"Dispossession by Stealth: An Exploration of Public-Private Blurring in England and Ontario"[1]

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Abstract

The neoliberal restructuring of the nursing home industry has seen new forms of privatization and new market-like processes within policy-making and service provision. These dynamic changes to public goods are often conceptualized as 'accumulation by dispossession'. In this paper, we focus on nursing homes in England and Ontario. They provide a timely window through which to view the complex processes of public-private blurring. We conclude with a question: should we switch conceptually to 'dispossession through accumulation, in order to facilitate a shift of attention from the firm and from formerly non-market spaces to the relations of care.

Introduction

The neoliberal restructuring of the nursing home industry has seen new forms of privatization and new market-like processes within policy-making and service provision. At a theoretical level, researchers in the political economy tradition have often conceptualized these dynamic changes to public goods as 'accumulation by dispossession'. At the empirical level, academic literature has tended to focus on private finance initiatives (PFIs), or public-private partnerships (P3s) as they are usually labeled in England and Canada, respectively, as well as on the contracting out of discrete services in health care, education, transportation and so on.

In this paper, the empirical focus is on nursing homes or care homes as they are often called in England. We focus on these facilities, whose residents need access to 24-hour nursing care, for two main reasons. First, although under-valued and under-researched, these facilities are of course important to those living and working in them, to their families and friends, but also to the broader society. And they are becoming more important, as our populations slowly age and the prevalence of chronic conditions slowly increases. To cite an example of their broader importance, by one estimate (Leys 2016, 24) NHS hospitals in England spend £900M each year for patients who should be discharged from hospital but cannot because needed nursing home places are unavailable. In Canada, these acute hospital patients are labeled as Alternate Level of Care (ALC) patients, without nursing home or other suitable places to go.

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According to the Canadian Institute for Health Information, there were 6671 such patients in 2016, and they spent a median of 182 days in acute hospitals (Picard 2016).

The second reason is that nursing homes, as the pressures on their capacities increase, provide a timely window through which to view the complex processes of public-private blurring. Concepts such as ‘public’ and ‘private’ may at first glance appear to be analytically clear, with public meaning the state sector, broadly understood, and private meaning institutions and activities in the business world. But public can embrace both state and formal economy, as it is in terms like pub or public house, and initial public offerings on a stock exchange. Private is then restricted to the household and to select other organizations and gatherings.

If the concepts are not entirely clear, the empirical reality is decidedly muddy. In health care, the payer may be the public purse or a private individual or entity. The provider may be located in the state sector or may be private, whether non-profit or for-profit. But there is more. Public payments may be allocated in market-like ways, through for instance bidding, requests for proposals or pay-for-performance mechanisms. The distinction between non-profit and for-profit organizations may diminish or disappear entirely, as the non-profits are forced by market-like procedures to behave in for-profit fashion. Public and non-profit organizations may engage for-profit organizations to manage some or all of their activities within the quasi-market environments they find themselves. Public discourse may become the language of business, as for example when the assessment of need is replaced by the assessment of demand. And of course as access to nursing homes is increasingly restricted, more and more care work is undertaken at home, usually invisibly to all but the predominantly women providing the needed care there.

Neoliberalism

Throughout health care and across national boundaries, there are strong pressures to privatize along one or usually along more than one of these paths. Neoliberalism is the label typically employed, at least within political economy, to make sense of these diverse aspects of the process of privatization. Yet too often neoliberalism serves as a cover for sloppy thinking, as all manner of contemporary ills are attributed to it without much supporting evidence.

Part of the problem is that neoliberalism can mean an ideology, a mode of governance and/or a set of policies, and has thus been implemented unevenly. It has nonetheless since the 1970s achieved hegemonic status throughout most of the world. Ideologically, it has championed markets free of government intervention as the principal bulwark of individual freedom. Citizens are transformed into taxpayers and consumers of the remaining government services, and their individual choices are a site for governing alongside the management of organizations, whether ‘public’ or ‘private’, all governed from a distance by the executive branch of government and by independent agencies (central banks, international trade tribunals, etc.) At the policy level, there are tax cuts, especially for the rich, union busting, cuts to social welfare (sometimes combined with workfare), the co-option and taming of non-governmental organizations to bid on discrete and measured services without core funding, and so on.

