

Financialization and non-disposable women: Real estate, debt and labour in UK care homes

Abstract

This paper contributes to debates on financialization, neoliberalism and labour by investigating the ownership of UK care homes by investment funds. This form of financialized ownership has been driven by debt financing and the realization of value from property assets. Financialization has also been shaped by labour. First, the low status of the mostly female workforce enabled investor buy-outs. Second, growing financial pressures have been partly absorbed by the interactive labour of care. This reflects a neoliberal model of investment and regulation, which treats workers as disposable – unskilled and replaceable. Yet many carers reject this, and by continuing to care under deteriorating conditions, they provide a source of value to investors. Third, however, carers’ refusal of disposability can also provoke resistance to financial discipline. This is one of several ways in which caring labour limits financialization. Despite recurrent crises, the system has been condoned by governments as it displaces responsibility for the failures of neoliberal welfare onto financialized corporations. Overall, the paper argues that financialization must be understood as constituted not only by financial practices, property assets and regulation, but also by specific forms of labour.

Keywords: financialization, neoliberalism, labour, care, real estate

Introduction

In 2011, the UK’s biggest chain of care homes collapsed, putting at risk the homes of over 30,000 elderly and disabled residents and leading to 3,000 staff redundancies (Pendleton and Gospel, 2014; Roberts, 2011). The company, Southern Cross, had been bought in 2004 by Blackstone, one of the world’s largest investment funds. Blackstone rapidly expanded the chain, realized profits by selling off its real estate assets, and sold its stake after just two years, leaving Southern Cross with a “ticking time bomb” of rising rent bills as properties were leased back from new owners (Neville, 2011). Problems mounted and in 2011 Southern Cross declared

insolvency, triggering a chaotic scramble to find new companies to run the care services (Department of Health, 2011: 9; interview with union official). The crisis of Southern Cross, and efforts to prevent a recurrence in other care companies, have raised questions about whether responsibility lay with investors, regulators or the government's austerity programme – although most care homes are privately run, the majority of residents receive at least some public funding. These questions are critical for over 400,000 older people who live in care homes and their 665,000-strong workforce in England (IPC 2014: 29; Skills for Care, 2017: 19), as well as for wider economic geographies of finance, labour and welfare.

This paper shows how, over the past two decades, a substantial part of the UK's care home sector has been taken over by private equity firms and other investment funds, which seek to achieve a return by buying up, restructuring and selling on companies. Investment funds have introduced new sources of financing and ways of realizing profits that have transformed the size, asset base and financial liabilities of care companies; the effects on care workers, residents and spaces of care have been significant. These shifts are understood as a form of financialization, whereby investors integrate non-financial corporations more deeply into liberalised capital markets, bringing new relationships of risk and power. In these corporations, financial activities consequently play a greater role in generating returns to a powerful class of investors, contributing to the spread of financial logics of investment to a wider set of actors (Froud et al. 2006; Krippner, 2011; Martin, 2002).

By examining a labour-intensive service sector, and one in which government plays an important role through both funding and regulation, the paper contributes to several debates regarding financialization. Some accounts see investors as having been freed from dependence on labour by financial routes to profit, such as asset sales (Froud et al. 2006; Rossman and Greenfield, 2006). This research confirms the significance of such activities, and identifies how specific financial innovations have responded to investors' appetite to trade, or lend against,

corporate real estate assets. Yet it questions the claims that financialization undermines the structural importance of labour, or that it encourages the adoption of financial rationalities among workers (Rubery, 2015). These shifts are challenged in the residential care sector, which is characterized not only by real estate that can be converted into financial assets, but also by labour-intensive service work, involving high levels of emotional and embodied labour (cf. McDowell, 2009). The paper further considers the role of socio-spatial divisions of labour in shaping financialization, by focusing on a sector dominated by female workers. This has contributed to the low status of care workers and the intensified exploitation imposed by financial pressures. Workers are treated by investors and neoliberal governments as a cost to be minimized and as disposable: they are not professionalized and are viewed as interchangeable, should individuals find working conditions intolerable or suffer injury (cf. Wright, 2006). But many carers resist the disposability that is imputed to them and to care home residents, three-quarters of whom are female (ONS, 2014). Instead, workers absorb pressures and persist in caring for residents, colleagues and their workplace. These commitments can generate value for investors, but they can also disrupt accumulation. Understanding tensions over disposability helps to theorize the relationship between labour and financial routes to profit, and also the limits to financialization (Christophers, 2015).

