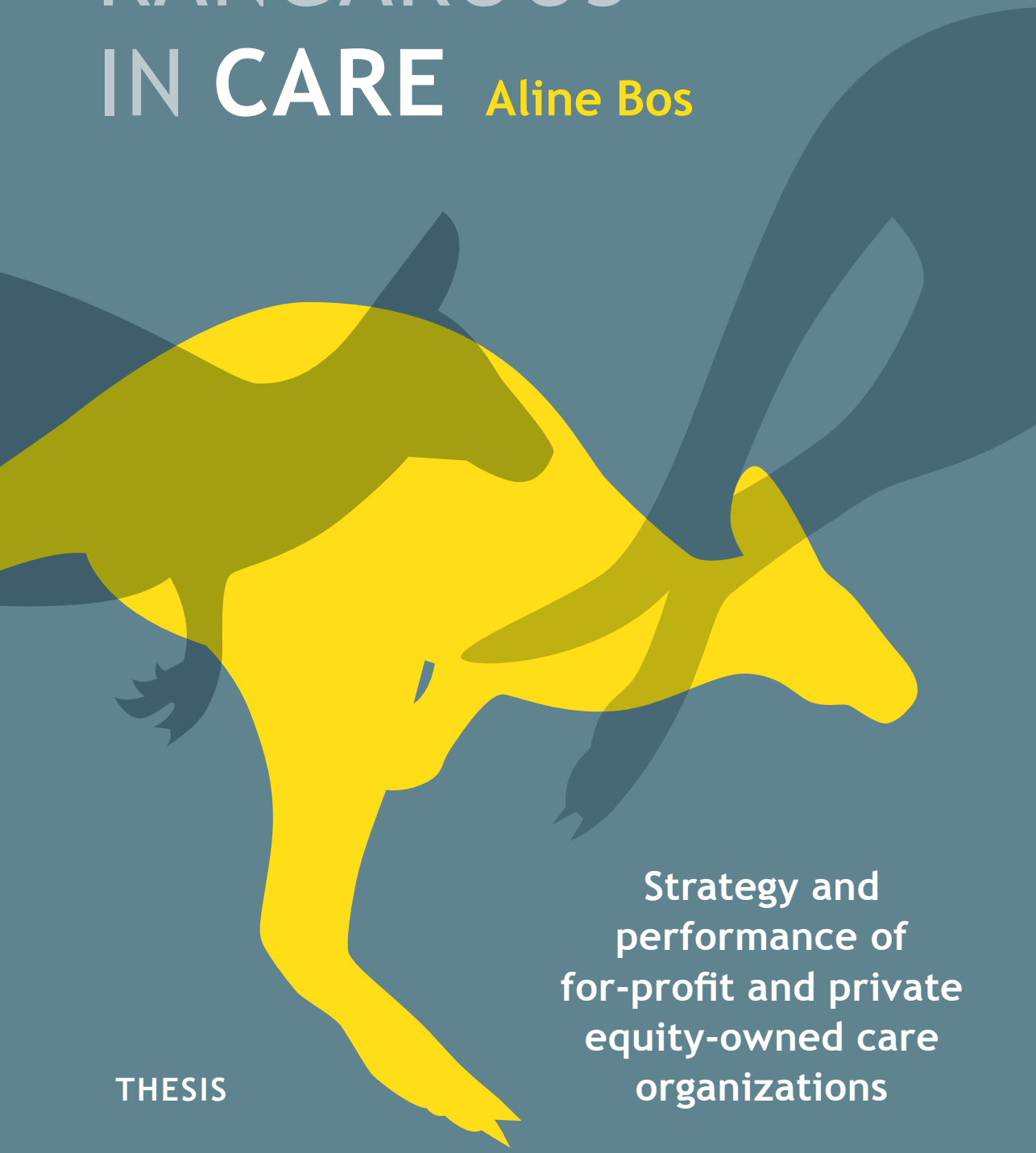
CORPORATE KANGAROOS IN CARE

Aline Bos



Strategy and performance of for-profit and private equity-owned care organizations

THESIS

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Corporate Kangaroos in Care

Strategy and performance of for-profit and private equity-owned care organizations

Corporate Kangoeroes in de zorg

Strategie en prestaties van commerciële zorgorganisaties, in het bijzonder zorgorganisaties die in handen zijn van private equity firma's

(met een samenvatting in het Nederlands)

Proefschrift

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ingevolge het besluit van het college voor promoties
in het openbaar te verdedigen op

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Aaltje Bos

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te Kootwijkerbroek

PROMOTORS

Prof. dr. J.P.P.E.F. Boselie
Prof. dr. M.J. Trappenburg

DOCTORAL COMMITTEE

Prof. dr. N. Bacon
Prof. dr. J.G. van Erp
Dr. J.K. Helderman
Prof. dr. G.C.M. Knijn
Prof. dr. M. Noordegraaf

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Introduction

1. INTRODUCTION

> *A baby kangaroo grows at a very high rate: from 1 gram at birth to 4-5 kilograms after 7 to 10 months. Eastern grey kangaroos keep on growing in adult life. They belong to the select group of animals with a capacity for indeterminate growth.*
> - Quesnel et al. 2018; Crusio 2014

> *Kangaroo hopping is the most efficient method of locomotion of all ground animals in the world, and it is extremely quiet. You would hardly notice a mob of kangaroos whooshing silently past you at top speed. An equivalent number or deer, which are similar in body sizes, would create quite a loud racket.*
> - Trishan's OZ 2019

The main question of this dissertation is *how for-profit and private equity-owned care organizations perform*. The wealth of for-profit owners is tied to the financial success of the organization in which they have ownership stakes (Ben-Ner & Ren 2008). Private equity ownership, then, is a particular type of for-profit ownership. Private equity firms own and trade unlisted, private companies with money from investors and banks. They seek to increase the financial value of the organizations they own, to realize a profit when they sell them in about three to seven years.

In the public debate, the profit-driven and unscrupulous behavior of private equity firms comes to the front. It leads to nicknames such as 'kings of capitalism' (e.g. Folkman et al. 2009), 'barbarians' (e.g. Koene & Boselie 2010), and 'locusts'. The 'barbarian' label was coined in the book 'Barbarians at the gate' (Burrough & Helyar 1989), about the take-over of the American biscuit and tobacco company RJR Nabisco by the private equity company Kohlberg Kravis Roberts (KKR). The RJR Nabisco story placed private equity in the corporate greed image of the 1980s. In 2004, the then German chairman of the Social Democratic Party Franz Müntefering introduced the notion of 'locusts' for private equity firms. Locusts have powerful hind legs which allow them to leap vigorously. Locust swarms can be plagues, devouring all the vegetation they encounter (National Geographic 2019). Just like locusts, private equity firms are 'falling on companies, and stripping them bare before moving on' (Economist 2019).

Private equity firms have their roots in the corporate United States (U.S.). In the 1990s and 2000s, the growing private equity industry broadened its scope to territories and to sectors that were previously 'unknown lands' to them (Figure 1.0). Private equity funds were flush with cash (so called 'dry powder') waiting to be invested. One of the sectors private equity firms increasingly laid their eyes on was healthcare. Healthcare deals by private equity jumped to a record. Nowadays, healthcare nearly represents 30% of all transactions by private equity deal count globally. About half of these deals is in the area of healthcare providers and related services (Bain & Company 2019).

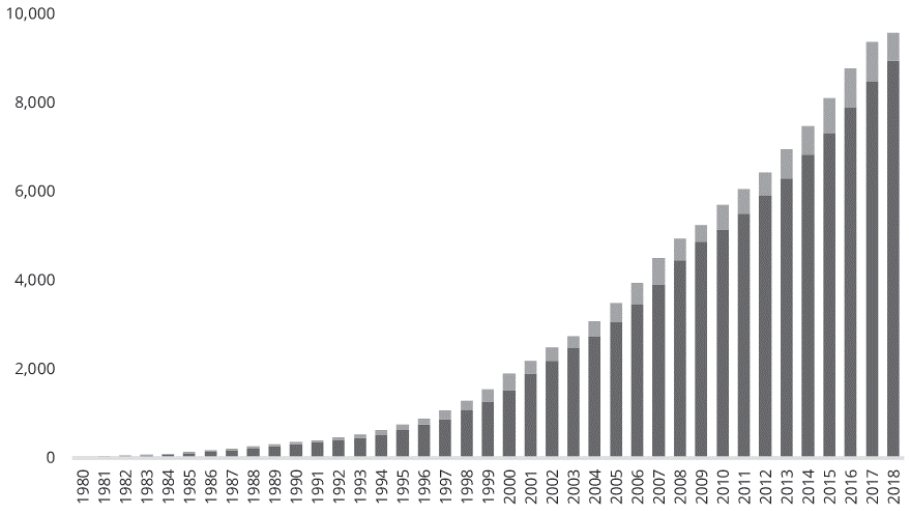

Figure 1.0 Number of private equity firms worldwide, over time (Source: Preqin 2019)

This dissertation focuses on the role of for-profit ownership in general and private equity ownership in particular, in organizations that provide care services. Most research in the dissertation is on nursing homes, while chapter 6 also reports on private equity ownership in child day care and home care. The evidence in care sectors led to an alternative metaphor for private equity firms: the corporate *kangaroo*. Just like locusts, kangaroos metaphorically hop from one organization to another. The rapid growth of the baby kangaroos resembles the dominant focus of private equity firms on increasing the size of the care organizations they own. Moreover, the relatively unfamiliar 'habitat' of care narrowed the corporate kangaroos' freedom of movement and increased financial risks. During profitable periods, then, the 'corporate kangaroos' whooshed almost silently past the organization's work floor employees and clients.

These ‘kangaroo’ conclusions are based on and further explained in the next chapters. This first chapter serves as a basis for the study. It outlines the neoliberalist trend of the past decades, which serves as an important background to the subject of this study (paragraph 1.1). Thereafter, different types of ownership are placed on a continuum of ‘commercialization’ (paragraph 1.2), and the multidimensional performance approach is introduced (paragraph 1.3). Finally, the sub questions that come with the main research question are presented, and the study outline is explained (paragraph 1.4).

1.1 STUDY BACKGROUND: NEOLIBERALISM

Some decades ago, the presence of private equity firms in care services would have been hardly conceivable, and a profit focus in nursing home care, home care or child day care would be frowned upon in many Western countries. Although the existence of private equity ownership in such sectors is still not very familiar to the wider public, the delivery of care services by for-profit companies is quite common nowadays. This change can be understood against the background of neoliberalism (e.g. Szebehely & Meagher 2018).

The shift to neoliberalism

In the 19th century, the prevailing liberal ethos in Europe and North-America favored minimal intervention by the state and maximal freedom for the market. However, this trust in the ‘magic of the market’ diminished hugely after the economic Great Depression of the 1930s and the Second World War (Judt 2010; Kuttner 2018). The period of 1950-1970 was characterized by the ‘post-war consensus’ or ‘democratic capitalism’ (Reich 2008). This consensus consisted of a mixture of markets with state interventionism (a mixed economy), Keynesianism (a managed market economy, in which governments deficit-spent their way out of recessions), and a growing welfare state. In both the U.S. and Western Europe, a more or less oligopolistic system – with organizations led by ‘corporate statesmen’ – combined the thriving economy with a growing middle class. The growth of pay and benefits went in tandem with increasing productivity (Judt 2010; Kuttner 2018; Reich 2008). By some, this post-war period is referred to as a ‘Golden Age’ that was ‘marked by the expansion of public services, unemployment and old-age benefits, and an increase in real wage income’ (Muehlebach 2012: 5).

Nevertheless, declining economic growth, increasing unemployment, and rising levels of inflation in the 1970s tempered the 'Golden Age' enthusiasm. The post-war consensus, including its Keynesianism, seemed unequipped to deal with the economic issues. Moreover, shortcomings of the consensus-model came to the front: it did not provide the best value for money, innovation lagged, and stockholders were relatively passive (Reich 2008). The confusion and insecurity of those days opened up possibilities for the ever lingering ideas about capitalism. Liberalists argued that the length of the 1970s economic depression was caused by undesirable government intervention (Crouch 2011).

Support for this rehabilitation of the 'you can't beat the market' idea was legitimized by academics of the Chicago School, with spokesman and Nobel Prize winners Hayek and Friedman, the latter stating: '*The scope of government must be limited. Its major function must be to protect our freedom from both enemies outside our gates and from our fellow-citizens: to preserve law and order, to enforce private contracts, to foster competitive markets. Beyond this major function, government may enable us at times to accomplish jointly what we would find more difficult or expensive to accomplish severally. However, any such use of government is fraught with danger*' (Friedman 1962: 2). Large oligopolies teetered due to globalization and technological developments. There was no place for corporate statesmen anymore, because you 'fail as you try to become all things to all people' (Reich 2008: 76). In Europe, the fall of the Berlin wall in 1989 further boosted the idea that capitalist ideas were superior (Fukuyama 1992). Marketization seemed a universal panacea that was believed in by both left- and right-wing politicians; governments in both the U.S. and Western Europe undertook enormous efforts of deregulation and privatization.

The dominant theme of the new, neoliberal policy consensus was 'that free markets in which individuals maximize their material interests provide the best means for satisfying human aspirations, and that markets are in particular to be preferred over states and politics, which are at best inefficient and at worst threats to freedom' (Crouch 2011: vii). These *neo*liberal ideas differ from their liberalist origin, in the way that they give a much more sacrosanct status to the free market, pleading more radically for the prevalence of private interests over public interests instead of balancing them. The shift has been labeled as one from a market *economy* to a market *society*, in which free market principles are extrapolated to the entire society (Achterhuis 2010; Bloom 2017; Crouch 2011; Sandel 2000).

Neoliberalism's pervasiveness

After four decades, the popularity of the neoliberalist set of ideas seems to be waning. The financial crisis of 2007-2008 is often put to an example of what can go wrong due to deregulation and limited government control. To many, the free-market agenda has failed spectacularly. Neoliberal principles would erode the conditions for the survival of democracy (e.g. Brown 2015; Kuttner 2018; Reich 2008), and lead to the growing problem of concentrated market power (e.g. Stiglitz 2019).

Yet, despite loads of critique, neoliberalism is still alive and kicking, and 'if it will die away – if it ever happens – it will die very slowly' (Achterhuis 2000: 23). Crouch (2011: viii) even states that 'neoliberalism is emerging from the financial collapse [of 2007-2008] more politically powerful than ever. Whereas the financial crisis concerned banks and their behavior, resolution of the crisis has been redefined in many countries as a need to cut back the welfare state and public spending'. This dissertation is focused on aspects of the ongoing neoliberalist agenda that are still very relevant today: for-profit and private equity ownership in care service sectors.

1.2 COMMERCIALIZATION OF PUBLIC SERVICE DELIVERY

The object of study is the organization that delivers intimate types of care. Based on 'publicness' literature, nursing home care, home care, and child day care are regarded as *public* services (e.g. Bozeman 1987, 2007; Bozeman & Bretschneider 1994; Haque 2001; Moulton 2009; Perry & Rainey 1988). The delivery of these services depends for a vast amount on public funding, and all three services are subject to a high degree of government regulation and oversight. Furthermore, they can all be regarded as central to the daily lives of citizens depending on them. The nature of these services is ingrained with public value. Delivering these types of care means representing wider social impacts (Haque 2001; Coursey & Bozeman 1990).

Commercialization, then, is the extent to which organizations 'act businesslike' and are increasingly driven by monetary concerns (Goddeeris & Weisbrod 1998; Maier et al. 2016). The underlying rationale of commercialization is the impact of competition based on financial performance. The commercialization of *public* services is part of a debate about the applicability of such competition in public

service sectors and of the ultimate effect of such competition. While the proponents of increased commercialization claim that it comes with more efficiency, reduced public spending, greater responsiveness to customer needs, and higher quality, opponents argue that such commercialization instead leads to higher costs, inequality between citizens with different resources, and lower quality, because commercialization increases the risks of skimping – the cutting back on hard to observe quality aspects (Haque 2001; Hodge 2000; Kitchener et al. 2008; Petersen & Hjelmar 2014; Weech-Maldonado et al. 2012).

After several decades of neoliberalism, commercialization is omnipresent in organizations providing public services. Such commercialization becomes apparent, among else, in the types of ownership of organizations that deliver care services. It makes the subject for-profit and private equity-owned care organizations part of the often very ideological debate. 'Many arguments for and against for-profit provision (…) rest on theoretical claims about *ideal typical* behaviors and organizations. Yet whether or not organizational form makes a difference (…) is an empirical question' (Meagher & Cortis 2009: 25). This study therefore provides empirical evidence on the for-profit (private equity) form of ownership of care organizations.

In the following subparagraphs, the different types of ownership – government (public), non-profit, for-profit and private equity – are placed on the scale of commercialization (Figure 1.2a). Private equity ownership is regarded as the ultimate form of commercialization in public services.

Public organizations acting business-like

For public services, New Public Management (NPM) ideas became relevant in the 1980s. Neoliberalism formed the ideological and theoretical foundation for this NPM paradigm (Petersen & Hjelmar 2014). Efficiency, results orientation, customer orientation and value for money were placed on the agenda of administrative reform (e.g. Hood 1991; Hood & Peters 2004; Pollitt 2000). The traditional paradigm of public administration was regarded too weak and bureaucratic in its service provision (O'Flynn 2007; Pollitt & Bouckaert 2004). In their bestseller *Reinventing Government. How the Entrepreneurial Spirit is Transforming the Public Sector,* Osborne and Gaebler (1992) introduced a new style of government organizations using apparently universal business techniques.

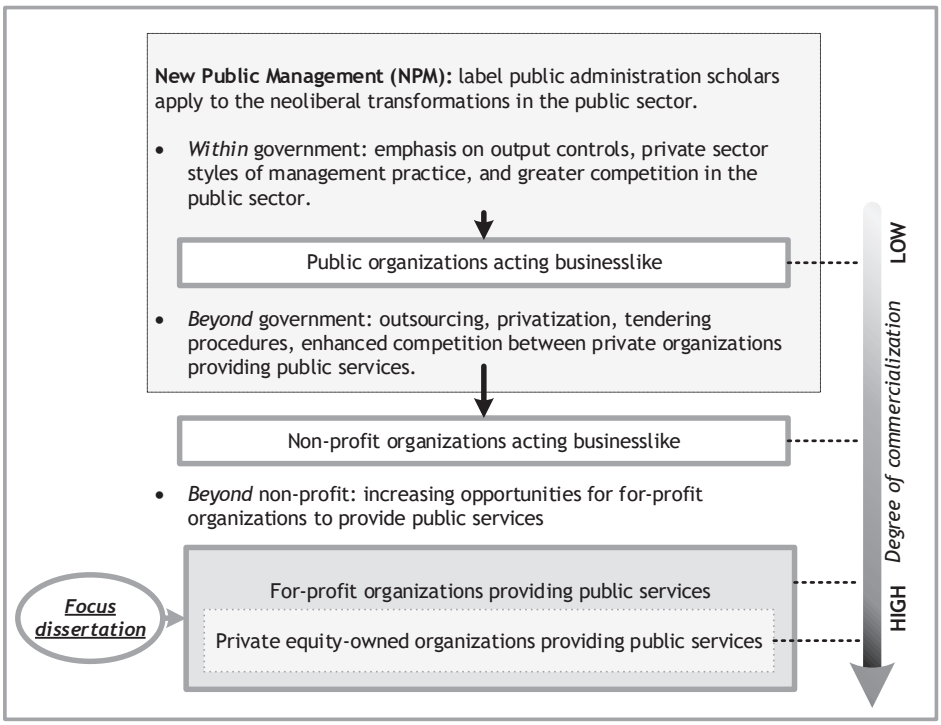

Figure 1.2a Degree of commercialization per ownership type

The neoliberalist New Public Management also heralded an era of privatization, tendering procedures for public services, and outsourcing. Finding an appropriate balance between public and private provision of services was a dominant theme in public management since the 1980s (e.g. Bøgh Andersen & Blegvad 2006; Crouch 2011). Within the NPM paradigm, the balance shifted more and more to the private provision of public services, and to increased competition between private providers of public services, being both non-profit and for-profit. Public responsibility for regulation and financing of public services did no longer necessarily imply public production and ownership (Petersen & Hjelmar 2014).

Non-profit organizations acting like for-profit organizations

The types of services under study (nursing home care, home care, child day care) have traditionally been provided by private non-profit organizations (e.g. Bode 2006; Buhler-Wilkerson 2007; Evers & Laville 2004; Gray 1986). 'Private' here refers to the legal type of the provider, which is for example a foundation. 'Non-profit' refers to the fact that the surplus of the revenues of the organization is used to achieve the objective of the organization and is *not* used to distribute income to

the organization's shareholders or leaders. The incentive to maximize this surplus (or: profit) for a personal gain is therefore absent. 'The individuals who control non-profit organizations have no legal ownership stakes' (Ben-Ner & Ren 2008: 2). Non-profits perform the kind of public-type functions typically identified with government – such as helping the disadvantaged, and providing care services.

Weisbrod (1998: 1) describes a 'massive change' in the non-profit sector: 'Seemingly isolated events touching the lives of virtually everyone are, in fact, parts of a pattern that is little recognized but has enormous impact; it is a pattern of growing commercialization of non-profit organizations' (cf. Kerlin & Pollak 2011; Maier et al. 2016). Based on a systematic review of the literature, Maier et al. (2016: 64) observe that non-profit organizations have undergone remarkable changes since the 1980s, that made them more similar to for-profit enterprises. These changes include 'the growing use of more calculable, rational tools and procedures' (Hwang & Powell 2009: 292), and an increased emphasis on efficiency and effectiveness (Meyer et al. 2013).

For-profit and private equity-owned organizations providing public services

'Moving services from private non-profit ownership to private for-profit is expected to expose suppliers to greater competitive pressures' (Petersen & Hjelmar 2014: 6) – and therefore increased commercialization. Goddeeris and Weisbrod (1998: 2015) regard the conversion of non-profit organizations to the for-profit form as 'commercialism carried to an extreme'. Although the provision of care services by for-profit organizations is nothing new (e.g. Gray 1986), its rising share in many Western countries is (Barron & West 2017; Cabin et al. 2014: Genet et al. 2011; Karsio & Anttonen 2013; King & Meagher 2009; Meagher & Cortis 2009; Mercille 2018, Mukamel et al. 2014; Stolt 2011; Winblad et al. 2017; see also chapter 4 in this dissertation).

Moreover, the possibility to earn a profit by delivering public services 'opens the barn door' for private equity firms. In other words: once the role of for-profit ownership increases in sectors providing public services, private equity ownership automatically becomes a possibility. Private equity firms are a specific type of for-profit ownership. Around the year 2000, private equity firms began playing a more prominent role in care sectors, especially in U.S. nursing homes (e.g. Cadigan et al. 2015; Harrington et al. 2012). More recently, private equity became more common in other care sectors and in other Western countries as

well (e.g. Harrington et al. 2017; Holly 2018; Ivory et al. 2016; Meagher et al. 2016; Winblad et al. 2017).

A private equity company owns and trades unlisted, private companies. It creates one or more funds that obtain capital commitments from investors such as pension funds, insurance companies, or wealthy individuals – the so-called 'limited partners'. Using the fund's capital, along with a loan commitment, the private equity company acquires organizations (portfolio companies). Private equity firms generally work with a three to seven year exit horizon (NVP 2019); the portfolio company will be sold within that timeframe. During this period, the private equity owner seeks to increase the financial value of the portfolio organization, to realize a profit when it sells the company. The profits in case of such an exit are distributed among the fund investors (usually 80%) and the private equity firm (usually 20% of the profits, often after a hurdle rate of 8%). Furthermore, private equity firms charge a management fee to the limited partners for managing the fund (usually 1-2% of the money put in) and can also charge fees for consultancy and management services to the portfolio company (Figure 1.2b).

The central investment strategy of private equity firms is the buyout, in which the private equity company is majority or full owner of its portfolio organization. In most cases, the private firm gets actively involved in the operations and strategy of its portfolio companies and puts management efforts into supporting them (Strömberg 2009). In addition, private equity firms try to overcome principal-agent problems (Jensen 1989) by encouraging portfolio company management to act in shareholders' interests through equity incentive schemes. Private equity representatives also take roles on the supervisory boards of portfolio firms and often have a dominant role in appointing new executives (Bacon et al. 2013).

When compared to 'regular' for-profit ownership, private equity ownership of organizations delivering public services means a further increase of commercialization (Figure 1.2a). Private equity firms act in the purest of markets; they have a stronger focus on financial performance and efficiency than other for-profit organizations (Jenkinson et al. 2016; Wright et al. 2009). Their business model aims at financial returns for the limited partners as well as the general partners of the private equity firms – within a demarcated time frame and often using high levels of leverage (Burns et al. 2016; Duhigg 2007; Froud & Williams 2007; Palepu 1990). This 'pure form of capitalism' (Financial Times 2005) therefore serves as the ultimate illustration of what neoliberal ideas of 'business-like' operating entail in sectors providing public services.

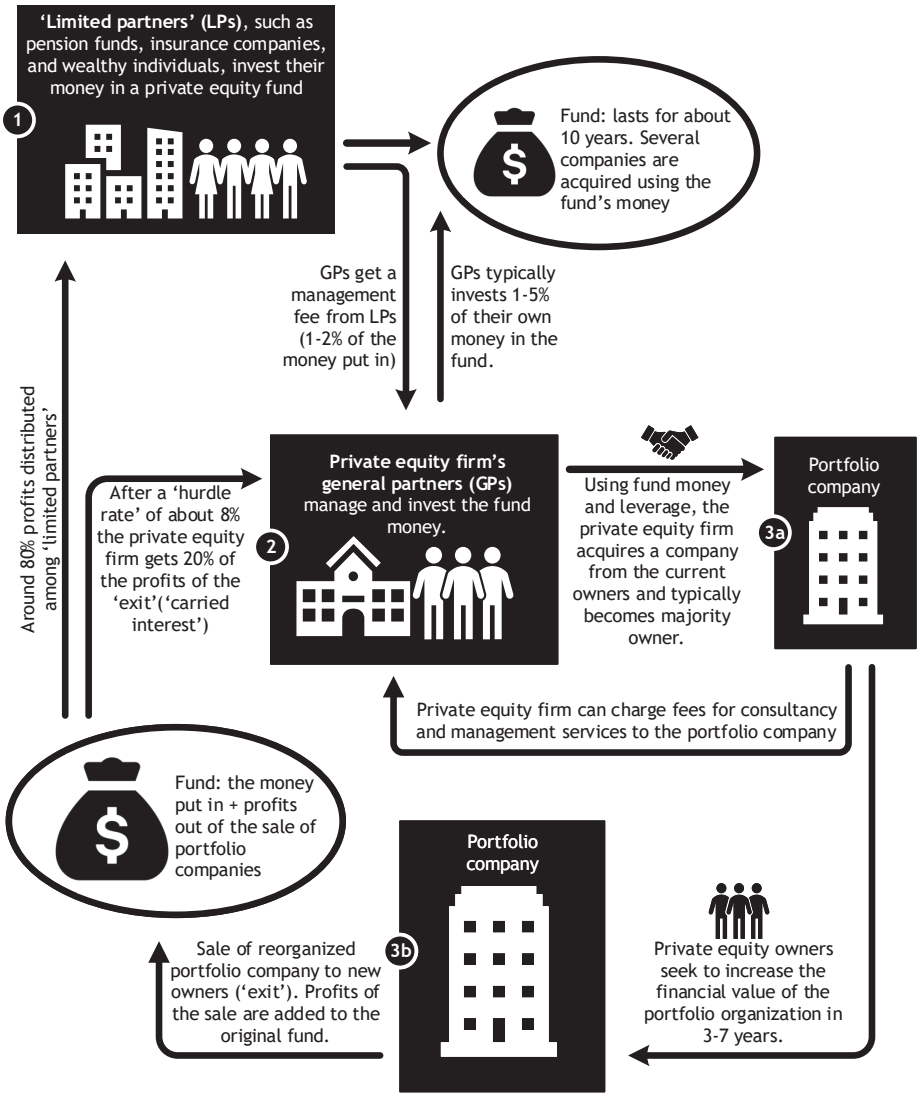

Figure 1.2b The business model of private equity firms

In short, the commercialization of organizations providing public services differs per type ownership type. Commercialization increases from public (government) organizations, to private non-profit, to private for-profit, with private equity ownership as the ultimate form of commercialization. It was also noted that the level of commercialization has risen *within* each type of ownership over the past decades. This study concentrates on the higher end of the commercialization continuum: for-profit and private equity ownership of organizations providing care services (Figure 1.2a).

The size of private equity
The four biggest private equity firms worldwide are Blackstone (New York), The Carlyle Group (Washington DC), KKR (New York), and CVC Capital Partners (London). These private equity firms raised enormous amounts of funds in the past five years, up to 82,9 billion dollars (PEI 2019). Although these four private equity firms employ only about 6.000 people, the economic value of the businesses held by their funds is far greater. For example, the 275 companies in Carlyle's portfolios employ about 725.000 people. KKR is shareholder of about 115 companies where about 720.000 employees work. It makes both Carlyle and KKR 'bigger employers than any listed American company other than Walmart'. In general, private equity-backed companies account for 23% of America's midsized companies and 11% of its large companies (The Economist 2016). 'In the U.S. alone, private equity firms are estimated to employ nearly 9 million people when their portfolio companies are aggregated' (EY 2019: 5).
In the Netherlands, private equity firms also have a large share in the economy. They own about 1.400 portfolio companies with a total of 380.000 employees. The combined turnover of these portfolio companies is about 87 billion euros, equal to 14% of the Dutch gross domestic product (NVP 2019).

1.3 MULTIDIMENSIONAL PERFORMANCE AND STRATEGY

The central question in this dissertation is *how* organizations that provide public services and that operate at the high end of the commercialization continuum *perform*? Performance is viewed as a multidimensional construct, incorporating variables that are relevant to the *primary* stakeholders *within* the organization: shareholders (owners), employees, and clients (cf. Hillman & Keim 2001). It considers organizational performance, employee well-being, and client well-being as the central dimensions of performance.

By placing the outcomes for these stakeholders at the center of the study, this dissertation builds on ideas from stakeholder theory. As neoliberalism gained ground in the late 1970s and early 1980s, so did stakeholder theory at that time. The theory was presented as a new conceptual model to understand how businesses operate; it originates from scholarly work on 'business ethics' and 'social corporate responsibility'. Stakeholder theory counteracts the idea that business and ethics are two separate domains, and that business decisions do not have any ethical content. The theory is often viewed as a way to solve 'the problem of the ethics of capitalism' (Freeman et al. 2010: xv).

Stakeholder theory is traditionally interpreted as the opposite of shareholder theory. While the shareholder approach focuses on maximizing returns to the owners of capital (i.e. the shareholders), the stakeholder theory proposes that all stakeholders should be treated like shareholders (Boatright 2006). Stakeholder theory raises questions such as for whom value is created or destroyed by busi-

ness decisions, that is, who is harmed or benefitted by decisions (Freeman et al. 2010; Freeman 1994). The fundamental distinction between shareholder and stakeholder theory is that the last 'demands that the interests of *all* stakeholders be considered, even if it reduces company profitability' (Smith 2003: 86). Stakeholder interests are considered as an *end* in themselves. The focus is on relational rather than transactional interactions (Hillman & Keim 2001; Smith 2003).

However, several proponents of the shareholder theory argue that the presentation of the stakeholder approach as an alternative to the shareholder approach is false; stakeholder management rather complements the shareholder approach (e.g. Boatright 2006). Stakeholder management is a means to the end of profitability (Smith 2003: 87): the only way to maximize value sustainably is to satisfy stakeholder interests. It is claimed that Friedman, one of the icons of neoliberalism, perceived stakeholder management not so much as social responsibility, but rather as the very basis of capitalism (Freeman et al. 2010; Hillmer et al. 2001). Even Henry Kravis, co-founder of one of the world's leading private equity firms (KKR), claims that 'you have to focus on all stakeholders. It's a new thing to us and something we're really hammering. Long-term value is only achieved if growth benefits all stakeholders in a company' (Kravis 2008, in: Freeman 2010: 28).

These competing views can be labelled as the 'mutual gains perspective' and the 'conflicting outcomes perspective' (cf. Van De Voorde et al. 2012). The 'conflicting outcomes perspective' emphasizes trade-offs between different dimensions of performance; it regards the outcomes for different stakeholders as a 'zero-sum game' (e.g. Smith 2003; Duhigg 2007). In contrast, the 'mutual gains perspective' assumes that the outcomes for the different stakeholders will reinforce each other in the same positive or negative direction (e.g. Boatright 2006; Freeman et al. 2010; Hillman & Keim 2001).

By applying the multidimensional performance approach, this study adds empirical evidence on what the role of commercial providers of public services means for different stakeholders. The dimensions of organizational performance, employee well-being, and client well-being are defined very broadly, as the operationalization is partly driven by the availability of data (details on the broad definitions of the dimensions as well as the operationalizations can be found in appendix E). This multidimensional performance approach is supplemented with the strategies executed in the care organizations. Corporate strategy is the 'pattern in a stream of decisions' over time, which is a combination of deliberately planned change by

top management and emergent events imposed by environmental forces (Mintzberg & Waters 1985). In this way, a better understanding of *how* performance gets created becomes possible.

1.4 RESEARCH QUESTIONS AND STUDY OUTLINE

Against the background of the ongoing pervasiveness of neoliberal ideas, this dissertation studies the performance of for-profit and private equity-owned care organizations. The shift from non-profit to for-profit ownership, as well as from 'regular' for-profit to private equity for-profit ownership is conceptualized as a rising level of 'commercialization': the extent to which organizations 'act businesslike'. Commercialization is studied in care organizations: nursing home care, home care, and child day care. These sectors are of particular relevance with regard to the subject of the study. The commercialization of care – at least in the Netherlands – is a relatively recent development in the broad neoliberal trend. It only started in the 1990s, after the fall of the Berlin wall, and was still considered undesirable a decade before (Heijne 2018). The reservations regarding commercialization of care show the sensitivity of the subject, as care is about intimate services that come with intensive interaction with and emotional attachments to clients (e.g. Rodriguez 2014). The fear for a dominant focus on profits in care, at the expense of employee and client well-being, leads to vigorous debates and underscores the need for a multidimensional performance approach. The elements of commercialization, multidimensional performance and strategy are combined in the main research question: *How do for-profit and private equity-owned care organizations perform?* The 'how' in the research question refers to the strategies that are executed by private equity owners in care organizations.

The following sub-questions are used to further structure the study:

1. *What is the state of knowledge on the performance of for-profit and private equity-owned care organizations (i.e. nursing home care)?*
2. *What strategies are executed by private equity owners in care organizations?*
3. *What is the organizational performance of private equity-owned care organizations?*
4. *What is the performance of private equity-owned care organizations with regard to employee and client well-being indicators?*

Figure 1.4 shows the overall research model.

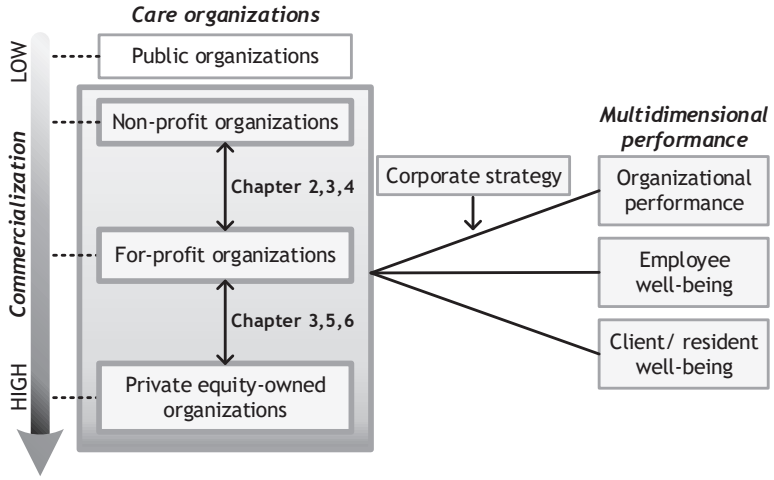

Figure 1.4 Research model

To answer the research questions, the first chapters in this dissertation apply a broad focus by including a large amount of care organizations. In chapter 2, a systematic review of the empirical evidence on for-profit nursing home ownership provides a basis for understanding what a profit status means for different stakeholders. It applies the multidimensional performance approach by analyzing financial performance, employee well-being and client well-being of for-profit nursing homes in comparison to their non-profit counterparts. The bulk of evidence on for-profit nursing homes is based on studies from the U.S. Chapter 3 adds insights on private equity ownership as a particular form of for-profit ownership. It synthesizes two systematic literature reviews on the impact of private equity across sectors (appendix C) and for-profit nursing homes (chapter 2). The combined reviews lead to propositions on the impact of private equity in care services. Chapter 4, then, focuses on the Dutch nursing home sector. The for-profit nursing home market in the Netherlands has been lagging behind in comparison to other Western countries, but is currently gaining ground. This cross-sectional study describes this emergent for-profit nursing home industry, and identifies factors that contribute to its growth. The following chapters switch from a broad focus to an in-depth focus; chapters 5 and 6 present three longitudinal case studies on private equity-owned care organizations (nursing home care, home care, and child day care). Finally, chapter 7 gets back to the kangaroo metaphor at the start of this introduction, and presents the main conclusions and implications of the study.

Table 1.4 Overview research questions and publication status of the separate chapters

Ch.	Title	Research questions and publication status
1	Introduction	-
2	Financial performance, employee well-being, and client well-being in for-profit and not-for-profit nursing homes: A systematic review	RQ1: Wat topics have been studied with regard to financial performance, employee well-being, and client well-being in relation to nursing home ownership? RQ2: What are the outcomes of these topics for financial performance, employee well-being, and clients well-being, and how are these outcomes related to each other? Published in *Health Care Management Review*
3	Just another business? Private equity in health services	RQ1: What makes health services (not) 'just another business'? RQ2: What impact of private equity in health services can be expected, based on a review of both private equity and nursing home literature? Published in *The Routledge Companion to Management Buyouts*
4	For-profit nursing homes in the Netherlands: what factors explain their rise?	What is the current status of the Dutch for-profit nursing home sector, and what factors stimulated its expansion? Published in the *International Journal of Health Services*
5	What happens to a nursing home chain when private equity takes over? A longitudinal case study	What happens to a nursing home chain when private equity takes over? Published in *INQUIRY*
6	What happens when private equity takes over? Two case studies in social care organizations	What happens to care organizations when private equity takes over? Under review at a peer reviewed journal
7	Conclusions and Discussion	How do for-profit and private equity-owned care organizations perform?

Table 1.4 provides an overview of the chapters and their respective research questions. The dissertation is based on journal articles, hence there is some overlap in the introduction and literature paragraphs of the chapters. Moreover, although the order in the collection of articles in this dissertation shows a certain logic, the overall structure of the dissertation rather emerged after conducting the separate studies than that is was determined at the start of the research process. The dissertation should therefore not be read as a monograph, but rather as a bundle of separate articles about a similar subject. In addition, the format of the chapters differs somewhat, as they were shaped for different academic outlets.

Some articles have multiple authors. Detailed information on the contribution of the PhD-candidate and co-authors is therefore provided in appendix F. The PhD-candidate was the lead author in all the articles.

2

Financial performance, employee well-being, and client well-being in for-profit and not-for-profit nursing homes: A systematic review

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ABSTRACT

Background: Expanding the opportunities for for-profit nursing home care is a central theme in the debate on the sustainable organization of the growing nursing home sector in Western countries.

Purposes: We conducted a systematic review of the literature over the last ten years in order to determine the broad impact of nursing home ownership in the U.S.. Our review has two main goals: (1) to find out *which topics* have been studied with regard to financial performance, employee well-being, and client well-being in relation to nursing home ownership; and (2) to assess *the conclusions related to these topics*. The review results in two propositions on the interactions between financial performance, employee well-being, and client well-being as they relate to nursing home ownership.

Methodology/Approach: Five search strategies plus inclusion and quality assessment criteria were applied to identify and select eligible studies. As a result, 50 studies were included in the review. Relevant findings were categorized as related to financial performance (profit margins, efficiency), employee well-being (staffing levels, turnover rates, job satisfaction, job benefits), or client well-being (care quality, hospitalization rates, lawsuits/complaints), and then analyzed based on common characteristics.

Findings: For-profit nursing homes tend to have better financial performance, but worse results with regard to employee well-being and client well-being, compared to not-for-profit sector homes. We argue that the better financial performance of for-profit nursing homes seems to be associated with worse employee and client well-being.

Practical Implications: For policymakers considering the expansion of the for-profit sector in the nursing home industry, our findings suggest the need for a broad perspective, simultaneously weighing the potential benefits and drawbacks for the organization, its employees, and its clients.

Keywords: systematic review; nursing homes; for-profit; performance; well-being

2.1 INTRODUCTION

A nursing home is viewed as a place of residence for people who require round-the-clock nursing care and have significant difficulty coping with the required activities for daily living. In the U.S., over half of all nursing home residents are aged 85 or older. Nursing home residents suffer from a wide array of physical or mental disorders, and the majority can be considered as long-term care patients: they will never recover to the point where they can take care of themselves (Sengupta et al. 2015).

The demand for nursing home care is likely to grow. The number of people in the 80 years and above category is growing faster than any other segment of the population. The European Union (EU) forecasts that public expenditure on long-term care will almost double by 2060 in its member states (European Commission 2012: 197, 224). Likewise, the number of people using long-term care services in the U.S. 'is projected to increase from 15 million in 2000 to 27 million in 2050'. (U.S. Dept. of Health and Human Services 2013: 3). This growth poses challenges in terms of both costs and care quality with regard to the sustainable organization of the nursing home sector. A central question is whether nursing home care should be delivered by for-profit or by not-for-profit providers.

In Western countries, long-term care for frail elderly people is delivered through a mix of for-profit and not-for-profit facilities. In the United States, 68% of all nursing homes are for-profit (U.S. Dept. of Health and Human Services 2013). In the U.K., 42% of the major care home providers (i.e. those with three or more homes) for older and physically disabled people are for-profit, and 55% of all care home beds are in for-profit facilities (Forder & Allan 2011: 13). Eight of the ten largest U.K. care home providers are for-profit companies (Lakhani & Whittell 2012). In Canada, the mix of providers varies by province, with for example 52% for-profit nursing homes in Ontario, 30% in British Columbia, and 15% in Manitoba (McGregor et al. 2006). European countries also vary in the extent to which they allow or encourage for-profit nursing homes. In the Netherlands, for-profit nursing homes are not allowed although an exception is made for private, small-scale facilities. In Finland and Sweden, where nursing home care was traditionally run by the public sector, an increasing number of private for-profit providers have established themselves in the market (Heponiemi et al. 2014: 116).

Opinions differ strongly as to the desirability of extending the trend of growing for-profit nursing home care (e.g. Dyson 2014; GAO 2010; Sennero & Pollard

2014). The key difference between for-profit and not-for-profit nursing homes is in the identity of those who possess ultimate control over them: owners versus boards of trustees: 'the wealth of owners is tied to the financial success of the nursing home in which they have ownership stakes, whereas the individuals who control not-for-profit nursing homes have no legal ownership stakes' (Ben-Ner & Ren 2008: 2). If income exceeds operational costs, not-for-profit nursing homes typically put that 'profit' back into the facility. A for-profit provider may choose its own objectives, resources, and management perspectives, and this can affect the nursing home organization as a whole, its employees, and its clients. It is claimed that for-profit providers can contribute to leaner nursing home organizations and improved management control systems that will keep costs under control (e.g. Weech-Maldonado et al. 2012). for-profit providers may also feel pressure to compete on price and quality, and this may result in higher quality care that is also more efficiently organized (Konetzka 2009). However, for-profit nursing homes may favor financial returns for their owners over high quality care (e.g. Kitchener et al. 2008). If, as is likely, their management objective is to provide returns to investors, for-profit owners could prioritize profits over employee and client well-being (e.g. Harrington et al. 2000).