These aspects of neoliberalism are largely assumed and unquestioned, including by political forces on the center-left. For example, markets and market players are assumed to be much more efficient than governments. Influential arguments for this view of hegemonic neoliberalism have been advanced by David Harvey (2005), about whom more later. Switching to the other side of the theory-fact dialogue, we now turn to some empirical research on nursing

homes in England and the Canadian province of Ontario in the period between 1997 and 2016. In doing so, we do not mean to suggest that the blurring of public and private is accidental, and merely an obstacle facing those of us who seek to understand the nursing home sector. Quite the contrary. The blurring is intentional, an ideological initiative designed to obscure the inroads that for-profit firms are making into the sector, a governance move to shape decision-making at all levels, and a policy thrust to open up a site for the absorption of surplus capital.

The Economics of Blurring

First, some background on the economics of blurring. England currently has about 217,000 nursing home places in about 5144 facilities. According to Harrington et al. (2017), 81% of the homes are for-profit, while the rest are either non-profit (7.5%) or run by local councils (11.5%). The for-profit share is growing, with an earlier estimate from 2011-12 putting the for-profit share at 75% (Choiniere et al. 2016:44). Ontario, with about 78,000 places in about 647 homes, has over 56% for-profit, over 27% non-profit and over 16% municipal government ownership. The Ontario homes tend to be larger than those in England and, like the case in England, the for-profit share is growing. Over two-thirds of the places opened since 1998 have been in for-profit facilities, with 81% of these for-profits owned by corporate chains, the nine largest of which now own 55% of the for-profit homes and 31% of all Ontario homes.

In both jurisdictions, government policies have been largely responsible for the privatization shifts in ownership. With the election of the Blair government in 1997 came a 'modernization' agenda aimed at local authorities. Various social services, including funding for nursing homes, were devolved to local councils, but tax raising authority was not devolved. As a result, the councils were generally unable to resist Downing Street policies to establish 'best value' competitive tendering outcomes. With lower rates of pay and inferior conditions, the 'independent' or private homes appeared to offer better value and were awarded most of the business.

Starting in the late 1990s, Ontario added about 20,000 nursing home places through a competitive bidding process. Although formally open to non-profit and municipal organizations as well as to for-profit ones, the latter enjoyed a competitive advantage. They were better able to pool their bidding expertise and they had much readier access to capital funds than their competitors. The provincial government of the day claimed to be establishing a 'level playing field', but it was clearly tilted in favour of the for-profits.

Although the policies and the results have differed somewhat by jurisdiction, the trend has been the same: the for-profit ownership of nursing homes has grown in both relative and absolute terms since the late 1990s, and large corporate owners have become increasingly present if not dominant. In England, merger and acquisition efforts have led Peter Scourfield (2007) to coin the term 'caretelization' in his writing about corporate penetration of the care home (nursing home) market. By 2009, the four largest chains had a 24.1% share of English for-profit homes (Scourfield 2011, 138). In Ontario, Extendicare, Chartwell, Sienna (formerly Leisureworld), Revera, OMNI Health Care and Schlegel are both large and aggressively expanding chains, with 42% of all the for-profit homes (and almost 53% of their places) by 2014. The story does not end there, however. Blurring has also increased in both England and Ontario, albeit in different economic ways. I now turn to one way in England, and another in Ontario.