Alongside financial actors and labour, the state is an important actor in the care sector. This raises the question of why high-risk investor strategies and their negative impacts on care services and workers have not been more effectively regulated. The explanation proposed here is that corporate debt serves to displace responsibility for care from the government to private companies and their creditors. The paper thus advances debates about neoliberal welfare that have tended to focus either on marketized care services or indebted households (Langley, 2008; Soederberg, 2013): a crucial role is also played by large-scale financialized corporations.

Financialization, neoliberalism and care

These arguments combine insights from three bodies of literature: on commodified caring labour, welfare based on debt and investment, and labour within financialized firms.

First, labour scholars and social geographers have studied the neoliberalization of care as an ideological and policy programme that seeks to reshape the state and welfare around market principles (Hall, 2011). A primary concern of this literature is how fiscal and competitive pressures on the cost of care have affected workers. Such pressures tend to deepen inequalities, given socio-spatial divisions of caring labour (Cox, 2013; Duffy, 2005). In particular, the commodification of care has taken advantage of its historic status in the west as domestic 'women's work' (Anderson, 2000), which has been constructed as requiring 'natural' caring qualities, rather than as productive and skilled labour worthy of substantial remuneration (Dyer et al., 2008; Green and Lawson, 2011). With reduced public funding for welfare under austerity programmes, recent scholarship has been concerned with how state retrenchment has intensified the exploitation of care workers, many of them migrants who are recruited to fill low-status labour shortages in richer countries (Burns et al., 2016a; Connell and Walton-Roberts, 2015; Schwiter et al., 2018). Resistance to austerity and its inequalities has been the primary focus for most trade unions in the sector (Burns et al., 2016b).

Vital as these accounts are, they have tended not to engage with debates about financialization, whether at the macroeconomic, firm or household scale. Most focus on domestic and informal spaces of care rather than the large, labour- and asset-intensive, residential care sector, in which financial actors have come to play a major role in reproducing and reconfiguring the tensions between markets and care. As Roberts (2016: 135) notes, "a narrow focus on austerity risks obscuring some of the longer-term structural transformations that have taken place under neoliberal capitalism [including] (...) financialization".

In contrast, a second perspective tends to see financialization as diminishing the importance of wage labour and public services. Instead, household debt and investment play an increasing role

as the basis for welfare and social reproduction. For cultural economists, neoliberalism works through the cultivation of 'investor subjects', who care for the self through asset-based risk management (Langley, 2008). Recent studies have focused on the deepening logics of investment in sectors such as childcare (Gallagher, 2017) and the increasingly uneven and ambivalent forms of asset-based welfare in housing markets (Fields, 2017; Ronald et al., 2017). Proceeding from a different theoretical perspective, but similarly concerned with the household rather than workplace or firm, are theories of financialized social reproduction that centre on debt and unwaged labour. Here, feminist political economists have identified unpaid, gendered labour as an advancing financial frontier – whether by microfinance debtors or volunteers whose activities underlie social impact bonds (Dowling, 2016; Rankin, 2008). This scholarship helps to show how financialization is an uneven and differentiated phenomenon, and points to the emotional labour that generates returns to investors. Taken together, these accounts raise questions about processes of financialization in the residential care sector, which involves extensive property assets, but also a huge labour force, caring for residents who are unlikely to perform as ideal financial subjects.

A third literature explores labour within financialized firms in other sectors. It suggests some ways to bridge the two areas of research set out above, on commodified caring labour and financialized welfare. Countering claims that financial activities have substantially displaced labour in the creation of value, scholars have shown how the demands of increasingly powerful investors have intensified workloads and insecurity among employees to meet performance metrics or headcount reduction targets, with productivity increases often being captured by capital rather than feeding into wages (Appelbaum and Batt, 2014; Cushen and Thompson, 2016). Varying institutions and regulations have lessened the impacts of investment fund ownership in some jurisdictions (Gospel and Pendleton, 2014). Yet these are less effective in preventing additional value being extracted from uncodified aspects of the employment relationship, such as those relating to discretionary effort (Appelbaum et al., 2013). That can be particularly significant in care work. One business model that has attracted particular attention

from scholars of labour and corporate strategy is that of private equity firms. These investment funds buy companies using high levels of debt, combined with equity from investors and a smaller share of their own capital (Froud et al. 2006). Private equity firms play an active role in the management of companies, aiming to increase their value and returns to investors, before selling them on, typically within 3-5 years (Appelbaum and Batt, 2014; Froud and Williams, 2007). Their business strategies are mediated by managers and workers within portfolio firms (Clark, 2009), and research has identified a variety of responses to financialization from employees (Cushen, 2013). These include “cynical and calculative behaviours in circumstances where employees understand themselves as a quantifiable, disposable commodity” (Cushen and Thompson 2016: 360). However, in care, workers may seek to mitigate the impacts of financial pressures on service users by absorbing their effects (Burns et al., 2016a).