Given these uncertainties, we present a systematic review of the literature published between 2004 and 2014 on the role of nursing home ownership in the U.S. and compare evidence on for-profit and not-for-profit nursing homes in the private sector. We have focused on the U.S. because most studies on this topic relate to American nursing homes. We build on insights from the Human Resource Management (HRM) literature on multi-stakeholder perspectives by distinguishing relevant differences for the organization as a whole, its employees, and its clients (Beer et al. 1984). The main aim of this review is to qualitatively assess and summarize current evidence related to the effect of nursing home profit status by answering two research questions:

RQ1: What topics have been studied with regard to financial performance, employee well-being, and client well-being in relation to nursing home ownership?

RQ2: What are the outcomes of these topics for financial performance, employee well-being, and client well-being, and how are these outcomes related to each other?

Based on the findings, we offer two propositions on the interaction between financial performance, employee well-being, and client well-being as related to nursing home ownership.

Previous reviews of for-profit nursing home ownership have focused on the relationship between ownership and quality of care indicators (Comondore et al. 2009; Hillmer et al. 2005). Further, more than 80% of the articles used in these earlier reviews were published prior to 2004 meaning that these reviews are mainly based on publications that are now more than a decade old.

Our systematic review of the literature on for-profit and not-for-profit nursing homes makes two contributions. First, it updates the earlier reviews by assessing articles published between 2004 and 2014, with 72% of the articles reviewed here not having been included in previous reviews. Second, whereas previous reviews have concluded that for-profit nursing homes appear to provide lower quality care (Comondore et al. 2009; Hillmer et al. 2005), our systematic review synthesizes the accumulated evidence on a much broader spectrum of criteria. We regard care quality as just one of the possible indicators of client well-being, and also consider hospitalization rates and the incidence of lawsuits and complaints. Furthermore, we also include differences between for-profit and not-for-profit nursing homes with regard to financial performance and employee well-being. Our presumption is that there will be some kind of relationship between financial performance, employee well-being, and client well-being, although we are unsure as to the nature of that relationship. In addition, we include studies where the ownership status is the independent variable and others where ownership is a covariate.

2.2 THEORETICAL FRAMEWORK

We view nursing home performance as a multidimensional construct, incorporating variables that are relevant to various stakeholders (i.e. owners, employees, and clients). We build on HRM research, in which Beer et al. (1984) distinguish multiple stakeholders and define multidimensional performances for HRM policy and practice outcomes, including organizational effectiveness (e.g. financial outcomes), and individual well-being (e.g. satisfaction). Various scholars have stressed the need to balance a range of outcomes and, by treating nursing homes as social systems, we place the outcomes for the different stakeholders at the center of our study. Our premise is that performance is created in the way that

owners, employees, and clients are jointly affected by a nursing home's type of ownership (Freeman et al. 2010). Taking a broad perspective, this review explores whether positive outcomes for one stakeholder come at the expense of other stakeholders, or whether all can gain. We therefore introduce two competing perspectives derived from the literature on HRM and performance (e.g. Van De Voorde et al. 2012): the 'mutual gains perspective' and the 'conflicting outcomes perspective'.

Mutual Gains Perspective

The 'mutual gains perspective' holds that positive/negative outcomes for one stakeholder are accompanied with similar outcomes for other stakeholders. For example, if nursing homes provide inferior care quality, this is accompanied by a poor financial outcome. This 'mutual gains perspective' states that the outcomes on different dimensions reinforce each other in the same direction. Recognition of this perspective is seen in the expression 'doing well by doing good': paying attention to all stakeholders will benefit all stakeholders (Falck & Heblich 2007; Laszlo 2008). In this regard, for-profit nursing homes might function as not-**just**-for-profit homes and purposefully treat the multiple stakeholders in a balanced way because this provides a win-win situation. Several studies in the area of HRM indeed highlight the possibility to create parallel positive outcomes for both employees and employers (e.g. Macky & Boxall 2007).

Conflicting Outcomes Perspective

Arguing from the alternative 'conflicting outcomes perspective', a skeptical view can be perceived of the concept of performance as a multidimensional construct. The conflicting outcomes perspective views the maximization of value for one stakeholder as not necessarily benefitting other stakeholders. Hence, the overall impact of a nursing home profit status may be a trade-off in terms of positive and negative outcomes for the different stakeholders. For example, if an for-profit nursing home adopts a profit maximization perspective – with a focus on economic efficiency, minimizing costs and maximizing profit for shareholders – this may well come at the expense of employee well-being (for example fewer staff and therefore higher work pressure), and client well-being (for example less activities and less time available for individual care). In comparison, not-for-profit facilities may emphasize public service values by prioritizing medical and personnel aspects of care, and by reinvesting their revenues back in the facilities (e.g. Haley-Lock & Kruzick 2008; Harrington et al. 2000; Heponiemi et al. 2011). The

broader HRM literature observes the possibility of conflicting outcomes related to employee well-being and financial performance. For instance, a high level of people orientation in leadership has been related to low financial performance (Van Veldhoven 2005), while aiming for high financial performance may come at the cost of intensified work and job strain for employees (Ramsay et al. 2000).

To summarize, the 'conflicting outcomes perspective' sees potential trade-offs in different dimensions of performance, whereas the 'mutual gains perspective' assumes that the outcomes for the different stakeholders will reinforce each other in the same positive or negative direction. By using a multidimensional performance construct, we explore which of these perspectives is most appropriate for describing the impact of for-profit ownership in comparison to not-for-profit ownership of nursing homes.

2.3 METHOD

Our systematic review of the literature is based on the replicable and transparent steps specified in the PRISMA method (Liberati et al. 2009). The PRISMA checklist in Appendix B records how we followed the required steps.

Data Sources and Searches

The Picarta, Scopus, Pubmed, Google Scholar, and Web of Science databases were searched for relevant studies. The searches were conducted in January 2015. The references of retrieved articles were manually searched for further material. The terms searched for in titles and abstracts were: "healthcare / health services AND ownership", "for profit nursing home", "investor-owned AND healthcare", "profit AND healthcare" and "ownership conversion AND healthcare".

Inclusion Criteria

We used six inclusion criteria in selecting or rejecting studies identified in the database searches. First, they had to be in English. Second, we only included studies that were published between 2004 and 2014. Third, we only reviewed studies that were published in peer-reviewed journals. Fourth, we only selected studies that included U.S.-based research. Fifth, studies had to be empirical, and we excluded commentaries, reviews, and theoretical analyses. Sixth, studies had to have investigated the differences between private for-profit and private

not-for-profit nursing homes in terms of variables that were relevant to financial performance, employee well-being, or client well-being. Only studies that satisfied all six criteria were included in the review.

Variables

The central variable is the profit status of nursing homes. We study whether a nursing home's profit status influences the variables that emerge from our review. These variables are categorized into the dimensions of 'financial performance', 'employee well-being', and 'client well-being'.

Nursing home profit status. Generally, three types of ownership can be distinguished within the nursing home industry: public, private for-profit, and private not-for-profit. Our review focuses on the differences between private for-profit and private not-for-profit nursing homes. Several of the studies we reviewed also included public facilities in their sample. As our focus is on the difference between private for-profit and private not-for-profit nursing homes, we excluded the results for public homes from our analysis. We did this for three reasons; first, the nature of many public nursing homes is distinct from that of private ones. Public facilities are often linked to particular populations (e.g. military veterans) or serve as a safety net (e.g. many city or county facilities) (Grabowski et al. 2013: 15). Moreover, there are relatively few public nursing home facilities in the U.S. (6.8%: U.S. Department of Health and Human Services, 2013). Second, the available evidence pushes us in this direction since the majority of studies (57% of the studies included in our review) treat ownership as a dummy variable (for-profit versus not-for-profit). Third, the studies that do include public homes as a separate category mainly show that the results of for-profit nursing homes can be contrasted with those of not-for-profit *and* public nursing homes (Amirkhanyan et al. 2008; Dobalian 2004; Grabowski & Angelelli 2004; Grabowski & Castle 2004; Haley-Lock & Kruzich 2008; Mueller et al. 2006; Park & Stearns 2009; Seblega et al. 2010; Zhang et al. 2008; Zinn et al. 2005). Another subset of the studies that distinguish public homes do not report results for this specific category (Akinci & Krolikowski 2005; Konetzka et al. 2004; Konetzka et al. 2006). The number of studies that report differences between not-for-profit and government facilities in comparison to for-profit homes is relatively small (Bardenheier et al. 2005; Grabowski et al. 2004; Konetzka et al. 2004; Zhang & Grabowski 2004). For these three reasons, we treat the profit status of a nursing home as a dummy variable.

Financial performance. Financial performance covers variables that affect the performance of the organization as a whole, in our study the variables used address profit margins and efficiency.

Employee well-being. 'Ownership is an important structural factor to consider as an influence on human services job quality because of its presumed relationship to organizational goals and behavior' (Haley-Lock & Kruzich 2008: 448). We treat employee well-being as a broad concept that includes both subjective employee experiences (such as satisfaction) as well as objective measures of working conditions. In this area, the following variables emerged from our literature review: staffing levels, turnover rates, job benefits, and job satisfaction.

Staffing levels were mainly presented as hours per resident day, as an indicator of the time professionals have for carrying out their tasks in a fulfilling way. Several studies regard staffing levels as a structural measure of care quality (e.g. Hillmer et al. 2005). However, we treat staffing level as an employee well-being variable because: (a) research on the relationship between staffing levels and direct quality of care suggests analytical differences between them, for example in studying the impact of staffing on resident outcomes (e.g. Schnelle et al. 2004); and (b) the quality of nurses' working life is related to staffing levels with staffing adequacy having been directly related to work intensification and emotional exhaustion (Aiken et al. 2002; Laschinger & Leiter 2006). Turnover rates are an indicator of HRM practices, with long-term investments leading to lower turnover (Batt & Colvin 2011). Job benefits include salaries and staff training. In general, these variables have been related to job satisfaction (e.g. Harter et al. 2002), but job satisfaction is also included as a separate variable to reflect an employee's perceived well-being in terms of the job and working conditions.

Client well-being. We relate client well-being to direct care quality outcomes, hospitalization rates, and the rate of lawsuits and complaints. Care quality can be defined by clinical measures, such as the prevalence of catheter use, pressure ulcers, and use of anti-psychotic medication. A second dimension of care quality is the number of serious deficiencies identified in facilities that fail to meet the federal standards for Medicare and Medicaid participation. Deficiencies provide an overall measure of quality.

The second variable linked to client well-being is the number of hospitalizations linked to a nursing home. This is justified on the basis that the majority of hospitalizations are potentially avoidable (Givens et al. 2012). We have categorized

hospitalizations as a client well-being variable because hospitalization is likely to be physically and mentally stressful for frail elderly people living in nursing homes, and may result in a further decline in health and have limited clinical benefit. Most of the articles addressing this topic suggest a negative link between hospitalization rates and care quality.

Finally, we include the number of lawsuits and complaints as a client well-being variable and include articles that investigate their prevalence in for-profit and not-for-profit nursing homes as an indicator of client satisfaction. Figure 2.3 summarizes the indicators that emerge from our literature search for each dimension distinguished.

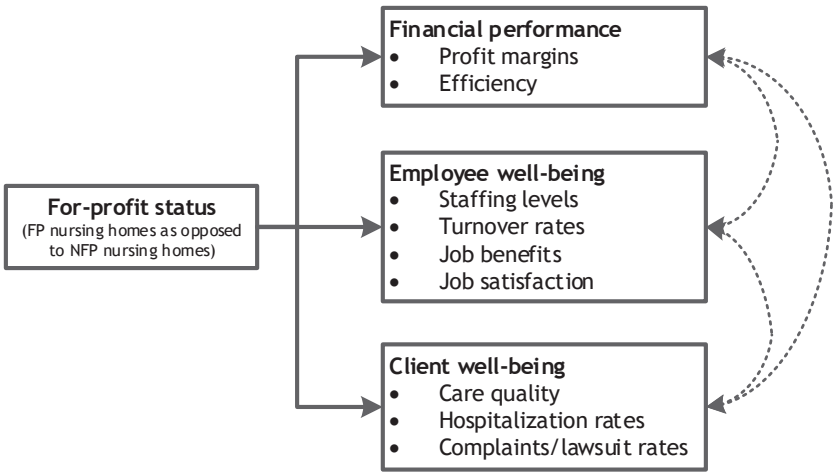

Figure 2.3 Conceptual Framework

We judge the outcomes on each dimension from the perspective of the relevant stakeholder (i.e. the organization as a whole, the employee, or the client). For example, higher profit margins are regarded from the organizational point of view as positive results, and higher staffing levels are evaluated from an employee perspective as positive.

Quality Assessment

In the final part of the review, we analyzed each study for its methodological quality using a quality assessment tool, to remove low quality studies. This tool uses eight criteria to assess three study aspects: design, sampling, and statistical analysis. The tool was adapted from an instrument developed by Cummings et

al. (2010) that has been used in earlier systematic reviews (e.g. Bronkhorst et al. 2014). Appendix A summarizes the quality assessment findings and provides the quality scores for the individual articles. We stress the findings of high quality studies in our findings.

Article Selection

The decision to include a study was determined in a three-step procedure. First, the bibliographic data and abstracts of retrieved studies were evaluated for concordance with the formal inclusion rules (the first four inclusion criteria). Studies that failed any criteria were discarded at this stage. The full texts of the 83 remaining studies were retrieved for critical appraisal. We then consulted senior scholars in the field to add to our list of relevant studies for the subsequent in-depth analysis. In the second step of the inclusion procedure, the full texts were checked against all six criteria and excluded if they did not satisfy all the criteria. In reviewing the full texts, studies were classified according to their focus into the 'financial performance', 'employee well-being', and 'client well-being' categories. We extracted the publication year and journal title, the country of origin, the methods used, and relevant findings and place this information in a database.

2.4 RESULTS

Search Results

The database searches yielded 2,028 potential articles. Another 58 studies were identified through the manual review of references, resulting in a total of 2,086 candidate articles (Figure 2.4a). Using the selection criteria, 83 of these studies were identified for full-text retrieval and in-depth study. Next, 11 additional articles were identified by six senior scholars in the field (see acknowledgements), leading to 94 full texts for in-depth review.

Of these, 27 were then rejected because they did not address the topic of our study (for example, focusing on variables such as nursing home market structure that transcended the organizational level) and six because they did not present empirical data (review articles etc.). We then applied the quality assessment tool (see Appendix A) to the remaining 61 studies and another 11 were excluded since they were rated as low quality. At the end of this process, 50 publications had therefore satisfied all the criteria and were included in the review.

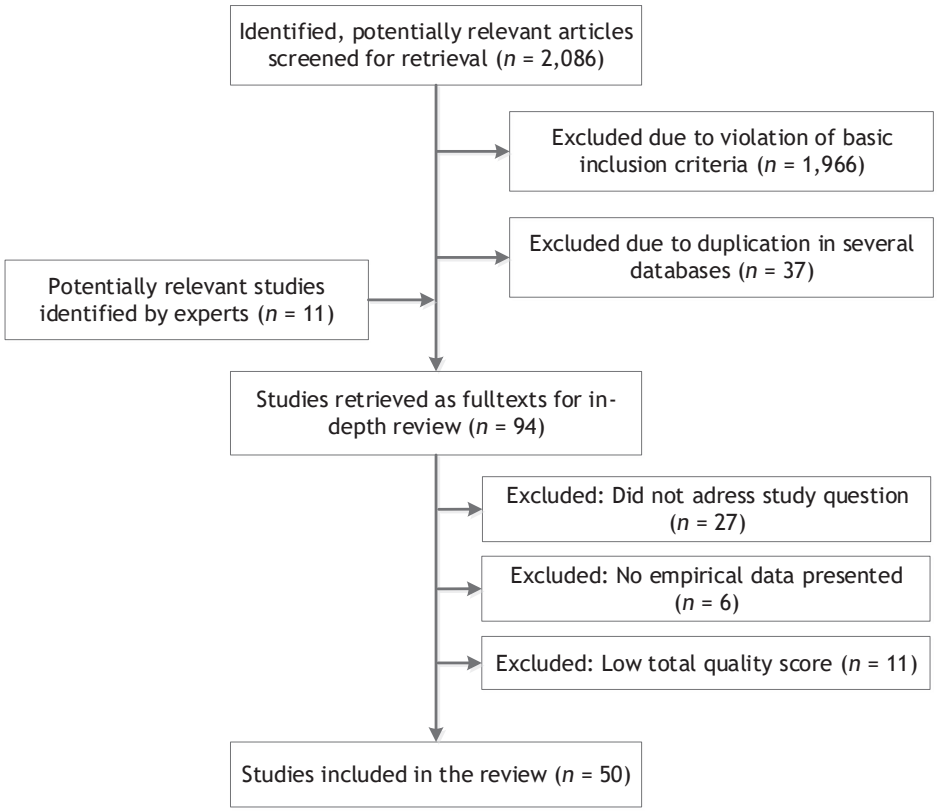

Figure 2.4a Flow Diagram for Search and Selection Processes

Having established our sample, we first considered some characteristics of the papers found. First, we noted a downward trend in the number of articles over time. The publications mostly reported quantitative studies, with only three studies combining quantitative and qualitative methods (see Table 2.4a). Twenty-nine of the included studies (58%) drew some of their data from the same data source, namely the Online Survey, Certification and Reporting (OSCAR) data network maintained by the Centers for Medicare and Medicaid Services (CMS) in cooperation with statewide long-term care surveying agencies. Only one study focused on financial performance and employee well-being variables simultaneously (Kash et al. 2007). Four others combined employee well-being and client well-being variables (Akinci & Krolikowski 2005; Decker 2006; Grabowski & Stevenson 2008, Konetzka et al. 2004). Thus, only 5 of the 50 studies (10%) have included variables related to more than one of the dimensions distinguished in this review.

Table 2.4a Details of the studies included in the review (*n* = 50)

Study Characteristic	Included Studies, *n* (%)
Type of empirical study	
Quantitative	47 (94%)
Quantitative and qualitative	3 (6%)
Design	
Cross-sectional	49 (98%)
Longitudinal	1 (2%)
Publication year	
2004-2006	28 (56%)
2007-2009	16 (32%)
2010-2012	3 (6%)
2013-2014	3 (6%)
Focus of article[1]	
Financial performance	6 (12%)
Employee well-being	18 (36%)
Client well-being	30 (60%)

1. Some studies focus on more than one variable, thereby covering more than one dimension. The total number of studies focusing on each of the three performance aspects is therefore higher than the total number of individual studies in the review.

In half of the studies reviewed, ownership was treated as an independent variable and, as such, the main focus. The other studies used ownership as a control variable (or covariate) and these are indicated by the superscript [c] in the tables (and listed below those adopting the independent variable approach). The proportion of for-profit nursing homes in the individual studies ranged from 44% to 86%, and the proportion of not-for-profit homes from 14% to 51%. The average split between for-profit and not-for-profit homes across all the samples was 69% – 29%, which is roughly in line with the 68% – 25% distribution of ownership types in the U.S. nursing home industry (U.S. Dept. of Health and Human Services 2013).

Profit Status And Financial Performance

Six of the studies (12%) included in the review focus on the differences in financial performance between for-profit and not-for-profit nursing homes (see Table 2.4b).

Profit margins. Two of these studies addressed differences in profit margin between for-profit and not-for-profit homes, and found that for-profit nursing homes have significantly higher profit margins (Kash et al. 2007; Weech-Maldonado et al. 2012). These are seen as robust outcomes since both studies control for relevant organizational and market level variables, such as chain membership, case-mix,

per capita income, and market competition, in determining the relationship between ownership and profit margins

Table 2.4b Details of Studies that assessed Financial Performance

Reference	Sample	Relevant findings: FP versus NFP nursing homes[1]
PROFIT MARGIN		
Kash et al. 2007, *Health Care Management Review*	1,014 Texas facilities	FPs: higher operating profit margins
Weech-Maldonado et al. 2012, *Health Care Management Review*	11,236 U.S. facilities	FPs: higher operating and total margins[3]
EFFICIENCY		
Lee et al. 2009, *Health Services Research*	107 Kansas and Missouri facilities	FPs: more efficient
Zhang et al. 2008, *Health Services Research* [c]	8,361 U.S. facilities	FPs: more efficient
OTHER		
Davis et al. 2009, *Nonprofit and Vol. Sector Quarterly*	134 Florida nursing home administrators	No differences in Entrepreneurial Orientation of FPs and not-for-profits
Givens et al. 2013, *Journal of the American Geriatrics Society*	4,177 U.S. nursing home residents with advanced dementia	FPs: more likely to refer to *skilled* nursing home (possibly because of financial considerations)

[1] FP refers to for-profit; NFP refers to not-for-profit
[c] refers to a study in which ownership is a covariate

Efficiency. Two of the other studies show that for-profit nursing homes have higher efficiency levels than not-for-profit ones (Lee et al. 2009; Zhang et al. 2008). The first of these controlled for quality variations, whereas ownership is only a covariate in the second.

Two other studies had findings that we link to financial performance. First, the study by Davis et al. (2009) shows no differences between not-for-profits and for-profits in the extent to which they can be associated with innovativeness, risk-taking, and proactiveness (i.e. entrepreneurial orientation). Second, the study by Givens et al. (2013) concludes that for-profit nursing homes are more likely to transfer their residents to skilled nursing units, and suggests that this is due to financial considerations with the Medicare payments for skilled nursing services much higher than the Medicaid daily rate for long-term nursing home care.

Overall, evidence on financial performance is relatively scarce. The few studies identified show that nursing homes with a for-profit status can be associated

with higher profit margins and higher efficiency levels. Further, although Davis et al. (2009) failed to find differences between for-profit and not-for-profit nursing homes with regard to their entrepreneurial orientation, Givens et al. (2013) suggest that for-profit homes do weigh financial considerations more seriously in their referral decisions than not-for-profit homes.

Profit Status and Employee Well-being

Eighteen out of the 50 studies reviewed (36%) include employee well-being variables (see Table 2.4c). The most prevalent variable used was staffing levels although turnover was also prominent. We also found some studies addressing job satisfaction and job benefits.

Table 2.4c Details of Studies that assessed Employee Well-being

Reference	Sample	Relevant findings: FP versus NFP nursing homes[1]
STAFFING (occupational categories: RN, LVN, CNA)[2]		
Grabowski & Stevenson 2008, *Health Services Research*	194,556 U.S. OSCAR surveys. 383,937 facility-quarter records	RN staffing levels decrease after conversion from NFP to FP
Kash et al. 2006, *The Gerontologist*	1,014 Texas facilities	FPs: lower staffing levels in each occupational category
Rantz et al. 2004, *The Gerontologist*	92 Missouri facilities	No significant differences in overall staffing levels
Seblega et al. 2010, *Medical Care Research and Review*	11,611 U.S. facilities	FPs: lowest mean values for all types of nursing staff and lower skills mix
Akinci & Krolikowski 2005, *Applied Nursing Research* [c]	90 Pennsylvanian facilities	FPs: lower staffing levels for each occupational category
Decker 2008, *Health Economics, Policy & Law* [c]	10,606 U.S. facilities, 21,212 observations	FPs: lower RN staffing levels
Feng et al. 2008, *Medical Care* [c]	9,996 U.S. facilities; 77,622 observations	FPs: lower staffing levels for each occupational category
Intrator et al. 2005, *The Gerontologist* [c]	17,635 U.S. facilities; 137,190	No differences with regard to employment of nurse practitioners and physician assistants
Konetzka et al. 2004, *Health Services Res.* [c]	60,283 surveys from 18,134 U.S. facilities	FPs: lower staffing levels (significant for RNs, RNs+LVNs, CNAs, $p < .001$)
Mueller et al. 2006, *The Gerontologist* [c]	14,147 U.S. facilities	FPs: significantly lower total, LVN, and CNA staffing levels

Table 2.4c Details of Studies that assessed Employee Well-being (continued)

Reference	Sample	Relevant findings: FP versus NFP nursing homes[1]
Park & Stearns 2009, *Health Services Res.* [c]	15,217 U.S. facilities; 55,248 facility-year observations	FPs: more likely to be low-staff facilities ($p < .01$)
TURNOVER		
Castle & Engberg 2006, *The Gerontologist*	854 facilities in Missouri, Texas, Connecticut, New York Pennsylvania, New Jersey	FPs: higher turnover for all occupational categories
Kash et al. 2006, *The Gerontologist*	1,014 Texas facilities	FPs: higher turnover for all occupational categories
Castle 2005, *The Gerontologist* [c]	419 facilities in Kansas, Maine, Mississippi, South Dakota, Texas	FPs: higher turnover for all occupational categories
Castle et al. 2007, *The Gerontologist* [c]	72 facilities in Colorado, Florida, Michigan, New York, Oregon	No differences in turnover rates
JOB SATISFACTION		
Decker et al. 2009, *The Gerontologist*	2,146 U.S. CNAs, working > 30 hours a week	FPs: lower intrinsic job satisfaction, but not lower overall satisfaction
Choi et al. 2012, *The Gerontologist* [c]	863 RNs in 282 nursing facilities, New Jersey	FPs: lower RN job satisfaction
JOB BENEFITS		
Haley-Lock & Kruzich 2008, *Nonprofit and Vol. Sector Quarterly*	54 Wisconsin facilities	FPs: negatively related to CNA job benefits
Kash et al. 2007, *Health Care Management Rev.*	1,014 Texas facilities	FPs: lower expenditure on employee benefits and staff training

[1] FP = for-profit; NFP = not-for-profit

[2] RN = Registered Nurse; LVN = Licensed Vocational Nurse; CNA = Certified Nurse Assistant. Occupational categories in order of hierarchy: RNs have the highest level of training, CNAs the lowest.

[c] Refers to a study in which ownership is a covariate

Staffing. Eleven studies identified staffing level differences between for-profit and not-for-profit nursing homes, and in general found that for-profit nursing homes have lower staffing levels for direct care professionals: that is, for-profits are more likely to be low-staff facilities (Park & Stearns 2009). While five studies

found lower staffing levels across all occupational categories (Registered Nurses, Licensed Vocational Nurses, and Certified Nurse Assistants), two other studies show significant differences between occupational categories (see Table 2.4c). Two studies failed to find differences in staffing levels between for-profit and not-for-profit nursing homes (Intrator et al. 2005; Rantz et al. 2004) but none found more favorable staffing levels in for-profit homes. The results do not show different patterns between studies treating ownership as a central independent variable and those in which ownership was a covariate.

An interesting, high quality study in this area is by Grabowski and Stevenson (2008) who studied ownership *conversions* and concluded that staffing levels decrease after a switch from not-for-profit to for-profit ownership, even after controlling for chain affiliation, case mix, and local economic conditions.

Turnover. A second common variable related to employee well-being is the difference in turnover rates between for-profit and not-for-profit nursing homes. While one study found no difference in turnover rates (Castle et al. 2007), three other studies did find significantly higher turnover rates for all occupational categories in for-profit nursing homes than in not-for-profit homes (see Table 2.4c). A study, ranked as high quality, by Castle and Engberg (2006) controlled for chain membership and local economic conditions, and found higher turnover rates for all occupational categories in for-profit nursing homes. The study by Kash et al. (2006) similarly controlled for competition, chain membership, and case mix, and came to similar conclusions. Castle (2005) also reports higher turnover rates in for-profit nursing homes. The study that did not find any differences treated ownership as a covariate. We therefore conclude that, overall, the studies provide strong evidence for turnover rates being generally higher in for-profit nursing homes.

Job satisfaction. The two studies that considered job satisfaction found lower satisfaction scores in for-profit nursing homes than in not-for-profit nursing homes (see Table 2.4c). However, specific conditions apply to this statement. While Decker et al. (2009) did find lower *intrinsic* job satisfaction (which is about responsibility, self-direction, skill development, and observed accomplishments associated with doing the work) in for-profit homes, the *overall* job satisfaction was not significantly different between for-profit and not-for-profit nursing homes. Moreover, the study did not control for relevant variables such as case mix. The other study, by Choi et al. (2012), treated ownership as a covariate, and found lower Registered Nurse job satisfaction in for-profit nursing homes. The evidence thus points towards lower job satisfaction in for-profit nursing

homes, but only under specific conditions and therefore we view the evidence as relatively weak.

Job benefits. Two final studies compared job benefits in for-profit and not-for-profit nursing homes. Both studies controlled for case mix and competition, and Kash et al. (2007) also for chain membership. Both studies report better job benefits in not-for-profit homes (Haley-Lock & Kruzich 2008; Kash et al. 2007).

Overall, the studies that have investigated employee well-being generally conclude that not-for-profits have higher staffing levels, lower turnover rates, offer greater job satisfaction, and better job benefits.

Profit Status and Client Well-being

The majority of studies in our review (31 out of 50; 62%) deal with variables that relate to client well-being (see Table 2.4d). In 18 of these studies, ownership is treated as a covariate. Studies on client well-being address two aspects: direct measures of care quality outcomes (such as pressure ulcer incidence and violations of regulations); and indirect measures such as the number of hospitalizations (transfers of nursing home residents to a hospital) and the lawsuit and complaint rates.

The largest group of these studies focus on direct care quality outcomes (20 studies) and in twelve of these studies ownership is treated as a covariate. The other studies focus on the number of hospitalizations (ten studies; six of them treating ownership as a covariate) and on lawsuit/complaint rates (two studies in which ownership is a central independent variable).

Care quality. Nine out of the 20 studies on direct quality outcomes found no differences between for-profit and not-for-profit nursing homes. Eight studies identify higher quality outcomes in not-for-profit nursing homes, while three studies report diverse outcomes for different quality indicators, variably favoring for-profits and not-for-profits or finding no differences (see Table 2.4d). None of the studies found for-profit homes consistently outperforming not-for-profit ones. Most of the studies that treated ownership as a central independent variable included several control variables such as chain affiliation, resident case mix, and competition. Two of the studies that failed to find any differences between for-profit and not-for-profit nursing homes did not include any control variables (Bardenheier et al. 2005; Zinn et al. 2005).

Table 2.4d Details of Studies that assessed Client Well-being

Reference	Sample	Relevant findings: FP versus NFP nursing homes[1]
CARE QUALITY		
Amirkhanyan et al. 2008, *Journal of Policy Analysis & Man.*	14,423 U.S. facilities	FPs: lower quality (violation of regulations)
Bardenheier et al. 2005, *Journal American Geriatrics Society*	1,409-1,488 U.S. facilities; 7,374-7,399 residents (1995/1997/1999)	No significant difference in pneumococcus vaccinations
Chesteen et al. 2005, *Journal of Operations Management*	42 Utah facilities; 890 CNAs	No differences on outcome quality
Grabowski and Stevenson 2008, *Health Services Research*	383,937 U.S. facility-quarter records; 194,556 surveys.	Care quality generally does not change following NFP to FP and FP to NFP conversions
Grabowski et al. 2013, *Journal of Health Economics*	874,143 U.S. residents	FPs: poorer post-acute care quality
Lau et al. 2004, *Health Services Research*	3,372 U.S. nursing home residents	No difference between FPs and NFPs in potentially inappropriate medication prescriptions
Williams et al. 2005, *The Gerontologist*	331 Philadelphia residents, 10 nursing homes	FPs: supervisors more often report resident pain; residents less likely to undergo professional pain assessment and to receive pain medication
Zinn et al. 2005, *The Gerontologist*	16,559 U.S. facilities	FPs (long stay): score worse on pressure sores, restraint use, and the prevalence of infection but better on 'loss of ability in daily tasks'. No difference for pain. FPs (short stay): score better for delirium and pain; lower percentage 'walk as well or better'.
Akinci & Krolikowski 2005, *Applied Nursing Research*[c]	90 Pennsylvanian facilities	FPs: lower quality (violation of regulations)
Barry et al. 2005, *The Gerontologist*[c]	156 facilities in Maine, Mississippi, New York, Ohio; 156 directors of nursing, 430 day-shift charge nurses	No significant quality difference for pressure ulcer incidence and resident social engagement
Baumgarten et al. 2004, *Journal Am. Geriatrics Society*[c]	59 Maryland facilities; 1,938 residents	FPs: lower quality (higher incidence of pressure ulcers)
Castle & Engberg 2005, *Medical Care*[c]	354 U.S. facilities in four states	FPs: greater use of physical restraints, no significant differences for catheter use, contractures, pressure ulcers, psychoactive drug use, and deficiencies

Table 2.4d Details of Studies that assessed Client Well-being (continued)

Reference	Sample	Relevant findings: FP versus NFP nursing homes[1]
Decker 2008, *Health Economics, Policy and Law* [c]	10,606 U.S. facilities, 21,212 observations	FPs: higher restraint use, but not after controlling for the percentage of Medicaid residents, Medicaid payments, occupancy
Grabowski 2004, *Medical Care* [c]	2,690 U.S. nursing home admissions	No difference in number of deficiencies
Grabowski & Angelelli 2004, *Health Services Research* [c]	13,736 U.S. facilities	FPs: higher prevalence of pressure ulcers
Grabowski et al. 2004, *Health Affairs* [c]	13,169 to 13,859 U.S. facilities per quality indicator	FPs: more incidences of pressure ulcers and physical restraints; NFPs: more daily pain
Kamimura et al. 2007, *Health Care Management Review* [c]	117 Michigan facilities; 86 North Carolina facilities	No quality differences (deficiencies, pressure ulcers) between FP and NFP chains
Konetzka et al. 2004, *Health Services Research* [c]	18,134 U.S. facilities; 60,283 surveys	FPs: more deficiencies
Konetzka et al. 2006, *Medical Care* [c]	1.704 U.S. facilities, 395,264 residents	No differences on the incidence of urinary tract infections and pressure sores
Zhang & Grabowski 2004, *The Gerontologist* [c]	5,092 U.S. facilities in 22 states	FPs: higher incidence of pressure ulcers, more catheters used
HOSPITALIZATIONS		
Gozalo & Miller 2007, *Health Services Research*	183,742 nursing home/ hospice residents in Kansas, Maine, New York, Ohio, South Dakota	FPs: greater likelihood of hospitalization ($p < .001$)
Grabowski et al. 2013, *Journal of Health Economics*	874,143 U.S. nursing home residents	FPs: poorer post-acute care: re-hospitalization after discharge (within 30 days) more likely
Hirth et al. 2014, *International Journal of Health Care Finance Economics*	278,848 U.S. nursing home residents	FPs: higher hospitalization rates that cannot be explained by resident differences
Konetzka et al. 2004, *Medical Care*	766 U.S. nursing home residents suspected of having pneumonia infections	FPs: higher hospitalization rate for residents with suspected pneumonia
Boockvar et al. 2005, *Journal of American Geriatrics Society* [c]	59 Maryland facilities; 2,285 residents, follow-up for 2,153 residents	FPs: increased hospital triage (residents transferred to hospital within three days of infection onset, worse resident results)
Decker 2006, *Medical Care* [c]	6,386 discharges in U.S. facilities	FPs: hospitalizations more likely

Table 2.4d Details of Studies that assessed Client Well-being (continued)

Reference	Sample	Relevant findings: FP versus NFP nursing homes[1]
Dobalian 2004, *The Gerontologist* [c]	16,760 U.S. facilities, 1,560,003, 1,536,525 residents	FPs: hospitalizations more likely
Intrator et al. 2004, *Journal of the American Geriatrics Society* [c]	54,631 residents, 663 facilities in Maine, Kansas, NY, and South Dakota	FPs: hospitalizations more likely
Intrator & Mor 2004, *Journal of the American Geriatrics Society* [c]	253 nursing homes in ten U.S. states, 2,080 residents	FPs: higher rate of hospitalization and a higher rate of death (without hospitalization) - but not statistically significant
Intrator et al. 2007, *Health Services Research* [c]	570,614 residents, 8,997 U.S. facilities	FPs: higher rate of hospitalizations
LAWSUITS/COMPLAINTS		
Johnson et al. 2004, *The Gerontologist*	478 Florida facilities	FPs: more lawsuits (but very weak association with ownership type)
Stevenson 2005, *Medical Care*	539 Massachusetts facilities	FPs: higher rates of complaints

[1] FP = for-profit; NFP = not-for-profit

[c] Refers to a study in which ownership is a covariate

We have only included medium and high quality studies in our review, and here two of the three high quality studies found worse quality outcomes in for-profits (Amirkhanyan et al. 2008; Konetzka et al. 2004). Stevenson and Grabowski (2008), in the other high quality study, consider ownership *conversions*. Their study is unique in that it is the only one in our review where the independent ownership variable changed over time. It nuances the negative results seen in other studies in that they show that a change from not-for-profit to for-profit ownership is not accompanied by a change in care quality.

Overall, most studies report no difference between the care quality provided in for-profit and not-for-profit nursing homes. While several studies do suggest better care in not-for-profit homes, none of the studies found that for-profit nursing homes consistently outperform not-for-profit ones on this variable.

Hospitalizations. When it comes to the number of hospitalizations, the evidence is clear-cut: for-profit nursing homes show higher hospitalization rates than their not-for-profit counterparts (see Table 2.4d). The high quality study by Hirth et al. (2014) suggests that the higher hospitalization rates in for-profit nursing homes

are due to a greater willingness, or ability, of not-for-profit nursing homes to manage cases in-house. Their study also shows that differences cannot be explained by resident characteristics. Konetzka et al. (2004) in another high quality study, after controlling for chain affiliation, resident payer sources, and resident characteristics, find evidence for higher hospitalization rates for residents with suspected pneumonia in for-profits. We therefore conclude that the evidence showing higher hospitalization rates in for-profit nursing homes is convincing.

Lawsuit/complaint rates. The two studies that emerged from our search that addressed lawsuits and complaints both show a higher rate of lawsuits and complaints in for-profit nursing homes after controlling for facility size (see Table 2.4d). Johnson et al. (2004: 344) found that litigation activity was 19% higher in for-profit homes than in not-for-profit ones. Stevenson (2005) found that for-profit nursing homes have higher complaint rates.

Overall, none of the studies reviewed found that for-profit nursing homes consistently outperform not-for-profit ones in terms of direct care quality indicators, while several studies found that not-for-profit nursing homes scored more highly on a range of quality indicators. Further, for-profit nursing homes show higher hospitalization rates, and are subject to more lawsuits and complaints.

Profit Status and Multidimensional Performance

In the available evidence, for-profit nursing homes demonstrate better financial performance than their not-for-profit counterparts, with higher profit margins and greater efficiency. However, these positive findings with regard to financial performance do not go hand in hand with positive findings for employee well-being and client well-being. for-profit nursing homes tend to have lower staffing levels, higher turnover rates, lower job satisfaction, and less job benefits than not-for-profit nursing homes. Likewise, with regard to client well-being, for-profit homes are more likely to score worse on care quality outcomes, have higher hospitalization rates of their residents, and are more often the target of complaints or lawsuits. Most of these results are robust, controlling for relevant variables such as market features, resident characteristics, and sometimes also chain affiliation. While Hirth (1999) warned of a potential bias in the ownership-quality literature because competition was not taken into account, more recent research does often control for competition (e.g. Amirkanyan et al. 2008; Grabowski et al. 2103; Grabowski & Castle 2004; Grabowski & Stevenson 2008; Kash et al. 2007).

Here, we employ a multi-stakeholder perspective in which we combine the results from all 50 studies.

First, based on the results, it seems that policies and procedures that improve profit margins and efficiency require strict control over personnel costs and resident costs. The suggestion that deteriorating client well-being can be partly blamed on the for-profit motive is certainly not undermined by our review of the last ten years of literature. If anything, the 'conflicting outcomes perspective' is supported with regard to 'financial performance' versus 'employee well-being' and 'client well-being': although a nursing home's for-profit status can be associated with positive financial performance, it can at the same time be related to predominantly worse outcomes in terms of employee and client well-being. Only one of the studies included in our review combines financial performance and employee well-being, and this found that higher profit margins in for-profit nursing homes are matched by lower expenditure on employee benefits and staff training (Kash et al. 2007). This leads to the first proposition drawn from our systematic review:

Proposition 1: *The 'conflicting outcomes' perspective applies to for-profit nursing homes in that better financial performance is associated with worse employee and client well-being.*

Second, it seems that poor results for employee well-being appear to go together with negative outcomes for client well-being in for-profit nursing homes. The three studies that combined staffing and direct care quality measures (Akinci & Krolikowski 2005; Decker 2008; Konetzka et al. 2004) all showed this pattern. Grabowski and Stevenson (2008) presented a more nuanced picture in that the decreasing staffing levels in nursing homes converting from not-for-profit to for-profit did not lead to changes in the direct care quality indicators. As such, the 'mutual gains perspective' seems applicable to employee well-being and client well-being, leading to our second proposition:

Proposition 2: *The 'mutual gains' perspective applies to for-profit nursing homes insofar as better employee well-being is associated with better client well-being.*

Figure 2.4b provides a summary of the findings and the propositions.

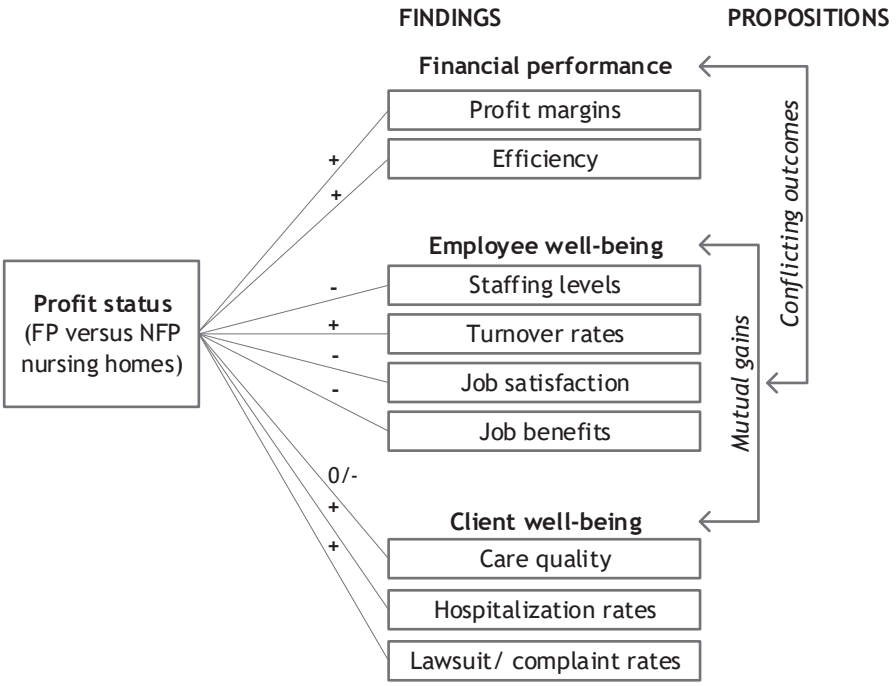

Figure 2.4b Summary of the findings and the propositions[1]
[1]The figure shows the differences between for-profit (FP) and not-for-profit (NFP) nursing homes. A '+' means that FP nursing homes generally score *higher* on this variable than NFP nursing homes, a '-' means that FP nursing homes generally score *lower* than NFP nursing homes. A '0' means that there is no difference between FP and NFP nursing homes.

2.5 CONCLUSIONS AND IMPLICATIONS

Conclusions

The implications of for-profit ownership of nursing homes have been a controversial subject for decades. Concerns are expressed that the focus on profits comes at the expense of care quality for the frail and elderly that reside in nursing homes. An extensive body of research exists on the differences between for-profit and not-for-profit nursing homes. To date, individual articles and reviews have largely focused on client well-being OR employee well-being OR financial performance, whereas the discussions on the significance of profit status in nursing homes are often about the interaction *between* these outcomes. The reviews by Comondore et al. (2009) and Hillmer et al. (2005) both show a lower quality of care in for-profit nursing homes compared with not-for-profit ones. Our systematic review of the literature on for-profit nursing home ownership, and

its effects, over the last ten years shows that these earlier outcomes are largely supported by more recent research, although we also report articles that fail to find care quality differences between for-profit and not-for-profit nursing homes. Going beyond recent reviews of the effects of nursing home profit status, we apply a multi-stakeholder perspective that results in a multidimensional performance construct that incorporates financial performance, employee well-being, and client well-being. for-profit nursing homes, when compared to their not-for-profit counterparts, show better financial performance, but tend to score worse on most employee well-being and client well-being variables. These outcomes are robust and we did not find differences between studies in which ownership is the central independent variable and those in which ownership is a covariate (which can be interpreted as an indicator of the absence of publication bias). Furthermore, the high quality studies at the center of our review include relevant control variables such as case mix, chain affiliation, and per capita income.