In England, a creative device known as OPCO/PROPCO (operating company/property company) has emerged. It provides what is called 'corporate securitization', a sale-and-

leaseback financial tool that facilitates the acquisition of companies. The company raising capital funds is able to avoid the risk of business failure. Southern Cross, a huge nursing home chain, found itself locked into a long-term lease with annual rent increases while local councils began to cut back on the funds they could and would provide in support of individual nursing home residents. As a result, Southern Cross had to declare bankruptcy and sell off its properties at a loss to its creditors after a period of considerable anxiety for its residents and their families. Meanwhile, its OPCO/PROPCO partner, the Blackstone private equity company, had purchased Southern Cross for £162M in 2004, and sold it for £770M by 2007, just before the bankruptcy proceedings began.

In Ontario, several of the large chains have started to sell their management expertise to non-profit and even municipal homes. They have at times been joined by large consulting firms such as KPMG, PwC and Deloitte in persuading the managements of these homes that they could cut costs in the face of fiscal pressures and burdensome, changing regulatory requirements. In the process, these 'third-party management' subsidiaries of nursing home chains gain "valuable insight into specific geographic markets" and create "a pipeline of potential future acquisitions" (Chartwell 2007,19). With these and other examples of the economic blurring of public and private in nursing homes, it becomes increasingly difficult to regulate the facilities and to hold their ownerships accountable.

Ideological Blurring

The blurring is reinforced by the language increasingly used in the nursing home industry. The replacement of assessment of need by assessment of demand, and the application of the label 'independent' for private facilities in England have already been noted. Independent facilities are certainly independent of public control, as the advocates of neoliberalism since Hayek have preferred (Harvey 2005, 20, quoting the founding statement of the Mont Pelerin Society). Other terms in widespread use in both jurisdictions include 'partnership' (often combined with 'competition' in what is itself a blurred fashion), 'consumer choice', 'bottom line', 'best value' (by which is meant lowest cost) as the sole or dominant criterion to employ in a bidding process, 'business case' and 'business plan'. Furthering the normalization of markets, 'citizens' are replaced by 'taxpayers', customers', and consumers'. As Poole and Mooney (2006, 565) explain in the English context, New Labour's "pragmatic" approach called for "the obscuring and reconstruction of the public-private distinction in public services in the interests of 'modernization' and 'public' service quality". Starting with 'reform', many of the now-fashionable nouns with the prefix 're' (e.g., restructure, reconfigure, reconstitute, reconstruct, reorganize) are presented as signifying progressive change from tired old ways, when they turn out to signify cuts to public services.

OLTCA, the for-profit trade association in Ontario's long-term care industry, is working hard to attract membership from the non-profit sector, notwithstanding the existence of a parallel trade association (in a branding exercise, now called advantAGE) that is explicitly by and for the non-profit organizations in nursing home and home care. OLTCA is also promoting the adoption of lean techniques borrowed from private industry, the measurement of management performance, and the commercialization of enhanced medical and assistive technologies. Meanwhile, the centrist Ontario Liberal Party, after vigorously criticizing Public-Private Partnership (P3) schemes in opposition, rebranded them in 2004, soon after being elected to

office, as ‘Alternative Finance Mechanisms’ or ‘Alternative Financing and Procurement’ procedures, essentially leaving them intact.

The Blurring of Policy Settings

The blurring is further reinforced in both jurisdictions by the interchange of key personnel from one position to another in the nursing home industry and in its broader settings. Senior managers and policy makers have moved with disconcerting frequency and in various directions from political office to consulting firms to trade associations to facility management to corporate boards to think tanks. The revolving doors have enabled these key personnel to consolidate their thinking and actions, often by means of costly conferences they organize through for-profit firms. Their thinking and actions have usually involved claims of being pragmatic, balanced and apolitical, while promoting social harmony and efficient government, and while rejecting analyses that would draw distinctions between public and private as being tainted by ideology. It is however this rejection that is ideological. In fact, the three-fold distinction between public, private non-profit and for-profit is vital to the analysis of quality and of access, but in Canada the organization and dissemination of official statistics increasingly obliterates this distinction. Yet private, for-profit homes tend to be of lower quality and to be less accessible (McGregor and Ronald 2011).

