Homecare Association

Responsible capital in social care

Investment, profit, and policy choices facing the government

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The Prime Minister's speech on social care on 29 July 2026[1], and the publication of the Co-operative Party's report, *The Power of Co-operation in Care*[2], have renewed a long-running debate about profit and private investment in adult social care. Much of that debate treats private capital as a single category and assumes that ownership form is a reliable proxy for quality and public value. Neither proposition is supported by the evidence. This paper maps the different forms of capital that finance care, explains the distinct ways in which returns are generated, and evaluates policy choices available to the government.

The Homecare Association is agnostic about ownership models. We represent providers of every type and size - for-profit, not-for-profit, small, medium and large - and our focus is the same: the quality and outcomes of care; fair treatment of the workforce; willingness to innovate and improve; financial resilience; and the way any return or surplus is generated and used. Ownership may shape incentives and financing structures, but the label alone does not establish whether an individual provider is well led, financially responsible, or delivering quality care.

The paper's central recommendation is that the government should regulate behaviour and financial resilience through a responsible-capital framework, rather than use ownership form as a proxy for quality. The key points are as follows.

- **Private investment is not a single category.** Founder and family equity, bank lending, bond finance, private equity, real estate investment trusts, pension and insurance funds, and growth capital for technology all behave differently and pursue different objectives over very different time horizons.
- **Capital works differently across care settings**. Care homes are capital-intensive businesses in which property, debt, rent, and long-term asset values are central to the financial model. Homecare is comparatively asset-light: most costs are recurrent employment and operating costs, while investment is more likely to fund growth, technology, systems, working capital and acquisitions. The nature and scale of returns, and the risks associated with them, therefore need to be assessed differently across service types.
- **Private equity and similar institutional ownership are a minority of the whole market.** Social care remains a highly fragmented market dominated by small and medium-sized providers, rather than by private equity. Skills for Care reports that 84 per cent of adult social care organisations have fewer than 50 employees, while 37 per cent have only one to four employees.[3] Under independent industry analyst LaingBuisson's broad ‘private equity’ classification, which includes some investors, such as listed property investors, that are not private-equity funds in the strict sense, the shares of

[1] Prime Minister Rt Hon. Andy Burnham MP speech on social care, 29 July 2026, London.
[2] Co-operative Party (2026). The Power of Co-operation in Care.
[3] Skills for Care (2025). The state of the adult social care sector and workforce in England.

revenue are 13.7 per cent in older people's care homes,[4] 11.7 per cent in younger adult specialist care,[5] and 12.8 per cent in homecare and supported living.[6] The ten largest care home providers hold 18.1 per cent of the market between them, and the ten largest homecare providers 16.4 per cent, with the largest homecare provider holding only 2.7 per cent market share. The mainstay of investment in homecare remains the equity of owner-operators, often supported by bank lending. Many are locally rooted businesses whose contribution extends beyond care provision to local employment and economic activity. Adult social care in England was estimated to contribute £77.8 billion in gross value added (GVA) to the economy in 2024/25.[7]

- **The mixed market was a deliberate consequence of reform, not an accident.** The NHS and Community Care Act 1990[8] made local authorities principally commissioners rather than providers, reflecting several objectives: controlling an open-ended social security budget, reducing institutional care, introducing a mixed economy of provision, and widening access to independent capital. These aims also made provider diversity, personal choice and local responsiveness part of the settlement, considerations that should be weighed alongside fiscal and operational consequences if it is reversed. Any proposal to reverse that settlement must model the acquisition, capital, workforce and operating costs, rather than assume that sums currently described as profit would become available for reinvestment.
- **'Profit' and 'surplus' are also used to cover several distinct mechanisms.** Dividends, rent, interest, management fees, and capital gains raise different policy questions. Whether a return is responsible depends on its terms and effect on care, employment, resilience and reinvestment, not simply on the identity of its recipient.
- **Financial headroom is a precondition of sustainability, not a synonym for extraction.** Recurrent income must cover the recurrent costs of safe care, including fair pay, training, and supervision. Providers also need liquidity, reserves, and access to capital to absorb shocks and invest. A reported profit or surplus is one source of that headroom, but it is not the only measure of viability and it is not the same as cash available for distribution.
- **Ownership alone is an insufficient guide to quality.** There are excellent and poor providers in every category. Some studies identify average differences between ownership groups, including weaker outcomes on some measures among private-equity-backed providers, but they do not establish that the label itself causes those outcomes. The more actionable questions

[4] LaingBuisson (2026). Care Homes for Older People UK Market Report 36th Edition.
[5] LaingBuisson (2026). Adult Specialist Care UK Market Report. 8th Edition.
[6] LaingBuisson (2026). Homecare and Supported Living UK Market Report 7th Edition.
[7] Skills for Care (2025). The state of the adult social care sector and workforce in England, 2025. Leeds: Skills for Care, section 1.3, 'Economic contribution'.
[8] NHS and Community Care Act 1990.

concern leadership, culture, staffing, commissioning, funding, leverage, governance, and the resources available for improvement.

- **Sentiment among participants in the Big Conversation runs strongly against profit.** Early platform results show hostility to private equity, offshore ownership and profit in general, alongside support for publicly run services.[9] The exercise is open and valuable, but it is a self-selected engagement platform rather than a representative opinion poll. It should therefore be treated as a powerful reputational and political signal, not as a statistically representative measure of public opinion.
- **The sector needs large-scale investment.** LaingBuisson values the older people's care home estate at £27.3 billion, notes that 43 per cent of capacity is not purpose-built and finds that property investors are currently the most important source of funding for new care homes[10]. If the government discourages a source of capital, it needs an answer to where the replacement will come from.
- **Changing ownership without fixing funding may move rather than solve the problem.** Wales' transition towards not-for-profit children's social care has already prompted concerns about sufficiency, costs, and implementation. It remains too early to assess the reform's eventual effects, but the experience shows why funding, capital and transition arrangements must be designed alongside any restriction on ownership.
- **A better frame is responsible capital.** The government should assess all providers against common, proportionate tests: whether investment sustains or adds capacity, modernises assets or improves services; whether debt, rent and other commitments are sustainable; whether ownership and related-party transactions are transparent; whether care and employment outcomes are good; and whether sufficient resources are retained for resilience and reinvestment. This approach can encourage productive and patient investment, support the growth of co-operative and not-for-profit models, and restrict financial engineering that threatens continuity of care.

[9] Casey Commission (2026). The Big Conversation on Care.
[10] LaingBuisson (2026). Care Homes for Older People UK Market Report 36th Edition.

1. Purpose and context

On 29 July 2026, the Prime Minister, the Rt Hon. Andy Burnham MP, delivered a speech on social care in London.[11] He made three announcements: that Baroness Casey's independent review would be brought forward by a year, to 2027; that the government would act now to strengthen the social care workforce, building on the Fair Pay Agreement due to take effect in 2028-29; and that cross-party talks on reform would begin immediately. He set out a vision of a preventative, person-centred National Care Service, collaborating with the NHS and built on support at home wherever possible.

The speech itself was conciliatory in tone. It focused on the workforce, on working more closely with the NHS and on the search for a cross-party consensus, rather than on an assault on independent provision. Some elements of the wider debate, however, have put the role of profit at its centre. A Co-operative Party report argues that the pursuit of private profit is at the heart of the crisis,[12] and campaigners, unions and parts of the press have echoed that view. Some commentators, in their sharpest form, argue for taking the sector back into public hands. This paper aims to inform the debate by describing how the sector finances itself and by outlining realistic options if the government wishes to change the investment pattern.

The Homecare Association represents over 2,100 homecare providers of every size and ownership type - small, medium, large, for-profit, and not-for-profit. Skills for Care reports that 84 per cent of adult social care organisations have fewer than 50 employees, while 37 per cent have only one to four employees.[13] Many excellent providers, judged on the quality of care, fair treatment of their workforce, and willingness to improve, are for-profit. Excellent providers are also found among charities, co-operatives, employee-owned businesses and other not-for-profit organisations. We are therefore agnostic about ownership models and more concerned with outcomes, employment, resilience, and the responsible generation and use of returns.

It is from this position that we approach the debate. We welcome the Co-operative Party's report and its ambition to improve care. We differ from its central proposition that the pursuit of private profit is the decisive cause of the crisis and that not-for-profit ownership is, by itself, the answer. Ownership may affect incentives and deserves scrutiny, but measures directed loosely at profit could discourage needed investment without correcting the leadership, governance, funding, commissioning, workforce, and regulatory conditions that contribute directly to poor care and poor employment.