Based on this analytical approach to care – as gendered and racialized labour, subject to austerity and to financialization at the corporate scale – the next section sets out the study’s methods.

Methods

This research began by tracing investment fund ownership of UK care homes since the first private equity buy-outs in the early 1990s. Industry rankings of the largest care providers were combined with company filings giving data on ownership. The overall aim was to identify the significance of this form of ownership, rather than broader changes affecting the sector as a whole, such as privatization and austerity, although their interactions with financialization are explored. However, current official data on the workforce and employment conditions, the National Minimum Data Set for Social Care, only distinguishes between the public and independent sectors; the latter includes non-profits and small-scale private companies, so to distinguish the specificities of investment fund ownership, alternative sources of data were required.

To examine financialized business practices and their effects on staff and care services, case studies were undertaken of three of the UK's largest care companies that are owned by private equity firms or other investment funds. Several leading scholars of corporate financialization consider case studies to be the most useful approach, given a lack of comparable data on firms and the sheer number of variables affecting their performance (Appelbaum and Batt, 2014; Froud et al., 2006). The case studies drew on corporate filings, specialist reporting and policy documents, which were used to analyze changes in ownership and corporate strategy over time.

Interviews further explored why these changes had occurred and how they had been experienced by different actors in the sector. A total of 25 in-depth, semi-structured interviews were conducted with 8 investors or managers who had current roles or historical experience in relevant companies, industry representatives or analysts; a senior official involved in regulating the sector's finances; 6 union officials at the regional or national scale, based in various areas of the UK; and 10 care staff in different parts of England. Interviews were undertaken between October 2015 and September 2016. Care staff were recruited through unions and community networks, while other interviewees were approached directly.

In the interviews, care staff were asked about their experience of working for different employers, and changes following an investor buy-out (where applicable), including to terms and conditions of their employment; the quality of work and care; workforce retention and morale; and what they saw as the reasons for, and constraints on, any changes. The care staff interviewed had between 1.5 and 14 years' experience in the sector, and had all worked for more than one employer. Interviews with private equity managers and industry experts explored the reasons for investing in the sector, and particular companies and regions; investment strategies, barriers and perceived risks, including public funding and regulation; and their treatment and perceptions of the workforce. The perspectives of trade union staff and the regulator were also sought on these issues. The diversity of informants meant that the number within each group was small, but together the data enabled a fuller analysis of the sector than could have been achieved through a larger sample of any one group alone.

The recruitment of care staff was challenging due to factors such as fear of potential employer retaliation, or local and transnational caring responsibilities among low-paid, migrant workers (cf. Salazar Parreñas, 2005; Wills et al. 2010). Initial plans to interview five staff at each of the case study companies therefore had to be adapted to include some with historical rather than current experience of working there, and others who had worked in different companies, which had the benefit of enabling some comparison. To minimize the risk of negative repercussions for participants, quotes taken from interviews were anonymized and the companies are named only when reference is made to publicly available information. Thematic, manual coding was conducted on an iterative basis. The following section combines this empirical material with policy and academic literature to explain how the post-war care system provided the conditions for the emergence of investor control, before presenting an analysis of care home ownership.

Conditions for financialization

The trajectory of financialization among UK care homes has been shaped by pre-existing divisions of responsibility for care. An understanding of care as unskilled, women's work is reflected in the arrangements for social care that pre-date neoliberal reforms. Whereas a national-scale, socialized healthcare system was established in the UK in 1948, the state has never assumed full responsibility for social care. Instead, individuals have been required to cover the costs of their care on a means-tested basis. (In 2019, the threshold for self-funding was set at £23,250.) Care has been provided either informally or by a non-professionalized workforce, in both cases mostly by women (Bell et. al., 2010; Thane, 2009).^j Responsibility has also been fragmented across national and local government, complicating accountability for funding and governance of the sector. Public funding for care has been administered locally, but within a policy and fiscal framework strongly shaped by central government (Phillips and Simpson, 2017).

