long term care. The next chapter sets out the research



design and methodology used in the thesis. In doing so, it builds on the discussion so far undertaken in chapters one and two.

## CHAPTER THREE: RESEARCH DESIGN AND METHODOLOGY

### INTRODUCTION

The discussion in Chapter One highlighted the ‘level-of-analysis problem’, noting that much of the Social Policy literature has been centred on the macro-level, in the sense of being concerned with the effect of the world market on national policy making. Chapter Two discussed the emergence of internationalized welfare firms, concentrating on the long-term care market, where private provision has gone furthest in the UK. Chapter Two noted that little work has been done on these kinds of firms, and surveyed what is already known about them and some of the issues that are relevant to their continuing growth.

This thesis has two complementary aims. *Firstly*, it aims to build on what is known about large and internationalized welfare firms through an empirical and exploratory study of large and internationalized firms within the UK market for long term care. This first aim is pursued at two levels of analysis, both of which have been somewhat neglected in the Social Policy literature on globalization. Research questions are discussed below, drawn from the discussion in Chapter Two, which are best approached at a micro level of analysis centring on company case studies. The results of this micro level of analysis are then used as the basis for an adapted version of Ruigrok & van Tulder’s meso level of analysis, centring on the relationships between these firms and other key actors. Throughout the thesis there is an emphasis on issues of quality and quality assurance (QA). The rationale for this is that regulation in this sector is centrally concerned with the quality of care delivered (see Chapter Two), and because there is little relevance to a study of this sector that is not centrally concerned with outcomes for the users of the service.

This meso level of analysis also allows the *second* aim of the thesis to be pursued. This is to make a contribution to the debate within Social Policy (and other disciplines)

concerning the deterministic claims relating to globalization discussed in Chapter One. Thus the relationships between internationalized providers of care and other key actors could be analysed in the light of claims about the loss of power by nationally based actors, and the state in particular. Whilst the findings from such an analysis would not necessarily apply to all sectors of the economy, or even the whole of the service sector, the extent to which they are consistent with or contradictory to deterministic claims about the relative power of different actors has relevance for the overall debate about globalization. This would particularly be the case if the findings showed that the state and/or other actors had substantial power or influence over the case study firms, since it would contradict the argument that such actors are always weak in their dealings with internationalized firms.

As the basis of the study, the three largest private providers of long-term care in the UK were chosen as case studies. 'Largest' was defined in terms of the number of beds provided in the UK, rather than the number of homes owned or managed, since some companies would have larger homes than others. Numbers of beds, as well as homes owned or managed, for each of these firms (at 21 June 1999) are given in the table below.

COMPANY	HOMES	BEDS
Company 1	221	16,390
Company 2	146	8,354
Company 3	95	5,972

Table 3.1: Number of Homes and Beds

(Source: CCMN, June 1999)

Restrictions on time, the size of a PhD thesis, and resources meant that the research was focused upon the UK market. The international perspective is therefore dealt with by reference within the research questions to the form and extent of internationalization of both the firms and the non-firm actors, and the impact of this on their behaviour and relationships with each other within the UK market. As will be seen in Chapter Four, the results of the research revealed that all three firms were

internationalized in some form to some extent. Elsewhere in the thesis, reference is therefore made to ‘large and internationalized’ firms. Whilst this represents some degree of conflation of the simply large on the one hand with the internationalized on the other, given that all three firms *were* internationalized in some way this was unavoidable. However, it does confirm that there *is* in fact a tendency towards internationalization among such firms, and provides the basis for the meso level analysis of their relationships with other actors .

The following sections discuss in turn the design of the micro-level analysis; the design of the meso-level analysis; and finally the methodological questions and problems which related to both of these.

### **THE MICRO-LEVEL ANALYSIS**

Chapter Two showed that, like manufacturing firms, service firms are becoming increasingly internationalized, but that, unlike manufacturing firms, little work has been done on the nature of such firms and the strategies they adopt (Dunning, 1993; Daniels, 1993; Enderwick, 1989a). Work done on the expansion of internationalized firms in the UK hospital market in the 1980s (particularly Mohan, 1991), indicates that they may have a qualitative impact on the way services are provided, through their innovative role in work organization for example; whilst analysis of the hotel industry (Dunning & McQueen, 1981) indicates that multinationals may have competitive advantages arising from economies of scale, managerial and organizational expertise, and training and instruction manuals. Chapter Two also discussed the new concern with quality and regulation that has accompanied the growth in private provision of welfare services, and the relevance of this to firms’ internal modes of organization in terms of both quality control and financial control. However, it was observed that the largest firms in the long term care market have grown through a process of merger and acquisition (M&A), which often presents problems of integration and ‘cultural fit’. The evidence and issues surveyed in Chapter Two can therefore be used to generate a detailed set of research questions concerned with the behaviour and functioning of the case study firms. The research questions are as follows:

- 1) What is the corporate history of each firm (with reference to the M&A process)?
- 2) What goals and strategies do they have?
- 3) What is the form and extent of internationalization of each firm?
- 4) How has being part of a large and internationalized organization affected their operation?
- 5) How are they organized (with particular reference to quality assurance systems)?
- 6) How has the process of acquisition and concentration affected (5) above?
- 7) What impact do issues of profit and cost have on quality?
- 8) What are the differences & similarities between the firms?

Case study is a method often used in Business Studies. Here, it is seen as particularly useful in, ‘relatively less-known areas, where there is little experience and theory available to serve as a guide...’ (Ghauri et al, 1995: 87). According to Ghauri et al (ibid): ‘The main focus is on seeking insight rather than testing: instead of testing existing hypotheses we seek insight through the features and characteristics of the object being studied.’ Case studies are often of an ‘explanatory, exploratory or descriptive nature’ (ibid: 88; see also Zikmund, 1997: 107). According to Yin (1994: 13) a case study is an empirical inquiry that, ‘investigates a contemporary phenomenon within its real-life context’. This thesis has an important exploratory element since, as already noted, little is known about large firms in this sector. The choice of the three largest private providers allowed for comparison between large firms, as in research question eight.

As is usual with case studies (Ghauri et al, 1995: 89), two main sources were available with which to answer the micro-level research questions. These were, firstly, the personnel, especially at management level, of the firms themselves; and secondly, various documents and publications. As with the meso-level analysis discussed below, interviewees were chosen by purposive or ‘judgmental’ sampling. This form of sampling is often used in case-study research (Saunders et al, 1997: 145), since it enables the selection of key people who will best be able to answer particular research questions. Problems of access made it particularly important to consider carefully which key people to approach. The more members of an organization approached (and

the more of employees' time therefore taken up), and the more sensitive the information sought, the more likely were conditions to be attached. The primary condition was likely to be a guarantee of anonymity (of the firm, not just the individual). This was important since obtaining information from interviews which could not be related explicitly to the firm would hinder the cross-referencing with other forms of information which was vital in order to substantiate interview data and build up an overall picture of that firm.

The Heads of Quality Assurance (QA) of the three firms, as opposed to personnel who might have had a better knowledge of the firms' *strategies*, were chosen as interviewees for two main reasons. Firstly, this was in keeping with the focus of the study on quality issues. Furthermore, the Heads of QA, as opposed to lower level quality managers, would have an overall view of the functioning of the firm and the impact of organizational issues. Secondly, the details of strategy, especially where they involved questions of finance, were likely to be more sensitive than issues of quality. This was largely because a firm's strategy is at the heart of its attempt to gain competitive advantage over its rivals and has a direct bearing on profitability. It was therefore considered that little information would be provided on strategy which went far beyond what was available from other sources, without conditions of anonymity being attached. The reluctance to divulge information relating to strategy and finance was confirmed in interview with Margaret Grant, who had responsibility for quality at Company 3 but who was also on the firm's board of directors, when a hostile response was given to a question which she misunderstood to be about the firm's financing strategy (the question was actually concerned with local authority funding).

Whilst issues of quality may also be sensitive, they are likely to be less so than those of strategy. This is particularly the case where they are concerned with overall quality regimes rather than the evaluation of outcomes, unless the firm considers itself to have a particularly high quality of service. In relation to this latter point, there is always the danger that firms' representatives will use the interview in a way which is intended to serve public relations purposes, and this must be recognised when analysing the resulting data.

Furthermore, documentary information relating to the broad outline of strategy was likely to be fairly easily available. Firms are required by law to explain their overall strategy (including mergers and acquisitions) to shareholders and others interested in their activities through their annual reports (Vause, 1997). These Reports can often be obtained simply by making a request to the firm in question, although there is no guarantee that they will be sent to non-shareholders. They do, however, need to be read critically since although they must be factual and meet certain accounting and other standards, firms will use these as an opportunity to promote themselves in the best possible light (Vause, 1997: 223; Ghauri et al, 1995: 56). However, according to Vause (1997: 222), 'It is reasonable to expect the annual report to provide sufficient information about a company's strategy and the success of its implementation to date.' In the event, not every annual report for every company for every relevant year could be obtained (See Appendix Four). However, the thesis did not rely on annual reports alone for documentary evidence relating to the firms, but also used the trade press which provides a continuing commentary on issues of strategy and merger and acquisition. Further sources of documentary evidence included company press releases and internet sites, and business databases available on the internet (a rapidly growing source of company information - see Vause, 1997: 213).

Therefore, whilst interviews provided the primary source of information relating to questions four to seven, documentary sources were the main sources of information for questions one to three, although sources are cross-referenced throughout. The key people interviewed were Bob Jones, Head of Quality Assurance at Company 1 Care Services; Jane Bartlett, Quality Assurance Manager at Company 2; and Margaret Grant, Professional Services Manager at Company 3. Two of these, Jones and Bartlett, allowed some time for their QA manuals to be looked at, and Jones provided a copy of Company 1's Quality Review Manual, which corroborated what they had said in interview about QA. The opportunity also arose through a personal contact to be shown around a home in the Hastings area belonging to Company 1 and to interview its manager. Whilst this did not fit into the research design, the opportunity was taken up in order to provide background for the study. The interview guide for company QA managers is reproduced in Appendix Three, whilst general issues relating to interview research are discussed in a later section of this chapter.

The nature of the research questions for the micro-level of analysis meant that issues were touched on which related to actors which Ruigrok & van Tulder (1995) conceptualise as external to the firm, notably finance and supply (see Appendix One). These issues are not analysed in this thesis with reference to external actors, i.e. at the meso level of analysis. The criteria for choosing the non-firm actors for the meso level of analysis are discussed in the next section.

### **THE MESO-LEVEL ANALYSIS**

In order to be an effective tool for analysis in the long-term care market, Ruigrok & van Tulder's model needed some modification. As utilised by Ruigrok & van Tulder (1995: 68), the concept of the 'bargaining arena' is concerned with power relations between core firms and other actors. This question of power is clearly important to the globalization debate, and therefore also has great significance for this thesis. This is discussed further below. However, the thesis also attempts to provide a more in-depth qualitative analysis of the processes at work in, and the outcomes of, the relationships between the firms and the other actors. As with the micro-level analysis discussed above, there was thus also an exploratory aspect to the meso level of analysis. So, although the idea of private firms operating within a 'complex' of relationships with other actors was retained, this was conceived of in a somewhat different way to Ruigrok & van Tulder.

To begin with, Ruigrok & van Tulder's model required some modification in terms of the choice of actors to be included. The thesis' emphasis on quality provided a basis for choosing the non-firm actors which were included in the study. The globalization debate has been concerned principally with two actors: states and firms. For this reason, and because of the crucial role of state agencies in the long-term care sector as both regulators of quality and purchasers of services, the state was retained as a key actor. The workers who do the actual caring remained relevant, since no organization can function without them and the conditions of work and the morale of staff are a key influence on the quality of care. Whilst Stopford & Strange (1991: 227) claim that



their evidence calls into question the concept of class, as Radice (1998) points out, Ruigrok & van Tulder (1995) provide the basis for including labour in analyses concerned with globalization. Finally residents themselves and older people's organizations more generally were included, although this provided some methodological problems which are discussed below.

Other actors which Ruigrok & van Tulder do include in their model are not included in this study. Distributors are not relevant to this study given the nature of the 'product' (service) being provided. Suppliers and financiers are relevant to the overall functioning of these firms, but have no direct bearing on the quality and delivery of care which the thesis is concerned with. However, as indicated above, issues of finance and supply did arise in the micro-level analysis to which Chapter Four is devoted.

The analysis of the relationships between the case-study firms and each of the other actors was divided into three aspects, the first two of which relate to large and internationalized firms within the long-term care sector generally, and the third of which relates specifically to the case-study firms. Each of these aspects can be discussed with reference to a set of research questions.

The first aspect concerns the *attitudes, perceptions and goals* which inform and motivate each of the non-firm actors considered. In the meso level of analysis, actors or agents are conceived of as organizations, rather than as individuals or classes for example. It is through this focus on organizations, and organizational capability, that we are able to undertake a 'meso' level analysis of relationships between key actors. As acknowledged in Chapter One, however, the weakness of this approach is that, like every other level of analysis, by focusing on that particular level we must leave aside other levels if we are to have 'a stable point of focus' (Singer, 1961: 78; see Chapter One). Thus in gaining something we lose something else, since on the one hand organizations must operate within a wider economic and social environment, whilst on the other they are composed of individuals.

The starting point for the analysis is the goals of the organization being considered. These goals define what it is the organization is trying to achieve; in a sense they define

the very *raison d'être* of the organization. However, the way in which these goals are pursued, and the way they are formed and interpreted, will be affected by the attitudes and perceptions of individuals who undertake key roles within the organization. This thesis makes use of interviews with key people within the organizations considered as a major source of data. Given the organizational focus of the thesis, this raised both conceptual and practical problems.

Where key people are interviewed primarily as representatives of *organizations*, rather than simply as individuals in their own right, a problem is encountered in 'separating' the individual from the organization. For example, how do we know that the information yielded by the respondent does not simply reflect their own worldview, rather than that of the organization? There are several answers to this. One is that, to a certain extent, individuals in key positions *are* the organization in so far as they have executive power within it. However, large organizations are rarely run by a single person and, as acknowledged below, respondents were not always the first choice of the researcher. However, to a certain extent individuals are also socialized by their organizations, and it is their job to represent those organizations. Hence the importance of understanding the nature of the organization itself, explored in this thesis in the second aspect of the analysis (discussed below), which is concerned with the form and extent of the organization. Thus whilst the first aspect of attitudes, perceptions and goals is discussed first here, it should be remembered that these are not static. As well as helping to shape, they are also partly shaped by the form and extent of the organization, and are open to change over time. Finally, in both the interview itself and in analysing the data, care was taken to consider the role of the individual within the organization, and any evidence of conflict or differences of view within it.

Attitudes and perceptions which are relevant to this thesis include attitudes towards private provision generally and awareness of the size and internationalization of the leading firms in the sector, which help to condition the actions of the non-firm actors towards large private providers generally. It also includes perceptions of and attitudes towards quality and regulatory issues, which this thesis is particularly concerned with.

The research questions which were addressed for each set of non-firm actors in relation to this first aspect are as follows:

- 1) What are their overall goals or aims?
- 2) What is their assessment of the overall shift towards private provision in the sector?
- 3) How aware are they of the size and internationalization of the leading firms in the sector?
- 4) What are their perceptions of and attitudes towards large and internationalized firms?
- 5) What are their perceptions of and attitudes towards quality and regulatory issues?

The second aspect is a 'structural' one in the sense that it is concerned with the *form and extent of organization* of each of the non-firm actors in the long term care sector. These are the general conditions which affect the 'balance of power' between the firms and each of the other actors (although it is not assumed that these relationships are necessarily ones of conflict). At any given moment in time, the existing form and extent of organization of each of the non-firm actors constrains and sets limits to the possible strategies they may follow in pursuit of their goals. This includes their ability to influence the behaviour of the case study (and other) firms. It also includes decisions to attempt to *change* the form and / or extent of their organization. This is the element of 'structuration' in this analysis. As Giddens (1984: xxi) points out, this reflects Marx's famous statement that: 'Men [sic] make history, but not in circumstances of their own choosing'.

In general, the greater the *extent* of their organization, the more powerful they will be. For example, a union with more members is, *ceteris paribus*, more powerful than one with fewer members. However, the *form* of their organization may also affect their capacity to act and the precise way in which they pursue their goals. The same is true for the extent of their *internationalization*, which Ruigrok & van Tulder (1995) identify as a key factor affecting the bargaining position of other actors in relation to internationalized firms. They argue that in general the more internationalized other actors are, the more bargaining power they will have vis a vis the firm. However, in practice this depends on the nature of the actor's international organization. A union, to extend the example, may belong to an international federation, but this may not be

an effective instrument for action (Ruigrok & van Tulder, 1995: 85). This underlines the importance here of the qualitative analysis of the *form* of organization, as well as the *extent* of that organization.

The research questions which were addressed for each set of non-firm actors in relation to this second aspect are as follows:

- 1) What is the form and extent of their organization?
- 2) What is the form and extent of their internationalization?
- 3) How do they pursue their goals, given the answers to (1) and (2) above?

The third aspect, which follows from the first two, is *firm specific*, in that it is concerned with the particular set of relationships between each of the firms discussed in Chapter Four and the other actors. The first and second aspects thus provide the essential context for an examination of the actual relationships between the case study firms and the other actors, including incidents of direct bargaining. This is perhaps the most exploratory aspect of the meso level of analysis, as it sets out to discover ‘what actually happens’ in these relationships. The research questions which were addressed for each set of non-firm actors in relation to this third aspect are as follows:

- 1) What experience do they have of relationships with specific firms?
- 2) How are these different to each other?
- 3) What distinguishes these from similar relationships, e.g. with smaller firms?

Relevant to this third aspect were also the attitudes of each of the three firms to the various non-firm actors, and their experiences of relating to these actors. The research questions which were therefore addressed for each of the firms in relation to this third aspect are as follows:

- 1) What are their attitudes towards and perceptions of each of the non-firm actors?
- 2) What experiences do they have of relating to each of the non-firm actors?

The data for the meso-level analysis was derived from three main sources. First, interviews were conducted with key people from each of the non-firm actors. These are discussed immediately below. Second, the interviews with the QA managers from each of the three case-study firms, in addition to focusing on the questions relating to the micro-level analysis, also covered questions relating to each of the three non-firm

actors from the point of view of the firms themselves. Thus, information could be gathered on the firms' experiences of, and attitudes and policies towards, state regulatory and purchasing agencies; trade unions and staff related matters; and residents' committees (see below for the significance of these). The results of this were then cross-referenced with those obtained from the interviews with the non-firm actors. Third, as with the micro-level analysis, relevant documents were analysed. These included government acts and reports and the trade press, all of which performed an important function in Chapter Five in setting out the framework of analysis relevant to government policy and strategy in relation to the goals, and the form and extent of organization, of state agencies, as discussed below. The publications of unions and older people's organizations also yielded important information relating to Chapters Six and Seven respectively.

As with the interviewees from the firms, the key people to be interviewed from the non-firm actors were chosen by purposive or 'judgmental' sampling. The logic of this was imposed by the meso level model described above. Thus, the key organizations which represented each of the three non-firm actors were identified, and then key people from each of these were approached for interview. The criteria for the selection of these key people was that they should be the people with overall responsibility for the long-term care sector within that organization. However, at the initial interview with each of the organizations approached, the respondent was asked if there was anyone else whom it would be appropriate to talk to. A judgement was then made about whether that person would indeed yield the information required. This practice therefore offered a means of both checking if the initial respondent was an appropriate interviewee and of identifying others. It did, however, mean that more people were interviewed from some organizations than from others; this often resulted from factors such as the way in which that particular organization was structured and the resulting distribution of roles within it.

Problems were encountered in carrying out this process which related equally to all three of the actors. Some organizations which were approached were unable to provide an appropriate interviewee. Others took so long in responding that, after a number of reminders, a decision had to be taken to abandon the attempt at interview.

Some individuals within organizations delegated the task to another person within that organization; it was not, therefore, always possible to interview the person considered to be most appropriate. A list of people interviewed for the thesis, including the positions of those who did not respond, is given in Appendix Two.

Problems specific to each of the non-firm actors were also encountered in operationalizing the meso level model. The concept of the bargaining arena used by Ruigrok & van Tulder (1995) is based principally on organizations, since those actors who are unable to organize at all by definition have little bargaining power. As discussed above, the focus on organizations, and the importance of the actors' form and extent of organization, were retained in this thesis. However, choosing appropriate organizations was not always a straightforward process. Where it was difficult, this did not ultimately undermine the emphasis on organizations, since the nature of the difficulty encountered tended to illustrate the relative strengths or weaknesses of that actor, in terms of the form of its organization and its overall capacity to organize. This will be discussed in relation to each of the non-firm actors.

A problem arose immediately upon applying the research design to state agencies, since these were organized at a local level and were divided between Health and Local Authorities. This is in itself a key issue which will be discussed in greater detail in Chapter Five. The problem for the methodology employed revolved around the choice of key people to be interviewed, since there were potentially a great many of these given the multiplicity of local state agencies - too many in fact for in-depth interviews with each one. Nationally based officials would not have any direct experience of dealing with the case-study firms, whilst a survey of locally based ones would not yield the depth of information which was sought. Through cross-referencing directories of major providers (L&B, 1998; Parry, 1998), those authorities with high numbers of homes belonging to the case-study firms were identified. The numbers of these were relatively low, but securing interviews with key people from these proved difficult due to constraints on their time arising from the pressure of work. The solution adopted was to analyse the overall, national issues relating to both the goals and the form and extent of organization of state agencies with reference to key documents, such as government acts and reports. These documents reflect the role of the national

government in setting the parameters of 'for-profit' participation in the delivery of services, and in shaping the agencies which regulate it. This was then supplemented by interviews with key state actors in one particular locality, which could then act as an exemplar in terms of illustrating actual practice and experience in relating to the case-study firms.

The use of one locality as an 'exemplar' does not suggest, however, that the chosen locality was 'representative' of the 'average' locality. This would provide problems in any case, since a sample of one would be too small to attempt such generalization. The chosen locality, Albion, is distinct in two important ways. Firstly, the two Health Authorities in Albion, East Albion and West Albion, both had higher than average numbers of homes owned by the case study firms. The area was chosen for this very reason (as well as for the willingness of key people in the area to be interviewed). At the time of interview, West Albion had eight homes belonging to Company 1, two belonging to Company 2, and one which had recently been acquired by Company 3. East Albion had three homes belonging to Company 1, two belonging to Company 2, and five belonging to Company 3. Thus, both Albion Health Authorities had higher numbers of homes consistent with a good spread of homes belonging to all three firms than any other health authority. They were chosen on the basis of health rather than local authorities since the case study firms have much higher numbers of nursing homes than residential homes. Secondly, Albion was distinct in terms of its relatively high numbers of self-pay clients, which may explain why it also had high numbers of private homes. This raised particular issues in relation to purchasing for Albion County Council, as will be discussed in Chapter Five. These two factors mean that the data collected in relation to Albion cannot be over-generalized from. Rather, Albion's greater experience of dealing with the case study firms is used to illustrate in an exploratory way the issues which may arise in the relationship between state agencies and the firms. This data is then discussed in Chapter Five in the context of the general and nationally relevant issues identified from the document analysis.

The key people interviewed from state agencies were therefore the Heads of the Registration and Inspection Units in East and West Albion Health Authorities - Maria Smitham and Dianne Fenn respectively; and key people responsible for commissioning

on behalf of Albion County Council - Adam Warden, the Local Services Manager, and Gordon Saydon, Strategic Commissioning Manager. These key people reflect the current division of labour between Health and Local Authorities: the regulators came from the Health Authorities because the case study firms have many more nursing homes than residential homes, whilst the purchasers were chosen from the Local Authority as this could be expected to carry out more purchasing from private nursing homes than Health Authorities. This also provided an opportunity to examine the relationships between key people from different state agencies - not just regulators and purchasers, but Health Authorities and Local Authorities. These interviews were then cross-referenced with those conducted with the firms' QA managers, for the 'firm specific' aspect of the analysis.

The only person interviewed for Chapter Five with a nationally based position was Julia Owen, Senior Project Manager for the Americas at the Invest In Britain Bureau. She was interviewed primarily in relation to the terms of entry of foreign firms, which in this study relates primarily to the American-owned Company 2. This was relevant to the research question on the form and extent of internationalization of the non-firm actors.

Another problem relating to state agencies concerned differences in regulatory structures and practices between the different parts of the United Kingdom. Although the thesis is concerned with the UK as a whole in terms of the operation of the case study companies, the analysis of their relationships with state agencies was confined to the operation of the English system and its proposed reforms. This was necessary to avoid over-complexity.

The key unions in the long-term care sector were identified through a series of telephone calls to those unions which were likely to organize in this sector, and through the process described above of checking for other key people at the initial interviews. The main interviews for Chapter Six were therefore with the following people: Steve Morton, UNISON Director of Policy and Research; Peter Stephens, UNISON National Officer for Healthcare; Kevin Fenton, a Research Officer employed by UNISON in the Public Services Privatization Research Unit; Mike Gresham,



National Secretary of the Public Services Section of the GMB; Laura Pole, a Research Officer working with Mike Gresham at the GMB; and Louise Saber, Independent Sector Advisor to the RCN. A brief telephone interview was also conducted with Tom Douras, the Trade Group Secretary at the TGWU for this sector, during which it was established that the TWGU's presence in private care homes was virtually non-existent and that the union had little interest in it. It did not prove possible to secure an interview with Roger Kline, National Secretary for the NHS at MSF, but it was established in discussions with administrative staff that MSF's presence in this sector was also virtually non-existent. The higher number of interviews with UNISON staff reflects both UNISON's internal structure (in terms of specialization of roles) and the attention UNISON had paid to the sector, and to large firms in particular, through research and campaigning activities. Gresham and Pole of the GMB were interviewed together on a three-way basis. Questions put to the firms' QA managers for the 'firm specific' aspect of the analysis included those related to their experiences of labour market conditions in the sector, as well as unionization per se.

Operationalizing the meso level model for the residents themselves was particularly problematic. Many (although by no means all) users in residential and nursing homes require high levels of support, mentally and emotionally, as well as physically. A relative increase in those aged 85 or over has increased 'dependency' levels still further (RCN, 1996: 3). Finding mechanisms for the effective participation of such people in their own care is a genuine challenge. In terms of the parameters of this study, a paradoxical situation was encountered whereby one of the actors had little or no autonomous organizations of its own. Unlike staff, for example, where there may be little union organization but the potential to join or form one, the reasons for this arise from the needs of the constituency itself for support from others.

Given the lack of autonomous organizations of care home residents, there were two foci around which the analysis of the relationship between the case study firms and older people themselves was centred. The first focus was organizations which claim to represent or campaign on behalf of older people. These may be concerned specifically with the delivery of long-term care, or may be concerned with the interests of older people generally. They usually are not directly controlled by older people themselves,

but have charitable status. It was hoped to interview a representative from the campaigning organization of older people, the National Pensioners' Convention, but despite repeated attempts to arrange an interview this did not prove possible. Key people from four organizations were therefore interviewed for this chapter. Two of these organizations, Help the Aged and Age Concern, are widely recognised as the largest and most influential organizations concerned with the interests of older people generally. The key people interviewed here were Tessa Garton, Head of Planning and Development who managed the policy unit at Help the Aged; Ian Davis, Business Advisor at Help the Aged; and Evelyn Edwards, Director of Information and Policy at Age Concern. The other two organizations, Counsel and Care and the Relatives Association (which has since changed its name to the Residents and Relatives Association), are concerned specifically with long-term care. The key people interviewed here were Les Martin, Deputy General Manager at Counsel and Care; and Alison Alexander, Advice Coordinator at the Relatives' Association.

The other focus around which analysis was centred were the ways in which older people resident in homes run by the case-study firms may have been encouraged to express their opinions through meetings at the home level, usually facilitated by care home staff. Linked to this was the role of relatives, who may be involved in decisions affecting residents, and who therefore sometimes attend such meetings. This information was gained through the interviews with the firms' QA managers.

Methodological questions which related to both the micro and meso levels of analysis are discussed in the next section.

## **METHODOLOGICAL QUESTIONS AND PROBLEMS**

The use of qualitative methods such as semi-structured interviews has led to much debate about whether quantitative or qualitative methods are more scientific. Qualitative methods have been criticised as being 'unscientific' because they are not quantified, whilst quantitative methods have been accused of sometimes aggregating rich phenomena into artificial and meaningless numbers. As Held et al (1999: 11) point

out, in the globalization debate statistical evidence of global trends has often been, 'taken by itself to confirm, qualify or reject the globalization thesis, even though such a methodology can generate considerable difficulties... Any convincing account of globalization must weigh the significance of relevant qualitative evidence and interpretative issues.' However, different research methods and techniques are appropriate to different research problems (Kvale, 1996: 66; Ghauri et al, 1995: 83). This thesis took a primarily qualitative approach, utilising both semi-structured interviews and documentary analysis, since such an approach allows for a richer analysis of issues such as organizational form, and the processes of interaction between different actors. Where quantifiable data has been relevant, this could often be obtained during the course of a largely qualitative interview. For example, the best source of information relating to the level of union membership in the long-term care sector was the unions themselves, hence the appropriateness even here of utilising interviews.

Semi-structured interviews are particularly suited to yielding qualitative data since they aim to obtain information which can answer specific research questions, but allow for in-depth probing on particular points. The interviewer must be flexible enough to allow the respondent a high degree of freedom in how they answer the questions and in what order, and to allow the interview to proceed in a way that permits the flow of a 'normal' conversation, whilst at the same time ensuring that the interview yields the information required, usually within a prescribed amount of time. This requires a great deal of skill on the part of the interviewer (Ghauri et al, 1995: 65); Kvale (1996:105) has gone so far as to suggest that the interview researcher is a 'craftsman' rather than simply a 'scientist'. These skills must be applied not just during the interview, but also beforehand, when the interviewer has to, '*create a situation* where the respondent willingly offers time' (Ghauri et al, 1995: 67, emphasis in the original). This can involve expending a great deal of time and effort on sending letters and making telephone calls. The advantage of semi-structured interviews is that they permit for a more accurate and clearer picture of the respondent's position or behaviour (Ghauri et al, 1995: 65), allowing for checking, clarification and elaboration. However, they may be difficult to interpret and analyse, and as with other methods, involve issues of reliability and validity. They may also involve issues of confidentiality which sometimes require the respondents to remain anonymous when the results are reported. It is

important for ethical reasons that this be discussed with the respondent prior to the interview and that her/his wishes be accorded with. In this thesis, all the names of individuals have been changed except for those from older people's organizations, whilst the names of organizations have not been changed except that of the health and local authority area.

Documents may be an effective source of both quantitative and qualitative information. They are often used in historical studies, but may also relate to relatively recent events. Bryman (1989: 189) offers a four way typology of documentary methods of analysis, encompassing studies which are quantitative/recent, qualitative/recent, quantitative/historical and qualitative/historical. By this typology, the use of documents in this study is primarily qualitative/recent. However, the thesis' findings are historical in the sense that events in the long term care sector are changing continually and rapidly, and the results of the study must be considered in this context. Furthermore, documents were sometimes the source of quantitative data, but problems were encountered here in relation to the comparison of data across organizations, in terms of being able to compare like with like (Bryman, 1989: 198).

This problem of comparability is best illustrated in relation to the concept of 'internationalization'. The research questions for both the micro and meso levels of analysis address the 'form and *extent* of internationalization' of the various actors. Ruigrok & van Tulder (1995: 154) use five measures of internationalization of companies, based on the percentage for each company of assets, sales, employment and shares listed abroad, and the composition of top management by nationality. Not all of this information was available from annual reports or the trade press for each firm considered in this thesis. There were other measures that could have been utilised for long term care firms. For example, the three largest firms in the UK market were chosen for this thesis on the basis of the number of beds operated in the UK. A similar measure could have been used for internationalization, such as the number of beds operated outside the firm's home country, or the number of different countries within which each firm had operations. However, simple comparison on this kind of basis would ignore the fact that there may be different *types* of internationalization, based on differences of strategy or subtle differences in the type of services provided by the

parent company. Even in manufacturing, as Held et al (1999: 237) point out, ‘global production and distribution systems do not depend solely on ownership or control but rather may simply involve cross-border production networks between firms’. This is one reason why Held et al (1999) include qualitative studies of specific industrial sectors, as well as quantitative measures of FDI flows, in order to build up a true picture of contemporary patterns of global production.

In this study, therefore, quantitative information was gathered where it was available, but equal attention was paid to the question of the *form* of internationalization. This provided results that are closer to the traditional case study qualitative ‘portrait’ of the organization, rather than results that are strictly comparable on a quantitative basis. The same is true for the non-firm actors, in that information on membership of international organizations (derived from interviews as well as documents) does not provide insight on how effective such organizations are, as discussed above in relation to the meso level research questions.

The results of any kind of research are open to challenges based on questions of reliability and validity. Yin (1994: 36) defines reliability in relation to case studies as follows: ‘The objective is to be sure that, if a later investigator followed exactly the same procedures as described by an earlier investigator and conducted the same case study all over again, the later investigator should arrive at the same findings and conclusions.’ One prerequisite for allowing such repetition is, of course, to document the procedures followed in the original study, and this is done throughout this chapter for both the micro and meso-levels of analysis (see also Kvale, 1996: 209). The circumstances under which evidence was collected should also be recorded (Yin, 1994: 99), for example the date and place of an interview (these details are given in Appendix Two). Kvale (1996: 88) defines reliability as ‘how consistent the results are’. This consistency can be achieved in interviews by avoiding ‘leading questions’, and in transcription by clearly stating the ‘rules’ that were used and sticking to them, as discussed below (ibid: 235). Kvale (1996: 88) defines validity as, ‘whether an interview study investigates what is intended to be investigated’. According to Kvale (ibid: 236), validity in interview research should be addressed throughout all stages of the research, rather than simply through, ‘inspection at the end of the production line’. This can be

done, for example, through the checking process during the interview, as discussed below.

The first step is to ensure that the interview guide or schedule is derived in a consistent way from the research questions. Ghauri et al (1995: 66) recommend that the interview questions be compared several times with the research questions, both to test the consistency between the two and to see whether the questions are thorough and correct enough to elicit the desired information. In this study, the differences between non-firm actors at the meso level, and differing degrees of prior knowledge about different actors, sometimes led to the specific questions used for one set of actors being different from those of another. For example, in relation to the research question regarding the form of its organization, interviewees from a union might be asked: 'How does UNISON organize in the long term care sector?'. However, this information was already known for health authority registration and inspection units because it is given by law, so instead they would be asked questions about how they interpreted their functions in practice, or in what circumstances they brought particular enforcement measures into operation. The purposive nature of the sampling also meant that sometimes different questions might be asked of different people in the same organization who performed different tasks. Examples of interview guides used in this thesis are provided in Appendix Three.

However, as discussed above, the flexibility required within the actual interview situation if the full strengths of semi-structured interviews are to be utilised also needed to be taken into account. Respondents, for example, may yield information which is sought without being directly asked that question. The flow of the conversation may lead questions to be asked in a different order to that given in the guide. Respondents may even yield important and relevant information which had not previously been considered by the researcher which needs to be followed up. The interview guide is therefore precisely that: a guide. The interview transcript may therefore differ significantly from what might be expected from the interview guide, in terms of the order of questions or even the precise questions asked and answered. It is here that the skill or 'craftsmanship' of the interviewer comes into play in ensuring that the original goals of the research are pursued. This is also a fundamental reason

why interviews should be triangulated with other sources of data (as discussed at the end of this chapter).

According to Kvale (1996: 144), 'the quality of the original interview is decisive for the quality of the later analysis.' Kvale offers six 'quality criteria' for an interview: the extent of spontaneous, rich, specific, and relevant answers from the interviewee; the shorter the interviewer's questions and the longer the subject's answers, the better; the degree to which the interviewer follows up and clarifies the meanings of the relevant aspects of the answers; the ideal interview is to a large extent interpreted throughout the interview; the interviewer attempts to verify his or her interpretations of the subject's answers in the course of the interview; the interview is 'self-communicating' - it is a story contained in itself that hardly requires much extra descriptions and explanations. Although such ideals may often be difficult to reach, they can serve as effective guidelines. These were guidelines which the research for this thesis attempted to utilise.

As is common practice, the interviews for this study were tape-recorded in order to allow for in-depth analysis at a later date. This meant that the first task to be accomplished before analysis could take place was transcription. This is not a straightforward task, since in rendering the spoken word into text a process of 'translation' involving a number of critical decisions has to be undertaken (Kvale, 1996: 163). Thus, all interviews within the study must be transcribed according to the same 'rules', especially if more than one person is involved in transcribing or if the transcriber is not the person who conducted the interviews. In this study, some of the interviews were transcribed by the interviewer, and some by another person. The rules of transcription were that the interviews should be transcribed word for word without any attempt to correct grammar, but with 'ums' and 'ers' left out. However, Kvale's (ibid) observation that the interview tape-recording remains the primary data was taken seriously: whenever there was doubt about a section of the transcript that was not transcribed by the interviewer (and author), the tape was listened to again in order to arrive at the greatest possible accuracy.

Ghauri et al (1995: 71) advise that even where an interview is recorded, notes should also be taken. This not only ensures that crucial points are recorded twice, but demonstrates interest and keeps the interviewer alert, rather than allowing the tape to do the 'listening'. This turned out to be particularly good advice when the interview with Louise Saber of the RCN demonstrated one of the pitfalls of in-depth interviews: it was discovered after the interview had finished that the tape had not recorded. The responses could therefore be reconstructed from notes immediately after the interview. Kvale (1996: 132) points out that the social context of an interview, in terms of the 'emotional tone' or 'mood' of the interview and the nature of the surroundings, may also be relevant to its interpretation. These things should be stated when reporting the results of interviews, as well as the actual words spoken. The vast majority of the interviews conducted for this thesis were in office environments and involved a helpful and friendly manner from the respondents. The reader should assume that this was the case when reading the results of the interviews, except where something different is explicitly stated.

As Ghauri et al (1995: 96) point out: 'To analyse data we have to code them so that they can be broken down, conceptualized, put together and presented in an understandable manner.' In qualitative studies, 'coding requires extra care, and a balance between creativity, rigour and persistence has to be achieved.'(ibid) Kvale (1996: 189) suggests a number of possible 'steps of analysis'. These include the condensation and interpretation of meaning *during the interview* referred to above, and the interpretation of the transcribed interview. The latter involves three parts: 'structuring', i.e. transcription itself; 'clarification', i.e. the elimination of superfluous material and distinguishing between the essential and the non-essential; and 'analysis proper', i.e. developing the meanings of the interviews. Kvale (ibid) suggests five main approaches to this analysis of meaning: condensation; categorisation; narrative; interpretation; and ad hoc. The interviews conducted for this thesis were analysed by coding the sections of each interview according to their relevance to the research questions. This was followed by an analysis of meaning which comes closest to what Kvale refers to as 'narrative', in the sense that the material was presented as a coherent 'story'. This was appropriate because the research questions served as an explicit guide to ordering the material, and because the data collected was relatively straightforward



rather than requiring the, 'deeper and more or less speculative interpretation of the text', required in what Kvale (1996: 193) refers to as 'meaning interpretation'. Nevertheless, in analysing the data care was taken to consider the incentive of the respondents to exaggerate or otherwise distort information.

Documentary sources of evidence can also be assessed on the basis of reliability and validity. For example, reliability may be questioned where an incomplete set of documents are collected. This problem can be mitigated by stating clearly which documents were obtained, and this information is given in Appendix Four for company annual reports and other unpublished documents. Other documents, such as published government reports, are given in the bibliography in the normal way. As discussed in relation to the micro level analysis, the set of company annual reports collected for this study was not entirely complete. However, annual reports were obtained for all three case study firms for 1997, the crucial year for M&As in the long term care sector. Furthermore, data on strategy and corporate history could also be obtained from the trade press, to which there was unhindered access.

Problems of validity in documentary sources may relate to the question of how different documents measure a particular concept, and whether like is being compared with like. This was discussed above in relation to the concept of 'internationalization', where the solution adopted was to take a more qualitative approach. Saunders et al (1997: 173) point out that an assessment of the reliability and validity of documentary evidence will involve a recognition of the original purposes of the document. Documents cannot be taken at 'face value'; as already discussed in relation to annual reports, they may reflect the bias of the author and this bias has to be explicitly recognised. Documents, however, have a number of advantages. Since they are 'non-reactive' (that is, they are not the product of investigations in which individuals are aware of being studied), the possible biases which are often thought to derive from interviews are removed (Bryman, 1989: 197). Documents can also provide access to information in cases where the relevant individual may be fairly inaccessible, such as senior executives (*ibid*), as also discussed in relation to the micro level of analysis.

An important way of enhancing the validity and the reliability of a study is through triangulation. i.e. the combination of methodologies in the study of the same phenomenon (Ghauri et al, 1995: 93; Yin, 1994: 90). Yin (1994: 92) identifies two conditions relating to triangulation, ‘convergence’ and ‘non-convergence’ of different sources of evidence. Convergence is, ‘when you have really triangulated’ (ibid), i.e., when different sources of evidence converge on the same facts. Non-convergence is when the study has multiple sources of evidence which nevertheless address *different* facts. The present thesis incorporates both of these; sometimes either documentary or interview material was the principal source of data for particular research questions, but wherever possible the two sources were cross-referenced. As discussed above, interview material from *different* respondents was also cross-referenced (especially that of the firms’ QA managers with that of other actors) as a further means of verification.

The next chapter discusses the results of the micro-level case studies, whilst Chapters Five, Six and Seven discuss the results of the meso-level analysis.

## CHAPTER FOUR: FIRM LEVEL CASE STUDIES

### INTRODUCTION

This chapter presents the micro level analysis of the three case study companies, organized around the research questions detailed in Chapter Three. The case studies of each of the three companies are broken down into three sections. Section One: *Corporate History and Strategy* discusses Research Questions 1 (‘What is the corporate history of each firm, with reference to the M&A process?’) and 2 (‘What goals and strategies do they have?’). Section Two: *Internationalization* discusses Research Questions 3 (‘What is the form and extent of internationalization of each firm?’) and 4 (‘How has being part of a large and internationalized organization affected their operation?’). Conceptually, we should draw a distinction between sheer size on the one hand, and internationalization on the other. In practice, however, as was indicated in Chapter Three and as shown by these case studies, it is extremely difficult to draw a distinction between these two characteristics because all of the firms were internationalized in some form. This may itself be seen as an indicator of the intensity of the globalization process. These large and internationalized organizations stand in stark contrast to the majority of the industry, which, as Chapter Two discussed, currently remains characterised by small businesses. Section Three: *Quality Assurance and Organization* discusses Research Questions 5 (‘How are the firms organized, with particular reference to QA systems?’), 6 (‘How has the process of acquisition and concentration affected this?’) and 7 (‘What impact do issues of profit and cost have on quality?’). Most of the data for this section is drawn from the interviews with the firms’ QA managers. Considering the respondents’ roles within their respective organizations, there is a danger in semi-structured interviews of this kind that answers relating to question 7 in particular will tend towards the banal or will be misleading. Nevertheless, it is possible that some light may be shed on how these organizations manage the apparent tension between cost and quality, and this will be shown to have been the case for at least some of the answers. The chapter as a whole ends with a section which discusses Research Question 8 (‘What are the differences

and similarities between the firms?’), and offers some conclusions with reference to the issues of strategy and internal organization raised in Chapter Two.

As indicated in Chapter Three, there is some discussion in this chapter of issues relating to finance and supply (i.e. economies in the purchasing of supplies by the firms). These are discussed here purely in terms of their relevance for the internal functioning of the firms, not in terms of the firms’ relationships with external actors (i.e. financiers and suppliers). The impact upon Company 2’s American parent company, Company 2 (USA), of policies pursued by its home state is also dealt with here in relation to Research Question 4, since this is clearly important to the functioning of the firm and is important for assessing the effects of internationalization. However, the relationship of Company 2 (USA) with the US state is not dealt with in this thesis at the meso level of analysis, since the thesis is focused upon actors within the UK market.

## **COMPANY 1**

### **1: CORPORATE HISTORY & STRATEGY**

Company 1 is the UK’s largest private healthcare company. Its status as a provident society means that technically it is non-profit making. It is included here as a ‘private’ company on the basis that it can reasonably be regarded as behaving in the market as any for-profit firm would: it is not a charity, rather it must compete with other providers for business, must do this in a cost-effective way, and has attempted to expand and gain market share throughout its existence (Maynard & Williams, 1984: 107). The doubling of Company 1’s advertising budget between 1979 and 1981 has been taken as evidence that the organization had adopted, ‘a more expansionary, marketing-oriented strategy’ (Griffith & Rayner, 1985: 15). The increasing arrival of for-profit organizations into the British healthcare market after 1979 had intensified competition (Papadakis & Taylor-Gooby, 1987: 68), compelling Company 1 to adopt

the strategic thinking of its for-profit competitors. Like other long term care providers, Company 1 has borrowed substantial sums in order to fund the expansion of its care home operations (CCMN, February 2000). However, it may be the case that features of Company 1's organization associated with its provident status may influence the nature of its strategy and its capacity to achieve its goals, and this will be discussed further in this section.

Company 1 was formed in 1947, and had at that time 38,000 individual subscribers to its private medical insurance (Annual Review, 1997: 6). It expanded thereafter primarily on the basis of mergers with other provident societies (Papadakis & Taylor-Gooby, 1987: 57). Its core business has always been health insurance, in which it is the market leader. Expansion in the number of subscribers increased gradually until the early 1970s, when it dropped briefly before expanding rapidly (ibid). Despite this, however, Company 1 (along with the other provident associations) suffered losses for the first time in 1981 (Maynard & Williams, 1984: 107). The problems experienced by provident associations, and Company 1 in particular, related in part to the rise in the cost of servicing subscriptions. This has meant that although total subscriptions have risen, the surplus generated from the gap between subscription income and benefits paid out has fallen (Griffith & Rayner, 1985: 22).

From the late 1980s competition in health insurance increased as banks, building societies and insurance companies entered the market. By 1996, Company 1's share of the market had fallen to 46% (L & B, 1996). Whilst one major healthcare provident society decided to demutualize to raise the capital necessary to compete, the above factors have influenced Company 1's move into areas of healthcare other than insurance, as well as their expansion abroad (discussed below). The threat to its core business of health insurance made it crucial for Company 1 to seek out other, potentially more profitable, areas of provision. Company 1 had provided medical centres and nursing and pathology services since the late 1950's (May & Brunson, 1999: 286), and formed the independent Nuffield Nursing Home Trust (later Nuffield Hospitals) in 1957 (Griffith & Rayner, 1985: 34). The organization also now provides private hospitals, screening services (Papadakis & Taylor-Gooby, 1987: 68), and most recently long-term care services. The move into private hospitals in 1978, on an

explicitly 'for-profit' basis, also reflected Company 1's strategy of presenting itself as a fully fledged Company 1 'health service' (Griffith & Rayner, 1985: 40).

Company 1 initially entered the long-term care market in 1985 when it developed a home for the frail elderly in Milton Keynes (Griffith & Rayner, 1985: 47). It briefly exited the market in December 1994 by selling its 10 nursing homes to Country House for £27m. However, Company 1 re-entered the market in May 1996 by buying back the Country House Group, which by then had 30 nursing homes, from the brewery group Greenalls (Community Care Market News, May 1996). Shortly prior to this, Company 1 also launched a long term care funding product, and a nursing home network information service. By the end of 1997, Company 1 had 210 care homes, as well as 74 homecare branches (Annual Review, 1997: 9). As indicated in Chapter Three, it is now the largest provider of long term care in the UK, with 221 homes and 16,390 beds (CCMN, June 1999).

In August 1997, Company 1 purchased the Goldsborough chain (AR, 1997: 41). Goldsborough Healthcare plc had come to the market in March 1994 (CCMN, April 1994), but in June 1996 Company 3 had made a hostile takeover bid for the company, which was successfully resisted by Goldsborough's board. In May 1997, Goldsborough put up about 40% of its care home portfolio for sale (CCMN, May 1997), and at the beginning of the following month agreed a deal for the purchase of the company as a whole by Company 1 (CCMN, June 1997). This included an unconditional offer from Company 1 for the 9% of Goldsborough's shares which were held by Company 3 (CCMN, August/September 1997). In addition to its care homes, Goldsborough also owned the second largest independent home care business in the UK and six acute hospitals (ibid; Company 1 Annual Review, 1997: 8).

Company 1 had also acquired 14 nursing homes from Community Hospitals Group plc in June 1997 (AR, 1997: 41; CCMN, August/September 1997). Company 1 described all the new homes as being at the top end of the market in terms of quality. Edward Lea, Company 1's finance director, declared that Company 1's 'goal is to build a high quality network of nursing homes' and 'to provide an integrated range of services for this market' (CCMN, June 1997). The new homes, most of which were in

the Midlands, would he said, provide 'an excellent geographic fit with Company 1's existing network mainly in the south East'.

However, it was the purchase of the Care First Group, formerly the TC Group, which led Company 1 to become the largest private provider of long term care in the UK. The TC Group was itself formed from the merger of Takare and Court Cavendish. In December 1993 Takare was the largest long term care company in the UK with 5370 beds (CCMN, April 1994). Court Cavendish came to the market in July 1993, and subsequently pursued a successful acquisition strategy which included the acquisition of Greenacre (CCMN, April 1994). Court Cavendish saw that 'speculative new build is not the only approach and better risk/reward ratios can be achieved through acquisitions during periods when land and building costs are rising and new beds take more than 9-12 months to fill.'(ibid) In September 1996 Takare plc and Court Cavendish Group plc merged to form the TC Group (TC/Care First AR, 1996). Takare were apparently of the view that the Court Cavendish management 'had a lot to offer them', and would bring on board new ideas on marketing, advertising, training and human resource management as well as giving assistance with product development, acquisition policies and better price differentiation (CCMN, August/September 1996).

At the time of the merger TC Group comprised 125 care homes with 11,742 beds and over 13,000 employees, making it by far the largest group in the sector at the time (CCMN, August/September 1996). However, group figures for the year ended 31 December 1996 were generally poor (CCMN, April 1997). The title of the group was later changed to the Care First Group, and new management information systems were implemented. Computer systems were introduced into all facilities throughout 1997 and linked to the group's head office through an ISDN network. Ron Reid, the company's finance director, told CCMN (April 1997): 'this capability will no doubt assist with the administration and finance functions, reduce operational costs and also provide databases for future service development, customer relationships and new market initiatives.' Keith Bradshaw, chairman, expected 'significant cost saving opportunities' in expanded group purchasing programs for food and other consumables, as well as 'prospects for rationalisation of some homes with sub-optimal occupancy rates which might even mean closure of some of the beds' (CCMN, April

1997). £1m was to be cut from central overheads in 1997, and so-called 'delaying' was to take place in the original Takare Group through review of the original regional management structure. At this time the management of the merged group was also determined to convert a number of the homes into individual facilities catering for specialist client groups such as people with learning disabilities, the younger physically disabled and those with neurological disorders. This would involve the development of 'protocols and procedures' to meet the needs of these different groups (CCMN, April 1997).