Implications for Theory

This review has several limitations which we now consider, and these often suggest opportunities for future research. First, we adopted the operationalizations and measurements of the dependent variables directly from the individual papers reviewed. As such, there is some variation in the way the individual measures of the dependent variables, such as care quality or profit margins, are defined.

Second, we found only very limited research into several of the variables addressed, and this calls for further research. For example, not many studies address financial performance, or several of the employee-level variables such as employee satisfaction. Most of the research to date has focused on client well-being variables, and especially on care quality. Further, the focus in care quality measurements is on clinical measures, such a pressure ulcer prevalence. Given that people often spend the last years of their lives in nursing homes, we would suggest adding broader quality of life indicators such as social engagement, client satisfaction, and family caregiver satisfaction (e.g. Gawande 2014). For example, Li et al. (2013) found that residents in for-profit nursing homes showed significantly lower consumer satisfaction.

Third, the results of this review suggest that the consequences of the profit status of a nursing home can in different aspects be interpreted as conforming to the conflicting outcomes perspective as well as to the mutual gains perspective. Our conclusions are largely based on separate studies that cover varying samples

while focusing on a single stakeholder. We would encourage future research to combine variables that are relevant for multiple stakeholders in a single study and investigate whether our propositions can be supported. We also suggest that it would be particularly valuable to study ownership conversions (from not-for-profit to for-profit) to see if any changes occur in financial performance, employee well-being, and client well-being after conversion (e.g. Grabowski & Stevenson 2008).

Fourth, the distinction we made between for-profit and not-for-profit might be too coarse (King & Meagher 2009: 35). The debate on nursing home ownership is entering a new phase in which attention is shifting from the for-profit and not-for-profit divide to the complicated ownership structures seen *within* the for-profit sector (Stevenson et al. 2013), including the role of private equity owners (e.g. Harrington et al. 2012; Pradhan et al. 2013; Stevenson & Grabowski 2008). The early empirical studies on this topic for example show that private equity owned nursing homes have higher operating and total margins than other for-profit nursing homes. The differences *within* for-profit nursing home ownership therefore seem worthy of a study in their own right. At the same time, researchers need to be more precise with regard to not-for-profit nursing homes. Twenty-nine of the 50 studies included in our review treated profit status as a dummy (yes/no) variable, often without making clear if the not-for-profit category includes only private not-for-profit nursing homes, or *also* public nursing homes. Since public homes often work for particular populations or serve as safety net providers (e.g. Grabowski et al. 2013), it would help clarify outcomes if results were specifically tied to not-for-profit or to public providers. The indistinct dividing line between private not-for-profit and public homes is a weakness of existing research that placed limitations on our review.

Fifth, we used broad search terms in finding articles relevant for this review. The broad scope of the search terms enabled us to identify a wide range of potentially relevant articles. At the same time, more specific search terms (such as 'family caregiver satisfaction') might have revealed other publications that were not included in this review.

Finally, the review focuses on studies based in the U.S., where the majority of nursing homes are 'for-profits'. The relatively few not-for-profit nursing homes in the U.S. 'tend to focus on the clinically more severe and financially more lucrative end of the payer spectrum' whereas for-profit facilities 'usually have a less lucrative payer mix' (Konetzka 2009: 339). As we noted in our introduction, other

Western countries are increasingly seeing it as desirable to extend the availability of for-profit nursing homes. In contrast to the U.S., not-for-profit nursing homes in these countries may emphasize a community-oriented mission, including care for the less profitable patients. Further, in the U.S., not-for-profit nursing homes are granted some specific advantages including income and property tax exemptions and access to tax-deductible donations and bonds (Hirth et al. 2014). Translating the findings from our review to other territories therefore needs caution. Some studies in Canada and Finland have indicated that outcomes are indeed similar in terms of employee well-being (e.g. Heponiemi et al. 2011a; Heponiemi et al. 2011b; McGregor et al. 2005), and client well-being variables (e.g. McGregor et al. 2006, 2011). However, further research is needed in other countries to determine whether outcomes are similar in different institutional contexts.

Implications for Practice

For policymakers considering the expansion of the for-profit nursing home industry, our findings suggest the need to adopt a broad perspective, simultaneously weighing up the potential benefits and drawbacks for the organization as a whole, for its employees, and for its clients. Careful consideration is needed in balancing the results on the different dimensions for multiple stakeholders. This is true in any situation, and one needs to be cautious in applying findings in one country (e.g. the U.S.) to elsewhere. As mentioned earlier, the outcomes of this review might reflect an underlying distinction in the U.S. nursing home industry with its two-tier system. In this system, the superior care quality offered in not-for-profit nursing homes is related to their inclination to shun Medicaid patients because these provide less money for health services. for-profit nursing homes are more willing to accept Medicaid recipients, but may well offer a reduced care quality. This leads to a situation 'in which elitist not-for-profit providers serve healthier, more educated, and affluent consumers and for-profit homes provide substandard quality to everyone else' (Amirkanyan 2008: 676; Mor et al. 2004). Given these concerns, it is important to remember that all the high quality studies in our review controlled for market variables that might distort the relationship between ownership type and the dependent variables. Here, the high quality studies controlled for poverty rates, per capita income, or for the percentage of Medicaid recipients in the area where a nursing home was located (see Appendix A). Moreover, the first set of studies in other Western countries point in the same direction as U.S. studies in terms of employee well-being and client well-being. The evidence thus emphasizes the continuing importance of nursing home ownership in policy decisions on the structuring of a sustainable nursing home industry.

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3

Just another business? Private equity in health services

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ABSTRACT

We focus on the role of private equity firms in health services, in particular in nursing homes. The chapter starts with a conceptual framework that explains why health services are *not* just another business (the 'public value frame'), as distinguished from health services as 'just another business' (the 'market frame'). Subsequently, we synthesize two systematic literature reviews on the impact of private equity across sectors and for-profit nursing homes. Based on both reviews, we propose that private equity owners are mainly successful from a market frame perspective. They seem to enhance financial/ organizational performance in health services, but mainly reduce staffing levels. This comes with no or slightly negative consequences for clients. We suggest that private equity owners, especially in nursing homes, should focus on a more strategic balance between organizational/ financial performance, employee well-being and client well-being. Our chapter recommends two shifts in future research on private equity: from its impact on organizational/ financial performance to its impact on product and services quality and from research to *what* the impact of private equity is to case studies that explore *how* private equity creates impact.

3.1 INTRODUCTION

Private equity activity has become a generally well-known phenomenon over the past 30 years, with its roots in the corporate U.S.. During these years, private equity firms have widened their geographical as well as their sectoral scope. This has involved increased activity in Europe and more deals in services compared to manufacturing (Guo et al. 2011). Especially since the 2008 financial crisis, private equity firms have increasingly acquired organizations providing services that are central to the daily lives of citizens (Ivory et al. 2016), such as health services. This chapter therefore focuses on the role of private equity firms in health services. We develop a conceptual model to explain why health services organizations are perhaps not 'just another business' for private equity investment, and use this model to explore the impact of private equity in health services.

The health care sector accounts for approximately 12% of private equity deal activity worldwide, as measured by the number of deals. Investment has surged in the health provider and related services subsector, totaling over half of the global deal value in health care for the year 2015. Private equity investment in so-called 'healthcare-heavy assets', a label the firms apply to assets with meaningful exposure to reimbursement risk, continues to grow, with investors becoming more comfortable with reimbursement risk (Bain 2016: 8-10). In 2010, the first industry-specific private equity trade association was established in the health care sector: the Healthcare Private Equity Association (HCPEA). The increasing pervasiveness of private equity in healthcare is motivated by two developments. First, private equity firms – having funds available – look for "deals that will not sour even if the economy does" (Evans 2011). Second, private equity is expanding to fill the health care gap as many governments are retreating from health services provision, and encouraging increased private sector involvement to attract capital and to deliver health services.

The largest proportion of health services private equity deals occur in the U.S., in particular in nursing homes. For example, four out of ten largest for-profit nursing home chains in the U.S. were purchased by private equity firms in the period 2003-2008 (Harrington et al. 2012). Private equity investors, however, also target other types of health services organizations such as U.S. emergency services (Ivory et al. 2016). Health services providers in Western Europe have also been acquired, for example, the Finnish healthcare service provider Terveystalo was acquired by the Swedish private equity firm EQT partners in 2013, the Swedish health services company Capio was acquired by the private equity firms Apax

and Nordic Capital in 2006, and funding from several private equity firms has backed small-scale nursing home facilities in the Netherlands.

The role of private equity in such health services organizations raises a number of concerns. Their focus on financial performance can be at odds with the delivery of high quality health services. In the public as well as the academic debate, it is questioned whether private equity interventions come at the expense of vulnerable patients (e.g. Duhigg 2007; Pradhan et al. 2014). For example, Ivory et al. (2016) report private equity-owned health services organizations have implemented checklists named 'Care to Cash', which may contradict key aims in health services such as providing 'care to vulnerable patients'. In line with this debate, this chapter develops a conceptual model to clarify how the nature of health services is fundamentally different from many other products or services, and suggests that health services are not 'just another business' for private equity firms. The specific nature of health services requires a multi-stakeholder and multi-dimensional performance approach to evaluate the impact of private equity investment, which includes financial performance as well as employee, and client/patient well-being. Subsequently, we consider the empirical evidence of the impact of private equity in health services. Since specific research on this topic is relatively scarce, we draw from other sources to formulate propositions: this involves systematically analyzing evidence over the last ten year on what we know about (a) the impact of for-profit nursing home ownership in comparison to not-for-profit ownership, and (b) the cross-sectoral impact of private equity. The combination of both reviews enables us to formulate propositions on the impact of private equity in health services. Finally, we identify certain knowledge gaps that could be addressed in future research.

3.2 CONCEPTUAL FRAMEWORK

By specifying the nature of health services, our conceptual framework aims to distinguish health services from manufacturing and services companies invested in by private equity. For a full understanding of the specific health services context it is necessary to evaluate the impact of private equity in health services from a stakeholder approach. Our focus is particularly on nursing home services, as nursing homes have been an important target of private equity in health services thus far, and subsequently most available evidence is on this subsector.

Not 'just another business'

To distinguish health services from other services and products, we introduce the market frame and the public value frame. The market frame starts from the idea that health services are a commodity. By treating health services as such, private equity can apply general interventions for improving efficiency and maximizing profits. However, we argue that health services are not 'just another business'. Health services do not fit into the commodification logic that is attached to the market frame. The market frame therefore needs to be complemented or even replaced by a public value frame. We here present four arguments that underscore the need for this public value frame, as an alternative framework for exploring private equity in health services. These four arguments are based on:

(a) the starting point for managing health services
(b) perceptions of organizational success
(c) perceptions of well organized labor
(d) perceptions of the client/ patient

First, the *starting point* for managing health services can differ. The way in which nursing homes operate can be seen as a touchstone for how societies care for their elderly and for societal values more broadly. Delivering health services is therefore not only creating value for money by delivering commodities, but also creating public value by being part of people's lives, and the broader society. It relates to what Sandel (2000) calls 'the moral limits of markets': when health services are commodified, that makes them a regular market exchange. This commodification may change the character of the service itself, as it may crowd out values worth caring about, such as accessible quality care for the elderly poor, human dignity, and happiness. From a market frame, health services commodities can be at a lower cost, as long as the care delivery fits within legal requirements; from a public value frame, the possibilities for lowering costs are related to public values that often transcend legal requirements.

Second, the view of economic value as the main indicator for *organizational performance* is too narrow. The client and the healthcare professional become intertwined in the nursing home service delivery. The 'commodity' thus cannot be separated easily between provider and client, as the quality of the service is heavily dependent upon – often intense – interactions and relationships between clients and professionals. Health services delivery is 'emotion work' (Hochschild 1983), as it occurs in face-to-face interactions with clients, it uses emotions to

influence patient's emotions, attitudes and behaviors; and the display of emotions by professionals has to follow certain rules (Zapf 2002). A market frame might overlook crucial aspects of the value creation process: the social capital that is built in micro action and relationships between staff and patients on a daily basis. Interventions from a market frame, such as the search for more efficiency, thus needs to be weighed against forms of social capital that are not easily measured, such as the quality of the relationships between patients and staff. For example, redeploying staff to improve efficiency can damage employee-client relationships that are essential for care quality.

Third, health services are labor-intensive which puts emphasis on the importance of good *labor management*. The labor-intensity leads to Baumol's cost disease: there are limits to the growth of productivity over time, since productivity gains come mostly from improved capital and technology (Baumol & Bowen 1966). Research shows how Baumol's cost disease applies to the U.S. health care sector (Bates & Santerre 2013). Productivity gains in the primary process – an important starting point for many private equity firms in reorganizing their portfolio organizations (e.g. Wilson et al. 2012) – are thus restricted. Moreover, it can even be argued that many health services need some staff slack because of unforeseen events for which extra staff are required immediately (for example, patient falls and acute episodes of distress), and the high risks of understaffing at those moments.

Fourth, the commodification of health services can blur the difference between 'ordinary clients' and nursing home *patients*. One difference relates to the fact that it is much harder for most nursing home patients than the 'ordinary client' of regular commercial day-to-day services to 'vote with their feet' when they are dissatisfied with the services delivered. Relocation to another nursing home will disconnect patients abruptly from relationships with staff and other patients, and is especially distressing for physically frail patients or those with other complicated health needs. In addition, places in other nursing homes can be scarce and might not be available directly. Another difference refers to the fact that it is relatively difficult for patients to identify care quality and to compare alternative nursing homes or care providers. This is partly because the quality of care is difficult to measure and assess compared to standard commodities, information is not readily accessible, and the most vulnerable patients are often least equipped to make the comparison at the times of highest need. There is a huge difference of knowledge between the care provider and the patient and information asymmetry may result in sub-optimal client choices of services and

facilities. These issues highlight the dependency of the patient on the nursing home, including high transaction costs directly related to building and maintaining client relationships. They call for a certain level of protection of the patients by the organization, service commissioners or the regulators responsible, and the restriction of socially undesirable profit-maximization (e.g. Hirschman 1980: 436).

These four characteristics of the nature of health services can also be applied to, for example, education or child day care services. Table 3.2 provides a summary of the characteristics, which can be categorized from a market frame and a public value frame.

Table 3.2 Summary of the ideal type market frame and public value frame for health services

	'Just another business' *Market frame: health services as a commodity*	**'Not just another business'** *Public value frame: health services as a service in its own right*
Starting point	Building a financially successful business within legal requirements	Building a financially successful business within a legal context and in addition also respecting public values
Organizational performance	Economic value is key to nursing home success	Economic value and social capital are both key to nursing home success
Organizing labor	Labor needs to be organized as efficiently as possible	The nature of the service implies some staff slack
Client/ patient	Dealing with the empowered client, who is making rational choices	Dealing with the dependent patient, who needs protection

From a shareholder approach to a stakeholder approach

What follows is a multi-dimensional performance perspective on health services organizations, as the delivery of health services implies the creation of value that goes beyond financial performance. Health service delivery also includes elements of public value, social capital, staff slack and patient protection. Good performance in health services balances financial performance, employee well-being and client well-being, as owners, employees, and clients are all affected by private equity ownership (e.g. Freeman et al. 2010). Research on the impact of private equity in health services therefore needs to start from a stakeholder approach, as opposed to the 'traditional' shareholder approach. We argue that a stakeholder approach in combination with a multi-dimensional performance model fits health services better than a shareholder approach.

In the shareholder approach, principals (owners) and agents (managers) are challenged to optimize financial interests to ensure long-term organizational competitiveness (Jensen & Meckling 1976). This approach is widely used in the buyout and private equity literature. It can be characterized by a focus on a limited number of stakeholders and a one-dimensional performance orientation (i.e. organizational and financial performance). In contrast, the stakeholder approach (e.g. Freeman 1984) starts from a multidimensional view of performance, with an emphasis on organizational outcomes, employee outcomes and societal outcomes linked to the different stakeholders involved (see for example the Harvard model, Beer et al. 1984). In this paper, we focus on three stakeholders in health services organizations: owners/ employers, employees, and clients. While acknowledging that society as a whole has a stake in health service provisions and outcomes, society is not included in our paper.

The stakeholder approach adds the possibility of dissimilar/ conflicting outcomes for different stakeholders. Scholars identify a variety of potential outcomes from organizational decisions that range from conflicting outcomes to mutual gains outcomes (e.g. Van De Voorde et al. 2012). From the 'conflicting outcomes perspective', the impact of private equity ownership for different stakeholders is a zero-sum game: positive outcomes for one stakeholder come at the expense of another stakeholder. At the opposite end of the continuum, the 'mutual gains perspective' assumes that decisions are possible that involve gains for all stakeholders. We will apply a multidimensional performance construct (see Figure 3.2), to explore which of these perspectives is most appropriate for describing the impact of private equity ownership in health services. The goal of this chapter is to formulate propositions on the impact of private equity in health services on organizational performance, employee well-being, and client well-being.

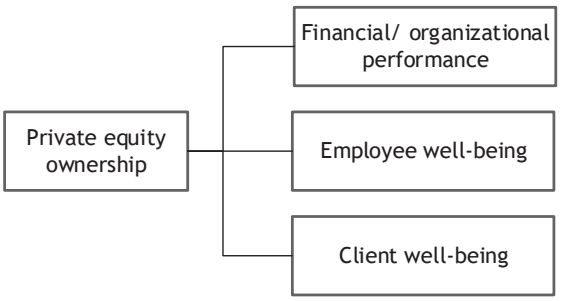

Figure 3.2 Multi-dimensional performance of private equity in health services

3.3 WHAT WE (DO NOT) KNOW ABOUT PRIVATE EQUITY IN HEALTH SERVICES

We argue that private equity in health services needs specific attention in academic research. Lessons can also be learned for other public services sectors such as education and child day care. Hitherto, research on private equity has been mainly cross-sectoral, often using databases – such as the CMBOR database – that incorporate businesses in several sectors. Seventy nine percent of the 62 papers included in our systematic review of the private equity literature over ten years presented cross-sectoral results (Appendix C). The few papers that focus on a specific sector are in nursing homes (8%) and retail (5%). We also found one paper for each of the following sectors: manufacturing, high technology engineering, telecom, and the automobile industry.

Evidence on private equity in nursing homes

The distinctive nature of health services calls for more sector-specific research on the impact of private equity in health services. The first studies in this area have focused on nursing homes and the findings are inconsistent. Although Stevenson & Grabowski (2008) find lower staffing levels in U.S. nursing homes following acquisition by a private equity firm, they report that staffing levels were already reducing pre-purchase. No harm to care quality is reported as a consequence. In contrast, Harrington et al. (2012) find no significant changes in staffing levels for private equity-owned nursing homes, but report higher levels of deficiencies post buy-out. Deficiencies are issued by the inspection when a nursing home does not meet minimal standards. A study by Pradhan et al. (2014) also reports significantly more deficiencies after private equity deals in nursing homes. This study also finds lower staffing intensity of Registered Nurses (the higher educated nurses working in U.S. nursing homes). Moreover, the number of higher educated professionals is reduced in relation to lower qualified care workers. With regard to financial performance, Pradhan et al.'s (2013) study reports improved financial performance of private equity owned nursing homes, while Cadigan et al. (2015) found little impact of private investment firms on the financial health of nursing homes. These studies all highlight one particular aspect of multidimensional performance. Given research on the impact of private equity in health services is relatively scarce and focused on one dimension at a time (i.e. organizational performance, employee well-being or client well-being), we draw from related literatures, to formulate propositions on the impact of private equity in healthcare.

Drawing from related literatures

We narrow our focus to private equity's impact on nursing homes in the United States (U.S.), for three reasons. First, American nursing homes have been acquired by private equity since 2000, and therefore there is relatively much experience in this area. Second, the very first studies on private equity in health services, as presented in the previous paragraph, have been in U.S. Third, although research on private equity in nursing homes is relatively scarce, there is a huge body of literature on the profit status of U.S. nursing homes, which is indirectly informative. In contrast to many other industries private equity invests in, nursing home ownership can also be not-for-profit or public. Research on the impact of for-profit status therefore provides insight into the question what it means to deal with nursing home care delivery in a commercial way: as 'just another business'.

Starting from the stakeholder approach, we applied a multi-dimensional performance perspective on the available empirical evidence. We conducted two separate systematic reviews of the literature (see chapter 2 and appendix C). In a broad search of empirical evidence over the last ten years, we systematically categorized all the evidence on the impact of private equity, and profit versus not-for-profit nursing homes on the basis of whether studies report on financial/organizational performance, employee well-being and client well-being. By combining what we know about the impact of for-profit nursing home ownership (step 1) and the cross-sectoral impact of private equity (step 2), we aim to draw propositions on private equity's impact in health services and to show knowledge gaps that need to be addressed by private equity scholars.

The reviews resulted in respectively 62 relevant studies on the impact of private equity across sectors, beyond health services, and 50 studies on the impact of a profit status in U.S. nursing homes. After in-depth review of full-texts, studies were classified according to the categories 'organizational performance', 'employee well-being', and 'client well-being'. For financial/organizational performance', the following variables emerged from our review: profit margins, efficiency, and innovation. For employee well-being, we included staffing levels/employment and other working conditions. Includes several variables such as employee consultation, trust in implicit contracts with employees, organizational uncertainty, institutional trust, CEO turnover, skill mix in nursing homes (indicating that higher educated professionals are replaced by lower educated and lower paid health care professionals), managerial discretion, and high commitment management practices, i.e. long-term investments practices that enhance

employee well-being. For client well-being, we analyzed studies on product or service quality. For more details on the methods in the two separate reviews, we refer to the separate reviews (Chapter 2, Appendix C). Figure 3.3a provides an overview of the two analyses.

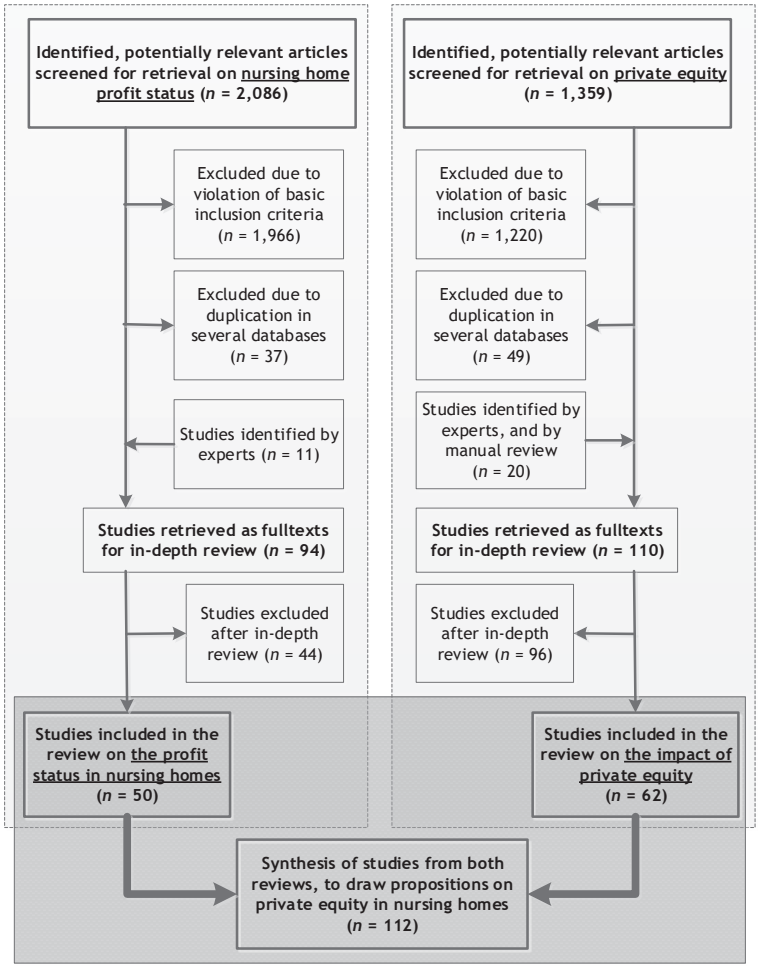

Figure 3.3a Overview of the steps taken in the systematic reviews, that form the data for this paper

Table 3.3 provides an overview of the findings from the review of the profit-status of nursing homes and the implications of private equity ownership. The majority of research on the impact of private equity focuses on variables of organizational/ financial performance. More than one-third (profit status of nursing homes) and four-in-ten (private equity ownership) of the studies consider

the implications for employee well-being. For the review of nursing homes, the majority of studies (over six-in-ten) concentrate on client well-being variables. This remarkable difference highlights the issues that private equity firms are likely to be assessed against when acquiring health services. While the emphasis of private equity scholars is on financial/ organizational performance, health policy scholars accentuate care quality considerations. We now consider in turn the respective outcomes for organizational/ financial performance, employee well-being, and client well-being.

Table 3.3 Overview of the results from the reviews[4]

	For profit vs. not for profit nursing homes (*n* = 50)	Private equity vs. non private equity ownership across sectors (*n* = 62)
Organizational/ financial performance	**12%**[1]	**74%**
Profit margins (profitability)	+[2]	+
Efficiency levels	+	+
Innovation (orientation)	0	0
Employee well-being	**36%**	**44%**
Employment/ staffing levels	–	+/–
Other working conditions, incl. job satisfaction and benefits	–	+/–
Client well-being	**62%**	**7%**[3]
Quality	0/–	0/–

[1] The percentage of the studies included in the review that provide empirical data on organizational performance, employee well-being, or client well-being variables.
[2] – = decrease/worse, + = increase/better, 0 = no effect/difference
[3] Four papers, of which three are about private equity in nursing homes
[4] The table only shows the variables that emerge in both reviews. The separate reviews contain more variables, such as bankruptcy rates, wages, industrial relations, turnover rates, hospitalization rates, and lawsuit/ complaint rates (see Chapter 2 and Appendix C).

By combining the outcomes from both reviews, we draw propositions on the impact of private equity in nursing homes.

Organizational/ financial performance

Based on the two reviews, we propose that private equity in nursing homes will be largely beneficial for financial performance and does not seem to harm innovation. First, the review on the profit status of nursing homes shows that for-profit nursing homes tend to outperform not-for-profit nursing homes with regard to profit margins. The review on the impact of private equity across sectors shows

similar results: in general, private equity-owned companies have higher margins than their industry counterparts which are not private equity-owned. We therefore assume that private equity increases the financial performance in private equity owned nursing homes. An initial study in this area (e.g. Pradhan et al. 2013) confirms this proposition, while a further study finds little impact of private investment firms on the financial health of nursing homes (Cardigan et al. 2015).

Second, efficiency is generally higher in for-profit nursing homes compared to not-for-profit nursing homes. Moreover, cross-sectoral research on private equity shows that private equity can generally be expected to increase efficiency. We therefore propose that private equity ownership in nursing homes stimulates the efficiency of health services delivery.

Third, with regard to innovation private equity investors are temporary owners with a potentially short-term time horizon that may reduce investment in new products and services. However, prior studies suggest private equity ownership does not restrict innovation. Similarly, an initial study reports that the profit status of nursing home is not associated with changes in the orientation on innovation. We therefore propose that private equity ownership will not hold back innovation in nursing homes. For financial/ organizational performance, we therefore formulated the following propositions:

P_1: Private equity increases the profitability of nursing homes.
P_2: Private equity increases the efficiency in nursing homes.
P_3: Private equity does not change innovation in nursing homes.

Employee well-being

We propose a negative impact of private equity's interventions on employment, i.e. staffing levels, in nursing homes. Research on the impact of private equity on employment across sector shows mixed results. Outcomes seem to be dependent on the characteristics and context of the portfolio company at the time of the acquisition. At the same time, the review on nursing homes indicates that for-profit nursing homes are associated with lower staffing levels than not-for-profit nursing homes. Moreover, an initial study reports lower employment levels in private equity-owned nursing homes compared to other for-profit nursing homes in Florida. This study also finds reduced employment post-buyout when compared to the pre-buyout period of the nursing homes (Pradhan et al. 2014).

With regard to employee well-being, research on the impact of private equity on working conditions is limited and shows mixed outcomes. In comparison, two studies report worse job benefits in for-profit nursing homes when compared to not-for-profit nursing homes (Haley-Lock & Kruzich 2008; Kash et al. 2007). We expect that the mixed findings for private equity across sectors on working conditions will bend to the negative side when it comes to private equity in the nursing home sector. For employee well-being, we therefore formulated the following propositions:

P_4: Private equity reduces staffing levels in nursing homes.
P_5: Private equity diminishes general working conditions in nursing homes.

Client well-being

We earlier described the labor-intensity of nursing home services and argued that many health services need some staff slack to deal with unforeseen events. Understaffing is therefore potentially damaging for client/patient well-being in nursing homes and staffing levels are closely tied to client well-being, i.e. care quality (e.g. Schnelle et al. 2004). Apart from research on private equity in nursing homes in particular, research on the impact of private equity on product or service quality is limited (such as the case study of Palcic and Reeves 2013). In contrast, the vast majority of studies on the impact of for-profit nursing home ownership focuses on the implications for care quality. Care quality is measured in different ways, ranging from the level of deficiencies, the number of inappropriate medication prescriptions, the incidence of resident pain, the use of physical restraints, the prevalence of pressure ulcers, to the loss of ability on daily tasks. The impact of for-profit nursing home ownership is associated with either no or worse care quality outcomes. Studies that directly addressed the impact of private equity on nursing home care quality tend to show similar findings. While two studies report no harm to quality (Stevenson & Grabowski 2008; Cardigan et al. 2015: 192), two other studies find reduced quality levels (Harrington et al. 2012, Pradhan et al. 2014). The study of Pradhan et al. (2014) also reported several quality indicators that were not influenced by private equity. In line with these studies on care quality, as well as the intertwining of employee well-being and client well-being, we formulated the following proposition on client well-being:

P_6: Private equity has no impact or a slightly negative impact on care quality in nursing homes.

Summarizing our arguments, we predict that private equity in nursing homes will be largely beneficial for financial performance and efficiency, and will not harm innovation. For employee well-being, we expect that private equity ownership overall has less positive impact. For client well-being, we predict that the impact of private equity in nursing homes is either neutral or negative. By applying a multi-dimensional performance framework, we thus predict varied outcomes for different stakeholders. In terms of the conceptual framework, on conflicting outcomes and mutual gains, we there propose the following (see also Figure 3.3b):

P_7: The conflicting outcomes perspective applies to the financial/ organizational performance when related to employee well-being and client well-being.

P_8: The mutual gains perspective applies to employee well-being and client well-being.

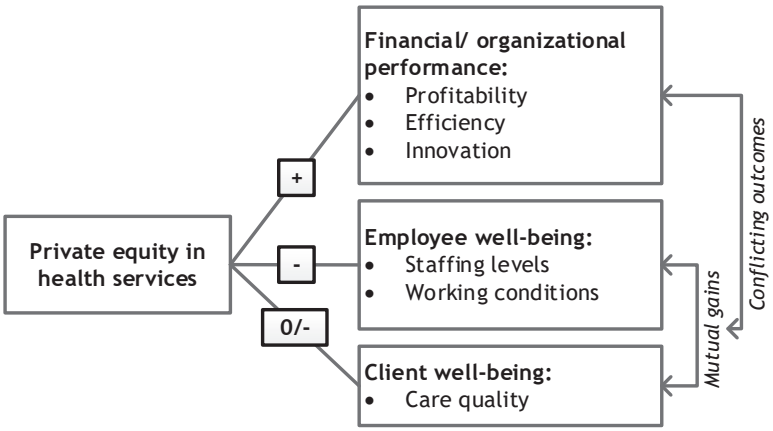

Figure 3.3b Propositions on private equity in health services

3.4 CONCLUSIONS AND FUTURE RESEARCH OPPORTUNITIES

Conclusions

While we argued in our conceptual framework why health services are *not* just another business, private equity investors nevertheless seem to treat health services as 'just another business'. Given the synthesis of the literature on both private equity across sectors and for-profit nursing homes, we propose that private equity owners are mainly successful from a market frame perspective. They are able to enhance financial/ organizational performance in health services. Evidence also indicates that private equity in health services can be associated with

lower staffing levels, which is rather a signal of a labor process that is organized as efficiently as possible, than of a labor process that incorporates some staff slack with an eye on unforeseen events for which extra staff are required immediately. These outcomes go together with no or slightly negative consequences for patients/ clients. The beneficial outcomes for employers/ owners seems to be associated with less fortunate outcomes for employees and clients, which fits in the conflicting outcomes perspective. We suggest that private equity owners, especially in nursing homes, should focus on a more strategic balance between organizational/ financial performance, employee well-being and client well-being, because such a balanced approach can lead to long-term organizational success (see also Oliver 1997; Deephouse 1999).

Future research opportunities

In addition to the conclusions and drawing on two systematic reviews, we identify two priorities for future research on private equity.

First, the review on nursing homes' profit status shows that health policy researchers mainly focus on the impact of ownership on measures of client well-being. In contrast, scholars that examine the impact of private equity ownership mainly concentrate on organizational and financial performance. Furthermore, the few papers that focus on the impact of private equity on client well-being are almost exclusively carried out by health policy scholars, and focused on care quality in nursing homes. We therefore observe a knowledge gap with regard to the impact of private equity on product and service quality. Some critics argue that private equity investors focus on financial engineering rather than operational improvements (e.g. Appelbaum & Batt 2014), let alone increasing products and/ or service quality for clients. More research is required on the impact of private equity acquisitions on client outcomes to evaluate a broader range of economic and social implications.

Furthermore, the public value frame underscores this need for more attention to measures of client well-being in private equity research. Public services, such as care for the elderly, should not only be judged by their economic returns, but also by their quality, or more broadly, by their contribution to social goals such as the overall health and well-being of citizens. Because health services organizations are an important target for private equity firms, this is another reason for increasingly incorporating client well-being variables in scholarly work on private equity.

Second, we found that results for employee well-being – and to a lesser extent client well-being – are mixed. Literature has not been able to provide clear explanations for such diverse findings. We assume this is due to context-specific factors, such as the type of private equity investor, the type of portfolio organization, and the type of sector, including government interference in that sector. To uncover the mechanisms that explain the implications of private equity ownership for different stakeholders, more qualitative research is needed. Instead of *what* the impact of private equity ownership is, the attention needs to shift to *how* private equity owners influence portfolio organizations. In this way, explanations can be found and deepened for the diverse outcomes, preferably with "longitudinal studies that chart the development and impact of changes" (Wright et al. 2009: 510-511). The focus then changes to understanding the *mechanisms* at work in private equity-owned portfolio firms, and to building new theory.

4

For-profit nursing homes in the Netherlands: what factors explain their rise?

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ABSTRACT

This exploratory mixed methods study analyses the characteristics of the emerging for-profit nursing home industry in the Netherlands and identifies the interrelated set of factors (context, trends and sector conditions) that contribute to its growth. Until recently, the Dutch nursing home sector relied almost exclusively on non-profit providers. Even though profit distribution in nursing home care is still banned, the for-profit nursing home sector is currently expanding. The study uses economic theory on non-profit organizations and 'mixed-form' markets to understand this expansion.

We find that changes in the regulatory framework have unlocked the potential of the for-profit nursing home sector, enabling for-profit nursing homes to circumvent the for-profit ban. The expansion of the for-profit sector was mainly driven by the low responsiveness of the non-profit sector to increased and changed demands. For-profit providers took advantage of this void. Moreover, they exploited 'cream-skimming' potential in the market, and used the wider care system to reduce their labor costs by relying on external specialist care. Another main driver was the access to financial capital from private investors (e.g. private equity firms).

4.1 INTRODUCTION

Nursing homes can be either public, non-profit or for-profit organizations. The share of for-profit nursing homes differs significantly among Western countries, ranging from 4% in Norway to about 76% in England (Eurofound 2017). For-profit nursing homes have received a lot of attention from scholars, mainly with regard to their performance in comparison to non-profit and public organizations (Bos et al. 2017; Comondore et al. 2009; Harrington et al. 2002; Hillmer et al. 2005; Hjelmar et al. 2018; Winblad et al. 2017). Research on factors that explain the role of for-profit organizations in the nursing home industry is less advanced. Although literature on the non-profit enterprise offers helpful insights about factors that might shape the organizational make-up of sectors, scholars also state that "there is very little understanding of the dynamic forces causing the expansion of the [non-profit or for-profit] sector into areas long dominated by the other" (Kingma 2003: 63; Weisbrod 1997: 544).

Current developments in the Dutch nursing home sector provide a good opportunity to increase our understanding of these dynamics. The Netherlands is known for its almost exclusively private non-profit provision of nursing home care (Jeurissen & Ginneken 2019). Until recently, the role of for-profit providers was negligible. No Dutch policies were directed towards the growth of the for-profit share and a ban on profit distribution in nursing home care for the elderly is still in place. Nevertheless, Dutch for-profit nursing homes are gaining ground.

This explorative study aims to understand how the Dutch nursing home market has opened up to for-profit homes: *What is the current status of the Dutch for-profit nursing home sector, and what factors stimulated its expansion?* It is, to the best of our knowledge, the first academic study aimed at describing and understanding the growth in for-profit nursing homes in the Netherlands. Our study builds on 'mixed-form' markets literature (Brown & Slivinski 2018; Rose-Ackerman 1990) and economic theory on non-profit organizations (Anheier & Ben-Ner 2003; Ben-Ner & Van Hoomissen 1992; Hansmann 1980; Salamon 1987; Weisbrod 1988).

4.2 THEORETICAL FRAMEWORK

For-profit and non-profit organizations

The principal difference between for-profit and non-profit organizations is "the presence of strict limits on the appropriation of the organization's surplus in the form of monetary gain by those who run and control it" (Ben-Ner & Gui 2003: 5). Both non-profit and for-profit organizations can earn a surplus, but the non-distribution constraint prohibits non-profit organizations from *distributing* surpluses to third parties. Instead, they must retain and devote surpluses to financing further development of their services, to benefit 'beneficiary stakeholders'(Anheier & Ben-Ner 2003; Hansmann 1980).

In order to understand the participation of for-profit providers in the healthcare system, it is useful first to review theories explaining the participation of non-profit providers. The 'third-sector rationale' and the 'contracting and trust-goods rationale' help to explain the presence of non-profit organizations in certain industries (Brown & Slivinski 2018). The 'third-sector rationale' understands the participation of non-profit organizations in a sector as a way of compensating for inadequate for-profit and government provision of services (Anheier & Ben-Ner 1997; Ben-Ner & Gui 2003). Non-profit providers might seek to step in, for example, when profit-maximizing behavior by for-profit providers such as cost-cutting leads to a fall in the quality of services or when government providers are unable to deal with heterogeneity in demand (Weisbrod 1988). The 'contracting and trust-goods rationale' views the organization instead as a nexus of contracts: it argues that, rather than a corrective for the failures of other providers, non-profit providers are the most efficient form of organizing the delivery of 'trust goods' – goods that are difficult for stakeholders to evaluate due to information asymmetry. Because non-profit providers are subject to the non-distribution constraint, consumers are less concerned about being exploited due to the information asymmetry, and hence the costs of contracting are lower, because less effort has to be made on regulating and controlling the contracted providers (Anheier & Ben-Ner 1997; Ben-Ner & Van Hoomissen 1992; Brown & Slivinski 2018; Hansmann 1980; Weisbrod 1988).

Factors that stimulate the entrance of for-profit organizations in non-profit sectors

The aforementioned theoretical arguments predict that the non-profit sector dominates in the provision of long-term care (LTC) services, however, many Western healthcare systems are organized as mixed markets that also include for-profit organizations (Eurofound 2017). The Dutch non-profit nursing home sector is also evolving into a mixed market. Literature on mixed-form markets points to possible reasons for the coexistence of different organizational forms in one sector and helps us to identify factors that might explain the currently changing make-up of the Dutch nursing home sector (Marwell & McInerney 2005; Rose-Ackerman 1990). We identify sector conditions, broader trends and context enablers.

Sector conditions

The profit motive incentivizes for-profit firms to enter a sector and expand when demand increases or changes (Hansmann 1980). In addition, for-profit organizations are more responsive to changing demand than non-profit providers because they do not face so-called 'trapped capital' (Hansmann et al. 2003). Although non-profit organizations aim at avoiding a negative net cash flow, they are not necessarily incentivized to minimize costs and to adjust capacity to demand. Hence, non-profit organizations tend to be slower in adjusting their capacity to changing demands than for-profit organizations.

A related factor that might lead to an increase of for-profit providers is heterogeneity in demand, giving non-profit and for-profit organizations the opportunity each to serve their own clientele. For example, non-profit nursing homes in the United States (U.S.) mainly target the "clinically more severe and financially more lucrative end of the payer spectrum", whereas for-profit facilities "usually have a less lucrative payer mix" (Konetzka 2009: 339).

Another related condition is the potential for 'cream skimming'. It is not unusual for non-profit organizations to cross-subsidize their services (Hansmann 1980). The surplus of payments made by individual clients is used to serve non-profit organizations' charitable clients. As for-profit organizations can choose to serve only profitable clients, they are able to compete on price and/or quality of services (Brown & Slivinski 2018; Rose-Ackerman 1990). In general, increasing prices in non-profit organizations beyond a break-even point, signals the market's

potential profitability, which may lead to for-profit organizations entering the market (Marwell & McInerney 2005).

Broader trends

Sector conditions are affected by broader trends: demographic developments, labor market circumstances, financial trends, and technological developments (Anheier & Ben-Ner 1997). For example, an ageing population would lead to an increase in demand for long-term care (LTC) services. Labor market circumstances determine the type of labor available and the fluctuations in labor costs. The non-profit and for-profit sectors may attract different types of labor and therefore changing labor market circumstances may affect them differently. For instance, the non-profit sector attracts more voluntary labor and so rising labor costs may give non-profit organizations a competitive advantage over for-profit organizations (Anheier & Ben-Ner 2003). Trends in the cost of financial capital can also affect the ownership composition. Non-profit and for-profit organization exploit different ways of attracting investment funds. For-profit organizations are able to attract private investors, such as private equity firms, because they can pay dividends, whereas non-profit organizations rely on financial means such as loans, donations, or grants. Finally, technological developments can lead to innovations that disrupt the current composition of the market (Christensen et al. 2010).

Context

These conditions and trends need to be placed in their regulatory, political and cultural context (Anheier & Ben-Ner 1997). Several contextual factors affect the emergence and growth of the for-profit sector. First, regulations can either promote or hinder the role of for-profit organizations (Brown & Slivinski 2018). For example, governmental regulations granting tax-exemptions to non-profit organizations give them a competitive advantage over for-profit providers. Second, the political and cultural context can be either receptive to or skeptical towards for-profit provision of healthcare services. For example, different types of welfare state can lead to different approaches to problem-solving that favor one organizational form over the other, because of more or less trust in the private sector. The American liberal welfare state favors for-profit provision whereas the social-democratic welfare states in Scandinavia favor public provision (Salamon & Anheier 1998). Third, path dependencies affect the emergence of for-profit providers: the ‘social origins’ of public goods provision and existing institutions create structures, norms and practices that can significantly influence

the organizational make-up of the sectors (Anheier & Ben-Ner 1997; Salamon & Anheier 1998). Fourth, the political and cultural context can be subject to broad, paradigmatic shifts. Most notably, the New Public Management (NPM) paradigm of the 1980s and 1990s encouraged business-like values such as efficiency, output measurement and customer orientation (Hood 1991). NPM heralded an era of privatization, tendering procedures for public services, and outsourcing. In many countries, the for-profit nursing home sector grew in response to the introduction of quasi-markets (Barron & West 2017; Karsio & Anttonen 2013; Mercille 2018; Stolt et al. 2011; Szebehely & Meagher 2018; Winblad et al. 2017). Figure 4.2 shows the schematic representation of the theoretical framework.