Although state responsibility for care was never complete, it has diminished with neoliberal reforms – most critically when public funding for the building of care homes was curtailed by limits on capital spending, which were a condition of the IMF's loan to the UK in 1976 (Hamnett and Mullings, 1992). With this crisis, increasingly powerful and globalized financial markets came together with emergent neoliberal expectations of the state as a promoter of markets and of personal responsibility (Harvey, 2005; Peck, 2010). As a result, the state's role as a developer of care homes was supplanted by voluntary organizations and, later, by the private sector (Laing, 2008). Subsequent UK governments have further promoted decentralized or private funding and delivery of care services (Hamnett and Mullings, 1992; Phillips and Simpson, 2017). By 2010, only 8 per cent of residential home places were in the public sector (Whitfield, 2012: 1).

Privatization has been easier to achieve in this fragmented, low-status sector than in other parts of the welfare state. A report commissioned by the private equity industry noted “the low level

of political opposition to privatization of social care services, which are largely provided by unqualified, low paid staff – compared with a high level of political opposition to privatization of health care services, which are largely provided by professionally qualified staff” (Laing and Buisson, 2012: 10). The composition of the workforce has also contributed to the devaluing of care. It is dominated by women, disproportionately migrants, black and minority ethnic workers, who face barriers to other parts of the labour market. The adult social care workforce in England is 80 per cent female and 20 per cent black or minority ethnic; a fifth were born outside the UK (Skills for Care, 2015: 4, 41). This has muted challenges to the increasing pressures on care workers, according to a union employee: “the whole system’s being propped up on goodwill and exploitation, and people are just turning a blind eye because it’s a job done by working class women.”

Privatization opened up care homes to direct control by investment funds. Following the development of the private equity industry in the 1980s, the first buy-outs in care took place in the early 1990s, prior to further deals and significant company expansion in the 2000s. As the remainder of the paper demonstrates, investment funds have introduced new sources of financing and riskier business practices to care companies. This distinguishes them from the other types of ownership that are prevalent in the residential care sector. Most numerous are small private companies that rely on more restrictive, less volatile financing from banks rather than capital markets (interview with investor). There are also several large-scale voluntary sector providers, which have tended to retain ownership of their property assets and reinvest surplus (IPC, 2014). The other large chains are controlled by investment funds: none of the major care companies are publicly listed because “Public markets [...] generally demand relatively modest gearing,” rather than tolerating the levels of debt that are taken on by private equity firms and similar actors to fund capital spending and company buy-outs (Laing and Buisson, 2012: 2).

By 2011, the largest financialized care companies were responsible for one in five care home residents (table 1) and smaller-scale financialized operators for still more.ⁱⁱ The major financialized care companies are especially worthy of attention as they own a large number of homes in poorer regions and serve a high proportion of care residents who rely on public support (Four Seasons, 2016; HC-One, 2016). Financial ownership is not simply a residue of pre-crisis trends: by late 2015, the number of major care companies owned by financial investors had increased, from six to seven of the largest ten.ⁱⁱⁱ

Table 5.1: Ownership of the ten largest providers of care homes, Dec 2010 - Jan 2011

Company	Beds	Ownership and relevant background	Investor ownership?
Southern Cross	38719	Shareholders 2002-6: Private equity (Blackstone)	Yes
Bupa	21088	Private	No
Four Seasons	17955	Private 1999-2006: Private equity (Alchemy / Allianz) 2006-8: Qatari sovereign wealth fund	Yes
Barchester	11786	Private: Ultra-wealthy individual investors	Yes
Anchor	4265	Non-profit	No
ECG	4075	Private: Esquire real estate investments	Yes
Care UK	3601	Private equity: Bridgepoint	Yes
Craegmoor	3441	Private equity: LGV Capital	Yes
Caring Homes	3422	Private	No
MHA	3405	Non-profit	No
Total beds, largest 10	111,757		79,577 beds
Total beds in sector	420,000		= 19%

Source: author's analysis based on ownership data from company filings accessed via Companies House, bed numbers by company from Laing and Buisson, 2011 in: IPC, 2014: 29 and by sector from Technology Strategy Board, 2012: 8.

Corporate debt and real estate practices

Restrictions on public capital expenditure created a need for private sources of investment to build or upgrade care homes. The integration of the care sector into capital markets resulted in part from that demand for capital. Increasingly, though, it was driven by the supply of debt financing, backed by investors seeking returns from real estate assets, in a regulatory environment permissive of high leverage (Coakley, 1994; Gotham, 2006). As in other property-intensive sectors, investors have sought to unlock value from care homes as real estate.