However, in August 1997, Care First's chief executive, Dr Chai Patel, resigned. According to Patel, the company had already embarked on a strategy which would put right its problems, but there were still 'too many chiefs' (CCMN, August/September 1997). In Patel's view, chairman Keith Bradshaw 'was proving more and more reluctant to let go of the reins of "his" company in the near term' (ibid). Interim figures for the half year ended 30 June 1997 demonstrated the extent of the company's problems, exacerbated by the decision to build until that year new homes, despite the unsustainability of historic occupancy levels and revenue fee levels (CCMN, October 1997). Payroll systems had not functioned properly and finance and control functions had not been able to provide monthly management accounts to the board of directors for much of the time. Observers concluded with hindsight that the executive directors had found it difficult to pull together as a team, and that some senior executives were very unhappy with the leadership and style of management of Bradshaw (ibid).

Against this background, Company 1 approached Care First in November 1997. Approaches also came from a consortium led by Dr Chai Patel, and another led by US venture capital group, Warburg Pincus, with 'involvement' from Merrill Lynch (CCMN, November 1997). Company 1's bid was initially rejected by Care First (<http://www.ukbusinesspark.co.uk/> 13.11.97), but it eventually acquired the firm on 31 December 1997 (AR, 1997: 41). The purchase of Care First made Company 1 the largest care home operator in the country with approximately 3.3% of all independent sector supply of nursing and residential homes (CCMN, November 1997). The chief executive of Company 1 said at that time that he was confident that Company 1 'has the management skills, resources and brand strength to develop fully the Care First



business, without which the group would never have contemplated making such a full offer for the company.’(ibid)

According to CCMN (November 1997), the original Takare portfolio made up almost two thirds of the homes, and some of these - 150 bed homes without en suite facilities and certain decorative attractions - would in due course require ‘considerable reconfiguration’. Company 1 would thus need to make significant capital investment, and operating bed numbers would inevitably fall, i.e. some homes would be closed. CCMN (November 1997) was of the view that Company 1 intended, ‘to use its mutual status to give itself sufficient breathing space to lessen the pressure to seek a short term fix on all the issues.’ Company 1’s 1997 Annual Review confirms its ability to make use of internal surpluses, ‘to invest in taking a long term view’ (1997: 7), although it also took out new debt to finance its acquisition programme (AR, 1997: 3). It seems, therefore, that Company 1’s mutual status has given it significant advantages in being able to make the necessary capital investment and plan for the long term without pressure from shareholders for short-term returns. According to Jacobs, Company 1 would ‘never be forced by analysts and institutional shareholders to make any decision for short-term expediency reasons.’(CCMN, November 1997) A similar view was given in interview to the author of this thesis by Head of Quality Assurance, Bob Jones:

We’re not a profit organization, there’s no shareholders to pay out and nobody can buy or sell [Company 1], other than the main board. So we’re not subject to hostile takeover bids or any of that rubbish which we [Goldsborough] suffered from in the past when we were on the stock exchange. A very nice position to be in. So that financial stability is a very good base [which]... we draw upon.

When Company 1 made the strategic decision in the past to invest in hospitals, it sought to put itself in a position where it could best afford to pay a premium price to buy into the sector (CCMN, December 1997/January 1998). In building up its care home portfolio, it also sought to put itself in a position where it could outbid all the

competition. With the purchase of Care First, CCMN (December 1997/January 1998) described Company 1 as:

clearly determined to build up a broad based healthcare group in care homes, domiciliary care, occupational health and clinical acute services. Since its reserves well exceed those required under solvency ratios for its UK and overseas PMI (private medical insurance) business, it clearly has the resources to develop major parallel business interests in the healthcare sector.

This is confirmed by its Annual Report, and by its Annual Review (1997: 6), which stated that the year had seen, ‘the acceleration of a strategy to create a fully rounded health care organisation, unique in being the leader in both the funding and provision of quality care to all sectors of the community’. Company 1’s acquisition of Care First was supported by the fact that it had access to cheap funding and would seek to improve occupancy and/or harden weekly fee rates for self pay clients, ‘by simply running up the “[Company 1] flag” outside the homes’ (CCMN, December 1997/January 1998). This suggests that branding is an important part of Company 1’s strategy.

In early 1999 Company 1 also acquired Primrose Care, a home care company which had 26 branches and 14 satellite offices, and in which Company 1 had previously had a minority interest (CCMN, February 1999). Company 1 was also aiming to expand its care home operations through transfers of local authority run homes (‘Company 1 Today’, 6.11.98; see Chapters Five and Six).

Bob Jones gave some clues as to why Company 1 was expanding out of the insurance market, although he stressed that such decisions were not within his domain. However, he did suggest that: ‘insurance was all your eggs in one basket, the insurance market is a lot tighter now than it was ten years ago. So it’s appropriate to not have all your eggs in one basket, and because Company 1 already had hospitals on board, it makes sense to move into other bits of healthcare.’ As a healthcare company which had been built initially on the basis of private insurance and then of private hospitals, the role of the NHS in British healthcare provision must clearly have a profound impact on

Company 1's strategy. Successive British governments have committed themselves to maintaining the principles of health provision which is free at the point of use, with significant changes only at the margins of this (of which the private provision of long term care is probably the most profound). This means that the scope for Company 1 to extend both its provision of private insurance and hospital treatment is limited by the near monopoly exerted by the NHS. Long term care provision, where private provision is now dominant, but where funding is available for this from the state, is a logical site for Company 1's expansion. According to Walker and Golding (1997), Company 1's expansion into long term care was also an attempt to control rising costs through vertical integration, i.e. treating insured clients in its own facilities. Nevertheless, the need for investment discussed above, meant that its new acquisitions would not immediately be profitable. Its Annual Review for 1997 stated: '... we are confident that our acquisitions will be earnings enhancing *in future years*.' (1997: 6 - emphasis added)

Company 1, then, is diversifying away from being insurance based into various forms of healthcare provision. As will be seen in the next section, this involves a strategy of significant overseas investment. In the long term care sector it has involved building rapidly through acquisition of existing companies, and then seeking to promote them through their re-branding under the Company 1 'label'. The significance of these acquisitions is demonstrated by the fact that in 1997 the total number of people employed by Company 1 in the UK expanded from 12,000 to over 30,000 (Annual Review, 1997: 6). Of these, 21,000 were employed in care homes ('Company 1 Today', 6.11.98).

## 2: INTERNATIONALIZATION

Since mid-1998, Company 1 as a whole has been split into five business units, all of which report to the main board. These are insurance, care homes, hospitals, Company 1's Spanish subsidiary, and new businesses. Company 1 has operations in seven countries other than the UK (Annual Review, 1997: 3). The foreign operations other than the Spanish subsidiary come within 'new businesses', and include dental, travel and overseas insurance interests in Ireland, Thailand, Hong Kong and Saudi Arabia

(Health Care Market News, July 1998). Company 1 Ireland was set up in early 1997 after the opening of the Irish market to competition, and became 'the first alternative to the State controlled monopoly in that country' (Annual Review, 1997: 17). The Hong Kong business was described as welcoming, 'the opportunities brought by the change to being part of China'. In Thailand, Company 1 had acquired a stake in the country's leading health insurer, which had continued to grow, although it had been affected by the downturn of Thailand's economy in 1997 (Annual Review, 1997: 9). Company 1 Middle East was due to be launched in 1998, offering health insurance 'both to local nationals and to the country's growing expatriate workforce'. Company 1 claims to insure four million people from 115 different nationalities who live in around 190 countries (Company 1 web site). The majority of these are British, living at home or abroad, but Company 1 claims that one million of its members live outside the UK. The organization claimed to provide, 'local knowledge on a global scale'(Company 1 web site).

Its Annual Review (1997: 8) indicated that in 1997 the organization had met its, 'ambitious target for international development', and had become, 'a more comprehensive international health care business'. The Review (1997: 17) stated Company 1's, 'objective of opening for business in at least one new country a year.' Company 1 International, within which foreign operations were then organized, was the organization's 'fastest growing business, with a 23% increase in members and two new overseas ventures in 1997' (described above). Its organization in Spain insured around 750,000 people, owned two hospitals and a network of primary care clinics (Annual Review, 1997: 17). The 1997 Annual Review described the Spanish organization as having 'established itself as one of the leading suppliers of sports related medicine, providing the official sports injury clinic for Barcelona Football Club within the club's Nou Camp Stadium, as well as supplying services for many more of Spain's leading football and sports clubs' (ibid). Bob Jones indicated in interview that the Spanish organization was likely to expand into the care home market.

Company 1 Care Homes in the UK forms one of the five business units mentioned above, and uses some of Company 1's central services, but according to Bob Jones was 'a relatively defined, relatively autonomous part of [Company 1], as are the other

bits.’ Jones jokingly labelled Company 1 as a whole ‘Big’ Company 1. Apparently it had ‘been a surprise to Big [Company 1] that when we joined them [Company 1] Care Services had more staff than the whole of Company 1 had before. So that’s been a nasty shock for them, there’s more of us than there is of them.’ Overall financial targets for Company 1 Care Homes are set by ‘Big’ Company 1. However, according to Jones: ‘The Managing Director of Care Services is on the main board of [Company 1]. So the main board agree, and he’s part of it. So... its not somebody up there doing something to us, we’re actually part of that overall process, as are the other four MDs that make up the five business units.’

In Jones’s view, Company 1 Care Homes had benefited considerably from access to Big Company 1’s systems and resources. Corporate communications was offered as a good example:

In the past whenever there was any press involvement, in my corporate past [Goldsborough] I used to have to make it up and give it to the Chief Exec. to rewrite and we’d bang it out. Now... a whole department does that for us, its wonderful. [A Company 1] journalist rings up ‘The Independent’, gets in there positively before they do it negatively. So there are very positive things we draw from there.

Similarly, Jones mentioned a medical directorate at ‘Big’ Company 1 run by ‘a very senior consultant’ who was ‘wheeled out in front of the media’ when necessary and who had ‘assisted us with one or two fairly difficult medical issues’, one of which had been the subject of a court order. A supplementary interview with Colin French, manager of a Company 1 home in Hastings, suggested that Company 1’s British staff had also gained from training exchanges with the organization’s foreign staff.

Jones saw Company 1’s mutual status and its brand name, both discussed above, as bringing particular advantages. According to Jones, Company 1’s mutual status gave it an ‘incredibly stable financial base... No profits go anywhere. Everything’s ploughed back into the business. There are a few people on a very nice salary but there’s no

shareholders to pay out. Unlike most large organizations.’ Of the Company 1 brand Jones said, ‘the ability to trade under the [Company 1] name’ was ‘very good for recruitment and initial impressions seem to be good for occupancy.’

However, Jones noted that: ‘There are down sides. We have a very good tight control on our IT [information technology] systems and the IT department... appear to have not cracked the problem of making bureaucracy work for you, as opposed to suffering from bureaucracy’. This stemmed partly from the fact that Company 1 ‘still are of the mindset of being insurance driven and don’t really understand our bit of the’ company. Jones thought it may also stem from Company 1 being more bureaucratic and less well managed in the past. This was being corrected under the new chief executive, who had ‘turned it round into a much more business orientated and business focused organization’. However, ‘There are bits of [Company 1] we recognise, and [Company 1] IS [Information Service] is one of them, that haven’t yet got there, as part of the new process, the new structure.’ There were thus clearly some problems relating to the bureaucracy which may exist within large organizations.

However, whilst size presents problems as well as benefits in organizational terms, in economic terms it seems to offer mostly benefits. This is mainly as a result of economies of scale, as confirmed in interview with Bob Jones. An example of this was given relating to incontinence products. According to Jones, Company 1’s main supplier, ‘will offer us 5% without any negotiation just because we’re bigger. Bang! We’ve just saved 5% on incontinence products, one of our major expenditures.’ This means that large organizations such as Company 1 are in a much stronger position economically than smaller organizations, even though their quality of care is not *necessarily* better. According to Jones, when compared to smaller organizations large organizations have ‘the potential to be better. And I think it is more likely to be monitorable on a more equipment level. But there will always be one man bands that do *exceptionally* well, and all credit to them. And when they’re for sale we’ll buy them.’

Being part of a large and internationalized organization has therefore provided both benefits and challenges for Company 1 Care Homes. Benefits have been gained from

increased resources and purchasing power, and from the advantages of branding. Company 1's willingness and ability to acquire smaller providers is explicit in Jones's comments. However, there are clearly some problems associated with bureaucracy and with the size of the organization. These are explored more fully in the following section.

### 3: QUALITY ASSURANCE AND ORGANIZATION

The information in this section was obtained mainly from the interview with Bob Jones, who described his overall remit as 'to create, implement and maintain the quality assurance system across my bit of the empire', i.e. Company 1 Care Homes. However, his job also involved a general aspect covering 'anything clinical'. He had working under him a team of specialists covering areas such as catering, home servicing, mental health and other technical areas, who also form the staff responsible for carrying out audits (although the term 'quality review' is preferred to 'audit'). Jones also made available a copy of the organization's Quality Review Manual.

The development of Company 1 Care Services' quality assurance system is tied inextricably to its corporate history. According to Jones, 'none of the corporate pasts had an appropriate review methodology, and we couldn't find anything off the shelf that would meet our needs.' 'Off the shelf' systems were regarded as having been developed for specific purposes which were unsuited to a large care home organization. The King's Fund 'Organizational Audit' (now the 'Health Quality Service Accreditation Programme', see King's Fund / Health Quality Service, 1999), for example, was developed for hospitals and was 'still very hospital orientated'. In addition, such systems were seen as aimed at 'individual or small numbers of users, rather than something with the range of spread that we have'. ISO 9002 was regarded as being extremely bureaucratic and involving high levels of paperwork. This was illustrated in relation to a coffee table that needed replacing:

I knew the minute somebody said 'change those tables' then all the ISO systems would swing into action. There'd be an approved supplier who'd been

audited, you'd have exactly the right paperwork, you'd have the guaranteed delivery time, they'd take away the old table. Everything would happen, but nothing told them to change the table in the first place. There's nothing that picks up that there is a quality problem.

ISO 9002 was thus being used as a supplement to the core system which was under development and which was tailored to the specific needs of Company 1 Care Homes. Ten homes had achieved ISO 9002, but this was not considered a priority.

The only national standard that was considered to have real worth was Investors In People (IIP) (see IIP, 1995), which was seen to be 'people centred' and 'about training the right people to do the right job at the right time'. At the time of the interview, Company 1 was still in the process of trying to decide whether it should aim at achieving IIP on a home by home basis or as a national organization. Goldsborough had achieved IIP as a whole organization prior to being acquired by Company 1, but was at that time one of only five organizations in the country with more than 5,000 employees that had done it that way. It was seen as a realistic option for Company 1 Care Services as a whole also to attempt IIP status in this way, although there was seen to be a problem regarding 'who we tie in with', since Company 1 had a national spread, whilst the Training and Enterprise Councils (TECs) which accredited the award were organized on a regional basis.

The quality system which Company 1 was developing for itself was based on the idea of 'critical success factors' developed by Oakland (1993). Oakland (1993: 415) saw critical success factors as crucial for identifying the *processes* which would lead to an organization successfully meeting its goals. According to Jones, the idea behind this was that 'in any procedure, whatever you want to call it, or in any organization, you can pull out the critical success factors, and if you get those bits right, the rest will follow, so you don't have to check absolutely everything.' This, it was hoped, would 'reduce the amount of bureaucracy and paperwork involved, but still get the same end product'. The overall requirements of any quality system were seen as being 'to collect information and then use that information'. The system Company 1 was developing was built around three 'strands'.



The first of these was at the time of the interview 'undeveloped', but was based on collecting information based on quality indicators such as the number of accidents. It was recognised that attempts to reduce the number of accidents may lead to inappropriate restriction of residents' liberty. So by monitoring the nature of accidents it was hoped that a balance could be struck between safety and liberty that would 'hopefully reduce the accidents without restricting people's mobility'. Incontinence and complaints were other examples of 'the sort of things that we might collect and collate information on, that we can turn round and use to develop the service'.

The other two strands of the system which were being developed were concerned with audit or 'review'. This involved policies and procedures being set down in a series of manuals. According to Jones, these would inevitably be

a little bit general because of the diversity of stock we have, ranging from a 19 bedded residential home to a 180 bedded home for frail elderly nursing. Some new build, some converted country houses, some 'what on earth is that building doing being a care home'... So when you have a diversity of stock it becomes difficult to write a set of operational manuals which are specific.

Nevertheless, it was expected that Company 1 would be able to produce a set of operational manuals which run to a common set of principles. There would be two strands of audit. Firstly, 'self audit', which would be guided by eight policy and procedure manuals, three of which had been written by the time of the interview. Secondly, 'external audit', which would be guided by a Quality Review Manual. External audit would be 'external to the care home, but not external to the company'.

Self audit was based on the principle that it should be possible to 'pull out each policy and procedure as a separate entity'. So, for example, there would be a fire manual covering everything relating to fire, which itself may be broken down into perhaps twenty defined areas. These were developing on the basis of a 'fairly simple checklist, where if you are doing everything on the checklist you know the policy has been implemented.' This has two purposes. Firstly it provides 'a record that the senior

person in the home has said “yes, we’re doing it”.’ Secondly, ‘it gives senior managers in the home the impetus to get the manual off the shelf and read it if they haven’t already, because they’re going to have to sign to say that they’ve done it, and it will give them the opportunity to review whatever procedure that they’re looking at at the time is actually working in their home.’ The results of such checking would not be collated centrally, although operational managers would check it had been done from time to time. Rather the purpose of self audit was to ‘drive that to make sure it happens’ and to give the staff ‘the motivation to sort their own problems out’. It was hoped staff would see self audit in a positive way, ‘rather than somebody coming along and saying “you’re doing this wrong, you’re doing that wrong, and you’re doing the other wrong”.’

‘External audit’ was based on the nationally organized team of quality assurance managers going into each home on a regular basis, ‘I’d like to think annually, but there’s a bit of a logistics problem, and we haven’t fully agreed what the time interval will be.’ The quality assurance staff would work through the newly developed Quality Review Manual with the home manager. The Quality Review Manual would be adapted to tie in with the eight policy and procedure manuals as they were written. The Quality Review Manual would also be based on the critical success factors idea, but would be ‘much more subjective - people walking round the place’. It was at this point that it was thought the system would pick up those factors which ISO 9002 did not, and would allow action to be taken on these:

because you’ve got a couple of experienced people, the home manager / matron and one of my quality assurance managers pottering round with a framework to look at things and ask specific questions about things, and identify things. That’s the only methodology to get us to the next process which is the action process, and that’s what I believe is the real property of assurance. Perhaps then the home manager and the quality assurance manager will have spent some time looking at the home in some detail but bearing in mind the critical success factors, and will then sit down and work out how to move forward. If they’ve found something that they think could be done better they have to decide how to put it right. And when we get to that action plan

process we'll also be joined by the operations manager... So we're not blue sky planning. We're actually planning what we want to change and how we're going to do it. So at the end of the process, at the end of that bit of the process, we will have a do-able action plan to move forward.

The corporate history of Company 1 Care Services has had a big impact on the system described above. In part, the system is being developed in the way that it is because Company 1 Care Homes has been built from disparate organizations. As Jones put it: 'some of my team and all of the people with whom we work come from different bits of the corporate past and inevitably if we chose one of those corporate pasts that would give a biased balance to what we did, so we decided to start afresh and invent anew.' Each of the three main previous organizations (Care First, Goldsborough and Company 1 itself, based at that time on the Country House portfolio) had its own specific way of doing things, all of which in Jones's view were problematic in some way. One of these corporate pasts, 'was run by the Gestapo and so had given quality an appallingly bad name, and it was used as a management sledgehammer. It was not used as a development tool.' This was seen as having had a particularly negative impact on staff:

People went in and picked faults with everything. Left all the staff very unmotivated or demotivated, and it was used as part of the disciplinary process. This is *not* service development. And to my mind, not only is it completely the wrong way to run quality, its so detrimental because you have such a selling job to do to get people to see quality in a positive light when they've been subject to that sort of regime in the past.

Another of the three 'corporate pasts' had 'had on the surface really quite a good system', but had failed to 'do the job', in Jones's opinion probably because of 'the way it was applied'. The third, 'had a lot of value but it didn't have all the strands coming together, and neither did it directly relate to policy and procedure manuals. That was the bit of development that was waiting from that corporate past.'

The existence of these 'different bits of the corporate past' had also presented some difficulties in homogenizing the policies and procedures of the new organization. As Jones explained:

we should be running all our care homes to agreed sets of policies and procedures and with that we've come from three different corporate pasts so we have... I would say we only have three sets of policies and procedures but we probably have about twenty different sets of policies and procedures about, and as we speak they are being rewritten to have one set of policy and procedure manuals, which every care home will have as the basic both set of values and set of operational procedures of how you run a care home.

The new system did, however, borrow from the previous ones, all of which were seen as having 'a level of value in their own right... We've taken the best of them all and put them together'.

Part of the rationale for creating an apparently entirely new system related to the 'political' problems associated with trying to cohere previously separate organizations. As Jones explained:

You've got to bear in mind that there's three different organizations that have come together. Everybody thinks that the bit they came from is better, and that to choose one of those would create such a potential political imbalance, and all of them were at a stage where they needed some development work anyway, so in reality it's easier to start afresh... But to try and... if staff thought it was an old one developed then they would... if they didn't come from that corporate past - that's the sort of problems you get when you try and put different organizations together. So to create it anew, even though some of it may well be plagiarized from the past, if you sell it as the new it would appear to give a much better flavour of 'this is a new product, a new item we can move forward with' rather than 'this is something we've nicked from one part of the past'.

Two particular problems were identified for Company 1's merger process. One was the speed of change. Jones estimated that Company 1 Care Homes had gone from having ten care homes to being the largest provider in the country with 225 in about eleven or twelve months. Based on the information given in Section 1, this may be a slight exaggeration, but the basic point is legitimate. The other problem related to the concept of 'culture', which was discussed in Chapter Two, and the diversity of the corporate cultures which Company 1 was attempting to unify. Jones introduced this word himself, without prompting from the interviewer:

Of the three major corporate pasts, they were very very different cultures, so it wasn't like taking two fairly similar companies and merging them together. We have the command and rule from the centre organization, the fairly laissez faire but tightly financed and controlled organization, and the very very democratic 'let's have a committee to discuss it' organization, bringing them together. So very very different cultures.

The new organization which Company 1 has developed is split into regions, with each region having a regional director. Below the regional directors are operations managers who 'run the business'. Regions may have seventy or eighty homes within them, and each is split into patches of between ten and thirty homes run by the operations managers. As Jones puts it: 'its such a complex empire it needs some level of bureaucratic hierarchy to run it.' Jones was persuaded by the view that:

the only way to run large organizations was with a bureaucracy even though bureaucracy had got itself a bad name, for other reasons, but in terms of actually managing a large organization, nobody's ever defined a better way to do it. So inevitably we've ended up with perhaps more of a bureaucratic structure than any of the pasts had. So there's a bit of that in it. We have to have a level of central control because if we didn't we would lose it, because it is that big. But I think what we have done is introduced a lot more pragmatism into things.

Jones expressed the view that had he chosen one of the systems, rather than create a new one, 'it would have disenfranchised the other two parts'. There were thus 'elements of rivalry' that existed 'right the way through' the organization. Balancing these was therefore seen as important to making the organization effective. This rivalry existed at

every level: the regions, the operations managers, and the homes level. It's a lot better now than it was at the beginning, and it's continuing to fade, but bearing in mind I had to begin inventing something on day one... if I had gone with a corporate past at day one there's no way I could have got some of the parties on board that I needed to get on board.

The only part of the organization in which no rivalry was apparent was at the centre, but this seems to have been a product of very careful organizational engineering. Part of this related to the failure of Care First to operate effectively prior to its acquisition by Company 1. As discussed in Section One above, Care First was itself the result of a merger between Takare and Court Cavendish, and had failed to successfully implement its strategy partly as a result of internal rivalry at the highest level. According to Jones: 'They both had very different ideas. In fact one wonders why they ever tried to merge in the first place. Its all right for [Company 1] to come in because it can take it forward and put them together as one, but for two rival organizations to vie for leadership just didn't work.' Staff who previously worked for Care First apparently 'jokingly tell you if you pop in the boardroom you can still see the blood stains on the carpet'. Company 1 resolved this situation by appointing a new management team with different personnel: 'You can extrapolate the same discussion I had about not picking one of the quality assurance models and creating anew. [Company 1] has done virtually the same with the management structure - not taking any of the old ones, creating anew, put a new guy in.' Of all of Company 1's constituent parts, however, 'Care First probably had the most different management style, and the ones who have probably had to move furthest into the new culture.'

According to Jones, who previously worked for Goldsborough, staff at that company were relieved to be purchased by Company 1, having fought off the previous attempt

at acquisition by Company 3. Company 1 were apparently seen as ‘a friendly organization who seemed to have the same values as we did’. For other staff, however, there was some feeling that Goldsbrough was becoming the dominant partner. The headquarters of Company 1 Care Services is situated in the building that was previously Goldsbrough’s headquarters, and the managing director of Company 1 Care Homes was the ex-chief executive of Goldsbrough. However, the operational director of all the care homes, ‘the guy who’s actually running the business’, was a new appointment who ‘didn’t come from any of the corporate pasts, and that’s one way to solve it.’

Jones’s own quality assurance team are highly centralized, ‘completely outside operations’, with Jones himself reporting directly to the managing director. However, the action planning discussed above

is agreed with the home manager and the operations manager so we should never get ourselves in the position where things are being proposed to operations that they’re not happy with, because they’re part of the action planning process - their audit, their review as much as ours. Inevitably there will be times when my team perhaps not concentrating on a particular home will begin to find a trend across a few homes where they’re not getting things moved forward perhaps as much as they see fit. I then have the opportunity to go and discuss with the more senior management the issues.

There may also be occasions when, ‘the people on the ground don’t have the authority to solve the problem, even though they knew what the solution was’. Jones gave an example where staff costs in a home were higher than expected, which turned out to be because they didn’t have any dishwashing machines: ‘They were actually bringing staff in to wash the dishes by hand. The manager concerned didn’t have the authority to go out and buy ten dishwashing machines because that was above their budget. I, however, have the authority to go to their boss and say “spend this and we’ll save you this”.’

Despite this, Company 1 'still haven't got it right' according to Jones. Effective communication was proving difficult across the organization's 221 sites. This was due in part to the information technology (IT) systems discussed in Section Two. According to Jones:

IT systems tend to be driven by finance and the three different pasts have three different financial systems, so until we get them all on to one system it's difficult to put any IT communications on the back of that. So for instance, if I want to send an emergency memo out to every care home, that's going first class post. We don't have a system to get things out quickly. So we still haven't yet got communications resolved.

In some ways Company 1 Care Homes was still going through a transition from three organizations into one. As Jones explained: 'We're still in the transitional phase of bringing it together. There are some things that are running as one and some things where we're still using the systems that belong to the past. We still have three pay rolls. One run in Leeds, one run in Telford, and one run out of Kingston.' This was attributed to the fact that Company 1 Care Homes was still a very new organization. This process of transition was also evident in the fact that the three main 'corporate pasts' continued to belong to provider associations (mainly the Independent Healthcare Association and the Registered Nursing Homes Association) as separate entities. According to Jones:

We probably have more than one membership with most of the organizations because each of the corporate pasts belonged to something and they've never stopped any subscriptions... Most of the organizations are a bit keen to have us on board, so even if the subscription only belonged to one of the corporate pasts, they're not going to be bothered.

Jones's account of the difficulties involved in homogenizing the new organization is consistent with the reference in one Company 1 publication ('Company 1 Today', 6.11.98) to, 'an intensive period during which the company has worked hard to start integrating the businesses which operate within care services into the famous



[Company 1] brand.’ As already discussed, branding is an important part of Company 1’s strategy. The Managing Director of Company 1 Care Homes, Graham Smith, stated in the same publication that the Company 1 ‘name now appears outside all of the company’s care homes and by the end of next year will be operating under consistent policies and procedures... homes will have been refurbished to a standard consistent with the requirements of the [Company 1] brand.’ Smith went on to say that: ‘The process of integration has at times been difficult. In the last six months we have had to close a number of homes with implications for residents, relatives and staff.’ The implications of home closures and changes of regime resulting from ownership transfers are discussed in Chapter Eight.

To the extent that companies like Company 1 are successful in implementing a unified quality system, this therefore seems likely in the short term to cause some disruption for residents as changes take place. In the long term, however, it is likely to level out, and probably raise the standard of care across the organization. However, this also raises the issue of diversity and choice since, as also identified above, smaller owners may have more economic difficulties, giving firms like Company 1 an advantage. As Jones put it:

Usually what’s special about [small providers] are there are a lot of people where the owner is the manager and lives and runs it, and its that. Its like going to a real cosy seaside bed and breakfast where you feel real homely, real comfortable, versus going into a Trusthouse Forte. You know if you go into a Trusthouse Forte you know what standard you’re going to get, and I suspect we’ll be a little bit better than that, but you know what standard you’re going to get, you know it’s always going to work, you know there’ll never be a problem. Whereas when you go to the B&B you may well find that you get up one morning the cooker’s broken so you can’t have your cooked breakfast, and ain’t that quaint. Well it might be quaint for a week or two, but not when you live there all year... So there’s a difference there.

This issue of the sometimes contradictory relationship between quality, standardization and choice will also be returned to in Chapter Eight.

The desire to retain some of the features of smaller providers was part of Company 1's rationale for giving home managers as much autonomy as possible without losing the benefits of belonging to a large organization. This meant that the quality of home managers themselves was of paramount importance:

It is the most important thing in our business. In the whole of the business, we get the right managers within the homes we're laughing. All sorts of things, whether you're talking financial control, occupancy, homely environment, quality, training, recruitment, the key - the right manager in the home... And if we ever lose sight of that we're done for.

According to Jones, the separation of his team from operations meant that, 'whatever recommendations or issues we come up with we're never driven by the day to day hassles of finance', such as problems of occupancy, for example. However, despite the ability of large firms to make use of economies of scale (discussed in Section Two above), finance did impact upon quality in the form of the cost of improvements:

Yes, one has to be [concerned with cost] because it's a commercial organization in which we live... There's a number of our care homes where the bedrooms have vinyl on the floor. As a nurse I'm not comfortable with that. I think we should have carpet on the floor, and slowly but surely over a number of years I strongly suspect we will move towards that. At the moment, if I snapped my fingers and said I want it all changing tomorrow, the last estimate I remember is that it would cost us two million quid. We haven't got an income stream that will pay for that two million quid tomorrow, so what's the point in me snapping my fingers and saying 'change the carpets'? One has to be pragmatic in the initial approach. What I can do is turn people's minds round and get them to begin to think that we should be moving towards carpets. So every time a floor needs relaying they don't just go automatically and put lining down, they put carpet down, and over a period of probably five years, I'll get the two million quid spent. So my job, if you like, in my pigeon hole is more of a political element and a concern with the politics of the company and changing

people's mindset. Whereas the team themselves when they're out and about doing the reviews at home level are more out identifying much more specific issues - the need for dishwashers.

This meant that a degree of pragmatism was required in effecting change: 'Its absolutely pointless us proposing things that can't happen. I can think of one of our homes that is built adjoining a derelict industrial site. It would be nice to close it down and rebuild it down the road. And you could extrapolate that example across a whole load of areas. You've got to be realistic about it.' Therefore Jones's 'challenge' was 'to find a different way to do it. See, we've got to be cost conscious.'

The supplementary interview with Colin French, manager of a Company 1 home in Hastings, indicated that the need for the organization's centre to be 'cost conscious' led to some internal bargaining over resources. The 'considerable reconfiguration' which CCMN (November 1997) saw the need for after the acquisition of Care First (discussed in Section One) had led to some homes being closed, whilst others had received new investment to bring them up to the Company 1 standard (the issue of home closures resulting from ownership transfers is discussed further in Chapter Eight). French's home was a marginal case, but he had been able to make the case to headquarters for new investment successfully, and significant improvements had been made to the physical layout of the home.

In Jones's view cost factors did not automatically work against quality: 'If one was a naive fool there would inevitably be a contradiction', but one needed to bear in mind that 'quality costs, but poor quality costs more'. Jones said he couldn't 'really think of an incident where the cost of a proposal that I've been involved with has been a factor in not doing it, because all the things we propose... nine times out of ten if you improve the quality you reduce the costs.' An example of this related to a home in Harrogate:

They were using veneered tables with paper table cloths and they were trying to attract a slightly more affluent client group so we changed to cloth table cloths. The outlay in buying those table cloths was significant, but the costs of

laundering table cloths are far less than the cost of buying the disposable paper ones. So we ended up with a better service and it looked more like an upmarket restaurant... whereby increasing the plushness, if you like, the quality of the home, you can attract a client who's willing to pay a higher income. So whilst you might have increased the costs by a little, you've actually increased the profit margin by more than you've increased the costs. Here, you've got to be commercial.

It can be seen, therefore, that Company 1 Care Homes put little faith in 'off-the-shelf' systems, like ISO 9002, although Investors In People was seen positively. Instead, the organization was developing its own detailed quality assurance system. Nevertheless, this was based primarily on *procedure* manuals, that is, it was concerned primarily with *process* (see Chapter Two), and this was confirmed by the Quality Review Manual which Jones made available. However, there was some monitoring of (largely physical or medical) outcomes as part of the 'critical success factor' approach. The Quality Review Manual also contained a 'resident satisfaction survey', involving a questionnaire for residents built around quality of life concepts such as fulfilment, privacy, dignity, choice, rights and independence. Company 1 also organized residents' and relatives' meetings, which are discussed in Chapter Seven.

The practicalities of building one organization from three very different ones has clearly had an impact on the shape of Company 1's emerging quality system, as well as its implementation. Not least among these practicalities has been the need to manage the internal 'politics' of the company, in terms of motivating and reconciling the perceptions of staff who previously worked for different organizations. The changes brought about by ownership transfers also have important implications for residents, which also surface in Chapters Five and Seven, and which will be returned to in Chapter Eight.

## COMPANY 2

### 1: CORPORATE HISTORY & STRATEGY

Company 2 is today the UK subsidiary of the American based Company 2 (USA). Company 2 (USA)'s first acquisition in the UK was Exceler, in which it first acquired a majority shareholding in August 1994, and then bought the remaining shares in February 1995 (AR 1996: 19; CCMN, April 1995). In May 1995, Company 2 (USA) took a 15% stake in Company 2 through a buy out of part of a Japanese stake in the company (CCMN, May 1995). The third major British firm acquired by Company 2 (USA) was Apta Healthcare, which was purchased in November 1996 (CCMN, November 1996). Apta was originally set up in 1984 and was first listed on the London Stock Exchange in 1994 through a merger with Realcare plc (ibid). At the time of its acquisition by Company 2 (USA) (then trading under the name of Exceler), Apta had 33 homes and 1294 beds. The merger of Exceler and Apta made Company 2 (USA) the fourth largest provider in the industry with 76 facilities and 3417 beds, only just behind Company 2, in which Company 2 (USA) had by this time a 29.2% interest. Company 2 (USA) was willing to pay a premium to access Apta's expertise in mental health, behavioural modification and programmes for the young physically disabled (CCMN, November 1996).

Exceler/Company 2 (USA) purchased the remaining shares in Company 2 in January 1997 (AR, 1997: 2; CCMN, December 1996/January 1997), making the combined company the second largest in the country. Chet Bradeen, the American managing director of Exceler at that time, believed that the enlarged group would benefit considerably from the increased resources available from Company 2 (USA), as well as economies of scale and 'synergies arising from group-wide application of commercial initiatives' (CCMN, ibid). When the chief executive officer at Company 2 (USA) first joined the board of Company 2 in May 1995, CCMN (May, 1995) commented that: 'Provision for care for the elderly in the past has gained from the infusion of business and quality assurance expertise from the USA through companies like [Company 3], Extendicare and Speciality Care. The arrival, therefore, of [Company 2 (USA)]'s chief

executive] who had previous links to Hillhaven and, therefore, to [Company 3], has to be viewed as positive for the development of the sector.’ Since its full acquisition of Company 2, Company 2 (USA) has chosen to trade in the UK under that name.

Jane Bartlett, Quality Assurance Manager of the ‘new’ Company 2, and an employee of Company 2 prior to its acquisition by Company 2 (USA), described the diversification of provision which had taken place with the merger:

One of the other things that happened with [Company 2] with the merger was that previously we’d been very much nursing homes for the frail elderly, and that had been the market. We now have residential units, we have EMI units, we have young disabled units, learning difficulties, so the amount of clients if you like that we have has increased tremendously.

However, the new combined UK company soon began to experience problems. In July 1998, REIT Asset Management (RAM), described by CCMN (July 1998) as a ‘newly formed specialist investor in UK healthcare properties’, acquired a total of 29 nursing homes with 1995 beds from Company 2 on a sale and leaseback basis. This method of funding has become quite widespread within the UK long-term care sector over the last three years or so as American real estate investment trusts (REITs) have entered the market (see Chapter Two). All 29 properties were to be leased back to Company 2 on a 20 year lease agreement, yielding the purchaser a rent of £6.5m a year with a rent review every five years. However, the terms of this depended very much on the strength of Company 2 (USA)’s guarantee as parent company, since, according to CCMN (July, 1998), ‘in recent periods it has been no secret that [Company 2] has struggled to balance its books in its UK operations and has even decided in some instances to put some of the homes that it acquired back on the market for resale.’

CCMN (October 1998) later stated that:

‘It has been generally understood in the sector that in the last year or so the company has struggled very hard to generate sufficient income to meet its rental commitments on the leases of its care home properties. Its lessors, in the

main, have insisted on a guarantee from the US holding company in order to protect themselves against non-payment. In particular, industry sources suggest that the company has had major difficulties in sorting out the former Apta Healthcare portfolio partly arising out of the fact that some of the original former skilled employees did not stay on with the group when the portfolio was purchased’.

Against this background, the then managing director left the company in October 1998 (CCMN, *ibid*). In the same month, Company 2 (USA)’s shares plunged on the New York Stock Exchange to around US\$5, only a fraction of the level they were some months before, as anxieties increased about the overall leverage of the group (CCMN, October 1998). By early 1999, Company 2 (USA) was experiencing severe problems (discussed in the next section), and Company 2 had to turn to some of the specialist property healthcare funds for more sale and leaseback money in June of that year, both for its own operations, and perhaps to assist Company 2 (USA)(CCMN, June 1999). According to CCMN (*ibid*), ‘some of these property companies were not necessarily very enthusiastic in taking on more [Company 2] exposure’.

Company 2’s overall strategy arises from Company 2 (USA)’s strategy of international expansion, and the problems Company 2 has experienced cannot fully be understood without discussing this. This is done in the following section.

## 2: INTERNATIONALIZATION

Company 2 (USA) was founded in the USA in 1989 (AR form 10k, 1998: 39), and soon became among the top 15 largest providers in terms of licensed beds and revenues in the care sector in the USA (CCMN, December 1996/January 1997). At the end of September 1996, Company 2 (USA) operated or managed approximately 18,700 beds in the USA. It also provided physical, occupational speech and respiratory therapy at approximately 850 long term care facilities, as well as pharmacy services for more than 41,000 licensed beds in 17 states (*ibid*). As its annual reports (1998 form 10k: 10; AR, 1996: 33) make clear, the firm’s ‘growth strategy has relied heavily on

the acquisition of long-term and subacute care facilities', both in the US and abroad. Its 1998 report (AR form 10k: 10) details the problems this strategy presented in relation to its US acquisitions:

Acquisitions present problems of integrating the acquired operations with existing operations, including the loss of key personnel and institutional memory of the acquired business, difficulty in integrating corporate, accounting, financial reporting and management information systems and strain on existing levels of personnel to operate such acquired businesses.

Such problems are discussed in the next section in relation to its UK acquisitions.

Company 2 (USA)'s expansion abroad began with the acquisitions in the UK detailed in the previous section. The extent of this expansion is illustrated for the years 1994 - 96 by Tables 4.1 and 4.2 below:

Facilities	1996	1995	1994
Domestic (US)	160	131	115
Foreign (UK)	75	28	18
Total	235	159	133

Table 4.1: Long-term and subacute care facilities (Company 2 (USA))

(Source: Company 2 (USA) Annual Report, 1996: 20)

Licensed Beds	1996	1995	1994
Domestic (US)	19,321	15,921	13,904
Foreign (UK)	3,420	1,437	840
Total	22,741	17,358	14,744

Table 4.2: Long-term and subacute care - licensed beds (Company 2 (USA))

(Source: Company 2 (USA) Annual Report, 1996: 20)



As detailed in the previous section, Company 2 (USA) took control of Company 2 in January 1997, and has traded under that name in the UK ever since. In addition to its acquisition of UK care homes, the company also expanded pharmaceutical and medical supply operations in the UK.

Following its entry into the UK market, Company 2 (USA) acquired subsidiaries in Spain, Australia and Germany. Company 2 (USA) acquired its majority interest in the Spanish Eurosar, S.A., in July 1997. By the end of 1998 Eurosar's nursing home operations had increased from eight to ten (AR form 10k, 1998: 15). As of the end of 1998, its Australian interests consisted of 38% of the equity of publicly held acute care provider Alpha Healthcare Limited, acquired in August 1997, which operated nine acute care facilities, and a majority interest in five hospitals formerly run by Moran Healthcare Group Pty Ltd, acquired in November 1997 (AR form 10k, 1998: 2). Company 2 (USA) saw its Australian operations as, 'a base for further expansion in the Pacific Rim' (AR 1997: 10), and in 1998 it acquired the medical supplies distributor Promedica Pty., Ltd., 'as part of its strategy to develop ancillary services in the region' (AR, 1998: 12). In December 1997, Company 2 (USA) acquired a majority interest in Heim-Plan Unternehmensgruppe, an operator of nursing homes in Germany (AR, 1997: 32), whose facilities numbered 16 by the end of 1998 (AR form 10k, 1998: 15). This was followed by the acquisition of the German company Procedo/Stocker GmbH by Company 2 (USA)'s UK pharmacy business, which allowed it to establish, 'a solid platform for expanding pharmacy and supply businesses throughout Europe' (AR, 1998: 12). According to Jane Bartlett, at the time of interview Company 2 (USA) were, 'looking to acquire I think in Belgium and France within the next six to nine months.' Company 2 (USA)'s annual reports confirm the strategy of international expansion, stating that: 'Because of the Company's foreign growth strategies, the Company does not expect to repatriate funds invested overseas' (AR, 1996: 32; AR 1997: 34).

Worldwide, the company had more than doubled its provision by 1997 in comparison with a year earlier, with 483 long term and sub-acute care facilities and 47, 103 beds (AR, 1997: 1). By the end of September 1999 these figures had increased again to 552 inpatient facilities and 53,600 beds. Of these, 373 facilities and 41,800 beds were

located in the US (1999 Third Quarter Results, 7.12.99). As of February 20, 1999, the company had 80,720 full-time and part-time employees worldwide (AR form 10k, 1998: 5). Calculations based on figures given in the annual report (ibid) show that of these 70,188 were based in the US and 10,532 were based abroad. The overall growth of Company 2 (USA)'s foreign operations is indicated by their percentages of total net revenues. These were 2% in 1995, 5% in 1996, 10% in 1997, and 9% in 1998 (AR form 10k 1998: 10; AR, 1997: 34). Foreign operations accounted for 17% of consolidated total assets by the end of 1998 (AR form 10k, 1998: 10). By the end of 1998, Company 2 (USA) operated 186 facilities with more than 11, 700 beds outside the US, an increase of 12% over 1997 (AR, 1998: 12).

The company's annual reports provide important insights into its strategic thinking in relation to internationalization. The rationale for international expansion would seem to lie both in the stated aim of seeking out 'favourable market conditions and regulatory environments' abroad (AR, 1996: 11), and in seeking higher profit margins than are available in the USA. Company 2 (USA)'s 1997 annual report described the company as, 'aggressively exploring new opportunities in the global healthcare market, where operating profit margins can be more attractive than those in the United States'(AR, 1997: 6). When entering a foreign market, there is evidence that some care is taken to obtain an understanding of the local market:

We continue to believe that the international market offers significant opportunities for us to export our operational expertise, quality care and integrated ancillary services. We believe our approach is prudent and appropriate: to look for markets that are open to foreign ownership and operation, to partner with established providers and to participate on a relatively small basis until we gain a fuller understanding of local market conditions. (AR, 1997: 2)

The basis of Company 2 (USA)'s operations is long term nursing care, but, in a similar way to some US hospital providers (see Chapter Two), most of its profits were made through selling ancillary services to nursing homes (both its own and those owned by others) (AR, 1996: 5). This was because (prior to the introduction of the

prospective payment system discussed below) US state compensation for such services provided for higher margins than routine nursing care. Long-term and subacute care in the USA is provided through its core company, with the ancillary services being provided through a number of subsidiaries (AR 1996: 5) including:

- pharmacy services;
- medical supplies;
- respiratory therapy;
- consulting services;
- temporary therapy staffing;
- hospice, radiology and allied services;
- assisted living residences; and
- rehabilitation therapy.

Different countries are seen by the company as offering different opportunities for its ancillary services: 'The pharmaceutical services division has seen significant growth in the United Kingdom, for instance, and Spain and Australia offer attractive opportunities for rehab services' (AR, 1997: 6). However, Company 2 (USA)'s outpatient rehabilitation facilities belonging to its then Canadian subsidiary (Columbia), which had been acquired in 1995, were sold during 1998 and the beginning of 1999 because they did not fit in with Company 2 (USA)'s strategy of selling ancillary services to its core long term care business (AR form 10k, 1998: 15).

However, by the end of 1998 Company 2 (USA) was experiencing difficulties with its international operations, as discussed for its UK care homes above, and as its annual report for that year indicates (AR, 1998 form 10k: 10):

Adverse results from [Company 2 (USA)'s] international operations have and continue to negatively affect [Company 2 (USA)'s] financial condition and results of operations. The success of [Company 2 (USA)'s] operations in and expansion into international markets depends on numerous factors, many of which are beyond its control. Such factors include, but are not limited to, economic conditions and healthcare regulatory systems in the foreign countries in which [Company 2 (USA)] operates. In addition, international operations

and expansion may increase [Company 2 (USA)'s] exposure to certain risks inherent in doing business outside the United States, including slower payment cycles, unexpected changes in regulatory requirements, potentially adverse tax consequences, currency fluctuations, restrictions on the repatriation of profits and assets, compliance with foreign laws and standards and political risks.

Furthermore: 'certain of the United Kingdom facilities have not achieved profitability targets established upon their acquisition' (AR form 10k, 1998: 22).

These comments on Company 2 (USA)'s international operations need to be considered in the context of problems experienced by the firm in its home market, which had already manifested themselves by the time of the publication of its 1998 annual report. These problems relate to its relationship with US state agencies, and have been exacerbated by its apparent over-borrowing. The relationship of Company 2 (USA) to state funders and regulators (and other domestic actors) in its home state, and indeed to those in other countries where it has operations, is a topic which could be pursued in depth using the meso-level analysis employed in relation to UK domestic actors elsewhere in this thesis. However, for practical reasons of cost, time and size the meso level analysis in this thesis is restricted to actors in the UK market. Nevertheless, some discussion of Company 2 (USA)'s relationship with state agencies in its home state must be carried out here, since this is crucial to an understanding of the firm's strategy and the problems it has encountered, which have in turn affected its UK operations.

Company 2 (USA) has experienced significant problems with regulatory authorities in the US, and was between January 1995 and July 1997 the subject of an investigation by the United States Department of Health and Human Services' Office of Inspector General (OIG) and the United States Department of Justice. The investigation included a review of whether Company 2 (USA)'s rehabilitation therapy subsidiary 'properly provided and/or billed for concurrent therapy services and whether it provided unnecessary or unordered services to residents of skilled nursing facilities', as well as a review of 'whether its long term care subsidiary properly disclosed its relationship with the Company's rehabilitation therapy subsidiary and properly sought

reimbursement for services provided by that subsidiary'(AR, 1996: 36). The 'negative publicity' surrounding the investigation had, 'from time to time... slowed the Company's success in obtaining additional outside contracts in the rehabilitation therapy business', which had 'resulted in higher than required therapist staffing levels', and had 'affected the private pay enrolment in certain inpatient facilities' (AR, 1996: 37). In addition, both individual states and private citizens were pursuing lawsuits against the company (some of which related to the actions of subsidiaries prior to their acquisition by Company 2 (USA)) relating to abuse, neglect or fraud (AR form 10k, 1998: 36). The OIG / Justice Department investigation ended with no action being taken against Company 2 (USA). However, following calls by President Clinton for an enforcement 'crackdown' against nursing home regulatory violations in the summer of 1998, the federal government, 'has proposed to terminate several of the Company's facilities from the Medicare and Medicaid programs, and has imposed bans on admissions and civil monetary penalties against several facilities, on the basis of alleged regulatory deficiencies.'(AR form 10k, 1998: 4)

Company 2 (USA) has also experienced financial problems which it attributes to a large extent to the system of state funding in the US. In the month to February 1999, Company 2 (USA) saw its share price fall more than 60% (CCMN, February 1999). This was attributed to a fourth quarter loss arising from Medicare payment changes and a declining demand for its therapy services. In an echo of the discussion which will follow in Chapter Five of this thesis, Company 2 (USA)told Wall Street that government reimbursement systems were no longer keeping pace with the cost of care. In an effort to save around \$150m a year, Company 2 (USA)fired 7490 employees, including 6% of inpatient services staff and 36% of rehabilitation workers.

The background to Company 2 (USA)'s problems lies in changes to the Medicare and Medicaid systems of reimbursement. Medicare is the US's health insurance program for older people, whilst Medicaid is the government insurance program for the poor. The Medicare scheme was introduced in 1965, yet by 1980 it was regarded as being in urgent need of reform if bankruptcy was to be avoided. This was because the insurance method of meeting health needs required the state to meet costs set by private providers, thus creating an incentive for providers to constantly raise prices.

Furthermore, Berkowitz (1991: 154) describes how increasing health costs set in motion a discourse whereby employers complained that costs to company insurance schemes were damaging their profits, thus affecting their international competitiveness. This has led to restrictions on health-related payments by the state, and the increasing use of Health Maintenance Organizations (HMOs) by employers. In this context, the US Balanced Budget Act of 1997 mandated the introduction of a new Prospective Payment System (PPS) from the end of 1998. This would replace the system by which costs were set by providers with one under which the US government would pay nursing homes and home healthcare agencies a fixed fee per patient per day based on the patient's designated 'acuity level'.

Company 2 (USA)'s initial response to these changes was that it was, 'uniquely positioned today to succeed in this new environment', because of its ability to offer an integrated package of diverse health services through its various subsidiaries (AR, 1997: 20). However, PPS undermined its strategy of seeking profits from the higher margins, and higher reimbursement rates, which could be obtained from providing ancillary services under the old system (AR 1997: 23), and its 1998 annual report stated that, 'the impact of PPS was both more rapid and more significant than we had anticipated, creating results for 1998 that are clearly disappointing' (AR, 1998: 9). The company claimed that its significant number of 'higher-acuity patients' which resulted from Company 2 (USA)'s old strategy actually rendered it more vulnerable to the profit squeeze engendered by PPS (AR, 1998: 9).