[11] Prime Minister Rt Hon. Andy Burnham MP speech on social care, 29 July 2026, London.
[12] Co-operative Party (2026). The Power of Co-operation in Care.
[13] Skills for Care (2025). The state of the adult social care sector and workforce in England.

2. How the current market came about

The paper is concerned principally with adult social care. Care homes, homecare, and supported living have different asset bases, market structures, and investment needs, and evidence from one segment should not be transferred to another without qualification. Children's social care is considered only where the Welsh reforms offer a relevant implementation comparison. The policy framework proposed here should therefore be calibrated separately for operating providers, property owners, and different service types.

Proposals to reverse outsourcing and bring provision back into public hands must reckon with why local authorities stopped providing most care. The present market was shaped by political choices and by practical pressures: uncontrolled expenditure, institutional models of care, constrained public capital, and the wish to develop a mixed economy of provision. Those choices can be revisited, but the problems they sought to address have not disappeared.

2.1 The 1980s and the perverse incentive

Through the 1980s, an open-ended social security entitlement paid for older people to enter private residential care, with no assessment of need and without a cap. Spending on it rose from about £10 million in 1979 to around £2.5 billion by the early 1990s. Contemporary analysts described this as a perverse incentive: it drew people into institutional care while community and home-based services went under-resourced, and private care homes multiplied to meet the demand it created. In 1986, the Audit Commission, in *Making a Reality of Community Care*[14], criticised the resulting muddle, and the government asked Sir Roy Griffiths to review the system.

2.2 Griffiths and the 1990 Act

Griffiths' 1988 report, *Community Care: Agenda for Action*[15], recommended that councils become enabling authorities, planning and purchasing care rather than providing it themselves, and that the social security money be transferred to them within a fixed budget. The recommendation was politically attractive because it promised two things at once: a mixed economy of provision, and control of a budget that was rising without limit. The 1989 White Paper, *Caring for People,*[16] and then the NHS and Community Care Act 1990,[17] put this into law, with the main community care reforms coming into effect on 1 April 1993. Councils became commissioners rather than providers, a purchaser-provider split was introduced, and provision shifted decisively to the independent sector. As the Association has set out

[14] Audit Commission for Local Authorities in England and Wales (1986). *Making a Reality of Community Care*. London: H.M.S.O.
[15] Griffiths, Sir Roy (1988). Community Care: Agenda for Action. A report to the Secretary of State for Social Services. London: HMSO.
[16] Department of Health (1989). *Caring for people: Community care in the next decade and beyond.* Cm. 849. HMSO.
[17] NHS and Community Care Act 1990.

elsewhere,[18] the Act sought to drive competition, efficiency and innovation, to reduce institutionalisation, and to build partnerships across the public, private and voluntary sectors. Subsequent reforms, including the introduction and expansion of direct payments, took this further by giving people greater choice and control over how their care and support is arranged and who provides it.[19]

2.3 Why capital mattered, and still matters

Capital became a central practical feature of the settlement. Expanding and modernising the care home estate required investment that was not allocated through constrained public capital budgets at the scale needed. Independent providers and investors supplied much of it, and over the following decades provision shifted decisively. On LaingBuisson's 2026 analysis, for-profit providers account for 85 per cent of older people's care home residents in the United Kingdom and not-for-profits for 11 per cent, leaving the NHS and local authorities together with about 4 per cent;[20] in homecare and supported living in England the independent sector accounts for around 98 per cent of provision and statutory services for about 2 per cent;[21] in younger adult specialist care in England the independent sector accounts for around 94 per cent of provision and statutory services for about 6 per cent.[22] These figures describe the market that now exists; they do not establish that every part of its development was inevitable or optimal. They show that replacing independent provision would require an explicit plan for both operating capacity and capital.

2.4 Quality then and now

It is tempting to imagine a lost golden age of public provision, but the record does not support it. Much of the impetus for reform came from serious failings in the old institutional model, including abuse scandals in long-stay hospitals, which were among the drivers of the move to community-based care. Quality under public provision was not obviously better than today, and, as section 8 argues, it has never been mainly a function of ownership.

2.5 The cost of reversing it

This history bears directly on current proposals because large-scale in-sourcing would involve substantial transition, workforce, and capital costs. Available aggregate data report markedly higher expenditure on local authority own-provision than the fees paid to independent providers, but the comparison is not fully like-for-

[18] Townson, J.K. (2024). Providers' perspective on the Care Act 2014. Local Government Association - The Care Act 2014 - 10 Years on From Royal Assent.
[19] Community Care (Direct Payments) Act 1996. The Act enabled local authorities to make payments to eligible people so that they could arrange their own community care services and came into force in April 1997. Direct payments were subsequently extended to wider groups and are now described in statutory guidance as a mechanism for promoting independence, choice and control.
[20] LaingBuisson (2026). Care Homes for Older People UK Market Report 36th Edition.
[21] LaingBuisson (2026). Homecare and Supported Living UK Market Report 7th Edition.
[22] LaingBuisson (2026). Adult Specialist Care UK Market Report. 8th Edition.

like. Unit costs and commissioned fees can differ in their treatment of capital, pensions, overheads, occupancy, service specifications and the needs of the people supported. Table 1 should therefore be read as an indication of the fiscal questions that require detailed modelling, not as proof that every public service is intrinsically less efficient.

Service	Local authority full economic cost, including capital	Independent-sector median council fee, which must cover all costs including capital
Residential care, older people (65+)	£1,796 per week	£968 per week
Residential care, working-age adults (18 to 64)	£2,165 per week	£1,217 per week

Table 1. Reported local authority full economic costs and independent-sector median council fees, England, 2024-25. Source: Personal Social Services Research Unit, Unit Costs of Health and Social Care 2025, using Adult Social Care Finance Return data for 2024-25. The figures are not a controlled comparison of otherwise identical services and should be interpreted with the qualifications in the text.

For 2024-25, the Personal Social Services Research Unit records a median operating cost of about £1,390 per resident per week for local authority residential care for older people, compared with a median fee of about £968 paid to independent-sector homes for state-funded residents.[23] Once capital is treated consistently, the reported full economic cost of local authority provision rises to about £1,796 per week for older people and £2,165 for working-age adults. The external figure is a fee rather than a direct observation of the provider's underlying cost and already has to cover the provider's cost of capital and any return.[24] Differences in case mix, occupancy, workforce terms, and wider obligations may also affect the comparison. The data nevertheless demonstrate that the fiscal case for wholesale in-sourcing cannot be based simply on recapturing private profit; the government would need to model acquisition, capital and operating costs on a consistent basis.

In Scotland, published council charges also illustrate the scale of the potential difference, while underlining the same comparability problem. In 2025-26 South Lanarkshire set the charge for its own residential care homes at £1,469.73 a week, compared with the £881.98 National Care Home Contract residential rate paid to

[23] Personal Social Services Research Unit (PSSRU) (2026). Unit Costs of Health and Social Care 2025 Manual.

[24] The £968 figure is the median fee councils pay independent homes for state-funded residents. Self-funders typically pay more for the same care: the Competition and Markets Authority found self-funder fees to be, on average, 41 per cent higher than the rates local authorities pay in the same home, and the Personal Social Services Research Unit records a self-funder residential fee of about £1,302 per week.

independent and voluntary providers.[25] The City of Edinburgh, calculating charges on a full-cost-recovery basis, put the weekly cost of its seven council homes at between £1,639 and £1,785.[26] These are not controlled like-for-like comparisons: council figures may include property, pension and corporate overhead costs, spare capacity or enhanced services, while the National Care Home Contract rate may understate the sustainable cost of provision. They support the need for transparent full-cost modelling, rather than a categorical conclusion about the relative efficiency of every ownership model.

The direction of the evidence is nonetheless consistent, even where its precise magnitude is not. The available figures point towards materially higher reported costs for local authority in-house provision and provide no basis for assuming that large-scale in-sourcing would release savings.

The mixed market developed in response to real problems of expenditure, capital and institutionalisation, as well as political choices about competition and the role of the state. Any proposal to alter it should be judged against a transparent counterfactual: who will provide the service, who will supply the capital, what employment terms will apply, how will continuity and choice be protected, and what will be the full fiscal cost.

3. The debate about profit: what is being claimed

It helps to separate the claims being made from the evidence. Several widely cited figures describe the largest providers rather than the sector as a whole, and the word "profit" is often used to cover very different things.