Isolating these aspects of the business was made possible by sale and leaseback arrangements, in which property assets are separated from the care service business (see Christophers, 2010). The properties could then be either used as collateral for loans or sold off and leased back to the care operating company. Sale and leasebacks were pioneered in the sector from the mid-1990s by a company called Nursing Home Properties, but interest rates on financing offered in exchange for the property assets remained high until such arrangements were deployed at scale. This required “the creation of large portfolios [of care homes in the 2000s], which were put together by the likes of Southern Cross, together with investment from, essentially, property investors” (industry analyst). Sale and leaseback arrangements have offered investors a straightforward financial route to profit. The capital unlocked from the sale of property means that they can quickly recover their initial investment, while retaining the option to buy the care operating company if it proves profitable, without further risk:

Sale and leasebacks, from a financial engineering perspective, can be phenomenally accretive. You can get all of your money back on the [property company] and then you have a call option on the [operating company – the care service business] and just hope that it works out. [...] It was bad, but it's exactly what Blackstone did with Southern Cross: they bought it, sale and leaseback, took all their money back and it blew up but they didn't lose anything. So aside from the moral issues there, they can be incredibly good uses of your balance sheet. (Investor)

Risks are transferred from investors to other actors: a care provider left without its property assets faces less favourable financing terms alongside a new rent bill. Companies have closed or sold homes that do not meet the higher levels of profitability required to meet those higher costs, or simply to raise cash to meet corporate debt repayments, leading to the eviction of vulnerable residents and the loss of jobs for workers (union official; investor).

Investors have also realized financial returns from fund management fees and the sale of care companies. The private equity business model incentivized the expansion of care home companies: fund managers take a percentage of profits, including from the selling on of portfolio companies, as well as ongoing capital management fees (typically 20 per cent and 2 per cent, respectively) (Appelbaum and Batt, 2014). They could easily access financing for deals from investors keen to lend against real estate: in an era of low interest rates prior to the 2007-8 financial crisis, investment banks and other actors lent “very high multiples of operating profits to fund acquisitions of property-based healthcare businesses” (Laing and Buisson, 2012: 13). Their expectations of rising asset prices encouraged the over-leveraging of care home chains in the 2000s. Capital inflows inflated the value of companies, which were left with heavy liabilities from debt-financed buyouts. This is starkly evident from the case of the Four Seasons care chain: in 2006, the company was acquired by investors for £1.4 billion, double its value when it had been sold two years earlier and 14 times the company’s reported earnings. The deal was almost entirely debt financed and imposed unsustainable costs. In 2009, Four Seasons required an £800 million debt restructuring – “one of the largest in Europe” triggered by the financial crisis (Ruddick, 2009). New private equity owners acquired the company in 2012 for 40 per cent less than the sum paid in 2009, and only 8 times its earnings, promising new and more stable financing. However, a decade after the global financial crisis, financialized care companies remained disproportionately indebted: in 2016, Four Seasons had 13 per cent of the debt across the residential care sector, compared to only 5 per cent of its beds.^{iv} In 2019, it collapsed into administration (FSHC, 2019).

These uses of leverage and the separation of real estate assets indicate that financialized care companies' difficulties are not solely the result of austerity. As one investor observed, "There's no reason that the taxpayer should be expected to prop up the capital value of nursing homes by paying rates which enable high interest bills to be paid on over-priced acquisitions of nursing homes." Another confirmed that, prior to the crisis, many care homes were acquired by landlords who "went absolutely nuts on leverage and acquired lots of care homes, which they then let out and they thought they'd absolutely killed it." But as financing became harder to obtain during the financial crisis, "lots of these debt packages went very, very toxic. [...] So the reason that the landlords went under has nothing to do with the operating environment – that's all to do with their overleveraging and sort of skulduggery."

Heavy financing and rental costs divert funds away from wages, infrastructure and resources for care and instead towards creditors. Much of that funding comes from public sources, yet regulation of care home ownership remains light-touch. Following the chaotic collapse of Southern Cross in 2011, to avert further crises, central government consulted on imposing stricter requirements on the owners of care homes. Ultimately, however, it opted simply to monitor the finances of major providers under a system of 'market oversight', which gives local authorities early warning of problems, so that they can ensure continuity of care in case of corporate failure. This has left the regulator as "a spectator at the accident rather than a preventative measure" (industry expert). Under this regime, responsibility for problems in care is largely displaced from central government to local authorities and the private sector, including investor-owned companies and their creditors. This diffusion of responsibility helps to reduce accountability for problems with care financing and working conditions. Such problems arise in part from insufficient and uneven public funding. However, although the sector as a whole has been affected by austerity, the specific implications of investment funds' strategies identified here have generated major crises and made greater demands of care workers and residents. The next section explores these. It also identifies some of the constraints imposed upon financialization by care.