Company 2 (USA)'s failure to get adequate take-up for its new package of care services from other providers resulted in the cutbacks noted above, plus further anticipated workforce reductions, restructuring and further 'streamlining' of operations, and across the board reductions in operating expenses (AR 1998; CCMN, February 1999). Restructuring activities were due to include the elimination of several senior corporate positions and a company wide wage freeze. Wall Street analysts indicated that what worried them was the company's high operating leverage and 'strained financial flexibility' (ibid). This had raised concerns among REITs that leased properties to Company 2 (USA) and other companies that such companies may not be able to keep up payments. CCMN (ibid) quoted UK industry analysts as suggesting

that, 'there is a clear message for those who have provided funding to [Company 2] in the UK', i.e. the UK company may also be unable to keep up payments. The situation for Company 2 was particularly precarious given that recent loans for Company 2 were only secured on the basis of a guarantee from Company 2 (USA).

Ultimately Company 2 (USA) was forced to announce that it would not make semi-annual interest payments due on 31 May 1999, and the group was informed by the New York Stock Exchange (NYSE) that its common stock would be suspended from trading on 29 June, and that the NYSE would apply to the Securities and Exchange Commission to delist that stock. Company 2 (USA) ultimately had to accept a 'chapter 11 plan of reorganization' (Company 2 (USA) press releases, 14.10.99 and 26.10.99), the equivalent of receivership in the UK. At the time of writing, Company 2 (USA) remained in chapter 11 protection, seeking approval from the bankruptcy court for, 'an overall restructuring of [Company 2 (USA)'s] capital structure' (ibid). According to Kent Phippen, managing director of Company 2 (USA)'s European operations, Company 2 and Company 2 (USA)'s other European operations would not be affected by the parent company's problems, but there would be 'some reorganization of senior management' within Company 2, following the departure of its managing director, Elaine Farrell (CCMN, October 1999).

The interview with Jane Bartlett took place on 30.10.98, prior to Company 2 (USA)'s entry into chapter 11 status. Bartlett said that she was 'well aware that [Company 2 (USA)] exists'. According to Bartlett, being part of Company 2 (USA) had provided benefits for Company 2 in terms of information technology and training in particular, which was 'helping us an awful lot... There's certainly been a vast amount of money been made available to bring in technology, to help us get things sorted.' At the time of interview, Company 2 were waiting for a new system to come in which 'will give us intranet access to a lot of training materials, some of which we are going to get verified and credited to NVQ level and we will be able to do an open learning NVQ in care. Quite possibly customer care would go on... we can effectively train 80 units at one time from a central location.' The company was 'currently developing with a consultant in the States a core competency manual which will come into the units for anybody to have and it will be a self-development manual.' In addition, OmniCell units

- sophisticated computer systems for the automatic dispensing, tracking, billing and reordering of medical supplies which Company 2 (USA) used in the US - had been installed in its UK nursing homes (AR 1997: 17).

Although Bartlett said exchange visits were in their early days, learning between the different national groups within the Company 2 (USA) umbrella seemed to be an important feature: 'If you talk to some of the staff in some of the units, they're saying "do you think we'll ever get to do exchanges" and "can we do this" and "can we do that". I think that'll probably come, but we've got to make sure we've got our act totally together first and that we're ready really for 2000, 2001... We've almost got there now.' Bartlett herself had been asked 'to have a look at the procedure manuals for the rest of Europe and to comment, obviously because of the experience that I've had in pulling these together and changing them [see below]. So whether that will take off in '99... I'm waiting really for the ball to come back.'

One of Company 2's clinical nurse specialists dealing with EMI had been to the States for a study tour to look at dementia models there, visiting several different facilities. Bartlett said that there had been some surprise at the level of physical restraint used in the US (for a discussion of this see Braithwaite, 1993). Her comments demonstrate that intra-organizational learning does not necessarily flow only from the centre to the divisions:

And they said come over, have a look at the planning unit, have a look at what we're doing. She's sort of got over there and has almost found that they're a good five or six years behind us in their methods. And whether it's because of the sue culture that they've got over there where you've got to make sure that everybody's well looked after because they'll sue you, they're still using a lot more restraint and they see restraint as a way of protecting the resident. And obviously they're at very little risk because they can't move, whereas that would be frowned upon tremendously here because we're still trying to encourage as much independence and give them some privacy even within the dementia units as much as we can. It was quite a culture shock to her I think, and I know that from someone from one of the dementia units in the States



that's been over and had a look at one of the model units that Carolyn has set up here... Its just something that shocked her to see restraint used and the amount of paperwork that they went through and there's disclaimers for everything. It was a totally different ball game, so I think that we're still very different, and hopefully we can learn from each other.

Such differences may lead nationally based staff to find their own solutions, perhaps looking outside the organization:

I think Carolyn went over hoping to get new ideas from them and has come back and has perhaps thought 'well maybe I need to look elsewhere and not to the States for the information', simply because it doesn't fit what we're looking for. I mean there's going to be other places to have a look at, and I know that she's making links outside the corporate company, just really to keep up to date and to make sure we're looking at the practices and deciding what is our best practice, trying to set the standard.

Whilst initiatives are likely to come from the centre, and therefore reflect American business culture, Bartlett claimed there was an awareness of the need to adapt to local (i.e. country) needs: 'I think they do recognise cultural differences, and possibly because of diversification across the world they perhaps recognise cultural differences and are very aware that what is really good here may not work in Germany, what's really good here may not work in Spain'. The intranet initiative had come from Company 2 (USA): 'they were aware of the technology and what it could do. They had a management introduction system where the managers are expected to work through certain training courses and they have training videos and the intranet working over there, and I think this is an extension'. However, Bartlett said 'I don't know whether to say we've Anglicised it or whatever, but there's been a lot of input from us saying "well that's great but its a little bit too over the top or a bit too USA for us to use over here." So we've had a lot of say, its not just coming over off the shelf, its actually been packaged very much for us.'

Nevertheless, Company 2 (USA) does seem to value standardization. Chet Bradeen, the American managing director at Company 2 in 1997, argued that: '[The UK] has a lot of variety and therefore gets inconsistency. This is eliminated when you deal with a corporation. You get a standard approach - a McDonald's approach - where you know standards are high.' (quoted in Inman & Sone, 1997: 26) From Bartlett's own account, some things did indeed appear to be standardised. All the regional and divisional operations staff had been across to attend executive training courses organized by Company 2 (USA) at Yale University, 'and that will continue next year so that new staff coming online will receive the same management training across the whole company.'

Bartlett thought that the overall effect of Company 2 (USA)'s ownership had been a definite advantage for Company 2:

We are able to use the expertise... of a lot more people, and that's certainly made a lot more difference, having that knowledge base to call on. Even with Carolyn finding out that we're possibly more advanced it has its positive side. It means perhaps that we have to do a bit more of our own research, but it sort of gives you the basis to say we're doing this really well, and perhaps we can help out there... Information exchange has been great. Networking facilities obviously have been superb, because with the States being so well set up and also, although we've only just started really looking at Europe and the sister companies there, there are companies in Asia[sic] and Australia, so if we start getting that together I can see that there'll just be so much information available. And as long we're managing it and not just getting information for information's sake we can all learn from it.

It is perhaps unsurprising that Bartlett should present the net effect of Company 2 (USA)'s ownership as positive, so her comments on this may be regarded with some scepticism. There is also some inaccuracy in her statement that 'there are companies in Asia', which perhaps casts doubt on her detailed knowledge of Company 2 (USA)'s other foreign operations, including the claim (quoted earlier) that Company 2 (USA) was intending to expand into France and Belgium (of course it is also possible

that she had information that was not known outside the company). However, it is clear that there was significant learning within the organization between national divisions, with most initiatives coming from the parent company in the US.

As noted above, in addition to the care services provided by Company 2, Company 2 (USA) has also expanded its pharmacy and medical supply wings into the UK. According to Bartlett, the medical supply wing is Company 2's major supplier of equipment and medical supplies. The pharmacy wing, however, was not at that time large enough to be Company 2's major supplier, with only 17 units in the UK. The pharmacy wing was seeking to expand in the UK, but at the time of interview, 'wouldn't be able to cope with the geographical spread of the [care] units'.

As with Company 1, Bartlett saw economies of scale, or 'buying power', as a major advantage, stemming in this case from the specialist activities of its medical supply wing:

We've noted reductions in costs since we've had [the medical supply wing] coming across, because their buying power is even bigger than one of the 40 / 50 home companies that we were before the merger and before Company 2 (USA) put us together. So certainly that helped tremendously. It also helped I would think in being able to source things. Because we've got the expertise. We've got a purchasing and procurement manager working on things and keeping up with advances as well. So I think being part of a corporate certainly helps there.

Bartlett also noted the difficulty this produced for small organizations given current market conditions:

a lot of the acquisitions that Exceler made have come about because they have been very very good homes and when the only manager set them up there was a lot more money to be made. With the real term amounts you get paid now per resident, it's almost impossible for some of these people to stay in business because they haven't got those economies of scale, because they haven't got

the buying power. And it's the only place really that can make the difference because you can't reduce staff costs and you can't not pay the wages. But if you're paying three times as much as we are for food each week and giving food to the same standard you find that you go into some homes and you may find that there's a sandwich for tea, whereas you look at the menus you'll find that there's three meals a day and choices at each. But it's the level or the standard that you can give I think, that's the difference.

The evidence given by Bartlett suggests that Company 2 has benefited to a considerable degree from Company 2 (USA)'s resources and expertise, although it would appear that learning within the organization is a two way process. However, Company 2's overall direction is determined by Company 2 (USA), despite the existence of some level of autonomy. This means that Company 2 is subject to the problems of its parent company as well as the benefits it can offer. At the time of writing, Company 2 (USA) remained in chapter 11 status and Company 2 was continuing to function 'normally'. However, this section demonstrates the risks as well as the advantages that may attach to internationalization.

### 3: QUALITY ASSURANCE AND ORGANIZATION

As was the case with Company 1, the data for this section derives primarily from the interview with the company's QA manager. Bartlett described her job formally as 'to ensure that the policies and procedures within Company 2 are complied with, and that those policies and procedures are in compliance with ISO 9002.' The company was 'committed to achieving ISO 9002 standard within every home, and each home goes for the standard individually'. ISO 9002 was considered useful primarily because it provided an administrative framework:

it gives us the process. It ensures regularity between all our homes so that every nurse can walk into any home in the country and be able to understand the paperwork, so that if we did need to transfer a nurse because of staff shortage... they wouldn't have to spend time relearning the paperwork or

getting to know what they were doing on the admin. side. They could then spend more time getting to know the residents and ensure the standards of care were there. ISO enables us to do that. It ensures that the administrative side is certainly done to the same level. Also, it means standards of care and the work practices are maintained to a certain level within every unit. I suppose that's where ISO stops and some of the other things come back in.

Nevertheless, ISO 9002 was considered 'mainly a foundation', rather than as adequate in itself. The problems which Bartlett saw with it were very similar to those identified by Bob Jones of Company 1, in that it dealt only with the most formal aspects of quality:

if in the policy manuals it was written that at three o'clock every afternoon all the residents would be wheeled into one lounge and the doors were going to be locked and all the staff would go down the pub, the non-compliance would be if they found a member of staff in the building, because that's what the policy says that we do, so you're showing compliance to policy. There will be very few checks to ensure that the policy is the best practice, so its the best practice part that comes in and that's why the policies have to be kept updated... it won't police the system for you, it will ensure that the standard's maintained to the standard you're setting yourself.

Like Company 1, therefore, Company 2 also supplements ISO 9002 with its own systems. The main quality manual 'lays out the compliance with the system of ISO', but there are also eight procedure manuals, 'which basically tell the general manager and the staff the way we expect and the standard of work that we expect within the home'. The system is 'policed' by 'internal process reviews' carried out by regional managers, 'where we're actually talking to members of staff about them, the way they feel about the home, the way they feel about themselves and their colleagues, teams that are working.' This also involved 'a lot of time talking to residents' (see Chapter Seven). Company 2 is organized in three divisions (North, Central and South) and twelve regions, with four regional managers reporting to each divisional director. The regional managers' reviews are checked by the divisional directors who 'police that

system to ensure compliance and also continuity'. Rather than comparing one unit to another, this involves monitoring,

the improvement the unit has made on the previous month's score. It also means that we're much more aware if something goes slightly wrong or if the home starts to slip or if there're problems, that it's picked up within, usually three or four weeks, or something like that, rather than waiting six months for the ISO audit, where it may be that the surveillance visit doesn't focus on care issues this time, it will look at housekeeping standards or admin. policies. We try and take a good cross section with the internal process review.

Bartlett also carries out a lot of 'ad hoc audits where felt necessary'. According to her:

I also am very much involved with the introduction of the learning organization into the company. I feel that quality is all encompassing and it affects the staff, so I tend to not just stick to the policies and procedures and have this sort of top down approach to quality. It's very much getting in amongst people, making sure the system's a living system and ensuring that everybody knows how to amend the system if something happens, or whatever, to keep continuously improving.

As with Company 1, the process of acquisition by Company 2 (USA) and merging with Exceler and Apta had been a somewhat difficult process. As did Jones, Bartlett also explained this with reference to the notion of 'culture', without prompting from the interviewer:

three reasonably small companies merged together to form this 150 home unit that we now see. It was three totally different cultures coming together. So probably for most of 1997 there was a lot of unrest and a lot of upheaval. People coming to terms with who, if you like, was going to end up in charge of [Company 2] or [Company 2 (USA)] or whatever it was going to be called... I think it was mostly people being unaware of what was physically going to

happen, and because they felt insecure it obviously affected some routines. At one stage there were three head offices, obviously, with three companies. None of the head office staff knew which head office would have been in the back of the... who was going to do the admin. or do the accounts or whatever .

This had important effects on staff relations. The process of merging these 'three totally different cultures' involved 'a lot of changes in some of the units because of the work practices coming in.' Apta had had a 'very centralized' business system and 'had been used to central office doing everything from ordering the supplies to dictating the budget to getting the light bulbs changed and everything else. The way the company's set up now is that each general manager is responsible for a cost centre, and they are run very differently.' This change from a centralized system to a more devolved one meant that Apta managers,

went from being matron managers and very much hands on nursing, and in some cases were actually called the nursing director. The emphasis was put more on them being a business person, so there's been a lot of staff development to get the skills necessary to take on that role. And there have been a few that have decided that they wanted to stay much more hands on nursing. Wherever possible they've been encouraged to take the care manager role within the unit, and that's happened in several cases, but some of them felt that it was like a demotion, because there was going to be this general manager, but you have the problem. So there were, I suppose, the normal trauma of bringing three cultures together and trying to get one that would work from the three.

This is consistent with CCMN's observation (October 1998), quoted in Section One, that some of the former Apta employees did not stay with the merged company. According to Bartlett, the rapid growth in the company,

meant that the head office team, admin. team, finance team, were coping with 150 units instead of 45, 46 units that they had been previously looking at, and I don't think that maybe that change was managed too well, in that they certainly

weren't prepared for the extra work and the lack of knowledge of the colleagues in the unit. You've got an administrator that fills in one A4 form every week and sends it through to the central office saying 'please buy me two packets of toilet rolls' and everything else, and then you've suddenly got an administrator who's trying to cope with putting the wages in at unit level, running the purchase ledger, invoicing. I don't know that we had the support for those people, so the internal customer, being the administrator of the unit or the general manager of the unit, was struggling with coming to terms with business and finance - whether that was actually there correctly, which again caused a bit of unrest.

The new, more devolved, system of administration had been extended from the old Company 2 to cover the new merged company. Exceler prior to the merger had been,

probably half way between the two. The manager of the home was seen as a marketing person and still very much clinically orientated but they [would] sell the beds and market the home and be involved with the local community, but probably not to the extent that the [Company 2] managers had controlled the cost centres, run to a budget and been held accountable for the budget. So they were mid-way between the two. Probably [Company 2] and Apta were the extremes.

However, according to Bartlett, the constituent parts were 'now one totally different company. I don't think you could say that any of the three companies exist any more. And its certainly not that the corporate culture has become the old [company 2] corporate culture. We've all been through this huge learning curve and a lot of things have changed.'

Bartlett herself had been a General Manager of an Company 2 unit at the time of acquisition, and had spent the first six months thereafter on secondment, 'really helping people come to grips with the bits of paper on the finance side and sort of organizing.' Having subsequently been offered the job of quality assurance manager she had spent the first six months in that post, 'looking at taking the best from all the procedural



manuals and changing the policies and procedures and adapting them to fit the different units.’ Again like Company 1, the process of merger had meant that the new company had acquired a mix of assets:

[Company 2] units had always tended to be purpose built and had been very much new-build. There’d been some conversions but quite a lot of the conversions where the old houses were left much as was and new wings have been built on, so the admin. section would be in the old house and then the purpose built unit added on. Some of the assets that have come together have been very mixed. Some of them have been local authority units that had been purchased by a private individual and then Exceler or Apta had acquired from other stock really, rather than building their own. So there’s a huge mixture now of assets and the way that’s come together.

The diversification of services which took place with the merger has also meant that, ‘the knowledge base that we’ve needed as a company has obviously expanded and we’ve had to look for specialists within each of the sectors to make sure that, again, that nursing issues or care issues are addressed properly, depending on the client base.’

Bartlett saw no contradiction between the profit and quality goals of the company:

Every nurse that works for the health service is there and takes away a salary. Even people that are working for some of the voluntary organizations will still have a salary at a certain level. So really with the culture that we all live in, I can’t see a problem with making a profit as long as we are selling first class quality care, and that is provided. I can’t see a problem with it at all.

As far as the different demands made by financial criteria and quality criteria were concerned, Bartlett argued that:

The financial performance criteria and the quality assurance criteria are really very similar. If we are making a profit for shareholders and our shareholders are happy with us, they will reinvest with us, which means we can move

forward with medical technological advances... I see increased occupancy on a local level, meaning that the area is happy with the standard.

As long as homes are 'filling up' because they have a good standard of care then, 'ultimately the shareholder, wherever they are, is going to get a better return on their investment. So I would say that it is definitely quality led.' Although it is plausible that there is a strategic approach based on raising quality, these comments tend to obscure the distinct difference between profit targets and quality criteria.

It can be seen that Company 2 has put ISO 9002 closer to the core of its quality systems than has Company 1. However, for Company 2 also, ISO 9002 was not adequate by itself, and the quality assurance system it had developed was fairly similar to that being developed by Company 1 Care Homes. Like Company 1, Company 2's system was also based on *process* reviews, although Bartlett emphasised the importance of 'talking to residents'. Company 2 also organized residents' and relatives' meetings, which are discussed in Chapter Seven.

Again in common with Company 1, Company 2 had experienced problems in homogenizing the different 'cultures' of its acquired firms into one. With Company 2 this seems to have been as much to do with the administrative and business side of the operation as the quality of service side, and appears to have caused considerable problems with staff from one of the acquired firms in particular, causing some of them to leave. There was no acknowledgement by Bartlett of any tensions relating to the relationship between cost and quality, but the financial problems which both it and its US parent have experienced clearly demonstrate the importance of profit and cost issues.

## COMPANY 3

### 1: CORPORATE HISTORY & STRATEGY

Company 3 was set up in 1985. Prior to Company 2 (USA)'s acquisition of Company 2, Company 3 had been the second largest long term care company in the UK, with a little under 4,000 beds (CCMN, April 1994). Only 50% of its business was wholly reliant on the state sector. This is still the case, and allows it to maintain higher occupancy rates than its competitors as it is not so restricted by LA budget restraint, although it does mean it is more exposed to the economic cycle. From early on in its existence, the US group National Medical Enterprises (NME) had a 42% majority shareholding in Company 3. NME also had a minority shareholding in Hillhaven, which it subsequently sold to Horizon Healthcare, leaving its Company 3 shareholding as its only interest in care homes (CCMN, April 1995). NME was a major acute care provider in the USA. In May 1996, NME, which by that time had changed its name, sold its 26,874,998 shares in Company 3 (CCMN, May 1996).

Reflecting its strategy of diversification in healthcare delivery, Company 3 acquired the entire share capital of Diagnostic Holdings Ltd in April 1995. Diagnostic's principal activity was the provision of medical diagnostic services operated out of three hospitals in Essex, Suffolk and Sussex (CCMN, April 1995). In November 1995, Company 3 acquired the retirement home management company Peverel, in a joint venture with Holiday Retirement Corp of the USA (<http://www.ukbusinesspark.co.uk/wee31246.htm>). In November 1996, Peverel acquired Care UK's retirement housing management operations, reinforcing its position as market leader in that area, providing services to 36,000 residents (AR 1997; CCMN, November 1996). Through Peverel, by May 1997 Company 3's 24-hour Careline monitoring service connected 27,000 people to emergency helplines (CCMN, August/September 1997). By the end of November 1997, Careline had expanded into the non-elderly sectors, bringing total clients to 35,000 (CCMN, February 1998).

In June 1996 Company 3 made a hostile bid for Goldsbrough Healthcare, which was subsequently acquired by Company 1 (see above). A similar approach had been made the year before, and on both occasions Goldsbrough's board had rejected the offer and requested that their shareholders take no action (CCMN, June 1996). According to CCMN (ibid), Goldsbrough did not have, 'a sufficient capital base to support adequately the growth of a diversified healthcare group'. On the other hand, there were good reasons why Company 3 was well placed to take over Goldsbrough (CCMN, ibid). Company 3 had invested considerably in product development, and had developed a capacity to provide for higher dependency clients, including persons with challenging behaviour, psychiatric needs, eating disorders, alcohol and drug abuse and head injuries. The 'potential synergy' of its care home operations with its Peveral business would also boost returns, allowing Company 3 to bring forward investment in management information systems and use more 'high tech' products to deliver its service. It also, 'knows how to put itself in the frame on long term contracts from local authority purchasers' (ibid). However, as detailed above, Goldsbrough's board successfully resisted Company 3's approaches, and the following year the company was purchased by Company 1.

In June 1997, Company 3 purchased the nursing home and assisted living division of PPP Healthcare, PPP Beaumont (AR 1997: 15), including nine premier nursing centres and a further two under construction (CCMN, June 1997). An important part of the transaction was that Company 3 would become the primary preferred provider of long term nursing care for PPP Healthcare customers as part of a new relationship. It was also proposed that PPP Healthcare customers would be able to access Company 3 nursing homes at preferential rates. PPP Healthcare is the UK market leader in long term care insurance, through its subsidiary PPP Lifetime. It was anticipated that the relationship would lead to the development of a range of technology and call-centre based services for their joint client markets to provide health information and support services. Pat Carter, chief executive of Company 3, commented that the relationship met three of the company's main objectives: it strengthened the company's core business by raising the element of privately funded residents, in geographically complementary facilities; it diversified Company 3's range of UK services in the expanding assisted living market, completing the product range between sheltered

housing and nursing homes; and it gave close links to the leading provider of long term care insurance in the UK (ibid).

Company 3's interim report containing annual figures for the twelve months ending 31 May 1997 pointed to 'three key messages' which help to illustrate its strategy (CCMN, August/September 1997). First, the company was outperforming the care homes sector in terms of occupancy (around 3% above the average during the course of the year) as well as operating profit per bed and internal rates of return. The higher proportion of self pay residents when compared to the rest of the sector was one factor helping performance. At this time 25% of Company 3's clients were self-pay - following the deals with PPP and the sale of twelve homes to Tamaris, this proportion rose to 31.8% (CCMN, February 1998).

Second, cash flow continued to be increasingly invested in related health and care sectors, reflected in the acquisition of Farm Place (which caters for people with alcohol and drug problems and eating disorders) and the commencement of construction of two medium secure units near Newbury and Milton Keynes. The company's annual report (AR, 1997: 11) stated: 'We see the whole area of behavioural medicine as having strong development potential with opportunities for further expansion.'

Third was the statement that it was just as likely to sell part of its care home portfolio rather than acquire more in the market, confirming its strategic plan of diversification. Company 3's annual report (1997: 14) stated: 'One of the Group's objectives is to increase further the contribution, before interest and tax, from non nursing home activities', and announced, 'a substantial reduction in our nursing home expansion programme' (ibid: 16). Margaret Grant, member of the board of directors of Company 3 with overall responsibility for quality assurance, commenting on Company 3's operations in hospitals and head & brain injury, stated in interview that, 'we believe in multi-diversity'. Company 3 had a target aimed at broadening its base to 50% non-nursing home activities by year 2000 (CCMN February 1998: <http://www.ukbusinesspark.co.uk/wee31246.htm>).

At the end of 1997 Company 3 acquired the care home provider Libra Healthcare. In March 1998, Peveral, the retirement home management company which Company 3 jointly owned with Holiday Retirement Corp (HRC) of the USA, purchased O.M. Limited for around \$8m. (CCMN, March 1998). O.M. Limited had a similar business to Peveral, managing 886 developments with 19,500 units. The deal increased the number of units managed by Peveral to more than 50,000. Also in March 1998, the US company Health Care REIT agreed to become a significant minority investor in Atlantic Healthcare Finance, an investment trust set up by Company 3 and HRC. The month before, Atlantic Healthcare had announced a series of deals involving the purchase of care home properties from Company 3 and Tamaris, which would be leased back by Tamaris. It was understood that Company 3 would retain its 49% interest in Atlantic Healthcare, but that its partner HRC would only hold a 20% stake, with the balance being held by Health Care REIT. Health Care REIT would also provide significant input into the management of Atlantic Healthcare (CCMN, March 1998).

At the end of May 1998, occupancy in Company 3 care homes was higher than the industry average at just over 90%, and the proportion of single rooms with en suite facilities had risen to more than 90%, near double the industry average (CCMN, August/September 1998). Nursing homes comprised 72% of group turnover and 69% of operating profit (previously 80% and 79% respectively), indicating some success for Company 3's strategy of diversification away from long term care provision (ibid). Local authority 'only' funded residents remained less than one third of 'census' levels, and self-pay clients had risen to 35%, reflecting Company 3's strategy of increasing its self-pay clients. At this time Company 3 had 16 operational behavioural medicine units of which 7 were new openings and 4 were new acquisitions. That portfolio comprised 618 beds, 293 acute and 325 chronic. Psychiatric beds made up 249 of these beds, 228 beds were brain injury, and the balance of 145 beds catered for people with learning disabilities, alcohol and drug abuse problems and various rehabilitative needs (ibid). CCMN (ibid) thought that the key to the rate of growth of the firm might be development of its Atlantic Healthcare associate through expansion of its property portfolio in the UK and other parts of Europe.

Company 3's higher proportion of self pay clients and its higher occupancy levels meant that it was out-performing its competitors in economic terms. However, it is an indication of the situation within the sector that, although Company 3 was regarded as 'the most commercially viable' of the large firms, CCMN (April 1999) saw it as having had to, 'run hard in recent years in order to simply stand still, because the market's perception of the value of care homes has fallen dramatically during this period'. Despite its relative success, therefore, Company 3 had 'not been successful enough to create major gains'. Figures released in February 1999 (CCMN, February 1999) showed that the major contributor to earnings was Company 3's long term care division, but that even this was experiencing problems.

In March 1999 the board of Company 3 agreed the sale of the company to Canterbury Healthcare. Canterbury was set up by Chai Patel, the founder and former chairman of Court Cavendish and former chief executive of Care First (acquired by Company 1 - see above). Canterbury's backers included the US investment bank Goldman Sachs and Welsh, Carson, Anderson & Stowe (WCAS), a leading US private equity firm set up in 1979. At the time of the acquisition of Company 3, WCAS managed a series of nine limited partnership investment funds, including the WCAS Funds, that make investments in connection with acquiring and building established businesses in the healthcare and information services industries (CCMN, March 1999). The board of directors of Canterbury comprised Chai Patel, Edward Siskind (a managing director of Goldman Sachs & Co.), Barry Volpart (a managing director of Goldman Sachs International) and Andrew Paul and Lawrence Sorrel (managing members of the general partners of the WCAS Funds). Tony Heywood, former finance director and executive director of Court Cavendish and Care First respectively, took on the role of chief operations officer for the whole group (CCMN, May 1999). Peter Churley, previously employed by Company 1 and Tamaris, was appointed managing director for the care homes division.

In August 1999, the new owners of Company 3 acquired 100% of the home care business, marketed under the name Careforce, which was previously owned by Company 3 in partnership with businessman Mike Rogers (CCMN, August/September 1999). The move confirmed that Canterbury would continue Company 3's strategy of

diversification, but also showed that care homes would remain central to the company's strategy. Patel indicated that Company 3 intended to increase its presence in the home care sector, but that home care, as well as rehabilitation and respite services, would be expanded *through* existing care homes. The firm believed that, 'the provision of a range of care services from a single location will lead to a more integrated solution for people requiring care.'(ibid)

In February 2000 Company 3 acquired the independent psychiatric hospital operator Priory Healthcare, which operated 13 acute psychiatric hospitals and three specialist residential schools (CCMN, February 2000). These were to be added to Company 3's existing mental health services to form the largest independent sector provider of mental health care in the UK, trading under the Priory name. About a third of the enlarged group's provision was funded by the NHS, with the rest being privately funded. Priory had previously been acquired from its US owners CPC in a management buyout in April 1996 (CCMN, October 1999).

Company 3's overall strategy then, has been to raise the level of self-pay clients in its care homes through concentration on the upper end of the market, allowing it to keep average care home fees rising ahead of the retail price index (CCMN, April 1999), whilst diversifying into specialist operations including psychiatric services, services for people with alcohol and drug problems, head injury and medium secure units. Alongside this it has developed a national emergency call operation and a substantial portfolio of retirement home interests through its partnership in Peveral. It was at April 1999 (CCMN) the second largest national provider of diagnostic imaging services. Through Atlantic Healthcare Finance, it had made substantial investments in property which allowed it to profit from the growing popularity of leaseback in the sector. Canterbury's strategy subsequent to its acquisition of Company 3 was to be to continue to build Company 3's businesses through a combination of internal growth and acquisitions. According to CCMN (March 1999) Canterbury believed the calibre of Company 3's facilities and management made it a pivotal part of Canterbury's strategy for long term growth.



## 2: INTERNATIONALIZATION

As can be seen from the above corporate history, Company 3 was, like Company 1, a British based company. However, unlike Company 1 it had not yet expanded abroad through direct provision. Neither had it grown through acquisitions of large existing firms. Rather it had grown predominantly on the basis of two linked forms of expansion. On the one hand, it had steadily acquired a number of smaller businesses specializing in both long term care and other health related fields. On the other hand, it had formed various alliances and joint ventures with other independent firms, many of them US companies. These included the initial majority shareholding held in Company 3 by National Medical Enterprises (NME) of America. NME first entered the British healthcare market in 1975, when it acquired many of the hospital assets belonging to the British firm United Medical Enterprises (Griffith & Rayner, 1985: 44). Company 3 was its biggest investment in long term care in the UK, from which it has subsequently withdrawn.

Other than the relationship with NME, Company 3's international partnerships to date have primarily involved real estate or retirement housing management. These have included its joint venture in Peverel with the US company Holiday Retirement Corp, and its partnerships with Holiday Retirement Corp and the US company Health Care REIT in Atlantic Healthcare Finance. Company 3 is likely to have benefited from the greater expertise of US firms in such ventures. Company 3 was also the first UK healthcare group to raise funds in the US financial market (AR 1997: 18). Furthermore, its most recent owners, Canterbury, were backed by the American investors Goldman Sachs and WCAS. It is also possible that Company 3 may decide to expand into Europe, either through direct provision of care services and / or through its real estate dealings. Canterbury's chief executive, Chai Patel, confirmed to CCMN (May 1999) that the group was actively considering a number of propositions regarding expansion into Europe including, 'a number of potential opportunities for the group across all its activities in Germany, France and Spain'.

How Company 3's international links have affected its operation is difficult to pinpoint, not least because the interview with Margaret Grant (professional services

manager at Company 3 and a member of the board of directors) yielded less information than that for the other two firms. Grant was unwilling to have the interview tape recorded, although she was happy for notes to be taken during it. She provided generally brief and guarded answers to the questions put to her. The interviewer was asked to leave the room twice during the course of the interview (which took place at Company 3's offices in Wales), so that Grant could take urgent and confidential telephone calls.

According to Grant, during the period of NME's part-ownership it 'was always understood' that Company 3 would eventually 'develop on our own'. Hughes went to the US for her induction into the company, and said 'you learn how to work when you work for an American company'. Company 3's executives had been to the US to see if the American systems could be adapted, but had found that they had a 'different system'. According to Grant, some standards in the UK were 'much better' than in the US, some were 'not nearly as good'. This tends to confirm the evidence given by Jane Bartlett of Company 2, that involvement with a US firm does not necessarily lead to a 'one way' subordination to American practices, but that cross-national learning is to some extent a two-way process.

Grant thought that Company 3's size gave it a definite advantage over smaller firms which were often run by single owner / managers. Company 3, on the other hand, was 'bigger than any single health authority'. Economies of scale in purchasing supplies were seen as 'a definite advantage'.

### 3: QUALITY ASSURANCE AND ORGANIZATION

The information for this section is derived primarily from the interview with Grant. Company 3 seemed to be the most sceptical of the three companies of 'off the shelf' quality systems. ISO 9002 was piloted in three homes, but not taken on board due to the high levels of paperwork and the fact that it was seen as 'product geared, not service geared'. Grant said that Investors In People had also been piloted in some homes. According to Maria Smitham, Head of the Registration and Inspection Unit in

East Albion, all of the PPP homes acquired by Company 3 in Albion had achieved Investors In People prior to their acquisition, and other Company 3 homes in the area had achieved it subsequent to this, as well as having, 'other kite marks attached to them as well'. Grant described the Investors In People 'pilots' as a learning experience, which could then be fed into the organization's own quality system. This is consistent with the perceptions of Smitham, who said that the PPP homes had aimed at the highest quality section of the market and that Company 3 had continued to market them under the PPP brand. However, Smitham thought any differences between the PPP homes and other Company 3 homes had disappeared as Company 3 had, 'looked at the good in each of the homes and they've tried to marry up what is good in each of them.'

Company 3's own QA system involved the setting of standards, the monitoring of outcomes and the following of operational procedures and schedules which are laid out in manuals. The operational procedures related especially to nursing, but also to things like kitchens and laundry. The company also had a training system which involved every member of staff going through basic induction training (including fire drills, safety procedures, etc.). All ancillary services - laundry, cooking, cleaning, maintenance - were done on site and in-house. Each of these departments was subject to an audit. There were 12 audits a year altogether in each home, which took place on a monthly basis. The home managers carried out the home level audit based on the guidelines that were set nationally.

Each home was subject to a regional manager (responsible for financial targets), a regional nurse (responsible for quality and standards), and a regional administrator. These regional officers were subject to two national officers - a director of operations who is responsible for functional management, and a professional services manager (Grant) who was responsible for quality and checked nurses' PIN numbers. These two national officers had formal equality, but in practice Grant was 'slightly higher'. The regional nurse would visit each home to check the audits. She would talk to the 'patient', and then check the notes to make sure these adequately reflected the patient's needs. The notes were of utmost importance since staff sometimes changed, although an effort was made to maintain consistency by having a named member of

staff who had primary responsibility for each patient. The patient would know who that person was.

The company also had a complaints procedure: 'In a perfect world we wouldn't have any complaints but in practice, of course, we do.' Company 3 had at one time tried to introduce quality circles, but Grant said these had quickly become 'grumbling circles', and so had been abandoned. Finally there was the '0800 number' or 'the whistleblowing number', which was 'one of the company's biggest assets'. This was a confidential line for staff, clients and relatives which came 'straight through' to Grant. People could talk about anything in confidence and Grant would deal with it 'directly, straight away'.

As is demonstrated by the corporate history given above, although Company 3 has grown through acquisition of pre-existing businesses, unlike Company 1 and Company 2 it has not been the result of merger between large pre-existing companies. Rather it has built on the basis of alliances which reflect its strategy of diversification, also discussed above. According to Grant, about 90% of Company 3's homes were purpose built, 'although we have bought in to some extent'. Grant acknowledged few difficulties encountered in building up a large organization. She said that Company 3 had no problems related to bureaucracy, although she did say that it was 'never easy' to integrate a pre-existing business once acquired - it took time for the transition to take place. She stressed instead that the company were 'clearly the best providers'. This claim was based on 'good occupancy levels'; according to Grant the company had waiting lists. Grant thought Company 3 had 'proved' that it was better than its competitors. This was the result of 'better checking systems' and the fact that 'everyone works hard, from the top down. I say from the top down, but we also believe in empowerment. Of course, everyone says that, but we do mean it.' Neither did Grant acknowledge any tension at all between the quality and profit goals of the company stating simply that 'quality always takes precedence'.

Considering Grant's reluctance to acknowledge any real problems relating to these matters, her comments may be regarded as more promotional than enlightening. Indeed, the more intangible aspects of semi-structured interviews discussed in Chapter

Three, such as the emotional tone or mood of the interview, in this case suggested that Grant was less open than Jones or Bartlett. The unwillingness for the interview to be tape-recorded is some indication of this. However, Grant's comments on occupancy are consistent with information given by CCMN quoted above, and her comments on the relative lack of problems associated with the growth of the company are consistent with Company 3's history of having avoided mergers with other large firms. Despite her assertion that 'quality always takes precedence', she indicated that quality and financial targets were monitored separately and simultaneously on a regional basis - clearly profit considerations were important to the company. The two were presumably seen as complementing each other through Company 3's strategy of attempting to attract self pay clients who would be willing to pay a premium for higher quality.

Company 3, then, could be said to be the least enthusiastic of the firms about 'off-the-shelf' systems such as ISO 9002. The quality assurance model it has developed would seem to be fairly similar to those of Company 1 and Company 2 in terms of being based on the governing of *process* by operational manuals. However, Grant did indicate that *outcomes* were monitored, although she provided no detail on how this was done and did not allow inspection of the firm's QA manuals. The introduction of 'the whistleblowing number' was an innovative means of feedback to the centre for staff, clients and relatives. Company 3 also organized residents' and relatives' meetings, which are discussed in Chapter Seven.

Other than the changes at the top level, detailed in Section One, it is difficult to say how the acquisition of Company 3 by Canterbury may have affected the firm's internal organization, since the interview with Grant took place prior to this. According to CCMN (April 1999) it was unlikely that the takeover would lead to many changes in regional management and care home managers, and care home staff would be 'minimally affected'. However, an early move out of Company 3's head offices in Leicester Square to Surrey seemed likely.

## **DISCUSSION AND CONCLUSION**

Each of the three firms examined can be seen to have had different corporate histories and to have followed different strategies. Company 1 Care Home's strategy results from the decision of the British based Company 1 to expand (both in Britain and overseas) into areas of healthcare other than insurance. Company 2's strategy results from the decision of Company 2 (USA) to expand internationally, whilst retaining long term care as its core business. Company 3 has followed a strategy of aiming at the top end of the UK long term care market, alongside sustained diversification into other health related areas.

The three firms had different degrees of internationalization in different types of activity. Company 1 has expanded individual insurance abroad (often for British nationals) as well as expanding direct provision of services abroad. At the time of writing, Britain remained the only country where Company 1 had significant care home provision. Company 2 (USA) has pursued a strategy of extensive acquisition of care facilities abroad, and the replication to some extent of the strategy followed within its home market, where ancillary services are sold to (its and others') care homes. Company 3 had no direct provision abroad, although there was some indication that this may change under Canterbury's ownership. However, Company 3 has had substantial investment from the US throughout its existence, and has made significant international alliances, focused on real estate and retirement housing management. These international links, as well as the sheer size which goes with them, have allowed all the companies to benefit from increased resources (including information technology), expertise and buying power. There is also evidence that Company 3 and Company 2 have experienced a degree of 'cultural exchange' with their US partners, although Company 2's experience demonstrates that some US practices (such as restraint) are not appropriate to the UK. However, there may be drawbacks for these firms in terms of a relatively high level of bureaucracy, as identified by Company 1's Bob Jones.

Although very different in a number of respects, the international aspects of these firms' strategies can all be regarded as 'market seeking' rather than 'client following'

(see Chapter Two). This results from their delivery of services direct to the end 'consumer', rather than to other businesses (as, for example, financial service firms may do). If the intention is to provide services abroad, as in the cases of Company 1 and especially of Company 2 (USA), direct investment must be made. Furthermore, the strategy of each of the firms can be seen to have been influenced by their positioning in, and the nature of, their home markets. Company 1's strategy resulted from a need to expand into areas other than insurance, but was influenced by the dominance of the NHS in its most 'natural' alternative market of acute medical provision. Expansion has thus been into long term care in the UK, and into other countries where opportunities exist for private health provision. Company 2 (USA)'s strategy has been influenced both by the greater experience arising from the more developed and concentrated long term care market in the US, which it is therefore able to export, and from the restriction of state funding in that market. There is also some evidence that the perception of 'favourable... regulatory environments' abroad (Company 2 (USA)AR, 1996: 11) may have influenced the firm's strategy (regulation in the UK will be discussed in the next chapter). The fact that the UK shares a common language with the US would also have added to its attractiveness. Company 3 has responded to the NHS' dominance in health services in the UK by expanding into profitable specialist markets such as brain injury and drug and alcohol addiction, as well as taking advantage of the long term care sector's need for financing through sale and leaseback. Through this and its concentration on the higher quality section of the UK long term care market, it has actively sought out the most profitable areas of health provision.

Mohan (1991: 857) argues that the entry of US firms into the British healthcare market in the 1980s was facilitated by their ability to borrow on Wall Street (see Chapter Two). The evidence from this chapter suggests that this advantage may have diminished somewhat. The more developed healthcare market in the UK has meant that British firms are now in principle able to secure finance both in the US and in the City of London, and sale and leaseback has become a major source of finance. As indicated above, Company 3 was the first UK healthcare group to raise funds in the US financial market in 1996 (AR 1997: 18). Furthermore, on entering the long term care market, Company 1 would seem to have been significantly aided by its mutual status, in terms of being able to make strategic moves when it was ready without pressure

from shareholders. Company 2, on the other hand, which initially gained from the ability to raise capital guaranteed by Company 2 (USA), may be significantly affected by the financial problems of Company 2 (USA). These have resulted in part from Company 2 (USA)'s high level of borrowing in order to fund its expansion plans both at home and abroad. Company 2's experience thus illustrates the increased risks, as well as the potential advantages, of internationalization. This is underlined by the evidence that Company 2 (USA)'s problems have resulted in part from the actions of US state agencies, something which neither Company 2 nor the UK state has any control over.

All the firms had similar internally developed quality assurance systems, with varying degrees of scepticism about ISO 9002. These were developed for the specific needs of each of the three firms, and were therefore likely to be more effective than ISO 9002 or other 'off the shelf' systems. However, as with ISO 9002, these were all primarily organized around *process* considerations, despite some orientation towards outcomes. In Mintzberg's terms (1979), firms such as Company 1 and Company 2 (USA) which deliver services in more than one country must be organized into some kind of divisionalized form or hierarchical structure which regulates its various units on the basis of financial output, that is, profitability (see Chapter Two). Company 1, for example, was organized into five business units, with financial targets set from the centre, whilst Company 2 (USA)'s annual report (form 10k, 1998: 22 - see above) indicated that some of its UK facilities had, 'not achieved profitability targets established upon their acquisition'. However, the concern with control of the labour process noted here bears most resemblance to what Mintzberg (1979: 314) calls the 'machine bureaucracy', which functions with generally low skilled labour on Taylorist principles. This is mitigated by the role of qualified nurses, whose work is also regulated to some extent by the standardization of *skills*, that is, by professionalization. The employment of nurses in nursing homes is a regulatory requirement (see Chapter Five), and they usually play a supervisory role to care assistants, who predominate. Nevertheless, their work is strictly controlled by the firms' QA procedures. Furthermore, despite the commitment of the case study firms to training programs, care assistants are generally low skilled and low paid (see Chapter Six). In a context where managerial control is increasingly replacing professional control in public



services generally (see Chapter Two), any moves away from such process controls within large firms towards greater professionalization are likely to be extremely limited. Relationships between the firms and their workers are considered at the meso level of analysis in Chapter Six.

The acquisition processes undergone by Company 1 Care Homes and Company 2 would appear to have been quite similar, with similar effects in terms of the difficulties of cohering the newly created organizations. The importance of this is indicated by the fact that both Jones and Bartlett volunteered this information before being asked for it, in response to other questions (concerned, for example, with how their QA systems were organized). The idea of 'culture', discussed in Chapter two in relation to M&As, was clearly an important way in which both Jones and Bartlett themselves made sense of these difficulties; there was no automatic 'cultural fit' between the merged firms. The very process of drawing up Company 1's QA system had been affected by the need to take account of 'political' considerations arising from the merger process, whereas changes in work practices appear to have led Company 2 to lose significant numbers of staff. This is a valid finding, since the incentive of the firms would be to understate such disruption, although Bartlett in particular claimed that these problems had been remedied. Company 3 seems to have been less subject to merger problems due to its history of gradual acquisition, although Grant did indicate that it was 'never easy' to integrate acquired businesses.

Bob Jones of Company 1 was most forthcoming in acknowledging some tension between cost and quality which had to be managed in a realistic way. There is some evidence that this leads to some internal 'bargaining' over resources, particularly following merger, which would be expected. However, the firms tended to view quality as an important part of their strategies, seeing a reputation for high quality as a way of increasing occupancy, and therefore profits. Company 3, in particular, aimed at the higher quality end of the market.

There has thus been substantial internationalization in the UK long term care market. This has developed in a parallel process to that of the concentration within the sector: the two are in many ways inseparable, both in practical and analytical terms, reflecting

the trend towards greater internationalization in the wider world economy. The implications of these dual processes of concentration and internationalization for both the globalization debate and for long term care in the UK are discussed in the final chapter. First, however, the relationship of large and internationalized firms with the other actors must be examined. This is done in the following chapters.

## **CHAPTER FIVE: THE STATE AND REGULATION**

### **INTRODUCTION**

This chapter focuses on state regulation of private care providers. However, the chapter also includes some discussion of state purchasers, since these have an important influence on the market. The discussion of purchasing is primarily confined to the influence of purchasers on quality and on the overall shape of the market.

As discussed in Chapter Three, the data for this chapter was derived from analysis of relevant government and other documents, supplemented by interview material from those responsible for regulation and purchasing in the locality of Albion, and with relevant interview material from the case study firms' QA managers. The interviews were conducted subsequent to the publication of the 'Modernising Social Services' White Paper (DoH, 1998b), but prior to the publication of the Care Standards Bill (2000), both of which are discussed below. Albion was chosen for its high number of homes belonging to the case study firms, as detailed in Chapter Three, and could thus act as an exemplar for the issues discussed in this chapter.

The chapter, as with Chapters Six and Seven which follow, is organized so as to answer the research questions relating to the three aspects of the meso level of analysis set out in Chapter Three, and the reader should refer back to these. Therefore, Section One ('Attitudes, Perceptions and Goals') deals with the goals of state regulation as set out in law and related guidance, as well as the interpretations of these by the respondents from Albion. It also discusses their assessment of the shift to private provision, and their perceptions of and attitudes towards large and internationalized providers. Section Two ('Form and Extent of Organization') analyses the existing form and extent of state intervention in the sector, and the ways in which these are currently being altered. The section discusses primarily national issues of organization, including the continuing debate over consistency and standard setting, supplemented

with interview material illustrating how these issues relate to the locality of Albion. This section also discusses the international commitments of the British state as they affect the long term care sector. Section Three ('Firm Specific Aspects') draws on the experiences of the respondents from the local state agencies in Albion to illustrate the issues which may arise in direct relations between regulators and firms, as well as on the interviews with the firms' QA managers regarding their experiences of the regulatory process.

### **ATTITUDES, PERCEPTIONS AND GOALS**

Regulation in the British market for nursing and residential care is the responsibility of health authorities, who must register and inspect nursing homes, and of local authorities, who must register and inspect residential homes. The distinction between these two types of homes is widely regarded as being an artificial one which reflects the historical development of the system (Edwards & Kenny, 1997: 9). The Acts which governed the responsibilities of the authorities at the time of writing were the Registered Homes Act (1984) and the NHS and Community Care Act (1990).

The provisions of the Acts are reinforced by 'A Better Home Life - A Code of Good Practice for Residential and Nursing Home Care', published by the Centre for Policy on Ageing (CPA) in 1996. This had the status of guidance for inspectors, but exceeded what was generally regarded as the statutory minimum. This begins by stating that:

Underlying all the recommendations and requirements set out in this code is a conviction that those who live in continuing care should do so with dignity, that they should have the respect of those who support them, should live with no reduction of their rights as citizens and should be entitled to live as full and active a life as their physical and mental condition will allow..... It is the interests of residents, individually and collectively, that should assume priority over the home, its owners, management and staff. (CPA,1996: 7)

The basic principles underlying the rights of residents are listed as follows:

Respect for privacy and dignity,  
 Maintenance of self-esteem,  
 Fostering of independence,  
 Choice and control,  
 Recognition of diversity and individuality,  
 Expression of beliefs,  
 Safety,  
 Responsible risk-taking,  
 Citizens' rights,  
 Sustaining relationships with relatives and friends, and  
 Opportunities for leisure activities. (ibid: 8-11)

In addition, three further principles are stated as necessary to ensure high standards of care:

- i) Necessary care, i.e. care and treatment should be provided only if it will be positively beneficial;
- ii) Continuity of care, i.e. residents should not have to move out of the home to receive additional care;
- iii) Care which is open to scrutiny, i.e. residents (and their relatives or advocates) should be able to complain about the care they receive without fear of being victimised or being asked to leave (ibid: 11-12).

Individuals who are in care should, if they are able, have made their own informed decision to be there.

‘A Better Home Life’ makes clear that the regular testing of residents’ views about the quality of the service they receive should be part of the management process (CPA, 1996: 25). Care plans for individual residents are essential to ensure that each resident receives the individual care he or she requires. Residents (and their relatives where appropriate) should take a lead in saying how they would like to be looked after (ibid: 46). With the resident’s permission, the care plan may be used by inspectors as one means of checking on the quality of care provided in the home. Homeowners and managers should welcome suggestions for improving or adding to the life of the home, and there must (residential homes) and should (nursing homes) be a clearly established complaints procedure (ibid: 68). However, managers and staff should be particularly

alert to the general hesitancy of residents and relatives to complain for fear of recrimination.

‘A Better Home Life’ advises that inspectors should focus on quality of care and quality of life issues as much as on the fabric of the building (ibid: 126). Time should be devoted to asking residents and staff about standards of care provided. Courtesy, diplomacy and tact should be used when inspecting individual residents’ private rooms. The owner or manager must make it possible for inspectors to spend some time in private with individual residents. It should normally be possible for inspections to be conducted in a way which is seen to be constructive by managers and staff of the home. Recognition should be given to innovative and good care practice. Inspectors should give time to discuss and review with the owner or manager the objectives of the home and how the care of the residents can be enhanced.