3.1 What campaigners argue

- **Domination by private equity.** The Co-operative Party report states that 80 per cent of the largest care home providers are owned or backed by private equity, drawing on analysis by the New Economics Foundation.[27]
- **Profit extraction.** The same report estimates that around £1.5 billion is extracted as profit from social care each year, equivalent to about 10 per cent of sector revenue.
- **Offshore and financial ownership.** The union Unite states that 83 per cent of adult care home beds are in the private sector and that more than a third of the profits from public care spending flows to private equity firms or investors in offshore tax havens.[28]

[25] South Lanarkshire Council, Understanding care home costs and benefits.
[26] City of Edinburgh Council, answers to written questions, 20 March 2025 (pp. 22-23), records full-cost charges of £1,639 to £1,785 a week for its seven council homes. Both are compared with the 2025-26 National Care Home Contract residential rate of £881.98 a week (nursing £1,013.05), effective 7 April 2025.
[27] Co-operative Party (2026). The Power of Co-operation in Care.
[28] Unite (2026). Unite responds to Andy Burnham's speech on social care.

- **The remedy is public provision.** In its strongest form, the argument is that the sums now going to profit and rent should be reinvested, and that a genuine national care service should bring provision into public hands rather than leave it in a privatised market. On this view, regulating private capital is not enough.

3.2 What the wider evidence shows

- **The largest groups are a minority of a fragmented market.** Social care remains a highly fragmented market dominated by small and medium-sized providers. Skills for Care reports that 84 per cent of adult social care organisations have fewer than 50 employees, while 37 per cent have only one to four employees.[29] The ten largest care home providers hold 18.1 per cent of the market between them,[30] and the ten largest homecare providers 16.4 per cent, with the largest homecare provider holding only 2.7 per cent market share.[31] The mainstay of investment in homecare remains the equity of owner-operators, often supported by bank lending. Adult social care in England was estimated to contribute £77.8 billion in gross value added (GVA) to the economy in 2024/25.[32] Figures describing the largest groups are therefore not a description of the sector.
- **Private equity and related institutional ownership are a minority of the whole.** LaingBuisson, the independent analyst contracted to the Office for National Statistics, assigns 13.7 per cent of older people's care home revenue,[33] 11.7 per cent of younger adult specialist care revenue,[34] and 12.8 per cent of homecare and supported living revenue[35] to a broad 'private equity' category. The category includes some investors, such as the listed Real Estate Investment Trust (REIT) Welltower, that are not private equity funds in the strict sense. The figures should therefore be described as LaingBuisson's broad classification rather than as a pure measure of private-equity ownership. Either way, most provision is owned by founders, families, charities, housing associations, employee-owned organisations, local authorities and other investors.
- **Margins for many providers are modest.** In homecare, LaingBuisson's analysis of the statutory accounts of larger for-profit providers shows an average operating EBITDA (earnings before interest, tax, depreciation and amortisation) margin of 8.7 per cent in 2024-25, and many small and medium-sized providers are struggling to break even as employment costs rise faster

[29] Skills for Care (2025). The state of the adult social care sector and workforce in England.
[30] LaingBuisson (2026). Care Homes for Older People UK Market Report 36th Edition.
[31] LaingBuisson (2026). Homecare and Supported Living UK Market Report 7th Edition.
[32] Skills for Care (2025). The state of the adult social care sector and workforce in England, 2025. Leeds: Skills for Care, section 1.3, 'Economic contribution'.
[33] LaingBuisson (2026). Care Homes for Older People UK Market Report 36th Edition.
[34] LaingBuisson (2026). Adult Specialist Care UK Market Report. 8th Edition.
[35] LaingBuisson (2026). Homecare and Supported Living UK Market Report 7th Edition.

than fees. Where councils pay below the cost of care, and almost a third do,[36] providers are in effect subsidising the state. LaingBuisson's analysis of the statutory accounts of care home providers large enough to file a profit and loss puts the weighted-average EBITDAR margin at about 19 per cent for older people's care homes[37] and about 16 per cent for younger adults' homes, in accounting years ending 2025.[38] EBITDAR is measured before rent: it is the operating profit from which providers must still cover rent on leased premises, interest, depreciation and amortisation, leaving a considerably thinner margin of profit before tax (Figure 1). These averages also conceal a wide spread by payer mix, with operators focused on private payers earning materially more than those dependent on local-authority fees, whose margins have roughly halved over the past decade.

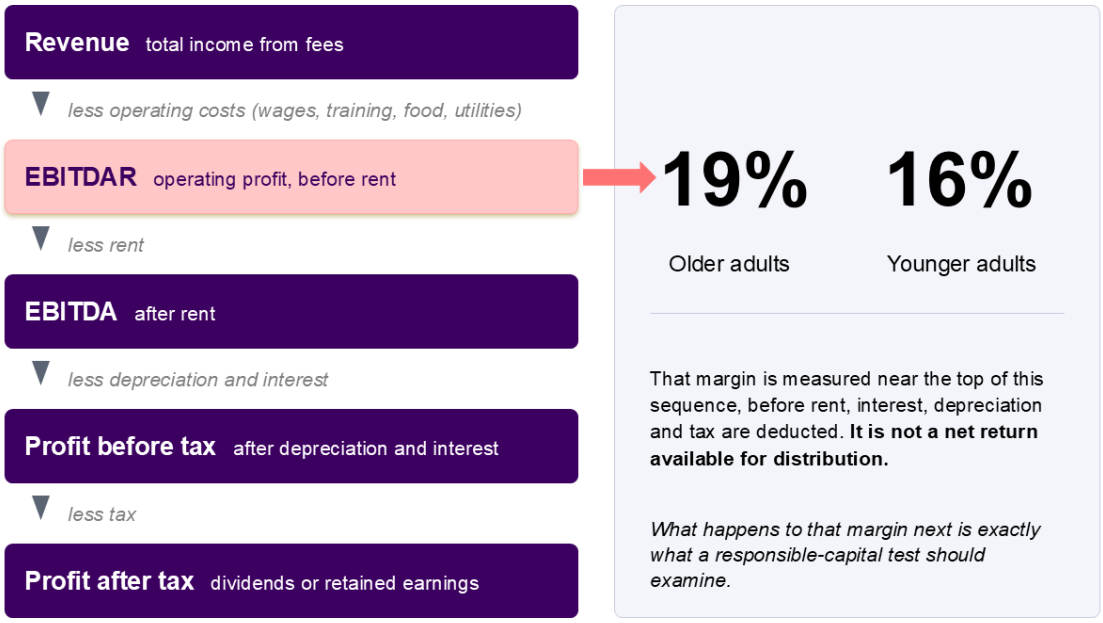

Figure 1: From revenue to retained profit. LaingBuisson's analysis of filed statutory accounts (2024-25). EBITDAR = earnings before interest, tax, depreciation, amortisation and rent.

None of this removes the need for scrutiny. Generating high returns through poor care, unfair employment, excessive leverage, opaque related-party payments, or unsustainable leases is unacceptable, whatever the ownership model. Equally, the existence of a return does not by itself establish extraction. Policy should identify the mechanism, the risk, and the outcome it is intended to change.

[36] Homecare Association (2025). The Homecare Deficit 2025.
[37] LaingBuisson (2026). Care Homes for Older People UK Market Report 36th Edition.
[38] LaingBuisson (2026). Adult Specialist Care UK Market Report. 8th Edition.

4. Participant sentiment and the reputational challenge

Any assessment of the options has to reckon with political and reputational sentiment. Baroness Casey's Commission has launched the Big Conversation on Care, in which participants submit short proposals and vote on those made by others.[39] It offers an unusually direct view of the concerns and priorities of people motivated to take part, but it is not a representative survey. Its results should not be generalised to the population without corroborating polling.

4.1 What participating contributors appear to want

Among the results reported so far, proposals for better paid, better trained and more valued care workers, a simpler system joined up with the NHS, prevention, support at home and greater help for unpaid carers have often attracted support above 80 per cent. On funding, many highly rated proposals follow an NHS-style principle of pooled risk and costs spread across a lifetime. These patterns align with several long-standing Homecare Association positions, while representing the views of participating contributors rather than a population estimate.