As we work to impose some sort of analytic pattern on the revolving doors circling rapidly in England and Ontario, let us leave you with a very few of the most prominent of the dozens of instructive examples we have assembled. In England, the Institute for Public Policy Research was integral to New Labour’s modernization push. Its first director, John Eatwell, became a key economic advisor and sat on several major financial authorities and private equity boards. Patricia Hewitt was the New Labour government’s Health Secretary in 2005, and would later work for FTI Consulting and would join the board of BUPA, a non-profit health insurance network with substantial nursing home and hospital holdings. Alan Milburn served as another Health Secretary under Prime Minister Blair, before becoming an advisor to both PwC and Bridgepoint Capital, the private equity firm behind Care UK. Blair also appointed Chaitanya Patel as his key health policy advisor, after Patel had set up Court Cavendish, which by the mid-1990s was Britain’s fifth largest nursing home chain.

A former Ontario Premier, William Davis, and a former Governor of the Bank of Canada and former Deputy Minister of Health Canada, David Dodge, led the merger of two REITs into what would become Revera, a large nursing home and retirement home chain now owned ironically by the Public Sector Pension Investment Board, which covers most federal government employees. Shelley Jamieson moved from directing OLTCA to a spell as Executive VP of Extendicare, and then became Ontario’s chief public servant. She is currently on the boards of Ontario’s Health Quality Council and of Cancer Care Ontario. David Caplan, the son of a former Ontario Minister of Health, joined the Ontario Liberal Cabinet as Minister of Infrastructure, overseeing the Alternative Finance program before becoming Minister of Health and then leaving political office for the business world.

Blurring and Governance

Governance is about the making of choices, at various levels. Privatization advocates are prone to claiming that individual consumers are best placed to make rational, self-interested

choices, and that robust competition produces improved efficiency and quality. Governments, by contrast, are said to produce inherently inferior efficiency and quality results.

These claims can be challenged on numerous grounds. At the individual level, the notion that rational 'economic man' thinks through the calculation of cost and benefit before choosing is effectively challenged in the relatively new field of behavioral economics. Psychologist Danny Kahneman was awarded the 2002 Nobel Prize for Economics (Lewis 2017). More prosaically and more tied to nursing home decisions, individual choice is at best very limited. In England, the "stripping down to a leaner acute/curative clinical model of hospital treatment and the shedding of 'continuing' and non-acute health care" (Vickridge 1995, 77) began before New Labour assumed office and continued throughout its tenure. As a result, the protection afforded by the NHS for free service at the point of care has been steadily if controversially reduced. Various financial barriers to nursing home care (and other types of care) have influenced the choices available to individuals in different economic circumstances, as the "boundaries between public and private finance and provision" of long term care have become "increasingly blurred" (Deeming and Keen 2004, 1390). What is clear is that individuals have carried the main and increasing responsibility for long term care in England. Moreover, public payment, routed through local (i.e., municipal) councils has been allocated on a means-tested basis (Godden and Pollock 2010), and indeed on a limited asset-stripping basis, with those holding assets over £23,250 having to pay the full cost of their care (Hudson 2016, 12). These provisions have the effect of reducing choice. Meanwhile, NHS beds have been reduced, putting more pressure on nursing home spaces. And the number of nursing home spaces has not in turn been increased, despite the gradual aging of the population.

A similar picture emerged in Ontario. Hospitals have been increasingly focused on acute care, and their managements increasingly concerned about the costs of patients they deem to be in the ALC category. The numbers of nursing home places has not matched the growth in the aging population, much less the additional growth in the numbers of younger individuals with chronic conditions or the numbers discharged as a result of dramatic reductions in psychiatric care beds. Acuity in nursing homes has thus been increasing, and wait times for admission have been growing. By 2012, an estimated 25,000 individuals were waiting to be placed in one of the 78,000 nursing home spaces (Galt 2012), notwithstanding the 20,000 additional places that had been opened in the decade leading up to 2006.