Both Maria Smitham of East Albion Health Authority and Dianne Fenn of West Albion Health Authority explained in interview the goals of their respective registration and inspection units in relation to the requirements of the 1984 Act. The two units tended to share policies, procedures and forms, so there was a close similarity of goals. Smitham said her unit was, ‘seeking to achieve hopefully a consistent standard within the nursing homes throughout East Albion Health Authority... what we’re seeking to ensure is that the homes are maintaining what they are required to maintain in terms of the requirements not only of the Health Authority but also in terms of the regulations which are, if you like, underpin the Act’. Smitham also made the point that the 1984 Act ‘talks about adequacy’, but that it was ‘up to the Health Authority to define the standards of adequacy which is applicable within its own boundaries’. This is done by using the national criteria as ‘the basic kind of skeletal form that we inspect against and into that we have added other bits and pieces in terms of specific issues that we need to look at’. Smitham defined her unit’s broad goals in the following way:

our prime focus is the patient that's in bed in the home... all our efforts are geared to ensuring that that person has a good quality of life and that they have some choice about what is happening to them within the home.

The main job of the authority was to ensure that minimum standards were met, although Fenn said that West Albion was 'always looking to raise quality' as well as enforce minimum standards. Both Smitham and Fenn also pointed out that standards were always changing. As Smitham put it, 'The standard of adequacy moves over time and is moving upwards.' This upward shift in standards was 'not always greeted very nicely' by homes.

On the purchasing side, Gordon Saydon, the Strategic Commissioning manager at Albion County Council, said that Albion's strategy was driven by the goal of, 'supporting more older people and supporting more of them in their own environments where we can'. This goal had influenced the decision to transfer the vast bulk of the authority's own homes to the independent sector, discussed below. Adam Warden, Local Services Manager at the authority, emphasised that the strategy was about taking on board, 'the government's view generally about prevention and to make sure that the kind of services we're going for really do meet the potential that people have rather than just their actual situation at the present time.' This meant not assuming that people who go into residential or nursing care would necessarily stay there, but recognising that it might instead be a temporary solution. Both Saydon and Warden stressed the important of user choice in purchasing care places.

The rationale for the shift to private provision of long-term care services by Conservative governments was discussed in Chapter Two. As noted there, attitudes of local authorities towards the private sector in the early 1990s, 'reflected a relatively crude, knee jerk reaction against what was often seen as inappropriate commercialization of social care' (Wistow et al, 1996: 90). Saydon and Warden indicated that such attitudes have generally evolved as local and health authorities have realized that private provision is unlikely to be reversed, and that standards of care may be high among some private providers. This is reflected in the fact that Albion County Council's first major transfer of homes to the independent sector (discussed below under 'Firm Specific Aspects') stipulated a 'not-for-profit solution', whereas its second such transfer did not. Gordon Saydon accounted for the shift in the following terms:

We started at the position where nobody wanted to transfer the homes and members [of the Council] in particular were very proud of local authority services... and that was strongly supported by the public consultation. Everybody said how good the homes were, how good the staff groups were, the quality was good, and they were naturally fearful of change but they were fearful that things would take a turn for the worse. The not-for-profit ethos was the one that fitted most closely with the public sector ethos, because we don't do it for profit, and that was why we went for that solution. I think we've moved forward. We're, five and a half coming up six years into community care where we've used a lot of private sector providers some of whom are very good quality, so there's less suspicion than there was from the people who are wanting to have services arranged by us... There is still some resistance, but not as much as there was and so I think that's the reasons for this time. The members are mostly concerned that we get a good quality solution at a price we can afford ...

Saydon thought that both voluntary and for-profit providers were 'concerned with quality because their reputation is at stake'. This evolution of attitudes is also reflected in the views of Smitham and Fenn, such as Smitham's comment that, 'most of our owners within East Albion are pretty good and they do endeavour to meet the standards all of the time'. The biggest problems came, according to Smitham, when homes complained that changes demanded by the inspectors were 'non-viable financially'.

Saydon and Warden were both aware in general terms of the existence of large and internationalized organizations, with Warden for example regularly reading 'Community Care Market News' (CCMN), but neither had a great deal of knowledge of the operation of the case study firms in their area, since in Albion these tended to concentrate on self-pay clients, as discussed below. Both Smitham and Fenn were aware of the existence of large and internationalized firms, and had substantial experience of dealing with the case study firms in their work (as discussed in the section on 'Firm Specific Aspects'). In terms of the international links of such



companies, Smitham said she was aware of 'some of them'. Fenn said that she was aware of them, and that it had caused some problems:

Oh yes, it's very ... that is a problem because the names are constantly changing. It does cause a lot of confusion because you think well is this a new company or you know what does it actually mean, and then you get told 'oh no we're not a new company it's just the same as before, we've just been taken over by ... but the part ... you know as far as you're concerned we're the same.' Well you know that sets you thinking and you really have to spend a lot of time checking out that it really is the same company.

Smitham did not think large and internationalized firms had any particular significance to the way she did her job:

I think in terms of some of the companies who have links with overseas personnel, if I can put it like that, I don't think that they are any more difficult to deal with than anybody else, if I'm honest. Some are slightly more difficult, but it depends on how they are driven, you know, if they're driven by a company who looks at the bottom line all of the time then that actually is slightly more difficult, but by the same token most of the larger companies understand the issues around quality and they know that if they don't deliver quality they're not going to have people coming into their homes. At least I hope that's how it works!..... I mean I think that most large operators, and we have a few in this area, actually do listen to what you have to say. They may not always agree with you, with what you're trying to spell out but they do listen and if they understand that it is about improving the situation they will endeavour to do something about it. Particularly if you can demonstrate that what they're doing is actually having a detrimental affect on the people who live in the home and that's how you ... I mean I think that's how most reasonable people would respond.

Fenn, however, had more reservations:

I understand that you must ... or large companies are managed on the lines ... on business lines but I think sometimes you need to separate out the business that you're running. You can't automatically assume that you run a factory for motorbikes in the same way as you run a nursing home, there are differences and the basic principles for management, you know, that you get people like John Jones going on about, should be the same, but I think you've got to acknowledge that there has to be some local differences because you're dealing with a local population and people who need care.

Gordon Saydon, Strategic Commissioning Manager for Albion County Council said that, 'in terms of overall awareness of current policies, how to develop strategies, how to develop quality assurance programmes, my view is the larger providers are just far superior because of the sheer size of their organization.' These remarks, however, were concerned with large independent providers generally, not necessarily for-profit or internationalized ones. Saydon also said that where a decision was being taken in relation to 'a large contract with an organization', its overall reputation would influence the outcome, 'particularly depending on what referees might say about them'. The large scale contracting out of homes by Albion had involved all bidders being asked, 'to supply a minimum of two referees that we can follow up to check on things like quality of services.' These referees consisted of, 'Other authorities who they are doing business with.' When asked about how awareness that a parent company had financial problems might affect a bid, Saydon said that they would 'think very carefully', although he did point out that the authority had sometimes made individual placements into homes that were run by receivers.

Warden thought that the 'branding' of private providers was 'quite weak'. Whilst he acknowledged the existence of the Company 1 brand, he questioned whether there were any others. However, he did think that where branding occurred it would affect user choice: 'It certainly would affect user choice wouldn't it, you know, if users could feel confident in a brand. If people are worried about health aspects and that brand is associated with good health care it would perhaps be a reflection of user choice.' Warden was aware of 'the American experience' of consolidation and was concerned that if this was repeated in the UK it might damage choice: 'the whole point of setting

up the market was to create a diversification of supplier and yet it consolidates into, like it has in America, several market areas, into a few national players. We will end up with less choice for users than we had before.’ This issue is returned to in the concluding chapter.

The experiences of Smitham, Fenn and Saydon in dealing with the case study companies will be discussed in the section on ‘Firm-Specific Aspects’. Their perceptions of, and attitudes towards, quality and regulatory issues will be discussed in the next section in relation to the organizational changes proposed by the White Paper ‘Modernising Social Services’ (DoH, 1998b) and the new National Required Standards (NRS) for social care.

### **FORM AND EXTENT OF ORGANIZATION**

This section begins with a discussion of the ‘form and extent of internationalization’ of the British state in relation to the long term care sector, before moving on to discuss the form and extent of domestic state intervention (see research questions in Chapter Three). The section begins with a discussion of the terms of entry of foreign care firms into the British market, since this will be the first ‘contact’ that a foreign firm makes with British state institutions. In terms of the case study firms, this would most obviously affect Company 2 / Company 2 (USA), although Company 3 has also received US investment. As discussed in Chapter Two, there are potentially a wide range of discriminatory regulations which may affect the entry of foreign service firms into a market, although these are more often employed by developing countries than by economically advanced ones (Enderwick, 1989b: 220). However, Julia Owen from the Invest in Britain Bureau was not aware of any regulatory barriers to entry for foreign firms in this market. Neither are there any restrictions imposed by the British state on its home firms’ operations abroad.

Like other states, Britain’s international economic links are mediated by a series of supranational institutions, although there is not a coherent international regime governing FDI and MNCs (as there is with the WTO for trade, for example). The

primary mechanisms for governing international investment are bilateral investment agreements, of which there were 1,523 in 1998 (Held et al, 1999: 258). The Organization for Economic Cooperation and Development's (OECD) attempt to set up a Multilateral Agreement on Investment (MAI), which would have eliminated virtually all controls on FDI, was postponed indefinitely in 1998 following vocal opposition from various political and voluntary groups and disagreements between governments (for a critique of the MAI see Davis & Bishop, 1998/99). However, membership of the OECD continues to require governments to abide by explicit codes and standards which involve according 'national treatment' to international investors and enacting 'transparent, liberal and stable foreign investment rules' (Held et al, 1999: 258). 'National treatment' means that there are no regulatory barriers to entry by foreign firms, and once here they must be treated in exactly the same way as domestic firms are treated (Hoekman & Primo Braga, 1997: 302).

It is possible that the MAI agenda will be revived within the World Trade Organization (WTO) at some future date. The WTO also administers the General Agreement on Trade in Services (GATS), which was agreed at the Uruguay Round of negotiations (Hoekman & Primo Braga, 1997: 302). This operates on the basis of general principals such as national treatment for foreign operators and 'most favoured nation' (MFN) treatment (i.e. all foreign firms must be treated alike), as well as on the basis of specific negotiated obligations which countries have to opt into or 'schedule'. Analysis shows that most countries in practice only committed themselves to limited specific obligations, and 'continue to maintain numerous measures that violate national treatment' (Hoekman & Primo Braga, 1997: 302). However, the WTO has continued to promote the cause of services liberalization, with potentially far-reaching implications for health and social services. The WTO is clear that reforms in health services should be, 'whenever possible, market-based' (WTO, 1998: para. 34). One paper notes that, 'new forms of private sector involvement have opened breaches for increased domestic *and* foreign participation' in health services (ibid: para 9, emphasis in original).

As a member of the European Union, the British government is also bound by the European Public Procurement Directive (EPPD) (EU, 1992), which seeks to increase

cross-border competition between providers of public services within the single market. The EPPD stipulates that governments should not discriminate against foreign providers and that no ‘non-commercial’ considerations should be used when procuring public services. The EPPD is discussed further in Chapter Six.

The British state therefore has significant involvement in international agreements and supranational institutions. As is most often the case with such agreements today, these tend to commit governments to liberalizing measures rather than imposing supranational regulation upon *firms*. The EU does, however, affect the regulation of firms through directives aimed at protecting working conditions. An example of this is the Working Time Directive (EU, 1993), which is discussed in Chapter Six.

There are therefore significant institutional constraints on the policies of the British government. However, the attitude of British governments in the post-war period has been an extremely liberal one in relation to FDI generally (Held et al, 1999: 257), and insofar as it is privately provided, healthcare has been no exception. As Chapter Two showed, foreign (mainly US) healthcare firms have been active in the British market since the 1970s. Firms are thus routinely accorded ‘national treatment’. The supranational agreements discussed above do not, therefore, conflict with the approach of British governments, but rather have been voluntarily entered into in accordance with their worldview. Indeed, as its name suggests, the purpose of the Invest in Britain Bureau is to encourage foreign firms to invest in Britain and to provide assistance for them to do so (IBB, 1998), although Julia Owen said that IBB dealt mainly with high-tech firms who were seen as bringing particular benefits into the country

According to Enderwick (1989b: 219), many arguments made in favour of restrictions on trade or investment in services confuse this with the need for some form of domestic regulation to safeguard standards: ‘What is required is “appropriate regulation” to maintain the standard of services offered on the market irrespective of where such services are produced.’ This is clearly the approach taken by the British government in the long term care market. As indicated above, ‘appropriate regulation’ in this market is fragmented between health authorities and local authorities. The respective authorities must ensure that the purposes and aims of establishments are

clearly set out and that the standards of care they offer match these aims and objectives (CPA,1996: 123). Each authority has its own registration and inspection unit, which comes under the auspices of the authority rather than any national body. There is thus currently no real national, let alone international organization, although the national government decides on the 'shape' of the regulatory framework, and individual local authorities are inspected and audited by the Social Services Inspectorate and the Audit Commission.

The primary legislation relating to care homes is the Registered Homes Act (1984), which requires all providers of nursing homes and of residential care homes in the private and voluntary sectors to be registered. Residents must not be admitted until a certificate of registration is issued. Registration authorities must ensure that all prospective managers / owners of homes possess some relevant qualifications or have some proven experience of employment within residential care. An owner can apply for dual registration as a residential and nursing home, and must satisfy both relevant authorities to do so. Once the initial certificate of registration has been issued, owners should notify the authority of any intended change of ownership - registrations are not automatically transferred to new owners or managers. In extreme circumstances, the authority may cancel the registration of a home, in which case the registered person may appeal.

Residential homes are inspected by the local authority whilst nursing homes are inspected by the district health authority. All registered homes and (since 1991) local authority homes must be inspected twice a year, although authorities may choose to visit more often (CPA,1996: 125). At least one visit should be unannounced. Where an owner or company owns several homes, the authority may make such a visit to satisfy itself that the homes' managers are receiving adequate supervision and support. Inspections will vary in content, focus and length of time depending on any outstanding issues identified on previous inspections. Following initial registration, an inspection should be made within the first three months of the home becoming established, or when a new manager of a home has been appointed. In the case of dual registration, joint inspections may take place, and there has been a growth in the numbers of joint inspection units in recent years. The authority should ensure that a report of the

inspection is sent to the owner and the manager, drawing attention to any specific points of consultation and specifying any variation in the registration requirements. Both East and West Albion Health Authorities managed to carry out their two statutory inspections a year, plus two medication or pharmacy inspections. Smitham also mentioned nutrition inspections which were done once a year.

Where inspectors come across a problem in a home, the first step is usually to issue a recommendation concerning necessary changes, and provide a timescale within which such changes must be made. The setting of appropriate timescales require inspectors to use their judgement, and are the outcome of negotiation between the inspector and the home manager. Both Smitham and Fenn emphasised the need for inspectors to be 'reasonable' in such negotiations. Where a recommendation is ignored, or the problem to be rectified is more serious, requirements are issued. These have the force of law, and can result in court action leading ultimately to the closure of the home. Both Smitham and Fenn regarded such action as unusual, with Fenn describing it as 'really rather drastic'.

There was some difference in emphasis between Smitham and Fenn concerning how effective they thought these powers were. Smitham was clear that she thought they were adequate, emphasising the possibility of going for 'urgent closure'. Fenn, however, thought the procedures for closure were 'very laborious really'. This was because an owner could appeal against an enforcement notice, and 'remain in operation until the outcome of the appeal'. The paperwork attached to such action was also seen as problematic by Fenn because it was time consuming: 'I know that all units around the country are relatively under-resourced, and its fine as long as you're getting on with the routine work. Once you come into a problem, such as a potential closure or even serving a notice or investigating complaints, then that detracts from your usual routine inspections for nursing homes.' Smitham, however, thought that: 'The Act gives you a lot of power if its used correctly... I mean you have sufficient powers to ruin somebody's business... that is a lot of power so one needs to use it very wisely in my opinion.' This applied to large companies as well as small ones, since if a home was closed and the inspectors could 'reflect that back to fitness then you would be talking about not allowing the company to continue'. It is obvious that serious action against a

home belonging to a large company would also damage its brand image. Smitham thought that it was ‘improbable that it would get to that stage with a large company.’ Smitham had only been involved in one case where a home had closed as a result of court action, and this was a small business.

The fragmentation of regulatory responsibilities between different locally-based authorities gives rise to the potential for inconsistency between them in the inspection and enforcement of standards. This will be discussed in the next section in relation to the experiences of particular firms. The Burgner Report on ‘The Regulation and Inspection of Social Services’ (Burgner, 1996, 45; 4.4.19) identified this as a problem, stating that: ‘There is a strong case for greater central guidance on standards while preserving necessary flexibility locally.’ According to the report, the ‘great majority’ of provider groups, whether private sector or charitable, favour a shift towards national standard setting (ibid: 40; 4.4.1). There was great concern about a perception of lack of even-handedness, resulting from regulation being the responsibility of local authorities - who also have responsibility for providing and purchasing services (ibid: 46; 4.5.1). The report also argued that, ‘some of the problems associated with dual registration - dual inspection and the accompanying bureaucracy and time wasting - could be considerably alleviated if there was more joint working between local authorities and health authorities.’ (ibid: 67; 4.9.8)

Fenn acknowledged the problems such fragmentation might cause for large firms with homes spread across the country, since ‘lots of the requirements of the Act are interpreted in different ways throughout the country’. Smitham on the other hand, whilst acknowledging the existence of some variation between authorities, thought that this was somewhat exaggerated, and had been ‘...used by companies, or by private individuals, to make a point’. The two Albion inspection units were able to overcome the problems of fragmentation to a certain extent by meeting on a regional basis with other units. These meetings took place on a quarterly basis, and were intended to prefigure the new regional commissions which would be set up as a result of the government’s Modernising Social Services initiative (discussed below). These regional meetings allowed units to share information and ideas, although Fenn said that it was:



very difficult at the moment because we don't know what it's going to look like! You know, and we think it's going to be one way, somebody knows it's going to be another way and ... but I mean we feel that we have to network at least so that we're all informed in the same way, and we share what we have now in terms of our inspection forms and the material that we use.

Contacts with units outside the region took place through the hierarchy of the regional groups, which met together nationally, or through direct telephone contact. The regional meetings, and the national meetings of regional representatives, did not formally consider issues relating to the monitoring of companies' quality of delivery across the boundaries of health authorities, but Fenn thought it might be a good idea:

... there are plenty of moans and groans and it would be good if someone would take the initiative to ... you know ... I find it quite irritating sometimes when people, they have a lot of bad things to say about a particular group and everybody jumps on the bandwagon about it, if you like. But it's not ... I don't think you can generalize like that... One of the homes is reasonable, we don't have so many problems with it, and the other one isn't... they're local issues really, but it would be interesting if ... it would be an interesting piece of research for someone to do perhaps, to look at these standards throughout the company.

There was some difference in practice between Fenn and Smitham in terms of direct contact with other units by telephone. According to Smitham:

... there are occasions when people have said to us, 'well they don't do that up in so and so'. So we say 'well fine, I hear what you're saying to me but I will need to check this out.' So then all you do is make a telephone call and say you know 'I was told by blah blah blah, what is the situation?' And then they will tell you exactly what's happened so you've then got a much firmer base on which to operate, and it also means some consistency of approach in terms of how people are dealing with things.

Fenn, on the other hand, said she would not take this kind of action.

The New Labour government's initial response to the problems of fragmentation in the regulation of long-term care was the 'Modernising Social Services' White Paper (DoH, 1998b). This acknowledged three principal problems in the current system: the lack of independence arising from local and health authorities combining purchasing, providing and regulatory functions; the lack of coherence arising from the split between health and social services; and the lack of consistency arising from the large number of different authorities across the country imposing varying standards. The paper proposed setting up eight regional Commissions for Care Standards in England, which would bring regulation of all residential, nursing home and domiciliary care for both adults and children under their authority, and which would work to new national standards. The management boards of these Commissions would include representatives from local authorities and health authorities, plus user and provider representatives. The Chairs would be appointed by the Secretary of State (DoH, 1998b: 4.12). There would be recourse to an Ombudsman for complaints against a Commission's exercise of its duties, and rights of appeal against deregistration to a Registered Care Tribunal (ibid: 4.14). Although there would be provision for central funding to the Commissions, they would be expected to be self-financing through fee income paid by regulated providers. Fee levels would be set by central government. This is important, since the level of these fees could possibly exacerbate the financial squeeze on smaller providers discussed in this section.

Each Commission would decide how its workforce should best be deployed, for example, whether it should use area offices or teams. The workforce would 'consist of people with skills and qualifications from both social care and health care, including nurses.' (ibid: 4.16) Work would be done, 'on developing more uniform methodologies for registration, inspection and enforcement, so that there is greater consistency of practice than at present.' (ibid: 4.18) Providers would be registered if they met the required criteria and standards.

The White Paper states that: 'Arrangements will be made to ensure that there is no unnecessary duplication, for example when several branches of the same organization

are to be registered', but fails to elaborate upon this. However, it does state that: 'The Government believes that greater use could be made of risk assessment procedures in order to ensure that greater attention is paid to providers where risks to users appear to be greater.'(ibid: 4.54) This would mean that providers would be assessed in relation to various factors, 'including past history, previous concerns or complaints, and other matters.' Other QA mechanisms, such as independent accreditation schemes, 'could also be taken into account in determining the level of attention paid to a particular provider.' The internal QA mechanisms used by large firms are not mentioned in the White Paper. This has important implications for those firms in terms of the way they might relate to the new Commissions, given that their primary QA systems were developed internally, with independent schemes such as ISO 9002 generally being marginal. However, although details are not given in the Paper, it clearly leaves room for a more flexible relationship between large providers and regulators, especially where the provider has established a good 'track record' in terms of its quality of care. Nevertheless, the White Paper makes it clear that all care home providers would continue to have a minimum frequency of inspections of two per year.

The White Paper also acknowledged the difficulties which may arise from the administrative distinction between residential and nursing care, and the need for homes to register with two authorities (with perhaps different standards and procedures) if a resident was to remain in the same home once they required a greater level of care. The Paper proposed to tackle this through encouraging the development of homes designed to cater for a wide range of needs, which under the new system would need only to register with one Commission. Other attempts to reduce the separation between health and social services included the discussion document 'Partnership in Action' (DoH, 1998c), which outlined provisions for pooled budgets between Health Authorities and Social Services Departments, lead commissioning where one authority may transfer funds and functions to the other, and more integrated provision. These principles have been applied to older people through the Better Government for Older People initiative, in which 28 local pilots are developing and testing various inter-agency strategies (ibid: 11). The government's response to the Royal Commission on Long Term Care (RCLTC) (NHS Plan, 2000), discussed below, extended provisions

for the joint working, and possible merger, of health and social services for adults still further.

'Modernising Social Services' (DoH, 1998b) also proposed the setting up of a new Long-term Care Charter to set out at a national level what users and carers could expect from health, housing and social services. A General Social Care Council would set practice and ethical standards for staff. Further work was to be undertaken concerning the 'confusion and variation' in complaints procedures highlighted by the Office of Fair Trading inquiry into care homes (ibid: 4.56. See OFT, 1998).

The first step in turning the proposals into law was the publication by the government of the Care Standards Bill (2000). The most significant change to the original proposals included in the Bill was to set up a single National Care Standards Commission (NCSC) for England rather than eight regional commissions. This was expected to take over responsibility for regulation by April 2002. In Wales the regulatory function was to be carried out by a new arm of the National Assembly for Wales. The Bill also contained provisions for regulating private and voluntary hospitals and clinics, to be carried out by the NCSC through a separate division for healthcare regulation. In announcing publication of the Bill, Secretary of State for Health Alan Milburn said that, as recommended by the RCLTC, the NCSC would advise the government on trends in social care and monitor both the quality and availability of provision. The Care Standards Bill would replace the Registered Homes Act (1984), which would be repealed in its entirety. This Bill had not been published at the time the interviews for this thesis took place, so that the interviewees responded to questions on these issues based on the proposals in the White Paper, including that for regional commissions to be set up. However, questions concerning regulation did cover the possibility of a national regulatory body.

The original White Paper (DoH, 1998b: 4.46) acknowledged the inconsistency which may arise from the fragmentation of responsibility between authorities, and from the relative lack of guidance offered by the Registered Homes Act (1984) and its regulations. This was to be dealt with through reducing the number of authorities from 250 to eight (later a national commission for England, as detailed above), and through

the development of national regulatory standards. The tension between 'national prescription and local discretion' would be overcome by the development of, 'a limited range of standards to apply at a national level, with a certain degree of flexibility allowed more locally.' (ibid: 4.48) These standards would focus on, 'the key areas that most affect the quality of life experienced by service users, as well as physical standards.' They would need 'to have regard to costs and effectiveness when they are being developed.' Overall, standards would be set at three 'levels':

- 1) those set firmly in legislation, which would be non-negotiable (e.g., that the person in charge of a nursing home must be a registered nurse or medical practitioner);
- 2) those spelled out at national level (e.g., required procedures for the proper selection and vetting of staff);
- 3) those allowing for interpretation by the Commissions (e.g., timescales within which specific below-standard accommodation must be upgraded).

The White Paper stated that the standards for all the various services would be developed through a consultative process. The first step in this was the commissioning of the Centre for Policy on Ageing (CPA) by the Department of Health (DoH) and the Welsh Office in February 1998 to advise on proposed national standards for the largest group of services - residential and nursing home care for older people. The outcome of this was to be the subject of consultation, and would provide a basis for developing standards in other areas. The CPA set up a 31-strong advisory panel including representatives of regulators and provider associations to draw up the standards, as well as conducting a survey of care homes and consulting with a total of 989 individuals or organizations (CCMN, February 1999). The standards were submitted early in 1999, and were published in August of that year under the title, 'Fit for the Future?' (DoH, 1999b). They concentrated on input and process measures, but with the outcomes expected from these clearly stated in each case, and with the evidence that would be required to demonstrate compliance with them often stated as 'discussion with residents'.

The physical and staffing standards have been the source of much controversy. The physical standards included proposals that all residents should have the choice of a single room; that shared rooms in existing homes should account for no more than

20% of overall resident places; that single rooms currently in use should be at least 10m<sup>2</sup> in size; and that new conversions should contain rooms sized 12m<sup>2</sup> minimum with additional space for en suite facilities. The standards set out minimum requirements for staff ratios and training levels, including that one third of nursing home care staff should be registered nurses. Provider associations such as the National Care Homes Association (NCHA) and the Registered Nursing Homes Association (RNHA) argued that the proposals had not been properly costed, and would force many operators out of business (CCMN, February 1999). Sheila Scott, chief executive of the NCHA, which represents smaller owners, resigned from the CPA advisory panel in January 1999 over this issue (CCMN, Dec/Jan 1998/99).

According to CCMN (February 1999), the proposal that no more than 20% of places in any given home should be shared would be particularly damaging to some sections of the industry. Large numbers of small converted homes, owned primarily by small businesses, would be unable to meet these standards. The DoH itself (DoH, 1999, regulatory impact statement, 2.8) estimated that 20-23% of independent sector residential homes, 12% of nursing homes, and 55% of local authority homes would not meet the space and amenity standards, whilst 54-56% of nursing homes would not meet the staffing standards. L&B's analysis suggested that even these figures may be somewhat optimistic (CCMN, August/September 1999). The full extent of the impact would depend on the time scale for their implementation. According to L&B (1999-2000: 174), a period of perhaps 10 years would, 'allow non-compliant care homes to exit the market gradually with the minimum of disruption.' According to CCMN (October 1999), 'No other major European country' requires a skill mix of one third registered nurses.

Whilst the CPA acknowledged arguments from those representing small businesses that some residents prefer to share places for reasons of companionship, it concluded that this is all too often used as an excuse to retain shared accommodation for purely economic reasons. As well as leading to the closure of many small homes, the standards are likely to lead to local authorities continuing to withdraw from provision, since many of their homes would be non-compliant, but subject to regulation for the first time (L&B, 1999-2000: 174; Jones, 1999: 2). On the other hand, CCMN

(February 1999) argued that providers of new build and other homes which did meet the standard would welcome it, 'in private at least', because of its likely significant effect in cutting excess capacity. L&B (1999-2000: 174) thought that the closure of small homes would lead to new investment in 'made to measure' facilities, which could best be made by larger providers. If the standards do encourage a wave of new build, this is likely to result in larger homes which are able to take advantage of economies of scale in provision. The implications of this are discussed in the final chapter of this thesis.

According to L&B (1999-2000: 174):

A possibly unintended effect of the proposed National Required Standards will be to favour corporate over independent [small] providers. Corporate portfolios are less likely to be out of compliance with the new physical standards on Day 1 of the new system. The new standards will reinforce the competitive advantage of larger homes, where corporate investment is focused. Moreover, the new standards as drafted by CPA place a heavy emphasis on both procedures and training, which well managed groups will be much better placed to comply with than owner managed homes.

The standards are therefore likely to encourage greater concentration within the industry. According to CCMN (July 1999): 'Despite the currently depressed state of the sector... there remain opportunities for investors in the nursing and residential home sector. These opportunities will be all the greater if the proposed National Required Standards do in fact precipitate an industry shake-out.' CCMN (August/September 1999) predicted that closures would accelerate, possibly leading to a sudden shortage of supply if the transition period was too short. However, this could lead to 'a shift in the balance of power between providers and purchasers, in favour of providers', which in turn could push up fee rates. It was unlikely that any standards would be introduced before April 2002 (DoH, 1999, 2.14).

Fenn and Smitham had differing attitudes to the proposed changes. Fenn was clear that both the regional commissions and the national standards would be an improvement:

Well I think it can only be better, ultimately for the patients or residents, whatever you like ... because its aim is to improve the lives, the quality of life for residents and it can only be better for all potential proprietors really, if they're not having to cope with different standards on a national basis and they're not having to cope with two organisations, like health authority inspectors and social services inspectors, so it's got to be better.

As far as the regional commissions were concerned, however, Smitham couldn't 'see anything startling in it'. She was most interested in how the changes would affect the regulation of private hospitals: 'I mean the rest is like your life, it changes, you know your job changes from time to time, the people you report to change from time to time, and as long as it's about improving standards as you go along, does it really matter who you're working for?' Smitham did think, therefore, that the new standards were 'absolutely' a step forward.

Whilst this thesis is primarily concerned with regulatory issues as the most direct way in which state agencies affect the quality of care, purchasing related issues also have some impact on it. Despite its continuing growth, the corporate sector in the community care market is still relatively undeveloped when compared to other sectors of the economy, and accounts for a minority of overall provision across the country (see Chapter Two). However, elderly care markets are highly localized, giving rise to the possibility of local monopolies or near-monopolies. Nevertheless, the same pattern of fragmentation amongst providers appears in almost every locality, i.e. no one firm currently dominates any particular local market. According to L&B (1997: A189):

Outside small and isolated communities there is no area in the UK where supply side concentration begins to match the concentration of purchasing power in the hands of local authorities, which now account for about 75 per cent of all new care home placements.



It is possible, however, that this may change if smaller providers are forced out of the market. One factor influencing such concentration of provision is the operation of purchasing agencies themselves, and in particular the level of fees paid by local authorities.

Research published by the Joseph Rowntree Foundation (Laing, 1998) claims that there are frequent disparities between the fees paid by state agencies and the true cost of long term care. It is estimated that a total of £80m a year is spent on bridging the gap between care home fees and the amount that state agencies are willing to pay. The research, published in June 1998, suggests that at that time around £350 per week for nursing home care at 1997/98 cost levels offered a reasonable return to an efficient provider of good quality amenities and care. However, this was £40 above the Department of Social Security (DSS) rate, and was more than most local authorities were prepared to pay. The NHS funded about 15,000 residents - fees paid by them were typically more generous than those paid by local authorities, so the issue of disparities between fees and actual costs rarely arose in relation to them. Only half the 95,000 residents receiving DSS preserved rights payments were having their fees covered in full. The research also identified hidden disparities where the full fees met by local authorities or the DSS were being cross-subsidized from other sources. This included voluntary sector homes with access to their own charitable funds, but also for-profit homes where self-paying residents were being charged more than publicly supported residents for identical accommodation and care. It was calculated that for every £5 a week that local authorities were able to save per head, there would be a saving for the state of £75m a year - a bill that would pass to individuals, their families and other agencies.

The research also showed that local authority funded residents often received better quality accommodation than DSS preserved rights clients (CCMN, June 1998). As near-monopoly (monopsony) purchasers of care, local authorities were able to secure higher-grade rooms for their clients. A sample survey of 600 care homes found that 31% of local authority funded residents were occupying a single room with en suite bathrooms, compared with only 11% of preserved rights clients. The report concluded

by calling for the transfer of responsibility for preserved rights clients to local authority purchasers to end such inequalities, a proposal adopted by the government in its response to the RCLTC (NHS Plan, 2000). The report also recommended that local authorities should seek more proactively to encourage investment on good quality, efficient provision and to drive out low quality providers. The report called on local authorities to set differential baseline fee rates according to the type of investment they wish to encourage, building on the practice of a small number of local authorities which currently pay premiums to care homes which meet defined quality criteria.

According to William Laing, the figures on local authority fee rates:

help to explain why the profits record of larger, publicly quoted care home companies supplying the state funded market has been disappointing in recent years, and why share values have performed poorly. It also explains why new-build nursing home development among corporate, for-profit providers has markedly slowed down. There are now few locations in the country where expected returns are sufficient to justify commercial investment in good quality, new nursing home stock for a clientele dependent entirely on state funding. (quoted in CCMN, June 1998)

CCMN's survey of local authority baseline fee rates (CCMN, June 1999) showed that fees would continue to fall behind true costs for the year 1999/2000. Whilst increases were broadly in line with those of previous years, they took no account of the additional costs faced by providers, such as the National Minimum Wage, the Working Time Directive and increasing difficulties in the recruitment of qualified nurses (see Chapter Six for a fuller discussion of these). However, some relief to wage cost pressure would result from the introduction of new employers' National Insurance rates in 2001/2002. Whilst generally too low to cover costs, the survey revealed great diversity in fee rates in different parts of the country, reflecting higher costs in areas such as the South East. CCMN (ibid) also suggested providers in some areas may be in a slightly stronger position in negotiating with purchasers, due to a lower availability of beds. At least three local authorities were paying different rates in different parts of their respective counties, reflecting the higher costs of providers in some areas. Care

home owners had also expressed anger at the November 1998 increases in income support rates for care home residents with preserved rights, which were also widely regarded as being too low to cover costs.

On the whole then, state purchasers were able to use their near-monopsony position as an effective means of holding down fee rates. Whilst limitations in state funding for care places affects all providers, whatever their size, it is likely to further increase the tendency for restructuring and consolidation in the sector, ultimately favouring the larger, more efficient, providers.

The overall issue of how long-term care costs should be paid for in the future, given demographic trends which are likely to raise the ratio of people in need of such care, was reported on by the Royal Commission on Long Term Care (RCLTC, 1999). The main proposal of the report was that personal care should be separated from living and housing costs and available, after assessment, according to need and paid for from general taxation. The report also proposed the setting up of a National Care Commission which would have a wide remit. Although not concerned with day to day regulation of care homes, this would have 'a strategic overview of the whole business for delivering long-term care for older people', including the taking of 'an overall independent view on national quality standards' as well as monitoring resource and demographic issues, and keeping 'under review the market in residential care' (RCLTC, 1999, Chapter 7). As discussed above, the government decided that insofar as such a function was necessary, it would be allocated to the NCSC.

The Commission received evidence that in the previous 10 to 15 years the independent sector had invested between £10 - £12bn into the sector, much of which, of course, had been provided by fees paid by the public sector (RCLTC, 1999: 7.6). The erosion of profitability in recent years had meant that providers claimed they could not achieve an adequate return on their investment. The effect of this was thought to be twofold: in the short term many providers may cut standards; in the long term there was a danger that the independent sector would not be willing to provide the extra capacity that would be required by demographic trends (RCLTC, 1999: 7.9) The proposed National Care Commission should thus have 'as one of its major functions,

the responsibility to look at the market, including the supply of capital in the long term and the high quality provision which will be needed as demand grows.’(RCLTC, 1999: 7.12)

The government’s initial response to the Commission (DoH press release 1999/0117, 1.3.99), which indicated a less than full acceptance of its recommendations, caused disappointment among organizations of and for older people, (Dunning, 1999). The full response, published at the end of July 2000 (NHS Plan, 2000), rejected the main recommendation that personal care as well as nursing care should be free to all. Nursing care only, defined as any task undertaken by a qualified nurse, would be free, whilst personal care would continue to be subject to means testing. Whilst the unconditional state funding of nursing care may alleviate some of the financial problems of private providers, it is likely to disproportionately benefit large providers, since these tend to provide more nursing than residential care. Ultimately, however, the funding problems affecting providers depend as much on the overall level of resources made available to state purchasers as they do on the principles of who pays. The government did, however, in its response to the Commission commit significant amounts of money to funding ‘intermediate’ care, with the aim of increasing the independence of older people and reducing their dependence on long term care. To the extent that this is successful, it may lead to occupancy in the sector falling still further, increasing still more the financial pressure on providers.

The relationship between quality and purchasing is a complex one, especially given the restricted budgets of local authorities. In principle, the purchasing power held by local authorities should give them a strong bargaining position to push up the quality of care provided. However, since registration and inspection units must remain at arms length from the purchasing function, their role is usually confined to providing purchasers with information about whether a home has met the minimum registration standards. This means purchasers must commit resources of their own to gathering information about quality. Unsurprisingly, budget restrictions are often thought to produce an emphasis on purchasing low cost care within minimum quality requirements, rather than an emphasis on improving the overall quality of care.

CCMN (June 1999) found that a minority of local authorities did have some mechanism for trying to improve quality. Eleven local authorities were found to have schemes for making additional payments for homes meeting quality criteria, or for decreasing payments for those that do not. A further 24 local authorities indicated that they made additional payments for single rooms and/or en suite facilities, or reductions for shared rooms. Other local authorities had set minimum standards for all homes wishing to receive placements which were equivalent to the criteria applied for quality premiums. Typically such requirements are based on recruitment and selection procedures, training, quality assurance and in some cases minimum room sizes. These authorities did not make additional payments, but their set fee rates tended to be higher than the basic rates paid by local authorities which paid quality premiums.

Both Adam Warden and Gordon Saydon of Albion County Council emphasised that decisions about placements in Albion were based on user (and relative) choice. However, where users were reliant on state funding, this obviously meant that choice was limited to what the Authority could purchase. In Warden's words: 'the relatives would be given information on what's available locally and who is likely to accept our fee level'. The authority had only two block contracts - one for homes still run by the authority itself (most of which were due to be transferred to the independent sector), and one for 17 units that had previously been run by the authority but that had already been contracted out to an independent non-profit provider. This meant that Albion had no block contracts on nursing homes. The predominance of spot contracts was partly a result of Albion's relatively low fee levels. According to Warden: 'Our fee levels are quite low and we maintain that they are adequate, even so it would be difficult to get below that... we would doubt whether the providers would want to move to a block contract at our fee levels.' Some providers had said that 'they subsidize our users with privately funding people'. This was confirmed by Saydon, who said that many providers 'would like us to pay significantly more than we do'. Saydon said the authority was:

doing a piece of work with representatives of the independent sector to actually look at the... try and get to the bottom of what the true costs of residential care and nursing home care are, because they consistently claim that we don't pay

enough. We obviously are responsible for trying to spend public money as wisely as we can and making it stretch as far as we can. And its a very simple equation, the more we pay for an individual place the less the number of places we can manage.

Warden said Albion was having ‘grave difficulty’ in providing enough places with the resources available to them. In fact, although neither Warden nor Saydon were able to provide detailed figures, they could not think of any contracts at all with the case study firms. This was thought to be the result of low fee levels in a generally affluent, home-owning area, where larger firms were likely to concentrate on the relatively high numbers of self-funding clients. The only exception to this was the bid by Care First (prior to its acquisition by Company 1) for the contract ultimately given to the non-profit provider, which would have guaranteed funding for residents *and* capital investment under the Private Finance Initiative. This is discussed in the next section.

Warden himself said that, due to the low fee levels paid by the authority and the high numbers of self-funding residents in the county, in contrast to the near-monopsony position of some authorities, Albion County Council was, ‘not a very big player in the market’. It was consequently more difficult for Albion to use its purchasing function as a tool for raising quality, although Warden did point out that it would not help a provider to ‘get a reputation for not being used by the local authority’. Warden said that Albion was ‘reviewing our placements all the time’ and that residents were ‘visited and the quality of service they are getting is measured’, although he did not elaborate on what this measurement consisted of. Other than this, the authority seemed to rely on making sure homes met minimum standards, i.e. that they were registered. Warden pointed to, ‘the normal systems of complaints and where it gets serious enough referrals to statutory investigation sections.’ Warden acknowledged, however, that ‘the inspection units try and keep at arms length, that’s the way they’re set up... so formal lines of contact are really not as strong as you might think in the same area and that’s the way it runs.’

The main formal contact with the local authority registration and inspection unit was through an annual summary compiled by it and ‘logged information on the last visits

from the inspection unit.’ Saydon said that the contracts team had a ‘protocol agreement’ with both Local Authority and Health Authority regulators whereby they were notified of any homes that had outstanding ‘Regulation 20’ notices under the Registered Homes Act (1984). These could be to do with a variety of things such as the fabric of the building, cleanliness or staffing. Any homes with such outstanding notices could not go on the authority’s list of approved providers. Saydon said the authority had been, ‘very open with the independent sector about this... we will review all the people we are responsible for in the home at the time if a notice is issued and we will not make further placements there until the position has been addressed. So until the quality improves.’

The arms-length relationship between Albion County Council as a purchaser and the Health Authority registration and inspection units was confirmed by Smitham, who said that the Health Authority inspection unit would simply send the local authority a list of homes that had been registered and were thus considered to be ‘fit to operate’. Smitham continued: ‘we can’t answer detailed questions to those who hold contracts. If the contract manager calls us up and says... you know this home... is this home all right to place somebody in, our standard answer is that we have no issues about this home, if we don’t.’ Local authorities therefore had to draw up their own contracts with providers and were responsible for monitoring them. However, Smitham did say that if the local authority ‘ask us the right questions we can answer them, but we can’t volunteer information.’ The ‘right questions’ might be, for example, ‘do they [the home] have a quality assurance programme?’ or ‘do they have difficulty in recruiting staff?’. This general arms-length approach was also confirmed by Fenn, who said: ‘we can’t recommend a particular home... sometimes if they [local authority purchasers] have concerns about somewhere they will get in touch with us, sometimes if they wish to make complaints they come to us although they should in the first instance go back to the home and make the complaint.’ The two agencies might also liaise if a particular resident was felt to be vulnerable. Overall, however, the inspection units were ‘supposed to remain at arms-length and not collude with anybody about what’s a good home and what’s a bad home.’

Thus, whilst the near-monopsony position of some local authorities allowed them to hold down fee rates, the evidence from Albion indicates that it is unlikely to be used as a means of raising the quality of provision. As discussed above, CCMN (June 1999) found that a minority of authorities actively used their position in this way. However, the relative absence of such activity by local authorities results from the structural separation of the purchasing and regulatory functions, and the clear mandate which each type of agency must follow.

It is clear that the problems of fragmentation in the regulation of long-term care are being addressed by the current government. The government's response to funding problems in the sector has also been discussed. The evidence from this section is that policies in both areas are likely to lead to greater concentration of provision in the sector, since large firms with more resources and economies of scale are better placed to withstand the associated costs than smaller firms. Given the tendency towards internationalization in services discussed in Chapter Two, and the findings of Chapter Four concerning the substantial internationalization of large firms in this sector, this shift to greater concentration is likely to be accompanied by increasing internationalization. The government's commitment to a liberal trade and investment policy and its associated international agreements can only reinforce this.

The officers from Albion interviewed for this thesis had developed a variety of ways of fulfilling their functions within the existing institutional and legislative constraints. There were some differences between Smitham and Fenn, both in terms of their practice and in terms of their responses to the government's proposed reforms, but on the whole their practices were similar and they were broadly in favour of the forthcoming changes. Their specific practice in relation to the case study firms is discussed next.

### **FIRM-SPECIFIC ASPECTS**

Both Smitham and Fenn had a great deal of experience in dealing with the case study firms, and these experiences will be discussed here. However, at the request of both



Smitham and Fenn, it will not be possible to identify which firm in particular is being discussed in every instance. Nevertheless, the discussion is included in this section since it relates to direct experience of dealing with the specific firms we are concerned with. Where the firms are explicitly identified, we cannot assume that these experiences can be generalized for the whole of the firm's provision across the country - these experiences concern homes delivering care in Albion only. However, they provide useful information in illustrating the *types* of issues and problems that may arise in the relationships between the firms and state agencies. This information also needs to be considered in the light of that derived from the interviews with the firms' QA managers. (It should be noted here that, as indicated in Chapter Four, the interview with Grant of Company 3 elicited less information than those with Jones and Bartlett.) Finally, Gordon Saydon's experiences with the former Care First will be discussed.

The starting point for relations between firms and regulators is the registration process. This involves identifying a 'fit person'. According to Fenn, 'with a company that's quite difficult because a company has a Board of Directors, etc., etc., a Chairman and a Board of Directors, so technically we should check them all out and by checking them all out I mean they all have to have a police check.' In practice the process was as follows:

we would request the name of the Chairman and the Board members and then I ask who will be the fit person, we have to have a named fit person. It's not very helpful to have the company as a fit person, you know, because if something goes wrong then you need ... say there was a serious problem then you need to contact a fit person, you couldn't contact 50% of the board and the Chairman, you know it's unrealistic so a person is nominated by the person to be the fit person and we check, and we do the police check and we check the CV's and references and we also check, we need a bank reference and we need to look at the financial side, the business side, all of that... that will tell us quite a lot about the company and then we obviously have a meeting very early on with the representatives of the company. In the case of nursing homes or hospitals it will be the person who is going to be the manager, the person who is going to be the fit person for the company and you know people like the operational

manager or ... whoever we think, and they think, it's appropriate to discuss the plans and policies and procedures with etc. etc. I mean it's quite a long process. We need to see all the company's ... within big companies they usually have standard kinds of policies and procedures for various things and we would ask to see all of those... as well as their business plans and operation plans, the whole lot... to see if they're viable to take on another commitment.

The registration process also involved going through the company's QA manuals, although both Smitham and Fenn made it clear that this did not substitute for inspection of the homes concerned.

Company 1's Bob Jones was very much in favour of the regulation process taking more notice of firms' internal QA systems:

There's a number of ways forward with regulation, and one of the things that I would like to see... is that if an organization can demonstrate it has an effective operating quality assurance system then maybe the regulators will begin to accept that or the product of that as their inspection process, as opposed to coming along and doing the inspection process themselves. Maybe that's pie in the sky. It may be that in the future they will only accept some form of accredited quality assurance system, and immediately you start to think 'oh my God, I should have gone down the ISO road'... but I would argue that [Company 1] with its size and with the structures we've put in could use the [Company 1] system as a standard for care homes and maybe that could become an accreditable system.

Jane Bartlett said she did not, 'think personally that the industry is ready for self regulation. I do get out and see a lot of independent units and I would be extremely concerned that if it went to self regulation it wouldn't work.' However, she claimed that Company 2's monthly internal process reviews were 'being taken on board by health authorities, social services, as being a regular report'. Smitham said that a firm's internal procedures might make some difference to her practice, although they clearly did not alter the requirement to be inspected by the Unit:

Well I think there are issues, aren't there, for me there are some homes I spend a lot of time and there are some homes that I don't, and that's because I know that there are homes who are not going to present me with problems. It doesn't mean I don't check and it does not mean that I don't test what I'm told, but what it does mean is that I am relatively sure in my own mind that there won't be a problem. If there is then I spend longer there.

Smitham said that in part this confidence that problems would not arise stemmed partly from the firm's internal QA system, but also from confidence,

in [the] people who operate it and that boils down to local people in local situations, doesn't it?... Some people operate their quality assurance systems very well, some people don't. And it's glaringly obvious when it doesn't operate, frankly... I always say if it's not seen it's not done... if I find through testing randomly that it's ... what I see on paper is not what's happening then I go into it in much more depth and I spend more time, so those are the kinds of balances and checks one has to put in. And there are some homes that are operating very well under one person that don't operate so well under another...

West Albion Health Authority's guidelines on the 'Application for Registration of a Private Hospital, Nursing Home or Mental Nursing Home'(1999) (which are the same as those for East Albion) make it clear that any change in the ownership of a home, or any change in 'the management structure of the organization running the home', requires a new Certificate of Registration to be issued. Fenn said that this could be a lengthy and costly procedure:

if it is a new registration, and strictly speaking if it's a new company taking over, then it should be a new registration which costs money and ... if it is a new company then they must go through the registration procedure again and that takes a year, because we do go through it in exactly the same way.

Fenn said that homes did not always tell the Registration Unit when changes of ownership took place:

But I mean they can change ... you know so rapidly and sometimes they don't tell us, we find out from the Financial Times or somebody down the road will tell us.

From Company 2's perspective, Bartlett said that this requirement for re-registration could be frustrating:

In some cases it gets almost silly. Just after the merger Elaine Farrell, who's now the Managing Director, was one of the Divisional Directors and because she was going to be the registered person for the company, representative, for all these Health Authorities, the fact that she'd been a general manager and regional manager for [Company 2] counted for absolutely nothing even in the same health authority for the Exceler homes, and she had to go along and have fit person interviews with the same person that had given her the fit person interview for a home up the road. So some of it is ludicrous.

The biggest issue for all of the QA managers from the case study firms in relation to regulation was the perceived inconsistency between different registration and inspection units. Company 1's Bob Jones thought there were 'huge disparities' between the way different authorities interpreted the regulations:

One of the biggest problems overall with regulation is it's so non-specific that they are subjectively interpretable by those who regulate, and now there lies the problem. The regulations are written in such woolly language you can make them mean whatever you want.

The perceived pettiness of some inspection officers was identified as a particular problem by Jones:

There are a number of occasions when the regulatory arrangements do identify and then solve problems that could give clients significant problems. But there are also huge areas where the regulators haven't got a hope of picking up a problem and don't, and that's with my ex-inspector's hat on. For a company like ours, in the nicest possible way the regulation is almost an irrelevance. Its sometimes a pain in the butt, its almost irrelevant, because we have every intention of doing right. Our *raison d'être* is to give a quality service. So whilst we're happy to use regulators as a good source of advice, we will always strive to aim higher than any regulator would look anyway... So from that point of view, regulation and even more stringent regulation doesn't bother me. What does bother me is when regulators are petty. And unfortunately there are quite a few of those around. Perhaps less than there used to be, but there are still a number of regulators around whose pettiness is unbelievable. I'm mindful of an exchange of letters with a particular registration officer who was getting uptight because we wouldn't tell her the make of paint we were putting on some tiles in the bathroom. What's it got to do with her? You show me the regulations that are bothered about the make of paint! I can't believe this. So what use is that in relation to protecting the clients?