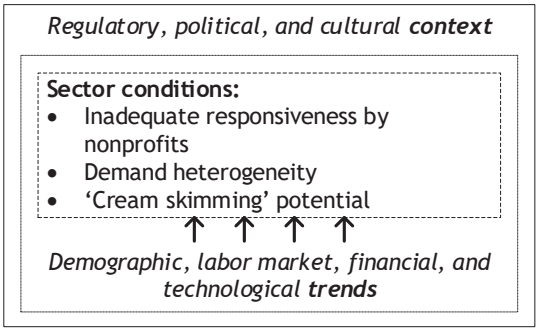

Figure 4.2 Summary of factors that can facilitate for-profit entry in non-profit dominated sectors

4.3 INSTITUTIONAL BACKGROUND

The comprehensive, universal LTC system in the Netherlands enables every citizen in need of LTC to rely on public funding. The Netherlands is one of the highest LTC spenders on nursing and personal care services among all OECD countries (OECD 2019).

In 2015, there was a major reform of LTC regulation in the Netherlands. The reform aimed to bring about a move from residential to non-residential care (Maarse & Jeurissen 2016). It also decentralized the LTC sector, delegating commissioning power to regional LTC offices. The reform reduced the responsibility of the government: instead of having overall control of the LTC delivery, the government would instead finance and safeguard the functioning of the LTC market.

For a person to get access to LTC and public financing in the Netherlands, they have to undergo both a care needs assessment and means testing. The care need

is determined by the Care Assessment Centre (CIZ) and gives a person access to public LTC funds (Wlz; Dutch LTC law). The Wlz regulation provides three options for care financing. The first and most frequently chosen option is the in-kind intramural package, which is used in non-profit nursing homes. It is an elaborate care package and also includes housing. For the in-kind intramural package, a regional LTC office contracts nursing homes within its region. People choosing the in-kind package are placed in a contracted LTC facility based on the suitability of the nursing home and on vacancies. The second financing scheme is an in-kind extramural package called the total home-care package (HCP, in Dutch: VPT) or the modular care package (MCP, in Dutch: MPT). Within this financing scheme, the regional LTC office only purchases the provision of care; care recipients organize and finance their own housing. This can be their own house or an apartment on the site of a nursing home. With MCP, the care is still contracted by the regional LTC office, but the eligible person can adapt the care package, for example by abstaining from the food services in the HCP package. The third option is funding in the form of a personal budget (PB, in Dutch: PGB), which allows clients to arrange their own extramural care instead of delegating this task to the regional LTC office. As both the second and third financing schemes are intended to facilitate the provision of care at home by making housing a private responsibility, both are considered to be extramural financing schemes.

4.4 METHODS AND DATA

We applied a mixed-methods approach in which we combined both quantitative and qualitative data to answer our research question.

Quantitative methods and data

Definitions

Dutch for-profit nursing homes are defined as facilities that have the legal status of a private for-profit company (private limited company, general partnership or sole proprietorship). Private equity firm is defined as a company which owns and trades unlisted, private companies; it creates one or more funds that obtain capital commitments from investors such as pension funds, insurance companies, or wealthy individuals. Using the fund's capital, along with a loan commitment, the private company acquires so-called portfolio companies, which are sold within three to seven years on average.

Data sources

There was no dataset available that included all the different types of Dutch nursing homes. Hence, we constructed such a dataset for this study based on two (semi-) public datasets: data from the Netherlands Patients Federation (2019) – period 2015-2017 – and data from the Dutch National Healthcare Institute (ZiN) of 2016 (ZiN 2017). We added data on regional characteristics (i.e. socio-economic indicators) from the Netherlands Institute for Social Research (SCP 2018) and Statistics Netherlands (CBS 2019b).

Variables and analysis

To ascertain the legal status, types of ownership, and the year of opening for each for-profit nursing home, we searched their respective websites, local news articles (using LexisNexis), ownership information from the Amadeus dataset (financial data and company information for European companies; Bureau van Dijk), and publicly available inspection reports of the Dutch Health and Youth Inspectorate. We then tried to obtain missing data through e-mail correspondence with the nursing homes. We also constructed a dichotomous variable for chain membership; nursing homes were categorized as chain members if they were part of a parent company with two or more nursing homes. Furthermore, we calculated the percentage of nursing homes owned by the four biggest chains, and used the ZiN-dataset to estimate the average number of clients living within the different types of nursing homes. The Netherlands Patients Federation data were used to identify significant differences in the client ratings between the different nursing home types, conducting the Welch t-test that corrects for unequal variances.

The regional statistics include the socio-economic status of the region and the average value of the buildings in euros. Regional statistics were linked by means of four-digit postal codes. The socio-economic status (SES) uses a standardized measure whereby zero equals the average Dutch neighborhood, and shows positive (higher) and negative (lower) scores than the SES average.

Qualitative methods and data

In addition to the quantitative analyses, we carried out a qualitative analysis to identify the distinctive features of for-profit nursing homes and to understand the factors that hinder and stimulate the growth of the Dutch for-profit nursing home

industry. The research ethics committee exempted this research for the Medical Research Involving Human Subjects Act (WMO).

Data collection

Twenty-two semi-structured, in-depth interviews were conducted with a total of 25 participants (See Table 4.4). All participants signed an informed consent form. The interviews consisted of the following two questions for directors and experts in the nursing home sector: (A1) What is the organizational model in the for-profit nursing home? (A2) What are opportunities and barriers for growth of the for-profit nursing home industry? Other questions were applied in the interviews with the (representatives of) clients of for-profit nursing homes: (B1) What were the reasons to choose this particular nursing home? (B2) What were the reasons to choose for a for-profit nursing home? (B3) How do you evaluate living in a for-profit nursing home? Interviews were audio-taped and transcribed verbatim.

Table 4.4 Profile of the participants

Background	Interview participants	
	n = 25	Participant no.
Director/ staff for-profit facility (facility related to chain)	5	6, 8, 22
Director/ staff for-profit facility (stand-alone facility)	5	5, 10, 11, 12
Client for-profit facility (or representative of a client)	5	1, 2, 3, 14, 15
General sector expert	5	4, 7, 9, 13, 16
Institutional actor[1]	4	17, 18, 19, 21
Director/ staff non-profit facility[2]	1	20

[1] Participants from the Ministry of Health, long-term care trade association non-profit sector, and LTC offices.

[2] The table lists the current positions of the participants. Many of them also had expertise on or experience in the non-profit sector.

Sampling

Participants were purposefully selected based on pre-selected criteria. These criteria included (1) the participant has expertise on the Dutch nursing home sector, (2) this expertise is based on at least three years of experience (this criterion does not apply to the client group of participants), and (3) the expertise was expected to add to the range of perspectives included in the sample. As the study had an explorative basis, maximum variation sampling was applied to capture a wide range of perspectives. We stopped adding new participants to our sample when we reached thematic saturation.

Data analysis

We applied inductive thematic techniques to identify major underlying themes in the interview data using Atlas.ti. Two researchers independently drafted a list of recurrent codes derived from the data. The two researchers collaboratively refined an initial set of codes that captured the main ideas in the data. Subsequently, the codes were collated into broader themes. For all themes, both the number of coded interview segments on the theme and the number of respondents that shared information on the theme were written down to weigh the relative importance of the themes, and to determine the central findings.

4.5 RESULTS

We start by outlining relevant regulatory, political and cultural context variables. Thereafter, we provide a description of the current make-up of the Dutch nursing home sector, including the distinctive characteristics of the for-profit nursing homes. The last paragraphs present our findings on the sector conditions and the broader trends that stimulated the for-profit expansion in the Dutch nursing home industry.

We acknowledge that many factors are strongly interconnected but we discuss each factor separately for the sake of analytical clarity. The dynamics between the factors are addressed in the discussion section.

Context

Regulatory context

The LTC reform of 2015 provided two opportunities for for-profit entry to and expansion in the Dutch nursing home sector.

Firstly, the profit ban for intramural care services prohibits the allocation of profits to third parties for nursing homes that apply the in-kind intramural care package. However, the ban does not apply to care delivered through the extramural financing schemes (i.e. HCP, MCP, and PB) or to nursing homes with fewer than seven people (Ministry of Health Welfare and Sport 2005). Although these extramural schemes were introduced to facilitate the provision of care at home, they are increasingly used to provide nursing home care for groups of care-recipients at

one specific location – that is, the clustered provision of extramural care. In this way, for-profit nursing homes circumvent the ban on profit distribution but are still able to receive public funding to provide care to people who are assessed by the CIZ as requiring nursing home care.

Secondly, affluent residents of non-profit nursing homes have to make high co-payments, and this opened up a market for for-profit nursing homes. All three financing schemes (in-kind, HCP/MCP and PB) come with obligatory co-payments that vary with the residents' income and capital. The maximum co-payment is €2,365 per month for the in-kind intramural package, and €862 per month for the extramural financing schemes in 2019. This system of obligatory co-payments is beneficial for the for-profit sector as the co-payment in their financing schemes (HCP/MCP and PB) is much lower than for the in-kind package in non-profit nursing homes. Hence, the in-kind intramural package is less attractive for a more affluent clientele, who can use the €1,500 per month difference in co-payments to rent an apartment in a for-profit nursing home. For the majority of for-profit nursing homes, prices for rent and services range from €3,000 to €4,500 per month, but could reach €7,500 per month (Thaens 2015). The cost of care, which is covered by public budgets and obligatory co-payments, is additional to the monthly rent and services prices – i.e. 'topping up' services (Szebehely & Meagher 2018).

Political and cultural context

The Netherlands should be considered a hybrid welfare state, resembling different welfare state types (cf. Arts & Gelissen 2002). The Dutch political context represents a decision-making model that is consensual, decentralized, horizontal and in collaboration with its stakeholders (Hendriks & Toonen 2001). Its political context is characterized by a collaborative relationship between government and non-profit sectors. Non-profit enterprises have been the dominant organizational form in the Dutch nursing home sector since World War II. Capital funds for non-profit entities were widely accessible, and, as a consequence, the entrance of for-profit providers in the healthcare sector was discouraged (Jeurissen 2010). The preference for non-profit providers was legally reinforced by a profit ban in 1977 (Plomp 2011).

Characteristics of the for-profit sector

Table 4.5a provides an overview of the descriptive statistics on the Dutch for-profit nursing home sector in 2019, which consists of 274 for-profit nursing homes, 12.2% of the total number of nursing home locations. For-profit nursing homes are much smaller than their non-profit counterparts: whereas for-profit homes have 20 clients on average per location, this number is 64 for non-profit homes. This implies that approximately 4.0% of the total nursing home client population lives in for-profit homes.

The majority of for-profit facilities are chain-affiliated. The proportion of for-profit nursing homes that are stand-alone is higher for homes that rely on PBs than for homes which rely on HCP/MCP. Most for-profit locations are owned by private individuals. One in five publicly-contracted for-profit nursing homes is private equity-owned; one in four is owned by an international chain.

Finally, our results show that for-profit nursing homes are more frequently located in affluent regions. For-profit facilities working from a PB, in particular, are situated in regions with a significantly higher socio-economic status and with a higher average value of buildings.

We found that the for-profit nursing home industry grew substantially over the years: 50% of the active for-profit nursing homes opened in the last three years (Figure 4.5). Approximately 50% of the for-profit nursing homes were already active before the LTC reform of 2015. These for-profit nursing homes relied on private payments or PBs. During our research, we obtained plans of for-profit chains indicating their intentions to open 45 new nursing homes in the near future, implying short-term future growth of at least 16% of the total number of for-profit nursing homes relative to 2017.

We also found an increasing uptake of HCP packages, which reflects the growth of the for-profit nursing home sector. Although HCP packages can be used to fund care at home, respondents highlighted that these packages are primarily used for clients in clustered living facilities that are mainly for-profit. The increase in HCP uptake is much higher (17% in 2016 and 19% in 2017) than for in-kind intramural packages (-2% and -1% respectively) (CBS 2019a).

Table 4.5a Descriptive statistics for-profit nursing home sector

	Non-profit	For-profit	
		For-profit contracted by the regional LTC office (HCP/ MCP)	*For-profit financed by personal budget (PB)*
Number of nursing home locations	87.8% n=1968[a]	12.2% n=274[b]	
		5.9%	6.3%
		n=132	n=142
Average number of clients[c]	64.2 (58.11) n=1678	22.9 (19.52) n=32	15.5 (5.13) n=21
Legal status ultimate owner			
Limited liability firm	-	98.5%	93.0%
Sole proprietorship or general partnership	-	1.5%	7.0%
Type of owner			
Privately owned	-	53.8%	78.9%
Investor	-	7.6%	19.0%
Private equity	-	20.5%	3.5%
International chain	-	26.5%	0.7%
Chain affiliation			
Chain membership	95.24%	81.8%	69.0%
Percentage nursing homes owned by the four biggest chains	6.1%	38.6%	40.9%
Geographical distribution			
Average SES (2017)[d]	-0.33 (1.18)	-0.10** (1.21)	0.13*** (1.07)
Average value buildings (x1000 in euros)[e]	210.54 (50.38)	219.88** (61.33)	219.48* (62.87)

Sources: Netherlands Patients Federation, National Healthcare Institute (ZiN), Netherlands Institute for Social Research, Statistics Netherlands

***p<0.01, ** p<0.05, * p<0.1

Standard deviation between parentheses

a. The number of intramural care providers in the ZiN dataset

b. Eight for-profit nursing homes were excluded, as it is unknown which financial package they apply; 20 nursing homes were excluded because they work from HCP/MCP, but obtained a non-profit status

c. Estimation based upon the numerator of the rate of psychotropic drug use per nursing home (ZiN dataset); since not all nursing homes reported on this measure, the number of nursing homes are smaller than the total number of nursing homes

d. Based upon a standardized measure: 0 represents the average Dutch neighborhood

e. In the region of the residence

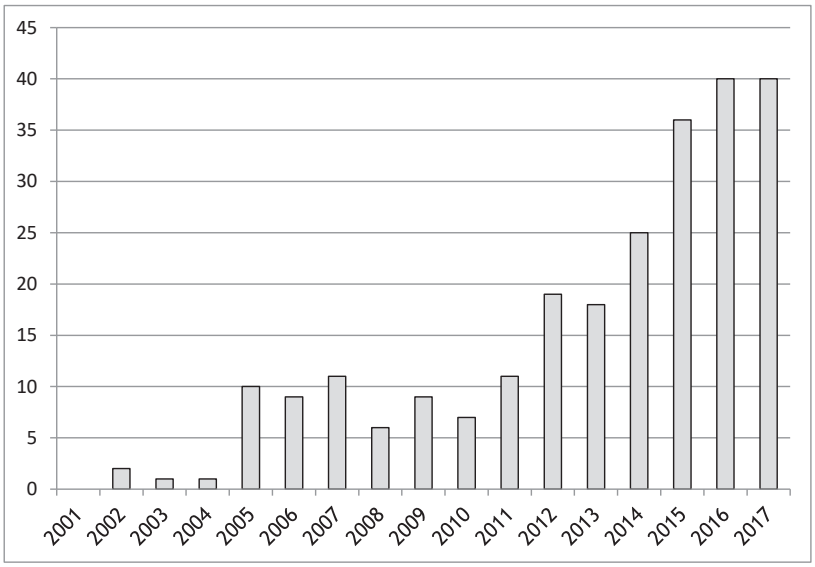

Figure 4.5 Growth for-profit sector (year of opening)
Note. There was 1 missing and 16 locations were opened in 2018, but were already included in the Netherlands Patients Federation dataset of 2017. Facilities that were closed were not included in the dataset.

Sector conditions

'Cream skimming' clients

For-profit nursing homes exploit the 'cream skimming' potential in the sector by selecting the type of clients they wish to serve. For-profit nursing homes working from the PB scheme are able to select their clients whereas other nursing homes have to accept clients referred to them by the LTC office. Participants from the for-profit sector confirm that they select clients based on how they fit with the existing group of residents and on the ability of staff-members to take care of certain client needs (i.e. severity of their disease). Moreover, despite the promise that clients can live in for-profit facilities until they die, participants mention examples of residents who, because of the severity of their disease, still had to move to a non-profit nursing home.

Inadequate responsiveness

For-profit nursing homes seem more responsive to changing demands than their non-profit counterparts. There have been increasing shortages in the Dutch nurs-

ing home sector; the number of people on waiting lists has almost doubled since 2017 (Hinkema et al. 2019). This left a vacancy for the for-profit sector to fill.

Moreover, for-profit nursing homes have been more responsive to the increased demand for a 'well-being' approach that focuses on well-being rather than the medical aspects of nursing home care, and that encourages small-scale nursing homes that feel 'just like home'. Participants state that for-profit nursing homes are frontrunners in the implementation of the 'well-being' approach whereas the non-profit sector often represents large-scale, bureaucratic and medically-oriented organizations. The qualitative data further indicate that the elderly of today, and their families, are increasingly demanding: they articulate their wishes and ask for environments that fit their lifestyle, which often does not align with the current supply of traditional non-profit nursing homes.

Participants provided numerous illustrations of what the 'well-being' approach means in practice. For example, the quality of food and food preparation is regarded as an important aspect of well-being. Another aspect of well-being is the living environment of for-profit facilities, which often includes nice outdoor spaces and large private rooms that residents can furnish themselves so that they feel at home, whereas many non-profit nursing homes provide fully-furnished rooms. Client participants stated that they also considered choosing a non-profit nursing home but that these looked too much like *"institution[s]"* (P2) or were *"too clinical"* (P3). In contrast, for-profit locations have common rooms that *"look like a hospital or traditional nursing home as little as possible"* (P11), for example through "*open front doors for residents [with dementia], and the absence of safety measures at the stairs"* (P22).

Our tentative analysis of the client ratings of the Netherlands Patients Federation finds that the well-being and customization approach in for-profit nursing homes is highly appreciated by residents. Although the number of for-profit nursing homes in our sample is relatively small, we find that client satisfaction is significantly higher at for-profit providers for all indicators (Table 4.5b).

Although non-profit nursing homes aim at moving in the direction of the 'well-being' approach and small-scale units, they are hindered by their heritage of large-size real estate, and an organizational culture in which the medical perspective on nursing home care is strongly embedded: *"Most for-profit providers benefit from their newness"* (P21). The Dutch for-profit nursing homes do not

start as large-scale organizations that converted from non-profit to a for-profit status, but rather as newly established organizations.

Table 4.5b Difference between the type of nursing homes and their client ratings

	Non-profit	For-profit[a]
Average score accommodation (scale 1-10)	7.94 (0.58)	8.78*** (0.39)
Average score employees (scale 1-10)	8.16 (0.43)	8.77*** (0.48)
Average score for listening (scale 1-10)	7.78 (0.48)	8.39*** (0.61)
Ratio of clients who would recommend the nursing home (dichotomous variable: yes/no)	0.92 (0.08)	0.95*** (0.07)
N	1.108	32

Source: Netherlands Patients Federation (2014-2017)
Standard deviation in parentheses
*** p<0.01, ** p<0.05, * p<0.1 (alternative hypothesis that for-profit ratings > non-profit ratings)
a. all for-profit providers were combined (HCP/MCP & PB financed) because the number of observations was deemed too low to separate the two groups

Utilizing the current care system

We found another factor that was at the benefit of for-profit nursing homes and that does not fall neatly into one of the predefined theoretical categories. Whereas most non-profit nursing homes employ staff for specialist care, for-profit homes are able to reduce labor costs by not hiring expensive staff for specialist care. Instead, specialist care in HCP/MCP-funded for-profit facilities often relies on geriatric specialists seconded from non-profit providers. Specialist care in PB-funded for-profit facilities relies on general practitioners (GPs). Hence, for-profit nursing homes greatly benefit from the wider healthcare system: they utilize the current care system to reduce their labor costs. GPs have raised their concerns about the limits of their profession in this organizational model: *"There was fuss about the role of the GPs in for-profit nursing homes working from PBs. Formally, these elderly live at their own home, which makes the GP the first point of contact for medical care. When 20 elderly people with severe dementia live in one place, however, it can be questioned whether this is manageable for GPs"* (P21). GPs perceive the care for the elderly in these types of homes as too severe and too specialized. Consequently, the Dutch Ministry of Health, Welfare and Sport (2019a) began questioning this for-profit nursing home strategy.

Although participants observed that the 'well-being' demand is mainly articulated by more highly educated elderly, our data provide no clear evidence for the heterogeneity of demand proposition as presented in the theoretical framework.

Broader trends

Demographic

Demographic trends have led to an increase in both the absolute and relative number of elderly in the Netherlands, and this trend is likely to continue in the upcoming decades. On average, the new generation of elderly is better educated than previous generations and wealthier in terms of equity (Commissie Toekomst zorg thuiswonende ouderen 2020). More than half of the elderly in the Netherlands have wealth in excess of 100,000 euros, and one in ten have wealth in excess of half a million euros (CBS 2019c). The older population is often able and willing to pay extra for a nice place to live and for extra services. One client participant stated, for example: *"I asked my sons: is it financially possible for me to live here? It was no problem. (…) Then what else can I wish for?"* (P14).

Labor market

The qualitative data highlight an important labor market trend: the relative size of the labor force diminishes while nursing homes need extra healthcare professionals (Commissie Toekomst zorg thuiswonende ouderen 2020). Respondents from both the for-profit and the non-profit sectors stated that labor shortages are to the relative benefit of for-profit nursing homes. The for-profit business model enables more time with clients, as the additional financial income for services is also used for the deployment of personnel. Moreover, the PB funding scheme liberates for-profit nursing homes from several bureaucratic rules by which nursing homes that rely on traditional in-kind funding schemes must abide. Participants from the for-profit sector state that they *"avoid the red tape that comes from working with LTC offices"* (P10), hence, more time is left to be with the clients. Participants also observe more 'hospitality employees' at for-profit nursing homes, such as cooks and hostesses – *"attention personnel"* (P22) who relieve the work of medical staff. Hence, for-profit nursing homes seem to be more attractive employers and face less difficulty in attracting care professionals.

Financial

Increasing financial pressure on the Dutch healthcare system seems to have contributed to the growth of for-profit providers. Without cost-cutting, the healthcare budget is forecasted to double in 2040, compared to 2015, crowding out financial sources for other collective goods (Ministry of Health, Welfare and Sport 2019b). The LTC reform of 2015 aimed at bending the increasing cost curve, leading to decreased LTC funding (Maarse & Jeurissen 2016). After a loud public outcry against the austerity cuts to LTC and its consequences (e.g. care quality scandals, long waiting lists in non-profit homes, and the deteriorating reputation of non-profit nursing homes), LTC received significant extra public funding from 2017 on (Ministry of Health, Welfare and Sport 2019c). *"Elderly do not want to go to a traditional [non-profit] nursing home; these homes rightly have a bad name."* (P11). Compared to sectors for domiciliary care and care for the disabled, the nursing home sector has been financially weak (CBS 2019d). In 2016, 39% of the nursing homes were loss-making entities (CBS 2017). According to the participants, many for-profit firms are less affected by these circumstances, mainly because their revenue model combines private and public funding. Where public funding for care costs (case-mix adjusted annual fees) is tight, the private funding arrangements in the Dutch for-profit nursing home sector allow homes to compensate by increasing fees for real estate and for additional services and amenities.

Another relevant financial trend is the changing access to and costs of financial capital. Due to market-oriented healthcare reforms, non-profit healthcare providers bear more financial risks, which makes banks more reluctant to issue loans (Plomp 2011). For-profit nursing homes have easier access to capital because they can circumvent the dependency on bank loans, for example by turning to private equity firms. Private equity firms can inject large sums of money into the for-profit sector, enabling them to expand quickly. Indeed we found that private equity firms are active in the for-profit nursing home sector (Table 4.5a). Once their investments have generated growth in the for-profit providers, private equity firms tend to sell the provider. Three private equity-owned Dutch nursing home chains were sold to international chains, comprising 49 locations in total. In all three cases, they were sold to French healthcare chains (Korian or Orphea). Several respondents expressed their concern about private equity firms' involvement in the for-profit nursing home sector as their focus might be on short-term profit maximization at the expense of quality. Client rating data tentatively suggests lower scores for private equity firm-owned nursing homes than other for-profit entities (Table 4.5c).

Table 4.5c Private equity ownership of nursing homes in 2016; client ratings 2014-2017

	Non-private equity owned nursing home	Private equity owned nursing home
Accommodation	8.84	8.63*
	(0.43)	(0.31)
Employees	8.91	8.46***
	(0.44)	(0.44)
Listening	8.62	8.01***
	(0.50)	(0.55)
Information	8.44	7.88***
	(0.55)	(0.60)
Recommendation	0.97	0.92**
	(0.04)	(0.07)
N	19	16

Although participants from the for-profit sector mentioned examples of the use of technology (e.g. home automation), technological trends were not mentioned as a main trend that explains the current for-profit sector expansion.

4.6 DISCUSSION AND CONCLUSIONS

This study is, to the best of our knowledge, the first academic study aimed at mapping for-profit nursing homes in the Netherlands and understanding the factors that stimulated its growth. We found substantial recent growth in for-profit nursing homes in the Dutch LTC system. Fifty percent of the currently active for-profit homes were established in the last three years, resulting in a for-profit market share of 12% (measured in the number of nursing home sites). In comparison to their non-profit counterparts, Dutch for-profit nursing homes are more often small-scale and more focused on high-income clients. The for-profit sector consists of both stand-alone homes and chains, including private equity-owned chains.

An interrelated mix of context variables, sector conditions and broader trends has stimulated for-profit nursing home expansion in the Netherlands. First and foremost, the regulatory context changed. The reforms designed to encourage deinstitutionalization of elderly care unlocked opportunities for the for-profit nursing home sector. For-profit nursing homes embraced new extramural funding schemes which allowed them to circumvent the for-profit ban. In other words, the

for-profit sector exploited loopholes in the regulatory framework. We found that the peak of the number of newly established for-profit nursing homes coincided with the implementation of the LTC reform.

In addition, several sector conditions created opportunities for for-profit newcomers in the nursing home sector. A first condition was the inadequate responsiveness of the dominant non-profit nursing home sector. The non-profit sector was unable to respond to the demographically-driven increase and change in the demands of a new generation of elderly. The for-profit sector provided an alternative to the traditional non-profit nursing homes. For-profit nursing homes were able to acquire this role because most of the for-profit nursing homes are newly established organizations, able to design their organizational model from scratch. For-profit nursing homes established a well-being approach that tallied with the wishes of their clientele, while non-profit nursing homes were less able to do so. This finding runs contrary to findings in Nordic countries (i.e. Denmark, Finland, Norway and Sweden) for which a previous study found that traditional nursing homes were able to reform their nursing homes from a medical to a social care model (Szebehely & Meagher 2018). Tentative analyses find that for-profit providers' focus on well-being resulted in higher client ratings than the non-profit sector.

A second sector condition encouraging for-profit sector growth was the 'cream skimming' potential for for-profit nursing. We found that for-profit organizations target a relatively affluent clientele, partly in response to the greater wealth of the current generation of elderly compared to previous generations. The PB-financed nursing homes are particularly able to reap the benefits of 'cream skimming' because they enjoy more freedom to select their clients than the HCP/MCP-funded for-profit nursing homes.

A third sector condition was the design of a for-profit business model that relies heavily on the wider care system for specialist care by using geriatric specialists seconded from non-profit providers or by relying on general practitioners (GPs). For-profit nursing homes reduce labor costs by utilizing the wider healthcare system. This 'system utilization' was not found in literature and therefore adds to our understanding on what factors stimulate the expansion of for-profit providers in mixed markets.

These sector conditions need to be seen in the context of the aforementioned demographic changes, as well as financial and labor market changes. Due to an

affluent clientele that pays for additional services and their avoidance of red tape in the case of PB-financed care, for-profit nursing homes have more financial leeway to hire 'attention staff' and to have a high staff/client ratio. This, in turn, makes for-profit homes more attractive employers relative to non-profit nursing homes. Hence, labor shortages are to the relative benefit of for-profit nursing homes. In addition, an important financial driver for the for-profit providers' rise was their access to financial capital from private investors (including private equity firms). The money injection by private equity firms fostered the for-profit sector's growth, while non-profit organizations were unable to attract such capital and also faced difficulties in getting bank loans. Furthermore, the financing of for-profit organizations with both public and private funding enabled them to rely less on public funding, shielding them somewhat from austerity measures.

Limitations

Our methods come with some limitations. Firstly, specific case-mix control variables were not available. Our qualitative data indicate that non-profit nursing homes tend to have a heavier case mix, but this could not be controlled for in our study. Secondly, our view of for-profit nursing homes is limited to homes detected by the Netherlands Patient Federation or ZiN. Since some stand-alone homes might be unknown to them, there might be a slight underreporting of the number of for-profit homes. Thirdly, a relative low number of for-profit nursing homes received 15 or more client ratings in the Netherlands Patients Federation dataset. We therefore present these quantitative data as supporting evidence to our qualitative findings. Finally, a large proportion of the participants in our study were working in or were affiliated with the for-profit sector, which might lead to a bias in the qualitative data in favor of for-profit nursing homes. Data from the for-profit sector were therefore constantly compared to data from other participants. Results were only included if they were confirmed by participants from different backgrounds (Table 4.4).

Implications

The growing for-profit nursing home sector sparks governance questions. Based on the qualitative and quantitative findings, we outline several possible governance implications related to the composition of the market, care quality norms, and accessibility.

The for-profit nursing home growth has two interconnected implications for the market composition of the Dutch nursing home sector. The first relates to market consolidation. The four biggest chains in the for-profit sector in the Netherlands already own about 40% of all the for-profit nursing homes. Consolidation could have negative consequences for the quality of care: studies on U.S. nursing homes have found that for-profit nursing home chains provide inferior quality of care (Harrington et al. 2012; Kitchener et al. 2008). The second implication relates to private equity firms investing in for-profit nursing homes. In countries such as Sweden, Norway, Canada, the United Kingdom and the U.S., private equity firms are active within the nursing home sector (Harrington et al. 2017; Winblad et al. 2017). Our data show that Dutch nursing home chains are also partly owned by these firms. The consequences are unclear because the international evidence on the quality performance of private equity firms is inconsistent: studies present both indications of lower quality in private equity homes, (Harrington et al. 2012; Pradhan et al. 2014) and no harm to quality of care (Stevenson & Grabowski 2008). Our data tentatively suggest that client ratings are lower among private equity-owned nursing homes (Table 4.5c). The changing composition of the Dutch nursing home sector towards for-profit chains and the presence of private equity firms demands close scrutiny with regard to their long-term consequences.

A second and related implication of the presence of the for-profit sector concerns quality norms. We found that for-profit nursing homes seem to score better on client satisfaction rates – in contrast to U.S. findings (Li et al. 2013), but in line with the findings from Sweden (Stolt et al. 2011). The latter study reported that private nursing homes "seem to focus more on personal service aspects rather than on structural prerequisites for care quality" (Stolt et al. 2011: 565). Most literature reviews from the U.S. report lower care quality in for-profit nursing homes than in non-profit homes (Bos et al. 2017; Comondore et al. 2009; Hillmer et al. 2005). Studies in Nordic countries do not unequivocally support these findings (Hjelmar et al. 2018; Winblad et al. 2017). Further research is needed on *how* for-profit ownership affects care quality in Dutch nursing homes.

Lastly, the presence of the for-profit sector also has implications for the accessibility of the nursing home sector. Although we found some examples of for-profit nursing homes that target low- and middle-income groups, the majority of for-profit nursing homes target high-income elderly. The 'cream skimming' behavior of for-profit providers further perpetuates the polarization of the nursing home sector. These two factors raise concerns about the general accessibility of the Dutch nursing home system for lower income groups due to the more limited op-

tions available to them and due to potential differences in waiting lists (Plaisier & Den Draak 2019).

Although the for-profit sector has possibly eased the waiting lists for nursing home care and has shaken up the unresponsive traditional LTC market, there are serious governance risks associated with the for-profit sector providing nursing home services. If the for-profit nursing home sectors maintain its low profile, as it has been able to do for most of its existence, the societal implications could be profound and might counter the benefits associated with the for-profit sector.

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Ethical issues

The study has been reviewed by the ethics committee on the basis of the Dutch Code of conduct for health research, the Dutch Code of conduct for responsible use, the Dutch Personal Data Protection Act and the Medical Treatment Agreement Act The ethics committee has passed a positive judgment on the study.

5

What Happens to a Nursing Home Chain when Private Equity Takes Over? A Longitudinal Case Study

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ABSTRACT

We analyzed what happens to a nursing home chain when private equity takes over, with regard to strategy, financial performance, and resident well-being. We conducted a longitudinal (2000-2012) case study of a large nursing home chain that triangulated qualitative and quantitative data sources from five different data sources. Results show that private equity owners continued and reinforced several strategies that were already put in place before the take-over, including its focus on keeping staffing levels low; the new owners added restructuring, re-branding, and investment strategies such as establishing new companies, where the nursing home chain served as an essential 'launch customer'.

5.1 INTRODUCTION

Private equity firms own and trade unlisted, private companies. A central investment strategy of private equity firms is the leveraged buyout (LBO), which is characterized by high leverage, large management ownership, and active corporate governance (Palepu 1990). In a LBO, the private equity firm creates a fund that obtains capital commitments from investors such as pension plans, insurance companies, and individuals. Using the fund's capital, along with a loan commitment on behalf of the fund, the private equity firm acquires a so-called portfolio company, and holds the portfolio company for approximately three to five years (Gilligan and Wright 2008). During this period, it seeks to increase the value of the company, to realize a profit when it sells the company. The profits in case of such an 'exit' are distributed among the fund investors and the private equity firm (GAO 2010).

In the past two decades, private equity interventions have been the issue of several public debates. Private equity opponents argue that the increased leverage in LBOs make firms short-term oriented. In addition, buyouts would often result in a redistribution of wealth from employees to investors (Burns et al. 2016; Duhigg 2007; Froud & Williams 2007; Palepu 1990). In contrast, proponents argue that the organizational changes in LBOs improve manager's incentives to maximize value, leading to improved company performance (Palepu 1990).

Since the 1990s, private equity firms regard the health care sector as an attractive investment area (Robbins et al. 2007). The health care sector captures approximately 10% of the private equity deal activity worldwide, with providers and related services as the most popular sub sector (nearly 50% of the total healthcare deal volume). Providers and related services include large 'healthcare-heavy assets', the label private equity firms apply to 'assets with meaningful exposure to reimbursement risk' (Bain & Company 2015: 7). The involvement of private equity firms in health services fits into the global movement towards involving the private sector to attract capital and to deliver health services (Cuff et al. 2012). Private equity in health services is most visible in the U.S. nursing home industry, where four out of the ten largest for-profit nursing home chains were purchased by a private equity firm in the 2003-2008 period (Harrington et al. 2011). Moreover, in countries such as Canada, Norway, Sweden and the United Kingdom, large for-profit nursing home chains are increasingly owned by private equity investors (Harrington et al. 2017). It is therefore very relevant to study private equity in nursing homes.

Studies on private equity in U.S. nursing homes show mixed outcomes. Pradhan et al. (2013) reported that private equity owned nursing homes show better financial performance than other for-profit nursing homes, while Cadigan et al. (2015) found little impact of private investment purchases for the financial health. On staffing, Stevenson and Grabowski (2008) found reduced nursing home staffing after private equity transactions, but they reported that staffing levels were already decreasing pre-purchase. Yet another study found lower staffing of registered nurses (RNs) in private equity owned nursing homes (Pradhan et al. 2014). Harrington et al. (2012) found no significant changes in staffing levels in the post private equity purchase period, in part because staffing levels in large chains were already lower than staffing in other ownership groups in the pre-purchase period. And while Stevenson and Grabowski (2008) reported no difference in quality, two other studies reported significantly higher levels of deficiencies after private equity purchases, being an indicator of worsened care quality (Harrington et al. 2012; Pradhan et al. 2014). Another study showed that nursing homes that underwent chain-related transactions had more deficiency citations in the years preceding and following a transaction than those nursing homes that maintained common ownership (Grabowski et al. 2016).

These mixed findings imply that outcomes may vary, depending on private equity owner's strategies and contextual characteristics of individual portfolio companies. Scholars therefore stress that: *"[there is] a scarcity of cases reporting in any detail on the kind of restructuring that takes place in individual companies after they are acquired by private equity firms […]. There is a requirement for fine-grained research […] at the micro level"* (Rodrigues & Child 2010: 1322). They stress the need for *"longitudinal studies that chart the development and impact of changes"* during private equity ownership (Wright et al. 2009).

We conducted a longitudinal case study, in a large U.S. nursing home chain that is currently private equity-owned. We studied the strategies that were executed both before and after the acquisition. Furthermore, we examined financial performance, as well as quality performance measures over time. The central research question was: What happens to a nursing home chain when private equity takes over? Our study adds to previous studies on the topic, by focusing on 'how' private equity is at work in an industry that is taking care of frail elderly.

5.2 METHODS

Case Selection

This foundational study used a longitudinal case study (2000-2012) of a private equity owned U.S. nursing home chain, named Golden Living. The company was named Beverly Enterprises until the LBO by Fillmore Capital in 2006. Golden Living owned more than 300 nursing facilities in 21 states[1] and additionally delivered assisted living, rehabilitation therapy, hospice services, group purchasing to healthcare companies, and healthcare staffing. The company, originally founded in 1963, employed about 42,000 employees in 2012. The case study methodology allowed for an in-depth, focused analysis of the nursing home chain, and was ideal for examining a contemporary set of events, over which we had little or no control (Yin 2003). LBOs are complex phenomena where context is important. Little is known about strategies and results after LBOs in nursing homes, and a case study approach is well suited as an exploratory and exemplifying analysis. We believe this is one of the first in-depth case studies on the private equity phenomenon in general, and the very first in the nursing home sector in particular.

The case was purposively selected for three reasons. First, Golden Living, a publicly traded company on the New York Stock Exchange since 1982, was purchased by private equity firm Fillmore Capital in March 2006 for about $2.3 billion. The period of private equity ownership was considered as long enough to study developments over time. Moreover, Golden Living was one of the largest LBOs in that period. The effects and strategies are therefore relatively well documented, and it makes the case very relevant from a welfare point of view. Second, Golden Living was acquired by a midsized private equity firm. The majority of private equity deals in health services is carried out by midsized PE firms (Robins et al. 2008). Third, strategic changes in a company can be initiated by any new owner or leader of a company, whether it is a private equity owner or not (Zhang et al. 2010). In 2000, a new President and CEO was appointed and the ownership transfer to Fillmore Capital was also accompanied by a new CEO in 2006. Since we have gathered data for the period 2000-2012, we were able to compare the leadership change without private equity backing to the leadership change that was initiated by the new private equity owner.

It is important to note that Golden Living was already a large, NYSE-listed public for-profit chain. The company converted from being publicly listed and under SEC regulations, to private equity ownership. This private ownership comes with far

less regulatory scrutiny and compliance cost. While public companies are highly subject to short-term profit demands by market investors, private equity owned companies have more latitude for longer-range strategic planning. The results of the case have to be interpreted against this background.

Data Sources

We triangulated qualitative and quantitative data sources as part of a deliberate search for confirming and disconfirming evidence. Our mixed-methods design had a longitudinal and comparative approach for both quantitative and qualitative data. We analyzed changes over time, and contrasted strategies and outcomes in our case with industry developments.

First, we analyzed qualitative data over the period 2000-2012, as available in press releases, Provider Magazines, and reports of litigation actions. The annual top-50 information on nursing home chains in Provider Magazine, including an analysis of the main developments and strategies in the industry of each particular year, served as the main background to compare the strategies of Golden Living to those of other U.S. nursing home chains. We did a structured search in LexisNexis on the search terms "Golden Living" (965 hits, selection of 88 articles) and "Beverly Enterprise" (996 hits, selection of 134 articles).[II] In addition, we interviewed purposively selected respondents: a central Golden Living executive, two representatives from private equity firm Fillmore Capital, the CEO of Golden Living, and an attorney involved in a class action lawsuit against several facilities of Golden Living. These qualitative data provided insights in the company's strategies.

Second, we compiled a dataset for Californian nursing homes (covering about 1.200 facilities for each year), using cost report data of the California's Office of Statewide Health Planning and Development (OSHPD) for the period 2000-2012. We compared relevant outcomes for Golden Living facilities with regard to financial performance and resident well-being for the pre-, and post purchase period, and weighted the results for Golden Living against industry counterparts. For the analysis, we excluded non-profit, government, and hospital-based facilities from the comparison group, because they have very different financial patterns. One limitation of the study was that we did not have access to company financial data after 2006 and California nursing home cost data may not have been representative of the company's overall financial picture. Although there were no indications that the Californian Golden Living facilities differ strongly from the company's

facilities in other states, generalization of the data to the whole company ask for utmost caution. We added quantitative staffing data and deficiencies (violations of quality regulations) for all Golden Living facilities in the U.S. compared with other U.S. nursing homes from the Online Survey, Certification and Reporting data (OSCAR, covering about 14.700 facilities).

Concepts and definitions

Our case study focused on the concepts corporate strategy, financial performance and resident well-being.

Corporate strategy. Strategy was a central concept in this study, because we focused on 'how' private equity is at work. Corporate strategy is about organization-wide changes, as initiated by top management. Strategy was approached as a combination of deliberately 'planned' change and emergent events 'imposed' by environmental forces (Mintzberg & Waters 1985). Qualitative data were the main data source for reconstructing strategy over 2000-2012. In addition, from the datasets, we regarded payer mix as an indicator of strategy, because nursing homes that focus on maximizing financial performance may shift resident census from Medicaid in favor of financially higher paying Medicare and private payers (Cadigan et al. 2015; Konetzka et al. 2006). Furthermore, we also regarded staffing, as well as skill mix, as part of a deliberate strategy, because these variables give information about the management of labor costs. Staffing is also closely related to quality outcomes, and often regarded as a structural measure of resident care quality (Grabowski et al. 2016; Hillmer et al. 2005).

Financial performance. Financial performance included four variables. First, we included operating and total margins, which have been regarded as traditional measures of financial performance in healthcare literature (Cadigan et al. 2015; Weech-Maldonado et al. 2003). In addition, we included data on the long term debt/asset ratio (since private equity firms may use relatively much debt in their portfolio companies) and net income per patient day (Gilligan and Wright 2008; Palepu 1990).

Resident well-being. From the national On-Line Survey and Certification and Reporting System (OSCAR) dataset we included data on about 300 Golden Living facilities and total U.S. nursing homes on total deficiencies, and serious deficiencies. Deficiencies are often used in academic studies as a measure of care quality (Grabowski et al. 2016; Hillmer et al. 2005). Nursing homes participating

in Medicare and Medicaid are required by federal law to disclose all deficiencies. At last, data on litigation actions against the company reported in the news were identified. A definition of each variable included is provided in table 5.2.

Table 5.2 Concepts, variables, definitions, and data sources

	Variables	Definition	Data source
Corporate strategy	General strategy	Organization-wide changes, as initiated by top management	Press releases, Provider Magazines, interviews
	Payer mix	The percentage of revenue from Medicare, Medicaid (called Medi-Cal in California), and other payers (i.e. the sum of revenues from self-pay patients, managed care patients and other payers).	California's Office of Statewide Health Planning and Development (OSHPD) for the period 2000-2012
	Staffing hours ppd	Average number of staffing hours ppd, of direct care professionals: Registered Nurses (RNs), Licensed Vocational Nurse (LVNs), and Nurse Assistants (NAs).	OSHPD data 2000-2012 and Online Survey, Certification and Reporting (OSCAR) data for 2003-2012
	Skill mix	RN productive hours /(LVN productive hours + NA productive hours). The composition of nursing staff by licensure/ educational status.	OSHPD data 2000-2012
Financial performance	Operating margin percentage	Net from Health Operations / Total Health Care Revenue. Focuses on core business functions and excludes the influence of nonoperating incomes and expenses.	OSHPD data 2000-2012
	Total margin percentage	(Total revenue – total expenses) / total revenue. Includes all operating and nonoperating revenues and expenses.	Idem
	Net income per patient day (ppd)	Net income of the company / total number of patient days.	
	Long term debt/ asset ratio	Long term debt / total assets. Percentage of assets that are financed with loans and financial obligations lasting more than one year. General measure of the financial position of a company.	
Resident well-being	Total deficiencies	Deficiencies are issued to facilities that fail to meet the federal standards for Medicare and Medicaid participation. Deficiencies are classified into several categories on the basis of their scope and severity.	OSCAR data 2003-2012
	Serious deficiencies	So-called level G or higher deficiencies, including those deficiencies that that cause harm or jeopardy to residents.	
	Litigation actions	Major lawsuits by the state or federal government or private parties reported in the media.	Press releases and reports of litigation actions

Data analysis

Qualitative data from press releases as well as the interviews were categorized chronologically and then thematically content analyzed using software for qualitative data analysis (MaxQDA). We inductively added and specified codes while analyzing our data. We stopped adding new codes at the point of theoretical saturation. The qualitative data from the interviews supported and specified the findings on strategy.