4.2 Hostility to profit among participants

The platform results on ownership and profit are particularly pointed. Proposals to ban billionaires, private equity and offshore ownership have attracted support in the region of 83 to 87 per cent among those voting on them, while proposals to limit profit have averaged around 85 per cent. There is similarly strong participant support for expanding not-for-profit and directly run provision. These figures cannot be read as representative public-opinion percentages, but they are a serious reputational signal. The vocabulary used is commonly that of profiteering and asset stripping, rather than investment and access to capital.

4.3 Three important caveats, and three openings

Three features of the exercise should temper how the results are read, and each is also an opportunity.

- **It is a self-selected sample, skewed to older respondents.** On one participant's analysis of more than a thousand submissions, the average age of those submitting was around 60, with only about 4 per cent under 30 and 15 per cent under 45.[40] The results reflect the most engaged voices, not a representative cross-section of the public.
- **There is a funding paradox.** Support was high, around 90 per cent, for the principle of contributing throughout one's working life, but collapsed to below 20 per cent when proposals asked people at or near retirement to contribute, whether through national insurance on pension income, a retirement levy or

[39] Casey Commission (2026). The Big Conversation on Care.
[40] Hollow, N. (2026). 'I voted on 1,000 Big Conversation in Care proposals. Here is what I learned', Care Home Professional, 20 August 2026.

housing wealth. The enthusiasm for free care sits alongside a reluctance to pay for it, which is a difficulty for the Treasury as much as for the sector. The Japanese government navigated this dilemma by introducing its own long-term care insurance system in 2000, funded through taxation and premiums paid by everyone over forty.[41] This minimised financial pressure on younger generations, while showing them the benefits when they were experiencing the care needs of ageing parents. The reform was captured in a memorable phrase: a shift from care by the family to care by society. The insurance is now a settled and accepted part of everyday life, woven into the routine of growing older.

- **Working-age adults are barely heard.** People who draw on care as working-age adults, including those with learning disabilities, acquired brain injuries, lifelong physical disabilities and autistic people, featured in only a small fraction of proposals, very few of them submitted by younger people. A national conversation can be open to everyone and still be shaped overwhelmingly by a few voices.

The implication for investment policy is clear, but should be stated carefully. Sentiment among engaged participants currently runs strongly against private capital, while representative public attitudes require further evidence. The policy risk is that legitimate concern about harmful financial practices produces crude measures, such as blanket profit caps, that affect responsible providers as well as the structures causing the concern. Section 13 considers the implications for public debate.

5. Forms of investment in the care sector today

The single most useful distinction is between owning the buildings and owning the operating business. A care home is both a property and a service. In many modern structures, these are owned by different parties: a property investor owns the building and leases it to an operator, who employs the staff and delivers the care. In homecare, the distinction largely falls away because homecare providers own very little property; their value lies in their workforce, contracts, reputation, local management, and technology.

5.1 The main sources of capital

Founder and family equity, supported by bank lending

Founder and family ownership is a mainstay of the sector. Many providers are owned by the people who built them, who have invested their own money and often borrowed from a bank secured against the business or the property. Their horizon is typically long, sometimes generational, and their return comes from the operating surplus and potentially an eventual sale. LaingBuisson identifies providers' own

[41] Nuffield Trust (2018). What can England learn from the long-term care system in Japan?

equity, leveraged by bank loans, as the largest single source of investment in the sector.[42,43,44]

In many small care businesses, the owner is also the founder, manager, and principal risk-bearer. Returns to the owner may therefore compensate for several things at once: managerial work, capital invested, personal guarantees, entrepreneurial risk, and the opportunity cost of building the business. Dividends in such businesses should not automatically be interpreted as passive extraction.

Bond finance

Several larger not-for-profit providers raise money by issuing bonds, effectively long-term loans from investors, repaid with interest. This route is largely restricted to not-for-profit providers with the scale and covenant strength to access the debt markets.

Private equity

Private equity firms buy operating businesses intending to increase their value and sell them, usually within three to seven years. In care this means homecare providers, care home operators, specialist and children's services. The return comes from growth in the value of the business rather than from rent. Private equity has funded much of the consolidation of the last two decades and has, in places, brought capital for expansion, management capability, and investment in systems and technology. It can also, where structures are aggressive, rely on high leverage that weakens resilience.

Real estate investment trusts and other property investors

A real estate investment trust, or REIT, is a property-owning company or group operating under a special tax regime. In the UK, qualifying REITs are exempt from corporation tax on the income and gains of their property-rental business and are generally required to distribute at least 90 per cent of their property-rental profits to shareholders.[45] In care, REITs and other property investors own the buildings and lease them to operators on long leases, often for 20 to 35 years, earning rent and benefiting from any rise in property values. LaingBuisson describes property investors as currently the most important source of capital for new care homes, mainly those aimed at people who fund their own care. Examples of specialist listed vehicles include Target Healthcare and Impact Healthcare. These companies are landlords; they do not themselves provide care.

A common structure is the sale-and-leaseback, in which an operator sells its buildings to a property investor and leases them back. This releases capital, which can fund expansion or repay debt, while the operator continues to run the homes. Welltower, a large US-listed REIT, has acquired substantial UK care home property

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[42] LaingBuisson (2026). Care Homes for Older People UK Market Report 36th Edition.
[43] LaingBuisson (2026). Adult Specialist Care UK Market Report. 8th Edition.
[44] LaingBuisson (2026). Homecare and Supported Living UK Market Report 7th Edition.
[45] HM Revenue & Customs. Investment Funds Manual, IFM22050: Real Estate Investment Trust: Conditions and Tests: Distribution Condition: General.

interests, including Care UK property companies and, more recently, portfolios of homes previously owned and operated by Barchester, HC-One, Aria Care and Danforth. The latter transactions prompted a Competition and Markets Authority review because of potential effects on competition in local care markets.[46] The concern there is about market concentration, not about the REIT's involvement in care.

Pension, insurance and infrastructure investors

Increasingly, care homes are viewed as long-term infrastructure, alongside student accommodation, logistics and data centres. Pension funds, insurers and infrastructure funds invest either in the property or in the operating business, seeking stable returns over decades. It is worth remembering that much of this money ultimately belongs to ordinary people, since the beneficiaries are often teachers, NHS staff, local government employees and private-sector workers whose pensions are invested in listed property and infrastructure.

Growth equity and venture capital for technology

External investment in homecare is more likely to take the form of growth equity or venture capital than property investment. Their capital supports acquisition and growth, investment in digital care planning, artificial intelligence, remote monitoring, and the operational systems needed to run services at scale. These are, notably, among the priorities that ministers themselves support.

Not-for-profit, charitable, co-operative and employee-owned models

A substantial part of the sector has no external shareholders. Charities, housing associations, and community benefit societies generally reinvest surpluses; co-operatives and employee-owned businesses may also return value to members or employee owners, depending on their legal form. Well-run providers across these models can invest substantially in services, staff and communities. Their principal constraint is access to capital on terms that suit their model, since much conventional social investment does not fit not-for-profit or co-operative structures. This is an area where policy could make a material difference, as set out in section 11. It should be added that the ownership form does not by itself guarantee how the surplus is used, a point taken up in sections 7 and 8.

[46] Competition and Markets Authority (2026). Welltower / multiple care homes merger inquiries.

5.2 A summary of the investor types

Investor	What they own	How they earn a return	Typical horizon
Founder or family owner	The operating business, often the property too	Operating surplus	Long term, often generational
Bank lender	Debt secured on the business or property	Interest	Medium to long term
Bondholder	Debt, mainly issued by not-for-profits	Interest	Long term
Private equity	The operating company	Growth in business value, then sale	Around 3 to 7 years
REIT or property investor	The buildings	Rent and property appreciation	Decades
Pension or insurance fund	Equity or debt	Stable long-term returns	Decades
Growth equity or venture capital	Equity in growing, often technology-led, providers	Growth in business value	Around 3 to 7 years
Charity or housing association	The organisation, no external shareholders	Reinvested surplus	Indefinite
Co-operative or employee ownership	The organisation, held by or for members	Reinvested surplus and member benefit	Indefinite

Table 2. The main forms of capital in adult social care and how each earns a return.

5.3 The scale of private equity

LaingBuisson adopts a deliberately broad classification labelled private equity, which includes some investors that are not private equity funds in the strict sense, such as the listed REIT Welltower. Table 3 reports that published classification. It should not be interpreted as a pure estimate of conventional private-equity fund ownership.

Segment	Revenue share under LaingBuisson's broad 'private equity' classification
Care homes for older people	Around 13.7 per cent
Younger adult specialist care	Around 11.7 per cent
Homecare and supported living	Around 12.8 per cent

Table 3. Share of revenue under LaingBuisson's broad 'private equity' classification. This includes some investors that are not private equity funds in the strict sense. There are no stock-exchange-listed care home operating groups in the United Kingdom.