Company 2's Jane Bartlett also thought there was 'huge variation' between the requirements of different regulating authorities. Although Company 2 itself was organized into regions (see Chapter Four), these cut across different regulatory authorities. The internal structure of the company did not, therefore, provide an opportunity to match up the firm's regions with the requirements of different regulators:

You could have probably, if you took the regional manager for Bromley, they're probably dealing with at least three or four health authorities and probably eight or nine social services. And if you've got all of those with totally different audit criteria its very difficult to have a company standard because you're adding bits. There's one local authority, I don't know which it is, its one of the Albion ones, that insists that we have a laminated sign in every bathroom that gives the temperature that the water must be, and we must check with the

thermometer. We've got to have a laminated sign. Now that to me stinks because this is meant to be someone's home. If it was my home there's no way I'd want a laminated sign stuck on my wall. So we've had to introduce that as a local policy to that particular home because it's the only home we have in that area that satisfies that health authority, but it's certainly not something I'd like to see across the rest of the country.

Bartlett also claimed that authorities sometimes enforced inappropriate standards:

We've almost gone full circle with them currently because they're looking at the assets more than the patterns of the residents. I'll give you a sort of example, I don't want to regionalize it for it to cause a slur on the region that I'm going to pick, but if you went up into Newcastle, somewhere like that, you can go into one of the homes that I'm thinking of that is absolutely great, it's friendly, it's cosy, very homely, not very large, and we're having a tremendous fight with the health authority because they're saying... that we've got twin rooms and we should be giving everybody a single room, and they haven't got en suite facilities, and things like that. Now if you actually go and talk to the residents there some of them would prefer perhaps to be in a single room, but a lot of them like companionship, they come from communities where they've probably shared a bed with four or five other brothers and sisters and they do not want - Bromley OK, yeah lovely, let's have hotel type drapes and furniture like this - but if we brought one of those residents down here they would hate it because it would be like living in a hotel. And I think sometimes our own perceptions of what we would expect, if we went in now we'd expect a bath everyday, and we'd expect a reasonable standard of furniture, and we'd expect so much space, but we're imposing that on people without actually listening to what they want. And I think in a lot of ways health authorities are doing that, and maybe they're getting too caught up in the amount or the volume of air that we have, or the way things look, rather than getting into the actual cause and saying 'what is the care like?', 'how do the staff feel?'... Residents actually don't want what they're trying to force us to do... Sad fact.

The variation between regulating authorities led Bartlett to be in favour of, 'one regulatory board for the whole of the UK':

Its a procedural nightmare currently, because we're working with different social services having different expectations, different standards, different formats for audit, health authorities doing the same thing. And we're all after the same thing. It's like I say, you've got someone saying about the size of rooms, someone else saying whether there's en suite facilities, someone else saying that we should have liquid soap and not hard soap. You seem to be getting lost in this rigmarole of paper and everything else and we're not really focusing on the main issue as I see it. I'd quite like to see one regulatory body...

Grant also thought there was a 'wide variation' in the way regulating authorities interpreted standards. She pointed out that Company 3 was 'bigger than any single health authority', but did not elaborate on the implications of this. She said 'conformity' and 'consistency' were the most important things to Company 3, and for this reason would have 'no objection' to the setting up of a national regulatory body.

In trying to compare the case study firms Smitham said that: 'It's very difficult because some homes in large companies perform very well whereas others don't... And it's tied into where they are located, it's tied into who's managing the home and it's tied into the philosophy of that particular home.' An example of how the nature of particular homes within the company would affect the delivery of care, related to the purchase of homes in the area belonging to PPP by Company 3 (discussed in Chapter Four). According to Smitham, the PPP homes aimed at the highest quality part of the market, and therefore offered better care than some others run by Company 3:

now there is a defined difference between what was [Company 3] homes and the PPP homes in terms of the staff and in terms of the environment. Not a lot but there was and in terms of the issues and the image of PPP homes and the image that they sold to the public, so it was a very ... there's a big contrast in it, I mean PPP sold themselves as quality homes, you know, able to do anything

for anybody, oodles of staff, you know, there at your command type issue. Now that in an area like East Albion is very welcomed by people because you have certain pockets of East Albion where people are looking for that, when they walk into a home they expect it ... you know it's not about 'thank you very much for having me, I'm grateful you're going to keep me secure and give me the care that I need'. They are articulate people, they know what they want, they understand their health needs and therefore they can articulate those and they expect the staff and the service to be there... and most of our population base is like that, so it's a bit difficult isn't it. In terms of other homes... they're situated in a different part of our catchment area. Now although some people are very articulate who go into those homes and they can, you know, articulate their needs well, there are other people who can't and you see the contrast there... So those are the kind of subtle nuances that you get within the homes and I mean that's just one company.

In West Albion, Fenn said that changes of ownership had sometimes caused problems, especially in relation to changes of personnel:

I can think of one of the large companies where .... I don't think always they understand what a nursing home is as opposed to a hotel or a leisure centre or somewhere because they have a... it's very important in nursing homes that you have continuity of staff and managers and I can think of one where they are always changing the manager, the regional managers and the local manager and it's a home where we've had a lot of problems... We've had a lot of problems between both the general practitioners and the home and I've got, I'll just get one sort of case sorted out and the care manager understands the relationship... you know how to ensure a good working relationship with staff and with GPs, when they're whisked off or they leave or somebody else comes in and you go through the whole thing again and then you find that the next one, above the local manager, has also changed and they haven't got any idea ... and it's those sort of things that are extremely time consuming and frustrating... And it's very frustrating to people like the General Practitioners as well because, you know,



it is difficult to understand why you have to keep repeating things over and over...

There was one home where Fenn estimated that there had been about ten changes of management in the last five years. As a result of her previous experiences with such changes, she would take the initiative as soon as she learned that new changes were taking place:

So the minute I hear that this one particular home – which is the love of my life – that the manager's gone, I will take down the details of the new one and I will take the initiative because I don't want anything to go wrong... because of this difficulty. So that I can inform them what's been wrong in the past, in case they didn't know and the way it should ... what was agreed would happen for the future when such and such a situation, and then I satisfy myself that everybody knows and that there's no excuse for something to go wrong. It is hard work to have to do that! But it's also hard work if we've got lots of complaints and, you know, things going wrong. So it's six of one and half a dozen of the other really.

Fenn said that another home belonging to the same organization, but which had not had many changes of management, had not caused much difficulty.

Fenn felt frustrated that effort put into building relationships and improving standards could be disrupted by changes in personnel:

I find that the standards... you know, you do a lot of work to get standards raised and then the minute you have somebody new move in they all go down again, they don't all go down again but many of them go down... because they don't realise, you see if as a manager you change you initially don't know your staff and if they're the same staff who were there before and who need to be carefully monitored and to ensure that they were performing their jobs in the right way and you don't know about all the difficulties that went on in the past, then unless you are aware of it when you take up a new post, you know, the

staff will go back to their old ways. It's very sad to say, but in a big company where they feel they've got no commitment to anybody you know, and a lot of them think, 'oh yes this is a very rich company, they're always changing and they don't care about their staff', there is absolutely... no commitment, they're not proud to be working for a particular firm or business.

Fenn said that in her experience there was in general less commitment among staff working for larger firms than small ones: 'I don't feel there's any loyalty among the ground staff to their employers. As you know, if the ground staff are unhappy then... well that reflects on the care that they give or the job that they do.' Fenn thought managers needed to make sure that staff:

gel together, that they can work together, that they're happy together, that they have confidence in their employers and then they will .. You will have a happy workforce who will not be disgruntled in any way who will be happy in their work, and this will ultimately affect the way in which they provide their care, instead of moaning to the residents, 'oh you know we haven't got enough staff and they're cutting them down again, and do you know my cheque last month and it just wasn't paid in.' This is the sort of thing that starts to happen, when you get an unhappy workforce. And then the other thing that happens as a result of that is that you get staff leaving and then they write horrible letters to us complaining about what went on, and sometimes being embroidered you know. And we have a duty to investigate all complaints and so we have to go shooting off on these ... taking the time out from our usual work to go and investigate the complaint. And there is one large home that I'm constantly having to do this with.

Smitham also thought that staffing issues were important. According to her, some companies, 'have difficulty in retention of staff', whereas Company 1 did not:

Other companies have difficulty in retention of staff ... As with contrast to another company that I deal with, [Company 1], they have very little turnover. Now in fact one of the issues around their lack of turnover, I would say, is not

because people are not ambitious it's because they have a system whereby they recognise development of staff and they actually have a method of rewarding staff if you like, and it may not be financial reward but they do recognise and reward staff for the development and their contribution to care. So those are the kinds of issues that you can pick out in terms of the differences between companies.

Fenn said that how well a company was managed had a big impact on her work:

And I suppose the thing with large companies is that you never actually get to meet the people who are pulling the strings for want of a better word. You can meet the regional manager but the regional manager can change after six months and there's somebody different there... I never feel that I can actually talk to somebody who's going to be there for any length of time, who will have an influence on what is happening long-term at ground level.

When dealing with a home belonging to a large firm, Fenn said she would, 'start with the local manager, and if I don't get any results I will then ring the regional manager and ask for an appointment.' She said it was rare for managers within the firm above the home level to take the initiative in contacting her, unless they were:

disagreeing with what I'm saying. If they don't like what I'm saying then they're on the phone very quickly to me, but I mean its very rare now for... say somebody at regional level to actually write to me and say 'Mr So and So's now gone and now I'm in post and I would like to come and meet you whenever it's convenient.' Its usually me who does that.

Smitham also said that she would normally deal with the home manager, but that people further up the firm's hierarchy may get involved where there was a problem or a complication. She gave the example of some changes that needed to be made to a home's kitchen which involved digging up the road to lay new power lines. This took longer than expected:

So, yes, some people at head office did speak to me, I mean they normally telephone me and say 'oh, who is this woman, what are you doing,' you know, 'how dare you ...' no they don't talk to people like that, they're quite reasonable people to deal with as I've said. Well I've found them reasonable to deal with, I mean in the same way as anybody would probably try at times to get things out of me they would try as well, but that's guaranteed to recognise the fact and also to deal with it.

Company 1's Bob Jones said that there would be times when he would attempt to move negotiations away from the home level:

At the end of the day keeping your registration officer happy is one of the things that we do because it's easier. But there are times when they're asking for unreasonable things that we, I say do battle but I try and avoid getting into battle, but I move the discussion out of the home, because the relationship between registration and our home is an individual relationship with each individual home and nine times out of ten they can sort out their own problems. But if it begins to get sticky or tricky then I'll move the discussion away from the home and focus it on me. I'll have the negotiation with them so the relationship with the home doesn't become soured.

According to Jones, many inspectors preferred to deal with the company's HQ:

They're usually more happy about that because most see 'ah, we're getting somebody from the centre'. Unfortunately, there seems to be one or two registration officers out there who are on a real power trip. If they can negotiate with somebody in the centre instead of the home, they'd really rather do that, thank you.

In an interesting reversal of Smitham's claim (quoted in the previous section) that firms sometimes play inspection units off against each other, Jones claimed that some authorities did this with different providers:

It seems to us that they are more interested in almost having a go at a large organization, because they then turn that round and they can use that as a standard. So if they get a [Company 1] home to do something they can then go along to all the other operators and say 'but [Company 1] have done that'. So its an interesting relationship. I mean I've obviously sounded fairly negative about registration officers. There are a number of authorities that are absolutely brilliant, we have a very good relationship with, and good working relationship, good development. But it seems like the ones who stand out really stand out.

Smitham was very aware of the differences between large and small firms in terms of their 'financial viability', stating that large firms 'can actually get equipment a lot quicker because they can spread their risk'. She said that a lot of smaller homes, 'feel that in a sense they're being squeezed out of the market'. In terms of how smaller providers compared with large ones, however, she said that this, 'depends on the person who's at the top of the home'. Smitham thought that homes owned by large firms did not tend to experience the same problems as small owners in the sense of not having appropriate equipment, for example:

They don't have those kind of problems, they have different types of problems in terms of financial issues around the environment. The environment in most of the large company homes is very glossy, very comfortable ... they have the equipment and they usually have a central bulk equipment buying area and storage area whereby they can get extra equipment in, very fast, if they need it. Whereas the smaller homes don't have that ... and one wouldn't expect them to have it and if they are in fact facing some financial squeezing in terms of their financial viability then in effect what happens is they come up against it quite hard.

In Smitham's experience, the problems faced by large firms had more to do with staffing and management issues:

Well they have the same problems as other people have, I mean they have the same problems in terms of equipment in terms of getting quality of staff, in terms of quantity of staff, in terms of the management of homes .... They have all of those issues and those who concentrate more on looking at the quality of the care that's being delivered and looking at how their staff are performing tend to perform better. So in other words those who concentrate on developing staff tend to do a little bit better.

In contrast to Smitham's perception that large firms had more resources, Fenn thought that large firms were under pressure from their own headquarters to reduce costs:

I do find that the large operators are constantly cutting ... and I think that is one of the reasons why, maybe some of the managers don't last for long in some of these firms. They're getting pressure from their bosses to make better use of the resources they've got and they're getting pressure maybe from people like me, to maintain their staffing levels, to the staffing levels that have been set.

This pressure to contain costs could affect the time scale over which changes deemed necessary by the Inspection Unit could be introduced:

One company which is generally I think very well run, but the individual managers of the homes have their own budget, which is a good idea but they have .. they also can't overspend or anything but sometimes they have to phase in work which is quite urgent because of ... I suppose it's good in a sense really, but I think that once these budgets have been set there's no slack, and there's not contingency sometimes... So then we say well you must have six inch restrainers put on all the windows above ground floor level, they might say well actually we'll have to put that into next year's budget, we can't do it now. That's quite an important thing, actually, to do and should ... I feel sometimes that the company should really have some kind of contingency for the managers so that they have a little bit laid by to do emergency works like that.

In a situation such as this, the level of enforcement action taken by the Unit would depend on the urgency of the task to be done. Where something is not clearly covered by the law and is not life threatening, the inspectors would point out the problem to the home manager and leave the details to them: 'if something's been pointed out and you know about it, then you as the proprietor or the... You have to decide whether its a risk worth taking or not.' Where something is a legal requirement or likely to cause harm it would be enforced:

Unless it's a legal requirement and then you know you can force it through, it is the ... because things like when we've got... flagstones and the patio in the middle of summer which are uneven and likely to cause an accident when somebody walks outside, ideally they should be repaired or made good or whatever. To prevent an accident.

Whilst Smitham and Fenn had a great deal of experience of dealing with the case study firms, as discussed above, Albion County Council had no real experience of purchasing from them. Saydon said that his, 'understanding of [Company 1] is that their costs are quite high, so we wouldn't normally purchase care there unless there was a third party willing and able to pay the difference, the top up.' From the firm's side, Jones said that Company 1 was heavily dependent on the amount of resources which local authorities had to spend, but aimed at winning more contracts than its competitors, especially small operators, through delivering higher quality care. He saw this emphasis on quality as particularly important because, despite low fee levels, authorities were increasingly demanding higher quality:

More and more I anticipate that service requirements will be more clearly defined by purchasers, and a number of our purchasers are local authorities. It becomes increasingly difficult to both demonstrate that you can meet, and meet, those standards for small operators. And to give you a good example, I have two catering advisors working for me, who are totally on the ball when it comes to environmental health legislation. There's a whole load of new legislation around homes that has to have an analysis and critical control point.

We sat down and met with our lead environmental authority, I think we saw yesterday, and go through our policies and procedures which were the best he'd ever seen, and we think we can probably sell those onto small operators. That's a typical small example of how we will be driven more and more, you have to have specialist advice in order to be able to maintain the business and meet the standards that purchasers are beginning to drive. We can afford it because we're a big organization, a one man band can't. So I think more and more one man bands will go to the wall and people like us will buy them up. That's actually the reality of it.

Jones also thought that because of the increasing dependency of clients, there may be a move towards different fee levels for perhaps four or five different categories of resident according to their degree of dependency.

According to Jones, Company 1's size enabled it to provide a reasonable level of care for local authority fee levels that was not possible even for a medium sized firm:

... the private clients, that is the true market. Goldsborough, whom I used to work for... had deliberately begun to realign all its homes to head more for the private clients because... the poor funding from local authorities meant in some areas it was becoming difficult to give the right quality of care. Now within the large organization with economies of scale, it's easier to be able to give an acceptable quality of care with local authority funding. I'm sure if the board strategically could wave a wand and realign all our homes and fill them with private clients, they'd probably do it tomorrow because that takes away some of the difficulty of inadequate local authority funding.

Bartlett said that Company 2 was also mostly reliant on local authority funding, which she also thought was too low:

Oh it can be extremely problematic. The local authorities... again this comes through that the NHS have complained about bed blocking and acute beds being used for the care of somebody that does not need to be in an acute bed,



and therefore the NHS are looking to move people into either short term nursing care or long term nursing care. Health authorities don't hold the budget then, that placement that then goes to social services and social services have a pot of money that's only so big and that has caused an awful lot of problems and we're well aware that there's, if you like, a resident that wants to come into the home, the relatives want them in the home, they're stuck in hospital, and there is not the funding there, and they've got to wait until the board sits every other month to release the funds for them to come in, and it can be very, very upsetting for the relatives and the resident. And there have been cases where the resident has died in hospital, not through lack of care, but maybe the terminal care could have been given somewhere except in a huge ward, so yeah, it does affect it very much. And it seems to get tougher as well. Last year by the time we got to February there was almost no movement into the homes through social services. Most of them had run out of money and they're waiting for April for the new financial year to start. So yeah, it does cause huge problems.

Company 2 (USA)'s annual report for 1997 reveals that its operating margins in the UK had been lower than expected as a result of the generalized under occupancy in the sector (AR 1997: 27).

As already noted, it was clear that in Albion the case study firms could concentrate on private payers rather than the local authority. However, prior to its acquisition by Company 1, Care First had initially been involved in putting in a tender to run 17 homes under PFI arrangements, which Albion ultimately contracted out to an independent non-profit organization. Saydon, who was the project manager, said Care First 'were the only private sector bidder in the running at the time and they were a strong bidder', since, 'as far as we were aware from the information they'd supplied and what we knew about them, they'd got access to significant resources by way of people, property, funding... to be able to deliver what we were looking for.' Saydon said that the internal management and quality systems of organizations tendering for this process were an important consideration: 'we want to know how an organization manages its staff, how it manages its buildings, does it sub-contract, if so what are its

sort of rules for sub-contracting. Are they signed up to any particular quality assurance programmes, are they accredited under any particular scheme, so all of that will be looked at.' This meant looking at the organization's procedure manuals and, 'spot visits to some of their other homes.'

Care First, however, 'decided not to pursue their bid with us and withdrew so that left us with only not for profit organizations, which wasn't a problem for us because we were actually seeking a not-for-profit solution.' This 'not-for-profit solution' would have required a for-profit provider like Care First to set up what Saydon called 'an arms length not-for-profit subsidiary'. Their incentive to do this may have revolved around 'tax advantages' or the selling of support services for profit to the not-for-profit subsidiary. It may also have been a way for them to build links with local authorities who were in favour of the 'not-for-profit ethos'. As indicated above, Albion was not applying these not-for-profit criteria to the second tranche of homes that were being transferred to independent management.

With regard to Care First's decision to withdraw from the process, Saydon said they had, 'got past what we call the first invitation to negotiate stage, so we were happy with their proposals in principal and it was part way through the second stage when we wanted detailed financial bids submitted that they withdrew.' The reasons Care First gave for their withdrawal related to the 'open negotiation' process which Albion used to choose the final contractor, whereby all bidders were kept informed of any issues and questions relating to the process at each stage:

They said that they weren't entirely happy with that and would have preferred to have run a, sort of a, if not a fully closed certainly a much more closed bidding process whereby they'd have submitted and we'd have accepted or not, depending upon what we felt about it. We wanted a negotiated procedure because what we wanted to achieve was the best outcome for the Council, particularly for the older people and the staff concerned and we believed that was best achieved through the ability to negotiate throughout the whole process with all the bidders.

However, Saydon's view, which he emphasised was 'a personal view', was that Care First

were aware of the takeover bid by [Company 1] at the time, and putting in a bid for a business... to take over a business which in our case was somewhere in the region of around about £12 million a year annual turnover, so it was a significant size, was taking their energies away from trying to resist the takeover. That was my reading of their reasons for withdrawing, but they weren't the reasons they gave us.

Saydon indicated that extensive building and refurbishment being carried out by the independent provider as part of the deal involved, 'the need to move people sometimes from one part of the building to another, sometimes from one home to another. You can't knock down a home and rebuild it with people in situ obviously, so that has to be managed very carefully.' The Authority thus carried out close monitoring of the process through monthly meetings with the provider. Had Care First's acquisition by Company 1 taken place shortly *after* the winning of such a contract by Care First, the disruption to residents caused by the renovations would have been amplified by two rapid changes in regime, firstly from the local authority to Care First and secondly from Care First to Company 1. Such changes can be an unsettling and sometimes fatal experience for residents, an issue which is returned to in the concluding chapter.

None of the case study firms had put in bids to run the second tranche of homes which were in the process of being contracted out by Albion, but Company 1 had since become the largest operator of local authority residential care in the UK, through partnerships with Staffordshire and Powys councils (CCMN, April 1999). Staffordshire leased 20 homes with 830 beds to Company 1, also on a non-profit making basis. A spokesman for Staffordshire told CCMN (April 1999) that Company 1 was selected because it offered the best option financially. Staffordshire's decision also involved representatives of the council visiting other Company 1 homes to examine the company's policies and procedures. A significant advantage was gained by Company 1 because it was the preferred provider of UNISON, which represented the majority of the 900 staff who transferred. The council decided to transfer the homes to the

independent sector in order to give it access to Residential Allowance, also a key factor in Albion's transfer. As well as the Powys transfer, which involved 12 homes with 327 beds, Company 1 had contracts with Bedfordshire ('Company 1 Today', 6.11.98), Bromley and three unitary authorities in Berkshire.

The final way in which firms may relate to the state is through attempting to change policy or practice through the process of lobbying. Jones was clear that Company 1 sometimes did this through provider associations, such as the Independent Healthcare Association (IHA) and the Registered Nursing Homes Association (RNHA), as well as through other broadly based groups:

Without a doubt. We are big enough and will lobby independently if we so wish, but there may also be times when we feel the need to lobby through a third party... Its difficult to think of something, but there might be times when one wouldn't want to come out and say '[Company 1] thinks this', but that might actually be our agenda.

Company 2 was also a member of the IHA and the RNHA. Bartlett described the RNHA as, 'independent groups that have formed to, if you like, lobby together and look at forward trends.' The benefits of this were described as follows:

I think it's focused and being able to be kept aware of trends, what other companies are doing and also very much giving us a better power to influence... the change in Community Care Act obviously meant an awful lot of difference in the way that the company was funded. We'd certainly noticed the difference. Company 2 prior to the merger had a much larger percentage of private pay residents. With the, bringing in the Exceler and the Apta units as well, we now have quite a lot of social services funded residents, and the amount in real terms that is given to a home to look after a resident per week has gone down tremendously. And obviously that has an effect. So its given us the ability to join together with other independent healthcare providers and lobby the government, and come up with facts and figures and ratios to move that forward and hopefully eventually get the better care that we can.

Grant said Company 3 was a member of the IHA, which she thought was 'becoming more effective' as a lobbying body. She said that Company 3 would like 'to be included in the making of the rules'; since low quality would affect the firm's share price, it had no motivation to evade the rules. She said she was involved in a Department of Health committee, but did not specify which one. She thought the government was 'getting better' at listening to private providers, but was 'not quite there yet'. The new chief executive of Company 3, Chai Patel, has been an extremely influential figure in long-term care, playing a key role in the Continuing Care Conference (CCC) for example (see Chapter Seven for a discussion of this). Patel also chaired the long-term care working group of the Better Regulation Task Force, an independent advisory body set up by the Chancellor of the Duchy of Lancaster, Dr David Clark. This published a review of long-term care regulation in 1998 (BRTF, 1998), which concluded that the current regulatory arrangements failed on each of its five principles of transparency, accountability, targeting, consistency and proportionality. It made a number of recommendations to government, including that the regulation of nursing, residential and domiciliary care should be unified; that a national agency with wide-ranging membership should be created to advise the Department of Health on care standards; and that locally based inspection units independent of local and health authorities should carry out inspections. Although it is clear from the discussion above that not all these recommendations were accepted by the government, 'Modernising Social Services' (DoH, 1998b: 4.4) explicitly states that the government's plans were designed according to the Task Force's five principles. Through his role in the Better Regulation Task Force, Patel was also a member of the CPA's advisory panel on the new National Required Standards.

## **DISCUSSION AND CONCLUSION**

With the expansion of private provision in long term care in the 1980s, the form of state intervention in the sector has shifted from provision to funding and regulation. The form of the current regulatory system is clearly fragmented. The division of the system into locally based authorities, as well as the split between health and local authorities, leads to inconsistencies in the regulatory process and the enforcement of standards. However, this system is undergoing a process of reform which will centralize, standardize and increase the power of the state. The new National Required Standards in particular will raise the standards which private providers will be required to meet, whilst the creation of the National Care Standards Commission will introduce greater consistency across the country. Contrary to the crude globalization thesis, the powers of the state are thus increasing in this sector. In common with most private providers, all of the three case study firms relied significantly on the state for funding, although this was less the case for Company 3. Through its regulatory and funding functions the state therefore retains decisive power in terms of shaping the overall framework within which the firms operate.

However, contrary to the way the globalization debate often portrays the interests of state and firms as being necessarily antagonistic, the exercise of state power in this case does not appear to be against the long term interests of large and internationalized providers. Respondents from the case study firms themselves identified the inconsistency between regulatory authorities as their biggest problem, and all were broadly in favour of the proposed regulatory changes. As Grant put it, 'consistency' was what Company 3 thought was most important. Indeed, the firms' very nature as large organizations with a geographical spread far larger than that of the current regulatory authorities has itself been one of the factors that has highlighted the extent of unevenness in regulation. In addition, the firms or those close to them may have exerted some influence on the reforms through their own lobbying or opinion-forming activities, such as Chai Patel's participation in the Continuing Care Conference (see Chapter Seven) and the Better Regulation Task Force.

The decisive power of the state is most effectively demonstrated by the evidence that its policies are likely to alter the very structure of the sector itself. However, the changes in the structure of the sector which are the likely outcome of the reforms are also in the long term interests of the firms. The high costs which regulatory reform will impose on private providers, which are unlikely to be adequately compensated for through increased funding levels, will affect all providers. This may have damaging consequences even for large firms such as Company 2, whose American parent company is experiencing serious financial difficulties (see Chapter Four). However, the economics of the sector mean that it will be the larger firms, which are able to take advantage of economies of scale and innovative management systems, and which have easier access to extra funds, which will find it easier to survive.

State policies will undoubtedly lead to a new wave of 'rationalization' within the sector. As discussed in Chapter Two, and examined in some detail in Chapter Four, there has already been significant consolidation within the sector, especially during 1996 and 1997. Whether intentional or not, the likely effect of government policy will be to facilitate even greater consolidation, especially given the current over-capacity in the sector and the difficulty which smaller providers will have in meeting the new standards. As Company 1's Bob Jones said of good small providers: 'when they're for sale we'll buy them' (see Chapter Four). These processes of regulatory reform on the one hand, and concentration among providers on the other, seem to confirm the observation made in Chapter Two, that there may in fact be a 'symbiotic' relationship between state and firm, with the actions of each encouraging a concentration and formalization of the power of the other.

Chapter Four also demonstrated that there was significant internationalization among the case study firms. This chapter has indicated that the British regulation process does not consider either internationalization or the nationality of firms as a factor necessitating special attention. The government's policies in this sector, as in most others, is for openness in international trade and investment, and this is consistent with its international commitments on such matters. However, given the 'market seeking' nature of these firms, and the role which 'favourable market conditions and regulatory environments' (Company 2 (USA)AR, 1996: 11) seem to have played in Company 2

(USA) investing in Britain and other countries (see Chapter Four), the possibility that a strengthening of the regulatory framework may act as a disincentive for foreign firms to invest here must be considered. This would mean losing the expertise that US firms in particular may bring with them (notwithstanding the different and sometimes undesirable practices that may be common in the US). The same set of incentives may also lead to domestic providers increasing their overseas investments. Yet the evidence is that Company 2 welcomed an end to the inconsistencies of the current system as much as the other case study firms, and Company 2 is as likely as other large firms to gain in the long term from the increased concentration in provision which is likely to occur, provided Company 2 (USA) can survive its current financial problems. Given the existing internationalization among large providers, therefore, the government's commitment to an open trade and investment policy means that increased concentration in the sector is also likely to be accompanied by increased internationalization.

However, although the state is largely successful in setting the parameters within which private organizations operate, it is clear from the evidence in this chapter that there is a constant process of bargaining within those parameters, and one which will inevitably continue once the reforms have been implemented. Both the officers of Albion County Council and of the Albion Health Authorities appeared to have lost the automatic suspicion which characterized relations between state authorities and private providers in the initial period of expansion of private provision. However, there was some disagreement between Smitham and Fenn about the difference large and internationalized firms might make to their jobs and to the delivery of care. Whilst this may reflect a more guarded or 'diplomatic' response on the part of Smitham, it is clear that it also reflects different experiences, involving different homes from the firms. This underlines the importance of not over-generalizing from the Albion data; what this data does is rather to illustrate some of the issues which can *potentially* arise in the relations between firms and state agencies.

Nevertheless, this data can be triangulated with that given in other chapters. For example, Fenn indicated particular problems for regulation arising both from the restrictions imposed on homes where they operated limited budgets within the



structure of the firm, and to frequent changes in personnel. Fenn did not identify the firm in either of these cases, but we saw in Chapter Four that Company 2 experienced problems in its merger process relating both to the culture change which the introduction of devolved budgets involved for some staff, and to the loss of experienced staff, partly as a result of these operational changes. Issues relating to the disruption which may be caused by the process of M&A will be returned to in the final chapter. Despite these particular problems, Smitham's observation that large firms were unlikely to meet the same problems as smaller firms in terms of being able to pay for improvements which were necessary to raise quality is consistent with the findings of Chapter Four. Smitham and Fenn both agreed that staffing issues were particularly important for large firms, and this will be discussed in the next chapter.

Although both Smitham and Fenn agreed with the necessity for consistent standards, Smitham thought that disparities between authorities were sometimes exaggerated by firms. All the firms were keen that regulators should take more notice of their internal QA mechanisms. Smitham and Fenn indicated that they already did this to some extent, although unsurprisingly, they differed with the firms about the amount of external regulation which remained necessary. As indicated above, 'Modernising Social Services' (DoH, 1998b) does acknowledge the need to avoid, 'unnecessary duplication, for example when several branches of the same organization are to be registered'. Respondents from the firms themselves and both Smitham and Fenn were consistent in describing the way the negotiating process between regulators and firms would in practice move away from the home and to the firms' headquarters where a serious problem arose. Regulators' powers meant that in an extreme case the requirement of 'fitness' could be traced back to the ultimate owner, with serious consequences for the company as a whole. This situation seems unlikely to occur, and in practice once registration has taken place it is the home which is inspected, with recourse to the firm's headquarters where necessary.

Overall then, this chapter has demonstrated that, far from being powerless, the state is standardizing and centralizing its regulatory powers. Reforms initiated by the government will impose costs on all private providers which even large and internationalized firms will not be able to evade. However, these firms are best placed

to manage such change, and are therefore likely to benefit in the long term from the restructuring of the sector which is likely to occur. State policies, therefore, are facilitating increasing concentration and internationalization in the sector.

## CHAPTER SIX: STAFF AND UNIONS

### INTRODUCTION

Staffing issues are particularly important to the quality of long-term care. 'A Better Home Life' (CPA,1996: 71) states that: 'The quality of life which residents experience will depend to a great extent on the calibre of the staff caring for them. A trained and experienced staff team, which is well managed and adequately paid, is likely to provide high quality care in a responsive and understanding atmosphere.' However, where staff turnover is high, pay is low and training is inadequate, the quality of care is likely to suffer. Staffing is also a major economic factor affecting providers: it has been estimated that, for a typical 50-bed nursing home, wages account for three quarters of total costs (OFT, 1998: 9).

There are a number of different staff groups who work in care homes. Imber (1977) divides residential care staff into three main groups: supervisory staff, who are responsible for 'administering drugs, changing dressings, reading to residents, playing games with residents, organising social events, and paperwork'; care staff, who are responsible for 'washing clothes, washing residents, dressing residents, making beds and taking residents to the toilet, sluicing'; and domestic staff, who are responsible for 'preparing food, cleaning, tidying and washing up'. Davies & Knapp (1981, 70) suggest a possible fourth category of office and secretarial staff. 'A Better Home Life' (CPA, 1996: 71) uses a different four-way categorization: managerial staff; care staff, including both nurses and care assistants; administrative and clerical staff; and ancillary staff, including cleaning, laundry and catering staff.

Current law requires that homes be run with an adequate number of staff who have the right balance of skills and experience to meet the needs of residents (CPA,1996: 72). Before registration, a prospective owner must draw up a staffing schedule to show how the staff team meets the residents' requirements. The schedule is subject to inspection and approval by the relevant inspection and registration authority, and the

onus is on the applicant to show that the right level of staffing with appropriate competence and training will be provided. Nursing homes must have a registered medical practitioner or first level registered nurse as the person in charge as well as employing other qualified nursing staff for nursing duties. The registration authority currently determines the staffing levels and skill mix appropriate to the needs of residents in each nursing home, and sets it out in a staffing notice before registration. As indicated in Chapter Five, the National Required Standards (NRS) stipulate that a third of staff in nursing homes should be registered nurses, a requirement likely to raise costs considerably.

This chapter is particularly concerned with what the CPA (1996: 71) defines as ‘care staff’, i.e. nurses and care assistants. Not all of these staff will be members of trade unions; one purpose of this chapter is to investigate the extent of unionization. The principal unions active in this sector in the UK are UNISON, which is primarily a public sector union, but which is also the main potential organizer of care and domestic staff, as well as nurses, given its general nature and the relatively recent expansion of the private sector in what has traditionally been a publicly provided service; the General, Municipal and Boilermakers (GMB) union, which is also a general union; and the Royal College of Nursing (RCN). The Transport and General Workers’ Union (TGWU) and MSF (Manufacturing, Science, Finance) also potentially have a presence in this sector, although as explained in Chapter Three, telephone calls established at an early stage that in practice this was negligible. As also indicated in Chapter Three, unlike the interviews with other respondents for this chapter, that with Louise Saber of the RCN was not tape recorded, and was therefore reconstructed from memory and notes immediately after the interview.

### **ATTITUDES, PERCEPTIONS AND GOALS**

The general goal of all unions is to protect and advance the interests of their members, usually with regard to pay and conditions of service. The goals of the unions considered here which relate specifically to the long-term care sector are inextricably linked to their assessment of the overall shift to private provision. This was a

particularly important issue for UNISON, which is explicitly a public sector union formed from a merger of the Confederation of Health Service Employees (COHSE), the National Union of Public Employees (NUPE) and the National and Local Government Officers Union (NALGO). Kevin Fenton, a Research Officer at UNISON, said it was, 'exceedingly problematic for an avowedly public sector union now to be faced with probably a third of its membership in the private sector, if you count water, energy production and distribution, and health care and local authority contracting out.' This meant that the first goal of the union was to try to retain as much provision as possible within the public sector. In the words of Peter Stephens, UNISON National Officer for Healthcare, the union was 'on principle... in favour of directly designed care, free at the point of use and funded through general taxation.' However, the union recognised that 'we've moved a hell of a long way away from that and are unlikely to get back to it in the foreseeable future'. There was some debate within UNISON about whether privatization as such was coming to an end, but nobody expected it to be reversed.

Fenton said that the overall effect on staff of the shift towards private provision had been 'demoralization':

because most people, particularly join the NHS because they care about the institution, they want to do public service, they want to do that, they don't want to be faced with having to work in the private sector. That's primarily the feedback that we get and there's a lot of hostility... if you ask Joe Soap or the average worker in the public sector that's forced to go in there they abhor the fact that organizations run for profit.

The effects of this shift to private provision presented UNISON with some difficult problems about how, and whether, to organize in the private sector, which will be returned to in the next section.

One response to the reality of private provision was to campaign for nursing care to be free at the point of use, whoever it was provided by. Stephens said this would involve, 'a removal of current means testing rationale'. UNISON had presented

evidence to the RCLTC to this effect, and were campaigning for the implementation of the Commission's recommendations, 'because though not perfect they are, we think, a good way forward.' Stephens said UNISON was also using the 'Partnership in Action' proposals (DoH, 1998c; see Chapter Five) to argue for the 'integrated employment' of health and social care staff either by the NHS or by local authorities as a way of keeping provision within the public sector. Where consideration was given to commissioning care from private providers, Stephens said that UNISON, 'would want a best value model applied to select who those providers should be.' The union preferred voluntary sector providers to private ones, and where provision by the private sector could not be prevented, UNISON campaigned for, 'much greater regulation of the use of private sector providers both in terms of quality of care they provide and in terms of the pay and conditions that they offer to staff...' Stephens said that where a private provider was chosen, 'we want lots of safeguards built in... in order to minimize the consequences.' These safeguards would involve the commissioning body applying employment criteria when choosing providers. The National Minimum Wage (NMW) was seen as an important way of safeguarding wage levels, and this is discussed in the next section.

The overall attitude of the GMB to private provision was less hostile than UNISON's. Mike Gresham, National Secretary of the Public Services Section of GMB, said he thought this was because GMB was a general union with more experience of negotiating in the private sector: 'we've always had members in the public sector and the private sector and the service sector. We have officers that negotiate with companies and with employers at national level, at regional level, at plant level, at department level...' Gresham said that the GMB's, 'ideal position is traditional areas of the public sector should remain within the public sector.' There 'was a view', for example, 'that education should not be for profit'. However, Gresham said he thought there was, 'a new realism that there will be, in future, we are in a mixed economy, there will be a pluralism of service delivery in this sector.' He said that he thought it was 'impossible' to expect all provision in long-term care to be public, given the constraints to public sector expenditure, and that, 'we don't subscribe to the view that everything that's private is bad. I mean I want Company 2 homes to make a profit, it's much easier for us to deal with an employer who's not facing

bankruptcy and insolvency...' Gresham was very aware of the problems confronting home owners, saying that, 'Private care home owners have been squeezed like hell for the last four or five years by local authorities.' All this led GMB to take a 'partnership' approach to private providers (see O'Donoghue, 1998), which will be discussed below.

The RCN was also interested in a relationship of 'partnership' with employers. Louise Saber, RCN's Independent Sector Advisor, described her particular role as being to work with the independent sector in order to increase RCN membership and to improve professional practice. She said RCN was 'neutral' on the issue of private provision; it did not matter who the employer was. What was important to the RCN was 'good practice'. Saber thought that the shift to private provision had probably 'improved practice overall'. She said that, 'badly paid and treated staff will not deliver good care'. It was therefore in the employers' interest to 'treat their staff properly', and RCN worked with them on this, particularly advising both members and employers on 'comparable pay and conditions' in the NHS. Saber said that the RCN also broadly agreed with the recommendations of the Royal Commission on Long Term Care.

UNISON was particularly aware of the size and internationalization of firms in the sector, since the Public Services Privatization Research Unit (PSPRU) which provided information to various public sector unions (including the European Public Services Union and the Public Service International, discussed in the next section) was based at UNISON's office and employed their staff. This was in the process of being wound up, partly due to the perception that privatization was coming to an end and partly because of organizational changes in public sector unions, but had done much work in monitoring and providing 'intelligence material' on multinationals and other large firms across a range of privatized public services. Kevin Fenton had special responsibility for social care within the PSPRU. Fenton thought that concentration of ownership in the sector was, 'going to be the major significant thing if it continues'. He thought that the imposition of the minimum wage would be a major factor in speeding up this consolidation:

So what I think is going to happen is that the very small ones [private providers] are going to go bust, they won't be able to soak up the costs of the minimum wage. They'll start collapsing and I think that's what the bigger ones will be waiting for because they'll start picking up, therefore, the clientele from social services departments and the economies of scale will allow them to soak up the minimum wage, and they'll become larger as a result. They'll get a greater and greater market share as a result and, I mean it's already gone down from 13 to six quoted companies, it wouldn't surprise me if you ended up with, say, four or five which is what we've seen in every single market of public service that's been contracted out. First of all you get 10 or 12 providers and then within a very short space of time you get it reduced down to two or three – monopolization..... I mean the significance of Company 2 (USA) is that in the space of two and a half years it became the second largest UK provider.

The GMB was also very aware of the size and internationalization of the leading firms, partly as a result of their links with the American Service Employees International Union (SEIU), which they shared with UNISON. However, there were some inaccuracies in the detail of what Gresham said, such as in the overstatement of the current involvement of multinationals in the UK market in the following quote:

the big threat is from the multinationals that are coming in. Currently, I mean the estimates are that they currently have 20% of the market. I think in five years they'll reverse it 80 to 20 possibly their way. Particularly the American people who are coming in. I mean we've had a few battles with some of the home owners, particularly the Americans who some of our contacts over there sent us information about fraud cases amongst certain of the companies that are trying to get a foothold in the UK.

According to Gresham, 'about three years ago the American Chamber of Commerce actually published a document advising American multinationals operating in Europe how to get round European legislation.'



Saber said the RCN was ‘very’ aware of the concentration taking place in the sector, partly as result of her role as ‘Independent Sector Advisor’. As with the general shift to private provision, she said the RCN was ‘neutral’ on this. She also said that the RCN was ‘not concerned’ with internationalization within the sector. Her statement that, ‘we only really deal with national organizations’, suggests a lack of awareness of the internationalization of the leading firms. She was, however, aware that the largest organizations had their own internal QA mechanisms, which she regarded as ‘beneficial’ and ‘effective’. She said that large firms could not make profits, ‘unless they can demonstrate quality’.

UNISON’s attitude to these large firms was considerably more hostile than the RCN’s. This almost certainly reflected UNISON’s nature as a public service union whose primary goal was to halt and reverse the shift to private provision. Fenton said that ‘one of the primary functions’ which the PSPRU provided was, ‘to expose or to prevent companies winning contracts or to expose what happens when you privatize.’ Fenton had very little sympathy for either small or large owners. Of small owners he said:

Because of the reductions in public spending the smaller homes are screaming, saying ‘we can’t afford to run our homes on the money supplied by the state’. I mean these people .... They make me laugh as employers, they really do. These organizations are funded by the tax payer every which way you think, they’re funded by the local state, they don’t pay sick pay, they don’t pay maternity pay, they don’t pay holiday pay or anything like that... they’ve got virtually no extra staff costs and they start screaming.

Fenton said he suspected, ‘that there’s quite serious abuse going on in [private] residential homes.’

Fenton’s perception of large, and particularly American, firms was that they were essentially corrupt. He interpreted a statement by Company 2 (USA)’s chief executive that the British market was ‘underdeveloped’ as meaning:

that the American market is so competitive that the way that they manage and operate their homes in the American market they can transpose to the UK market and because our health authorities are probably not so rigorous they know all the scams, basically, to pull with the health authority or the public funding bodies. That's what they probably think, they think that what we've learnt in the States we can bring over here – the companies that are already over here are national companies, with the exception of [Company 3] who may well have learnt a few things off the executives [of its US associate]..... they, as I said, operate in a highly competitive market that they'll know the short cuts around – or how to cut margins, how to cut costs, how to operate more effectively, how to deal with the public bodies... how to deal with suppliers, how to deal with patients, how to get high turnover, you know – all those things that I'm not intimate with... It was the subtext, I think, of what Turner was saying. It seemed to me that what [he] was saying in straightforward everyday language is that this is a new market, they're right mugs over here, they really don't know how to pull the strokes – we do!

Fenton thought that such firms knew, 'how to get away with the minimal treatment of patients':

Because that seems to be their practice in the States. It's what they do, they go out of their way to invite the triple, double billing type of operation. It's quantity, get as many in, treat as many as possible but with low grade care but dress it up as 'we're caring [Company 2 (USA)] and we look after our patients so well', etc., etc., etc. The language that Turner was using at the time, that's what it seemed to me it was about – that 'we know how to pull the scams'. When he talked about the profit margins could be as great as 8-10% here as against the States that seems to me to indicate the other side which is not so stringent regulations, not so much inspection, not so much public accountability.

This view of Company 2 (USA) was formed partly as a result of information given to UNISON by the SEIU relating to the investigation of the firm for fraudulent activities

discussed in Chapter Four. This information suggested that Company 2 (USA) had been fined relatively small amounts by individual states - the implication being that this was a risk worth taking in order to obtain revenue by fraudulent means, since it did not affect the overall operation of the firm because it did not have to admit to malpractice. Fenton thought this was fairly typical of American firms, quoting as evidence the head of the FBI who had apparently said that fraud within the US medical system was running at \$100 billion a year (see Inman & Sone, 1997).

When asked whether the competitive practices of the US might possibly have led firms such as Company 2 (USA) to become more efficient providers, Fenton was clear that, 'the one thing I'm not saying is that I think these are highly trained, honed, efficient organizations that have cut their teeth on a highly competitive market and that this is capitalism working at its best. I'm not saying that.' Fenton also said that he would like more information about the kind of internal management systems they used, but that he couldn't, 'get inside the organization, it's very difficult to... They're very suspicious.'

Stephens, however, pointed out that concentration of ownership in the sector could potentially benefit the union:

in the sense of removing one of the obstacles to organizing the sector. Obviously it has negative consequences in the sense that if the firms that are created will be stronger so should they decide that they want to resist union recognition they'll have more resources to do it. But at the same time you are removing one of the main obstacles in organizing the sector which is the multiplicity of small employers. On balance we think the concentration would actually to some extent be a move forward. There is some evidence that some of the leading firms are taking a more positive attitude on union recognition...

The GMB's approach to such firms was fairly positive. For example, Gresham said that, 'we would expect quality to improve because they do have money, they have access to money that should be reflected in investment in premises, investment in training, which should improve the quality of the service.' Gresham said GMB had

already concluded 'about 30' national agreements with multinationals operating in public services, giving the examples of a French company 'that provides everything from trains, water, local government services', and ISS, a Danish multinational 'increasingly getting involved in home care'. Gresham said that it didn't matter to GMB whether the employer was public or private: 'I think the partnership approach that we've taken has paid dividends. There are good employers in both the public sector and the private sector.' In long-term care, this 'partnership approach' had initially involved working with small owners by providing them with ready-made staff handbooks and contracts. This had been followed by the drawing up of hotel-type quality benchmarks based on up to five 'stars', in conjunction with the National Care Homes Association (NCHA), which was piloted by all the small owners in Brighton and Blackpool. This star system was important to the union because it included employment issues and health and safety, as well as more usual quality measures such as food and room size. Although GMB's emphasis had been on small owners up to that point, Gresham said of this latest initiative: 'we're launching this to hit the big players.'

All the unions were broadly in favour of the changes to regulation proposed by the 'Modernising Social Services' White Paper (DoH, 1998b), although Gresham said he thought the time-scale for introduction was too long. Stephens thought that the merging of nursing and social care regulation into one agency was beneficial for UNISON since, 'if you're attempting to influence things you've got one agency you're trying to influence and not two.' Stephens was impressed by the way the American SEIU had been able to, 'influence the awards of public contracts and the regulation of the nursing and care home sector.' He said the SEIU had, 'often used, actually, quality concern and quality issues as part of their organizing drives, which is something we've not really done'. Saber thought that the existing regulatory arrangements were 'too fragmentary' and that national standards were necessary. This is consistent with the RCN publication 'Nursing Homes: Nursing Values', which identifies, 'an urgent need to... introduce a national audit system [and to] set national regulatory standards and protocols' (McClymont et al, 1996: 21). However, Saber said the RCN was concerned that the 'nursing component' may not be 'adequately catered for' under the new arrangements. Her statement that, 'social workers are not equipped to inspect nursing

homes', indicates a concern that nursing issues may be subordinated to those of social care. Saber also said the RCN thought that acute nursing should have been 'included' in the reforms, something that was subsequently included in the Care Standards Bill (2000).

Both Saber and Stephens thought there was a case for regulation at the firm level rather than just of homes. Stephens said:

I think that's a way of getting consistency across all the homes. If you have an approach that assesses the whole direction of the company, and you can also then introduce wider concerns than simply fabric of the building and quality of care that's being delivered. Things like the workforce planning, skills available, training and career development, that sort of thing. And there is some evidence that the expansion of the sector has reached a point now where there are some staff shortages being acknowledged, so if they're going to have any way of sustaining development of the sector they need to upskill their workforce and make it more attractive to people to stay. Levels of turnover are very very high and that can't really contribute to quality of care.

Saber, however, thought that those firms that could demonstrate good performance through their internal systems might legitimately claim a 'lighter touch' from the regulators.

Gresham also said he thought, 'that it is important that at a corporate level they are inspected, not just about the facilities, but about their standards and their ethos and their philosophy on care.' GMB had made submissions to government that any firm bidding to provide public services of any kind should have to meet criteria relating to four areas: competence and quality; health and safety; equality; and staff employment. These would involve the commissioning body in an assessment of the firm as a whole: 'if a home owner, whether its an individual home owner or a multinational company, they've got to demonstrate to the authority that as an organization they've got the competence and that individuals within that organization have got the competence.'

Overall, then, the attitude of the RCN and of GMB to private providers, and large and internationalized ones in particular, was more 'neutral' and less hostile than that of UNISON. It is clear that UNISON's basic hostility to these firms arises primarily from its character as a public sector union, and its consequent emphasis on retaining as much provision as possible within the public sector.

### **FORM AND EXTENT OF ORGANIZATION**

Although each of the unions organized different groups of workers, there was considerable overlap in the types of workers who might potentially be members of the different unions. UNISON organized the lower part of the hierarchy of worker, from cleaners, through care assistants to nurses. GMB organized all workers in the sector through its Association of Professional and Executive Staffs (APEX) wing, but had launched a bid for the organization of managers (see Edmonds, 1998). The RCN organized nurses only, but this included a number who were also small owners or managers. Saber described the RCN as 'the voice of nursing'. This put the RCN in some degree of competition with UNISON in particular, for organization of lower ranking nurses. Stephens said UNISON cooperated well with the RCN on things such as the pay review body, but that their interests were 'significantly different' in this sector:

... their interest isn't really in collective bargaining in these homes. They don't seek, even where they have members, they don't seek to bargain with the employer. Their role is to provide professional services to the registered nurses and to a limited extent represent them in disciplinary and grievance issues. They make no effort to organize, in any sense that we would understand it, the homes.