Admission in both jurisdictions rests with public authorities, with a mix of public and private funding, and with placement tilted to private facilities. In England, local councils are allowed to recoup part of residents' income support benefit if they contract with private homes, but only if they contract with private homes (Godden and Pollock 2010). In Ontario, regional health authorities allow potential residents to list up to five homes they would enter if such are to be found in their locality and when the wait list gets to them, but presumably for reasons of perceived quality differences they have to wait longer for entry to public and non-profit homes (Buchanan 2011). Moreover, for-profit chains on occasion go bankrupt or move their licensed beds to new locations to take advantage of land prices and/or to profit from the private construction of publicly funded new builds, further reducing resident choice (Armstrong, Armstrong and MacLeod 2016).

Public information on limited quality indicators is available by facility in both jurisdictions, but the information is heavily geared to medical care as distinct from social care concerns, and is subject to gaming. There is "no centralized system for collecting and tracking nursing home revenues, expenditures and staffing levels" in English nursing homes (Harrington

2016, 30), leaving those interested to search through private industry market reports. In Ontario, the nine indicators reported by CIHI are all medical in orientation, and to date there are no data reported on 'social engagement'.

Decisions are increasingly made within the confines of for-profit corporate chains in both England and Ontario. Most of them are privately held and thus not subject to public accounting scrutiny. They are subject to state inspections, but these are infrequent, focused on process indicators rather than outcome ones or structural ones (such as staffing levels), and weakly enforced (Choiniere et al. 2016). In Ontario, for example, with 74 inspectors responsible for 630 homes, it was estimated that in 2012 it would take five years before all were visited (Welsh 2012). In sum, the nursing home 'market' provides scant opportunity for informed choice by individual potential residents and family members, decisions are increasingly made by for-profit entities far from public scrutiny, and the state tends to favour private, for-profit providers, despite evidence of their poorer quality. On the governance front, as on the ideological and policy fronts, blurring of the public-private distinction is underway, and is not accidental. Rather, it helps to conceal dispossession of the public domain by private interests.

Conclusion

Let us close by returning to the notion of 'accumulation by dispossession', which was introduced by David Harvey (2003, esp. 137-82) and subsequently cited and developed widely. It can refer to the dispossession by capital, in its unceasing quest for growth, to appropriate land, water, plants and so on, in particular from peasants and Indigenous peoples, as well as public services. Hence this geographer's analysis of imperialism and his emphasis on what he terms 'spacio-temporal fixes' as a series of temporary and incomplete solutions to contemporary bouts of the over-accumulation of capital. There can be no doubt that there exist today vast piles of capital, notably in pension funds, seeking safe places to invest. This phenomenon has resulted in, and prompted, the shift in emphasis from capitalist production to capitalist finance, from expanded reproduction within the capital/labour dynamic to accumulation by dispossession with the expansion of capital's sway over new terrains.

What merits consideration today, and we'll leave you with this, is whether the stress should be on *accumulation by dispossession* or whether we should switch to *dispossession through accumulation*, placing the stress on *dispossession*. Put another way, accumulation by dispossession centres on the firm and its expansion into formerly non-market space. Dispossession through accumulation, by contrast, centres on the relations of care, shifting at least some of the attention to subjective practice in the service sector.

This may be just a word game played by academics with nothing better to do. But it may suggest something real, notably in the context of nursing homes. The 'Reimagining' research project out of which this presentation comes uses rapid, site-switching ethnographies as a key methodology. We have been particularly taken by questions of food and laundry for the vulnerable residents of nursing homes. Mealtime is typically the highlight of their day, and what residents can wear is one of the few tools they still have with which to establish and reinforce their individual identities. To commercialize their food and laundry in particular is, it might be argued, to dispossess them. More generally, the restless commodification of other aspects of health care, of education, and of the rest of what we have called the welfare state may suggest that in broad strokes we may be moving unsteadily to a regime of 'late neoliberalism' (McGimpsey 2017). Is this an avenue of inquiry worth pursuing?

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