6. How returns are made: the many meanings of profit

Political debate often uses “profit extraction” as though it described a single act. In reality, there are several distinct mechanisms by which money leaves a care business, and each raises a different question (Table 4). Treating them as a single category is the source of much of the confusion.

Mechanism	Who receives it	The question it raises
Dividends	Shareholders and owners	Is the surplus reasonable, and is care quality maintained?
Rent	Landlords, including REITs and pension funds	Are the lease terms sustainable for the operator?
Interest	Lenders, including banks and bondholders	Is the level of debt prudent and resilient?
Management and monitoring fees	Investors and related parties	Are related-party charges transparent and fair?
Capital gains	Owners, on a sale	Does the sale support or undermine continuity of care?

Table 4. The different mechanisms often grouped together as “profit”, and the distinct policy question each raises.

The identity of the recipient does not determine whether a return is reasonable. Rent paid to a pension fund or interest paid to a bank may support legitimate long-term investment, but either can threaten care if the terms are excessive or poorly aligned with the operator's income. Conversely, a dividend is not necessarily harmful where

care is good-quality, staff are treated fairly, the provider remains resilient, and sufficient resources are retained for investment. The collapse of Southern Cross in 2011 illustrates the danger of excessive leverage and poorly aligned property arrangements. The policy objective should therefore be to examine the terms, transparency, and effect of each mechanism, encouraging sustainable capital and restricting arrangements that undermine continuity of care.[47]

Underlying these mechanisms is a point the debate often omits: a return is the price of capital, not a windfall. Anyone who commits money to care, whether a family owner borrowing against their home, a bank lending to a provider, or a pension fund investing its members' savings, forgoes other uses of that money and bears real risks, including fluctuating occupancy, fee settlements that lag costs, regulatory change, movements in property values, illiquidity and the possibility of failure. The expected return rises with the risk borne because investors require compensation for bearing it; higher risk does not guarantee higher reward, and some who take it lose. Much of the institutional capital in the sector is in fact drawn by the relative stability of care rather than by the prospect of outsized gains, so the level of return the sector must offer reflects the level of risk it presents, which public policy can itself influence.

This shifts the relevant test. What matters is not simply whether a return is earned, but whether it is commensurate with genuine exposure to risk and whether the financial structure allocates that risk responsibly. Returns are legitimate where investors bear an appropriate share of the downside associated with the return they receive; concern arises where structures allow returns to be protected or extracted while a disproportionate share of the risk of failure is transferred to residents, staff, providers or the public purse. It also points to a policy lever: because required returns reflect risk, a more stable funding and regulatory environment, through predictable fee uplifts, longer contracts and less abrupt policy change, could lower the sector's cost of capital and, with it, the returns providers must offer. That is a more durable approach than attempting to cap returns directly, and the counterpart to the public capital set out as Option H. The framework in section 12 accordingly makes the responsible alignment of risk and return a principle of responsible capital.

7. Why every provider needs financial headroom

A recurring confusion is the assumption that any reported profit is money taken out of care. Several concepts need to be separated. Recurrent income must first cover the recurrent costs of delivering safe care, including wages, training, supervision, and regulatory compliance. Cash and reserves provide liquidity and resilience. Retained profit or surplus can strengthen reserves and help finance investment, while external debt or equity may also provide capital. A provider can report a loss in a particular year and remain viable, but persistent deficits without reserves, support, or access to capital are unsustainable.

[47] Wearden, G. (2011). The rise and fall of Southern Cross. The Guardian, 1 June 2011.

Financial headroom, built from adequate recurrent income, liquidity, reserves, retained earnings and access to capital, enables a provider to do the following:

- **Remain resilient.** Reserves absorb shocks, whether a sudden rise in costs, a delayed payment from a funder, a bad debt, a fall in occupancy, or an event such as a pandemic. Without them, a single shock can tip a provider into insolvency, which is the event that most threatens continuity of care for the people who rely on it.
- **Invest in the workforce.** Fair pay, training, supervision, career development, and wellbeing are recurrent operating costs and should be covered by recurrent income. Retained earnings can support transition, innovation, and additional investment, but permanent improvements cannot sustainably be financed from a one-off surplus where fees remain inadequate.
- **Maintain and modernise the estate.** Buildings must be kept safe and brought up to standard, and legacy stock replaced. As set out in section 9, this is a very large and continuing call on capital.
- **Provide equipment and technology.** Moving and handling aids, vehicles, assistive technology, electronic care records, remote monitoring, artificial intelligence, and cybersecurity all require investment.
- **Grow to meet demand.** Expanding capacity and reaching underserved areas requires capital that a surplus either provides directly or makes it possible to raise.
- **Service and attract capital.** Interest on prudent borrowing must be covered, and lenders and investors will only commit capital to an organisation that can generate a return, or at least a dependable surplus.

This is why 'not-for-profit' is misleading if taken to mean 'no surplus'. Charities, co-operatives and housing associations need income to exceed expenditure over time so that they can maintain liquidity, resilience and investment. NHS bodies also require sustainable finances, although their funding and capital arrangements differ from those of independent providers, and they may be supported through public funding. LaingBuisson's accounts analysis illustrates that not-for-profit organisations can report substantial surpluses, particularly those also providing housing.[48] The central legal distinction is that a not-for-profit cannot normally distribute its surplus to external shareholders; the label does not by itself establish how effectively resources are used. The same scrutiny should apply across ownership models.

7.1 The procurement paradox

Public procurement illustrates the importance of financial capacity. When a council or NHS body tenders for care, it may assess the bidder's economic and financial standing through proportionate measures such as turnover, cash flow, liquidity, and

[48] LaingBuisson (2024). Adult Social Care in the UK Scale, Structure, Funding and Financial Performance of the Independent Sector.

debt-to-equity ratios. It may also consider audited accounts, guarantees, or other mitigations. While there may be no requirement for every bidder to report a profit in every year, the purpose is to establish whether the supplier has sufficient financial capacity to perform the contract and protect continuity of public services.[49]

The tension is therefore more precise than a contradiction between profit and no profit. Public authorities expect providers to demonstrate sufficient financial capacity and resilience, yet purchasing practices can undermine that capacity where prices, volumes, and contract terms do not cover the sustainable cost of delivery. The state cannot protect continuity merely by prohibiting distributions if the underlying service remains structurally under-funded.

The tension is sharpest where commissioning is under-funded. When a council sets fees below the cost of safe delivery, as almost a third do,[50] it makes it difficult to maintain liquidity, reserves, and the investment capacity that commissioners themselves need providers to possess. The provider is asked to absorb structural losses while remaining a reliable long-term partner. Resolving that tension requires adequate prices, realistic assumptions about paid and unpaid working time, funded employment improvements, and contracts that allow a reasonable margin for resilience and reinvestment.

This reframes the central question. It is not whether every organisation must report a profit in every period. It is whether the system provides sufficient recurrent income, liquidity and capital for safe, resilient and improving care; how financial returns are generated; and what providers retain and reinvest. Those are the questions addressed by the responsible-capital framework in section 12.

8. What does ownership tell us about quality?

The strongest version of the argument assumes that ownership form determines outcomes. The evidence does not support using ownership as a sufficient test of an individual provider. Excellent and poor providers exist in every category. Co-operative and employee-owned organisations can be excellent, as can family-owned and other commercial businesses. Ownership structures may nevertheless affect incentives, access to capital, and tolerance for risk, and those mechanisms should be examined rather than dismissed.

Counter-examples caution against treating any category as a guarantee. Public and not-for-profit services include examples of excellent care and serious failure; the same is true of commercial provision. Recent cases involving neglect of people with

[49] Procurement Act 2023, section 22, permits proportionate conditions of participation relating to a supplier's legal and financial capacity. Government guidance identifies evidence and measures including audited accounts, turnover, cash flow, debt-to-equity and liquidity ratios, while allowing proportionate mitigations and alternative evidence so that SMEs, voluntary-sector providers and new entrants are not unfairly excluded.
[50] Homecare Association (2025). The Homecare Deficit 2025.

learning disabilities have included different ownership models.[51] These examples do not prove that ownership is irrelevant, but they show why the label alone cannot substitute for evidence about leadership, staffing, governance, and outcomes. The same caution applies when ownership changes.