Saber herself emphasised that, although the RCN considered itself to be a union, it concentrated on, 'professional issues, rather than simply pay and conditions'. Saber said that, 'over half of registered nurses nationally are in the RCN', but that it was, 'less well organized in the long-term care sector'. She said that the NHS was the

RCN's 'core business', but that it was, 'working to recruit now in the long-term care sector'. This often meant attempting to, 'identify and recruit members who may be lone nurses in homes'. Stephens said he thought the RCN claimed 20,000 or 30,000 members in the nursing home sector. This was far more than UNISON, which Stephens estimated had, 'less than 2000 members in the whole sector'. This was out of an estimated potential membership of, 'something in the region of 100,000 people in the healthcare group and probably 300,000 for UNISON as a whole'. Gresham said that the GMB's overall membership in the sector was also small:

In those areas that we have managed to get in and recruit it's 100%, perhaps 90%, but because in a small home you might only be talking about half a dozen, perhaps less than 10 people, yeah? And usually we can sort of mop them all up, but I've got to say that for every one home that we've got membership in there's plenty that we haven't.

GMB and UNISON tended to get most of their members in private providers from those in homes that had transferred from local authority ownership or management. Gresham said that a lot of GMB members had transferred over to the private sector in Albion. Membership was also fairly high in some homes owned by voluntary organizations; the GMB, for example, had significant membership in the Royal British Legion, whilst UNISON had about 100 members in Leonard Cheshire Homes. However, during the course of 1999, and subsequent to the interview with Gresham and Pole, GMB signed two recognition agreements with private operators, Southern Cross Healthcare and the Highfield Group (CCMN, Dec.1999 / Jan. 2000). Highfield operated 75 homes with 3,580 homes, and the agreement covered around 5,000 employees. This reflected GMB's 'partnership' strategy of concentrating on mutual training needs with employers, which is discussed below. A telephone interview with Tom Douras of the TGWU confirmed that members of that union tended to be in voluntary organizations where not employed by public bodies. Douras said the TGWU tended to organize in large workplaces and organizations, and would not organize staff in small workplaces or organizations, 'unless they came to us'. Membership of the unions within the case study firms will be discussed in the next section, but it can be

noted here that, consistent with the figures for the sector generally, it was very low although the RCN had more individual members.

The lack of any existing 'tradition' of unionization within the private long-term care sector caused problems for UNISON in particular when trying to decide if and how to organize within it. Partly this was due to UNISON's nature as a public service union which was politically opposed to private provision, as well as being used to bargaining with public sector bodies. Both Stephens and Fenton indicated that UNISON would not organize within the private medical sector (other than nursing homes) due to political reasons. On the other hand, both agreed with Steve Morton, UNISON Director of Policy and Research, that in relation to the long-term care sector, '... in principle we're strongly committed to organizing workers in whatever the area that public services are provided, whoever is the provider.' Fenton said that sometimes:

isolated outbreaks of groups of workers in residential or nursing homes come to the union saying 'we're having problems with our employer, will you come and organize us or will you help us?', and that's occasionally happened. And then the regional officer will have to make a decision whether she or he spends a lot of time dealing with it.

The question of whether and how to organize the sector in a more strategic way was a serious problem for the union. Morton explained that:

In practice we find it quite hard to do because our resources are particularly tied up in quite large local government branches and our members there face a whole range of difficulties and we have to have, well we have a continuing argument about the interests of people on the margins or economic outsiders as against those who are relatively advantaged. I say that in relative terms but by and large unions represent the interests of those on the inside because they're in work. And certainly in terms of the balance of our membership, proportionately more are in secure employment and so an important continuing discussion within the union is how you shift resources from the relatively better off sectors and particularly with the... better off branches towards moving



organizational resources, particularly the time of organizers, but also financial support to organizing in the much more difficult to organize fragmented workplaces that you get...I mean it is a problem within the public sector but it becomes more acute when you have a range of private companies, many of whom are uneasy about the role of unions in any case.

By 'economic outsiders' Morton meant, 'those who I classify in marginal employment, that is in low-pay, in temporary, in casualized work, and many of them I think will be in this sector of care for the elderly.'

Morton identified two practical problems relating to actually organizing in the sector. The first related to 'time and money', whilst the second related to organizational issues, and in particular the fact that, 'at the formation of UNISON we had powerful sectoral groups formed with an executive council with a high level of negotiating autonomy, but community care, care for the elderly... doesn't fit easily within a local government or a health service frame which encompasses both.' On the first of these problems, time and money, Fenton said: 'its all about cost-benefit at the end of the day isn't it?... how much is it going to cost to organize and how much is the union going to gain from it?' Stephens elaborated on this further:

we want to organize them, but we have to ... we're a very cash strapped resource-low movement, we have to decide what target is going to make the most effective number of members in the shortest possible time. Because you'll notice I didn't say what's going to generate the most cash for the Union. Because if we were looking at it in terms of what generates the most cash for the union, we wouldn't organize private contractors at all. What we would say what we need to do is increase our managerial membership where 50% of the managers aren't union. But UNISON doesn't say that. We want to organize workers that need union representation. Having said that we have to do that in a way that's sustainable in terms of resources that we have. It's not a formal decision, there is nowhere on paper that it says we are not prioritizing the nursing home sector, but in practice we are not prioritizing the nursing home sector.

Instead of prioritizing workers in the long-term care sector, UNISON had decided to prioritize private contractors in ancillary services such as NHS cleaning and catering, where Stephens said the union had, 'signed up national recognition agreements with seven out of the ten national contractors, the big market players.' This area therefore offered the union the greatest returns for the amount of effort it took. Stephens said:

We've not abandoned in the longer term organizing in the nursing home sector but I think the key to that will be can the restructuring that we're going through in terms of our staff and branches generate enough cash resources to fund organizing staff to go out and do organizing in these areas. We're not going to be able to do it from our existing structures and resources; we need to generate resources that can be thrown into organizing campaigns at the nursing home sector. Now we could be criticised for saying that we de-prioritize the area that arguably needs us most but on the other hand if that's the area that you're not going to be able to organize effectively in the short term you have to make a judgement.

Stephens said that prior experience had brought the union to the position of de-prioritizing the long-term care sector:

After the 80s the whole sector expanded tremendously. That didn't really involve any transfers of staff because these were new facilities opening up so generally speaking we didn't have any foothold into them. In certain regions we made periodic organizing efforts and/or people contacted us from individual homes and it's on the basis of that experience that we decided for the time being that they're not a priority target, because those regions that tried to organize in those sectors experienced that it consumed an incredible amount of officer resources because they're not a sector that are activists, get involved in organizing much. Our activists are in hospitals and to some extent the community services, they will not go out, they wouldn't be allowed to have time off from their employer for a start to go out and organize nursing homes, with a few individual exceptions... Therefore we actively send in officers, you

know, paid staff to try and organize which is quite expensive, very time consuming, and the number of members you get out of it and they generate a lot of case work. So taking a very hard approach they're not really worth it in the short term.

This leads onto Morton's second point about the organizational structure of UNISON. Stephens said that this could be a barrier to organizing in the sector:

we have a problem that our branch secretaries don't necessarily want to go off and recruit in this sector because they know that it will generate a lot of casework for them and these members don't fit into the entire branch structures, they're more difficult to service and represent than members based in hospitals and so on and so on. Obviously these are generalizations, there are good examples here and there but as a general rule activists either can't or won't follow them up, so it has to fall back on paid staff. Now obviously some unions, particularly in the United States, have used a paid staff organizing approach. There are big institutional obstacles inside UNISON to prevent us from doing that on any sort of wide-spread scale, for a couple of reasons. One, we have lots of financial problems, so releasing that amount of resources wouldn't be easy. Two, the tradition of the way we organize is having regional officers attached to secure employers and carry out a casework and organizing role in relation to those employers. We've not traditionally had, until relatively recently, any people who are appointed as organizers. So if you're a regional officer with a geographic patch with one big hospital trust, community services trust, a few private contractors in the hospital and 10 nursing homes within your areas and some GP practices, 40-50 GP practices, it's obvious what's going to consume the vast amount of your time. It'll be the demands of the members in the hospital, followed by the community services trust, followed by the private contractors, and a very long way down the list of priorities will be doing anything in the sectors where we don't currently have any members. OK, so because of the way we've been organized there's been big barriers to freeing up any resources to direct at the nursing home sector.

The problems of organizing in the long-term care sector had led the union to be much more flexible about the organizational forms it used, and to experiment with a number of different organizing methods. Stephens said one of these involved, 'taking money away from the centre head office of the union to free it up for specific projects'. One such project based in London created, 'mobile paid staff who move around from area to area and generate projects in areas based on an assessment of what recruitment opportunities there are.' However, Stephens went on to point out that, 'even with all that if you free up resources to deal with recruitment and organizing there's still a debate about whether the nursing home sector is the right place to deploy those resources and our view at the moment is private contractors are a much better bet.'

There was also some organizational difficulty where members *were* recruited in the long-term care sector. UNISON's usual way of organizing, in NHS trusts for example, was to have employer-based branches. In long-term care, however, even where members belonged to a large private company, there were not enough of them to make this effective. In Stephens words: 'Because our membership is so weak, the number of activists is so low, it's usually not sustainable to have employer-based branches. There are one or two exceptions, but as a general rule, what happens is they're attached to the nearest NHS employer branch, on a geographical basis.' Again, some organizational innovations had been attempted:

There are one or two regions that have developed a geographically based multi-employer branch which deals with all employers in one area. In the East Midlands there's a branch called Nottingham Healthcare, that has members in the community trusts, the GP practices and the nursing homes in Nottingham, so it's a multi-employer branch. Having said that it's still... its principal area of membership is still the community trust.

In London a 'London Voluntary and Independent Agency Branch' was set up, but although its 'definition of membership' included private care homes, it was in practice a voluntary sector branch. Although this worked in London due to the high density of population, this was not being recommended for other areas, even in the voluntary sector. A different structure again was being tried in Wales, where the union was going

to have six branches based on lead employers, 'with a sort of sub-branch structure for the nursing homes within the main branch but that sub-branch structure's actually resourced by a paid member of staff, so what few activists you do have can concentrate on recruiting and organizing and the paid member of staff can deal with the administration and case work.' Stephens said that, 'the idea of creating a paid member of staff who's a resource for voluntary and nursing home members is one that's doing the rounds at the moment and there are ways of doing that, they can be funded by branches if you get large branches to fund these posts, they don't necessarily have to be funded from the central funds of the Union.' In sum, Stephens said that: 'the new approach is to say, you know, people should shape their branches based on what's workable in their own area.'

GMB faced similar organizational problems, especially since its strategy had been to target the small home owners. This meant that where there were a few members in a home they would be attached to a general branch. However, the aim was to move towards geographically organized branches, which mirrored those of the NCHA, the national organization of small owners. According to Gresham:

In Scotland and in Yorkshire we've actually formed carers branches on a geographical area... So we have everyone who is within the care sector actually in that specific designated branch and it pays benefits quite considerable, because they're all talking about the same thing when they go to a branch meeting.

UNISON had begun to think very strategically about how and whether to organize within large private providers. At the time of interview, Fenton was in the process of moving posts to become UNISON's National Officer 'responsible for bargaining relationships with the private sector and developing the union strategy in how to deal with the private sector'. This was to focus on making decisions about whether to target particular firms for unionization. Fenton described some of the strategic considerations which related to this:

I've sat with the health group and tried to help them pick one or two of the nursing home groups but what's problematic is the scale of the enterprise, because you're talking a home, maybe, with 40-50 employees. I mean those homes are spread all round the place, all round the country. Now unless you are very specific and say we're going to pick that firm because they've got x number of contracts and some of our members have transferred across so we're going to go and say right we're going to go for that one, and then once you've done that send a warning signal to the rest and say 'well OK look we're serious about talking with you, we're serious about organizing'.

Stephens said that some headway had been made on a regional basis with ANS, a private firm running 49 homes with 3,350 staff in 1998 (AR, 1998: 1). The South East and Eastern regions of UNISON had adopted an approach based on 'consolidation', which involved the following: 'take the homes where we had any members at all and concentrate on just organizing in them and then approach the employers one by one, concentrating on a few leading employers...' ANS had been chosen because, 'there was a particular combination of transfers and we had quite a membership base in ANS, so we had a bit of a concerted effort'. This had resulted in about 200 members within those regions. UNISON had also had a 'base' of about 100 members in the North West in a specialist company, Community and Integrated Care Limited.

Strategic decisions relating to large providers were profoundly affected by various pieces of legislation, in particular the Employment Relations Act (1999), the European Acquired Rights Directive (EU, 1977), the National Minimum Wage (NMW), and the EU's Working Time Directive (EU, 1993). The Employment Relations Act (1999) implements the proposals of the Fairness At Work White Paper (DTI, 1998), and provides for union recognition where 50% of the workforce are members or where a majority (of at least 40% of the workforce) vote for it in a ballot. Fenton said this would provide the basis for trying to organize in large firms. Which firms would be targeted had not at that time been agreed but would, Fenton said, be either those that were easiest to organize in or those that were most sympathetic to union organization. Fenton said: 'What I'll be doing is ranking the homes and saying, "right, who are we going to be approaching for a national recognition deal". Because what we'll be doing

is going to them and saying, “look, you either sign now or we’ll run a campaign and we’ll enforce it legally”.’ Fenton said one argument the union might use to convince these firms, ‘is the union will help stop their high turnover of staff, because they have a phenomenal turnover of staff, because they pay such crap.’ Gresham, however, pointed out that there was some ambiguity within the Fairness at Work proposals as to whether the bargaining unit would be the company or the individual home. Saber said the RCN was also intending to use the Fairness at Work proposals to obtain recognition, but that this may prove difficult, since nurses seldom formed the majority of workers in nursing homes.

An important place to start for such organizing, for both UNISON and GMB, was the European Acquired Rights Directive (EU, 1977), since most membership of the two unions in the private care sector was as a result of transfers from local authorities. The TUPE directive protects the conditions of employment of workers who transfer from the public to the private sector, including the right to union membership. The Acquired Rights Directive is implemented in the UK through the Transfer of Undertakings (Protection of Employment) Regulations (TUPE, 1981), which ensure that workers are entitled to continue working under the same terms and conditions (including union representation) agreed with their original employer when a transfer takes place to a new one.

According to Morton, ‘... once the decision is taken to put the tender out, there is a pattern of particular companies moving into monopoly and near monopoly positions, and you want to secure agreements with those and get a negotiating relationship with them.’ Gresham said that GMB was able to use transfers as a way of recruiting more members:

Where there are members in companies that they’re taking over they [GMB’s regional officials] will be negotiating about the whole transfer question. I know that they’ve been able to use that as a recruiting tool, because you know when you’re being taken over it’s always a time of uncertainties and insecurities and we have been able to make inroads in recruiting there. So the more information we can provide about the company that’s taking over, it puts them in stronger

position both with that company and also with potential members to say ‘well look you know we’ve got information on what’s going to happen’.

Gresham said that GMB had ‘a number of little local agreements where there’s been transfer’, as a result of TUPE.

The NMW, established by the National Minimum Wage Act (1998) and introduced in April 1999, was set initially at £3.60 per hour, with exceptions of £3.00 per hour for 18-21 year olds and £3.20 per hour for workers aged 22 and older receiving training. These rates were due to increase by 10 pence for adult workers from October 2000, and 20 pence for 18-21 year olds from June 2000 (CCMN, February 2000). It has been estimated that less than 10 % of private care home providers had prepared a strategy to deal with the likely impact of the NMW (CCMN, February 1999). The NMW would add ‘millions of pounds’ to the cost of care, with the number of business failures over the two years subsequent to the NMW’s introduction likely to increase as a result (ibid). L & B (1999-2000: 171) estimated that the total cost to private and voluntary care homes would be over £90 million per annum, falling most heavily in the North of England. The impact of the NMW on the sector would be uneven geographically, reflecting local labour markets. Homes in the North of England, East Midlands and Wales were likely to be most adversely affected. L & B’s analysis of the impact of the NMW (CCMN, June 1999) estimated that the rate of increase required to cover the costs ranged from £7.09 per week in the Yorkshire and Humberside region to 80 pence per week in London. Few local authorities in the areas most affected appeared to have made concurrent adjustments to fee levels. The above-inflation pay awards granted to NHS nurses in 1999, in response to the widely recognised problem of lack of trained nurses, were also likely to lead to higher wages in the private sector. Recruitment difficulties across all providers of nursing care (discussed in the next section) had also led to a rise in the use of (more expensive) agency staff, and to some providers recruiting from abroad.

All the unions agreed that the NMW would have a significant effect within the sector, and had campaigned for it as a means of improving pay. However, they also thought it was set too low. The tactic, therefore, was to use it as a base-line and then attempt to



negotiate a mark-up. UNISON's target minimum rate was set at a pound above the NMW at £4.60 per hour, whilst GMB's minimum target was £4.00 per hour, which they had already succeeded in negotiating in local government and which had risen to £4.34. Morton said that UNISON was:

running courses for our officers on both the new legislation and its organizing implications so that we use the law, particularly in sectors like this, and whatever emerges in terms of the recognition, the new recognition law, under the Fairness at Work, to go into homes and, I mean often its a question of getting a foothold, and the Minimum Wage, I think, provides the basis often for workers unsure of their rights, uncertain as to who to turn to, for the union to provide that support... So Minimum Wage, working time, recognition, all provide us with the opportunity, if we're prepared to take it, to organize workers in this sector.

The Working Time Directive was implemented through the Working Time Regulations (1998), which came into force on 1 October 1998. These set a working time limit of an average of 48 hours per week, which applies to casual and agency staff as well as those on more permanent contracts. Many unions have criticised the facility for individuals to opt out (in force until 2003) because it may provide a way for employers to intimidate less organized staff (TUC, 1998). A report on the effects of the Working Time Directive (PWR, 1999) on care home operators found that the increase in the wage bill resulting from the directive for the 'average' residential home was likely to be about £3,500 per annum, mainly as a result of the entitlement to three weeks paid annual leave (rising to four weeks after November 1999), a point also made by the GMB's Mike Gresham. The report found that the proportion of employees working in excess of the 48 hour limit imposed by the directive was less than two per cent, but that staff in 74% of organizations had signed an agreement to work more than an average of 48 hours a week.

One way in which the unions could take advantage of new legislation was to offer help to employers, particularly small owners, as a way of promoting organization and better conditions. GMB had offered smaller employers help from their legal and research

departments. Laura Pole, a Research Officer at GMB, said this was a way of saying to employers:

‘Let’s work together on this because you’re going to have to comply with this... you’re going to have to acquaint yourself with the law and what they’re going to do.’ Because for them it’s quite a challenge to keep abreast of all these changes, and we can sell the fact that we will assist you to implement this and to make sure that you’re compliant.

Similarly, Stephens said that UNISON had offered some employers help with education and training as a way of, ‘increasing the skills of members - they will mostly be members in practice, or potential members - we can make them more marketable and thereby raise the wage level in the sector, as well as giving us an input into the sector and a sort of presence there.’

Gresham said that knowledge of the regulations and laws relevant to the sector were crucial when attempting to organize:

One of the things that we have noticed, or we’ve found imperative, is that our officers and recruiters who go into this sector actually need to be well briefed and knowledgeable on the sector as a whole, on things such as regulation and inspection, funding arrangements, employment law issues – you can’t send a boilermaker into a private care home, because it’s an entirely different sort of strategies that are needed. Traditionally with recruitment you’ve gone and organized the workers and then knocked on the employers door. One of the things that we’ve done is organized the owners or establish a relationship with the owners. Because these homes are close communities, you know, the influence of the home owner or the manager tends to dictate what the... Warwick University did some research... a significant number of trade union members joined the unions because their bosses tell them to. So if you go in like a bull in a china shop, our experience in this sector, if you go in aggressively, it tends not to pay dividends. If you can establish the relationship it pays dividends. Hence things like the handbooks and things like that that we

produce and the quid pro quo is that we'll give this to you, you give us the members.

The strategy with larger providers had to be different, since they would have their own legal and research resources, although Pole still emphasised 'partnership': 'With some bigger ones it might be more a question of we'll have to go to the wire, and "you will be forced to do this by the law", and again try and get them to get a partnership approach to it rather than an adversarial approach.'

It is clear that in this sector there is a greater reliance by the unions on lobbying and regulation of working conditions than would otherwise be the case, which results from their inability thus far to significantly organize the sector. Stephens acknowledged this: 'I think we don't generally have strategic policy saying we're going to concentrate on lobbying. It's emerged because the weaknesses or the difficulties of organizing in the sector mean that we're not in practice organizing the sector, therefore the only thing we can put our influence into is lobbying.' Stephens did say, however, that this may change if the returns to the effort that was being put into organizing among private contractors of ancillary services declined. Gresham said of GMB's attitude to using the law: 'Our policy is that we would rather negotiate than litigate, but we're not frightened of doing the litigation route.' The general approach, therefore, was to use the legislation as a bargaining tool. Pole explained this in relation to the NMW in a way which also reflected UNISON's approach: '... for any company it must be better to have a negotiated, gradual approach to something rather than leave it all 'til April [1999] and they have to make the changes overnight... Let's talk about how to deal with it prior to the date of it coming, so again it's all about starting those talks.'

All the unions belonged to international federations. UNISON was a member of the Public Services International (PSI) and the European Public Services Union (EPSU). The PSPRU at UNISON worked partly for the PSI and the EPSU. GMB was a member of nine international federations in total. Of these, the ones relevant to the long-term care sector were PSI, EPSU and FIET, the International Federation of Commercial, Clerical, Professional and Technical Employees, which has since merged with other federations to form the Union Network International (UNI) ([www.union-](http://www.union-)

network.org). UNISON also had links with FIET and sometimes participated in events organized by them, but was not a member as FIET was primarily a private sector organization. Gresham said that FIET had been formed in order to get ‘different service unions under one umbrella’ in response to privatization and the consequent increasing involvement of multinationals in public services: ‘... they realized about six or seven years ago that within the service sector, none of the international trade union groups had actually got any coordinated strategy, so they embarked on it and they’ve been pretty successful in cleaning, security, care sector.’ Gresham said FIET was particularly useful as a means of obtaining information. FIET held regular meetings of its affiliates in different sectors, including the care sector, the cleaning sector and security. The circulation of information was also the main benefit which the RCN derived from its international affiliation, the International Council of Nurses, which Saber said enabled the sharing of examples of good practice.

The meetings organized by FIET tended to concentrate on European-wide issues, as did those of EPSU. EPSU talked to the European Commission about issues such as the Working Time Directive. The most important issue, according to both UNISON and GMB, which EPSU dealt with was the European Public Procurement Directive (EPPD) (EU, 1992). As discussed in Chapter Five, this stipulates that no ‘non-commercial’ considerations, such as conditions of employment, should be used when procuring public services. Gresham said the New Labour government was in the process of relaxing this requirement and had indicated, ‘that non-commercial activities can be taken into consideration, not “should be” taken into consideration, we haven’t got that far yet...’ According to Stephens, ‘the Labour government have argued to us that they can’t write into either local government contracts or health contracts that employment conditions must be protected and quality or health and safety must be given due consideration. They can adopt it as a policy but they can’t write it into contracts.’ EPSU therefore lobbied at the European level to get an ‘employment dimension’ included in public procurement, and both UNISON and GMB were in favour of local authorities using such staffing criteria when making commissioning decisions.

According to Stephens, EPSU’s efforts had been ‘extremely unsuccessful’:

Because the European Commission's dialogue with the trade unions is conducted by the employment side of the commission who are pro-union... So they can control directives like the Working Time Directive and write in union influence into those directives, which are then translated into national legislation. The Public Procurement Directive is controlled by the other sort of wing of the commission, the pro-capitalist, globalization, free market, European capital wing, controlled by Leon Brittan... So they just tell the employment division to keep well out of trade matters, because this is a matter of trade and therefore not appropriate for the employment part of the Commission to get involved in. And within the internal politics of the Commission the people on it are ... the employment commission is much weaker than the competition division. And then of course you have the shadowy influence of the European round table of industrialists... They're the key big European corporations who lobby the competitions side of the Commission on things like the Public Procurement Directive, and they're determined that there shouldn't be employment considerations written into awards of public contracts. I think they could live with changes in policy but they don't want it in legislation.

Stephens also thought that, 'the Americans may occasionally try and put pressure on the Commission', in order to keep employment criteria out of contracts.

In long-term care, it was the example set by the American SEIU (discussed in the previous section) which impressed both UNISON and GMB the most. Stephens said that the organized international federations were less important than concrete links with foreign unions such as the SEIU (even though the SEIU was also a member of FIET) :

International links are relevant, those formal bodies in relation to this are not particularly relevant. They are relevant for other things, I mean the EPSU is central in terms of getting European Directives on public sector issues, but not particularly relevant to this. The real relevance of international links here is the

links that we've made with the SEIU and other unions that are organizing to just exchange information and ideas about how to organize. There's not been any co-ordinated bargaining approach, we're not at anything like that level.

Stephens said that UNISON also had links with the American Confederation of State, County and Municipal Employees (ACSCME), a primarily public sector union. However, Stephens thought it was the SEIU, 'that have made the running in terms of nursing home organizing, and those of us that are pro-organizing as it were always quote the SEIU..... As far as I know the SEIU is the only one that's really made any impact on the sector.'

The GMB was equally impressed with the SEIU, Gresham describing it as, 'The American equivalent to the GMB... Very impressive trade union, we're very good friends with quite a few of them...' The SEIU organized all service employees, including care staff, cleaners, catering staff, janitorial staff and security staff. Gresham described the SEIU's recent history as follows:

About 10 or 12 years ago they were in the complete doldrums and their general secretary, or their president, at that time was a bloke called John Sweeney who's now John Monk's equivalent. He took a decision to actually organize the non-organized service sector, and their membership went from 400,000 to over one million in six to eight years. They're a very, very aggressive trade union. I mean they brought out ... they shut down New York a couple of years ago because they tried to organize and recruit all the janitors and cleaners in the apartment blocks and they did, but it meant that some Madison and Park Lane garbage wasn't being collected from the stairs. They're very, very impressive and their new president, a bloke called Andy Stern, is certainly one hell of an organizer, very impressive. They organize, well again in the sector, a lot of Puerto Rican, a lot of Mexican, a lot of immigrant and black workers who are traditionally non-unionized, no culture of unions, and they've actually gone out very aggressively and recruited. They've been over to teach us a few things.

Andy Stern had been a guest at GMB's conference in the year prior to the interview, and Gresham had been to the SEIU's conferences. Yet despite Gresham's admiration for the SEIU, their 'very aggressive' approach could not be more different from the GMB's 'partnership approach'. The SEIU's biggest success was in organizing the staff of Company 2 (USA), which will be discussed in the next section.

Although impressed by the activities of the SEIU, it is clear that international links were useful primarily for the information and inspiration they yielded, rather than for their ability to increase bargaining power. The activities of EPSU, for example, in trying to obtain an 'employment dimension' within the European Public Procurement Directive had not been successful. None of the unions were able or willing to engage in the kind of aggressive organizing within the sector which they admired in the SEIU. As discussed above, this left them with a nationally-based strategy reliant to a significant extent on using state regulations and laws as the basis of bargaining. Within this context, the unions' relations with the case-study firms will be discussed in the next section.

### **FIRM-SPECIFIC ASPECTS**

As indicated already, union membership across the sector was generally low, and this was reflected in the figures for the case-study firms. Stephens said that UNISON membership figures for all the case-study firms was 'negligible'. Gresham said that GMB was in a very similar position, with membership across the case-study firms at 'two or three per cent, possibly. Very, very low.' Gresham said that GMB had 'some' Company 1 membership in Yorkshire, but none in the Greater London area. Gresham also said that registered nurses in nursing homes would be RCN members, but that 'the RCN will not necessarily be their representative body.' Saber said that the RCN did not yet 'have formal agreements' with the case-study firms, but would seek to secure these through 'partnership' and the Fairness at Work legislation.

Stephens said that Company 1 was conducting talks with UNISON over recognition within its residential homes, but not within its nursing homes. Both UNISON and

GMB had more members in the case-study firms on the residential side rather than the nursing side, mainly because these members originated in local authority homes that were transferred to the private sector. Stephens said in relation to Company 1 that:

in a sense, what they're doing is recognising that we have a base in the [residential] care home sector, in that there are large numbers of people being transferred out of local authority... care into privately provided care. I don't think they would want to give us a foothold, which we don't have at the moment, in their nursing home operations.

Stephens said that Company 1 had taken the initiative as a result of impending transfers involving UNISON staff:

... we'd raised some issues at a local level in one or two homes and obviously our branches had made it clear that when the main transfer took place they'd be demanding recognition, but [Company 1] took the initiative to say 'look let's not wait until the actual transfers take place, lets talk nationally overall.'

However, Stephens said that such negotiations had to be conducted carefully, since in other sectors:

we've had one or two contractors that have presented us with recognition agreements that we don't think are worth anything and then gone round bidding for contracts and claimed to be in discussion with UNISON, you know, and 'we're a union friendly employer'. So people are utilising some form of paper recognition as a means of securing market advantage. That hasn't really happened yet in our sector, but it could do I suppose...

Gresham said that in GMB's experience Company 1 had an anti-union approach, although he thought there might be some places where Company 1 would have to grant recognition as a result of the Fairness at Work legislation. Although he did not know the details of this, Company 1's Head of Quality Assurance, Bob Jones, confirmed that Company 1 was 'going through the process' of dealing with the



Fairness at Work legislation. Asked further about union organization, Jones said that although it was not his area of responsibility, Company 1 had, 'always had and will continue to maintain good links with the Royal College of Nursing, who are a union as well. So there's always been that link... I always bring up the Royal College of Nursing, because I was once on the council of the RCN.'

Stephens said that as a result of its weak organization and the factors discussed in the previous section regarding the union's 'cost - benefit analysis', UNISON had decided not to attempt to gain recognition from Company 2 or Company 3 at that stage. According to Stephens, Company 2 and Company 3 'are known to be the most anti-union...' This statement was informed by experiences, some of which dated back to the 1980s,

where people have transferred across [from the NHS], they're the people we've had lots of individual disputes with about disciplinary grievance issues, no big strikes or anything, but lots of poor treatment of staff and disciplinary grievance issues which, in our view, is designed to remove the transferred staff as soon as possible after the date of transfer, just basically harass them out or make it so uncomfortable that they decide to leave and then they don't need to deal with it.

This related not simply to union members, but to other staff who had rights under TUPE,

and thereby being more expensive than other groups of staff. I think they do have a hostile attitude to trade unionism as well, but I think the main motivation for them is that they inherit staff from the health authority or trusts who cost them a lot more than the staff that they employ themselves and they want to remove them as soon as possible, so they have two tactics. They either offer them fairly generous voluntary redundancy, or to the people who don't go after that's been put on offer they try and make life as uncomfortable as possible so that people just quit.

However, some doubt must be cast on these claims as far as Company 2 is concerned, since Stephens acknowledged some confusion over which firms had links with each other, believing Takare (which was later acquired by Company 1 - see Chapter Four) once to have been 'linked to' Company 2.

Gresham also displayed some imprecision in his characterization of the attitude of some firms towards the unions. He claimed that:

we've had a few battles with some of the home owners, particularly the Americans, who some of our contacts over there sent us information about fraud cases amongst certain of the companies that are trying to get a foothold in the UK..... I mean the Americans as employers are vehemently anti-Union in the homes and particularly in this sector.

This information related to information passed by the SEIU, who had succeeded in gaining a recognition deal with Company 2 (USA) after a series of strikes. Company 2 (USA)'s annual report for 1996 (AR, 1996: 28) indicates that the company had negotiated new contracts at eight facilities in the US in order to avert a strike by the SEIU. However, Gresham said that Company 2 had not had a significantly more hostile attitude to the unions since its acquisition by Company 2 (USA). He put this down to the fact that, 'a lot of the [Company 2] management is still the old [Company 2] management that we've had a relationship with, particularly in Scotland.' This relationship stemmed from the time when, according to Gresham, Company 2 had been set up by a hotel chain and subsequently bought out by the management, at which time GMB had a recognition deal in the hotels.

Of all the union representatives interviewed, Fenton had the greatest knowledge of Company 2's parent company, Company 2 (USA). When Company 2 (USA) first began to invest in the UK, UNISON had planned to carry out a joint campaign against it with the SEIU, involving American residents of Company 2 (USA)'s homes who had made complaints against the firm relating to allegations,

of fraud and corruption in the US. We'd been writing a book at the time on fraud and corruption in public services, as a result of privatization, so it fitted nicely into the work we were doing. So the idea was that we'd do a joint campaign and the Americans were going to bring over a whole team of ex-users of [Company 2 (USA)] and shop stewards who were involved in working there and we were going to do..... and what it also fitted into at the time was that UNISON were running a national public service campaign at the time, leading to a big demonstration and concert and all these sorts of things; it fitted in nicely with that as well. But the long and short of it was that the legal team here looked over the material that we were going to use and gave it to a leading QC who specialized in libel law who said "you cannot be involved in the campaign whatsoever because the Company will sue you"; so we had to pull out.

The SEIU were more successful in their campaign against Company 2 (USA) in the US:

The SEIU were very successful because they ran a half page ad in the Wall Street Journal basically saying '[Company 2 (USA)] are being investigated by the FBI, do you know anything and if you do phone this number', and [Company 2 (USA)'s] stock fell \$2.50 a share and wiped out \$100,000 of the .... What's it..... I can't remember the name of the chairman .... off of his personal fortune.

Fenton claimed that this action had a major influence on the recognition deal which Company 2 (USA) subsequently signed with the SEIU. Fenton thought that British unions could learn a lot from American ones like the SEIU, who organized company-focused campaigns in which they would, 'go in and find out as much detail as possible'. UNISON's goal in attempting to run this campaign against Company 2 (USA) was part of its overall campaign against the private provision of services.

Company 2's Head of Quality Assurance, Jane Bartlett, confirmed the lack of union organization in the company, saying: 'there's not been much union involvement at all.

The company doesn't currently recognise the union, but it may well change with the legislation'. However, she did say that Company 2 had good relations with the RCN, which she described as, 'a union of sorts'. Bartlett said that the firm had, 'always used RCN guidelines anyway', and that many Company 2 homes had RCN 'resource centres'. These were libraries, 'that any nurse from the hospital or any other nurse can come in, pick up RCN leaflets, hold seminars and things like that.' Bartlett said the company encouraged nurses that did not work for it to use the resource centres, partly as a way of tackling the perception that working in a nursing home was 'second class' when compared to working in the NHS.

Fenton confirmed Stephens' comments that Company 3 had been hostile to the union when TUPE transfers had taken place, giving a particular example where staff in a Scottish health authority were redeployed within the authority following a transfer because Company 3 would not agree to employ unionized staff. Pole said that GMB did not have 'much experience of dealing with' Company 3, but was aware that a number of public sector homes had been acquired by the company. This meant they would have to be carefully monitored:

we'll have to keep tabs on that because it'll be things like, you know, 'how do they apply TUPE?', you know we need to keep that kind of information coming in because... if, for example, we know that certain companies are not going to apply TUPE, or haven't done in the past, we're going to have that information to hand when they take over a local authority's workforce, so that we can say 'there's a concern here'. So there's a concern, but because of the disparate nature of the sector that is quite a challenge.

When asked in interview whether Company 3 had any union organization, Margaret Grant simply said: 'We don't have unions.' She said it was in the terms and conditions of employment that the company did not recognise unions, although staff could be members on an individual basis. She declined to elaborate on this further, except to say that it was, 'just a decision that was taken right from the start.' However, she said Company 3 encouraged staff to be members of 'the professional body', the RCN.

Fenton claimed that Company 3 had been harmed by adverse publicity surrounding its early US partner, which he said had an, ‘appalling record on patient violations and accusations of kidnapping.’ Fenton said Company 3 had pulled out of an early PFI project as a result of, ‘the adverse publicity, you know, this is a firm that’s owned by an American company that’s been sued in the States for patient violation, for fraud, for corruption, for this that and the other.’ This US company had in turn pulled out of Company 3, Fenton thought possibly as a result of Company 3 ‘saying “look, you’re making it impossible for us to operate here”.’ Fenton said that the US company had also ‘got driven out of Australia’ as a result of a campaign run by a doctor whose son had been a resident of one of the company’s homes: ‘... he says his son was subjected to quite serious abuse and had a nervous breakdown. So he waged a one-person campaign against this firm and drove them out of Australia.’

The lack of union organization among the case-study firms meant that they could pay wage rates based on what local labour markets would stand. Jones said that this was Company 1’s practice, with pay set on a home by home basis, but that Company 1 had to decide, ‘Whether or not it will go the same way as the National Health Service, i.e. the same pay across the country or whether or not it remains local.’ Jones said that he personally was in favour of it remaining localized: ‘I think we should stick with the local labour market pay rates... It’s not about the rate you’re getting, its about where you’re working, which is very different depending on the cost of living. You know, it’d be nice to wave a magic wand and have everybody across having the same cost of living, but life ain’t like that.’ Bartlett said that in Company 2, also, ‘Pay rates are very regional, so if we were talking about Bromley, it would be totally different if you talked maybe about Sheffield or somewhere like that.’ Grant confirmed that the same was true for Company 3.

The low wages paid across the sector meant there was potential for competition on pay between firms. Jones said that Company 1 found it was competing on pay, ‘all the time.’ However, he said that the low level of state funding limited the amount the firm could afford to pay staff: ‘You’ve also got to bear in mind, I think it’s 80% of our clients, are state funded not private funded. State funding has a limit, so unless that limit changes we can’t pay more. We might want to, but we can’t.’ Bartlett said

Company 2 also had to be mindful of the competition: ‘We did a massive survey at the end of last year, and sort of rung competitors, got staff to go to other homes and find out pay rates before they were set, and we do try and remain competitive.’ However, competition on pay was not always in the company’s interests:

Its difficult sometimes, because you can get into almost pay rate wars..... because if we did it the nursing home down the road would do it, and then you’d get that all of a sudden you’re paying perhaps the qualified nurses three pounds an hour more. And its not the be all and end all, I think some of the other staff benefits are also important... we try to remain competitive in every area.

Grant said of pay, simply: ‘We never expect to be the highest payers.’

Grant gave an indication of the flexible nature of Company 3’s workforce, describing it as ‘mobile’ and mostly female. The ‘nucleus’ was full-time, especially the trained nurses, but there was ‘fluidity’. She said Company 3 had a ‘high proportion’ of part-time female staff, some of whom had two separate posts within the organization. Grant accepted that consistency and continuity of staffing was important, but said there were ‘severe’ recruitment problems, among trained nurses in particular. Both Jones and Bartlett made similar comments, with the following from Jones being typical:

In terms of the qualified staff, there’s a national nursing recruitment crisis whatever organization you’re in, public, private, whatever, and it’s only going to get worse. The projections demonstrate that there are fewer people coming into training and the requirement... its all right for Frank Dobson saying ‘there are x number more nurses’, they just aren’t there. And if the public health service recruits x number more nurses, that means there’s x number less available for the independent sector. There is a major problem. Its going to get even worse because some bright spark worked out that, I can’t remember the figures, but something like 60% of the workforce is in its last fifteen years of working life. They’re predominantly middle aged at the moment but that’s... what the hell happens when they all retire? Big problem with qualified staff.

Company 2 (USA)'s annual report for 1998 (AR form 10k, 1998: 21) indicates that: 'operating costs in the United Kingdom were impacted by increased temporary staffing costs due to a nursing shortage.'

These problems were compounded by the status attached to working in a private nursing home for older people. Jones explained that : 'We suffer the problem, and this is a very honest comment, that the independent sector as opposed to the public sector is seen as a second class citizen. Elderly care as opposed to something else you might work in is seen as the bottom of the pile. So we don't necessarily get the pick of the staff.' The problems attached to recruitment and retention of less skilled staff were somewhat different, and related more directly to pay levels. Jones said:

There are problems with unqualified staff but they tend to be different. I can think of two examples. We've got a home in Manchester where they opened a large supermarket down the road and you can get a couple of pence more an hour for stacking shelves. Care assistant versus shelf stacking. So they go. There's one of the homes down in Kent where they're... building the largest shopping centre in Europe... and we've got two homes just adjacent to that.

Both Jones and Bartlett thought the NMW would have an effect on their respective companies, although despite her comment about not being 'the highest payers', Grant claimed it would not. Jones said that there were some areas of the country where Company 1 had slowly raised wages over a period of time in order to get them up to the required level in time. Bartlett said the impact on Company 2 would also vary regionally, but that the size of the company would allow it to absorb these costs:

... the Minimum Wage is going to affect some of the smaller individuals [i.e. home owners] concerned in a tremendous way. And with the regional spread, it's probably not going to affect us at all in the South East... You get up into perhaps Newcastle, again probably it'll be East Midlands, there will be an effect. But again because of the spread, because the way things are, with also having the States [i.e. Company 2 (USA)], the amount of profit we make will

go down, but its not going to be like someone's bread and butter... or anything like that.

Staff relations are obviously important to the smooth functioning of the company and the achievement of its goals. Unsurprisingly, all the Heads of Quality Assurance said staff relations generally were 'good' or 'quite good'. Both Jones and Bartlett said there were factors additional to pay which were important in achieving this. Bartlett, for example, said pay was, 'not the be all and end all. I think some of the other staff benefits are also important.' Jones said he believed, 'the single biggest recruitment problem or success, is the quality of the manager of the home. You get the right person in charge and your recruitment problems begin to diminish. You get the wrong person in charge and they go up.'

As discussed in Chapter Four, the merger process was a time of disruption; how this was handled was crucial for staff relations. Jones claimed that in Company 1 this had been successful as evidenced by the latest topic of conversation among staff:

The hot topic at the moment, which perhaps is a good indication of how staff are feeling, is what the new dresses are going to look like. As we go through a process known as branding where the... a significant number of the homes still have their own signs and in order to brand them as [Company 1] there are certain things they have to go through, and one of them is new frocks.

At Company 2, however, the merger process had caused considerable difficulties, with some of the former Apta staff choosing to leave (see Chapter Four). Bartlett said that in 1997, following the merger process, Company 2 had had to look,

at terms and conditions of employment and how it was going to be all brought into one company. It did cause an awful lot of problems, coming up October, November last year. In January the new terms and conditions were introduced. Most people, I'd say probably 90, 95% of people were very happy with the outcome, and we've moved forward a lot, but I would say that if you look back to the Company 2 Homes as was in 1994-95, last year put us back and I would



say now that people are becoming a lot more aware of staff benefits, training that's available.

All the Heads of QA said that training was important. Company 1 had a 'Professional Development Centre' (Annual Review, 1997: 23), which provided continuing professional education for nurses and National Vocational Qualifications (NVQs). Jones said that training would, 'come together more over the next twelve months as we head down the road to Investors in People'. As discussed in Chapter Four, Company 2 was introducing an intranet which would allow it to, 'effectively train eighty units at one time from a central location'. Bartlett said that Company 2 was, 'pushing staff development and people taking responsibility for their own learning, and encouraging that actively.' She said that the firm's resources allowed it to, 'ensure that we've got adequately trained staff and that staff are happy with their terms and conditions, and therefore I'm convinced that that is reflected in the care that the residents get.' Grant said that every member of staff at Company 3 had induction and 'ongoing training', which amounted to a minimum of five days a year, although in practice it was more than that. Each home had its own trainer who is responsible to a regional trainer, who in turn was responsible at the national level. In addition to this there were 'special courses'.

Training was therefore seen as important to the functioning of all the firms. However, as Chapter Four indicated, these firms operated primarily on the basis of standardization of the work process rather than standardization of skills through professionalization. It is clear from this chapter that wage levels and the overall 'crisis' in nurse recruitment were the most important factors when seeking to attract and retain enough competent and adequately trained staff. As 'A Better Home Life' points out (CPA, 1996: 71), the conditions under which staff work, and the effect of these on their morale, are important factors in the quality of care delivered. Large firms may have an advantage when compared to small owners in being able to provide better training and marginally higher wage levels, and their QA systems may be effective in maintaining an acceptable quality of care. However, these observations need to be set alongside those of Fenn and Smitham in the last chapter (see Chapter Six, 'firm specific aspects'), which suggest that some large firms (although, according to

Smitham, not Company 1) may have problems with staff loyalty and retention. It is clear that staffing conditions within the private care sector as a whole fall significantly below those in the state care sector (L&B, 1997: A153), and in most other sectors.

Whilst the low level of unionization within the firms permitted them to pay according to local labour market conditions, two of the three firms acknowledged that the NMW would have a significant impact upon them. This reinforces the importance of the state, since this would be the case even if the unions did not exist. All the firms were more sympathetic to the RCN than to the other unions, despite the fact that the RCN had not managed to secure national agreements with any of them. The evidence from UNISON regarding the union's experience of TUPE transfers, and the comments of Grant herself, suggest that Company 3 was the most hostile to unionization. Company 1, on the other hand, had taken the initiative to begin talks with UNISON about recognition. Nevertheless, the fact that this was prompted by the TUPE legislation and the Fairness at Work provisions (the Employment Relations Act, 1999), and the fact that even the RCN felt the need to resort to the latter, again reinforces the relative weakness of the unions and their reliance on the state.

## **DISCUSSION AND CONCLUSION**

It is clear from the evidence in this chapter that the extent of union organization across the sector generally, as well as within the case study firms specifically, is very low. This is a valid conclusion, since if anything the incentive of the union officials interviewed would have been to overstate the extent of membership. Although there were some limited successes in signing or moving towards recognition agreements, such as UNISON's talks with Company 1, union membership was negligible. In some cases this limited extent of organization was compounded by problems arising from the *form* of organization. This was the case for UNISON in particular, since it was geared to organizing employer-based branches within large public bodies. However, in the long term care sector, as Stephens put it, 'Because our membership is so weak... it's usually not sustainable to have employer-based branches'. Various alternative methods of organization had been experimented with in the sector, but these imposed higher

costs on the union in terms of the resources necessary to make them work. The union thus had to undertake a 'cost-benefit analysis' of whether this sector was the most effective place to employ these resources.

The organizational form of UNISON also impacted on its strategy through the medium of the attitudes, perceptions and goals which arose from it being primarily a *public sector* organization. There was a degree of hostility towards and suspicion of the private sector, and large and internationalized firms in particular, which was lacking in other organizations. Fenton was clearly the most hostile of the respondents. This may have stemmed from his position as a researcher in the PSPRU - his function in the union was to collect information on multinational firms which could be utilised for campaigning activities. Stephens, on the other hand, was primarily responsible for organizational matters, and thus took a somewhat more pragmatic approach. All agreed, however, that the union's ultimate goal was to retain as much provision within the public sector as possible; yet there was a realization that the dominance of private provision was unlikely to be reversed. The difficulty the union was having adapting to these changed circumstances is demonstrated by the internal debate over how its goals should be pursued in this sector, and even whether it should be organizing within it at all. This debate indicates that the organization was not monolithic. The outcome of all these factors, however, was that the union had effectively 'de-prioritized' the sector. Nevertheless, there is some inconsistency in UNISON's decision not to organize within the private *acute* sector, apparently on principle, whilst its decision to de-prioritize long term care was more pragmatic. It is possible that the union could take such a 'principled' stand in the acute sector because that sector is fairly small and the dominance of the NHS seems assured. In long term care, however, private provision has become the norm and this is unlikely to be reversed.

UNISON's approach differed from that of the GMB and the RCN, both of which took a 'partnership' approach. For the RCN this stemmed from the form of its organization as a more 'professional' body, whilst the GMB was not a primarily public sector union and had substantial experience of organizing among private employers. Gresham's comment that, 'I want [Company 2] to make a profit', contrasts clearly with those of Fenton, for example. Nevertheless, Gresham displayed some imprecision

about the activities of multinational firms in the sector, which would seem to reflect general perceptions of these type of firms (informed to a large extent by the American SEIU) rather than actual experience. It is clear, however, that GMB was more pragmatic in its approach to private providers, including large and internationalized ones, than was UNISON. However, both the GMB and the RCN were confronted by the difficulty in practice of organizing in the sector and faced similar problems to UNISON. Despite Gresham's desire to 'hit the big players', GMB's strategy of 'partnership' was more successful with smaller providers. Large firms have their own resources, and therefore no need for the GMB. The unions' weakness meant these firms could effectively ignore them, whether their attitude was friendly or hostile. The RCN was something of an exception to this in that the case study firms had a positive attitude towards it, again because of its professional status.

The international links which the unions had did not compensate for their weaknesses in the domestic arena. Whilst these links provided them with information and inspiration, they made no fundamental difference to their bargaining position. As Stephens put it: 'There's not been any coordinated bargaining approach. We're not at anything like that level'. The one attempt by UNISON to use these international links directly, by combining with the American SEIU to influence negatively the entry of Company 2 (USA) into the UK market, had to be abandoned due to the danger of legal action against the union.

The unions' weaknesses in the sector deprived them of direct bargaining power, forcing them in practice to rely on the intervention of the state to pursue their goals. UNISON's dependence on the state, which was clearly also the case for the other unions, is demonstrated by Stephens' comment that: 'I think we don't generally have strategic policy saying we're going to concentrate on lobbying. It's emerged because the weakness or the difficulties of organizing in the sector mean that we're not in practice organizing the sector, therefore the only thing we can put our influence into is lobbying.' In terms of directly increasing or retaining union membership, reliance on the state entailed using the Employment Relations Act (1999) and the TUPE regulations. In terms of directly improving workers' conditions of employment, this entailed ensuring that the National Minimum Wage and the Working Time Directive

were applied properly, and lobbying for the NMW to be increased. The NMW and the WTD are particularly important, since they will have an impact across the sector as a whole, not just in those areas where the unions have a presence such as in homes recently transferred from local authorities. Indeed, the weakness of the unions in the sector is evidenced by the fact that firms are able to determine wages on the basis of local labour markets. The unions are only able to have an impact on this through ensuring that the NMW is applied.

Whilst the NMW and the WTD will affect both large and small providers, they will ultimately have the same effect as the state funding policies and new regulatory standards discussed in the last chapter, i.e. they will place more pressure on the smaller providers and thus accelerate consolidation within the sector. The economies of scale which large firms can make use of will give them an advantage over smaller providers in being able to accommodate the increased costs associated with these interventions by the state.

Paradoxically, despite the hostility towards large private firms by some in UNISON, Stephens indicated that this consolidation may actually make the unions' task easier, since it would remove, 'one of the main obstacles in organizing the sector which is the multiplicity of small employers'. Where recognition could be obtained, this would particularly benefit UNISON because, as discussed above, the form of its organization is suited to large employer-based branches. To some extent then, what holds for the relationship between the state and large private providers (see Chapter Five) may hold for the unions: concentration in the organization of one may be reflected in the other. Company 1's talks with UNISON are one example of this. However, Company 1 appears to have taken this action because it will in time be compelled to do so by the state, not because the union has been in a position independently to compel it to do so. It is thus clearly the state which is leading and facilitating this organizational concentration within the sector.

The extent of union organization in the sector has been shown to be minimal. This arises partly from the structure of the sector itself, which currently includes a multiplicity of small providers and relatively small workplaces. The barriers to union

organization thus include the time, effort and money which would be needed to organize such a fragmented workforce. The organizational forms of the unions themselves, especially in UNISON's case, have compounded these difficulties. The unions have therefore had little choice but to pursue their goals through the medium of state intervention. These interventions by the state will have a significant effect in raising the costs of providers and thus facilitating greater concentration in provision. This chapter therefore confirms the findings of Chapter Five, that the state is the decisive actor in the sector, but that its actions are likely to disproportionately benefit large and internationalized providers in the long term.