Extracting value from low-status workers and service users

While selling companies and their assets has generated windfalls for investors, they have made continuous efforts to reduce the share of revenues going to labour, rather than creditors, landlords and investment funds. The heightened pressures imposed on companies have been partly absorbed by investors' ability to exploit distinctive characteristics of the care workforce and service users, as well as the nature of care work.

When the first private equity firms entered the sector in the early 1990s, they went further than previous private operators in reducing labour costs. This reflected their need to meet heavier financing costs and achieve high rates of return to investors: financialization exceeded privatization. The "dominant feature" of early private equity deals in the sector was the opportunity to "get the labour costs down by 30 per cent," in large part by reducing staffing levels and wages, according to a former private equity partner. Such changes have contributed to stark pay differences within care: in 2013-14, public sector carers earned a mean wage of £10 per hour compared to £6.96 in private companies, which was also substantially less than in voluntary organizations, where pay averaged £7.57 (Skills for Care, 2015:63). Care workers' wages are low even in financialized homes that have mostly private clients, despite their high fees and less need for cross-subsidy of publicly funded residents, according to investors, staff and unions. Carers also reported that investor buy-outs of private homes – even *prior* to austerity – led to significant reductions in sick pay and extra pay for working on public holidays. For example, in one chain bought by a private equity firm in the early 2000s, staff lost the equivalent of 7.5 days' earnings per year because of changes to bank holiday pay. These changes represent a substantial deterioration in the terms and conditions of a workforce that is largely working-class, mostly female, and disproportionately black and minority ethnic.

Initial cuts to labour costs that accompanied buy-outs have been compounded as financialization deepens, with companies' rising financing costs and rent bills. For example, in one chain facing financial difficulties several years after a private equity take-over, workers

were subject to a five-year pay freeze from the late 2000s. It became harder to obtain basic equipment: “during those times it’s really, really horrible. You cannot buy anything, [even a] commode” (care staff). Thus, a first round of transferring resources away from workers to investors has been succeeded, in the medium-term, by intensified pressures arising from a company’s weakening financial position, as debt levels rise and assets are removed. Workers and residents help to absorb the costs of debt and rent, while continuing to sustain the company through their labour and fees.

These dynamics are obscured by a neoliberal model of labour markets, the state and care quality that does not recognize the effects of financial pressures. Investors insisted that initial cuts to labour costs could be achieved “without noticing an impact” (former investor). The regulatory regime is also based on the claim that “the sector has operated as a market for a good number of years and has proven itself as a market” (regulator). Power imbalances between carers, residents and investors are ignored; all actors are treated as narrowly self-interested, potentially mobile, market participants. Such a partial vision helps to rationalize returns to investors as well as limited public responsibility for care and workers. These blind spots in the neoliberal vision can be brought into view by feminist care ethics. Care ethics recognise the interdependent, emotional and embodied characteristics of social subjects, emphasising the importance of relationships of responsibility, which are responsive to particular, differing needs (Clement, 1996; Held, 2005).

A crucial element of the neoliberal model is the low value accorded to care workers, who are treated as if they are disposable and can be easily substituted. An official insisted that poorer pay and conditions in the private sector compared to publicly run care represented “value for money” for local authorities commissioning services, arguing that workers can choose to pursue other opportunities in the labour market. This concern for cost rather than retention reflects the low status of the non-professionalized workforce. Indeed, care has one of the highest rates of staff turnover of any sector in the UK economy (ONS, 2017; Skills for Care, 2016: 34). The low

status of the workforce also diminishes concern among investors and regulators about injuries experienced by carers carrying out more intensive, highly physical labour. For example, care staff reported colleagues suffering health problems as a result of working alone rather than in pairs in understaffed homes. Sole carers were more likely to suffer back injuries when lifting immobile residents, and “then they are also in need of care”. The costs are displaced from investors to the individuals or other parts of the state, in ways that staff felt were unrecognized by the official regime for inspecting care home standards. Rather than regulators being concerned with care workers’ health and welfare, the focus is on ‘consumers’ alone. In contrast, care ethics understands care as co-produced by these different actors and dependent on the relationships between them. This perspective recognizes that the interactive nature of care means that staff and consumers are intimately related, so pressure on one group heightens the vulnerability of the other. For example, after cuts to sick pay, some carers said that they were compelled to work when unwell, despite the vulnerability of residents to infection. Personal knowledge of, and sustained relationships with, residents are also important to good care, but suffer with staff turnover, according to interviewees.