A recent example illustrates the limitations of ownership change as a quality intervention. The Care Quality Commission (CQC) rated Brushwood House care home in Liverpool inadequate in 2023 when operated by an independent provider.[52] Liverpool City Council then took the service into direct operation. In the CQC's first assessment under the council, published in September 2026, the service remained inadequate overall.[53] Safe and well-led remained inadequate, while effective, caring and responsive had fallen from requires improvement to inadequate. Many of the concerns identified across the two assessments were similar, including weaknesses in leadership and governance, staffing, medicines management, care records, and risk management. A single case cannot prove that one ownership model outperforms another, but it illustrates why changing ownership alone does not guarantee quality improvement.

The more actionable determinants of quality include leadership, culture, staffing, supervision, commissioning, funding, governance, and financial resilience. Providers need sufficient recurrent resources and organisational capacity to invest in these. The Co-operative Party report's contributors repeatedly identify commissioning at the lowest possible price and chronic underfunding as decisive barriers. Changing ownership without changing those conditions would leave important causes of poor care untouched. For homecare, we examine some of these structural drivers in more detail in our recent paper, *Homecare: commissioning is the key to quality, fair work and better outcomes*.[54] It shows how below-cost fees, fragmented purchasing, insecure volumes and payment by the contact minute can undermine continuity, workforce security, provider investment and quality across different ownership models.

For the same reason, not-for-profit status is not a guarantee of performance or equitable access. Some not-for-profit care homes for older people primarily serve those able to pay higher private fees and accept few or no residents at council rates. Some organisations in every ownership category retain substantial resources without investing sufficiently in their workforce. This is not a criticism of not-for-profit provision, which at its best is exceptional; it is a reason to ask consistent questions of every provider about access, outcomes, employment, and the use of resources.

Research identifying associations between ownership and outcomes must be taken seriously. UK and international studies have associated private-equity ownership with higher leverage and, on some measures, poorer quality. One large observational study of CQC ratings found that private-equity-backed chains and

[51] Hewitt, D. (2026). 'She died, they did nothing': Families say CQC not protecting disabled people in care. ITV, 25 June 2026.
[52] Care Quality Commission (2023). Inspection report on Brushwood House, Speke, Liverpool.
[53] Care Quality Commission (2026). Inspection report on Brushwood House, Speke, Liverpool.
[54] Townson, J.K. (2026). *Homecare: commissioning is the key to quality, fair work and better outcomes*. Homecare Association.

independent for-profit homes had an adjusted probability around seven percentage points higher of being rated ‘requires improvement’ or ‘inadequate’ than not-for-profit homes, while for-profit chains not backed by private equity were closer to the not-for-profit group. Private-equity chains nevertheless performed better than independent homes on the ‘well-led’ domain. The study does not establish that ownership itself caused these differences. Its authors identify possible mechanisms, including cost pressures, staffing and governance, while also acknowledging potentially important unmeasured differences in occupancy, staffing characteristics and resident case mix. The wider evidence points to further mechanisms, including leverage and payer mix, that policy can measure and regulate directly. The appropriate conclusion is neither that ownership is irrelevant nor that it determines quality, but that ownership-associated risks should trigger proportionate scrutiny of the mechanisms through which harm may arise.[55]

The practical implication is narrow but firm: the evidence justifies scrutinising the structures associated with poorer outcomes but not prohibiting them on the strength of the label alone, and so points to regulating the mechanism rather than the ownership form.

9. The investment challenge

Any restriction on investment has to be weighed against the scale of capital the sector needs. LaingBuisson estimates the older people's care home estate at £27.3 billion, based on an average value of about £61,000 per bed across roughly 441,000 beds, with values ranging from about £30,000 per bed for poor legacy stock to about £150,000 for new, purpose-built homes.[56]

The estate needs both modernisation and expansion. Around 43 per cent of current capacity is not purpose-built, and at a replacement rate of only 1 to 2 per cent a year, it will take decades to modernise. At the same time an ageing population will require significant additional capacity. Property investors are currently the most important source of funding for new care homes. In homecare, the investment need is different in kind: it is not bricks and mortar but consolidation, operational systems, and technology.

This raises the central question that any restriction on investment must answer: what source of capital, public or private, will replace it and on what terms? The public sector has not so far allocated capital on the scale required and would face substantial fiscal trade-offs in doing so. Institutional investors can invest instead in other sectors. Poorly designed restrictions could therefore reduce new capacity at a time when demographic pressure is rising; a credible reform must specify the replacement capital rather than assume that need alone will attract it.

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[55] Patwardhan, S., Sutton, M. and Morciano, M. (2022). Effects of chain ownership and private equity financing on quality in the English care home sector: retrospective observational study. Age and Ageing, 51(12), afac222.
[56] LaingBuisson (2026). Care Homes for Older People UK Market Report 36th Edition.

The financial conditions that drew capital into the sector have themselves changed, which sharpens this question. For much of the past decade, low interest rates and investors' appetite for stable, long-term income made healthcare property attractive to pension funds, banks, and real estate investment trusts, and that capital financed much of the sector's growth and modernisation. Higher borrowing and construction costs, and rising expectations on energy performance and digital infrastructure, have since made investment more demanding and more selective. Property advisers such as Savills, Knight Frank, Christie & Co and CBRE still describe social care as an attractive long-term sector, but report that investors now scrutinise asset quality, future capital requirements and operator resilience more closely before committing.

A crucial distinction follows: demand for care is not the same as demand for care property. A council may require an additional care home, and commissioners may back it, but a lender or investor will still question whether the completed building will generate an acceptable return over 20 or 30 years after covering borrowing and construction costs. Because investors value a care home based on the returns they require, an increase in those required returns can lower its value even if occupancy and quality remain unchanged, which tightens loan-to-value ratios and makes refinancing more difficult. Experts have described this type of financial pressure as an ‘asset shock’: a gradual weakening of financial resilience through changes in asset values, borrowing conditions and investment behaviour that can build on balance sheets and in development pipelines well before it becomes visible as fewer care places.[57] It is a further reason why measures that deter patient capital would compound a squeeze that is already under way, at the very moment the estate most needs renewal.

If the government wishes to limit forms of private investment, it must therefore identify the public, charitable, co-operative or alternative private capital that will take their place. Otherwise, a restriction may reduce the total available to a sector that needs more of it. Option H considers how the state might supply patient capital, while recognising the associated fiscal and delivery choices.

10. Lessons from Wales and Scotland

Two recent experiences within the United Kingdom are relevant, because the Co-operative Party report holds up Wales as a model to follow.

10.1 Wales: removing profit from children's social care

The Health and Social Care (Wales) Act 2025 establishes a phased transition intended to restrict the extraction of profit from specified children's social care services. From April 2030, children may not generally be placed with a for-profit provider, subject to exceptional arrangements. Implementation is continuing, so it is too early to judge the reform's eventual effects. Evidence to Senedd committees and

[57] Gemmel, J. (2026). ‘Understanding how asset resilience, investment and financial markets shape the future capacity of adult social care’, LinkedIn, 31 July 2026. Gemmel attributes the concept of the ‘Asset Shock’ to earlier work by Ashley Wilson.

warnings from local government, provider bodies and the Chartered Institute of Public Finance and Accountancy have nevertheless raised legitimate questions about sufficiency, transition costs, contract hand-backs and market stability where reform is not fully funded.[58,59,60]

The Welsh drafting also illustrates the importance of defining the desired behaviour carefully. Because the permitted forms cannot have share capital, some employee-owned structures that issue shares to staff may fall outside the permitted model even though employee ownership is one of the alternatives reformers wish to encourage. The lesson is not that the policy has already failed, but that restrictions based on legal form can produce unintended boundaries unless funding, capital, and organisational diversity are considered together.

Reform advocates also identify a substantial decline in not-for-profit provision in the adult care home market in Wales as private investors have expanded.[61] Their concern is that leaving existing incentives untouched may gradually narrow rather than preserve a mixed market. Both points deserve weight: ownership patterns can change in ways that affect policy objectives, while changing legal form without sufficient funding and transition support can destabilise provision. If the government wishes to grow the not-for-profit share, it will need to provide suitable capital, viable commissioning and development support as well as legislation.

10.2 Scotland: a National Care Service that stalled

Scotland moved away from its proposed National Care Service after concerns about cost, complexity, governance and centralisation,[62] while some unions and campaigners objected that the model would retain independent provision and commissioning. The experience is relevant principally as a lesson in implementation: structural reform can lose support from different directions if funding, accountability, and the delivery model are unresolved. It is not, by itself, evidence for or against profit in care.