## CHAPTER SEVEN: RESIDENTS AND OLDER PEOPLE'S ORGANIZATIONS

### INTRODUCTION

Around 400,000 elderly and disabled people live in registered care homes, of whom over 300,000 are supported by public funds (CCMN, June 1998). Older people are the largest user group in both health and local authority services. As with other areas of welfare, there are profound issues of power concerning the relationship between users of long term care services and those who provide them (Barnes, M., 1997; Bennett & Kingston, 1993). In care services for older people this is a particularly difficult issue, since many users have a sense of 'not wanting to be a burden' and 'not wanting to cause trouble' (Williams & Keating, 1998). This provides a basis for the easy disempowerment of users - they may in fact need to be actively encouraged to have their say. In addition, many users of long term care services require a high degree of support of various kinds.

As a result of the lack of autonomous organizations of care home residents, the meso level analysis of the relationship between older people and the case study firms centred on two foci, as discussed in Chapter Three. The first focus was organizations which claim to represent or campaign on behalf of older people. Thus interviews were conducted with key people from Help the Aged, Age Concern, Counsel and Care and the Relatives' Association (now the Residents' and Relatives' Association). These are charities and not directly controlled by older people themselves. It was hoped to interview a representative from the National Pensioners' Convention, a campaigning organization of older people, but this did not prove possible. The other focus around which analysis was centred was the ways in which older people resident in homes run by the case study firms, and their relatives, may have been encouraged to express their opinions through meetings at the home level. This provided a focus on actual residents which was consistent with the thesis' concern with the *organization* of relevant actors,

rather than individuals. This second focus is discussed primarily in the section on the firm specific aspects of the analysis.

### **ATTITUDES, PERCEPTIONS AND GOALS**

All of the organizations had similar goals. Both Evelyn Edwards, Director of Information and Policy at Age Concern, and Alison Alexander, Advice Coordinator at the Relatives' Association, stated improvement in the quality of life for older people as their organization's key objective. Age Concern was particularly concerned with funding issues in long-term care, with Edwards arguing that nursing and personal social care should be free at the point of use. The 'empowerment' of older people was seen as important for Edwards, who described Age Concern's goal as enabling older people to 'advocate for themselves'. Garton, Head of Planning and Development at Help the Aged, emphasised the need for 'independence and inclusion for older people and their direct participation in decision making at an individual and collective level'. Alexander said the Relatives' Association wanted to involve relatives more in homes, and sought to achieve its goals by 'working in a partnership between families and homes'. Les Martin, Deputy General Manager at Counsel and Care, described the organization's objective as to provide 'advice and help' for older people, but also 'to influence the work of practitioners and the policies of managers and also the key opinion-formers who actually come up with legislative change. To try and bridge the gap between the experience of individuals and the making of policy.'

In terms of the overall shift towards private provision, two of the respondents, Edwards and Alexander, thought that standards of care generally had improved, largely as a result of the stricter regulation imposed by the Registered Homes Act (1984). Edwards, for example, felt that 'we are no longer running with the poor quality care in the local authority sector', and that the regulatory changes accompanying the shift to private provision had, 'had a tremendous impact on local authorities... of looking at the sufficiency of their own homes. So I would think that that has to be good, even if in some cases they've had to sell some of them because they can't put them up to standard.' Expectations of the quality of care had been raised, 'even if you don't get



it'. Garton also saw 'some very interesting and positive developments within the private sector as well as in the public sector and voluntary sector'. However, Alexander drew attention to 'the commercial pressures of running a home'; in particular falling occupancy rates, falling profits and fee restraint by local authorities. According to Alexander, this led to a situation where relatives sometimes complained that residents 'only get the basic care and nothing else'. Edwards, Martin and Alexander also saw the cross-subsidization between private payers and state funded residents which some providers practice as problematic, as, according to Alexander, it meant private payers were 'not really getting the care they're paying for'.

Both Edwards and Alexander also saw staffing issues as important. Whilst Edwards drew attention to the low wage levels in the sector, Alexander was concerned that if firms cut their staffing levels as a response to under occupancy this could lead to the employment of agency staff, with a corresponding impact on continuity of care. According to Alexander, residents rated continuity of care 'as the most important thing to them in all of our surveys'. Edwards was also concerned with the level of training provided to care staff - Age Concern was providing training materials in recognition that 'an awful lot of the teaching willy nilly is going to take place on the site anyway', since providers cannot necessarily afford to let staff go on day courses.

Choice was also seen as a major issue in the shift to private provision. For Garton, the 'Modernising Social Services' White Paper (DoH, 1998b) had concentrated too much on commissioning rather than the assessment process, which was 'disappointing'. According to Garton;

there's an assumption which the White Paper strongly reiterates that if you've got a variety of providers, you've got a variety of services, even if the same person is setting the terms of the contract with the providers and that just seems to me illogical and not the case... I think it's another example of government listening to the voices and the strong voices out there are the purchasers and the providers and not the users, so the interesting conversation for the purchasers and the providers is the one that goes on between them, and actually the interesting conversation ought to be the one between the

purchasers and the users to find out the user's viewpoint and say 'this is what we want, who's going to provide it?'

Martin also saw problems arising from the dominant purchasing position of local authorities, which allowed them to hold down or force down fees, perhaps leading to a reduction in the number of care homes, thus limiting choice.

Edwards was also concerned about the shift in the role of local authorities, in that she thought it possible that they would lose skills and expertise as a result of losing their function as providers:

I would think that a useful role that local authorities have played has been to bring together care providers and to develop training programmes for them and I don't know where that's going to sit into the future because really local authorities will gradually lose all their expertise in this kind of area and I suppose that it's an interesting discussion about whether, just as social workers work with persons, whether we need to be thinking more constructively about the role of social services in terms of understanding institutional/organisational bodies who are significant in social services and running some kind of skills based thing around that.

Alexander said in relation to the changing role of local authorities:

people are still a bit disturbed about the amount of local authority homes that are closing. I think and feel that it reduces their choice because they chose to go into a particular home and now it's closing ...

The issue of local authority home closures was also one identified by Martin, who argued that 'there is some evidence that frail and vulnerable people are affected quite deeply by the consequences of the home they live in being sold off and then having to move, and the mortality rates can increase dramatically in the immediate weeks following closures'.

Ultimately, it was thought that choice could best be safeguarded by promoting alternatives to residential and nursing care. Edwards, for example, advocated institutions developing rehabilitative procedures, instead of assuming that people would go into a home 'for life'. This could be problematic in practice, she thought, because it may involve 'more money for more intensive care', which would lead to fee increases which local authorities may not be willing to pay. It may also involve lower occupancy rates which private providers would see as threatening their interests. Garton said she had 'never actually met anybody who wanted to go into residential nursing home care'. Some people may need to go into a home for safety reasons or because they could not cope in their own homes, 'but its a hell of a loss, that loss of one's home, the loss of one's neighborhood, the loss of one's independence and one's former self.' This meant that improvements needed to be made to the nature of support provided in people's own homes, and that alternatives like sheltered housing needed to be investigated. Garton thought that 'what... we ought to do and be promoting very strongly is that loss of physically independent living does not mean loss of autonomy'.

The respondents varied in their awareness of both the size and internationalization of the largest firms. Most were aware of these issues at a general level, but as Edwards put it, 'not in any detail'. The exception was Ian Davis, whose responses are discussed below. In relation to the question of size, Alexander 'seem[ed] to remember its not a great deal'. Martin had a greater awareness of size than this, as well as an appreciation of the process of acquisition, and gave a fairly accurate estimate of the number of homes owned by a firm like Company 1 as being between 200 and 250. Whilst his estimate of 1% of the market for the biggest provider was somewhat low (it being closer to 3.5%), he thought the large providers attracted 'much more than 1% of the attention from key policy makers because actually they are big enough to have somebody in their organization who's, I don't know... called the policy analyst.' Therefore, despite the 'very small proportion of the market' they controlled, they were able to play 'a part significantly beyond their size' :

No, these organisations are able to devote a fair amount of energy and attention to thinking about problems that exist within the market and then to actually kind of crack open those kinds of problems by some thoughtful

analysis and some careful crafting of words on a bit of paper. And meanwhile the poor bloody infantry, so to speak, the other 90% or whatever who aren't part of a big group are affected by the responses of government or local authorities to the things that are said to, and the messages coming from the big providers.

Edwards said Age Concern was, 'aware of the bad feelings around Takare [subsequently acquired by Company 1 - see Chapter Four] which was the first of the big providers I suppose to have hit the scene and started developing a reputation for starting in the North where labour costs were cheap and so on and some people had the view that it was minimal care. I don't know enough to comment to you on that.' However, she said that 'we have an awful lot of respect' for Chai Patel, 'and for people we know who have gone into some of these large providers as kind of directors of training and all the rest of it, that there are things to be said in favour of large scale providers'. Similarly to Martin's point about the influence of large providers, however, she did wonder 'whether the voice that comes through isn't perhaps not always the right voice' from the private sector. Garton was also aware of the 'shift from small cottage industry type homes towards the bigger providers.' Her perception was that large providers had 'a large number of the beds', but she did not have detailed figures. She thought that this probably meant there had been a shift towards greater standardization, but that this did not necessarily equate to improvements in quality.

However, Help the Aged did have a Business Advisor, Ian Davis, who was on secondment from Deutsche Bank. Garton said that Help the Aged did not monitor large firms in the private sector 'in any systematic way but we keep an eye on what's going on'. Davis did most of this monitoring, and according to Garton most of the information relating to it was 'in Ian's head'. Davis was due to retire in March of 1999, and Garton made no mention of a replacement. It is therefore unclear how Davis's expertise might feed into Help the Aged's policies or strategies in any systematic or long-term way. The interview with Davis was not tape-recorded, but extensive notes were taken during it. Davis's understanding of the market in long-term care was that the largest firms were involved in a 'series of defensive mergers'. This meant that the falling occupancy rates and profits associated with local authority funding restraint led

firms to attempt to 'buy out the competition'. This was dangerous because '50% of mergers end in disaster'. Any policy shift away from residential care in the future would be welcomed by Help the Aged, but would cause even greater problems for firms in the private sector. Davis thought there was a limit to the extent to which economies of scale could mitigate the situation for larger providers, since 'beyond a certain size, economies of scale disappear'. Firms had shied away from new, purpose built, homes because these could become out of date if standards rose. Leaseback was therefore a strategy for passing risk onto real estate investment trusts (REITs). Davis clearly had an extensive knowledge of the sector and its economics. However, his comments failed to acknowledge that small owners would face many more difficulties than large ones. These smaller providers are as likely to be acquired by large firms in the forthcoming period as are other large providers.

Awareness of internationalization was lower than that of size generally. Edwards, for example, knew only that internationalized firms 'exist but not knowing what they are'. Only Martin had any awareness beyond this, which was derived from reading the trade press, which meant that he could 'only talk in headline cliché type level'. He had seen reports in 'Community Care Market News' (CCMN) and in the financial pages of newspapers, and recalled reading an article in 'Nursing Times' (Inman & Sone, 1997) on US multinationals entering the British market.

Both positive and negative features were perceived as attaching to large firms. Edwards thought that, 'there are arguments which may well show that some of these larger providers may actually be - because of the cost-effectiveness of numbers - be actually providing *better* quality in their care homes' (Edwards's emphasis). Garton thought that the specialization which large firms may be able to engage in, such as the creation of dementia units by Company 3, was 'the sort of pre-emptive thinking which can go on if there's that little bit of extra time and space and personnel to develop things like that.' Martin made a similar point:

I think that the big organizations bring with them some important bits of cultural trappings that are missing in small businesses. Which is about having the space, the time and the energy within the organization to think about things

rather than simply react to things. To invest time in thinking about devising systems and structures that are helpful to busy practitioners, so if you've actually got a big company that puts some time and effort into having a quality assurance department that devises ways of measuring quality and devises ways for people to check the ways that they are performing in relation to those measures then it might be fair to say that they are more likely to get close to providing a quality service than a small organization that feels up against it financially and culturally in terms of how it does business with the local authority.

Alexander also saw potentially positive features in large companies in that, 'sometimes the large company can work well because you've got someone apart from the manager to go to to complain about any service you're not getting or whatever and if it's a responsive company then that can be quite effective.' She also saw large companies as offering the potential for partnership:

working positively you can get in with the company when it's taking over homes or whatever and offer to work together and start up groups and that kind of thing which they can be more open to. They might feel less threatened by them than a small owner/manager. But on the other hand for some people it can be a bit faceless, remote and unresponsive and inflexible. I suppose generally, I mean my experience of companies has been that it really is still down to the individual home and the home manager. Although you do get companies with a decent reputation or a not such a good reputation or whatever but generally it's a home you know, and you can have two different homes run by the same company and one's good and one's bad just because of the manager that happens to be there.....

However, some respondents saw cause for concern in the economic advantages that large providers may have over smaller ones. Alexander, for example, commented that:

I know that small providers in my experience, find it difficult in the market place in terms of ... partly economies of scale but employing staff and you

know getting a decent profit margin on the fees that they charge so I assume that large companies are doing rather better at it and maybe, you know, obviously have a larger voice with local authority contracting and so on.

In Garton's view, 'one of the problems with the small homes is the financial vulnerability, it's very easy for them to go bust and then you haven't got a home any more which is a risk and you probably don't get that quite so much with the somewhat larger providers.' Edwards thought that it must be 'very worrying times for small home providers'.

Martin argued that local authority purchasers were making,

deals with some of the biggest providers which are about depressing costs because they are organized in such a way as to be able to cope with driving down the cost obviously to a..... I mean I'm not an economist but there's a certain point where they can't tolerate that any longer but they have a negative effect on the rest of the market place in terms of the smaller providers who cannot cope with those costs that are forced down.

Such deals might come about, Martin thought, because 'some of those big companies are actually culturally closer to local authorities than small businesses'. So, even though a local authority may be motivated by a public service ethos, in terms of 'how it structures itself and runs itself as a bureaucracy' it may be closer to a large firm than a smaller one. Large firms, Martin thought, were more likely to have a realistic view of economic conditions than small firms, as well as the advantages of economies of scale. They were more likely to go for high occupancy, rather than high fees. They could then 'negotiate a fee with the local authority that then becomes a bargaining tool / stick / prod that's used with other small providers whose margins are not as... don't permit such levels of negotiation.' It clearly is the case that large providers are able to bear lower fees when necessary, at least in the short term, although they will not do this where they can find higher fees from private payers, as in Albion (see Chapter Five).

Transfers of ownership were seen as a particularly important issue by most of the respondents. Some were concerned that, as Garton put it, ‘where people live is being bought and sold over their heads... and that they have no say, they’re often not informed of the business decision, they’ve got no involvement, no preparation or reassurance if necessary. It’s just happened to people over their heads, which is very frightening and unsettling.’ This point was made very clearly by Counsel and Care, who, in a letter to the then Parliamentary Under Secretary of State at the Department of Health (discussed later), expressed particular concern ‘about residents who have experienced changes, often many changes in succession, in the ownership of the home in which they reside’. Martin personally was aware of a home, ‘which has actually been owned by a sole trader who owned a couple of homes and he sold them to Court Cavendish and Court Cavendish then got absorbed into Care First, and then Care First was bought by [Company 1], and that was four different owners in a five year period.’ Colin French, the Company 1 care home manager with whom a supplementary interview was conducted (see Chapter Four), indicated that his home had experienced multiple transfers of ownership. There were a number of effects which Martin thought might result from this:

... there may be relatively small changes which could appear to be insignificant but when taken in the context of the impact on the lives of the people who lived there may actually be quite big, you know in terms of the style. It's kind of difficult to tie it down, but it has to do with style, perhaps changes in individual staff, who don't like the new employer who have changed conditions of service who say, ‘I don't want to work here anymore’. It may be about things like uniforms or no uniforms. It may be about access to other activities, you know, the new provider says ‘well one of the extraneous costs here was that we kept taking people out in the mini bus. We ain't going to take them any more.’ You know, they will be small things in the context of the bigger policy issues but actually, in terms of the lives of the people who live there, which are defined by what time they get up in the morning, and what time they go to bed and what happens in between and they don't leave the house perhaps without any assistance.... and one of the key things that may well go with the change of ownership is actually a change of leadership and management, if only because



you actually want to shake things up and you move me from my desk to your desk and your desk to my desk and back again in the interests of giving those of us as managers the benefit of experience elsewhere.

Martin elaborated further that:

we should be careful not to generalize from relatively limited examples, but we would say on the basis of anecdotal evidence that, and evidence that comes from outside of the care sector certainly supports this, that a change of owner, a change of manager, a change of leadership can affect both the style and the substance of a service and if I was to go for something that was completely off the wall in comparison to this, The Sun newspaper is not the same Sun newspaper as I recall somebody having in my office in 1968. It's been owned by News International or whatever it was then called in 1968, since then it has the same title on the top and a completely different quality of information below it. And in a way you can buy a home and keep the same name and it's still the same Sunny Side as it's always been but over time, or actually quite dramatically, it's changed.

Alexander was also aware of problems relating to transfers. Although the example she gave related to a transfer from a local authority to a charitable trust rather than a profit-making firm, it illustrates some of the issues which are relevant to ownership transfers generally. The transfer had:

caused a lot of unhappiness for a couple of reasons but partly because staff weren't happy about terms and conditions changing and so a lot of the good staff left which made the relatives and the residents unhappy, obviously. The relatives were unhappy because the new company didn't want to recognise the relatives as a voice in the home and so just refused to do so.

Edwards, and Martin in particular, had concerns about large firms which related to the issue of choice in some way. Edwards thought that 'we have to look very carefully' at the issue of lack of provision in areas of scattered population: 'of provision of very

small facilities that perhaps the larger providers wouldn't want to do, in order to enable people to live near their own homes..... Now if by going in for more cost effective, economic build ups, it meant therefore that in some areas you couldn't get a local facility, I think that is retrogressive.'

Counsel & Care's letter to the Parliamentary Under Secretary of State at the Department of Health was also concerned with choice. As Martin put it:

if the industry changes shape and there's either fewer provisions or fewer providers then the actual choice you can make about where you go, you know it's a bit like shopping on the High Street. I mean you can wake up and not know what town you're in because actually there's always a Principles, in this kind of configuration in relation to a Burton's and a Top Man, aren't they all owned by the same group anyway? It's just a different sort of brand label on the outside. Well you know that might be the case in the care market .

What Martin called 'supply side market domination' was a particular issue:

although the present position is far from that in which any company will achieve anything like monopoly powers, it wouldn't be difficult for local dominance to occur either deliberately or by happenstance. We would view such developments with alarm... After all not only did the community care legislation talk about choice being important, it also talked about being driven by user need rather than provider need, and this is a great criticism of the public sector was that they had lots of provisions that suited their view of what was necessary to meet people's needs, and what was expected was to reverse that trend and to actually have a situation where local authorities were building services to reflect the assessed and stated needs of the people who have the service. If you get one supplier dictating what a home will look like, internally, externally and in terms of ethos, in terms of routines, regimes and rules, you've got Hobson's choice haven't you? You've got Henry IV's choice.

Martin also thought that the near-monopoly purchasing (monopsony) position of some local authorities threatened choice, since it allowed them to strike 'deals' with large providers who were more able to provide services at lower fee rates. Access to alternative services provided by small owners would thus be restricted.

As far as internationalization in particular was concerned, as distinct from size, Edwards could see both positive and negative features. On the negative side Edwards stated: 'I suppose there has to be the economic argument that says if they are crossing many continents that they may make decisions to pull out of one in a way that, say, a native provider couldn't do and that maybe the market is therefore slightly more volatile.' On the other hand she thought that: 'we may be bringing in some much better practices. It gives you the opportunity to look and get the best from elsewhere, so clearly there are some homes in America which have been designed in a way and with facilities that are possibly giving us new thinking. Or some of the other countries on the continent.'

In commenting on the issue of internationalization, Martin highlighted the fact that his opinions as 'an individual with a set of political views' might be distinct from those associated with his professional role, although he 'suspect[ed] that there'd actually be a degree of resonance one to the other' and that his statements were driven by his 'professional concern about how big organizations make decisions'. With that qualification he stated:

I've got no doubt at all that it's not a good thing that people should be making decisions in Philadelphia about the health and vitality of their corporation... I'm worried about the ways in which managers of an establishment in middle England may have to change the policy in relation to the purchase of shall we say incontinence pads for elderly dependent people based on the company saying, from its corporate headquarters in Philadelphia, 'we need to find a 1% saving in our nursing home operations in the UK'. And I can actually think about that not on a global level, but I know it's happened nationally in terms of what happens is that Health Authorities change their policies on how they'll relate to the private sector and the private sector then actually issues an edict

which leads to somebody being wet and uncomfortable in bed. And if that can happen in terms of how big organizations interact with their users within one country then the scope for the decision making being detached from the consequences grow much more marked when you cross the ocean to the States or whether you cross the Channel to Generale des Eaux or whoever else might own the railway line that I travel to work on.

Martin also remembered an encounter with a representative from Stakis Hotels from when he worked in a Social Services Department, at the time when Stakis were considering moving into the long term care market. The nature of Stakis' main business interests seemed to have caused Martin some discomfort: 'the fact that [Stakis are] known for swanky leisure focused hotels, perhaps close to casinos, that made it feel more incongruous really.'

Quality was obviously an important issue for all of the respondents in this group. All thought that there needed to be regular inspection of homes. Edwards specifically mentioned an adequate complaints procedure as important, whilst Alexander identified training and staffing as a particular problem, claiming that continuity of care was rated by residents as 'the most important thing' in all of the Relatives' Association's surveys. However, all the respondents thought that the way to approach quality issues was to find out what residents wanted. As Alexander put it: 'are they listening to their residents, do they have systems for listening to what the residents feel about the care and feeding back from there?'. According to Garton:

the place to start is with the services or is with the needs assessment, actually the initial personal assessment of what they want, what that person actually requires and their order or priority and then to construct ways of getting as near as possible to achieving that and then going back and checking out again how far that's happened. Whether the outcomes that person is seeking have changed and the different factors that have come up.

Garton had some reservations about what she saw as the drive 'on the professional side' to standardize assessment. This had positive features, but was:

an incredibly medical model and its very different from starting with what the user might want for themselves in their life, how they might want their life to be, and I think we probably need both but I don't see how they marry at the moment because especially that whole sort of medical/social assessment process is tremendously powerful .... and it has a momentum all of its own and it really does seem to me that when the big guys get hold of something and start galloping along it's the little guys, the users, who get trampled underfoot and you lose the counterweight ....

According to Garton:

the most important thing, as people tell us all the time, is the quality of the relationship between the individual providing the service and the individual receiving the service – how people are treated, whether they like the person who's supporting them, whether that person treats them like a whole human being with appropriate respect, being listened to and all the rest of it.

One way of ensuring that users were listened to was for them to be involved directly in the quality process. Edwards was in favour of the idea of lay inspectors, and in some areas older people themselves had carried out this role. Edwards was also in favour of residents' committees in homes. Age Concern had published a book 'some years back' 'to encourage user participation in the home', which focused on practical issues such as being able to choose what time to eat breakfast. The issue of residents' committees will be discussed further below, in relation to firm-specific aspects.

In relation to the current regulatory arrangements, Edwards thought that the level of funding was too low, and that this was preventing some authorities from carrying out their statutory two inspections of each home per year. She thought that this problem was exacerbated by the fact that inspection units were also responsible for complaints, which stretched them further. In general Edwards was in favour of strengthening regulation. Garton, however, was 'a bit fed up' with the argument that inspectors tended to concentrate on ensuring basic minimum standards as a result of limited

resources: 'because you can do good things or bad things with the same resources'. Garton thought that regulation didn't have to be 'a kind of here's my grid, tick, tick, tick.' It could instead be 'more proactive and positive', involving the spread of new ideas perhaps gained from interviewing residents. Garton thought the American regulatory system compared favourably with the British one because, 'they have so much more of a tradition of rights' and had a 'separate ombudsman/advocacy culture' alongside the regulatory function. Whilst Edwards saw a role for 'written returns to inform the process' of inspection, Alexander thought more help for staff on how to do paperwork might be needed: 'It's difficult because a lot of people who go into care don't do it because they like paperwork'.

Counsel and Care stood out from the other organizations, in that it had begun to publicly campaign for an industry regulator similar to those which regulate the privatized utilities. As Martin explained, this was:

born out of a concern that, really, in lots of other spheres of life there are regulators, you know, where previously publicly provided services have moved into the market place. In a different way one of the integral parts of that transfer process was the creation of Offwat, Offgas, Offtel and so on and I felt that what we'd seen was a major retreat, bit by bit, by local authorities from the provision of welfare services without anybody thinking about what that meant in terms of regulating services overall, as distinct from coming in and registering and then subsequently inspecting individual services. There was a big issue about the collective needs of older people who lived in homes, and we are talking about ½ million older people living in residential care or nursing homes across the UK - it's a not inconsiderable amount of people.

Counsel and Care had sent a letter (which the interviewer was not permitted to see, but which Martin quoted from) to the then Parliamentary Under Secretary of State at the Department of Health, explaining the reasons why it thought such a regulator was necessary. Seven issues (most of which have already been discussed in this section) were highlighted which the organization saw as relating to trends which could develop 'which could be quite hostile to the interests of those [the market] is intended to

serve'. These were: firstly, 'local authority (near) monopolies', which were holding down fees and thus leading to a reduction in the number of homes; secondly, 'ultimate financial responsibility', which related to local authorities' resources being controlled by central government, leading to 'a lack of clear accountability for situations where there is insufficient money to buy good services'; thirdly, 'discrimination against self-funders', relating to cross-subsidization; fourthly, transfers and sales; fifthly, homes closures; sixthly, 'narrowing of choice'; and seventhly, 'supply side market domination', leading possibly to local dominance.

Martin was the most informed about the quality assurance systems used by large firms, and thought that, 'many of them bring with them an infrastructure of support that will actually contribute to quality in terms of their having in-house quality assurance systems, in-house training, and internal audit'. He had seen the internal quality assurance manual of 'one of the component parts of what is now [Company 1] Care Homes' on a visit to one of their homes some years ago, and had been:

extremely impressed by the make up of that manual, the degree of detail and what I'd been told during the course of the conversation with a couple of managers of the home that I'd been at, about the processes that they use to comply with that manual. The sort of internal procedures were impressive at least on paper, but it was interesting how I got them described to me on a number of occasions from different sources within the organization as a great deal of harmony in those presentations.

However, like all the other respondents, Martin did not think there was a case for homes belonging to larger organizations being inspected less regularly or in a fundamentally different way: 'I mean frankly I think there's absolutely no substitute for going into homes and talking to the residents and talking to the staff and observing practice and observing the interaction between people.' He did, however, think that inspection should involve more of an, 'educational kind of perspective', rather than simply, 'identifying bad practice and listing it and telling people to do something about it'. The other respondents had similar views. Edwards, for example, thought that: 'there clearly is an argument for saying that you don't necessarily need to do exactly

the same inspection, nor in practice do you, of every facility'. Some homes may, therefore, need inspecting more often than others, but all were seen as needing some minimum inspection. This was true even where firms had their own QA systems because, 'they have to be seen to be equally treated with other bodies'.

Martin had some sympathy with the complaint made by large firms concerning the lack of uniformity of demands made by different inspection units. However, he thought that firms had often expressed this 'by a degree of bully boy tactics'. In particular, Takare (now incorporated within Company 1) had been accused of behaviour, 'where they would actually say listen we're not having your requirements on us, we've got it through elsewhere, we're not interested in listening to you telling us what you want, this is what we're doing and we'll fight you every inch of the way.' Martin felt that this put Health Authorities, 'under incredible amounts of pressure, which members of the public can't do in relation to their planning applications'. Counsel and Care thus:

came round to the view that there was a need for a national inspection service because of the, not just the fact that there was variability between one inspection unit and another, but that there was scope for providers to play one off against another and perhaps to drive down standards through that process. Whereas actually if you've got a centrally driven system with sufficient rigour within it, and power to enforce then actually you don't any longer have any of this...

As discussed in Chapter Five, the government ultimately opted for a National Care Standards Commission for England through the Care Standards Bill (2000). However, the interviews for this thesis were conducted prior to the publication of the Bill, when the expectation was that regional commissions would be set up, as proposed in the 'Modernising Social Services' White Paper (DoH, 1998b). Martin saw the possibility that similar problems could occur as a result of this regionalization, involving disparity between the different regional commissions: 'we want one approach across the eight commission areas, and we want that one approach to be the right one that can be demonstrated and held accountable and can be clearly understood by all those whom it affects; the enforcement agents and the people against whom the enforcement action's



taken.’ Despite Counsel and Care’s preference for nationally organized regulation, Martin thought the idea of regional commissions was not a bad one, since it involved an attempt to create, ‘a sort of sense of ownership, stakeholding within a kind of perceptible area’. He thought this should build on the experience of the locally organized inspection units that currently exist. Edwards said that Age Concern was also in favour of the proposals for regional commissions, and of regulation ‘becoming independent of local authorities’. Garton was also in favour of this, but was concerned that the commissions, and the standards they work to, should have enough flexibility to accommodate regional differences in users’ preferences.

Alexander could also see the argument for regional commissions, but was concerned that they may not be as accountable as locally controlled regulation. However, she argued that:

the regional thing is going to go ahead, I suppose what I'm saying is that if you're going to have regional inspectorates then can we make sure we've got the user voice in there somewhere, however they're going to do that, and that's what we'll be stressing rather than saying ‘oh no, you must be doing it at local level’. I think our policy position would be, ‘o.k. we're having regional boards but where's the user input?’

Garton took a similar view of the proposed commissions, stating:

I wish they had a stronger advocacy role and that they had real user involvement in the homes and I don't think there's much of a sign of that. I thought that it was a pity that the idea of having a children's rights officer and... somebody at the sort of commission level who had a children's rights brief wasn't replicated for older people. That would be good to have seen.

Martin thought that existing accountability at local level was somewhat illusory, and that actual practice, ‘was more to do with the culture of the local authority or perhaps the lead people within the authority’. He was of the view, therefore, that other

mechanisms based on stakeholding notions could be used to create accountability at regional level.

All the respondents were in favour of abolishing the distinction between nursing and residential care. Edwards, for example, argued that: 'clearly it's an absurdity to have the two separate, so we favour integration.' Both Alexander and Martin highlighted the anomalies and problems associated with two different types of registration, which sometimes led to residents having to move from one home to another because their needs had changed slightly. Martin, for example, criticised,

the idea that older people, who as a result of becoming a bit more unwell, should actually have to move to another place because it's registered to look after their nursing needs as against them being nursed in a place that they've made home. Why have to make two critical decisions after you've left the place you've lived in perhaps all your adult life, and you've made this critical decision to go into a home because you can no longer cope and then two years later somebody says 'well actually you'll have to go into another home now because you've become a bit more incapable'. We'd like to see a single care home emerge and that's more likely to emerge from a merging together of registration of nursing and residential care.

This section has shown that all the respondents had some awareness of the size and internationalization of the leading firms in this sector, although this often lacked detail, and awareness of internationalization was lower than of size generally. All the respondents saw both positive and negative features as attaching to the shift to private provision in the sector, and to the role of large and internationalized providers within it. There was no outright hostility to such providers, as there was with UNISON for example (see Chapter Six); indeed, the perception was that the overall effect of these changes had been to raise the quality of care. The respondents were generally in favour of some centralization of regulation, as in the 'Modernising Social Services' proposals, but had reservations regarding accountability and user input. Counsel and Care was most concerned with issues relating to the overall structure of the market, and had begun to campaign for an industry-wide regulator.

## **FORM AND EXTENT OF ORGANIZATION**

As indicated above, all the organizations considered in this section are charities, and that is reflected in the form and extent of their organizations. The nature of these organizations was most explicitly described by Garton who, when asked whether Help the Aged was an older people's organization, responded that it was instead a 'traditional charity' which was not organized on a 'democratic and accountable basis'. It was, she said, 'incredibly top down, central office, all the things it shouldn't be type organization'. It nevertheless was, 'doing some of the right things in channelling the money directly to older people at the local level'. Help the Aged and Age Concern, the two largest organizations considered here, which aim to promote the interests of older people in general, had the largest scope in terms of having a network of local groups which they supported and which fed into their activities at national level. Age Concern had about 1400 local groups throughout the UK, 1100 of which were in England. These were direct providers of services, mainly day care services such as day centres, luncheon clubs and visiting. The provision of information was also a key activity of these groups. They did not provide any significant level of residential services, but Edwards said they were 'increasingly becoming involved in domiciliary care'. Help the Aged, on the other hand, ran 'ten or so' residential homes.

Help the Aged tended to work with older people's or pensioners' forums around the country, most of which were linked to the National Pensioners' Convention (NPC). The NPC officer with responsibility for long-term care was approached for an interview for this study, but it did not prove possible to arrange one. Garton described the NPC as being 'largely composed or led by people who have been very active in the trade union field or in labour politics'. Garton saw this type of organization as being 'effective in some ways', but saw a problem in that, whilst many members of local pensioners' forums were women, few women were leaders of the movement nationally. Help the Aged also had a program called 'Speaking Up For Our Age', whereby it gave grants to local groups. Such support to local groups represented a third of Help the Aged's overall grant giving. Help the Aged also acted in a 'proactive' manner, for

example, organizing local groups around a campaign involving transport issues. Age Concern also worked with older people's forums, with Edwards, for example, mentioning the role of Lewisham Older People's Forum in organizing lay inspectors. The Relatives' Association also played a role in facilitating relatives to become lay inspectors.

However, this kind of collective local organization did not appear to have much impact on the delivery of long-term care. One exception to this was Age Concern's local group in Naresborough, which was 'fighting against' the closure of a home by North Yorkshire council because it was the primary facility in the town. On the whole, however, other kinds of nationally organized activities were more relevant to this sector. These included advice and advocacy, research and its dissemination, and various campaigning activities. All the organizations carried out these kinds of activities. Alexander, for example, managed the help line which the Relatives' Association ran, and information gained from this was then fed into the organization's policy work. The majority of the Relatives' Association's advice was dispensed, either to would-be residents or their relatives, when people were initially looking for a home to move into. They saw it as important to encourage people to look at more than one home before they took a decision.

Counsel and Care provided a very similar advice and information service, although Martin said they increasingly had to, 'engage in advocacy - determined advocacy - to assist people to secure their rights and we do that, not around the whole gamut of older people's needs, but I think we're very focused on community care issues and we're particularly adept at, and knowledgeable about, issues around residential care, nursing care'. Counsel and Care also issued press releases in response to letters received from residents or relatives, and a series of fact sheets which responded to questions frequently asked on the advice line. Help the Aged and Age Concern carried out very similar activities, with Age Concern, for example, aiming to cover about 250,000 calls a year, and Help the Aged covering 70,000. Edwards described Age Concern's fact sheets as, 'the centre of all that we do'.

This advice work, and the information which was gathered from it, was bolstered in all of the organizations by various research projects, the findings of which were then disseminated via books, articles, conferences, the press and other news media. Age Concern, for example, had 'about 22' books 'coming on stream' in the coming year, a significant number of which were for care providers, and in particular 'lower level care workers'. Garton indicated that an increasing amount of the research carried out by Help the Aged was, 'user focused and increasingly including older people directly... which are starting from older people's own experience'. Help the Aged was also carrying out research within three of its own residential homes around 'changing the culture of homes and making them more like people's homes, ordinary individual choice and so on and so forth'. Alexander pointed out that the Relatives' Association was a small organization with limited resources, but it had carried out a small research project 'looking at the relationships' between home staff, residents and relatives, 'and working out a training program that would encourage involvement'. Counsel and Care also carried out a number of research projects relating to, 'everyday life in homes - abuse, health care, incontinence, meals and meal times and so on'. At the time of the interview Martin was developing a research project concerned with issues of choice, in relation to the problems associated with ownership transfers discussed above. As indicated above, Help the Aged had a Business Advisor, Ian Davis, part of whose job was to monitor private providers of long-term care.

The research conducted by the organizations could be used to further their aims in two main ways. Firstly it could be disseminated in ways designed to influence providers and practitioners in the delivery of care, what Martin called practice and policy at a 'lower' level. Organizations thus organized conferences and workshops for various kinds of practitioners, as well as issuing literature aimed at them. Secondly, research fed into the various campaigning activities carried out by the organizations. Although some of this was directed at the public through the use of various media, whilst some of it involved direct lobbying, the goal was always to influence government policy. Martin, for example, described part of his responsibility at Counsel and Care as:

driving along our own kind of position on certain things and attracting attention to it, which you do in a variety of ways, you know you intervene in public policy by writing learned pieces which you send in when you're asked to... The health select committee are actually researching something we've got, we say we'll comment. We also try to influence public policy by press release and the things you say in the national press which is difficult to get into, the trade press which is much more easy for us to get access to... and by the radio circuits be they the national network or the locals.

Ways in which the organizations could try to influence government policy more directly included the use of a team to brief parliamentary groups in both Houses of Parliament, mentioned by Edwards, and written responses to various government initiatives. As Garton put it: 'I mean the range of work going on on the policy front is the sort of standard stuff of responding to government documents, white papers, green papers you name it, announcements of various kinds from the point of view of the interests of older people as we see them.' This involved, for example, responses to the report of the Royal Commission on Long Term Care, mentioned in particular by Edwards (see Age Concern Policy Unit, 1998), and responses to the 'Modernising Social Services' White Paper (DoH, 1998b), views on which were discussed above.

The organizations also took their own initiatives when attempting to influence government policy, trying to set the agenda according to the needs of older people as they perceived them, rather than simply responding to government initiatives. One example of this was Counsel and Care's attempt to promote the idea of an industry regulator. As discussed above, this had involved sending a letter to the then Parliamentary Under Secretary of State at the Department of Health, detailing the arguments for such a body. Martin described the response to this letter, which was prior to the publication of 'Modernising Social Services', as 'sort of a non-response... a bit of waffle'. However, Martin stated that: 'we ain't going to drop it now just because we bunged it out once and not quite attracted the attention we'd hoped for. We'll have another go.' Ideas on this issue were 'still evolving', but it was being followed up through the use of various forums, for example, a presentation to the

Annual Conference of the Scottish National Association of Inspection and Registration Officers.

Two of the four organizations were affiliated to international organizations of various kinds. Age Concern was affiliated to the International Federation on Ageing (IFA) and Eurolink Age, and Help the Aged was affiliated to Help Age International (HAI) and Eurolink Age. Counsel and Care did not belong to any international associations, but had contacts with the International Ageing Network. The IFA described itself as, 'bringing together academics, practitioners, activists and leaders of organizations of the aged across national boundaries and encompassing all the continents of the world' (<http://www.ifa-fiv.org/p01.htm>). Its main activity was to, 'provide a forum for the sharing of ideas, experiences and research'. The IFA had 'consultative status' as an International Non-Governmental Organization (INGO) with a number of supranational bodies such as the Economic and Social Council of the United Nations (ECOSOC) and the International Labour Organization (ILO).

HAI, 'advocate[d] at the international, national and regional levels based on the needs, views and experiences of the older people we work with' (Annual Review, 1998/1999: 1). It aimed to, 'increase the impact of community based organizations by sharing expertise and supporting the growth of new agencies'(ibid). The work of HAI was primarily oriented towards developing countries, and produced an influential 'Ageing & Development Report' in 1999 (HAI, 1999). Eurolink Age aimed to influence the European Union in the interests of older people through a variety of campaigning, research and consultative activities (AR, 1998-1999). These international organizations, therefore, pursued the same kinds of strategies of research and attempting to influence policy at the supranational level as the national organizations considered in this chapter did at that level. None of them did any substantial work in relation to long-term care, and they made no direct impact on the nature of long-term care in the UK, or on the activities of the case-study firms.

The organizations considered in this chapter therefore may have an impact on the long-term care market in the UK through a variety of means. Advice and advocacy is offered to users of long-term care services, whilst research and advice are offered to

practitioners, from managers to 'low-level' workers. Finally, the attempt to influence provision of care indirectly by influencing government policy is a central part of their activity. Their international links made no direct impact on their work on long term care. Direct relationships between older people's organizations and the case study firms, where they exist, will be discussed below, as will the use of residents' meetings within homes owned by the three firms.

### **FIRM-SPECIFIC ASPECTS**

The organizations considered here had very few direct dealings with any of the case study firms analysed in Chapter Four. All of them, however, participated in the Continuing Care Conference (CCC), as did Company 1 and Company 3 as well as other large providers and national care home associations. The CCC was formed in 1992, and described itself as 'a coalition of commercial, charitable and public service organizations with a mutual interest in providing better care for current and future generations of elderly people' (CCC, 1998). The CCC was chaired by Chai Patel, Company 3's current chief executive and the former chief executive of Care First. Alexander said in relation to the CCC that the Relative's Association aimed to work in 'partnership' with providers. Edwards described the Conference as being 'started by the insurance industry at a time when there was all this talk about long term care insurance schemes'. She said it had a sub-group which was chaired by Chai Patel, 'which was looking at care standards and contracts and so on for the industry... so one has a feeling that, at that level, with the big ones [private providers] that they are doing quite a lot of work to try and ensure good quality in their homes.' Alexander also mentioned work done on standards in this forum, as well as the development of a 'framework contract together for use for people who are paying privately in residential care' (CCC, 1998). Alexander commented in relation to this type of work: 'we try to get agreement on what's possible and what the user would like and what they feel is feasible, and get some sort of balance in there and keep each other informed'.

However, the motives of firms in working within the CCC should not simply be seen as altruistic - it is likely that their own strategic interests played a part. One of the



CCC's principal aims was, 'to persuade Government to provide incentives for individuals to make self-provision for long term care to complement state provision' (CCC, 1998). Although not directly concerned with the CCC, Bob Jones's comments regarding Company 1's membership of provider associations and links with other organizations may have some relevance here: '[W]e believe in maintaining links with outside organizations and because we've suddenly become the biggest a number of outside organizations are, I won't say beating a path to our door, but are dead chuffed that we're involved.' The particular advantages of this were twofold: 'One is keeping abreast of what's going on, and secondarily is being able to drive the central agenda. The more we can get involved with central organizations, the more we can drive the agenda. A bit selfish perhaps, but there you go.' In response to the question of which direction that might be in, Jones stated: 'Whichever is the strategic direction [Company 1] think it should be in.'

Other than links through the CCC, Martin indicated that Counsel & Care had approached the chief executive of Company 1 Care Homes for 'some money', and that he had 'responded positively' by providing 'a couple of grand'. However, he had seen a piece in 'Nursing Times' about Counsel & Care's promotion of the idea of an industry regulator, and had written to Martin asking if it was him who was quoted. Martin said he had not 'come back to us negatively since then', but Martin was unsure 'whether he'll give us a couple of grand when I ask him next time'. This raises an important issue about the funding of voluntary organizations and their independence. Martin was clear that: 'We certainly wouldn't modify our views on the need for a regulator on the basis of whether or not they'll give us some money.'

The direct relationships between older people's organizations and large firms therefore appear to be minimal. However, the case study firms did have varying degrees of support for, and implementation of, residents' and relatives' meetings in their homes. Such meetings were broadly favoured by the older people's organizations considered here. Edwards, for example, thought that there was 'a great deal to be said' for residents' committees.

Alexander said that in homes where the residents were 'more fit and able' the Relatives' Association was, 'trying to encourage residents' committees where residents would have a direct influence on how the home was structured and even to how employment or recruitment was done and that kind of thing – they would have an input in all the running of the home.' In nursing homes, where residents may be in need of higher degrees of support, they favoured relatives becoming involved, although not necessarily in the form of a relatives' committee. Alexander gave the example of a home in Berkshire (the owners of which she did not identify) where relatives' involvement in solving problems had led to them becoming 'permanent board members'. Alexander was in favour of meetings which included residents, relatives and staff, but said she thought it was up to the residents how these were organized:

because I mean we've found in some cases where relatives want to run a group and they need... They want to run it themselves and they find that the management are there all the time and that restricts the amount of discussion they can get, or for some relatives they find that too impeding to have the management there all the time or it's chaired and controlled by the members of the management rather than relatives themselves. So, you know, you have to be careful of that ....

The most important thing, Alexander thought, was that 'the interests of the residents must come first'. The Relatives' Association also encouraged 'locality groups' or 'area groups': 'we have about 30 area groups where people from different homes meet together – often at a carers centre or somewhere like that – so that they can compare experiences of homes or pass on good practice from their homes, that type of thing.'

Garton did have some reservations about residents' meetings, arguing that 'it depends how it's done... if it's done well and those things work well and they actually have an influence and an impact then yes I think it's a good idea. As a sort of add on "we're doing it because either because we have to or because it makes us look like good guys" then I think that's very different.' As a positive example, she described a scheme in Wolverhampton, run by a company called Extracare, where a residential home had

been replaced by 'extra-sheltered housing', and where the residents had an established 'decision making process'.

All three case study firms had some form of residents' meetings in their homes. Jones said that Company 1 were 'stimulating all the homes to have residents' / relatives' forums'. These tended to be 'dominated more by relatives than residents' because 'the dependency levels in the homes is such that realistically you're lucky to have a handful of clients that can walk, let alone actively participate in a meeting.' However, there were other ways in which Company 1 tried to involve residents. One was that, as part of the quality review, 'staff are charged with actually asking the residents - "go and talk to them".' Jones said that this 'doesn't happen as well as I would like it to at the moment, but I haven't quite got my head round how I can get that happening better.' However, although Jones felt Company 1 had 'a little way to go', all the clients or their relatives were intended to be involved in part of their own care planning process:

So they should be having input to the care they're getting. The traditional model though, the nurse told you what you were getting. The new model is 'you're part of this decision making process - how do you want us to help you?' Because part of the review checks the care records, we can pick up if that's happening, so residents will be involved as part of that process.

Company 1 also intended 'to send a questionnaire to every client in East Anglia so they have an opportunity to comment on the service'. It was not clear why this was being carried out in East Anglia in particular, although it is possible that this was intended as a pilot. It was thought that most clients would need help filling this form in because, 'probably 60 - 70% of our clients can't fill it in themselves anyway.' This raised a number of issues which Company 1 had a group looking at:

because if its a carer filling it in will they bias the answers to them as opposed to the client? And we had some examples of that in the past. If its the relatives filling it in, that in itself is not a problem because the relatives usually come up with good information anyway, but do we run the risk of simply tailoring the search to the relatives' needs rather than the clients needs, which sometimes are

very different. One would hope they were the same, but life ain't like that in a care home. Relatives have their own agenda.

Jones said he was in favour of a shift towards concentrating on what users wanted:

I mean at the end of the day we are a service to the users. Its been, I think, harder for professionals than lay people to get their head round moving from 'I'm the professional, I know best' to 'You're the user, what do you want?', and the professional aspect is then helping them do something, not telling them how they should do it. Obviously there are times when one has to make people aware of the risk of the choice they're making..... But I think as long as you document it and you go about it in an appropriate way it's all right.

He thought that there was some 'way to go' in terms of staff within Company 1 accepting this focus on users' preferences, but asserted that: 'Definitely that is the new [Company 1] culture. It isn't necessarily the culture of some of the [corporate] pasts.'

Jane Bartlett also asserted that what she called the 'user perspective' was 'of the utmost importance' to Company 2. This meant listening to the views and perceptions of residents and relatives, both through meetings and through listening on an individual level to residents. Bartlett was in favour of this because, 'you can actually get so much information by doing that, and it's then a true reflection on the real quality.' Bartlett said that Company 2 had 'just started along that road', and that it was something which she personally was 'very, very aware of and want to push even more than we're doing now'. Listening to residents on an individual level was built into the QA mechanism described in Chapter Four: 'We spend a lot of time talking to the residents again about any issues or comments that come up. Anything that's affected them within the last month within the unit, and they're picked quite at random by the regional managers.' There were three types of meetings which took place in homes - 'regular residents meetings'; 'relatives groups'; and 'staff groups to obviously pass messages round'. The company had had trials 'in a couple of areas' bringing all three groups together, which had:

worked very successfully because the relatives can say 'I don't think you're doing this right for my mum' and mum will turn round and say 'oh yes they are, I see so and so everyday', and its actually airing and ironing out quite a few things, so that's possibly something we're going to look at more in the future to bring all three groups together for a meeting rather than having individual ones. We're trying to get the team work from everybody.

These kinds of arrangements had been inspired by a research project which Company 2 had been participating in since January 1998 with a team from the University of Northumbria at Newcastle. This research was focused on Company 2's Northern region, which encompassed 13 homes from Lancashire to Newcastle, involving a spread of 'different types of unit'. The research involved each of the homes trying out a quality system called *Qualasses*, which had been 'developed by an outside consultancy'. The researchers were, 'interested in seeing the difference in organizational change with the introduction of *Qualassess*'. The *Qualassess* system,

works by having a coordinator within the home but is not with the manager of the home, and that coordinator will then get together residents, relatives and other members of staff to discuss quality issues. And although there's an agenda - so they may be looking at personnel... they may be looking at resident activities, they may be looking at the decour of the home or whatever - they will actually discuss it, and then they would feed back their findings to the general manager, with an action plan for the home, and things are actually acted on, so it's total, really, user involvement throughout.

Bartlett's experience of this project had been positive:

I mean if it carries on I'd like to see it introduced into more homes, because it certainly seems to be working..... the feedback coming from [the university] and coming from the consultancy that actually developed the system has been invaluable, and has helped me make decisions about things to improve.

As indicated in Chapter Four, the interview with Margaret Grant was of shorter duration than that with the other QA managers, and was not tape-recorded. However, Grant did say that Company 3 homes had meetings of residents and relatives, which both the home manager and the chef attended. It was seen as important for the chef to attend because most complaints related to food, laundry or activities, rather than to the quality of the building. These meetings took place four times a year in each home. The attendance of relatives was important because they were often needed to 'represent' the 'patients', who may not be able to articulate their own needs or opinions. The potential problems of this form of 'representation', in terms of the possibility of a conflict of views or interests between resident and relative, were not discussed in this interview as they were with Jones and Bartlett. Nor were similar issues relating to the presence of home managers at such meetings. When asked about the 'user perspective', Lloyd Hughes said that she thought this was a positive thing because, 'the company depends on its patients'. However, the use of the term 'patient', rather than 'resident' or 'user', may indicate a more paternalistic or medical approach towards users, although it may also simply be an indication of a long experience in nursing.

In sum, it can be seen that all three firms have some form of residents' meetings, usually with relatives present. The QA managers interviewed had different assessments concerning the presence of relatives at these meetings. Whilst Jones saw it as necessary, but identified the problems inherent in it, Grant saw it as a positive thing because it provided residents with 'representation'. Bartlett indicated that relatives meetings were usually separate from those of the residents, but that this was being reassessed as a result of the research which Company 2 was participating in. Bartlett saw the presence of relatives as mainly positive, not because they could represent residents, but because residents' opinions could be aired alongside those of relatives and staff, leading to more clarity. Company 2 was distinct in allowing outside agencies (in this case a university and a consultancy) to carry out evaluations in its homes, and being prepared to change practice as a result of this.