The reorientation of corporate resources towards financial actors therefore also comes at the expense of residents’ bodies and wellbeing. Such changes can take advantage of the limited mobility and capacity of many residents, which – contrary to the model of the neoliberal consumer – makes them unlikely to transfer to another home if care is poor or if fees rise. Indeed, for private clients, fees have been rising above inflation at a rate of 4-5 per cent per year, according to investors. Throughout the sector, and in part due to financialization, services are under-resourced in ways that are dehumanizing for residents and demoralizing for staff. For example, following a buy-out of his home by Southern Cross in the 2000s and staffing cuts, one former employee said: “I think for the staff there, they felt they weren’t giving the actual care that they wanted to give because they were under pressure all the time. A bit like treating [residents] like cattle I suppose, you get one done and move onto the next one, you don’t have the time to give the actual care that’s required.” These pressures continued even after another

set of investors had taken over ownership from Southern Cross, according to the interviewee's former colleagues. Reduced expenditure also reinforces the immobility of residents is within individual homes. Following a buy-out in another company, activities such as talking and singing with the residents gave way to a 'dreary', static regime in which carers served only as 'waiters' while residents slept in front of the television. Even more fundamentally, care staff reported management pressure to ration basic supplies such as incontinence pads, including in a home with a high proportion of residents paying private annual fees of £75,000. Prior to a private equity buy-out, "we were using quality materials, quality supply, and we never heard of over-budget, whereas [since] we have cheap things and we are always being told that we're over budget, cannot buy this, we need to be thrifty."

What these accounts reveal is that many care workers operate within a parallel system of values. They enact a much broader form of responsibility than the narrow, rootless personal interest on which the neoliberal model is premised. Instead, they are embedded in their relationships with residents, colleagues and their workplace. This refusal of disposability generates a source of value to investors. Commenting on the diminished employment terms imposed after a buy-out, one member of care staff said, "We just have accepted it because we like the home [...] It's the home itself, we are bought by the company but I think the staff that's been here is working for the home, not the company really." To prevent colleagues from having to deal with staff shortages, carers described feeling obliged to take on extra shifts and work up to 70 hours per week, although they faced exhaustion and illness. However, carers' broader sense of responsibility can also inspire resistance to financial discipline: "Sometimes you need to fight for what the resident needs. Really and truly, why would I care? But we do care."

These comments point to one of a number of constraints on financialization that emerge from care. While care workers' commitment to their workplace, colleagues and residents can be exploited by intensifying their labour, those caring relationships can also complicate efforts to raise profitability and extend investor rationalities throughout the sector. Despite being

reprimanded or threatened by managers for “overspending” on supplies for residents, staff reported frequently prioritizing care over budgetary considerations and “fighting” with management on behalf of residents. A further constraint on profit margins and the expansion of companies owned by investment funds comes from the labour intensiveness of interactive care work. Investors reported that it is very difficult to reduce wage costs in care homes below around 60 per cent of company revenues. Care’s labour intensity deters the continued expansion of companies even where financing is available: despite the benefits to investment managers of increased company size and economies of scale in financing that were described above, large care companies actually tend to experience “diseconomies of scale” according to industry sources. For example, as Southern Cross grew rapidly under private equity ownership, investors and care staff reported increasing complexity, poor communication and falling care standards. As a result of these problems, investors reported increased cautiousness about company expansion. In addition, although the undervaluing of care has facilitated privatization and high-risk financial practices in the sector, it has also limited the resources within the sector that are available for subsequent extraction by investors. With pay for care workers so low, companies have become unable to make further cuts to wages without breaching the legal minimum. Highly constrained public funding for care has also been limited as a source of greater returns to investors. These dynamics help to explain why investment funds control only a minority of the sector.

Conclusion

This paper has demonstrated the constitutive role of labour in financialization, alongside financial routes to profit and public policy. It has built on insights from labour scholars into how neoliberal care regimes are reliant on the commodified, but devalued, labour of a large, low-paid, feminized and racialized workforce (Boris and Klein, 2012; Duffy, 2005; Glenn, 1992; McDowell, 2009; McDowell and Dyson, 2011). The devaluing of the workforce, their work and clients formed the background to privatization. This then allowed investment funds to take a