Quantitative data were analyzed using Mann-Whitney U-tests to compare the scores of Golden Living facilities with other Californian for-profit facilities, using the Statistical Package for the Social Sciences (SPSS). Furthermore, we conducted Wilcoxon Signed Ranks tests for each variable, to compare pre-purchase period (2000-2005) and post purchase period (2006-2012) scores. We only reported outcomes of the pre-post analyses if we found remarkable contrasts in comparison to industry trends. At last, the OSCAR data on staffing and deficiencies were analyzed using Satterthwaite t-tests for unequal variances.

5.3 RESULTS

Corporate strategy

Mr. Floyd was appointed as the new CEO of Beverly Enterprises Inc. in 2001. As the largest for-profit chain in the U.S., Beverly faced serious financial problems at that time, like many other nursing home chains. In spite of efforts to turn around the company, Beverly faced a large number of lawsuits alleging neglect of residents and deaths in states like Arkansas, California, and Florida. The company was subject to a U.S. Health and Human Services Department and U.S. Department of Justice Corporate Integrity (oversight) Agreement from a 2000 settlement agreement for poor quality of care. As a result of these problems, Beverly company stock fell dramatically to less than $2 per share.

As the company's financial status and its stock prices improved in the following years, it became the target of an "hostile and secret acquisition of shares" by private investment firm Formation Capital. In 2005, Beverly's board of directors therefore announced an auction process "to maximize value for all of the company's stockholders as soon as practicable through a sale of the company". In March 2006, private equity firm Fillmore Capital acquired Beverly Enterprises Inc.,

which was then renamed Golden Living. The ownership change was accompanied by a newly appointed three-member board of directors, with Fillmore President Mr. Silva as the new chairman. Mr. Churchey was named CEO, and was replaced by Mr. Kurtz in 2008. For the pre- and post-purchase period, many strategies were continued and reinforced, while the private equity owners also applied some new strategies (See Table 5.3a).

Table 5.3a Summary of the main strategies executed

Continuing strategies (both pre- and post-purchase)	Post-purchase strategies
– Divestment*	– Restructuring*
– Diversification*	– Rebranding
– Intensified corporate control	– Relocation
– Staffing level control*	– Accelerated ICT investments
	– Increased skill mix and employee training and benefits

*An industry wide trend: strategy executed by many other for-profit nursing homes chains as well

Divestment and diversification

From 2001 onwards, Golden Living divested more than 150 nursing home facilities, mainly motivated by high patient liability costs in states like Arkansas and Florida. When the company started its divesture program, CEO Floyd explained that:

> "this first group of [20] facilities (…) were expected to generate (…) less than six percent of our total revenues , but they accounted for 20 percent of our total patient care liability costs projected for this year (…). Except for disproportionately high liability costs, these would be very successful facilities."

Although some single nursing homes were closed down, most of the nursing homes were sold to other nursing home chains, real estate companies or investment companies. Although the company mainly divested nursing home facilities, there were other divestments as well, such as the divestment of 141 outpatient therapy rehabilitation clinics and of 20 licensed home care agencies. Divesture was an industry wide trend at that time: slashed Medicare rates and high leverage forced many nursing home chains to shed unprofitable facilities. The divestment of unprofitable nursing homes continued in the post- purchase period. By 2006, Beverly was the second largest U.S. for-profit chain with 342 facilities, and 35.839

beds (Provider Magazine 2006). After more divestment, Golden Living was ranked fourth in size with 302 facilities and 30.790 beds in December 2012 (Provider Magazine 2013).

Mainly after 2004, the strategy of divestment was accompanied by diversification efforts. The company started to invest in new profitable services, such as rehabilitative services, Alzheimer's units, and hospice care. This diversification strategy was implemented to attract more private-pay and Medicare post-acute care revenue. CEO Floyd described the strategy as building Beverly "into a diversified eldercare services company, with ancillary businesses in the high-growth, high-margin areas of healthcare services". Again, diversification strategies were an industry wide trend at that time. This strategy continued post-purchase, with a focus on the growth of home health and hospice business. Furthermore, new company development was added. Post-purchase CEO Kurtz explained:

> "We've created companies ourselves, diversifying the revenue stream. We created a rehab company, we created a hospice company, a pharmacy company, a staffing company. We'll start a company that will provide transitional care management. So we create companies to create value."

Golden Living's nursing homes often served as the essential business for the development of its newly created companies. For example, in 2012, Fillmore Capital launched pharmacy services company AlixaRx, for which Golden Living served as the necessary "launch customer": AlixaRx started off with an agreement with Golden Living to provide pharmacy services to the company's more than 300 centers. Fillmore Capital's chairman of the board of directors Silva stated that "AlixaRx will be wildly profitable".

In spite of this diversification strategy to attract more Medicare and private pay patients, our analysis of the California OSHPD data showed the opposite: Golden Living served significantly more Medicaid patients from 2007 onwards. At the same time, from the private equity ownership in 2006 onwards, the percentage of revenue from private payers was significantly lower than this revenue stream in other for-profit companies in California (See Table 5.3b).

Intensified corporate control

Both before and after the acquisition, the respective boards executed a strategy of intensified corporate control. We found three manifestations of intensified

control pre-purchase. First, a new labor management system was introduced to facilitate greater control over the use of staff and to reduce the use of temporary labor. Second, performance related pay was introduced for managers. Each individual facility was judged by a scorecard, with factors such as pretax income, employee turnover, occupancy, bad debt and quality of care. Third, local managers were given a smaller span of control, being responsible for approximately ten homes each, about half the number they had been overseeing.

The private equity owners reinforced this strategy, by further reducing the span of control of local directors; they now managed six to eight nursing home facilities instead of ten. Post-purchase, the focus on performance-related pay was also enhanced. CEO Kurtz explained:

> "As part of the decentralization, we very dramatically increased the compensation for the leaders of our LivingCenters (…). [Their] performance, both financial performance and clinical excellence, defines how their pay would be allocated. (…) They can almost double their salary. We tried to switch more of the salary to compensation based on performance rather than just base salary."

Control staffing levels

A strategy that emerged from the analysis of the datasets, is the control of staffing levels, both pre- and post-purchase (See Table 5.3b). We found that the total staffing hours per patient day (ppd) in California, while being highly comparable to industry counterparts pre-purchase, became significantly lower from 2007 onwards. This trend also held for Certified Nurse Assistant (CNA) staffing hours ppd, and from 2009 onwards also for Licensed Vocational Nurse (LVN) staffing hours ppd, which were significantly lower for many years post-purchase. In contrast, from 2010 to 2012, Golden Living had significantly higher Registered Nurse (RN) staffing levels than its industry counterparts. The company stressed in its company information and in interviews that it deliberately increased the number of RN caregivers. The skill mix (the proportion of higher educated nurses when compared to lower educated nurses) was indeed significantly higher from 2009 onwards. While total staffing levels in California were lower during private equity ownership, the composition of staffing changed in favor of higher educated nurses. The national data on staffing show a roughly similar pattern. However, here we see that the total staffing as well as the RN staffing were also significantly lower pre-purchase, for the years 2003-2005. National data also showed a

Table 5.3b Median scores for Golden Living facilities for 2000-2012; compared to other for-profit facilities in California

	Pre-purchase			Post-purchase								
Variables\ year	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
STRATEGY													
Staffing hours ppd (California)													
- RN	.33	.31	.31	.33	.39	.30	***.22***	***.22***	.28	.35	.45*	.59**	.68**
- LVN	.62	.63	.61	.61	***.56***	***.63***	***.61****	***.71***	***.73***	***.72****	***.62****	***.50****	***.40****
- CNA	2.15	***2.21***	***2.26***	***2.33***	2.39	2.38	2.57**	***2.29****	***2.29****	***2.23****	***2.24****	***2.28****	***2.31****
- Total staffing (RN+LVN+NA)	3.10*	3.14	3.24	3.29	3.31	3.31	3.40	***3.24****	***3.29****	***3.28****	***3.31****	***3.35****	***3.44****
Staffing hours ppd (U.S.)[1]													
RN				***.50****	***.51****	***.50****	***.50****	***.50****	***.55****	***.62****	***.68***	***.76****	***.76***
Total staffing (RN+LVN+CNA)				***3.06****	***3.11****	***3.11****	***3.12****	***3.16****	***3.29****	***3.35****	***3.40****	***3.44****	***3.44****
Skill mix	.11	.11	.10	.11	.13	.10	***.07***	***.09***	.09	.12*	.16*	.21**	.26**
Payer mix:													
- Medicare	11.70*	10.72*	10.11*	12.23	***9.53***	***10.90***	23.05**	12.19	13.13	***12.36***	***12.19***	***11.81***	***11.57***
- Medi-Cal (Medicaid)	***64.97***	***69.88***	***69.10***	37.67	79.12	80.08	66.24	79.53*	79.03*	76.90*	79.27*	79.35*	79.86**
- Other payers	23.90	20.91	***17.47***	17.58	*9.58*	***6.94***	***8.28****	***8.90****	***7.84****	***7.24****	***7.82****	***8.30****	***6.92****
FINANCIAL PERFORMANCE													
Operating margin	5.56	9.87*	3.32	***-3.81****	***-5.99****	***1.33***	12.54**	10.47**	9.13*	12.47**	11.34**	15.00**	8.99*
Total margin	-.77	***-.82***	***-.91****	***-.96****	***-.87***	-.81	-.62**	-.83	-.74	-.72	-.64*	-.71	-.60*
Net income per patient day	5.18	9.69	3.19	***-8.76****	***-5.82***	***1.49***	25.35**	22.93**	20.82*	29.84**	18.23*	24.76*	13.61
Long term debt/ asset ratio	***.78****	***.00***	***.00***	***.00***	***-66.67****	***-84.02****	***.00****	64.91**	68.77**	***.00***	***.00***	***.00***	***.00***
RESIDENT WELL-BEING													
Total deficiencies (U.S.)[1]	-	-	-	***6.79****	***6.29****	***5.67****	***7.47****	***8.43***	***7.27****	***7.95***	***7.29***	***7.67***	***7.19***
Harm deficiencies (U.S.)[1]	-	-	-	***.34****	***.33****	***.37****	***.52***	***.63***	***.41****	***.39***	***.43***	***.44***	***.27****

* $p < .05$; ** $p < .001$; ***Bold italic***: lower score than industry counterparts; all other scores are higher than those of industry counterparts

[1] The mean U.S. scores on staffing and deficiencies were derived from the OSCAR dataset; the other scores were derived from the California OSHPD data

rise in RN staffing on the national level for 2010-2012, with significantly higher RN staffing for the year 2011. Golden Living's RN and total staffing levels increased after 2008 consistent with the substantial staffing increase in U.S. facilities, but its total staffing levels did not keep pace with the national trends.

Restructuring, rebranding, and relocation

Several post-purchase strategies mark a change when compared to the pre-purchase period. A first change in this respect is the legal restructuring of the company, by adding new layers and Limited Liability Companies (LLCs). With regard to the layering, Fillmore Capital created Pearl Senior Care LLC to purchase Golden Living. Pearl Senior Care in turn owned Drumm Investors, LLC, which in turn owned Golden Horizons (the operation company) and Geary Property Holdings (the real estate). The operations were thus legally separated from the buildings and the land of the nursing home facilities (See the chart in Appendix 1). Nursing home facilities in turn leased their buildings and land. Furthermore, Golden Living's nursing homes were split up into separate LLCs. The extra layers and LLCs often hinder state and federal oversight of quality of care and make it more difficult for the government to hold the company accountable (Stevenson et al. 2013). The private equity owner stated that risk reduction for the lenders was the main argument:

> "Our lenders required, as part of the financing, each property and each operating company to be set up in LLC's. It's safer for them. If one goes bankrupt… (…) And there may be marginal litigation benefit."

However, the legal structuring was not a unique private equity strategy: by 2008, the top 10 U.S. nursing home companies had converted most of their individual nursing facilities into LLCs, with separate management and property companies and complex multi-level ownership structures (Cuff et al. 2012; Stevenson et al. 2013).

A second change that marked the new company ownership was its rebranding. While the company was named Beverly Enterprises Inc. at the moment of the take-over, its name changed to Golden Gate National Senior Care (GGNSC) at the time of the acquisition. A deliberate rebranding effort followed, including internal and external research among consumers and employees, resulting in the 'Golden family' of company names. The nursing centers were named Golden

Living. The new company name was supported by new logos and graphics. Private equity owner Mr. Silva stated that:

> "[The new name] sets the stage for what the company is going to represent in the future. We want it to become the leading brand in long-term care."

A third post-purchase change was the relocation of the company headquarters (where about 600 people worked) from Fort Smith (Arkansas) to Plano (Texas) in 2011. The Golden Living Administrative Center, providing administrative services to all of the company's businesses, remained located in Arkansas. An important reason given for the move was the high litigation costs in Arkansas. The Golden Living CEO indicated:

> "It costs $ 17,000 per bed a year to defend against liability claims in Arkansas, versus a national average of $ 2,000 a bed per year. (…) It's perverse to me that one of the leading long-term care companies is based in a state where they don't have tort reform for nursing homes."

However, the company also stated that other factors pushed the move in 2011, such as travel expenses (consolidating near a "large hub airport' would save money), and a welcoming business environment (the State of Texas invested $2.1 million in Golden Living's headquarters relocation).

Focus on information and communication technology (ICT) and employee training and benefits

After the acquisition in 2006, our data point at an increased focus on both ICT, and employee training, and benefits. Although Golden Living reported ICT-investments pre-purchase, the number of ICT implementations accelerated post-purchase. New applications aimed at enhanced access to real time electronic health record charting, resident assessment and care planning, labor oversight, and cost reductions. CEO Kurtz stated that Golden Living "became much more sophisticated in the use of technology". He explained:

> "We invested heavily in mobile technology. It's all part of our strategy to try to become very efficient in giving information to our staff. Most of that information is about training, although we're also using mobile technology to help in the billing process, so it's more efficient how we bill. It also allows us to be more efficient in how we retrieve information."

In addition, qualitative data point at the investment in employee training and benefits. The company stated that it accelerated some employee compensations payments, and benefits, such as employer-paid life insurance, improved health-care coverage, and discounts on auto and home insurances, as part of the merger agreement. Golden Living also reported several investments in training. For example, it hired approximately 200 RNs as Directors of Clinical Education (DCE), who were responsible for clinical training for healthcare staff. Furthermore, the company stated that new CNAs were offered a 33-day course before they started working at Golden Living facilities. CEO Kurtz stated that:

> "the company invested heavily in training. We think that is one of the most important things we can do, to maintain quality. (…) We are pretty focused on making sure that our people are very fluent in policies and procedures. We're testing to make sure that they are fluent with their policies and procedures."

Financial performance and resident well-being

In addition to the strategies executed both pre- and post-purchase, we analyzed company scores on measures of financial performance and resident well-being (See Table 5.3b).

Financial performance.

Although Golden Living's operating margins in California were relatively low in the three years preceding the take-over, the company structurally outperformed its industry counterparts post-purchase, showing higher operating margins. We also found higher net incomes per patient day in the post-purchase years, with significantly higher incomes for the years 2006-2011. We did not find the same results for total margins, which also includes nonoperating revenues and expenses.

The long term debt to assets ratio of Golden Living's California facilities (the total liabilities divided by total assets) were rising considerably in comparison to industry counterparts directly after the take-over, but the long term debt ratios approached industry averages after those years. The long term debt ratios were significantly higher for the post-purchase period for Golden Living facilities ($Z = -2.46$, $p = .014$). In contrast, other for-profit facilities in California showed significantly lower long term debt ratios ($Z = -7.34$, $p < .001$) for the post-purchase

period. Golden Livings' long term debt ratios thus increased in association with the change in ownership.

Resident well-being

Golden Living scored significantly lower on the total number of deficiencies and on serious deficiencies nationwide pre-purchase. This lower number of deficiencies might be related to the earlier mentioned divesture program, in which the company potentially divested relatively deficient nursing homes. Post-purchase, mean scores were comparable to the national average for nursing facilities for most years, showing a shift to industry averages. This indicated that the private equity owned company did not improve quality of care.

Our qualitative data show that sizable litigation actions occurred in both the pre- and the post-purchase period. As noted above, Beverly was placed under a Corporate Integrity Agreement with federal oversight for its failure to comply with quality and regulatory requirements in 2000 which was removed in 2006 when the company was sold. In 2002, the company settled a case for elderly abuse with the California Attorney General, paid more than $2 million in penalties and fines and promised to improve the quality in all its facilities. It also settled a case with the Arkansas Attorney General for mistreatment and neglect of residents in 12 nursing homes in 2005. After purchase, Golden Living settled a $20 million suit with the U.S. Department of Justice (USDOJ) and the California Attorney General for false reimbursement for medical equipment by a subsidiary company in 2006. In 2011, a class action case for inadequate staffing levels in California Golden Living facilities was filed and later settled. Pennsylvania's attorney general also filed an action against Golden Living for inadequate staffing levels and fraudulent billing in 2012. The USDOJ intervened in an Alabama whistleblower suit against Golden Living's AseraCare hospice company in 2012. Finally, the USDOJ reached a 2013 settlement with Golden Living for providing inadequate wound care in Georgia (filed in 2010) that required a Corporate Integrity Agreement for federal oversight. However, the four other largest U.S. chains also had a number of litigation actions (Harrington et al. 2017). Golden Living had litigation actions similar to other large U.S. nursing home chains. Litigation actions, because of poor quality, continued to occur after the private equity purchase, which indicates that the private equity-owned company was not able to improve care quality i.e. resident well-being.

5.4 CONCLUSION

Research on the impact of private equity in health services shows mixed findings, as outcomes vary with private equity owner's strategies and the company context. We therefore shifted the focus from 'what' the impact of private equity is to 'how' private equity can have an impact in health services organizations. Our longitudinal, in-depth case study of the nursing home chain Golden Living generally shows how the private equity owner mainly continued and reinforced strategies that were already in place pre-purchase. Examples of ongoing strategies are the intensification of corporate control, diversification of services, and divestment of nursing home facilities. Under private equity ownership, Golden Living further pursued a strategy of low staffing levels in comparison to the national average in both the pre- and the post-purchase periods. Its gradual increase in staffing over time did not keep pace with the national growth in staffing in most years. It should be noted that Golden Living and most other for-profit nursing homes, in contrast to non-profit and government nursing homes, do not meet the minimum staffing levels for providing safe care recommended by experts and by the government (CMS 2001; Harrington et al. 2016). At the same time, the private equity owner invested in the composition of staffing, in favor of the higher educated nurses (RNs), which is in contrast to former research on skill mix (Harrington et al. 2012). Golden Living chose a strategy of 'brains' (fewer high-paid high-educated nurses) over 'hands' (many low-paid low-educated nurses).

The private equity owner also developed some new strategies in the post-purchase period, such as the rebranding of the company, increased investment in employee benefits and training, the relocation of the company's headquarters, the establishment of nursing home facilities as LLC's, rising debt ratios directly after the take-over, and the separation of the nursing home operating companies from the property company.

Many of the strategies executed under private equity ownership mimic industry wide trends, as the strategies of strict staffing controls, divestment, diversification and the restructuring of the company in LLCs were consistent with developments in other for-profit chains (Grabowski et al. 2016; Hurley et al. 2012; Kitchener et al. 2008; Pradhan et al. 2014; Stevenson et al. 2013). Moreover, scores on care quality indicators remained relatively low, as well as total staffing levels. We conclude therefore that the private equity owned company under study mainly conformed to other large for-profit nursing home chains. This is in line with theory about institutional isomorphism (DiMaggio & Powell 1983) that stresses

the similarities between organizations as a result of imitation or independent development under similar constraints. The case study thus revealed how private equity owners merely reinforced the profit-seeking strategies that were already in place pre-purchase, and added some strategies to further support efficiency, such as accelerated ICT-investments.

Furthermore, apart from operational strategies or financial engineering strategies (the extraction of wealth without necessarily adding value, e.g. Appelbaum & Batt 2014) our case study revealed how the private equity owner created financial value beyond the company itself by executing a novel strategy. The private equity owners used Golden Living as a 'launch customer' for putting new companies on the market, which had guaranteed income by contracting with the Golden Living nursing home facilities. This could explain why the private equity firm holds onto the nursing home chain relatively long, as most LBOs last only three to five years. Like other nursing home chains, the company used its related-party contracts to extract profits from the nursing facilities (Harrington et al. 2015). This finding uncovers a limitation of research on private equity, since it is mainly restricted to what happens within one portfolio organization.

Endnotes

[I] Source: http://www.goldenlivingcenters.com/home.aspx

[II] A complete list of the documents studied is available from the authors.

6

What happens when private equity takes over? Two case studies in social care organizations

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ABSTRACT

Private equity ownership of social care organizations can be perceived as the ultimate form of commercialization. This chapter investigates what happens to a home care and a child day care organization when private equity takes over. Changes in strategy, financial performance, and well-being of employees and clients were analysed. Two longitudinal case studies were conducted that combined qualitative and quantitative data from different data sources. Results show that a significant organizational growth strategy was dominant. Financial performance declined, as the private equity owners were ill-prepared for governmental reimbursement cutbacks. Implications for employee and client well-being remained limited.

6.1 INTRODUCTION

Private equity (PE) firms have become a well-known phenomenon over the past 30 years. An extensive body of literature on the impact of PE ownership has been developed in the private sector (e.g. Appelbaum & Batt 2014; Wright et al. 2009). A PE firm owns and trades unlisted, private companies; it creates one or more funds that obtain capital from investors such as pension funds, insurance companies, and wealthy individuals. Using the fund's capital, along with a loan commitment, the PE company acquires so-called portfolio companies. PE firms generally work with a three to seven year exit horizon, meaning that the portfolio companies in a fund will be sold within that timeframe (NVP 2019). During this period, the PE owner seeks to increase the financial value of the portfolio organization, to realize a profit when it sells the company. The profits in case of such an exit are distributed among the fund investors and the general partners of the PE firm itself. The central PE investment is the buyout, in which the PE company is majority or full owner of its portfolio organization. The PE firm typically takes an active role in strategic decision-making and monitoring performance (Wright 2013).

In the 1990s and 2000s, the United States (U.S.)-based PE industry broadened its scope to new territories and sectors. As PE funds were flush with cash waiting to be invested, the firms increasingly laid their eyes on service companies (Guo et al. 2011). For example, healthcare organizations nowadays represent more than 10% of all transactions by PE deal count globally (Bain & Company 2019). PE firms have increasingly acquired organizations that provide services central to the daily lives of citizens (Ivory et al. 2016; Meagher et al., 2016; Harrington et al., 2012, 2017). Scholars stress that *'[there is] a scarcity of cases reporting in any detail on the kind of restructuring that takes place in individual companies after they are acquired by [PE] firms'* (Rodrigues & Child 2010: 1322). Such research is extra relevant when it comes to social care that aims to enhance the well-being of children and adults, and in this way serves society (Kendall et al. 2006). This chapter therefore analyses two PE-owned organizations: one providing child day care, and one providing home care. The central question is: How do private equity-owned social care organizations perform? PE-ownership is conceptualized as the ultimate form of commercialization in the traditionally non-profit social care sectors, and describe PE-strategies that relate to the 'how' in the central question. Moreover, a multidimensional performance approach is introduced, differentiating financial performance and well-being. The literature paragraph explores what is already known, by combining economic and social care literature.

6.2 LITERATURE

Private equity ownership as the ultimate form of commercialization in social care

'Social care' here refers to child day care and home care (cf. Meagher & Cortis 2009). It is about forms of personal care and assistance for those who need extra support; it is about the production of *social* well-being (Kendall et al. 2006). In Western countries, social care has traditionally been provided by government and non-profit organizations (Buhler-Wilkerson 2007; Evers & Laville 2004). Influenced by neoliberal ideas, the welfare state is dismantled and social care provision increasingly shifted to for-profit providers (e.g. Taylor-Gooby 2002). This shift followed its own trajectory and pace in different countries, and constitutes an ongoing transformation in several welfare states (e.g. Blomqvist 2004; Davidson 2009; Karsio & Anttonen 2013; Meagher & Cortis 2009; Petersen & Hjelmar 2014; Salamon 1993; Sivesind & Saglie 2017). There are essentially two opposite opinions about such for-profit provision of social care. Proponents claim that increased commercialization comes with more efficiency, lower costs, greater responsiveness to customer needs, and higher quality. By contrast, opponents argue that a profit focus leads to higher costs, inequality between citizens with different resources, and lower quality through increased risks of skimping – the cutting back on hard to observe quality aspects (e.g. Petersen & Hjelmar 2014).

For-profit *private equity* owners in social care are a relatively recent and largely unnoticed development *within* the shift to for-profit provision. This chapter applies the concept of commercialization to categorize the different types of ownership: government, non-profit, for-profit and private equity for-profit ownership (Figure 6.2). Commercialization is the extent to which organizations 'act businesslike' and are driven by monetary concerns and competition (Goddeeris & Weisbrod 1998; Maier et al. 2016).

Commercialization took place both *within* and *between* these forms of ownership. Influenced by the New Public Management (NPM) ideas in the 1980s, efficiency, results orientation, customer orientation and competition came on the agenda of administrative reform (Hood 1991). A new style of government organizations that copied business techniques, changed traditional public organizations (Osborne & Gaebler 1992). However, ownership remained public. Commercialization was mainly directed towards the internal organization of government organizations.

Figure 6.2 Commercialization by ownership type

Private *non-profit* providers, then, normally use surplus of the revenues of their organization to achieve the organization's objectives. Non-profits often perform public-type functions – such as providing social care. Since the 1980s, many non-profit entities commercialized (Kerlin & Pollak 2011; Maier et al. 2016; Weisbrod 1998), which became apparent in 'the growing use of more calculable, rational tools and procedures' (Hwang & Powell 2009: 292), and an increased emphasis on efficiency and effectiveness (Meyer et al. 2013).

Goddeeris and Weisbrod (1998: 2015) regard the conversion of non-profit organizations to the for-profit form as 'commercialism carried to an extreme'. The possibility to earn a profit by delivering social care, opens the barn door for PE firms – known as the most 'pure form of capitalism' (Financial Times 2005), and 'capitalism on steroids' (Leleux & Van Swaay 2006). PE firms are a specific type of for-profit ownership. Around the year 2000, PE firms began playing a more prominent role in care sectors, especially in U.S. nursing homes (e.g. Cadigan et al. 2015; Harrington et al. 2012). More recently, PE also entered other care sectors in other Western countries (Bertelsen & Rostgaard 2013; Davidson 2009; Harrington et al. 2017; Holly 2018; Ivory et al. 2016; Meagher et al. 2016). Compared to their 'regular' for-profit counterparts, PE-owners have a stronger focus on maximizing shareholder returns (Wright et al. 2009; Jenkinson et al. 2016); they should therefore be considered as the ultimate form of commercialization.

The degree of commercialization thus increases from public (government) ownership, to private non-profit, and private for-profit, with PE ownership as the ultimate form of commercialization. This study concentrates on the high end of

the commercialization continuum: PE ownership of organizations providing social care to children or elderly.

What to expect? Strategy and multidimensional performance

Research on the strategies and performance of PE in social organizations is very limited. Hence, related literatures on for-profit social care and PE are consulted on what to expect.

Strategy

Strategy is the 'pattern in a stream of decisions' over time, which is a combination of deliberately planned change by top management and emergent events imposed by environmental forces (Mintzberg & Waters 1985). PE firms buy to sell. Portfolio companies are therefore more aggressively managed than 'regular' for-profit organizations. The PE business model comes with general strategies, such as increasing debt, margin improvement, and re-connecting management and ownership (Jensen & Meckling 1976). In addition, two contrasting strategies can be expected: a focus on growth or on efficiency (cf. Bruining et al. 2005; Rodrigues & Child 2010). PE firms are historically known for executing efficiency strategies. They streamline processes, reduce workforces, intensify asset use, and decrease costs. This strategy comes with high leveraging; the servicing of leverage 'gives managers little discretion and places pressure on them to avoid wasteful investment projects' (Wright et al. 2001: 116).

Especially from the 2000s onwards, this traditional PE strategy was supplemented by the growth strategy that aligns the level of debt to combine sufficient discipline with flexibility to pursue needed changes. The growth strategy is about the investment in market-leading technology and training, or the use of the initial portfolio firm as a platform, to which subsequent acquisitions are added. The emphasis is on 'deals with growth opportunities rather than those with traditional bust-up efficiencies' (Wright et al. 2001: 117).

Multidimensional performance

A multidimensional performance construct was applied that includes organizational performance, client and employee well-being. The construct builds on ideas from stakeholder theory, which is traditionally interpreted as the opposite of shareholder theory. While the shareholder approach focuses on maximizing

returns to shareholders, the stakeholder theory demands accounting for the interests of all stakeholders 'even if it reduces company profitability' (Smith 2003: 86-87; Boatright 2006; Freeman et al. 2010). However, several proponents of the shareholder theory argue that this contrast is false. Stakeholder management is a means to the end of profitability and therefore complements the shareholder approach (Boatright 2006; Smith 2003). It is claimed that Friedman, one of the icons of neoliberalism, regarded stakeholder management as the very basis of capitalism (Freeman et al. 2010: 11; Hillman & Keim 2001).

These competing views can be labelled as the 'mutual gains perspective' and the 'conflicting outcomes perspective' (cf. Van De Voorde et al. 2012). The conflicting outcomes perspective emphasizes that outcomes for different stakeholders function as a 'zero-sum game' (Smith 2003). In contrast, the 'mutual gains perspective' assumes that the outcomes for the different stakeholders reinforce each other in the same positive or negative direction (Hillman & Keim 2001; Freeman et al. 2010; Boatright 2006).

Financial performance

The combined evidence – on for-profit organizations, and on PE's impact in business organizations – points at an increased probability of PE-owned social care organizations. Previous studies in U.S. home care indicate higher profit margins, and more profit maximizing behavior in for-profits (Cabin et al., 2014; Huang and Kim, 2017; Grabowski et al., 2009). However, non-profit child day care providers can also behave as profit maximisers (Blau & Mocan 2002). Research on PE across sectors tends to report higher profit margins in PE-owned organizations – when compared to 'regular' for-profit counterparts (e.g. Davis et al. 2014; Datta et al. 2013; Pradhan et al. 2013), although some studies also find no difference or less profits (e.g. Cadigan et al. 2015; Scellato & Ughetto 2013; Kim & McCue 2013). Research on other indicator of financial performance is hardly available in social care. Hence, it is tentatively proposed that PE in social care can be associated with improved financial performance.

Well-being

Well-being refers to variables that might affect client and/or employee well-being. Combined insights from economic and social care literature show mixed findings. For client well-being (service quality), the evidence indicates that non-profit child day care organizations often, although not always, outperform

their for-profit counterparts. This observation holds for both 'structural quality' – inputs that are relatively easy to observe and regulate – and 'process quality' – such as classroom quality or child-caregiver interaction (Japel 2005; Koning et al. 2007; Sundell 2000; Morris & Helburn 2000; Sosinsky et al. 2007; Leviten-Reid 2012; Cleveland 2008). However, for 'outcome quality' (the contribution to the development of the child) no differences were found (Sundell 2000), and the robustness of the evidence is often weak (Noailly et al. 2007). In home care, some studies report either no or modest quality differences that favour non-profit providers (Rosenau & Linder 2001; Cabin et al. 2014); while other studies show mixed findings (Haldiman & Tseng 2010; Dalby & Hirdes 2008; Doran et al. 2007). Research on PE's impact across sectors is diverse, and mainly focused on U.S. nursing homes. Findings range from lower (care) quality (Harrington et al. 2012; Pradhan et al. 2014; Palcic & Reeves 2013), to no or some positive care quality results during PE ownership (Pradhan et al. 2014; Stevenson and Grabowski 2008).

For employee well-being, the different streams of literature again provide no clear answers. Although research in child day care indicates that for-profit centres work with less and lower educated staff (Mitchell 2002; Sosinsky et al. 2007; Morris & Helburn 2000), the much more extensive PE-literature across sectors shows mixed outcomes for staffing (cf. Boucly et al. 2012; Paglia & Harjoto 2014; Scellato & Ughetto 2013; Stevenson & Grabowski 2008), and for working conditions (cf. Boseslie & Koene 2010; Bacon et al. 2012). Such mixed findings are unsurprising when taking into account the different types of PE strategies and contingencies. Such strategies and contingencies are therefore included in the case studies in this chapter.

6.3 METHODS

This study presents the results of two (anonymized) case studies in Dutch PE-owned social care organizations: CC (child day care organization, owned by ABC Capital) and HC (home care organizations, owned by XYZ Capital).

Case selection

A list of PE-owned care organizations in the Netherlands cases was developed. Three sets of criteria were then applied for purposively selecting the two cases. First, the selected cases shared several basic characteristics. They were regular providers in their sector (i.e. not working in a niche market), they were mainly

publicly funded, and they were relatively large in their sector. Second, the essence of their service was comparable: the intensive interaction between low to intermediate educated employees, and clients. A last criterion was timing: both organizations were acquired by a PE firm in the year 2006, placing them in a similar context with regard to 'zeitgeist' and economic conditions.

Data Sources

The case studies combined qualitative and quantitative data from nine different data sources (Table 6.3). Triangulation was applied by combining interview data, publicly available qualitative data, and publicly available quantitative data. Multiple sources and perspectives were included, to obtain richness of results and inter-subjective validity. Where possible, a longitudinal approach was applied by including repeated measurements on the same units.

Table 6.3 Data sources

	Case	Data source	Relevant details
1	**Child day care: CC**	Interviews	Ten key respondent interviews: current and former CEO, PE firm, operating company's directors, overhead staff, employees.
		Lexis Nexis	Search terms: [CC], [CC1, including'child day care'], [CC2], [CC3], [ABC Capital, including'child day care']; 1.825 hits; 74 relevant articles
		Annual reports	CC deposited no annual reports at the Dutch Chamber of Commerce; reports for 2011 and 2013 were traced back online.
		Data sets	Bureau van Dijk (Amadeus) 2008-2017 Zephyr Mergers&Acquisitions data
		Documents	Area Health Authority reports 2008-2018, 190 facilities, 1.125 reports
2	**Home care: HC**	Interviews	Ten key respondent interviews: former CEO, PE firm, operating company's directors, overhead staff, employees.
		Lexis Nexis	Search terms: [HC, including'home care'], [HC1, including'home care'], [HC2, including'HC'], [HC3, including'home care'], [HC4, including'home care'], [HC5, including'home care'], [XYZ Capital, including'home care']; 1.160 hits; 42 relevant articles
		Annual reports	Years 2003-2009
		Data sets	Visible Care dataset 2008-2009
		Documents	Judicial verdicts Bankruptcy reports (2010-2012,2014-2016,2019)

First, media coverage in the Lexis Nexis newspaper database was systematically reviewed. Then, publicly available company information was analysed (annual reports, inspection reports, judicial reports, and bankruptcy reports). Thereafter, publicly available datasets on financial data and care quality were examined. Finally, twenty in-depth interviews were conducted between June 2017 and May 2019. The interviewees were purposively selected, based on their involvement in the case and on representing different positions.

Data Analysis

The cases were reconstructed over time, looking backwards by systematic exploration. The analysis of the data was directed towards the discovery of similarities, from concrete aspects to more abstract general findings. A common coding process was applied to the qualitative data that started from the broad codes 'strategy', 'financial performance', and 'well-being'. During this coding process, specific sub codes were inductively added, to cover the content of the data fragments more accurately. Data were analysed in an iterative process in which concept findings were formulated, and were set against and substantiated with data from different data sources.

Quantitative data (Bureau van Dijk; Area Health Authority quality reports) were used to describe developments over time and/or to contrast results in the case to those of industry counterparts (ICs). Descriptive results on financial performance for CC and its ICs were checked on significant differences using *Z*-scores. The Wilcoxon signed rank test was used to calculate differences between the case and ICs for the entire period.

Limitations

The methods come with some important limitations. Firstly, the secrecy of the private equity industry made access often difficult (cf. Appelbaum & Batt 2014). Although key players were interviewed on different levels, their cooperation was often committed under the condition of total anonymity. Several respondents did not allow the use of interview excepts, i.e. verbatim quotes, because of the risk of traceability and the sensitivity of the subject. Secondly, the dimensions of organizational performance, employee well-being, and client well-being are defined very broadly, and their operationalization is partly driven by the availability of data. In comparison to other countries such as the U.S., longitudinal and national datasets on for example quality scores were hardly available for both

the child day care and home care sector. Not all preferred data were obtainable for all years or for all relevant variables, and evidence on industry counterparts lacked for part of the data. Hence, a longitudinal design and a comparison to industry counterparts were not possible for every measure of performance.

6.4 RESULTS

Child day care case (CC)

Dutch children may attend child day care centres from 0 to 4 years. The implementation of the Dutch Childcare Act (2005) made the child day care sector wholly market-driven, and increased the presence of for-profit providers (Noailly et al. 2007). Waiting lists for child places, government investments, guaranteed cashflow, and opportunities for consolidation attracted PE firms to the Dutch child day care sector. In 2006, the Dutch PE firm ABC Capital acquired a 70 percent ownership stake in CC, which increased to 100 percent in 2012.

Strategies

In comparison to the previous owners of CC, ABC Capital placed greater weight on managerial and financial expertise than on sector expertise; respondents on the boardroom level state that the PE owner's focus was on financial output controls. The private equity owners created the CC holding that took control over financial tasks. Both interviewed managers and employees confirmed that ABC Capital-staff only interacted with the executive board of this CC holding, and not directly with actors outside of the boardroom. Boardroom level respondents stated that the main discussion topics between the PE staff and the executive board members were financial control issues, such as the closure of financially malfunctioning centres. The PE-owners were also more attuned to the use of PR techniques: they applied an extensive rebranding effort resulting in a new company name and logo.

From both the Lexis Nexis news coverage, as well as the Zephyr data, it becomes clear that the overarching focus was a massive growth strategy; ABC Capital implemented a buy-and-build strategy. Soon after ABC Capital purchased CC1 (about 100 facilities), it acquired CC2 (about 80 facilities) and CC3 (28 facilities). A holding company was then created, in which CC1, CC2, and CC3 became the operating companies. The growth continued through the opening of extra child

day care centres by a newly established department that was specially equipped for this task. CC also acquired other child day care organizations, some having more than 20 facilities. Several respondents state that ABC Capital provided the resources necessary for the expansion; the growth would otherwise not have been possible. In 2014, the separate operating companies were integrated into one organization. In the preceding years, several steps had already been taken toward a power shift from the operating companies to the holding, such as the introduction of a central works council, and the centralization of the facility and financial services.

In 2020, ABC Capital is in the process of selling CC to a consortium of two PE firms, one of them already being the owner of the largest Dutch child day care chain. It would make CC part of the biggest child day care company in the Netherlands, with a market share of approximately eight percent. The next biggest chain in the Netherlands has a market share that is less than half of that, while a large part of the sector consists out of small-scale providers.

Financial performance

Turnover development, profit margins, solvency ratios and current ratios from Bureau van Dijk were analysed to assess the financial performance of CC (Table 6.4a). CC largely followed industry trends, although its turnover decline was quite steep when compared to ICs, and its current ratios – the capacity to pay short-term debt obligations – were relatively low (Table 6.4b). Key respondents explained that ICs either had bigger financial reserves to draw upon and/or reorganized less drastically. Based on an annual report, is became clear that part of the money earned in previous years was granted to ABC Capital, and to a lesser extent to company reserves. Dividend payments to ABC Capital were charged to CC's profits, using a standard calculation method. If the profits of a certain year did not allow for the dividend payment, the sum was charged to the profit of the following year. In addition, respondents point at several risky acquisitions in the preceding years that turned out to be lossmaking projects in the new reality of governmental budget cuts. ABC Capital's interference intensified during the years 2012-2013, because CC was at the brink of bankruptcy. As banks were no longer willing to provide loans, ABC Capital provided the necessary financial resources to CC, partly in the form of loans.

Table 6.4a Scores for CC industry counterparts (ICs) averages

Year		Profit margin[†]	Solvency ratio[‡]	Current ratio[§]	Turnover development%[¶]	Number of employees development%[¶]
2008	CC	6,7	22,25	0,4	n.a.	n.a.
	ICs	3,5 (*n*=20)	32,7 (*n*=406)	2,2 (*n*=416)	n.a.	n.a.
2009	CC	10,0	35,80	0,5	15	n.a.
	ICs	3,8 (*n*=31)	33,8 (*n*=619)	2,3 (*n*=627)	21 (*n*=17)	9 (*n*=253)
2010	CC	8,9	41,37	0,6	10	n.a.
	ICs	3,4 (*n*=36)	31,0 (*n* =723)	2,1 (*n*=749)	14 (*n*=23)	9 (*n*=497)
2011	CC	5,1	41,49	0,6	3	n.a.
	ICs	3,4 (*n*=51)	29,9 (*n*=861)	2,1 (*n*=893)	5 (*n*=28)	4 (*n*=832)
2012	CC	1,5	24,01	0,6	-8	-4
	ICs	1,3 (*n* =51)	28,7 (n=925)	2,2 (*n*=978)	-6 (*n*=40)	0,8 (*n*=1061)
2013	CC	-14,4*	23,19	0,6	-12	-7
	ICs	-1,0 (*n*=54)	28,3 (*n*=987)	2,3 (*n*=1076)	-9 (*n*=40)	-5 (*n*=782)
2014	CC	-3,8	18,26	0,5	-10	-8
	ICs	-0,1 (*n*=65)	27,1 (*n*=1068)	2,1 (*n*=1172)	-8 (*n*=45)	-0,4 (*n*=827)
2015	CC	-5,8	7,99	0,6	-6	-11
	ICs	1,8 (*n*=46)	28,2 (*n*=1170)	2,3 (*n*=1285)	2 (*n*=42)	4 (*n*=817)
2016	CC	1,0	8,65	0,8	8	-2
	ICs	2,9 (*n*=34)	30,3 (*n*=1179)	2,2 (*n*=1302)	5 (*n*=30)	4 (*n*=598)
2017	CC	7,4	25,54	1,1	n.a.	3
	ICs	4,5 (*n*=12)	32,2 (*n*=477)	2,0 (*n*=526)	10 (*n*=8)	4 (*n*=606)

[†]'Profits/losses before tax'/'operating revenue'*100%; outliers of +/-20% were excluded; [‡]'Shareholder funds (i.e. total assets minus total liabilities)'/'total assets'*100%; [§]'Current assets'/'current liabilities';[¶]Percentage of growth/decline when compared to the previous year; outliers (>100) were excluded;. n.a.:not available; IC:Industry Counterpart; *CC-score differs significantly from ICs (*Z*-values, $p < .05$)

Table 6.4b Wilcoxon Signed Rank tests results for 2008-2017: CC versus ICs

Variable	*Z*-score
Turnover development	*Z*=-2.37, *P*=.018[†]
Profit margins	*Z*=-0.05, *P*=.96[†]
Solvency ratios	*Z*=-1,27, *P*=.203[†]
Current ratios	*Z*=-2.81, *P*=.005[†]
Number of employees development	*Z*=-2.20, *P*=.028[‡]

[†]Remains robust when only 100+ employee-companies are included. [‡]The result is *not* robust when only 100+ employee-companies are included (*Z*=-1.48, *P*=.14).