11. Options if the government wishes to change the pattern of investment

If the government concludes that it wishes to change the pattern of investment in care, a range of options is available. They differ greatly in ambition, in the risk of unintended consequences, and in how precisely they target harmful behaviour rather

[58] Welsh Government (2025). Health and Social Care (Wales) Act 2025.
[59] Concerns about funding and unintended consequences have been reported, including a Senedd committee session in November 2025 (Nation.Cymru, "Private care providers 'making hay' as plan to restrict profits 'backfires'").
[60] Samuel, M. (2025). Community Care. 'Bill to remove profit from children's care in Wales approved by Senedd', reporting CIPFA warnings of risks including contract hand-backs and market failure.
[61] CICTAR in partnership with TUC Cymru and Unison Cymru (2026). 'People in Cymru expect better for their communities'. Ownership structure of adult care home services in Cymru: trends and future implications.
[62] Scottish Government (2025). Future of the National Care Service: Ministerial statement.

than private capital in general. They are set out below from the lightest touch to the most restrictive. A final option, Option H, is different in kind: it is not a restriction at all, but the public capital that any serious restriction would require. They are not mutually exclusive, and the earlier options are, in our view, both lower risk and more likely to be effective.

11.1 Option A. Transparency and financial reporting

The government could require providers above a certain size to disclose their ownership structure, group relationships, levels of debt, related-party transactions, rent, and the destination of surpluses. This would shine a light on financial engineering without prohibiting any lawful structure and would give commissioners and the regulator the information needed to act. The main risk is the administrative burden, which can be managed by focusing on larger and more complex providers.

11.2 Option B. Strengthened market oversight, governance and resilience

The Care Act 2014 already gives the CQC a market oversight role for the largest and most difficult-to-replace providers, monitoring their financial sustainability. This regime could be widened and given sharper powers, for example, to require contingency plans, to set expectations on governance, and to intervene earlier where resilience is at risk. This targets the genuine problem exposed by Southern Cross, which was continuity of care, rather than private ownership as such. It differs in kind from transparency (Option A): where transparency publishes information for commissioners and the public to weigh, market oversight is a confidential, regulator-led assessment of financial resilience, aimed at heading off the disorderly failure of the providers whose collapse would be hardest to replace. The risk is that a heavier compliance regime bears most heavily on smaller providers, so it should be proportionate to size and complexity.

11.3 Option C. Limits on leverage and related-party structures

The government could act specifically against excessive financial engineering: for example, by discouraging very high levels of debt relative to earnings, by scrutinising unsustainable sale-and-leaseback arrangements, or by requiring related-party rents and fees to be transparent and justifiable. These address the behaviour that threatens resilience while leaving productive and patient capital untouched. The difficulty is calibration, since debt is a normal and often prudent part of financing, and thresholds set too tightly could deter sound investment.

11.4 Option D. Restrictions on offshore ownership and tax arrangements

Where the concern is that returns leave the country through offshore structures, the government could tighten tax rules and disclosure for care providers or attach conditions to the receipt of public funds. These address a specific public concern.

The appropriate target would be tax avoidance or arrangements designed principally to shift taxable profits, rather than international ownership or investment as such. The risk is that broad-brush measures also catch legitimate international investors, including pension and infrastructure funds whose capital the sector needs.

11.5 Option E. Conditions through commissioning and a responsible-capital standard

Rather than prohibiting ownership forms, the government could use the power of public commissioning to reward the behaviour it wants. This could include a statutory minimum price that makes fair pay and reinvestment possible, stronger and better-enforced social-value criteria, and a voluntary or mandatory responsible-capital standard covering leverage, transparency, fair employment and reinvestment. This works with the grain of the market and improves conditions for every ownership type. Its effectiveness depends entirely on commissioning being properly funded, without which social-value criteria are routinely overridden by the lowest price.

11.6 Option F. Active support for not-for-profit, co-operative and employee ownership

If the government wishes to see a larger not-for-profit and employee-owned sector, it could support that as an addition to provision rather than a replacement of it, and as a way of widening choice rather than as a judgement that these models are inherently superior. Measures could include a worker-buyout mechanism drawing on Italy's Marcora framework,[63] combining patient finance and development support with, in defined insolvency circumstances, a right of first refusal for workers forming a co-operative; new finance for buyouts through the British Business Bank and others; tailored co-operative development support, potentially through the existing Co-operative Development Unit; and new routes for ethical finance on terms that suit not-for-profit balance sheets, addressing the genuine constraint on access to capital that these models face. The limits are that it takes time, that it depends on viable commissioning, and that it complements rather than substitutes for wider funding reform.

11.7 Option G. Statutory removal of private profit

At the most restrictive end, the government could go beyond regulating private capital and seek to remove private profit from all or part of adult social care. This could mean legislating profit out, as Wales has done for children's services, or bringing provision into public hands through a public national care service. This is the option urged by some trade unions, campaigners and commentators, on the argument that the sums now going to profit and rent should instead be reinvested in care and in staff. A blanket removal of private profit would also affect thousands of small and family-owned providers whose owners have invested personal capital and

[63] Vieta, M. (2015). "The Italian Road to Creating Worker Cooperatives from Worker Buyouts: Italy's Worker-Recuperated Enterprises and the Legge Marcora Framework," Euricse Working Papers 78/15, Euricse (European Research Institute on Cooperative and Social Enterprises).

whose businesses contribute to local employment and local economies. That argument can overlook the fact that many providers already reinvest part of their returns in services, workforce, and capacity, but it responds to a real public unease about who benefits from public spending on care.

This is the option with the greatest transition and fiscal exposure. Removing conventional private equity alone would affect only a minority of provision and would not address rent, debt, or other forms of financial return. Bringing provision into public ownership would require sustained and significant funding to acquire or replace assets, establish operating capacity, and meet ongoing workforce and service costs. Aggregate unit-cost evidence suggests that the government should not assume public operation will release savings; indeed, it would likely cost much more, although the comparisons require careful adjustment for case mix and cost allocation. The Health Foundation's estimate of a universal and comprehensive social care system concerns a wider expansion of public entitlement, not a change of provider ownership. Bringing provision into public ownership would add acquisition, capital, and transition costs that are not captured by that estimate. Wales and Scotland further demonstrate the need for a fully funded transition and delivery plan. We would caution against this route unless the government specifies the capital, revenue, workforce and continuity arrangements that would replace existing provision.[64]

11.8 Option H. Public capital to replace private investment

The options above restrict, condition, or reshape private investment. None alone answers the question raised in section 9: if the government discourages a source of capital, what will replace it? The government could supply patient, long-term finance through an existing institution or a dedicated social-care investment vehicle, and could design products for commercial, charitable, co-operative, and employee-owned providers. Such lending has fiscal consequences, requires risk assessment, and must comply with subsidy-control rules. It may affect public borrowing and balance-sheet measures differently according to its design. Therefore, policymakers should appraise public capital transparently and employ it to attract responsible investment, instead of assuming it comes without cost or can fully substitute private finance.

11.9 A summary of the options

Option	What it would do	Principal risk
A. Transparency	Require disclosure of ownership, debt, and related-party dealings	Administrative burden

[64] Alderwick, H. and Allen, L. (2026). Social care funding: options for reform.

Option	What it would do	Principal risk
B. Market oversight	Widen and sharpen resilience regulation under the Care Act 2014	Disproportionate load on smaller providers
C. Leverage limits	Curb excessive debt and unsustainable leaseback	Hard to calibrate without deterring sound finance
D. Offshore and tax	Tighten tax and disclosure, or attach conditions to public funds	May catch legitimate international investors
E. Commissioning conditions	Reward responsible capital through price and social value	Ineffective unless commissioning is funded
F. Support not-for-profits	Widen choice by helping co-operative and employee ownership grow	Slow; depends on viable commissioning
G. Remove private profit	Legislate profit out or bring provision into public ownership	Very high cost; risk of exit, lost capacity and instability
H. Public capital	Offer long-term public loans to build and modernise capacity	Cost to the public purse; borrowing and subsidy-control limits

Table 5. Options from the lightest touch to the most restrictive, and a concluding enabling option.