significant stake in the sector and redirect resources from labour to financial actors. While real estate asset sales provide short-term profits, labour has retained a critical role in sustaining companies so that continued accumulation can take place. Financial pressures imposed by high rents and debts have been absorbed to a considerable extent by the bodies of carers and residents, and by the relationships between them. These impacts have not been recognized by the regulatory regime, which is modelled upon workers and residents acting as mobile market participants. In practice, however, many staff feel embedded in relationships of care and responsibility towards residents, colleagues and their workplace, and therefore endure deteriorating conditions while attempting to mitigate the effects on residents. This concern for place-based relationships of interdependence, highlighted by geographical care ethics, is occluded by the neoliberal vision that has shaped the governance of care. Thus, the extraction of value is permitted by the gaps between different views of the geographies of responsibility and mobility: in neoliberal theory, investors are concerned with companies' long-term success, workers act in their narrow self-interest, and consumers exercise choice. In reality, this model bears little relation to the unsustainable practices of investors and the continued efforts of carers to sustain services and relationships with vulnerable, immobile residents. In Melissa Wright's (2006) classic account of female, 'Third World' manufacturing workers, their value came from exploitation to the point of disposal. In care, it is the workers' refusal of disposability that is absorbing the distribution of value to investors and the crises that financialization creates.

However, the refusal of carers to perform as financial subjects has also constrained profits and the expansion of financial discipline. By asserting that they and the mostly female residents are non-disposable women, they constrain financialization. So too does the sheer labour intensiveness of care work, which creates diseconomies of scale. In addition, there is limited potential to extract further value from an already low-paid, poorly funded sector. Efforts to analyze both the extension of, and limits to, financialization, therefore need to take into account the implications of labour-intensive service work – including particular workforces, client bases

and forms of work. If in this case, a weak regulatory regime has done little to constrain financialization, comparative empirical research could further examine how institutional variation mediates the impacts of investment funds on care workers and services in other jurisdictions.

The regulatory regime for care companies' finances here has remained non-interventionist despite recurring problems. This is because financialization helps to displace the crisis of care from central government to the private sector and its creditors. Despite cuts to public funding, investors remain active in the care sector while they can profit from both their workforce and corporate assets. There is not, therefore, a total withdrawal of investment that would expose government to greater pressure. When financialized practices prove unsustainable – as in the collapse of Southern Cross or Four Seasons' debt crisis – the regulatory regime has apportioned responsibility to the private sector and local authorities. In this way, financialized corporations play an important role in depoliticizing failures of neoliberal welfare. They do so alongside household debt, which has been the focus of many accounts (Crouch, 2009; Searle and McCollum, 2014).

Despite these political uses, financialization tends to exacerbate the crisis of care, as high rent and debt bills drive up costs and undermine working conditions – producing staff shortages, poverty and illness – as well as diverting resources away from residents. These increase pressure on public funding. Other tensions between financialization and neoliberal policy could be explored in further research. For example, in what would have been an expansion of financialization, a private insurance market was envisaged to cover individuals' costs up to a cap, beyond which public funding would be available. However, those proposals were abandoned by ministers in 2017, in order to avoid increased state expenditure (Paul, 2015).

To address the crisis of care – its devaluing, austerity and unsustainable investor strategies – a more concerted challenge is needed. This must go beyond the everyday actions of care workers, trade union campaigns focused only on public funding, or isolated efforts by local authorities to

take homes back into the public sector (APSE, 2011; Martin, 2016). Recognizing the breadth of those affected by the issues, care workers organized through immigrant worker centres in the US have formed alliances with older people, service users and their relatives, as well as more established labour unions and sympathetic branches of government, in an effort to reshape the care economy (Boris and Klein, 2014; England, 2017). The success and potential mobility of such approaches needs to be evaluated, particularly in relation to financialization. The implications will be crucial to the future of both welfare and work.

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ⁱ The boundaries between 'healthcare' and 'social care' are complex and contested, but in essence the latter refers to support with the routine activities of daily living rather than medical care. Both are provided in nursing homes.

ⁱⁱ This takes into account the business model put in place by the private equity firm, Blackstone, during its ownership of Southern Cross.

ⁱⁱⁱ From 2011, private equity firms acquired several of the largest providers, and Care UK expanded rapidly under the control of Bridgepoint Capital. In 2014, US-based hedge funds took over the care chain, ECG, as it faced financial collapse (Health Investor, 2014). The same year, one of the largest chains, HC-One was acquired by a consortium comprising a US property investment firm, a UK consultancy, and a private investment fund based in Dubai, London and New York. It proceeded to expand significantly, including by acquiring 122 Bupa homes in 2017.

^{iv} Author's calculation based on reporting of £4 billion total sector debt (Careinfo.org, 2016); Four Seasons' £525 million debt (Health Investor, 2015), bed data from Age UK (Age UK, 2017).