Well-being

All respondents stated that ABC Capital's interference was largely invisible for both work floor employees and clients; its entrance in 2006 did not mark remarkable changes at child day care centres. ABC Capital did hardly interfere directly in the business operations. Key respondents argued that the room to remodel the operations was small, due to strict regulations. One of the interviewed managers stated that the regulations make most child day care centres very similar.

Table 6.4c Violations of quality requirements by CC-facilities as registered by Area Health Authorities

Year	% of facilities inspected violating child-staff ratio requirement		% of facilities inspected violating staff qualifications requirement		% of facilities inspected violating requirements in one/more domains‡	
2010†	12,5%	(*n*=41)	2,5%	(*n*=40)	37%	(*n*=41)
2011	15,6%	(*n* =78)	14,5%	(*n*=76)	53%	(*n*=76)
2012	7,5%	(*n* =95)	6,2%	(*n*=97)	53%	(*n*=97)
2013	8,2%	(*n* =112)	4,7%	(*n*=128)	36%	(*n*=128)
2014	10,3%	(*n* =147)	0,7%	(*n*=148)	42%	(*n*=148)
2015	5,7%	(*n* =159	0,7%	(*n*=159)	25%	(*n*=157)
2016	3,8%	(*n* =160)	0,6%	(*n*=158)	10%	(*n*=162)
2017	2,4%	(*n* =172)	2,3%	(*n*=171)	14%	(*n*=175)
2018	3,3%	(*n* =124)	0,8%	(*n*=125)	25%	(*n*=125)

†Because the number of reports is very limited for the years 2008-2009, the analysis starts in 2010.
‡The Area Health Authorities review requirements in the domains 'parent rights','personnel and groups','safety and health','accommodation', and'pedagogic policy and climate'. Most violations were found in the 'personnel and groups'-domain: 52% of the facilities violated requirements in this domain one or more times between 2008-2018.

However, as ABC Capital strengthened its control in times of financial downturn, the owner had an important say in far-reaching reorganizations that influenced employee well-being. Respondents on a boardroom level confirmed that the integration of the company in 2014 was driven by PE. This reorganization was accompanied by the dismissal of the directors of the operating companies, as well as a large part of the overhead staff. The Area Health Authority, responsible for the quality inspection of child day care centres, reported in 2013 that regional managers got more child day care centres to supervise, that temporary staff did not get tenure, and that permanent staff had to work at different centres. The report further stated that all this led to some unrest amongst both personnel and parents. Moreover, it also concluded that the reorganization led to 'several violations of the rules on quality with regard to the minimum number of professionals

in a group of children'. The number of employees at CC reduced drastically (-27 percent between 2012-2016, Table 6.4a). The analysis of all inspection reports available on CC from the Dutch National Register Childcare (*n*=1.125; 2008-2018) does, however, not unambiguously support this conclusion. It indicates that CC's quality indicator scores varied and somewhat improved over time (Table 6.4c). The interpretation of these data needs caution, as facilities that have been closed in the meantime can be missing in the databank.

Home care case (HC)

The second case study concerns a PE-owned home care organization, which also delivered maternity care services: HC. Home care includes a range of services to the elderly and disabled, such as out-patient medical care, nursing, and domestic help. In the 1990s, market mechanisms were introduced in the originally non-profit Dutch home care sector. The Social Support Act of 2007 further opened up the market to for-profit providers, leading to many commercial newcomers and harsh price competition on domestic help services. Seventy-nine percent of HC's shares were owned by XYZ Capital between March 2006 until its bankruptcy in December 2009. After the bankruptcy, media coverage in Lexis Nexus reported that most HC-employees transferred to another home care company. This new company had about 23.000 employees, and a national market share for domestic help of 25 percent in 2010.

Strategies

Respondents on the boardroom level described how XYZ Capital executed cost control measures, by requiring much more detailed financial reporting than was available before the takeover. The PE-owner confirmed that efforts were directed to the professionalization of financial information management and reporting. Respondents outside the boardroom stated that XYZ Capital's strictly financial approach was largely detached from the organizational operations. The PE owner attracted new top managers without any sector expertise. Inside the boardroom, respondents explain how the HC board had monthly meetings with XYZ Capital to discuss the financial numbers. Home care was approached by the PE-owner as just another business. A key respondent stated that it was assumed that working more efficiently, and providing better services than industry counterparts, would enable higher budgets. However, such market mechanisms turned out to be largely invalid in the home care market.

The financial approach became apparent in several strategic decisions during PE-ownership. One was the withdrawal from the unprofitable market of domestic help. Both newspaper coverage as well as respondents report that this decision was regarded as very remarkable within the home care sector, as the domestic help clients of today are the more intensive home care clients of the future. Another decision, described by a manager, was the sale of the lease cars of maternity professionals, which resulted in longer travel times. Furthermore, an interviewed manager stated that the payment term to creditors was raised from 45 to 90 days. Based on interviews and judicial verdicts, is becomes clear how the financial approach was further supported by the increased pressure on subcontractors to generate higher margins, the behaviour towards LTC-offices to get better budgets through lawsuits, and legal proceedings with former owners of the operating companies about financial clauses in the purchase agreements.

However, the predominant focus was again on growth through a buy-and-build strategy. The respondent from XYZ Capital explained how HC was a platform to link to several other acquisitions in home care, maternity care, mental health, nursing home care, and diagnostic services. These acquisitions are confirmed by Lexis Nexis data. The HC Group was created as the holding company for at least ten different organizational entities. Despite a policy context that aimed at preventing sector growth (i.e. maximized and reduced budgets), the annual reports show how HC was holding on to its growth ambitions. The company strived for increasing the number of contracts with LTC-offices. The enormous growth ambition was also illustrated by the acquisition of the bankrupt HC2 in 2008, which had been one of HC Group's subcontractors and delivered a substantial amount of the turnover and margins. Both respondents in the boardroom as well as respondents working close to the boardroom stated that the organization was constantly scanning the market for organizations that could be linked to the HC Group ('add-ons'). For example, HC Group considered the takeover of child day care centres, and attempted to acquire a huge Dutch home care organization that went bankrupt in May 2009.

Financial performance

Before the takeover by XYZ Capital, the annual reports already showed a decline in turnover development and profit margins of HC – the platform company; the negative results worsened under PE ownership (Table 6.4d). The 2006 annual report of HC mentioned financial risks, and the need for strict management of all aspects of the business. Current ratios and especially solvency ratios declined after 2006. The HC Group went bankrupt in 2009.

Table 6.4d Scores for HC and mean scores for industry counterparts (ICs)

Year	2002	2003	2004	2005	2006		2007		2008	
Variable	HC	HC	HC	HC	HC	ICs7	HC	ICs	HC	ICs
Turnover development %[†]	-	102	57	-4	25		-25	-5	-10	7
Profit margin[‡]	3,12	2,04	1,07	-0,45	-1,10	3,43	-2,73	1,20	-0,12	1,80
Solvency ratio[§]	30	22	19	25	27		6	22	5	22
Current ratio[¶]	1,37	1,26	1,22	1,31	1,25		1,04	0,66	1,05	0,66
Number of employees development %[†]	-	26	14	14	4		16	-3,8	-94[††]	0,6

[†]The percentage of growth/decline compared to the previous year. [‡]'Operating income'/'turnover' * 100%.[§]'Total equity capital'/'balance-sheet total'*100%.[¶]'Current assets'/'current liabilities' * 100%. [††]Downturn due to the closing of a loss-making facility.IC:Industry Counterpart. Data on ICs were derived from Statistics Netherlands (Publicly funded care organizations, key figures); only available for 2006-2008; cover a broader sector that include care homes, nursing homes and home care.

Bankruptcy reports and respondents mentioned a mixture of factors that caused the bankruptcy. First, XYZ Capital's purchase price had been based on more positive financial prospects. The HC Group turned out to be over-financed, which led to write-offs that were an important cause for the financial losses in 2007. Second, declining financial performance was also caused by the contracts signed with municipalities pre-buyout, on the delivery of domestic help – which turned out to be loss-making. Third, LTC-offices increased their control on subcontractors in 2009. The HC Group worked with many subcontractors. The stricter regulations for subcontractors led to a loss of about 10 million euros of turnover for the HC Group. Additional factors were increasing personnel costs (staff shortages led to the relatively expensive hiring of externals), and the loss-making activities from HC's nursing home and HC2. The leverage that was used to finance the PE-deal in 2006 further facilitated the financial decline.

Mid-2009, several LTC-offices rejected an 11 million euro home care enrolment of HC. As a consequence, the bank refused a previously requested reorganization credit. The company went bankrupt in December 2009. Bankruptcy reports list the main creditors: the bank (15 million euros), subcontractors and other partners (15 million euros), XYZ Capital (10,5 million euros), tax authorities (1,4 million euros), and the Employee Insurance Agency (1,1 million euros). Some financially healthy entities of the HC Group were drawn into the bankruptcy, as well as at least one of HC's subcontractors. The bankruptcy led to financial losses for around twenty maternity care organizations.

Well-being

All respondents stated that work floor employees were largely unaware of the entrance of the PE-owner in 2006; they had no contact at all with or knowledge of XYZ Capital, nor was there any direct communication between employees and XYZ Capital staff. This ignorance also applied to the team management level and employees in the works council. Closer to top management, the role of XYZ Capital was much more visible and tangible. The management of different operating companies was replaced. As the financial situation worsened, XYZ Capital intensified its control. The annual report mentioned the appointment of a new CEO, who drastically reorganized the management and overhead staff.

A boardroom level respondent stated that the PE owner initially also strived for more efficiency on the work floor, but learned that this was hardly possible in practice, due to regulations from LTC-offices. Before the bankruptcy, XYZ Capital's impact on employee well-being was limited. This changed after the bankruptcy in 2009. According to newspaper coverage in Lexis Nexis, the bankruptcy led to the firing of more than 1.100 employees of the HC Group. Respondents from the work floor level argue that, for many employees, this was the first moment they realized that their company was PE-owned. Lexis Nexis data report that about 800 HC-employees were transferred to a new owner, and three hundred HC-employees lost their job. In addition, work floor respondents stated that some sick colleagues were not taken over, that contracts were changed to new job positions and lower salaries, and that not all overhead staff was taken over.

For client well-being (i.e. quality), Consumer Quality Index data of 2008-2009 – which measured care quality from a client perspective – show that HC scored slightly higher than the national average on many indicators, such as 'experienced professional behaviour and safety in the service delivery', 'availability of personnel', and 'experiences in the area of mental health'. Other publicly available data on client well-being indicators are very scarce. Although employees interviewed describe how the bankruptcy caused some insecurity among clients, they also state that professionals continued to work hard to deliver quality care.

6.5 CONCLUSIONS AND DISCUSSION

Conclusions

Against the background of the ongoing pervasiveness of neoliberalism and its commercialization logic, the strategy and performance of two PE-owned social care organizations were analysed. Both cases show aspects of the efficiency strategy, through a focus on lean organizing of management and overhead staff, and cost control by improving financial information processes. However, the growth strategy was dominant. Organizational growth continued as the temporary PE-owners transferred or were planning to sell the social care organization to new owners that were even bigger, and had the funds to acquire such a sizable organization. This leads to comparatively high market shares of the organizations in their respective sectors.

In contrast to what was expected based on literature, the financial performance in the cases did not improve significantly during PE ownership. In the context of government cutbacks, the organizations even performed worse than their industry counterparts, and financial risks increased. The high dependency on government reimbursements (i.e. political authority, Andersen et al., 2012) was not given due consideration in the application of the PE business model to the social care organizations.

Finally, neither a 'mutual gains' nor a 'conflicting outcomes perspective' seems to fit the cases very well. PE's impact on the work floor only seeped through as the situation became financially challenging. This led to some negative consequences for employee and client well-being. However, as PE owners' interventions were primarily focused on reorganizing top structures and on growth; consequences for well-being were rather a side effect than the result of direct PE-interventions in work floor processes.

Discussion

The entrance of PE in social care organizations can thus be associated with increased organizational growth and financial risks, which leads to some broader implications and venues for future research.

First, although 'growth' is certainly not the exclusive preserve of PE-owned organizations, PE's large amounts of so-called 'dry powder' enables acceler-

ated growth for organizations lacking the resources (cf. Harrington et al. 2017). Research from other care sectors finds that organizational size can come with inferior care quality (Harrington et al., 2012), and a focus on numbers rather than people (André & Pache 2016). Such consequences are particularly worrisome for social care, which concerns the most intimate needs of highly dependent people. Moreover, the entrance of PE in social care sectors can come with the rise of large companies in sectors, and in that way affect 'the mix of institutional logics that organize a field' (Meagher et al. 2016: 808). It places PE in social care in current debates on the concentration of market power among leading firms in several sectors. Such power concentration can come with political power to influence policy (Stiglitz 2019; Harrington et al. 2017), and raises governance issues in the case of cross-border upscaling by PE firms – as is happening in the child day care case in this study. The actions of the resulting transnational corporations in social care might restrict the public accountability capacity of individual governments (cf. Kickbusch 1999). How to control social care organizations that are funded by national governments, but whose headquarters and CEOs are situated in other countries? PE in social care reinforces the development of transnational organizations, and therefore calls for addressing such questions in both scholarly and policy debates.

Second, PE in social care comes with higher risk acceptance (cf. Harrington et al. 2017). The PE business model of leveraging and generating returns on a fund level – not for every portfolio company per se – promotes risk-taking behaviour. The PE business model turned out to be relatively ill-prepared for the policy turbulence in the cases: one organization was at the brink of bankruptcy, the other one went bankrupt. Although research in business sectors also finds increased financial distress in PE-buyouts, it does not report higher bankruptcy rates (Tykvová & Borell 2012). The findings in our study raise the question whether this last finding also holds for social care organizations that are highly dependent on government reimbursements. Moreover, as social care is at the heart of Western welfare systems, the stakes are much higher; a bankruptcy can cause enormous immaterial harm next to material losses, such as reduced care quality, and distrust vis-à-vis the overall welfare system. The role of increased financial risk in commercialized social care is an interesting venue for future research and policy debate.

7

Conclusions and discussion

7.1 INTRODUCTION

This dissertation introduced 'corporate kangaroos', which refer to private equity firms owning care organizations. The private equity sector has been growing in the past years, with the abundance of fund capital in the sector being an important driver of 'food scarcity': the shortage of investment opportunities in the corporate kangaroos' traditional 'habitat' of business sectors. Hence, private equity firms broadened their territory, and entered care sectors in several Western countries (e.g. Cadigan et al. 2015; Harrington et al. 2012, 2017; Holly 2018; Ivory et al. 2016; Meagher et al. 2016; Winblad et al. 2017). Private equity ownership, being a particular type of for-profit ownership, should be perceived as the ultimate form of commercial ownership. This dissertation focused on the meaning of commercial ownership for organizations that take care of children and the elderly.

The preceding chapters provided reviews of the literature and empirical evidence on *the strategies and multidimensional performance of for-profit and private equity owned care organizations*. This chapter brings the evidence together, and formulates three main conclusions – using the 'corporate kangaroo' metaphor: the rapid growth of the baby kangaroos resembles the dominant focus of private equity firms on increasing the size of the care organizations they owned. Moreover, the relatively unfamiliar 'habitat' of care narrowed the corporate kangaroos' freedom of movement and increased financial risks. During profitable periods, then, the 'corporate kangaroos' whooshed almost silently past the organization's work floor employees, and clients.

This chapter briefly recaps the research model and study background (paragraph 7.2; more details are provided in chapter 1), and answers the sub questions and main question of the dissertation (paragraph 7.3). Based thereon, three main conclusions are drawn (paragraph 7.4). Finally, the main limitations (paragraph 7.5), and the theoretical and practical implications of the study are outlined (paragraph 7.6).

7.2 RESEARCH MODEL AND STUDY BACKGROUND

This paragraph reiterates the research model (figure 7.2), and briefly explains its central components: commercialization as connected to different ownership types, strategy, and multidimensional performance. The research model could be

understood against the background of the neoliberalist agenda of the past four decades. This agenda embraces the idea 'that free markets in which individuals maximize their material interests provide the best means for satisfying human aspirations, and that markets are in particular to be preferred over states and politics, which are at best inefficient and at worst threats to freedom' (Crouch 2011: vii). Although the popularity of neoliberalism seems to be waning, its ideas are still powerful in shaping the organization of care sectors – as becomes visible in the role of for-profit and private equity ownership in care services. In the way that kangaroos represent cultural signs to Aboriginals, the growing private equity industry could be regarded as a token for thriving neoliberalism; it is one of the most popular sectors to work for among business school students (Phalippou 2017).

Commercialization (left side figure 7.2) was defined as the extent to which organizations 'act businesslike' and are driven by monetary concerns (Goddeeris & Weisbrod 1998; Maier et al. 2016). For-profit and private equity ownership were viewed as the organizational forms that mostly facilitated such 'acting businesslike'. Care organizations that operate at this ultimate end of the commercialization continuum were at the center of the present study. The focus was on their strategies (*how*) and performance (*what*) (right side figure 7.2). Corporate strategy was defined as the 'pattern in a stream of decisions' over time, which is a combination of deliberately planned change by top management and emergent events imposed by environmental forces (Mintzberg & Waters 1985). In addition – building on ideas from stakeholder theory (Freeman et al. 2010; Freeman 1994) – performance was viewed as a multidimensional construct,

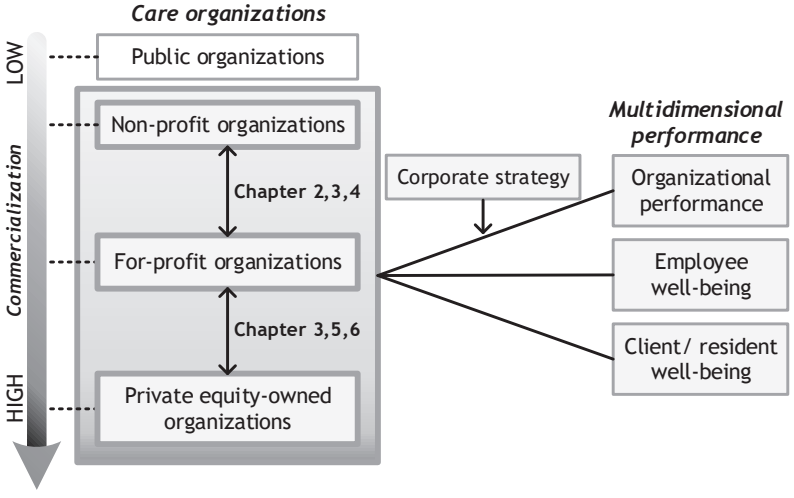

Figure 7.2 Research model

incorporating organizational performance, employee well-being, and client well-being indicators (see appendix E).

7.3 ANSWERING THE RESEARCH QUESTIONS

The dissertation consists of separate articles that each contribute to answering the main research question:

How do for-profit and private equity-owned care organizations perform?

The following sub-questions apply:

1. *What is the state of knowledge on the performance of for-profit and private equity-owned care organizations (i.e. nursing home care)?*
2. *What strategies are executed by private equity owners in care organizations?*
3. *What is the organizational performance of private equity-owned care organizations?*
4. *What is the performance of private equity-owned care organizations with regard to employee and client well-being indicators?*

In the following paragraphs, each sub-question is answered separately. The combined results lead to an overall answer to the main research question.

Sub-question 1: What is the state of knowledge on the performance of for-profit and private equity-owned care organizations (i.e. nursing home care)?

The nature of care (i.e. nursing home services) is fundamentally different from many other products and services. Reasoning from the multidimensional performance approach, at least four arguments underpin the specific nature of care services: (1) they incorporate *societal values* that cannot be commodified and cannot be captured easily in legal requirements; (2) while measurable performance indicators of *economic capital* are central in business organizations, hard to measure *social capital* is an inextricable aspect of care services, as this type of capital is built in micro actions and relationships between staff and patients on a daily basis; (3) the deployment of staff is not purely driven by efficiency, because some staff slack might be necessary in the case of unforeseen events for which extra staff are required immediately; and (4) a care client is often not an ordinary client that can effortlessly 'vote with his/her feet' in the case of dissatisfaction.

Instead, the client is relatively dependent and might need some protection. Care delivery is *not* just another business. Hence, for-profit and private equity-owned *care* organizations call for a study in their own right.

The systematic review of the literature on *for-profit* nursing home ownership in the United States (U.S.) found that the scarce evidence on organizational performance indicates higher profit margins and higher efficiency levels in for-profit nursing homes when compared to their non-profit counterparts. For employee well-being, the evidence points at worse results in for-profit nursing homes, with the majority of studies reporting for-profit homes to have lower staffing levels, higher turnover rates, and less job satisfaction and job benefits. Finally, the relationship between for-profit ownership and client well-being is either negative or absent.

However, these client well-being findings in the U.S. have to be nuanced by the tentative findings in the Netherlands, as presented in this dissertation. Chapter 4 suggests better performance of for-profit providers with regard to the well-being approach. This well-being approach comes with higher client satisfaction rates in for-profit nursing homes when compared to their non-profit counterparts. Although satisfaction and well-being aspects are only components of overall quality – that is: other care quality measures might show other results – the contrast needs some further exploration. Firstly, the contrast could be explained by the different populations that the for-profit nursing homes serve in each country: while for-profit nursing homes in the U.S. tend to have a less lucrative payer mix than non-profit nursing homes (Konetzka 2009), the Dutch for-profit nursing homes mainly target affluent clients. These affluent clients are able to pay for 'topping up' services: services that are added to the publicly paid care services (cf. Szebehely & Meagher 2018). Secondly, another explanation for the difference on this particular aspect of client well-being could be that the for-profit sector in the U.S. is a mature sector. It has been in place for decades and consists of many nursing home chains. On the contrary, the Dutch for-profit sector is relatively new and upcoming. Although there are signs of consolidation towards chains in the Dutch for-profit nursing home industry, the industry also consists of many stand-alone for-profit facilities. The stage of development and size might explain different findings as well.

Empirical evidence on the performance of *private equity-owned* care organizations is U.S.-based, scarce, and inconsistent for both client well-being and financial performance. This dissertation therefore added a systematic review of

the economic literature on the impact of private equity ownership across sectors. Based on the combined health policy and economic evidence, it was proposed that private equity-owned care organizations show higher profitability and more efficiency (organizational level), reduced staffing and worse working conditions (employee well-being), and no or a slightly negative impact on care quality (client well-being).

The systematic reviews of the evidence in different disciplines provided directions for the impact of private equity ownership in care organizations. At the same time, they conceal the variety that also becomes apparent in the evidence. Scholars have therefore called for a more in-depth understanding of private equity at work (Rodrigues & Child 2010). Hence, this dissertation presented longitudinal case studies of private equity-owned care organizations, to gain in-depth understanding of their strategies and their multidimensional performance.

Sub-question 2: What strategies are executed by private equity owners in care organizations?

In all three longitudinal case studies, the private equity firms were highly involved partners on the board room level. The general partners of the private equity firms communicated with the CEOs on a regular basis, had a decisive role in the selection of board members, and were appointed as members of the supervisory boards. The role of private equity owners in setting the strategic directions is therefore beyond question.

The case studies were used to investigate *how* private equity ownership works out in care organizations: what strategies were executed? The main similarity between the cases was the focus on organizational growth by applying a buy-and-build strategy. In two cases, the private equity owners aimed at enormous growth of the care organization through the acquisition of add-on organizations. The initial portfolio company was used as a platform, to which subsequent acquisitions were added. The (planned) transfer to a new owner, after the exit of the private equity owner, further enhances organizational size. In another case study, organizational growth was achieved through the diversification of services and, more importantly, through the development of related businesses. The huge nursing home chain served as a 'launch customer' for putting new companies on the market. These new companies had guaranteed income by contracting with the chain's facilities.

A similar pattern towards the development of large organizations became apparent in the private equity-owned Dutch nursing home chains that were studied in this dissertation. Three of them were sold to big international chains. Although it has to be acknowledged that many organizations in the respective sectors have grown *without* being backed by private equity, the private equity owners made such growth also attainable for organizations lacking the resources, and accelerated the development of big chains.

Another similar private equity strategy in the cases was the streamlining of organizational processes. The private equity owners reorganized overhead and management staff, and invested in financial information management. The cases reported the reorganization of different operating companies into one organization, a smaller span of control for managers, increased investment in real-time data ICT, and more detailed financial reporting demands. However, in all three cases, growth opportunities were much more central than efficiency gains through streamlining processes.

Sub-question 3: What is the organizational performance of private equity-owned care organizations?

While the systematic reviews of the literature pointed at improved organizational performance in private equity-owned care organizations, the case studies in this dissertation showed rather varying results. Organizational performance ranged from higher operating margins than industry counterparts, and higher net incomes per patient day in the post-purchase years (nursing home case), to irregular financial performance (child day care case), and declining solvency ratios – eventually resulting in bankruptcy (home care case).

All cases reported an increased debt ratio after the takeover by a private equity firm, which confirms the role of leverage that comes with financing private equity acquisitions. The leverage that private equity firms use to acquire a company is placed on the balance sheet of the portfolio organization. The case studies show that the application of general business principles, especially leveraging, made the care organizations relatively vulnerable in their changing policy environments. In the child day care case, the turnover decline was quite steep when compared to industry counterparts during recession, and its current ratios – the capacity to pay short-term debt obligations – was relatively low. Industry counterparts either had bigger financial reserves to draw upon and/or reorganized less drastically. In the home care case, the bankruptcy was attributed

to a combination of environmental pressures (such as stricter regulations for subcontractors by long-term care offices) and private equity involvement (such as increased leverage, lossmaking add-on acquisitions, and a high deal prize). The organizational performance in both cases was hit relatively hard by lower reimbursement schemes and stricter regulations.

Sub-question 4: What is the performance of private equity-owned care organizations with regard to employee and client well-being indicators?

The systematic reviews of the literature indicated reduced employee well-being, and no or slightly negative consequences for client well-being. These propositions appeared quite adequate for describing the employee and client well-being in the cases. In all three cases, the heavily regulated contexts were considered as a barrier for reorganizing on the employee level. Moreover, in two of the three cases, well-being results rather seemed the consequence of organizational responses to financial downturn than the result of intentional and direct private equity interventions in work floor processes from the beginning.

With regard to employee well-being, private equity owners' focus was more on professionalizing management and overhead staff (i.e. top structures) than on direct work floor interventions. In the nursing home chain case, some changes on the work floor level were found (e.g. increased professional skill mix). In the other cases, the ownership conversion did not mark significant changes in work floor processes. The private equity owners' direct interference in the business operations was very limited or absent. Employees were largely unaware of the new owner; the 'corporate kangaroo' whooshed silently past them.

However, the role of the private equity owner became more tangible for employees when the situation became financially challenging in two of the cases. Reorganizations were comparatively drastic when set against industry counterparts. They led to a relatively steep reduction in the number of employees in the child day care case. In the home care case, the bankruptcy led to dismissals and worsened working conditions for employees when they were transferred to another home care organization.

For client well-being, the nursing home chain's quality scores on deficiencies largely shifted to industry averages in the sector during private equity ownership – while having been significantly better than industry counterparts pre-buyout.

Based on the available evidence for the other two cases, consequences for client well-being are considered largely absent.

Based on the answers to the sub-questions, the main research question can be answered as follows.

Main question: How do for-profit and private equity-owned care organizations perform?

The systematic reviews of the literature on for-profit nursing home ownership, and the literature on the impact of private equity ownership across sectors led to a number of propositions. Private equity ownership in care organizations was associated with improved organizational performance, and worsened employee well-being. The performance with regard to client well-being indicators seemed rather absent, or slightly negative. The synthesis of the available evidence highlighted the overall direction of the corporate kangaroos' potential impact in care. Subsequently, a next step was taken in this dissertation, that aimed at more in-dept understanding of such commercial ownership forms in care organizations. In response to the call for case studies on what happens in individual companies after they are taken over by private equity firms (Rodrigues & Child 2010), three case studies on private equity-owned care organizations were conducted. The case studies included both the performance (*what*) as well as the strategies (*how*) of private equity-owned care organizations, and placed them in context.

The case studies shared two strategies that could be attributed to the private equity owner. The main strategy was one of accelerated organizational growth, either through add-on acquisitions of care organizations, or through the development of related businesses which had guaranteed income by contracting with the care chain's facilities. Growth opportunities, rather than traditional efficiency gains on the work floor, turned out to be central (Wright et al. 2001). A second private equity driven strategy was the streamlining of organizational processes, with a focus on reorganizing overhead and management staff, and investing in financial information management; financial reporting was a key concern for the private equity owners in each case.

The organizational performance varied between the cases and within the cases over time. Nonetheless, all three cases shared an increased debt ratio after their takeover by the private equity firm. Although the efficiency principle was not a

dominant strategy with regard to the primary processes in the care organizations, a 'lean' perspective *was* applied to the management of finance.

Work floor staff was largely unaware of the private equity owners. For management and overhead staff, the private equity ownership was much more evident, as this was the level of direct replacements and dismissals. The attention paid to operational improvements of the work floor processes became far less present. However, the impact of the private equity owner became more tangible for employees in the case of financial downturn; reorganizations were then relatively drastic when set against industry counterparts. For client well-being, slightly lower care quality ratings were reported for the nursing home case, while evidence for deteriorating client well-being seems largely absent in the other two cases.

Figure 7.2 provides a summary of the main findings.

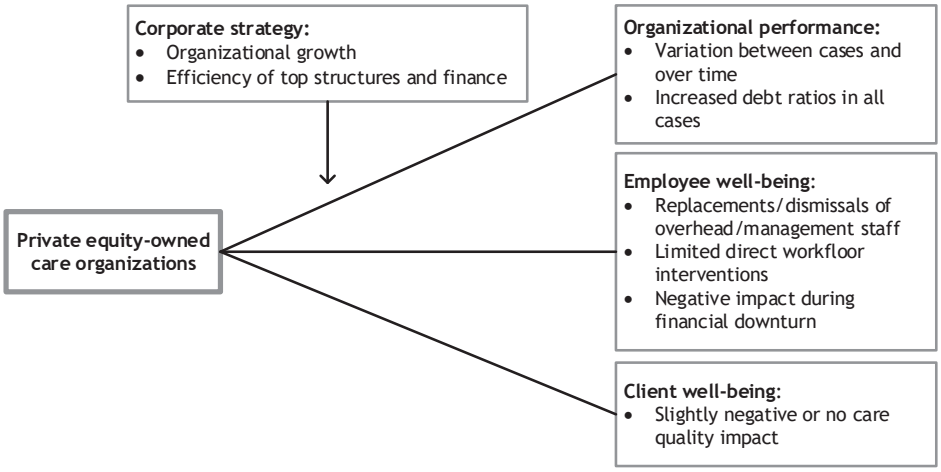

Figure 7.3 Summary of the case studies' results

7.4 MAIN CONCLUSIONS

Based on the results, as summarized in the preceding paragraph, three main conclusions are formulated.

Conclusion 1 – Private equity owners increase the size of care organizations

In the care organizations that were studied in-depth, the private equity owners mainly pursued organizational growth strategies – either by enhancing the size of the care organization itself, or by growth through related businesses (cf. Press & Woodrow 2009). This dissertation revealed a similar pattern in private equity-owned nursing home chains in the Netherlands. Moreover, for both the child day care case and Dutch nursing home chains, it was reported that private equity firm further increased organizational sizes by the sale of these companies to internationally operating chains. Hence, private equity owners increase the size of care organizations.

This conclusion is supported by developments in private equity-owned child day care in the U.S. and the United Kingdom (Roosenboom 2019), as well as by recent research on private equity in other care sectors, such as U.S. dermatology practices (Resneck 2018), U.S. physician practices (Gondi & Song 2019), U.S. ophthalmology and optometry practices (Chen et al. 2020), and residential care for children and youth in Sweden (Meagher et al. 2016). The rise of large care organizations might affect 'the mix of institutional logics that organize a field' (Meagher et al. 2016: 808). It places private equity-owned care organizations in current debates on the concentration of market power among leading firms in several sectors. Such power concentration might come with the ability to influence policy (Crouch 2011; Harrington et al. 2017; Stiglitz 2019), and might lead to greater bargaining power with for example health insurers (Gondi & Song 2019).

Conclusion 2 – Private equity owners enhance financial risks in care organizations

The application of the private equity business model (see figure 1.2b, chapter 1), in particular the use of leverage and 'lean' finance, made the care organizations examined less capable to weather unexpected challenges (cf. Roosenboom 2019). The increased debt ratio after the private equity takeover worked as a catalyst for the financial downturn in the home care case, while the lack of a solid financial buffer aggravated the financial struggles in the child day care case during economic decline. Similar findings have been reported in recent research on private equity-owned physician practices in the U.S. (Gondi & Song 2019), as well as in anecdotal evidence about one of the biggest nursing home chains in the U.S. (Whoriskey & Keating 2018). Hence, it is concluded that private equity

owners enhance financial risks in care organizations, or – as it is labeled in the private equity industry – in 'assets with meaningful exposure to reimbursement risk' (Bain & Company 2015: 7).

Interestingly, research in business sectors also finds increased financial distress in private equity-owned companies, but reports that such distress does not result in higher bankruptcy rates (Tykvová & Borell 2012; Wilson & Wright 2013; Wright et al. 2014). It should be questioned whether such a finding remains intact for private equity ownership in the *public* service context of care. The 'publicness' of care delivery, which is highly dependent on government policies and reimbursements (cf. Andersen et al. 2012), increases the risks of a business model that works from the idea of 'lean' finance, and mainly positive financial forecasts. Increased financial risks in private equity-owned care organizations hint at the problematic nature of relying on such a commercial ownership form as a vehicle for delivering care.

Conclusion 3 – Regulatory contexts restricted direct impact of private equity owners on well-being; impact on well-being was mainly indirect

Private equity ownership was associated with limited well-being changes for employees and clients during profitable times in the case studies. This limited impact can be related to the *public* service contexts of the cases. Regulatory arrangements and the role of agencies on which the care organizations depended were reported to narrow the private equity owners' opportunities for radical changes on the work floor (cf. Ben-Ner et al. 2012; King & Meagher 2009). Previous research on for-profit nursing homes confirms such a restricting role for quality regulations; for example, because these nursing homes implement staffing levels just marginally above state minimum standards (e.g. Harrington & Edelman 2018). This conclusion fits in the theory on institutional isomorphism. The case studies pointed at coercive isomorphism: private equity-owned care organizations largely behaved similar to industry counterparts, as a result of their development under similar constraints (DiMaggio & Powell 1983). Hence, the care contexts limited the changes due to private equity ownership.

Moreover, it should be questioned whether such changes were the private equity firms' main ambition in the first place. The rising debt levels, and the relative financial vulnerability in times of policy change and recession, lend some support for idea that the private equity owners focused on financial engineering

rather than operational improvements (Appelbaum & Batt 2014). Well-being consequences appeared more as an *indirect* result of such financial risk-taking in a public service context (see conclusion 2), than as a result of direct private equity intervention in work floor processes.

7.5 LIMITATIONS OF THE STUDY

This dissertation started with a systematic review of the evidence on commercial ownership forms, and an account of the emerging for-profit nursing home sector in the Netherlands. It then took a next step, by responding to the call for 'longitudinal studies that chart the development and impact of changes' during private equity ownership (Wright et al. 2009), because there is 'a scarcity of cases reporting in any detail on the kind of restructuring that takes place in individual companies after they are acquired by private equity firms' (Rodrigues & Child 2010: 1322). By its focus on private equity ownership, this dissertation simultaneously responded to the invitation from health policy scholars to shift attention from the for-profit / non-profit divide to the complicated ownership structures *within* the for-profit care sector (Stevenson et al. 2013). There might be huge differences between, for example, small for-profit firms ('the dwarves of capitalism') and big, private equity-owned chains. Hence, the last chapters provided case study results for private equity-owned care organizations.

The conduction of these mixed methods case studies turned out to be quite challenging in practice. The secrecy of the private equity industry made access often difficult (cf. Appelbaum & Batt 2014; Clark 2009). Moreover, the availability of data was often limited. Considerable effort was made to get access to respondents and data. This eventually resulted in relevant in-depth information and the possibility to take context characteristics into account. However, the 'simple – in a sense inelegant – methodologies' (Mintzberg 1979: 583) also came with some limitations. Not all preferred data were available for all years or for all relevant variables, and evidence on industry counterparts lacked for part of the data. Hence, a longitudinal design and a comparison to industry counterparts were not possible for every measure of performance.

In addition, it has to be acknowledged that other organizational factors than ownership form can also be very relevant for the strategy and performance of care organizations (i.e. age of the organization, chain affiliation, or organiza-

tional size; e.g. Akgündüz & Plantenga 2013; Morris & Helburn 2000). Moreover, the proportion of performance that can be attributed to the boardroom – where private equity firms asserted their influence – can be nuanced in general, as situational factors often play a major role (cf. Tolbert & Hall 2015). On the one hand, more advanced research methodologies that apply large-*n* designs could have controlled for other relevant factors. On the other hand, the longitudinal mixed methods design in the case studies was well able to disentangle the impact of situational factors and ownership.

Another limitation concerns the categorization of staffing levels, which is done differently throughout the dissertation. Staffing is regarded as an aspect of employee well-being in the systematic review (chapter 2), is categorized as part of company strategy in the U.S. nursing home case study (chapter 5), and is treated as a quality indicator in the child day care case study (chapter 6). It would have been more consistent to categorize staffing in the same way throughout the dissertation, but variations were made – among else in response to reviewer comments on earlier versions of the chapters. In this conclusion, staffing levels were categorized similarly as an employee well-being variable.

Finally, it should be noted that the variation in national contexts of the U.S. (chapter 5) and the Netherlands (chapter 6) is not analyzed as part of answering the main research question. The specificities of the U.S. nursing home context are accounted for in the concluding section of chapter 2. The focus was on the organizational level, and no obvious clues – related to strategy or performance – were (therefore) identified in the analyses of the cases.

7.6 IMPLICATIONS FOR THEORY AND PRACTICE

A number of implications for both theory and practice are derived from the findings in this dissertation.

Implications for theory

This dissertation combined insights from health policy and public administration literature on for-profit public service delivery, and insights from economic literature on the impact of private equity ownership. Consequently, there are contributions to both fields.

Firstly, with regard to health policy and public administration literature: the dissertation (re)introduced the importance of studying commercialization in public service delivery – especially when it comes to private equity ownership as its ultimate manifestation. While the focus in health policy literature has been on the differences between for-profit and non-profit (or public) care organizations (see chapter 2), the focus in this dissertation was also on differences *within* the for-profit sector (cf. Stevenson et al. 2013). Moreover, public administration literature coined 'New Public Management (NPM)' as the label for commercialization in the public sector. Public management, then, is about the balancing between sigma-type values (economy and parsimony), theta-type values (fairness and honesty), and lambda-type values (risk-aversion and resilience). NPM is mainly related to the sigma-type values, because 'its claims have lain mainly in the direction of cutting costs and doing more for less' (Hood 1991: 15; Hood & Jackson 1991). Yet, the conclusions in this dissertation emphasized aspects of commercialization that are related to the lambda-type values. The case studies highlighted the enhanced financial risks that are associated with private equity ownership in volatile care contexts. Hence, future research could study the relation between commercialization and increased financial risks in public service organizations (cf. Penn 2009; Gondi & Song 2019). Another interesting venue for future research could be to study the effects of a growing size of care organizations (cf. Harrington et al. 2012; Morris & Helburn 2000; Sosinsky et al. 2007).

Secondly, the dissertation added in-depth case study findings to the dominantly quantitative evidence in economic literature on private equity (see appendix C; some exceptions are Appelbaum et al. 2013; Boselie & Koene 2010; Clark 2011; Gospel et al. 2011; Westcott & Pendleton 2013). The case studies in this dissertation were an attempt to better understand the 'messy' reality of private equity-owned *care* organizations (cf. Wright et al. 2009; Rodriguez & Child 2010), while previous research mainly covered business sectors and is for a substantial part based on the CMBOR-database that reports survey results as filled out by managers (see appendix C). The case studies in this dissertation illustrated the strong interaction between private equity firms' impact and the specific context of the portfolio organizations. Moreover, the case study results pointed at the need to shift the level of analysis in private equity research from only individual organizations to the individual organizations *and their related organizations*. It was reported how private equity owners can create financial value beyond their portfolio company, by using the care organization as a 'launch customer' for putting new companies on the market, which have guaranteed income by contracting with the portfolio company (cf. Press & Woodrow 2009; Harrington et

al. 2015). The current focus on the individual organization as the level of analysis is not alert to such related-party profits extraction.

Implications for practice

Private equity firms will probably be with us for the coming years; private equity funds 'produced another impressive surge in investment value, capping the strongest five-year stretch in the industry's history' (Bain & Company 2019: 36; Den Brinker 2020). It is expected that a large share of the 'dry powder' in private equity funds will end up in healthcare sectors (Den Brinker & Motké 2020). Hence, enhanced understanding of for-profit and – in particular – private equity-owned care organizations is very relevant, and helps to put on the agenda some implications for practice. The following implications are not directed at regulating the private equity industry itself (e.g. Warren et al. 2019), but rather take the presence of private equity firms in care sectors as a starting point.

Firstly, this dissertation underscores the need to consider the effects of unbridled and international growth of care organizations. Both the study on the emerging for-profit nursing home industry in the Netherlands (chapter 4), as well as the study on private equity-owned social care organizations (chapter 6) show the tendency towards accelerated growth and international chains – boosted by private equity ownership. Scholars as well as the Dutch anti-trust authority (ACM) warn for of such enormous growth, by pointing at negative consequences such as the loss of control, and inferior quality (ACM 2018; Harrington et al. 2012; Kitchener et al. 2008). The ACM even explores the possibility to ban care organizations above a certain size (cf. Noels 2019). Recently, the Dutch Healthcare Authority (NZa) – that protects the interests of citizens with regard to accessibility, affordability, and quality of health care in the Netherlands – also warned for the role of private equity firms in the consolidation in health care markets. The authority states that, in such cases, its current instrumentation (i.e. concentration test) fails to deal adequately with the risks for the public values of accessibility, affordability, and quality (NZa 2020). A strategy is needed for anti-trust authorities to cope with the issue of private equity driven and international consolidation in care sectors.

Secondly, more transparency on ownership structures of care organizations is recommended (cf. Harrington et al. 2011). While mapping the Dutch for-profit nursing home sector (chapter 4), it was found that many for-profit nursing homes were organized through a web of several limited liability companies, for which it

was sometimes hard to trace back the ultimate owners. In addition, the nursing home case study (chapter 5) serves as an example of how private equity owners further increase this complexity. Transparency on ownership structures is very relevant with regard to issues of accountability (cf. Gondi & Song 2019; Poerink 2012).

Thirdly, the conclusions point at the importance of strict quality regulations in public service 'markets'. Such regulations are sometimes perceived as an administrative burden, but are very necessary in the case of commercial ownership forms. Moreover, adequate enforcement of regulations for quality and working conditions is essential when allowing high degrees of commercialization in public services (cf. Harrington & Edelman 2018).

Finally, the current owners of care organizations need to deliberately consider questions of succession – such as to sell (or *not* to sell) their organization to a private equity firm. The sale to a private equity firm might be financially attractive, but several questions need to be answered beforehand, such as: what are experiences of other organizations with the private equity firm? Who are the limited partners and what return do they demand, within what timeframe? What level of debt is used to finance the deal, and can the amount be justified in terms of financial risks and organizational stability? What guarantees can be made with regard to employee and client well-being? What legacy is there to leave behind and in whose hands will it be safe? (cf. Bos & Hesselink 2018).

Final remark

Though they prefer to move quietly, 'corporate kangaroos' should have a much more visible place in the public eye. They are in the spotlights at times, when a portfolio company goes bankrupt or when a private equity firm is said to have made huge profits. The focus is mainly on individual private equity firms and their particular portfolio companies in such cases. Yet, a broader perspective is also required. One that takes into account the seemingly indeterminate growth of the 'corporate kangaroo' sector itself, the potential growth of care organizations as private equity enters their sector, and the risky instability that the hopping animal might cause in public services. Do not let those kangaroos whoosh silently past sectors that are at the core of Western welfare states.