## DISCUSSION AND CONCLUSION

As discussed in Chapter Three, the application of the meso level of analysis to the relationships between the firms and residents themselves involved some difficulties, arising primarily from the lack of any autonomous organizations of residents. The organizations considered here are charities, acting in the interests of older people as they understand them. Some of these, such as Help the Aged and Age Concern, are large organizations involving some hundreds of local groups and have well organized national offices with a number of professional staff working for them. However, the *form* of these organizations predisposes them towards activities which are aimed primarily at influencing government policy. They did provide valuable services to residents and potential residents, through advice, advocacy and information. However, their direct contact with the case study (or other) firms was limited. Furthermore, although they had links with various international organizations, these made little difference to their work on long term care. Rather, these international organizations tended to replicate the policy work carried out by the nationally based organizations, but with the focus on influencing the work of supranational bodies rather than of national governments.

This does not necessarily mean that the organizations considered in this chapter had no influence over providers. Rather, that influence tended to be indirect. To the extent that these organizations are successful in influencing government policy, over regulatory issues for example, this will have a significant impact on providers. As well as direct campaigning work, research and its dissemination may also play an important role in influencing the 'climate of ideas' within which firms operate. This, of course, is difficult to measure, but it may be significant. For example, all of the organizations favoured residents' participation in their care through means such as residents' and relatives' committees, and it is possible that they have played a significant role in facilitating the adoption of such forums by the case study firms.

All of the case study firms had some form of such meetings. Meetings in homes belonging to all three firms were, however, initiated and facilitated by staff - meetings did not represent autonomous organization by either residents or relatives, and

nowhere was there the level of involvement in the overall running of the home favoured by Alexander in particular. The use of residents' meetings therefore seems to indicate that the firms have a consulting and responsive attitude towards their residents, rather than the existence of any fully fledged user control. This may be thought to be an appropriate balance, given the sometimes very high degrees of support required by some residents in nursing homes, which are the majority type of homes run by these firms. Residents will not necessarily wish to be involved in direct or intensive forms of participation, and there may be other mechanisms for seeking residents views. However, the standardization which is characteristic of these firms' delivery does not seem to permit much, or even any, variation in the way meetings are organized based on the preferences of residents.

There are other potential problems related to this form of involvement. As Garton pointed out, it may be done to make providers 'look like good guys'. Most problems, however, relate to residents' capacity to participate fully; they are there in the first place because they require care. This is well illustrated by the case of Company 1. As Jones put it: 'the dependency levels in the homes is such that realistically you're lucky to have a handful of clients that can walk, let alone actively participate in a meeting.' This comment is significant in more than one way, since it is true that some residents may have difficulty participating, but being able to *walk* is not a precondition for such participation. Jones did in fact demonstrate his awareness of the issues at stake here, through his identification of the problems attaching to a member of staff or a relative assisting a resident to articulate her or his views - relatives for example may have their own agenda. With regard to staff, Jones indicated that there was 'some way to go' in bringing about a new Company 1 culture based on users' preferences. These issues apply equally to all the firms, although as noted above Company 2 was distinct in permitting outside agencies such as a university and a consultancy to carry out evaluation in its homes and to change practice accordingly. This is significant, since it indicates that ownership by a foreign-based firm does not necessarily prevent it from exercising some flexibility and experimentation in these matters. This is also consistent with Bartlett's claim in Chapter Four that Company 2 (USA) permitted some degree of autonomy in the way care was delivered in its UK division.



The organizations considered in this chapter did have some direct contact with the case study firms through such forums as the Continuing Care Conference. However, as discussed above, it is likely that the motives for firms' involvement in such forums is motivated as much by their particular agendas as by a desire to improve care in general. As Jones said of Company 1's membership of provider associations: 'the more we can get involved with central organizations, the more we can drive the agenda'. Private firms have an interest in influencing such forums, not necessarily in a narrow or manipulative way, but in terms of influencing the overall debate about care and how it is delivered. As Papadakis & Taylor-Gooby (1987: 67) point out in relation to private health providers, firms have an interest in sustaining, 'an atmosphere of discussion over public and private welfare with a view both to cooperation with the NHS and to redrawing or blurring the boundaries between the two'.

There appeared, however, to be no antipathy to private providers on the part of the respondents from older people's organizations. Rather, there was an acceptance that standards and expectations may have been raised as a result of the shift to private provision, and some respect for figures such as Chai Patel. This is clearly an important outcome for the case study firms in terms of how other potentially influential organizations respond to them, and is perhaps one of the goals of their participation in forums such as the CCC. However, there was significant concern among the respondents from older people's organizations about questions of choice and about the impacts of ownership transfers. These impacts may involve changes of regime and, in the worst cases, closures of homes and the moving of residents. The latter can be extremely serious, as Martin indicated in relation to local authority home closures: 'there is evidence that frail and vulnerable people are affected quite deeply by the consequences of the home they live in being sold off and then having to move, and the mortality rates can increase dramatically in the immediate weeks following closures.' These issues will be returned to in the final chapter.

Whilst the respondents had some awareness of the size and internationalization of the case study firms, this was generally less than might have been expected. The exceptions were Ian Davis, Help the Aged's business advisor, and Les Martin of Counsel & Care, who had some awareness derived mainly from the trade press. There

was some recognition that there might be some gains from internationalization, such as foreign expertise, but there was also concern that internationalization might allow scope for greater economic ‘volatility’ (as Edwards put it). Chapter Four indicated that the case study firms did see being part of an internationalized organization as useful in allowing them to learn from abroad, although the information given by Company 2’s Bartlett suggests that American practices (such as restraint) may not always be the most appropriate for use in the UK. In addition, the potentially negative effects of Company 2 (USA)’s financial problems on Company 2 do bear out Edwards’s comments about the possibility of greater volatility in the market. Martin was also concerned that, ‘the scope for the decision making being detached from the consequences grows much more marked when you cross the ocean to the States’, a comment which again underlines the importance of firms such as Company 2 (USA) allowing some degree of autonomy among their national divisions.

All the respondents were adamant that large providers must be treated equally with other providers by regulators, although there was some acceptance that regulators should be able to be more flexible in recognising the differences between different types of providers. All the respondents were broadly in favour of the regulatory changes recommended in the ‘Modernising Social Services’ White Paper (DoH, 1998b), although Counsel & Care had begun to campaign for an industry regulator with powers affecting market structure rather than only quality narrowly defined. These are important issues, since this thesis demonstrates that the organization of large firms and the overall structure of the market may have an influence on the quality and type of care delivered. These issues will be returned to in the final chapter.

In sum, whilst the organizations considered here may have significant influence on the ‘climate’ within which care is delivered by private providers, their primary activity is geared towards influencing government policy. This orientation towards government policy confirms the centrality of state institutions and of government policy in shaping the environment in which firms operate, and is therefore consistent with the findings of Chapters Five and Six. It is the form and extent of state activity in the sector which determines the basis upon, and the constraints within which, private providers may operate. Indeed, the lack of any autonomous organization of users of long term care,

due to the very nature of that care in providing support for vulnerable people, underlines the importance of the state, through its regulatory activities, in protecting the interests of residents.

## **CHAPTER EIGHT: CONCLUSIONS**

### **INTRODUCTION**

Chapter Three stated two aims of this thesis: *firstly* to build on what was known about large and internationalized welfare firms through an empirical and exploratory study of large and internationalized firms within the UK market for long term care; *secondly* to make a contribution to the debate within Social Policy (and other disciplines) concerning the deterministic claims relating to globalization discussed in Chapter One. The results of the research have been presented and discussed in previous chapters. The purpose of this chapter is to discuss further these results and analyse their implications. These implications can accordingly also be split into two: *firstly* the implications for long term care of the process of consolidation and internationalization which the thesis argues is proceeding within the market; *secondly* the implications for the globalization debate of what is happening within the long term care market. The discussion of these two sets of implications overlaps considerably. This chapter deals with them in reverse order, looking first at the implications of the previous chapters' findings for the globalization debate. The rationale for this is that, as is argued below, developments within the market are largely the outcome of state policies - an argument of considerable importance for the globalization debate.

### **IMPLICATIONS FOR THE GLOBALIZATION DEBATE**

Chapter Three pointed out the difficulty of a direct quantitative comparison of internationalization in the case study firms. Chapter Four, however, showed that all three of the case study firms have experienced some degree of internationalization, although in different forms. Although at the time the research was conducted the UK was the only country in which Company 1 provided long term care homes, the firm had foreign operations in insurance, hospitals, primary care and dentistry, and its Spanish arm was considering moving into care homes. Company 2 (USA) was the most

internationalized in terms of long term care provision, with care home operations in five countries (of which Company 2 was the largest outside the USA) as well some overseas provision of pharmacy and medical supply services. Company 3 was the least internationalized in terms of provision, but had been majority owned by a US company at one point, and had significant alliances with US firms, particularly in real estate and retirement home management, as well as US based financing arrangements.

Furthermore, there is considerable evidence that such internationalization is increasing. Company 1's strategy was influenced to a considerable degree by the near monopoly of the NHS over hospital provision, which led it to expand into long term care provision in the UK, but to expand its other services abroad. In 1997, the only year for which an annual report could be obtained for the company, its foreign operations were its fastest growing business and it had announced an, 'objective of opening for business in at least one new country a year.' (Annual Review, 1997: 17) Company 2 (USA)'s strategy was clearly based on international expansion, although it was unclear what impact its 'Chapter 11 reorganization' would have on this. The impact on Company 3 of its acquisition by new owners could not be fully determined at the time of writing, but preliminary indications were that it was considering expansion into the rest of Europe (CCMN, May 1999). Concentration within the market has therefore been accompanied by internationalization, and this is likely to continue to be the case. This is consistent with the perspective adopted in Chapter One that there is a *process* of globalization which can be observed within the world economy, and with the discussion of increasing internationalization among service firms in Chapter Two. The strategy of internationalization pursued by the case study firms may be characterised as 'market seeking' rather than 'client following'.

Chapters Five to Seven presented the results of the meso level analysis of the relationships between these internationalized firms and other key domestic actors. Two of these actors, the unions and older people's organizations, were found to be generally weak in terms of their ability to exert any direct influence over such firms. Furthermore, the international links which these organizations have make very little difference to this lack of influence. In contrast to this, the state (and its agencies) has decisive power over such firms and the environment within which they operate. This

power is reinforced by the actions of the other two non-firm actors in seeking to compensate for their lack of direct power in relation to the firms by attempting to influence the policies of the state. However, this situation involves a number of complexities. There are complexities which relate firstly to the diffuse or indirect influence which may be exercised by older people's organizations and unions. Secondly, there are complexities that relate to the longer term outcomes of the state's actions in relation to the interests of the firms. The rest of this section explores these arguments and their associated complexities.

The overall evidence is that the state is the decisive actor in influencing the actions of the firms, primarily through its capacity to shape the environment in which they operate. This relates to the 'second aspect' of the meso level of analysis, i.e. the 'structural' aspects relating to the form and extent of organization of the various actors. Chapter Five shows that state policies relating to both funding and regulation are placing all private providers under considerable economic stress.

Evidence published by the Joseph Rowntree Foundation (Laing, 1998) discussed in Chapter Five indicates that the fees paid by state agencies frequently fall below the true costs of care, and that restrictions placed upon the funding of state purchasers by central government result in the effective demand for care falling significantly below what would be expected from demographic pressure. The effect this has on the industry as a whole can be gauged from occupancy rates. In March 1999 these were 85.7% for private nursing homes and 87.1% for private residential homes, well below the levels recorded prior to the 1993 Community Care reforms (L&B, 1999-2000: 182). This means that relative to effective demand there is considerable over-capacity in the industry, which will only be reduced through either a substantial increase in available funds for purchasing or in significant closures. The government's response to the RCLTC (NHS Plan, 2000) may alleviate this to some degree, but its decision to make only nursing care (strictly defined not to include personal care) free at the point of use will continue to hold down effective demand and will disproportionately favour large providers, which are concentrated in nursing care.

These economic pressures are clearly against the short term interests of all private providers. The evidence relating to Company 2 (USA) in Chapter Four shows that changes in state policies (in this case by the US state as well as the UK state) can lead to problems which threaten the very existence of even the largest and most internationalized of firms. However, Chapter Four also shows that the largest firms are better placed to withstand such pressures through economies of scale and greater access to borrowed funds. Thus whilst large firms may be significantly damaged (to a greater or lesser extent) by state funding policies, the overall effect of such policies is to produce an imperative for 'rationalization' within the for-profit sector which can only facilitate the process of concentration, and therefore by implication that of internationalization.

Chapter Five also shows that there is considerable evidence that state policies on regulation will soon impose heavy burdens on all providers, but that again these will be more easily borne by large firms. Chapter Five showed that the existing regulatory arrangements are widely regarded as inadequate. In particular, the QA managers of the firms themselves all articulated their frustration with the inconsistency which they regarded these arrangements as producing. The government is addressing this problem through its proposals for a National Commission for Care Standards for England, which would implement a new set of National Required Standards (NRS) for long term care. The consistency which it is thought this reorganization will bring has widespread support. However, the costs associated with the NRS will disproportionately affect small providers, who generally operate from smaller, converted, premises and who have less funds with which to make the required changes to such premises. Whilst the timetable for the phasing in of the NRS will determine to some extent the precise impact on the industry, there are fears of a 'mass desertion' of the industry, especially in the South East where small owners may attempt to take advantage of the current boom in property prices by selling up. As CCMN (August/September, 1999) pointed out, if this happens it may well lead to short term *under* capacity, thus increasing the bargaining power of providers in their relations with state purchasers. There is little doubt, however, as to the long term impact of the NRS on the structure of the industry. It almost certainly will provide another impetus towards

concentration, as large firms make the necessary adjustments and buy up some of the smaller firms which cannot cope.

In contrast to this decisive shaping of the industry by the state, the unions were generally weak in the sector. The RCN appeared fairly successful in recruiting qualified nurses, but this was primarily on the basis of offering professional services rather than collective organization. Among the less skilled workers who form the majority of workers in the sector, neither UNISON nor GMB had had any great deal of success. This was despite fairly different approaches. UNISON officials displayed considerable hostility to the private sector, and to foreign owned firms in particular, and took a 'traditional' bargaining approach to organizing. GMB was far more pragmatic towards private provision in general, and adopted a 'partnership' approach towards employers in the sector. However, both had very small numbers of members, both across the sector as a whole and within the case study firms. The difficulties of organizing in the sector had led UNISON to effectively abandon any major effort to do so in the foreseeable future, despite holding talks with Company 1 on the residential side.

This weakness of autonomous organization had lead the unions in practice to pursue their goals in the sector through the provisions of recent acts of parliament. The National Minimum Wage (NMW), the Working Time Directive (WTD), the Employment Relations Act (1999) and the TUPE regulations (1981) were all means of using the state to enforce better conditions for care workers and to extend or maintain union organization. Thus in terms of union - firm relationships, it was *the state*, rather than the two actors directly concerned, which had the decisive power. Both large and small firms generally oppose such measures. However, the effects of them upon providers generally was, and will continue to be, much the same as that of state funding and regulatory policies, i.e., it will facilitate still greater concentration because of the greater ability of large firms to withstand the economic costs of such policies.

All of the unions had international links. However, in practice these made very little difference to their bargaining position, other than as a source of information and inspiration (mainly in the guise of the American SEIU). This is a significant finding for the globalization debate, since the formal membership of international federations



proved to be less important than their lack of organization at the national level, and they therefore had to turn to the *nationally* organized state. On the one occasion that UNISON had sought to utilise its international contacts to make a direct impact on one of the case study firms, i.e., its planned campaign against the entry of Company 2 (USA) into the UK market, this had to be abandoned because of the likelihood of legal action. In this case, the company would have been the actor in a position to use the state against another actor. The unions were clearly much less organized at the international level, in terms of mobilizing resources and engaging in coordinated activity, than were the firms.

Older people's organizations were generally in a similar position to the unions in terms of having little direct influence over, or even contact with, the firms. There are, however, significant differences. It was not among the goals of these organizations to engage in direct bargaining with firms. The form of their organization predisposes them towards seeking influence through ideas rather than direct bargaining. They do this primarily through research, the provision of information and advice, and campaigning to influence government policy. Their international links are an extension of this way of organizing, seeking influence at an international level among, for example, supranational bodies. Once again, therefore, there is an emphasis on achieving goals through the medium of state policy and action.

The evidence from the meso level of analysis, therefore, overwhelmingly supports the conclusion that the state is the most powerful actor in this sector. This has important implications for the globalization debate surveyed in Chapter One, since it clearly contradicts the deterministic argument that the state is weak in comparison to internationalized firms. This conclusion cannot be overgeneralized from. There are clearly significant specificities related to this sector - what happens within it does not tell us all we need to know about the overall impact of the world market on the state, or about what happens in other sectors. However, all sectors have their specificities - the more evidence is accumulated about different sectors the more we are in a position to make an informed judgement about the overall role of the state.

Furthermore, the findings of the thesis contradict deterministic arguments in important ways. The deterministic thesis relies heavily on the notion of the possibility of 'exit' by internationalized firms (Weiss, 1998: 184). This is made clear by the quotation of Mishra (1999: 6) cited in Chapter One: 'Put simply, by providing capital with an 'exit' option, globalization has strengthened the bargaining power of capital very considerably against government as well as labour... Thus money and investment capital can vote with their feet if they do not like government policies...' Applied to this thesis, Mishra's argument would assume that both British firms like Company 1 and Company 3 and US firms like Company 2 (USA) would seek to shift their investment out of the UK in response to the imposition of stricter regulatory criteria by the state, especially as the new regulations will raise costs whilst state funding continues to be restricted. Yet there is no evidence of this. On the contrary all of the case study firms were broadly in favour of the regulatory changes, largely because they will increase consistency.

It may be argued that these particular firms are less mobile in the sense of being able to take advantage of 'exit', since as service firms they must invest where the service is consumed (as discussed in Chapter Two). It is therefore not possible for them to produce in low cost countries and then export to developed countries. This is certainly the case, and yet it in no way undermines the conclusion that the thesis challenges the deterministic argument. This is because, as Chapter Two demonstrated, services are not an irrelevant part of the world economy, but account for the majority of output in advanced countries, and form a large and growing proportion of international trade and FDI. Thus research such as this thesis, which investigates the internationalization of services in relation to the globalization debate, will become increasingly important as services make up a growing section of the world economy. The relative *lack* of mobility of service firms is an important argument against the deterministic thesis.

These findings have particular relevance for the debate on globalization within Social Policy, since there is a widespread assumption that the state is withdrawing from welfare, and that this is at least partly the result of globalization. However, this thesis confirms the view that, in this sector at least, the state has not withdrawn but rather that the *form* of state intervention has changed, in this case from direct provision to

funding and regulation. Regulation is particularly important here, since the evidence is that the impetus is towards more rigorous and more extensive regulation than has hitherto been the case. That the state may be changing the form of its intervention confirms the arguments of those like Weiss (1998, 1997), who have emphasized the adaptivity of the state within changing economic conditions. The growing regulatory powers of the British state are particularly important since many writers (Weiss, 1998; Ruigrok & van Tulder, 1995) regard Britain as a weak state when compared to others such as Japan or Germany, yet in this sector at least it is increasing its power.

As noted above, there are important complexities to this picture of the predominance of state power. Firstly, older people's organizations and unions may have ways of exerting influence which are alternatives to either direct bargaining with the firms or to influencing state policy. The GMB and RCN, for example, both took a 'partnership' approach to organizing in the sector, which involved offering employers resources and advice with a view to exerting some influence over them. However, where this was successful, it was likely to be with smaller employers who had limited resources, rather than with large firms. Part of the strategy of older people's organizations, however, was to change broad attitudes towards older people and the way services should be delivered to them. The effects of this are diffuse and difficult to measure, and this thesis does not attempt to do so. Nevertheless, it is likely that recent changes in the overall 'climate of opinion', fostered in part by the organizations considered in the thesis, have influenced the decisions of all the case study firms to organize regular residents' and relatives' meetings within their homes. The older people's organizations also provided valuable services to older people relating to long term care, such as information and advice.

There are also significant complexities to the relationship between the state and the firms, and to the outcomes of this. As noted above, state policies towards funding and regulation, as well as those which affect the labour market in the long term care sector, are against the immediate, narrowly conceived, interests of *all* firms, and may even lead to some *large* firms going out of business. It will almost certainly lead to some large firms being acquired by, or merging with, others. Yet these policies tend to have a more dramatic impact on small firms, thus leading to still greater concentration

within the market. This greater concentration can only be in the long term interests of large firms in general, and increase their structural bargaining power in relation to other actors, including state agencies.

It has also been argued that any new process of concentration is likely to be accompanied by the parallel process of internationalization which has been observed among these firms. This process of internationalization has also been facilitated by the state, since the New Labour government has continued to pursue the liberal policies of its predecessors on international trade and investment. Thus, rather than having regulatory regimes which discriminate against foreign firms, as is the case in some countries (see Chapter Two), the government has supported supranational agreements and institutions which tend to reinforce liberal trade and investment policies. This is the case with both the WTO's General Agreement on Trade in Services (GATS) and the EU's public procurement rules. These might be considered *institutional* constraints on the actions of the government, as opposed to constraints imposed by the market itself. However, as discussed in Chapter Five, they reflect rather than conflict with the government's worldview, and are voluntarily entered into.

Despite the overwhelming power which the state has to shape the environment within which the firms operate, it may be the case that the firms are able to exert some influence over the state and its agencies. This can best be demonstrated in relation to regulation. There has been a broad consensus in favour of changes which remove inconsistencies in regulation. The firms themselves have played an active part in the development of this consensus, through forums such as the Continuing Care Conference and through direct lobbying. In addition, key figures such as the current chief executive of Company 3 (and former chief executive of Care First), Chai Patel, have headed influential bodies such as the Better Regulation Task Force and the Continuing Care Conference, and have won the respect of some of those working for older people's organizations. Firms, therefore, have made active efforts to influence the policy process. Rather than simply opposing regulation, as authors such as Levitt (1968) argue they are likely to do (see Chapter Two), they have sought to influence its shape. Once again, it is difficult to measure how successful they have been, but it is clear from Chapter Five that, in contrast to small firms, they broadly welcome the

forthcoming regulatory changes because they are likely to lead to more consistency. It is also clear from Chapter Five that the relationship between the firms and state regulatory agencies is marked by constant bargaining, and this is unlikely to change after the implementation of the forthcoming reforms.

It has been argued, therefore, that the primary outcome of state policies in the long term care sector has been, and is likely to continue to be, a process of concentration in the supply of privately provided services, an outcome which is in the long term interests of those large and internationalized firms which remain in business. The introduction by the state of more rigorous regulatory criteria has generally been accepted by these firms. Indeed, they have played an important role in exposing the inconsistencies of the current regulatory system. In part, this is because such firms were already nationally (and, of course, internationally) organized entities seeking to standardize their own services across a large geographical area. They therefore are acutely aware of inconsistencies between regulatory authorities, whilst having both the resources and the organizational capabilities necessary to meet more rigorous criteria where they are imposed. Indeed, Chapter Four showed that their internal QA systems mirror the requirements of the regulatory system, and sometimes exceed them.

This has significant implications for the globalization debate, since whilst the state is the dominant partner, and its actions may be contrary to the immediate interests of even large and internationalized firms, they do not appear to be contrary to the *long term* interests of such firms. Rather the actions of the state appear to be fostering the development of such firms. This tends to confirm the arguments of those like Weiss (1998, 1997), who have argued that the state has been a facilitator of internationalization. It also appears to confirm the observation made in Chapter Two, that rather than there being a simple antinomy of interests between states and firms, as often assumed in the globalization debate, there may be a 'symbiotic' relationship between the two (see Mintzberg, 1979: 288). There is thus a symmetry between the 'new managerialism' within the welfare state, and the organizational form of large and internationalized firms. This is unsurprising, since the ideas which inform this new managerialism originate within the private sector. However, they have been utilised by state agencies in the external regulation of private welfare providers. As suggested in

Chapter Two, therefore, the relationship between state and firms does indeed appear to be marked by a process in which the actions of each encourage a concentration and formalization of the power of the other.

The implications for long term care services in the UK of the processes of consolidation and internationalization discussed in this section will be discussed in the next section.

### **IMPLICATIONS FOR LONG TERM CARE IN THE UK**

It has been argued above that state policies on long term care are likely to facilitate greater concentration and internationalization in the sector. However, this is not the stated aim of such policies, and therefore may be regarded as an unintended consequence of them. However, it cannot simply be regarded as a 'side effect', since there is a distinct economic logic to the process. The government is seeking the highest possible quality of care for the lowest possible cost, whilst also providing minimum standards of protection for workers in sectors such as long term care which tend to employ 'flexible' labour on low wages. This combination of the highest possible quality of care and the lowest possible cost can best be provided by large firms due to the economies of scale which they can utilise, and for the same reason such firms are best able to meet the costs associated with higher labour market standards. Thus government policies in diverse areas affecting the sector push increasingly in the direction of provision by large firms, which are also increasingly internationalized.

However, previous chapters show that there was a high degree of consensus attached to the proposed regulatory changes, with both the unions and older people's organizations broadly supporting them. Such support was based on the overt merits of these policies - i.e., they are seen as raising standards for the users of services - not on their consequences in increasing concentration and internationalization among firms in the sector. This is significant, since there was little detailed awareness of the internationalization of such firms among older people's organizations, and some reservations about provision by large firms. The unions, and UNISON in particular,

were often sceptical about, or hostile towards, large and internationalized firms, although there was a perception that their size may make them easier to organize (despite their perceived anti-unionism). This section explores the implications for long term care in the UK of the dual processes of concentration and internationalization.

This thesis has been centrally concerned with the issue of quality. Whilst the thesis has not attempted to evaluate directly the quality of care provided by the case study firms, previous chapters show that there are powerful incentives for large firms to maintain high standards of care. Chapter Four showed the importance to these firms of branding, which is dependent upon demonstrating high and consistent levels of care. Such consistency is achieved through strict control over the labour process through internal QA systems. In addition, all of the firms appeared committed to organizing residents' and relatives' meetings. The evidence from Chapter Four also indicates that the firms obtained significant benefits from their internationalization which may help to raise quality. Such benefits included access to more advanced information and communications technology, a wider pool of experience and expertise to draw upon, increased training resources and greater economies of scale. This was despite the use of practices in the US by Company 2's parent company, Company 2 (USA), which are widely regarded as unacceptable in the UK (issues relating to US practices are discussed below).

Chapter Five showed that state regulators, even when organized on a local basis, have significant power in their relationships with such firms, since if lack of 'fitness' can be traced back to the owner this could potentially endanger the existence of the entire firm (or at least its care home operations within the UK). In practice this is highly unlikely to happen, both because of the pragmatic way in which inspectors go about their job, and because the firm would not allow this situation to be reached. In addition, any negative publicity arising from poor standards uncovered during inspection would do considerable damage to the firm. In practice, therefore, care homes run by these organizations are involved in a two way process concerning the quality of the care they deliver: one involving an internal relationship between the home and the firm's central QA personnel, the other involving a relationship between

the care home (backed up where necessary by the firm's central resources) and external regulators.

The evidence therefore suggests that at present these firms are likely to provide a standard of care which exceeds minimum official requirements. However, if the process of concentration continues as expected, three areas of concern can be identified. These are: firstly, the effects of increased ownership transfers; secondly, issues relating to standardization; and thirdly, the possibility of a decline in the quality of care resulting from the interaction of the regulatory system with large providers. These will be discussed in turn.

Chapter Four showed that the process of merger and acquisition (M&A), which last peaked in 1997, involved significant problems for the two case study firms which had predominantly grown in this way, in terms of cohering the various acquisitions into a single organization. These generally related to the issue of 'cultural fit' identified in Chapter Two. Company 1's Bob Jones identified three main 'corporate pasts' and 'about 20 different sets of policies and procedures' which needed to be cohered into a single whole. Furthermore, these problems went beyond simple organizational problems, involving also 'political' problems of rivalry between the three pasts which impacted upon the very shape of the QA system eventually adopted. This rivalry existed at 'every level', from the regions down to the homes. In part these problems were caused by the inability of one of the 'corporate pasts', Care First, to integrate successfully the two firms from which it itself had been formed. Company 2 had experienced similar problems in integrating its three constituent parts into a single whole, with Bartlett describing the process as causing, 'a lot of unrest and a lot of upheaval'. In addition to these organizational problems, the financial problems affecting Company 2's parent, Company 2 (USA), examined in Chapter Four, illustrate the increased uncertainty that may arise when the acquiring firm is based overseas.

Both QA managers said these problems relating to the M&A process grew less over time, with Jones describing Company 1 as being in a, 'transitional phase of bringing it together'. Any new phase of M&A resulting from the pressures for rationalization discussed above is likely to disrupt these firms before they have fully settled into a new



way of working. Such transfers of ownership can have a significant effect on both residents and staff. This is the case for individual homes acquired by large organizations, as much as it is for existing firms acquired by larger ones, as is evidenced by Grant's comment that it was 'never easy' to integrate a pre-existing business once acquired. The potential effects on staff are evidenced by Company 2's loss of significant numbers of staff as a result of changed working practices after the merger (see Chapter Four). The process of ownership transfer also causes significant insecurity among staff. According to Bartlett, at the time of Company 2's merger, people were 'coming to terms with who, if you like, was going to end up in charge of [Company 2] or [Company 2 (USA)] or whatever it was going to be called... I think it was mostly being unaware of what was physically going to happen, and because they felt insecure it obviously affected some routines.'

The comments of Dianne Fenn in Chapter Five also indicate that changes of management at both the home and regional levels, which may result from ownership transfer or from internal reorganization or promotion, can also have a disruptive effect on the relationship with regulatory agencies:

I'll just get one sort of case sorted out and the care manager understands the relationship ... you know how to ensure a good working relationship with staff and with GPs, when they're whisked off or they leave or somebody else comes in and you go through the whole thing again and then you find that the next one, above the local manager, has also changed and they haven't got any idea...

Fenn's experience was that much hard work in raising standards within a particular home could be damaged when changes in management took place. Partly this was because the manager's relationship with his or her own staff had to be formed anew, and staff may in the meantime, 'go back to their old ways'. Frequent changes in management could also have an important impact on the attitude of staff:

It's very sad to say, but in a big company where they feel they've got no commitment to anybody you know, and a lot of them think, oh yes this is a very rich company they're always changing and they don't care about their

staff, there is absolutely... no commitment, they're not proud to be working for a particular firm or business.

As Fenn made clear, both the continuity and the morale of staff have a profound impact on the wellbeing of residents. There are also additional reasons why the impact upon residents of ownership transfer may be potentially far more serious than it is for staff. It is well known that physically moving residents is severely disruptive of their lives and wellbeing, for emotional and psychological reasons as well as physical ones, in the worst cases resulting in fatalities. Ownership transfers are likely to increase these physical transfers, as the new owner rationalizes its internal provision and closes some homes. Chapter Four shows that this was the case with Company 1's acquisition of Care First; as CCMN (November 1997) put it, the integration of Care First required 'considerable reconfiguration'. The supplementary interview with Company 1 home manager Colin French, quoted in Chapter Four, also tends to indicate that following acquisition there is internal bargaining over which homes will close; in this case the home in question narrowly avoided being closed, instead receiving extra investment.

However, even where homes are not closed, Chapter Four demonstrates that there will be considerable reorganization resulting in a change of regime for many homes. Such changes of regime brought about by ownership transfer may be just as disruptive of the lives and expectations of residents as physically moving them. How this is managed by the new owners is therefore crucial for the wellbeing of the residents. Three out of four of the respondents from older people's organizations were concerned about the potential impact on residents of what Garton called, 'where people live... being bought and sold over their heads' (see Chapter Seven). Les Martin of Counsel & Care gave some examples of the kinds of ways in which such changes could be disruptive for residents:

... they will be small things in terms of the bigger policy issues but actually, in terms of the lives of the people who live there, which are defined by what time they get up in the morning, and what time they go to bed and what happens in between and they don't leave the house perhaps without any assistance..... a

change of owner, a change of manager, a change of leadership can affect both the style and the substance of a service...

This was one of the points Counsel & Care had made in their letter to the then Parliamentary Under Secretary of State at the Department of Health, expressing particular concern, 'about residents who have experienced changes, often many changes in succession, in the ownership of the home in which they reside.' Garton had been concerned that residents had no say in such changes: 'they're often not informed of the business decision, they've got no involvement, no preparation or reassurance if necessary.' Issues associated with ownership transfer should thus be a key area of consideration in future policy decisions.

The second area of concern relates to issues of standardization. As noted above, there is considerable evidence that large and internationalized firms maintain a generally high standard of care. They do this through the operation of the QA systems discussed in Chapter Four. This involves standardising their 'product' across all outlets (i.e. homes), and such standardization is an important feature of its marketing (i.e. branding). This is the 'McDonald's' approach discussed in Chapter Two. Concerns arising from this process of standardization relate primarily to the possibility of effective local monopolies or oligopolies emerging. As discussed above, if forthcoming regulatory changes lead to a significant reduction in the numbers of small owners operating in the market, this will significantly alter the 'balance of power' between the remaining large firms and purchasing authorities in some areas. Les Martin claimed in Chapter Seven that some local authorities were already colluding with large firms, in order to reduce costs, in a way which damages choice. Whilst Martin did not provide any concrete evidence of this, it is certainly the case that any future shift in the direction of local monopolies will have important implications for choice.

This question of choice was a particularly important issue for older people's organizations. As Martin pointed out, the Community Care reforms aimed at increasing choice. Opening up provision to private providers was seen as a key way of accomplishing this, since state services were often considered to be monopolistic and provider driven (Griffiths, 1988: 7). It would thus be an irony if the outcome of the

government's attempts to raise the quality of care, whilst restricting the availability of funding, were to lead to 'community' care being delivered primarily by large and internationalized firms offering standardized services. Whilst the process of concentration may not go that far in the near future, there is a very real possibility of localized monopolies coming to undermine choice. Thus the relative reduction of small providers may lead some areas to lose the perceived advantages associated with them. As Company 1's Bob Jones put it, 'Usually what's special about [small providers] are there are a lot of people where the owner is the manager and lives and runs it... It's like going to a real cosy seaside bed and breakfast where you feel real homely, real comfortable, versus going into a Trusthouse Forte...'

This issue of standardization is also related to the issue of bureaucratization which large organizations are prone to. According to Jones: 'the only way to run large organizations [is] with a bureaucracy... So inevitably we've ended up with perhaps more of a bureaucratic structure than any of the pasts had... We have to have a level of central control because if we didn't we would lose it, because it is that big.' Company 1 had tried to mitigate the negative aspects of standardization and bureaucratization by allowing home managers some level of autonomy, but it is clear that the larger the organization is, the more it will be prone to bureaucratization. Such bureaucratization sits uncomfortably with the concept of 'community care'.

The evidence from the QA managers quoted in Chapter Five also shows that where homes run by large firms do manage to retain some individuality, this may be undermined by regulators demanding changes which undermine the attempt to create a 'homely' environment. Bartlett, for example, spoke of regulators being dissatisfied with a home in Newcastle which did not meet physical standards, such as those concerning single rooms and en suite facilities, but provided residents with the 'cosy' environment they favoured. This may, of course, be an argument which aims to justify inadequate provision. However, this question of the effect of regulation on the quality of care provided, especially where the company being regulated is a large one, relates to the third area of concern, i.e. the possibility of a decline in quality resulting from the interaction of regulation with large providers.

This third area of concern relates to research done on the nature of the regulatory system in the US in the early 1990s, referred to in Chapter Two. Braithwaite (1993) showed that the introduction of strict structural input standards in the US in the 1970s hastened concentration within the industry, as is likely to be the case in the UK. Large companies could most effectively meet the standards by building large homes which made use of economies of scale in provision. However, as discussed in Chapter Two, according to Braithwaite (1993) the combination of large homes (where management is separated from actual care provision) and input regulation resulted in 'ritualism' (i.e. fulfilling formal requirements regardless of the outcomes for residents), and the adoption of a 'disciplinary' approach to residents based on control and risk avoidance. Large homes came to embody the worst aspects of institutionalization. As discussed in Chapter Five, the new NRS in the UK concentrate on both process and structural input measures (both of which tend to favour large providers), although there is explicit reference to the outcomes which these are expected to result in and designated means for checking this. This is in contrast to the Australian regulatory system, which is based on a radical orientation towards outcomes (Braithwaite et al, 1993).

As is shown in Chapter Four, the case study firms' internal QA systems are based primarily on process considerations. As has already been argued, these tend to go beyond the minimum requirements of the current regulatory system. This is in contrast to Braithwaite's observations of care in US homes at the time of his research (1993: 40), where 'most corporate quality assurance programs demand no more than is required by government regulation.' If government policy ultimately facilitates concentration in the UK market to the extent whereby local monopolies do emerge, and if this is matched by a trend towards larger homes, it is possible that the standardized care within such homes may also move in a 'disciplinary' direction. Where large firms face less competition, the market-based incentives to provide high quality care will be reduced. This shifts more responsibility onto the regulatory system to facilitate and sustain high quality. If regulators pay inadequate attention to actual outcomes, they may provide an incentive for ritualistic behaviour.

None of this is inevitable, of course. Even with a greater degree of concentration than is currently the case, there may be cultural and historical reasons why care in the UK

does not develop in this way, especially considering the role older people's organizations and others have played in raising awareness of such issues. The prevalence of litigation in American society, for example, is an important factor in encouraging restraint as a way of avoiding the risk of accident and injury (Braithwaite, 1993: 43), which does not exist in the UK to the same extent. In fact, physical restraint is widely regarded as unacceptable in the UK. In addition, the NRS place some importance on 'discussion with residents' as a means of providing evidence that standards have been properly implemented. This is likely to provide some protection against ritualism, although the reluctance of some older people to complain must be acknowledged (see William & Keating, 1998), as well as the difficulty some residents may have in articulating themselves (see Chapter Seven).

However, as Braithwaite et al (1993: 52) suggest, there may be a need for 'constant reinvigoration' of the regulatory system (see Chapter Two). The US experience demonstrates the importance of continually monitoring the interaction between the regulatory system, the structure of the industry, and quality outcomes for residents. A number of respondents interviewed for this thesis had some sympathy with the idea that regulation should move beyond a concern with the quality of care delivered in homes, to encompass also companies as whole organizations, or with the idea that the market structure of the sector as a whole should be monitored and regulated. There is some evidence that forthcoming government reforms are moving in this direction, but the issue needs to be given more, and clearer, attention.

## **CONCLUSION**

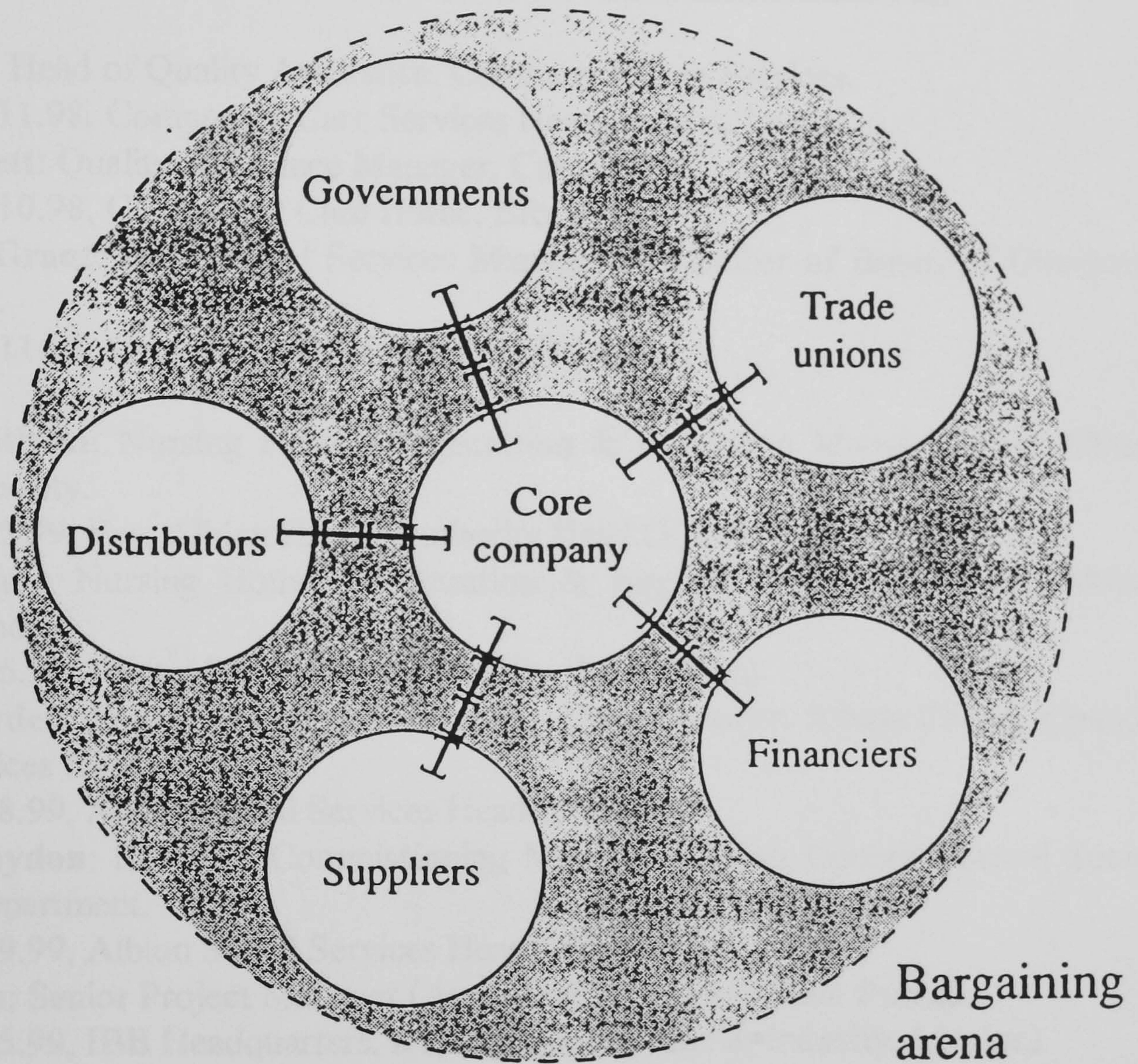
This chapter has shown that the thesis has important implications for the globalization debate, as well as for long term care in the UK. There is a process of concentration within the UK market for long term care, which is being accompanied by a parallel process of internationalization. Far from being powerless, the state has been shown to be the dominant actor in shaping this process of concentration. The implications for long term care involve concerns about the effects of ownership transfers,

standardization, and the quality of care arising from the interaction of the regulatory system with large providers.

The thesis has demonstrated the applicability of micro and meso levels of analysis to the debate about globalization and social policy, where a macro level of analysis usually dominates. Micro and meso levels of analysis are particularly appropriate when studying privately provided services. The meso level of analysis allows for relationships between actors to be examined in their true complexity, and the determinism which characterizes some other approaches to be avoided. The thesis has also demonstrated the fruitfulness, if not necessity, of an interdisciplinary approach to the study of globalization and social policy.

APPENDIX ONE

THE BARGAINING ARENA IN RUIGROK & VAN TULDER'S MODEL



Source: Ruigrok & van Tulder (1995: 68)



## APPENDIX TWO

### INTERVIEW RESPONDENTS

#### Primary Interviews (Respondent, Position, Date and Place of Interview)

**Bob Jones:** Head of Quality Assurance, Company 1 Care Services.

(13.11.98, Company 1 Care Services Headquarters, Leeds)

**Jane Bartlett:** Quality Assurance Manager, Company 2.

(30.10.98, Company 2 Care Home, Bromley)

**Margaret Grant:** Professional Services Manager & member of Board of Directors, Company 3.

(20.11.98, Company 3 Offices, North Wales)

**Maria Smitham:** Nursing Homes Registration & Inspection Manager, East Albion Health Authority.

(14.5.99, East Albion Health Authority Head Office)

**Dianne Fenn:** Nursing Homes Registration & Inspection Manager, West Albion Health Authority.

(18.6.99, West Albion Health Authority Head Office)

**Adam Warden:** Local Services & Community Care Manager, Albion County Council Social Services Department.

(19.8.99, Albion Social Services Head Office)

**Gordon Saydon:** Strategic Commissioning Manager, Albion County Council Social Services Department.

(29.9.99, Albion Social Services Head Office)

**Julia Owen:** Senior Project Manager (Americas), Invest in Britain Bureau.

(11.5.99, IBB Headquarters, Department of Trade & Industry, London)

**Kevin Fenton:** Research Officer, UNISON / Public Sector Privatization Research Unit.

(30.7.98, UNISON Headquarters, London)

**Steve Morton:** Director of Policy & Research, UNISON.

(21.10.98, UNISON Headquarters, London)

**Peter Stephens:** National Officer (Healthcare), UNISON.

(4.3.99, UNISON Headquarters, London)

**Mike Gresham:** National Secretary Public Services Sector, GMB / APEX  
and **Laura Pole,** Research Officer, GMB / APEX.

(8.3.99, GMB Headquarters, London)

**Louise Saber:** Independent Sector Advisor, Royal College of Nursing.

(22.3.99, RCN Headquarters, London)

**Tom Douras:** Trade Group Secretary (Health), TGWU.

(Telephone interview, 18.3.99)

**Tessa Garton:** Director of Policy, Help The Aged.

(18.12.98, Help The Aged Headquarters, London)

**Ian Davis:** Business Advisor, Help The Aged.

(18.12.98, Help The Aged Headquarters, London)

**Evelyn Edwards:** Director of Information & Policy, Age Concern England.

(12.1.99, Age Concern Headquarters, London)

**Alison Alexander:** Advice Coordinator, The Relatives Association.

(3.2.99, Relatives Association Head Office, London)

**Les Martin:** Deputy General Manager, Counsel & Care.

(5.2.99, Counsel & Care Head Office, London)

### **Supplementary Interview**

**Colin French:** Care Home Manager, Company 1.

(25.5.99, Company 1 Care Home, Hastings)

### **Positions of those not responding to interview requests**

National Organizing Officer (Long Term Care), National Pensioners' Convention.

Nursing Homes Registration and Inspection Manager, Birmingham Health Authority.

Nursing Homes Registration and Inspection Manager, North Essex Health Authority.

Nursing Homes Registration and Inspection Manager, West kent Health Authority.

Nursing Homes Registration and Inspection Manager, North Nottinghamshire Health Authority.

## APPENDIX THREE

### EXAMPLES OF INTERVIEW GUIDES

#### Example 1: Company QA Managers

Note: Interview questions were derived from the research questions detailed in Chapter Three, which were themselves informed by the discussion in Chapters One and Two. Interviews with company QA managers involved questions relating to both the micro level of analysis and the meso level of analysis ('firm specific' aspects). Interview schedules were also constructed to take into consideration the 'flow' of the conversation from one topic to another. Interview questions do not, therefore, necessarily follow the same chronological order as the research questions from which they were derived.

Q.1: Could you tell me what your job involves?

Q.2: Could you explain how your QA systems work?

Q.3: Do residents have any input into, or involvement with, quality assurance?

Do you have residents' / relatives' meetings?  
How effective are these?

Q.4: How do you think your QA arrangements are different to those of other firms?

Q.5: I understand the company has recently gone through a process of merger and acquisition. What has been your experience of this ?

Has it had any impact on your QA systems?

Q.6: Your company is a large organization. Do you think this gives it any particular advantages or problems?

Are economies of scale an advantage?

Q.7: I understand the company has international links. What advantages or problems are associated with this?

Q.8: What is the relationship of the UK division / care division to the company's headquarters?

Are financial targets set from the centre?

Q.9: In your experience, is there any tension between the profit making goals of the company and the quality of service goals?

Q.10: Are state purchasers the main source of funding for the company?

Q.11: What is your assessment of the current regulatory arrangements?

Are these adequate in your experience?

What changes would you like to see?

Q.12: Does the company belong to a provider association?

What benefits does this provide?

Are these associations a means for political lobbying?

Q.13: How would you describe staff relations within the organization?

What mechanisms do you use to motivate the staff?

Q.14: How are pay rates determined (localized or national rates)?

Do you think the introduction of the National Minimum Wage will affect the company?

Q.15: How easy do you find it to attract enough adequately trained staff?

What internal training arrangements do you have?

Q.16: Is there any union organization within the company?

What is the company's attitude to this?

Q.17: Are there any changes you would like to see to the provision of long term care?

Q.18: Is there anything else you would like to add?

## **Example 2: Respondents from Non-Firm Organizations**

**Note:** Interviews with respondents from non-firm organizations relate to the meso level of analysis. The interview guide given here represents the basic template for questions put to these respondents. As explained in Chapter Three, differences between the non-firm actors, and sometimes between individual roles within the same organization, meant that the actual questions put to particular respondents may have varied from this template to some extent.

Q.1: Could you tell me what your job involves?

Q.2: What are the goals of your organization?

Q.3: What is your assessment of the overall shift to private provision in long term care?

How has this affected users of these services?

Q.4: How aware are you of the size of the leading firms in the sector?

Q.5: How aware are you of the level of internationalization of these?

Q.6: What is the attitude of your organization to these firms?

Q.7 Do you know much about large firms' internal QA mechanisms?

Q.8: How do you think quality can best be monitored ?

Q.9: How effective do you think the current regulatory arrangements are?

Do you think there is a case for large firms to be treated differently from smaller providers in any way?

Q.10: What is your assessment of the 'Modernising Social Services' White Paper?

Q.11: How do you organize in this sector?

Q.12: What is the extent of your organization in this sector?

Q.13: Has your organization encountered any problems in pursuing its goals in this sector?

Q.14: Does your organization belong to any international associations, or have any international links?

What benefits has it gained from this?

Q.15: Do you have any experience with the case study firms?

Can you give examples?

Q.16: In your experience, in what ways are the case study firms different to each other?

Q.17: In your experience, how are these large firms different to smaller providers?

Q.18: Are there any changes you would like to see to the provision of long term care?

Q.19: Is there anything else you would like to add?

Q.20: Is there anyone else you think I should talk to?

## **APPENDIX FOUR**

### **UNPUBLISHED DOCUMENTS**

#### **Company Annual Reports (AR) and Reviews**

TC Group / Care First Annual Report 1996

Company 1 Annual Report 1997

Company 1 Annual Review 1997

Company 2 (USA) Annual Report 1996

Company 2 (USA) Annual Report 1997

Company 2 (USA) Annual Report 1998

Company 3 Annual Report 1997

ANS Annual Report 1998

#### **Other Annual Reports and Reviews**

Age Concern Annual Review 1998-1999

Age Concern Annual Report 1998-1999

Counsel and Care Annual Report and Review 1998/99

Eurolink Age Annual Report 1998-1999

Help Age International Annual Review 1998/1999

#### **Other Documents**

Company 1 Care Homes 'Quality Review for Nursing and Residential Homes'

West Albion Health Authority Application Form for Registration of a Nursing Home (& Guidelines)

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