12. A proposed framework: responsible capital for social care

Rather than framing the question as public versus private, or for-profit against not-for-profit, the government should ask which behaviours and financing terms strengthen care. Five tests provide a practical starting point: 1) whether investment sustains or adds capacity, modernises assets or improves services; 2) whether debt, rent and other commitments are sustainable; 3) whether beneficial ownership and related-party transactions are transparent; 4) whether care and employment outcomes are good; and 5) whether sufficient resources are retained for resilience and reinvestment. Running through all five is a single principle: returns should be commensurate with genuine exposure to downside risk, and financial structures should not transfer a disproportionate share of the risk of failure to residents, staff, providers, or the public. The distinction between productive investment, patient

capital and harmful financial engineering then becomes operational rather than rhetorical.

- **Productive investment,** which sustains or adds capacity, modernises assets or improves services, and which the government should encourage.
- **Patient long-term investment,** which finances the buildings and infrastructure the sector needs, and which the government should welcome where lease terms are sustainable.
- **Financial engineering,** where returns depend primarily on leverage, tax structures, or the extraction of value without adding capacity or improving care, and which the government should scrutinise and, where it threatens resilience, restrict.

Applied to the main forms of capital, this framework points to a clear and defensible policy stance (Table 6).

Capital or financial behaviour	Suggested policy stance
Founder and family equity	Encourage
Long-term pension and insurance investment	Encourage
REIT and property investment	Encourage where leases are sustainable
Prudent bank lending	Encourage
Private equity focused on operational improvement	Permit, with governance and transparency
Not-for-profit and co-operative models	Support access to suitable capital; judge on outcomes, as for any provider
Surplus reinvested in care, workforce and resilience	Encourage, whatever the ownership model
Highly leveraged financial engineering	Discourage and, where it threatens resilience, restrict

Table 6. A framework for influencing capital and financial behaviour.

12.1 Making the framework operational

A responsible-capital standard should use proportionate, segment-specific indicators. These could cover beneficial ownership and tax residence; group structure and related-party transactions; debt, rent and debt-service or rent cover;

dividend policy; liquidity and contingency arrangements; investment in maintenance and technology; workforce pay, turnover, sick pay, training and supervision; quality and safeguarding performance; and continuity plans for the failure of an operator or landlord. The appropriate measures and thresholds will differ between homecare providers, care-home operators, and property owners and should be developed with people who draw on care, workers, commissioners, regulators, providers, and financial experts.

The standard could support three proportionate responses: preferred capital, eligible for longer contracts or favourable public finance because it demonstrates additional public value; permitted capital, meeting minimum transparency and resilience requirements; and high-risk structures, subject to enhanced oversight, remediation or restriction where they threaten continuity or quality. Decisions should be evidence-based, reviewable, and applied consistently across ownership forms.

The framework applies common tests across ownership models while recognising that different structures create different risks. A well-run commercial provider and a well-run charity should both be able to demonstrate good outcomes, fair employment and sound finances. Equally, a charitable label should not exempt an organisation from scrutiny, and commercial ownership should not establish wrongdoing without evidence. Risk indicators associated with a particular structure should lead to proportionate examination of the relevant mechanism, not an automatic judgement about the provider.

The approach has two advantages. It targets the behaviours that threaten care and continuity, while allowing the government to distinguish responsible investment from extraction. It also preserves access to the capital needed for modernisation and growth, while providing a principled basis for enhanced oversight or restriction where financial arrangements create material risk.

Above all, it keeps the priority on commissioning and funding. A statutory minimum price for care, a properly funded Fair Pay Agreement, realistic purchasing of workers' paid time and commissioning for outcomes rather than the lowest hourly rate would do more directly for quality, fair pay and resilience than a change of ownership alone.[65] Responsible-capital regulation should complement that work, not substitute for it.

13. Implications for public debate

The evidence in this paper has implications for how the government, providers, and reform advocates conduct the public debate. The aim should not be to defend profit in the abstract, but to acknowledge legitimate concerns, describe the financing choices honestly and test competing proposals against their effects on people, workers, capacity and continuity of care.

[65] Townson, J.K. (2026). *Homecare: commissioning is the key to quality, fair work and better outcomes*. Homecare Association.

13.1 Acknowledge the legitimate grievance and identify the harm

Concern about making money from poor care, unfair employment, or financial arrangements that weaken services is legitimate. The debate becomes more useful when that concern is translated into identifiable harms: excessive leverage, unsustainable rents, opaque related-party payments, tax avoidance, poor employment practices, inadequate reinvestment, and poor-quality operations. Each can then be measured and addressed across ownership models.

13.2 Connect finance with capacity, people and continuity

Financial structures should be explained through their practical consequences. The questions are who will build and modernise the care homes an ageing population needs; who will fund workforce systems and technology; whether financial commitments remain sustainable when fees or occupancy change; and how continuity will be protected if an operator or landlord fails.

13.3 Describe the whole market, not only its largest groups

Public debate often concentrates on the largest groups and the most controversial structures. A complete account should also include the majority of small owner-operators who invested personal savings, family businesses, charities, housing associations, co-operatives, and employee-owned providers. It should nevertheless avoid using the diversity of the market to minimise documented risks among particular large or highly leveraged organisations.

13.4 Be candid about who pays

The Big Conversation suggests a tension among participants between support for universal care and willingness to adopt particular funding mechanisms. Ultimately, taxpayers, individuals, the public sector, businesses, or private investors must pay for quality care and the capital that supports it. Changing the ownership of provision reallocates those costs and risks; it does not remove them.

13.5 Include voices that are under-represented

The apparent under-representation of working-age adults and younger people in the engagement exercise merits active correction. The government and sector bodies should seek out people with learning disabilities, autistic people, people with acquired brain injuries or physical disabilities, unpaid carers, and younger workers. Their priorities may differ from those expressed in debates dominated by older people's care.

13.6 Test restrictions against a credible alternative

Any proposal for a profit or distribution cap should specify which return it caps, how it treats legitimate capital costs, how it measures compliance, and what behavioural

response it expects. It should then be compared with the responsible-capital framework: transparency, proportionate resilience oversight, scrutiny of leverage and related-party transactions, fair-employment conditions and adequately funded commissioning. The preferred option should be the one that addresses the identified harm with the least risk to capacity, diversity, and continuity.

13.7 A note on language

Language shapes the way people understand choices. Table 7 suggests a shift from defending categories of ownership towards examining outcomes, financing terms, and who bears the cost and risk. Readers should interpret it as guidance for a more precise debate, not as a set of campaign slogans.

Move away from	Move towards
Treating profit as inherently good or bad	Examining how returns are generated and what investment enables
Treating the largest groups as the whole sector	Describing market diversity while identifying structure-specific risks
Using ownership as a proxy for performance	Assessing outcomes, employment, and resilience across ownership models
Discussing finance without its practical consequences	Effects on people, the workforce, capacity, and continuity of care
Dismissing legitimate public concern	Identifying the harmful practice, its mechanism, and the proportionate response
Defending the status quo	Explaining how funding, commissioning, ownership and finance interact

Table 7. Reframing the public argument.

The purpose is to support a debate in which legitimate concerns about extraction can be addressed without obscuring the capital, recurrent funding, and organisational capability on which good care depends.

14. Conclusion

Debate about profit in social care is both inevitable and legitimate. It is weakened, however, when private investment is treated as a single category or every financial return as the same act. Adult social care is financed through founder equity, retained earnings, bank debt, bonds, property investment, pension and insurance capital,

private equity, charitable funds, and public money. Each creates different benefits, incentives, and risks.

The Homecare Association remains agnostic about ownership. Our tests are the quality and outcomes of care, fair treatment of staff, willingness to innovate and improve, financial resilience, and the responsible generation and use of returns. Ownership can affect incentives and risk and should inform scrutiny, but it is not a sufficient proxy for the performance of an individual provider.

If the government wishes to change the pattern of investment, it has options ranging from transparency and stronger resilience oversight to restrictions on particular structures or the removal of private profit. The earlier options are more readily targeted and involve less immediate disruption, although their effectiveness depends on design, enforcement, and adequate commissioning. More restrictive options require a funded plan for the capital, operating capacity, workforce, and continuity arrangements they would displace.

The most durable approach is a responsible-capital framework applied proportionately across ownership models. It should examine beneficial ownership, leverage, rents, related-party transactions, liquidity, reinvestment, employment and care outcomes, with enhanced oversight where risk is greatest. Coupled with adequate recurrent funding, fair commissioning and support for a plural market that includes co-operative, employee-owned, charitable, family and commercial provision, this offers a more precise response to public concern than either defending the status quo or prohibiting profit in the abstract.

Shaping homecare together

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