R

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A

Appendices

APPENDIX A – QUALITY ASSESSMENT OF THE STUDIES (CHAPTER 2)

We scored each study for the relationship that is the central subject of this systematic review: ownership and financial performance, employee/client well-being (the rating scale was adapted from Cummings et al. 2010).

Summary of the Quality Assessment of the Studies

Studies in which ownership is the independent variable (*n* = 33)

		Y	N
	DESIGN		
1*	Was the study related to an ownership change (NFP to FP) rather than relative differences (NFP vs. FP)?	1	32
2	Was probability sampling used or were all relevant facilities/respondents in the territory included?	28	5
3	Was a theoretical framework/model used for guidance?	17	16
	SAMPLE		
4	Was the sample size appropriate?	28	5
5	Was the sample drawn from more than one state/province?	18	15
6	Was the response rate more than 60%?	26	7
	STATISTICAL ANALYSES		
7*	Was outcome controlled for other factors (e.g. resident characteristics, market characteristics)?	17	16
8	Were outliers managed?	2	31
	TOTAL QUALITY RATING (max. 10 points): **LOW** (0-3) **MEDIUM** (4-6) **HIGH** (7-10)	**TOTAL QUALITY SCORE**	
		Low:	8 studies
		Medium:	19 studies
		High:	6 studies

Studies in which ownership is a covariate (*n* = 28)

		Y	N
	DESIGN		
1*	Was the study related to an ownership change (NFP to FP) rather than relative differences (NFP vs. FP)?	0	28
2	Was probability sampling used or were all relevant facilities/respondents in the territory included?	27	1
3	Was a theoretical framework/model used for guidance?	9	19

	SAMPLE		
4	Was the sample size appropriate?	28	0
5	Was the sample drawn from more than one state/ province?	22	6
6	Was the response rate more than 60%?	23	5
	STATISTICAL ANALYSES		
8	Were outliers managed?	9	19
	TOTAL QUALITY RATING (max. 8 points): **LOW** (0-2) **MEDIUM** (3-5) **HIGH** (6-8)	**TOTAL QUALITY SCORE**	
		Low:	3 studies
		Medium:	20 studies
		High:	5 studies

* Relatively important item, therefore given more weight. Such items get 2 points when the question can be answered with a 'yes' (compared with 1 point for the other items).

Scores of the Individual Studies in the Quality Assessment

		Design			Sample		Statistical analysis			Total	Quality[1]	Market control[2]
No.	Author, year, journal	1	2	3	4	5	6	7	8			
1[c]	**Akinci & Krolikowski 2005, *Applied Nursing Research***	0	1	0	1	0	1	N/A	0	3	MQ	N/A
2	**Amirkhanyan et al. 2008, *Journal of Policy An. & Man.***	0	1	1	1	1	1	2	0	7	HQ	Y
3	**Bardenheier et al. 2005, *Journal Am. Geriatrics Society***	0	1	0	1	1	1	0	0	4	MQ	N
4[c]	**Barry et al. 2005, *The Gerontologist***	0	1	1	1	1	1	N/A	0	5	MQ	N/A
5[c]	**Baumgarten et al. 2004, *Journal Am. Geriatrics Society***	0	1	0	1	0	1	N/A	0	3	MQ	N/A
6[c]	**Boockvar et al. 2005, *Journal of Am. Geriatrics Soc.***	0	1	0	1	0	1	N/A	0	3	MQ	N/A
7	Carter & Porell 2005, *Am.Journ. of Alzh.'s Dis. & Other Dem.*	0	1	0	1	0	1	0	0	3	LQ	N
8	Carter & Porell 2006, *Journal of Aging & Social Policy*	0	1	0	1	0	0	N/A	0	2	LQ	N
9[c]	**Castle & Engberg 2005, *Medical Care***	0	1	0	1	1	1	N/A	0	4	MQ	N/A
10	**Castle & Engberg 2006, *The Gerontologist***	0	1	1	1	1	1	2	0	7	HQ	Y

No.	Author, year, journal	Design			Sample		Statistical analysis			Total	Quality[1]	Market control[2]
		1	2	3	4	5	6	7	8			
11[c]	**Castle 2005,** ***The Gerontologist***	0	1	1	1	1	1	N/A	0	5	MQ	N/A
12[c]	**Castle et al. 2007,** ***The Gerontologist***	0	1	1	1	1	0	N/A	0	4	MQ	N/A
13	**Chesteen et al. 2005,** ***Journal of Operations Man.t***	0	0	1	0	0	0	2	1	4	MQ	Y
14[c]	**Choi et al. 2012,** ***The Gerontologist***	0	1	1	1	0	0	N/A	0	3	MQ	N/A
15	**Davis et al. 2009,** ***Nonprofit & Vol. Sector Quart.***	0	1	1	1	0	0	2	0	5	MQ	Y
16[c]	**Decker 2006,** ***Medical Care***	0	1	0	1	1	1	N/A	0	4	MQ	N/A
17[c]	**Decker 2008,** ***Health Economics, Policy & Law***	0	1	1	1	1	1	N/A	1	6	HQ	N/A
18	**Decker et al. 2009,** ***The Gerontologist***	0	1	1	1	1	0	0	0	4	MQ	N
19[c]	**Dobalian 2004,** ***The Gerontologist***	0	1	0	1	1	1	N/A	0	4	MQ	N/A
20[c]	**Feng et al. 2008,** ***Medical Care***	0	1	0	1	1	1	N/A	1	5	MQ	N/A
21[c]	Flynn et al. 2010, *Journal of Am. Geriatrics Society*	0	1	0	1	0	0	N/A	0	2	LQ	N/A
22	**Givens et al. 2013,** ***Journal of Am. Geriatrics Society***	0	1	0	1	1	1	0	0	4	MQ	N
23	**Gozalo & Miller 2007,** ***Health Services Research***	0	1	0	1	1	1	0	0	4	MQ	N
24[c]	**Grabowski & Angelelli 2004,** ***Health Services Research***	0	1	1	1	1	1	N/A	0	5	MQ	N/A
25	**Grabowski & Stevenson 2008,** ***Health Services Research***	2	1	1	1	1	1	2	0	9	HQ	Y
26[c]	**Grabowski 2004,** ***Medical Care***	0	1	0	1	1	1	N/A	0	4	MQ	N/A
27[c]	**Grabowski et al. 2004,** ***Health Affairs***	0	1	0	1	1	1	N/A	0	4	MQ	N/A
28	**Grabowski et al. 2013,** ***Journal of Health Economics***	0	1	0	1	1	1	2	0	6	MQ	Y

No.	Author, year, journal	Design			Sample		Statistical analysis			Total	Quality[1]	Market control[2]
		1	2	3	4	5	6	7	8			
29	Gruber-Baldini et al. 2005, *The Gerontologist*	0	1	0	0	1	1	0	0	3	LQ	N
30	**Haley-Lock & Kruzich 2008, *Nonprofit & Vol. Sector Quart.***	0	0	1	1	0	1	2	0	5	MQ	Y
31	**Hirth et al. 2014, *Int. Journ. Health Care Fin. Ec.***	0	1	1	1	1	1	2	0	7	HQ	Y
32	Horn et al. 2005, *The American Journal of Nursing*	0	0	0	1	1	0	N/A	0	2	LQ	N/A
33[c]	**Intrator & Mor 2004, *Journal of Am. Geriatrics Soc.***	0	1	0	1	1	1	N/A	1	5	MQ	N/A
34[c]	**Intrator et al. 2004, *Journal of Am. Geriatrics Soc.***	0	1	0	1	1	1	N/A	0	4	MQ	N/A
35[c]	**Intrator et al. 2005, *The Gerontologist***	0	1	1	1	1	1	N/A	1	6	HQ	N/A
36[c]	**Intrator et al. 2007, *Health Services Research***	0	1	0	1	1	1	N/A	0	4	MQ	N/A
37	Jogerst et al. 2006, *Journal of Am. Med. Dir. Ass.*	0	1	0	1	0	1	0	0	3	LQ	N
38	**Johnson et al. 2004, *The Gerontologist***	0	0	0	1	0	1	2	0	4	MQ	Y
39[c]	**Kamimura et al. 2007, *Health Care Management Rev.***	0	1	0	1	1	0	N/A	0	3	MQ	N/A
40	**Kash et al. 2007, *Health Care Management Rev.***	0	1	1	1	0	1	2	0	6	MQ	Y
41	**Kash et al. 2006, *The Gerontologist***	0	1	0	1	0	1	2	1	6	MQ	Y
42	**Konetzka et al. 2004, *Medical Care***	0	1	1	1	1	1	2	0	7	HQ	Y
43[c]	**Konetzka et al. 2004, *Health Services Research***	0	1	1	1	1	1	N/A	1	6	HQ	N/A
44[c]	**Konetzka et al. 2006, *Medical Care***	0	1	0	1	1	1	N/A	0	4	MQ	N/A
45	Kruzich 2005, *Administration in Social Work*	0	0	1	0	0	1	0	0	2	LQ	N
46	**Lau et al. 2004, *Health Services Research***	0	1	0	1	1	1	2	0	6	MQ	Y

		Design			Sample		Statistical analysis			Total	Quality[1]	Market control[2]
No.	Author, year, journal	1	2	3	4	5	6	7	8			
47	**Lee et al. 2009, *Health Services Research***	0	1	0	1	1	0	2	0	5	MQ	N
48[c]	**Mueller et al. 2006, *The Gerontologist***	0	1	0	1	1	1	N/A	1	5	MQ	N/A
49	Mukamel et al. 2005, *Health Services Research*	0	1	0	1	0	1	0	1	3	LQ	N
50	Noelker et al. 2009, *Journal of Aging and Health*	0	0	0	0	0	1	0	0	1	LQ	N
51[c]	**Park & Stearns 2009, *Health Services Res.***	0	1	1	1	1	1	N/A	1	6	HQ	N/A
52	Porell & Carter 2005, *Journal of Aging and Health*	0	1	1	1	0	0	0	0	3	LQ	N
53	**Rantz et al. 2004, *The Gerontologist***	0	1	1	1	0	1	0	0	4	MQ	N
54	Sawyer et al. 2007, *Journal of Am. Med. Dir. Ass.*	0	1	0	1	0	1	0	0	3	LQ	N
55	**Seblega et al. 2010, *Medical Care Research & Review***	0	1	0	1	1	1	0	1	5	MQ	N
56	**Stevenson 2005, *Medical Care***	0	1	0	1	0	1	2	0	5	MQ	N
57	**Weech-Maldonado et al. 2012, *Health Care Management Rev.***	0	1	1	1	1	1	2	0	7	HQ	Y
58	**Williams et al. 2005, *The Gerontologist***	0	1	0	0	1	1	2	0	5	MQ	N
59[c]	**Zhang & Grabowski 2004, *The Gerontologist***	0	1	0	1	1	1	N/A	1	5	MQ	N/A
60[c]	**Zhang et al. 2008, *Health Services Research***	0	1	1	1	1	1	N/A	1	6	HQ	N/A
61	**Zinn et al. 2005, *The Gerontologist***	0	1	0	1	1	1	0	0	4	MQ	N

[c] Studies in which ownership is treated as a covariate

[1]HQ = high quality study; MQ = medium quality study, LQ = low quality study. Articles in a bold typeface are ranked MQ or HQ and are included in the review. LQ articles are not included in the review.

[2]Market control indicates whether a study controls for poverty rates, per capita income, or percentage of Medicaid recipients in the area where nursing homes are located.

APPENDIX B – PRISMA CHECKLIST (CHAPTER 2)

TITLE		
Title	Identify the report as a systematic review, meta-analysis, or both.	✓
ABSTRACT		
Structured summary	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.	✓
INTRODUCTION		
Rationale	Describe the rationale for the review in the context of what is already known.	✓
Objectives	Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes and study design (PICOS).	✓
METHODS		
Protocol and registration	Indicate if a review protocol exists, if and where it can be accessed (e.g. Web address), and, if available, provide registration information including registration number.	N/A
Eligibility criteria	Specify study characteristics (e.g. PICOS, length of follow-up) and report characteristics (e.g. years considered, language, publication status) used as criteria for eligibility, giving rationale.	✓
Information sources	Describe all information sources (e.g. databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	✓
Search	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	✓
Study selection	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	✓
Data collection	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	✓
Data items	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	N/A
Risk of bias in individual studies	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	N/A
Summary measures	State the principal summary measures (e.g., risk ratio, difference in means).	N/A

Synthesis of results	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I) for each meta-analysis.	N/A
Risk of bias across studies	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	N/A
Additional analyses	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.	N/A
RESULTS		
Study selection	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	✓
Study characteristics	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.	✓
Risk of bias within studies	Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12).	N/A
Results of individual studies	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.	N/A
Synthesis of results	Present the main results of the review. If meta-analyses are done, include for each, confidence intervals and measures of consistency	✓
Risk of bias	Present results of any assessment of risk of bias across studies (see Item 15).	N/A
Additional analyses	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).	N/A
DISCUSSION		
Summary of evidence	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups.	✓
Limitations	Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).	✓
Conclusion	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	✓
FUNDING		
Funding	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.	N/A

Note: the checklist is based on Liberati et al. 2009; some of the checks are not applicable as they are intended for meta-analyses, not for systematic reviews.

APPENDIX C – SYSTEMATIC REVIEW PRIVATE EQUITY LITERATURE (CHAPTER 4)

PRIVATE EQUITY OWNERSHIP AND ORGANIZATIONAL PERFORMANCE, EMPLOYEE WELL-BEING, AND CLIENT WELL-BEING: A SYSTEMATIC REVIEW OF THE LITERATURE

Author: A. Bos

Year: 2015

ABSTRACT

The growth of private equity worldwide comes with an increasing controversy about its role in portfolio organizations. We conducted a systematic review of the literature over the last ten years. The review applies a multidimensional performance perspective, by including organizational performance, employee well-being, and client well-being variables.

Five search strategies plus inclusion and quality assessment criteria were applied to identify and select eligible studies. As a result, 62 studies were included in the review. Relevant findings were categorized as related to organizational performance (i.e. financial performance and innovation performance), employee well-being (i.e. employment, wage, industrial relations, and other working conditions), or client well-being (i.e. product or service quality), and then analyzed based on common characteristics.

Our findings show that the impact of private equity ownership on organizational performance is mainly positive. The impact of private equity on employee well-being is mixed, while private equity seems to be associated with no or negative client well-being changes.

INTRODUCTION

In a nutshell, private equity (PE) firms trade unlisted, private companies. The firms raise funds - for example from insurance companies, wealthy individuals, and pension funds – to invest in so-called portfolio companies. Their investment

is often accompanied by a significant share of borrowed money. PE can focus on start-up firms, or on later stage investments. Our focus is on buyouts in which PE firms acquire a significant equity stake in a *mature* firm (Bacon et al. 2008). PE firms become financially as well as strategically involved in their portfolio companies. The firms actively reorganize the portfolio companies, with an eye toward cashing out by selling them or taking them public, usually within three to seven years (Gilligan & Wright 2008).

From the 1980s onwards, PE has expanded geographically, and broadened its focus from mainly manufacturing companies to services companies as well (Kaplan & Strömberg 2009). After a dip of PE investments during the first years of the financial crisis (2008-2009), the PE industry prospers (Bain & Company 2015). The size and growth of PE worldwide comes with an increasing controversy about the impact of PE firms in their portfolio organizations. Proponents of the PE industry argue that PE firms help solve the agency problem by re-connecting management and ownership (Jensen 2007). They regard PE as a long-term investment vehicle for creating company value (Gilligan & Wright 2014; Wood & Wright 2010): PE firms improve companies by using strategies such as investment in technology and human capital, growth via acquisitions, and marketing. In contrast, opponents label PE firms as 'barbarians' and 'new kings of capitalism' (Folkman et al. 2009), stating that PE methods are only motivated by the prospect of making returns of 20% or more. They claim that PE firms mainly apply financial engineering tactics, that only reallocate money. PE firms are focused on strategies such as the sale of assets (with proceeds going to the PE firm), the aggressive use of debt, the abrogation of contracts with unions and suppliers, and the obtainment of tax advantages (Batt & Appelbaum 2014). Therefore, PE would be beneficial to PE firms themselves and to top managers, the 'value capture by the few' (Froud & Williams 2007), while being at the expense of other stakeholders.

As a huge body of research on the PE's impact in portfolio organizations is available, we present a systematic review that directly relates to this debate. We reviewed the literature on the impact of PE ownership on portfolio firms, for the period 2004-2014. Since owners, employees, and clients are jointly affected by PE acquisitions, we paint a broad picture of PE's impact. We start from a multi stakeholder perspective, and assess the impact of PE ownership on portfolio organizations across sectors, with regard to organizational performance, employee well-being and client well-being.

The article is structured as follows. We start with the three main contributions of this review, followed by the introduction of the multi stakeholder perspective. Subsequently, we discuss our method: a systematic review of the literature using the PRISMA method. The results are then presented for organizational performance, employee well-being, and client well-being. Finally, we draw conclusions and suggest an agenda for future research.

CONTRIBUTIONS

Scholars on PE have already conducted several literature reviews on PE (Bacon et al. 2013; Cumming et al. 2007; Kaplan & Strömberg 2008; Wood & Wright 2009; Wright et al. 2009a; Wright et al. 2009b; Wright et al. 2009c). Our systematic review of the literature adds to former literature reviews in three ways. First, it serves as an update of earlier reviews, by incorporating articles published over the past 10 years; 84% of the articles reviewed here have not been included in previous reviews. Around 40% of the papers reviewed in previous overviews were published before 2004. Former reviews cover a broader time period, including research on the first wave of PE in the late 80s as well as the second wave of PE in 2004-2007, while the nature of PE changed during this second wave (e.g. Wright & Bruining 2008). Moreover, the financial crisis in 2008 even led to more changes, with PE performance coming closer to that of public equity markets (Bain & Company 2015).

Second, previous reviews include published as well as unpublished papers. We only include published articles in peer reviewed journals. Moreover, we assessed a quality scan of the articles included in the review. In addition, we are the first in this field to use a *systematic* review approach for data searches, study selection and data extraction (PRISMA-method). This approach helps to identify relevant articles in the general field of PE research and finance, but also to identify also previously overlooked studies in health policy literature (e.g. Harrington et al. 2012; Pradhan et al. 2013, 2014; Stevenson & Grabowski 2008).

Third, we start from a multi-stakeholder perspective. Individual studies tend to examine either the managerial or the employee perspective (Wright et al. 2009a). Furthermore, the client perspective is largely new in this area, as it has not been included in previous overviews of the evidence. We involve multiple perspectives that include management, employees, and clients simultaneously. This overview provides the opportunity to identify potential differences in the impact of PE for these different stakeholders.

CONCEPTUAL FRAMEWORK

As organizations are social systems, the outcomes for different stakeholders are at the center of our study. We assume that owners, employees, and clients are jointly affected by PE ownership. The impact of PE-ownership in portfolio organizations is therefore viewed through a multidimensional lens, which incorporates variables that are relevant to different stakeholders. Such a multidimensional perspective is in line with the *stake*holder approach.

Shareholders, stakeholders, and a balanced approach

In research on PE, the *share*holder approach is dominant. The publication by Jensen and Meckling (1976) represents the classic shareholder approach in which principals (owners) and agents (managers) are challenged to optimize their financial interests and long term organizational competitiveness. This particular model is widely used in PE literature, given its focus on ownership, financial performance and incentives for agents to serve the interests of the principals. The 'traditional' shareholder approach can be characterized by a focus on a limited number of stakeholders and a one-dimensional performance orientation (organizational and financial performance).

While the shareholder approach thus focuses on maximizing returns to shareholders, the stakeholder theory aims at treating all stakeholders like shareholders (Boatright 2006), such as employee representatives (works councils), national and local governments, trade unions, employers' associations, and customers (Beer et al. 1984; Freeman 1984 2010). It gives more room for the possibility of different outcomes for multiple stakeholders (Beer et al. 2015). Such ideas are visible in, among else, the Strategic Balance Theory (SBT), that builds on the idea of balancing economic and non-economic dimensions of an organization. Deephouse (1999) finds that successful organizations are characterized by above average scores on both financial performance and social legitimacy, but not necessarily the best scores on either of these two dimensions. An explanation for this phenomenon is that excellent financial performance without social legitimacy can be symptomatic for exploiting employees and/or neglecting the impact of the organization on society. Balanced approaches on the individual level, focused on job demands and stress, are widely applied in health psychology (e.g. Maslach et al. 2001).

Conflicting outcomes and mutual gains model

We start from a multi-stakeholder approach, which perceives performance of organizations as the balancing between multiple dimensions. Our focus in on primary stakeholders *in* the organization, which are the owners, employees and clients. The multidimensional construct therefore includes measures of organizational performance, employee well-being, and client well-being. We then apply the conceptual models of conflicting outcomes and mutual gains, as borrowed from literature on Human Resource Management (Van de Voorde et al. 2012).

The conflicting outcomes perspective, or 'pessimistic perspective', views the maximization of value for the one stakeholder as not necessarily beneficial for other stakeholders. The perspective draws on aspects of the labor process theory (Appelbaum 2002). Central to the conflicting outcomes perspective is the idea that the adoption of advanced HR practices leads to intensification of work and employee exploitation. Employees have to work harder and experience increased levels of monitoring and control. HRM leads to increased organizational performance at the expense of employee well-being (Paauwe 2004; Peccei et al. 2013). We translate this conflicting outcomes perspective to the impact of PE ownership. PE ownership may be a trade-off or a zero-sum game in terms of positive and negative outcomes for different stakeholders. It related to the debate in PE literature on 'whether private equity builds value or only redistributes it at the expense of employees' (Goergen et al. 2014: 148). While top managers and PE firms benefit, other stakeholders lose benefits (Froud & Williams 2007). From this perspective, PE ownership is often regarded as a form of financial capitalism that threatens employment and working conditions (Bacon et al. 2013).

The alternative 'mutual gains perspective' or 'optimistic perspective' holds that positive or negative outcomes for one stakeholder go together with positive or negative outcomes for other stakeholders; outcomes are mutually reinforcing each other in the same direction. The adoption of progressive HR practices is expected to lead to a more rewarding work environment, leading to a better quality of work life. Employees are expected to repay the organization by putting in extra effort, thus contributing to organization performance (Peccei et al. 2013). The perspective fits into the social exchange theory (Blau 1964) and the norm of reciprocity (Gouldner 1960). Moreover, in social service contexts, the emotional contagion theory is relevant (Hatfield et al. 1994). Emotional contagion is the tendency of converging emotions of interacting individuals. Thus, employees' mood can affect the customer mood, and therefore contribute to more positive or

negative customer evaluations (Pugh 2001). When we translate this perspective to our central subject, we assume that when PE ownership results in inferior working conditions, this may be accompanied by worse financial outcomes. Evidence for this perspective comes with the sentence 'Doing well by doing good': paying attention to all stakeholders will benefit all stakeholders (Falck & Heblich 2007; Laszlo 2008). In this regard, PE owners might treat the multiple stakeholders in a balanced way, because this may provide a win-win situation. By building stronger businesses, all stakeholders are better off. For example, increased profitability of PE owned portfolio companies can go hand in hand with increased employment (Boucly et al. 2012) and improved employee working conditions.

In sum, the 'conflicting outcomes perspective' regards the impact of PE ownership for different stakeholders as a zero-sum game. At the opposite, the 'mutual gains perspective' assumes that the outcomes for different stakeholders will reinforce each other in the same positive or negative direction. We explore which of these perspectives is most appropriate for describing the impact of PE ownership.

Study attributes

The central study attribute is private equity (PE) ownership. We study how PE ownership affects the variables that *emerged* from our systematic literature search. These variables are categorized into 'organizational performance', 'employee well-being', and 'client well-being'.

Private equity ownership – PE ownership is treated as a dummy variable: an organization is either PE-owned, or not. Most articles included deal with PE-backed buyouts: in a typical buyout transaction, a PE firm buys majority control of an existing or mature firm. Although most buyouts are PE backed, buyouts can also be financed in another way (such as via debt financing by banks). We only include those papers that explicitly mention PE as the financier of buyouts. This means that some very interesting papers on buyouts are excluded from our review (e.g. Amess et al. 2007; Bacon et al. 2004). We include papers that study pre- and post-buyout developments, as well as papers that compare PE-backed buyouts versus non-PE-backed buyouts or versus other industry counterparts.

Organizational performance – Organizational performance includes variables that affect the performance of the organization *as a whole*. Organizational performance aspects included are financial performance and innovation performance. Financial performance is measured by variables such as profitability, efficiency,

bankruptcy rates, and financial management. Innovation performance is about investment activity/strategy, and entrepreneurial management practices.

Employee well-being – Literature on employee well-being mostly distinguishes 'happiness well-being', (Grant et al. 2007) – for example job satisfaction and commitment – and physiological and psychological aspects of employee health at work, such as burnout and vitality (Peccei et al. 2013). However, empirical evidence on PE ownership does not directly address these dimensions of happiness and health. We therefore use proxies for employee well-being, building on 'organizational climate' literature, that focuses on employees' perception of their work environment. This literature suggests a clear link between organizational climate and several employee attitudes and behaviors, such as satisfaction (e.g. Carr et al. 2003). Most papers on employee well-being in this review analyze the impact of PE ownership on employment, wage, and industrial relations. In addition, several papers deal with other working conditions, such as employee consultation.

Client well-being – We relate client well-being to product or service quality outcomes. Our search of the literature resulted in articles on the impact of PE ownership on care quality and on product quality in the telecommunications industry. Product or service quality is sometimes regarded as an aspect of organizational performance (e.g. Dyer & Reeves 1995). Our main criterion was which stakeholder group is mainly affected by a specific dimension. We view quality as the ultimate effect for the client.

Figure C1 summarizes the Study Attributes.

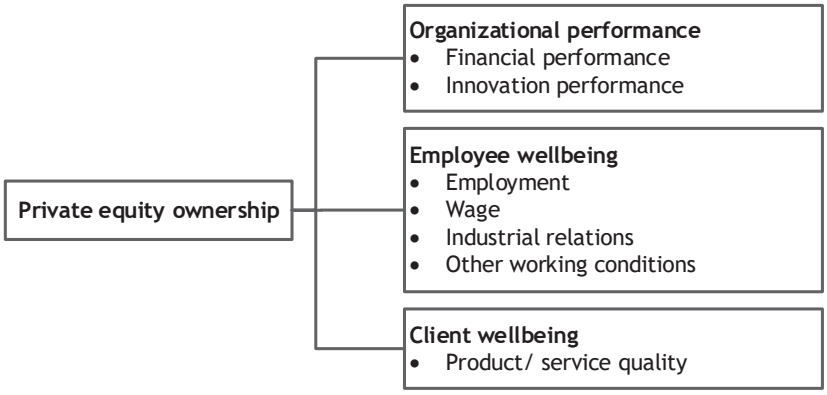

Figure C1 Study Attributes

We evaluate the outcomes per dimension from the perspective of the stakeholder on that dimension (organization as a whole, employee or client). For example, high wages can be positively evaluated from an employee point of view, but can be regarded as a symptom of less profitability from an organizational point of view.

METHOD

Our systematic review of the literature is based on the replicable and transparent steps of the PRISMA-method (http://www.prisma-statement.org/, see appendix C2).

Data sources and searches

The databases Picarta, Scopus, Pubmed, Google Scholar, and Web of Science were searched for relevant studies. The searches were conducted in January 2015. The references of retrieved articles were manually searched for further material. Our search terms in titles and abstracts were: “private equity AND effect”, “private equity AND performance”, “private equity AND strategy”, and “private equity AND buyout”.

Study selection

Studies were included if they satisfied all of the following criteria:

1. They were in English.
2. They were published between 2004 and 2014.
3. They were published in peer reviewed journals.
4. The research was conducted in North-America, Western-Europe and/or Australia.
5. They were empirical studies; commentaries, reviews, and theoretical analyses were excluded.
6. They investigated the impact of PE ownership on portfolio organizations, with regard to organizational performance, employee well-being or client well-being variables.

Data extraction

Study inclusion was determined in a three-step procedure. First, the bibliographic data and abstracts of retrieved studies were evaluated for concordance with formal inclusion criteria (criteria 1-4). Studies that violated any criteria were discarded at this stage. The remaining studies were selected for full-text retrieval and underwent critical appraisal. We consulted senior scholars in the field to further complete our list of relevant publications for in-depth study.

In the second step of the inclusion procedure, all full-texts were checked against criteria 5 and 6. Studies were again excluded if they did not satisfy these criteria. We excluded studies at this stage because they did not present empirical data (*n* = 19) or did not cover the study objective (*n* = 29). For example, excluded studies contain editorials, theoretical analyses, or publications that focus on PE returns to investors. We then reviewed each study for methodological quality using four quality criteria:

- Control group: The study compared PE-owned organizations to a control group of organizations (non-PE-backed buyouts or other industry counterparts);
- Longitudinal: The study uses longitudinal data, with pre and post buyout measurements;
- Objectivity: there is minimal risk of bias in the data. For example, survey data from managers might report a bias, as managers are 'likely to overstate performance and downplay limitations' (e.g. Goergen et al. 2014: 145);
- Control variables: Relevant covariates are included to control the relationship between PE ownership and the central dependent variables.

The criteria of our quality assessment aim at external validity indicators, since we want to present an overall picture of evidence on the impact of PE that endures in different contexts. If a study meets a criterion, it gets one point; studies have a minimum score of 0 points and a maximum score of 4 points (see appendix C1 for a summary of the results).

After in-depth review of full-texts, the results were classified according to the categories 'organizational performance', 'employee well-being', and 'client well-being'. We extracted publication year and journal title, country of origin, methods, relevant findings, and quality assessment scores in a database.

RESULTS

Database searches yielded 1,359 candidate articles. Another fourteen studies were identified by manual review of references. Next, we found six additional articles as identified by five senior scholars in the field (see acknowledgements). One hundred and ten studies were finally selected for full-text retrieval and studied in-depth. Sixty-two publications satisfied all criteria and are included in this review (Figure C2).

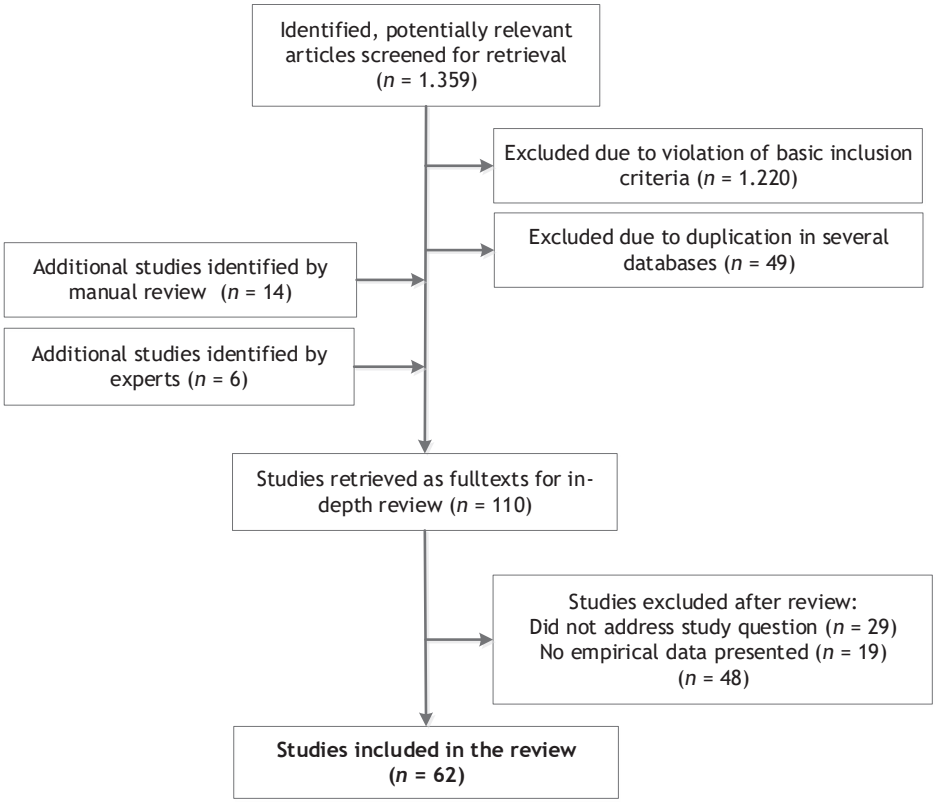

Figure C2 Flow Diagram for Search and Selection Processes

We first address some characteristics of the records found. These were mainly quantitative studies (Table C1). The majority of studies originated in Anglo-Saxon countries (U.K. and U.S., 63%). In studies that cover various European countries, a large part of the data is also drawn from the U.K.. An increase in studies meeting the inclusion criteria during the past ten years can be observed. Eleven studies (18%) draw part of their data from the database of the Centre for Management

Buy-out Research (CMBOR). CMBOR has a database of over 30,000 companies and is funded by Equistone Partners. In exchange for filling out surveys, managers receive trends reports about the European PE market.

Table C1 Details of the studies included in the review (*n* = 62)

Study Characteristic	Included Studies, n (%)
Type of empirical study	
Quantitative (e.g. accounting data, manager's survey)	48 (77%)
Qualitative (e.g. case study)	11 (18%)
Combination quantitative and qualitative	3 (5%)
Study sample sizes	
Less than 100	17 (27%)
100+	25 (40%)
500+	7 (11%)
1.000+	13 (21%)
Study origin[1]	
Europe (excl. single U.K.-studies)	23 (37%)
Single United Kingdom studies	18 (29%)
United States	21 (34%)
Australia	1 (2%)
Sectors	
Several sectors	49 (79%)
Nursing homes	5 (8%)
Retail	3 (5%)
Manufacturing firms	1 (2%)
High technology engineering	1 (2%)
Telecom	1 (2%)
Automobile industry	1 (2%)
Hospital industry	1 (2%)
Publication year	
2004-2009	13 (21%)
2010-2014	49 (79%)
Focus article[2]	
Organizational performance	46 (74%)
Employee well-being	27 (44%)
Client well-being	4 (7%)

1. Total number of studies exceeds 62 studies, because U.K.-studies are often combined with other European countries or U.S. studies.

2. Some studies focus on more than one country/level. The total number of studies is therefore higher than the total number of individual studies included in the review.

Ten studies focus on organizational performance and employee well-being variables simultaneously (Boucly et al. 2012; Davis et al. 2014; Goergen et al. 2011, 2014; Gong & Wu 2011; Kim & McCue 2012; Paglia & Harjoto 2014; Scellato & Ughetto 2013; Westcott & Pendleton 2013; Wilson et al. 2012). Three other studies combine employee well-being and client well-being variables (Harrington et al. 2012, Pradhan et al. 2014, Stevenson & Grabowski 2008). One last study investigates organizational performance and client well-being variables at the same time (Palcic & Reeves 2013). Thus, fourteen out of 62 studies (23%) combine variables related to the different categories as distinguished in this review (see figure C1).

Our quality rating shows that the overall quality of the studies is quite high (mean score of 2,7 on a scale from 0-4 points – see appendix C1).

Private equity ownership and organizational performance

Seventy-four percent of the studies included in the review are about the impact of private equity ownership on organizational performance variables, i.e. financial performance and innovation performance (see Table C2). On average, these are relatively high quality studies (*M* = 3.1).

Financial performance

Forty out of the 46 studies on organizational performance focus on financial performance variables, such as profit margins, productivity, growth, and bankruptcy rates. A vast majority of the studies shows improved financial performance over time, and/or in comparison to a control group. Only two studies report solely negative findings (Palcic & Reeves 2013; Viviani et al. 2008). Palcic and Reeves (2013) base their findings on one case, the Irish telecom operator Eircom. The second study finds lower long-run stock market performance of Italian PE-backed family businesses, as compared to the Italian stock market index. However, the quality rating for both studies is relatively low. Seven studies report no changes due to PE ownership (e.g. Cohn et al. 2014; Goergen et al. 2011, 2014; Jelic & Wright 2011; Meles et al. 2014; Wilson & Wright 2013; Wright et al. 2014). We now highlight some variables of financial performance more precisely: profitability, efficiency, bankruptcy, and financial management.

Table C2 Details of Studies That Assessed Organizational Performance

Reference	Sample	Relevant Findings	Quality[1]
FINANCIAL PERFORMANCE			
Acharya et al. 2013 *The Review of Financial Studies*	395 deals from transactions by large PEFs	Abnormal performance* + / Sales + / Operating margin +	4
Bergström et al. 2006 *The Journal of Private Equity*	1,350 U.K. LBO[2]-firms and a control sample of 4,029 firms	(Cumulative) abnormal returns* +	3
Bergström et al. 2007 *The Journal of Private Equity*	73 Swedish PE sponsored exits and a control group	EBITDA** + /Operating turnover (none)	2
Bertoni et al. 2013 *Small Business Economics*	78 Spanish firms that were subject to a buyout deal	Financial constraints +	3
Beuselinck et al. 2008 *European Accounting Review*	142 Belgian PE-backed firms and an equal number of control firms	Public financial disclosure +	4
Beuselinck et al. 2009 *Journal of Business Finance and Accounting*	488 Belgian PE backed and 488 non-PE backed companies	Timely recognition of losses +	4
Boucly et al. 2012 *Journal of Financial Economics*	839 French deals and a control group	Profitability + / Asset-sales growth + / debt + / capital expenditure + / credit constraints -	4
Burch & Lawrence 2013 *Argriculture and Human Values*	One U.K. supermarket chain, with 1,300 retail outlets	Divestment +/ Leverage + / Efficiency+	0
Cohn et al. 2014 *Journal of Financial Economics*	317 U.S. LBOs and a control group	Operating performance (none)*** / Leverage (none)	4
Cressy & Farag 2012 *European Journal of Finance*	93 U.K. PE-backed buyouts and 96 publicly owned counterparts) under distress	Recovery rate for secured debt (when under distress) +	3
Cressy et al. 2007 *Journal of Corporate Finance*	122 U.K. PE-backed buyouts and a matched sample of non-PE backed companies	Operating profitability +	3
Goergen et al. 2011 *Corporate Governance*	73 U.K. PE acquisitions and a control group	Profitability (none) / productivity (none)	3
Guo et al. 2011 *The Journal of Finance*	192 U.S. LBOs and a control group	Operating performance*+	4
Harford & Kolasinski 2014 *Management Science*	877 U.S. LBOs, management buyouts, and going private transactions and a control group	Abnormal returns +	4

Table C2 Details of Studies That Assessed Organizational Performance (continued)

Reference	Sample	Relevant Findings	Quality[1]
Jelic & Wright 2011 *European Financial Management*	1,225 U.K. buy-outs; 62% with PE-backing	Output + / Efficiency (none) / Profitability (none)	3
Katz 2009 *The Accounting Review*	123 U.S. PE-backed (both majority- and minority-owned) IPOs, and 24 non PE-backed (management-owned) IPOs[3]	Earnings quality reporting + / Upward earnings management - / Conservative reporting§ + / Abnormal return + (for majority stakes) and - (for minority stakes)	4
Landua & Bock 2013 *Long Range Planning*	267 European portfolio companies	Managerial efficiency + / Competitive position +	1
Levis 2011 *Financial Management*	1,595 U.K. IPOs (1,141 non PE-backed, 250 VC-backed, and 204 PE-backed)	Operating performance + / Market performance +	3
Meles et al. 2014 *Applied Financial Economics*	236 Italian firms (118 PE-backed and 118 non-PE-backed)	Post-exit operating performance (none)	4
Paglia & Harjoto 2014 *Journal of Banking & Finance*	3.874 U.S. businesses that received PE financing and a control sample	Sales +	4
Pradhan et al. 2013 *Health Care Management Review*	350 U.S. for-profit nursing homes, including five PE-owned nursing homes with 113 locations	Operating margin+ / Total margin+ / Operating revenue+ / Costs +	4
Scellato & Ughetto 2013 *Journal of Business Research*	241 European private-to-private buyouts and a control sample	Total assets growth + / Productivity (none) / Profitability -	4
Tykvová & Borell 2012 *Journal of Corporate Finance*	1.842 European buyouts and a sample of 5.342 control firms	Bankruptcy rates (in case of experienced PE firms) -	4
Viviani et al. 2008 *The Journal of Private Equity*	40 Italian PE-backed family businesses	Long-run stock market performance -	2
Westcott & Pendleton 2013 *Journal of Industrial Relations*	One exploratory retail case in Australia	Operating profits +	1
Wilson et al. 2012 *Journal of Corporate Finance*	32,474 observations on U.K. live buyouts and 1209 instances of insolvency	Productivity + / Profitability + / Revenue growth +	3
Davis et al. 2014 *American Economic Review*[4]	3,200 U.S. target firms and their 150,000 establishments	Operating margins + / Productivity +	4

Table C2 Details of Studies That Assessed Organizational Performance (continued)

Reference	Sample	Relevant Findings	Quality[1]
Goergen et al. 2014 *Human Resource Management Journal*	Four interviews; 106 U.K. buyouts	Lower productivity before and after buyout	3
Scholes et al. 2010 *International Small Business Journal*	104 European former private family firms, acquired via buyouts	Higher importance scores to efficiency and future growth / Expansion post-buyout	1
Wilson & Wright 2013 *Journal of Business Finance & Accounting*	153,000 U.K. insolvencies	PE backed buy-outs are no more prone to insolvency than non-buy-outs or other types of management buy-ins	4
Chen et al. 2014 *Journal of Corporate Finance*	1.132 U.S. minority equity investments	Abnormal announcement returns + / Post-acquisition operating performance +	4
Datta et al. 2013 *Financial Management*	208 U.S. public-to-private buyouts	Efficiency +/ Productivity + (until one year after the exit) / Profitability +	4
Palcic & Reeves 2013 *Telecommunications Policy*	A case study the Irish telecom operator Eircom	Bankruptcy (due to high leverage, cash extraction and underinvestment in the fixed-line network under PE ownership)	1
Wright et al. 2014 *Venture Capital*	153,000 U.K. insolvencies[5]	PE-backed deals are not riskier than the population of non-buyouts	4
Kim & McCue 2013 *Health Care Management Review*	PE-owned Hospital Corporation of America; 121 urban HCA hospitals	Cash flow margin + / Net patient revenues + / Total asset turnover ratio + / Operating expenses + / Profit margin (none) / Capital investment (none)	3
Cardigan et al. 2014 *Health Services Research*	11 transactions involving 1,555 U.S. nursing home facilities	Liquidity - / Total operating expenses + / Profitability + (but already increased prior to purchase).	3
Alperovych et al. 2013 *European Journal of Operational Research*	88 U.S. PE-backed LBOs	Efficiency +	4
Acharya et al. 2009 *Journal of Applied Corporate Finance*	66 U.K. PE portfolio company Boards	PE boards have a stronger focus on value creation	1

Table C2 Details of Studies That Assessed Organizational Performance (continued)

Reference	Sample	Relevant Findings	Quality[1]
Fee et al. 2012 *Journal of Corporate Finance*	289 distinct U.S. control change events of brands	Advertising expenditure -	4
Edgerton 2012 *Journal of Finance*	444 U.S. private firms (incl. 101 PE-owned), and 1,242 public firms	Corporate jet fleet size –	4
INNOVATION PERFORMANCE			
Bruining et al. 2013 *Small Business Economics*	108 CEOs of PE-backed and non PE-backed firms	Post-buyout entrepreneurial management practices §§ + / Increased financial leverage > administrative management +	2
Engel & Stiebale 2014 *Small Business Economics*	1,454 France and 1,690 U.K. PE-backed buyouts	Investment activity (none)	3
Lerner et al. 2011 *The Journal of Finance*	472 U.S. firms (6,398 patents) with at least one successful patent application filed	Innovation investment (none) / Influence innovations +	4
Link et al. 2014 *Managerial and Decision Economics*	419 U.S. entrepreneurial firms; one sixth attracted PE	Innovation strategy adoption +	3
Ughetto 2010 *Research Policy*	681 European manufacturing firm buyouts	Innovation activity impact dependent upon investor- and deal characteristics.	3

* Performance that cannot be explained by leverage, selection of firms or luck; difference between actual and expected return.

** EBIDTDA = Earnings Before Interest, Taxes, Depreciation of tangible assets, and Amortization.

*** Mean and median pre-interest return on sales, return on assets, and a measure of economic value added (EVA).

§ E.g. timely loss recognition

§§ A set of opportunity based management practices that can help organizations to remain vital and to contribute to firm and societal level value creation and competitiveness. Based on value creation; rapid growth is top priority; risk accepted to achieve growth, and promoting broad search for opportunities. Administrative management practices: focus on safety, slow, steady, more risk averse.

1. Studies were rated on a scale from 0-4, from low to higher quality (see the summary of the findings in appendix 2C).
2. LBO = Leverages Buyout
3. IPO = Initial Public Offering
4. On private *investment*, of which private equity is a subset
5. Data overlap Wright et al. 2014 and Wilson & Wright 2013

For profitability, operating performance and operating margin, seventeen studies are found (Acharya et al. 2013; Boucly et al. 2012; Cardigan et al. 2014; Chen et al. 2014; Cohn et al. 2014; Cressy et al. 2007; Davis et al. 2014; Datta et al. 2013; Goergen et al. 2011; Guo et al. 2011; Jelic & Wright 2011; Kim & McCue 2013; Levis 2011; Meles et al. 2014; Pradhan et al. 2013; Secallato & Ughetto 2013; Westcott & Pendleton 2013; Wilson et al. 2012). Twelve studies find improved results, five studies find no difference due to PE ownership, and one study finds lower profitability.

Ten studies include efficiency or productivity as a variable (Alperovych et al. 2013; Burch & Lawrence 2013; Datta et al. 2013; Davis et al. 2014; Goergen et al. 2011, 2014; Jelic & Wright 2011; Landau & Bock 2013; Scellato & Ughetto 2013; Wilson et al. 2012): six studies show improved scores, four studies find no differences. None of the studies reports worsened scores due to private equity ownership.

Additionally, five studies report the bankruptcy chances: the proneness to insolvency of PE-backed companies (Cressy & Farag 2012; Placic & Reeves 2013; Tyková & Borell 2012; Wilson & Wright 2013; Wright et al. 2014). Two high quality studies find no differences between PE backed buyouts and other buyouts or non-buyouts. Two other high quality studies state that PE-backed firms are doing better, having better recovery rates for secured debt (when under distress) and lower bankruptcy rates. One low-quality study ascribes the bankruptcy of a single case study to PE ownership.

Another six studies are about aspects of financial management behavior. The studies report improved public financial disclosure (Beuselinck et al. 2008), more timely loss recognition (Beuselinck et al. 2009), improved earnings quality reporting, and more conservative reporting (Katz 2009). Furthermore, boards have a stronger focus on efficiency, growth, and value creation (Acharya et al. 2009; Scholes et al. 2010), which becomes visible in for example advertising cost cutting (Fee et al. 2012) and reduced corporate jet fleet sizes for executives (Edgerton 2012).

Overall, the evidence shows convincingly that PE ownership is related to improved financial performance. The focus on financial performance indicators is reinforced by PE owners. Most studies show higher profits, and improved efficiency. The fear of PE firms as extreme financial risk takers is not supported by evidence on bankruptcy rates; some studies even show that PE does a relatively

good job in comparison to non-PE firms and that financial monitoring and reporting is improved by PE owners.

Innovation performance

An emergent theme in the field of PE research is the impact of PE ownership on the innovation performance of portfolio companies. In the discourse on PE owners as investors with a short-term horizon, one of the assumptions is that PE owned companies will reduce their investments in new and innovative products and services. We found five studies on innovation performance. The studies conclude that PE does not lead to any changes in investment activity overall (Engel & Stiebale 2014; Lerner et al. 2011); the investment activity varies with investor- and deal characteristics (Ughetto 2010). At the same time, PE ownership is associated with more room for entrepreneurship, more influential innovations, and the adoption of innovation strategies (Bruining et al. 2013; Lerner et al. 2011; Link et al. 2014). Hence, the evidence suggests that PE owners are rather providing room for innovation than limiting innovation opportunities in portfolio companies.

Private equity ownership and employee well-being

Twenty-seven papers study employee well-being variables in relation to PE ownership (Table C3). Overall, these studies show a lower quality rating than the mean of all studies and the studies on organizational performance (M = 2,3). The main employee well-being variable, in terms of the number of studies found, is employment/staffing levels, followed by wages, and industrial relations. Scholars also show some interest in other working conditions in relation to PE ownership, such as employee consultation and work practices.

Table C3 Details of Studies That Assessed Employee Well-being

Reference	Sample	Relevant Findings	Quality[1]
EMPLOYMENT[2]			
Amess & Wright 2007 *International Journal of the Economics of Business*	1,350 U.K. LBO-firms and a control sample of 4,029 firms	Employment (none)	2
Amess & Wright 2012 *Small Business Economics*	533 U.K. LBOs – 65% PE-backed; 9,096 control firms	Employment (none)	2
Boucly et al. 2012 *Journal of Financial Economics*	839 French deals and a control group	Employment +	4
Cressy et al. 2011 *Venture Capital*	57 U.K. buyouts, 83 controls	Employment -	4
Goergen et al. 2011 *Corporate Governance*	73 U.K. PE acquisitions and a control group	Employment -	3
Harrington et al. 2012 *Health Services Research*	10 U.S. nursing home chains – 1,977 facilities, of which 996 were PE-owned	Employment (none)	3
Jelic & Wright 2011 *European Financial Management*	1,225 U.K. buy-outs; 62% with PE-backing	Employment +	3
Paglia & Harjoto 2014 *Journal of Banking & Finance*	3.874 U.S. businesses that received PE financing and a control sample	Employment +	4
Pradhan et al. 2014 *Journal of Health Care Finance*	350 nursing homes per year - 2,822 observations over 8-year study period	Employment -	3
Scellato & Ughetto 2013 *Journal of Business Research*	241 European private-to-private buyouts and a control sample	Employment +	4
Stevenson & Grabowski 2008 *Health Affairs*	82 U.S. nursing home facility transactions, and 10 entire U.S. nursing home chain transactions (incl. 1.472 facilities)	Employment + (NA), Employment – (RN)[3]	4
Wilson et al. 2012 *Journal of Corporate Finance*	32,474 observations on U.K. buyouts and 1209 instances of insolvency	Employment +	3
Davis et al. 2014 *American Economic Review*	3,200 portfolio companies, both pre- and post-buyout	High job reallocation + 14% in 2 yrs	4
Goergen et al. 2014 *HRM Journal*	Four interviews; 106 U.K. buyouts	Employment –	3
Kim & McCue 2013 *Health Care Management Review*	PE-owned Hospital Corporation of America; 121 urban HCA hospitals	Staffing *none*	3
Gospel et al. 2011 *Corporate Governance*	One Spanish case study	Small job losses –	1
Clark 2011 *Industrial Relations Journal*	Automobile Association case in U.K.	Employment –	0

Table C3 Details of Studies That Assessed Employee Well-being (continued)

Reference	Sample	Relevant Findings	Quality[1]
WAGE			
Amess & Wright 2007 *International Journal of the Economics of Business*	1,350 U.K. buyouts and a control sample of 4,029 firms	Wage +	2
Jackson 2013 *UCLA Law Review*	108 U.S. PE-owned companies, control group with public companies	CEO pay (none) / Performance related pay +	3
Westcott & Pendleton 2013 *Journal of Industrial Relations*	One exploratory retail case in Australia	Employee pay+ (more performance-related)	1
Davis et al. 2014 *American Economic Review*	3,200 U.S. portfolio companies	Earnings per worker -	4
Goergen et al. 2014 *HRM Journal*	Four interviews; 106 U.K. buyouts	Wages -	3
Kim & McCue 2013 *Health Care Management Review*	PE-owned Hospital Corporation of America; 121 urban HCA hospitals	Labor costs *none*	3
Clark 2009 *The International Journal of HRM*[4]	Anecdotal data from several U.K. cases	Performance related pay for management; pension schemes as collateral for leverage	0
INDUSTRIAL RELATIONS			
Bacon et al. 2010 *Human Relations*	190 European managers' of PE-backed companies (response 7.3%); 16 interviews	Union recognition (none)	0
Westcott & Pendleton 2013 *Journal of Industrial Relations*	One exploratory retail case in Australia	Industrial relations (none)	1
Clark 2009 *Journal of Industrial Relations*	Anecdotal data from several U.K. cases	Recognition of collective bargaining agreements –	0
OTHER			
Bacon et al. 2010 *Human Relations*	190 European managers' of PE-backed companies (response 7.3%); 16 interviews	Employee consultation +	0
Bacon et al. 2008 *Human Relations*	Survey and archival data of 148 U.K. cases and 45 Dutch cases	High commitment management practices* (none)	2
Bacon et al. 2012 *Industrial Relations*	190 European PE-backed buyouts	High performance work practices** +	1
Boselie & Koene 2010 *Human Relations*	A case study in organization X (10.000-plus employees). 25 interviews	Organizational uncertainty + / Institutional trust -	0

Table C3 Details of Studies That Assessed Employee Well-being (continued)

Reference	Sample	Relevant Findings	Quality[1]
Gong & Wu 2011 *Corporate Governance*	126 U.S. PE sponsored LBOs	CEO turnover +	3
Pradhan et al. 2014 *Journal of Health Care Finance*	350 nursing homes per year - 2,822 observations over 8-year study period	Skill mix –***	3
Westcott & Pendleton 2013 *Journal of Industrial Relations*	One exploratory retail case in Australia	Employment conditions (for new employees) -	1
Appelbaum et al. 2013 *British Journal of Industrial Relations*	Four case studies of U.S. and U.K. PE buyouts	Breach of trust in implicit contracts with employees	1
Gospel et al. 2011 *Corporate Governance*	One Spanish case study	Few changes in work organization (employee voice and representation)	1
Clark 2011 *Industrial Relations Journal*	Automobile Association case in U.K.	Working conditions –	0
Clark 2009 *The International Journal of HRM*[4]	Anecdotal data from several U.K. cases	Managerial discretion -	0

* Significant long-term investment in a variety of new practices including: new payment schemes to increase employee commitment and retain skilled employees; employee involvement and team-based work organization to allow employees to contribute discretionary effort; increased training expenditure; and a commitment to providing job security. Focus on work organization and functional flexibility, job security, training, and non-pay terms and conditions of non-management employees.
**
- Change in work organization, and functional flexibility reflecting skills and the opportunity to contribute (such as formal training, flexible job descriptions and work time);
- Change in fairness practices that provide fairness of treatment to enhance employee commitment (such as harmonized terms and conditions, security of employment, and formal grievance procedures);
- Change in performance-related pay schemes intended to motivate employees to perform (profit-related pay)

*** Skill mix is the composition of the nursing staff by licensure or educational status; number of higher educated professionals as compared to the number of lower educated professionals. A higher skill mix means a relatively greater number of higher educated professionals.

1. Studies were rated on a scale from 0-4, from low to higher quality (see the summary of the findings in appendix C1).

2. Employment is sometimes dealt with as an organizational performance variable in PE studies across sectors, while it is seen as a quality indicator (i.e. client level variable) in sector-specific research in health care. In this study, employment is regarded as an employee well-being variable in all cases.

3. NA = Nurse Assistant; RN = Registered Nurse

4. Data overlap: Clark 2009 in *The International Journal of HRM,* and Clark 2009 in *Journal of Industrial Relations*

Employment

Critics often argue that PE interventions are detrimental to employment in existing companies. Although reduced employment can be a symptom of increased efficiency from an organizational point of view, it can be seen as worrisome from an employee's perspective. Evidence for this statement is supported nor rejected by the results in our review. We find mixed outcomes in the seventeen studies on employment. Six relate PE to reduced employment levels in portfolio organizations (Clark 2011; Cressy et al. 2011; Goergen et al. 2011, 2014; Gospel et al. 2011; Pradhan et al. 2014). Four studies report no change or difference (Amess & Wright 2007, 2012; Harrington et al. 2012; Kim & McCue 2013), or observe a difference between subgroups in the organizations, with one function group showing increased employment and another group showing reduced employment (Stevenson & Grabowski 2008). Six other studies find increased employment (Boucly et al. 2012; Jelic & Wright 2011; Paglia & Harjoto 2014; Scellato & Ughetto 2013; Wilson et al. 2012). Sometimes employment decreases at first, but is higher later on, due to high job reallocation (Davis et al. 2014). On average, the studies that report increased employment are rated as higher quality studies than the studies that report reduced employment levels.

Wage

We find the same mixed evidence on the relationship between PE ownership and wages, with two studies indicating increased pay levels (Amess & Wright 2007; Westcott & Pendleton 2013), two studies reporting no changes (Jackson 2013; Kim & McCue 2013), and three studies concluding that PE is related to reduced pay levels (Davis et al. 2014; Clark 2009; Goergen et al. 2014).

Industrial relations

Two studies find no effect of PE ownership on industrial relations (Bacon et al. 2010; Westcott & Pendleton 2013), while one study observes detrimental effects of PE on the recognition of collective bargaining agreements (Clark 2009). These studies are based on anecdotal evidence or surveys completed by managers; this evidence should be considered as relatively weak.

Other working conditions

Several individual studies report on other employee well-being aspects. At the one hand, studies report increased employee consultation, and more practices focused at enhancing employee well-being (Bacon et al. 2010, 2012). At the other hand, authors stress that PE is related to a breach of trust in implicit contracts with employees, the increase of organizational uncertainty, reduced institutional trust, increased CEO turnover, a reduced skill mix in nursing homes (indicating that higher educated professionals are replaced by lower educated and lower paid health care professionals), less managerial discretion, and worse working conditions (Appelbaum et al. 2013; Boselie & Koene 2010; Clark 2011; Gong & Wu 2011; Pradhan et al. 2014; Westcott & Pendleton 2013). Two other studies find no impact of PE on high commitment management practices, i.e. long-term investments practices that enhance employee well-being (Bacon et al. 2008) or employee voice and representation (Gospel et al. 2011). The quality of the studies in this area varies, but is generally low (M = 1.1).

In summary, employee well-being outcomes are mixed with regard to employment, wages and industrial relations as well as other working conditions, such as improved work practices and employee consultation.

Private equity ownership and client well-being

Client well-being variables assess the impact of PE ownership for clients, which becomes visible in quality of products or services. Our search resulted in four studies (7% of all studies included in this review) on client well-being (Table C4).

Three of the studies focus on care quality in U.S. nursing homes that are PE-owned. Two of these studies show an increased number of deficiencies after PE ownership, indicating poorer care quality, while one study finds no change in deficiencies. Other quality measures are not or positively related to PE ownership. A case study in the telecom sector in Ireland reports lower quality of services after a PE buyout. Overall, these studies tend to show negative outcomes, or no proof for the impact of PE on quality at all.

Figure C3 provides a summary of the findings.

Table C4 Details of Studies That Assessed Client Well-being

Reference	Sample	Relevant Findings	Quality[2]
QUALITY			
Harrington et al. 2012 *Health Services Research*	10 U.S. nursing home chains – 1,977 facilities, of which 996 were PE-owned	Number of deficiencies[1] +	3
Pradhan et al. 2014 *Journal of Health Care Finance*	350 nursing homes per year - 2,822 observations over 8-year study period	Number of deficiencies + / Other quality measures (none)	3
Stevenson & Grabowski 2008 *Health Affairs*	82 U.S. nursing home facility transactions, and 10 entire U.S. nursing home chain transactions (incl. 1.472 facilities)	Number of deficiencies (none) / Other quality measures (none) and +	4
Palcic & Reeves 2013 *Telecommunications Policy*	A case study of the Irish telecom operator Eircom	Quality of services -	1

1. Deficiencies = violations of regulations, used as an care quality indicator in U.S. nursing homes
2. Studies were rated on a scale from 0-4, from low to higher quality (see also the summary of the findings appendix C1).

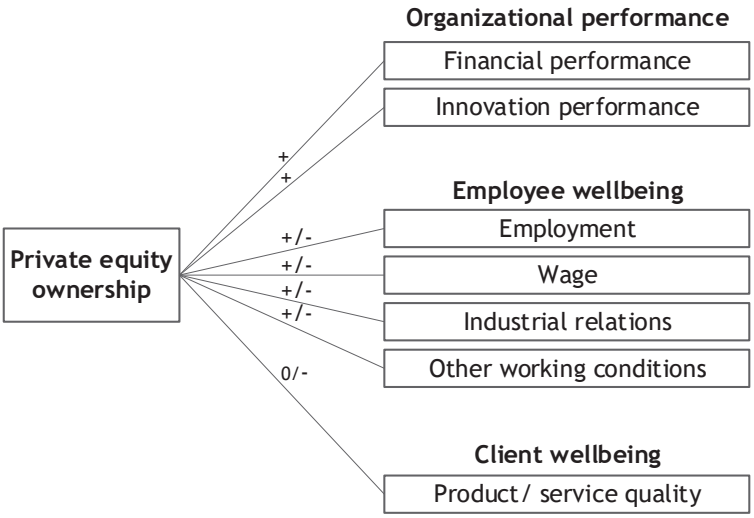

Figure C3 Summary of the Findings

CONCLUSIONS & DISCUSSION

Conclusions

Against the background of the increasing controversy about the impact of PE, our systematic review of the literature over the last ten years shows a nuanced picture and brings to the front some relevant issues. We reviewed the relationship between PE ownership and organizational performance, employee well-being, and client well-being. Firstly, most of the reviewed studies focus on organizational performance variables. Empirical evidence over the last ten years confirms the results of earlier reviews on this topic (e.g. Cumming et al. 2007; Kaplan & Strömberg 2008; Wood & Wright 2009; Wright et al. 2009b, 2009c). Although there is variation between individual studies, most studies associate PE ownership with improved financial performance. Furthermore, for innovation performance, evidence suggests that PE firms rather provide room for innovation than limit innovation opportunities in portfolio companies. Secondly, the outcomes for employee well-being variables are mixed. In their review of HRM practices, Wright et al. (2009a: 501) relate the mixed evidence to the heterogeneity of the PE phenomenon, and suggest that negative outcomes on for example employment might be due to the fact that PE firms invest in "ailing companies" where jobs were already insecure before PE investment, whereas employment increases in solid companies where PE owners aim at growth. Bacon et al. (2013: 16) review the impact of PE on employment and HRM in published as well as unpublished papers, and paint a more positive picture on employee well-being outcomes. They conclude that PE generally has positive effects on employment and wages. Thirdly, a limited number of studies on client well-being, i.e. the relationship between PE ownership and service or product quality, tend to show no or negative results.

Does the impact of PE investment in portfolio companies fit best in the mutual gains or in the conflicting outcomes perspective? The best researched area – the impact of PE ownership on organizational performance – shows the most positive outcomes. PE investor's impact on employee well-being variables is mixed. Scarce evidence on the impact for client well-being is also mixed, and leans a little more to negative outcomes. The further away from the board room, the less straightforward and positive the impact of PE seems to be – which might fit in the conflicting outcomes perspective between organizational performance and well-being variables. However, this conclusion is very premature, because of the mixed results for both employees and clients. This is underscored by the fact

that no clear pattern emerges in studies that combine variables in more than one category (i.e. organizational performance, employee well-being or client well-being).

Discussion

The outcomes of our systematic review of the literature highlight three venues for future research. Firstly, the review showed that there is hardly any evidence on the impact of PE ownership on the client level (i.e. quality). This knowledge gap needs to be filled, since most people will get involved with PE in their role as a client. This is crucial when it comes to customers buying products, but becomes even more important when PE investors get control over services that are central to the daily lives of citizens, such as nursing home care. First studies in this area indicate that the impact of PE ownership in this sector is leaning towards no or negative outcomes (e.g. Harrington et al. 2012; Pradhan et al. 2014; Stevenson & Grabowski 2008). More insight into the role of PE owners in the primary work process in their portfolio organizations helps the determine whether PE owners are merely financial engineers – as is stated by their critics – or whether and how they are able to really achieve operational improvements. However, we are aware of the fact that it can be complex to precisely disentangle the role of the PE owner from other factors; the relationship between PE owners and quality is likely to be complex, context-specific, and contingent. The impact of PE is likely to vary depending on a number of factors, ranging from the strategies that PE owners apply to the wider institutional en historical context of the portfolio organization.

Secondly, and related to our previous point: the mixed evidence – in mainly quantitative studies – calls for more high quality case study research, in which it is figured out in-depth how the outcomes for different stakeholders relate to each other, and in which specific context variables can be taken into account. Instead of *what* the impact of PE ownership is, the attention needs to shift to *how* PE owners influence portfolio organizations. In this way, explanations can be found and deepened for the diverse outcomes, preferably with "longitudinal studies that chart the development and impact of changes" (Wright et al. 2009a: 510-511). The focus then changes to understanding the *mechanisms* at work in PE-owned portfolio firms, and to building new theory from which hypotheses can be drawn for future research (Tsang 2014).

Thirdly, we observed that 18% of the studies included in this review draw (part of) their data from the same database (i.e. CMBOR), a large-scale quantitative dataset. We fully acknowledge the value of such extensive datasets, which give valuable insights by comparing data with control groups and over time. However, these data are reported by managers themselves and might therefore be biased, as managers are 'likely to overstate performance and downplay limitations' (e.g. Goergen et al. 2014: 145). Appelbaum and Batt (2014: 56) for example suggest that the 'transparency of PE firms is very limited. Academic studies rely on datasets that are partial in nature. There is a lack of publicly available, comprehensive data on the financial activities of PE funds; [this] makes it impossible to know the biases that are built into the data sets used in the analyses'. More differentiation in the number of data sources could strengthen the field of PE research.

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APPENDIX C1: SUMMARY OF THE QUALITY ASSESSMENT OF THE STUDIES INCLUDED (*N* = 62)

(part of appendix C)

	Criterion	Y	N
1	Control group	43	19
2	Longitudinal	38	24
3	Objectivity	41	21
4	Control variables	47	15
		# studies:	
0 points		7	
1 point		7	
2 points		6	
3 points		18	
4 points		24	
		Mean score:	
		2,7	

APPENDIX C2: PRISMA CHECKLIST

(part of appendix C)

TITLE		
Title	Identify the report as a systematic review, meta-analysis, or both.	✓
ABSTRACT		
Structured summary	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.	✓
INTRODUCTION		
Rationale	Describe the rationale for the review in the context of what is already known.	✓
Objectives	Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes and study design (PICOS).	✓
METHODS		
Protocol and registration	Indicate if a review protocol exists, if and where it can be accessed (e.g. Web address), and, if available, provide registration information including registration number.	N/A
Eligibility criteria	Specify study characteristics (e.g. PICOS, length of follow-up) and report characteristics (e.g. years considered, language, publication status) used as criteria for eligibility, giving rationale.	✓
Information sources	Describe all information sources (e.g. databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	✓
Search	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	✓
Study selection	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	✓
Data collection	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	✓
Data items	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	N/A
Risk of bias in individual studies	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	N/A

Summary measures	State the principal summary measures (e.g., risk ratio, difference in means).	N/A
Synthesis of results	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I) for each meta-analysis.	N/A
Risk of bias across studies	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	N/A
Additional analyses	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.	N/A
RESULTS		
Study selection	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	✓
Study characteristics	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.	✓
Risk of bias within studies	Present data on risk of bias of each study and, if available, any outcome level assessment.	N/A
Results of individual studies	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.	N/A
Synthesis of results	Present the main results of the review. If meta-analyses are done, include for each, confidence intervals and measures of consistency	✓
Risk of bias	Present results of any assessment of risk of bias across studies.	N/A
Additional analyses	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression.	N/A
DISCUSSION		
Summary of evidence	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups.	✓
Limitations	Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).	✓
Conclusion	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	✓
FUNDING		
Funding	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.	N/A

Note: the checklist is based on Liberati et al. 2009; some of the checks are not applicable as they are intended for meta-analyses, not for systematic reviews.

APPENDIX D – GOLDEN LIVING CHART (CHAPTER 5)

The legal restructuring results in the following simplified chart (Figure D). The chart does not take into account the nursing homes that retain the name Beverly Healthcare, which is the case for around 80 homes.

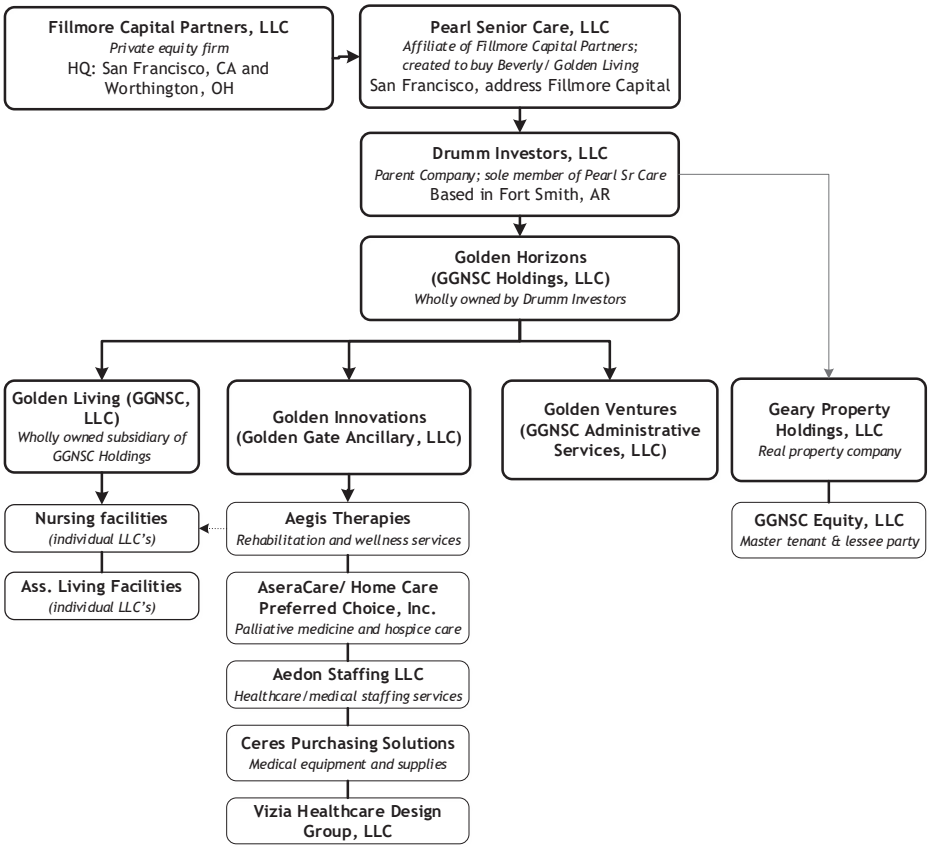


Figure D Organizational Chart Golden Living

APPENDIX E – OPERATIONALIZATION PERFORMANCE DIMENSIONS

Table E shows the variables which are included in the multidimensional performance approach, per chapter.

Table E Variables per chapter

Dimension	Variable
Organizational level	*variables that affect the performance of the organization as a whole*
Chapter 2	Profit margins, efficiency
Chapter 3	Profit margins, efficiency, innovation
Chapter 5	Strategy, profit margins, long term debt/asset ratio, net income per patient day
Chapter 6	Profit margin, solvency ratio, current ratio
Employee well-being	*subjective employee experiences and objective measures of working conditions*
Chapter 2	Staffing levels, employee turnover, job benefits, and job satisfaction.
Chapter 3	Staffing levels, working conditions
Chapter 5	Staffing levels, skill mix[1] (presented as part of the corporate strategy)
Chapter 6	Staffing levels, employee turnover
Client well-being	*subjective client experiences and measures of or proxies for care quality*
Chapter 2	Care quality, number of deficiencies[2], hospitalization rates, rate of lawsuits and complaints
Chapter 3	Quality
Chapter 4	Client satisfaction ratings
Chapter 5	Deficiencies, litigation actions by clients
Chapter 6	Violations of quality requirements, care quality ratings

[1]Both variables are in the chapter presented as part of the corporate strategy [2]Deficiencies are issued by the inspection when a nursing home does not meet minimal standards.

APPENDIX F – AUTHOR CONTRIBUTIONS PER CHAPTER

List of co-authors:

- Boselie, Paul (PB)
- Harrington, Charlene (CH)
- Jeurissen, Patrick (PJ)
- Kruse, Florien (FK)
- Trappenburg, Margo (MT)

Chapter 1 and 7:

Both the Introduction (chapter 1) and the Conclusion (chapter 7) were written by the PhD-candidate. The promoters provided helpful comments to improve the chapters.

Chapter 2:

The PhD-candidate and the promoters (PB, MT) designed the project. The PhD-candidate then conducted the systematic review, and wrote a draft paper. PB and MT were consulted several times during the process of analysis, and the formulation of the conclusions.

Chapter 3:

The PhD-candidate conducted the systematic review (appendix C), and wrote the paper about it. This review serves as a basis for chapter 3. Both promoters provided helpful comments to improve the review. The PhD-candidate and PB both contributed to the conceptual framework of chapter 3. Subsequently, the PhD-candidate wrote a draft of chapter 3, after which PB made additions. The paper was rewritten several times by both authors.

Chapter 4:

The PhD-candidate and FK designed the project, with the assistance of PJ. The PhD-candidate and FK wrote the background section and gathered the data. The PhD-candidate wrote the theoretical background of the chapter; additions and changes were then made by FK. FK analyzed the quantitative data, while the PhD-candidate and FK jointly analyzed the qualitative data. FK wrote the findings based on the quantitative data. The PhD-candidate wrote the findings based on

the qualitative data. PJ was consulted several times during this process of analysis, and the formulation of the conclusions. The conclusions were written by the PhD-candidate and FK. Based on the individual contributions, the PhD-candidate and FK share first authorship.

Chapter 5:

The PhD candidate designed the project. She carried out both the qualitative research as well as the quantitative analyses, with the exception of the data from the OSCAR dataset (on staffing and deficiencies) – these analyses were carried out by CH. CH opened up her network to get access to key respondents, which were then interviewed by the PhD-candidate. The PhD-candidate wrote a first draft of the paper, after which CH made some additions. The paper was rewritten several times by both authors.

Chapter 6:

Single-authored. The promoters provided helpful comments to improve the chapter.

S

Nederlandse samenvatting (Dutch summary)[i]

i Omwille van de leesbaarheid zijn de verwijzingen naar de literatuur opgenomen als eindnoten, die direct na deze samenvatting te vinden zijn. De complete referenties zijn terug te vinden in de literatuurlijst (‘References’).

HOOFDSTUK 1: INTRODUCTIE

Dit proefschrift beschrijft de strategieën en prestaties van commerciële zorgorganisaties, met in het bijzonder aandacht voor zorgorganisaties die in handen zijn van private equity firma's. Commerciële organisaties kunnen winst uitkeren aan hun eigenaren.[1] Private equity geldt als een bijzondere vorm van commercieel eigendom. Private equity firma's beheren fondsen waarin onder meer verzekeraars, pensioenfondsen en vermogende individuen hun geld beleggen. Met deze fondsen, in combinatie met bankleningen en een beperkte eigen inleg, kopen private equity firma's niet-beursgenoteerde organisaties; ze worden eigenaar van deze zogenaamde portfolio organisaties. Vervolgens proberen ze de waarde van hun portfolio organisaties te verhogen. Na gemiddeld drie tot zeven jaar verkopen ze de portfolio organisaties weer. De winst uit deze verkoop wordt verdeeld onder de beleggers in de fondsen én de private equity firma.[ii] Private equity partijen richtten zich oorspronkelijk alleen op het bedrijfsleven, maar hebben hun investeringsterrein gaandeweg vergroot – onder andere naar zorgsectoren.[2]

Private equity firma's worden in het publieke debat ook wel sprinkhanen genoemd: als een plaag strijken ze neer op een portfolio organisatie, vreten deze leeg en laten de organisatie na enige tijd kaal achter. Dit proefschrift gebruikt de kangoeroe als metafoor voor private equity in zorgorganisaties. Als bedrijfsmatige kangoeroes springen ze van de ene naar de andere zorgorganisatie. De zorgsector blijkt voor private equity partijen een relatief onbekende 'habitat', met beperkte bewegingsruimte en met eigen risico's. De onderzochte private equity firma's richten zich vooral op waardevermeerdering door enorme groei van zorgorganisaties, vergelijkbaar met de snelle groei van baby kangoeroes. Zolang het goed gaat met de zorgorganisaties, worden private equity eigenaren vrijwel niet opgemerkt door medewerkers en cliënten – net als bij kangoeroes is hun manier van voortbewegen dan vrijwel geruisloos.

Commercialisering van publieke dienstverlening

De opmars van commerciële zorgorganisaties in veel Westerse landen[3] is te begrijpen tegen de achtergrond van het neoliberalisme van de afgelopen vier decennia. Het dominante uitgangspunt van het neoliberalisme is dat 'vrije markten, waarin individuen hun materiële belangen maximaliseren, het beste middel

ii Figuur 1.2b in de introductie van dit proefschrift bevat een uitgebreidere toelichting op het verdienmodel van private equity.

zijn voor het bevredigen van menselijke aspiraties; markten hebben daarom de voorkeur boven overheden. Overheden zijn in het beste geval inefficiënt, en in het slechtste geval bedreigen zij individuele vrijheid'.[4] De populariteit van het neoliberale gedachtegoed lijkt inmiddels af te nemen. Tegelijkertijd blijven neoliberale ideeën bepalend voor de inrichting van organisaties en sectoren,[5] waaronder de sectoren voor verpleeghuiszorg, thuiszorg en kinderopvang.

Dit proefschrift past het concept 'commercialisering' toe voor de mate waarin organisaties bedrijfsmatig opereren en gericht zijn op winst.[6] Commercialisering is daarbij gekoppeld aan verschillende organisatietypen: op het continuüm van commercialisering (van laag naar hoog) staan publieke overheidsorganisaties, private non-profit organisaties, commerciële organisaties, en organisaties die in handen zijn van private equity partijen (zie ook figuur 1).

Multidimensionale prestaties en strategie

De centrale vraag in dit proefschrift is *hoe* (zeer) commerciële zorgorganisaties presteren. Daarbij worden prestaties multidimensionaal bezien: het gaat zowel om (financiële) organisatieprestaties, als om het welzijn van medewerkers en cliënten. Dit sluit aan bij de *stakeholder* benadering.[7] Terwijl de *shareholder* benadering uitgaat van het maximaliseren van de winst voor aandeelhouders, benadrukt de *stakeholder* benadering de belangen van alle stakeholders.[8] Overigens betwisten sommige onderzoekers een tegenstelling tussen de twee benaderingen (oftewel: het uitgangspunt van 'conflicterende uitkomsten'): het behalen van aandeelhouderswaarde is volgens hen alleen mogelijk door tegemoet te komen aan de belangen van alle betrokken partijen (oftewel: het uitgangspunt van 'wederzijdse opbrengsten').[9]

De studies in dit proefschrift beschrijven ook de organisatiestrategie van commerciële zorgorganisaties. Strategie is daarbij gedefinieerd als het 'patroon in een reeks van beslissingen' door de tijd heen; het is een combinatie van bewust geplande verandering door het topmanagement en spontaan ontstane verandering onder invloed van omgevingsfactoren.[10]

Onderzoeksvragen

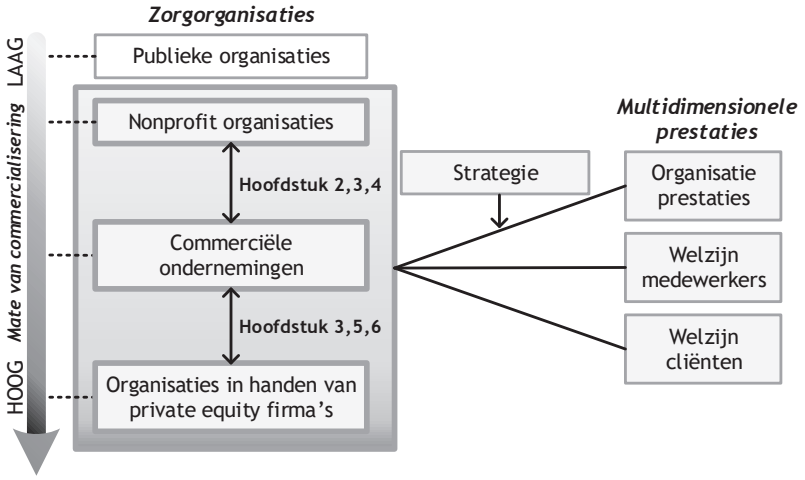
De volgende hoofd- en deelvragen stonden in dit proefschrift centraal:

Hoofdvraag: *Hoe presteren commerciële zorgorganisaties, in het bijzonder zorgorganisaties die in handen zijn van private equity firma's?*

Deelvragen:

1. *Wat is er bekend over de prestaties van commerciële zorgorganisaties, in het bijzonder zorgorganisaties die in handen zijn van private equity firma's?*
2. *Welke strategieën passen private equity firma's toe in zorgorganisaties?*
3. *Hoe presteren zorgorganisaties die in handen zijn van private equity firma's wat betreft financiën (organisatieniveau)?*
4. *Hoe presteren zorgorganisaties die in handen zijn van private equity firma's wat betreft het welzijn van medewerkers en cliënten?*

Figuur 1 vat de concepten samen in een onderzoeksmodel. De hoofdstukken 2 t/m 4 gaan in op de verschillen tussen non-profit en commerciële zorgorganisaties. Hoofdstuk 3, 5 en 6 gaan verder in op de *private equity* vorm van commercieel eigendom.



Figuur 1. Onderzoeksmodel

HOOFDSTUK 2. FINANCIËLE PRESTATIES, MEDEWERKERSWELZIJN EN CLIËNTENWELZIJN IN COMMERCIËLE EN NON-PROFIT VERPLEEGHUIZEN: EEN SYSTEMATISCHE REVIEW VAN DE LITERATUUR

Achtergrond en vraagstelling

In Westerse landen bieden zowel commerciële als non-profit organisaties verpleeghuiszorg aan. Vooral de Verenigde Staten (V.S.) kent een lange traditie van commerciële verpleeghuizen; 68% van de Amerikaanse verpleeghuizen is op winst gericht.[11] In meerdere Westerse landen neemt het aandeel van commerciële aanbieders toe.[12] Daarmee laait de discussie op over de wenselijkheid daarvan: bieden commerciële verpleeghuizen hogere kwaliteit tegen lagere kosten (het uitgangspunt van 'wederzijdse opbrengsten'), of maken zij winst ten koste van medewerkers en cliënten (het uitgangspunt van 'conflicterende uitkomsten')?

Dit hoofdstuk brengt systematisch wetenschappelijk bewijs in kaart over de prestaties van commerciële verpleeghuizen in de V.S. Deze prestaties zijn steeds vergeleken met die van non-profit verpleeghuizen. Twee onderzoeksvragen waren daarbij leidend: *(1) Welke aspecten zijn bestudeerd op het terrein van financiële prestaties, medewerkerswelzijn en cliëntenwelzijn in relatie tot commerciële verpleeghuizen?; (2) Wat zijn de resultaten op deze aspecten voor financiële prestaties, medewerkerswelzijn en cliëntenwelzijn, en hoe verhouden deze resultaten zich tot elkaar?*

Methode

Deze systematische literatuur review past de PRISMA methode toe. Via transparante stappen is gezocht naar relevante literatuur – voor de periode 2004-2014. In totaal zijn 2.086 mogelijk relevante studies geïdentificeerd; experts droegen nog elf additionele studies aan. Op basis van vooraf geformuleerde criteria werden uiteindelijk 50 studies geïncludeerd, die grondig zijn geanalyseerd.

Resultaten en conclusies

Voor financiële prestaties is relatief weinig onderzoek beschikbaar. Resultaten wijzen op hogere winstmarges en efficiency in commerciële verpleeghuizen. Voor medewerkerswelzijn zijn meer studies beschikbaar. Die studies tonen vooral dat commerciële verpleeghuizen overwegend minder personeel inzet-

ten. Hoewel hiervoor wat minder bewijs is, rapporteren studies ook een hoger verloop, minder aantrekkelijke arbeidsvoorwaarden en een lagere medewerkerstevredenheid in commerciële verpleeghuizen. Veruit de meeste studies zijn gericht op cliëntenwelzijn. Hier laat geen enkele studie zien dat commerciële verpleeghuizen consistent beter presteren dan non-profit verpleeghuizen voor indicatoren van zorgkwaliteit; tegelijkertijd tonen verschillende studies aan dat non-profit organisaties betere scores laten zien op diverse kwaliteitsindicatoren. De meeste studies vinden echter geen verschil tussen commerciële en non-profit verpleeghuizen. Aanvullende studies wijzen op hogere hospitalisatie ratio's en meer klachten en rechtszaken in commerciële verpleeghuizen.

Voorgaande leidt tot de propositie dat er sprake is van 'conflicterende uitkomsten' tussen financiële prestaties en welzijnsindicatoren in commerciële verpleeghuizen; het welzijn van medewerkers en cliënten past juist bij het uitgangspunt van 'wederzijdse opbrengsten'.

HOOFDSTUK 3. HET ZOVEELSTE BEDRIJF? PRIVATE EQUITY IN DE GEZONDHEIDSZORG

Achtergrond en vraagstelling

De rol van private equity firma's in de gezondheidszorg roept discussie op over de wenselijkheid ervan.[13] Dit hoofdstuk betoogt op basis van politiek-filosofische, sociologische en economische literatuur[14] waarom de aard van zorgverlening fundamenteel verschilt van veel andere producten en diensten. Vervolgens zet het systematisch empirisch bewijs op een rij. De volgende vragen zijn leidend: *(1) Wat maakt dat zorgorganisaties zich onderscheiden van het bedrijfsleven?; (2) Welke proposities zijn te formuleren over de prestaties van private equity firma's in zorgorganisaties?*

Methode

Verpleeghuizen in de V.S. hebben relatief veel te maken gehad met private equity firma's.[15] Deze sector geldt daarom als bruikbaar onderzoeksterrein om proposities te formuleren over de mogelijke impact van private equity in zorgorganisaties. Daartoe combineert dit hoofdstuk de systematische review van de literatuur over de prestaties commerciële verpleeghuizen (zie hoofdstuk 2) en een systematische review over de prestaties van uiteenlopende bedrijven die in handen zijn

van private equity (zie appendix C). De reviews leiden tot respectievelijk 50 en 62 relevante studies. De gecombineerde uitkomsten leiden tot proposities over private equity in zorgorganisaties.

Resultaten en conclusies

Met het oog op de eerste onderzoeksvraag beredeneert dit hoofdstuk waarom zorgverlening anders is dan veel andere producten en diensten op 'de markt'. Ten eerste gaat de definitie van succes verder dan financiële prestaties binnen de wettelijke vereisten. Zorgverlening impliceert ook het respecteren van publieke waarden die wettelijke vereisten overstijgen. Ten tweede staat daarmee niet alleen economische waarde centraal, maar ook sociaal kapitaal zoals dat bijvoorbeeld wordt opgebouwd in de relaties tussen zorgprofessionals en cliënten. Ten derde is de inzet van personeel niet alleen ingegeven door efficiencyoverwegingen, maar vraagt de aard van zorg juist geregeld om enige 'overbezetting' met het oog op onvoorziene gebeurtenissen. Ten vierde gaat het bij zorgverlening niet enkel om rationele cliënten die zelfstandige keuzes maken, maar veeleer om afhankelijke cliënten, die enige bescherming nodig hebben – o.a. omdat 'stemmen met de voeten' niet zomaar mogelijk is. Met het oog op deze vier argumenten dienen prestaties van zorgorganisaties in handen van private equity firma's niet beoordeeld te worden vanuit de *shareholder* benadering (wat gebruikelijk is in veel onderzoek naar private equity), maar vanuit de bredere *stakeholder* benadering.

Met het oog op de tweede vraag wordt geconstateerd dat er al enig onderzoek is gedaan naar de invloed van private equity firma's in Amerikaanse verpleeghuizen en dat de resultaten daarvan niet eenduidig zijn.[16] In aanvulling op deze inzichten maakt dit hoofdstuk daarom gebruik van aanverwante literatuur en komt zo tot de volgende proposities:

P_1: Private equity firma's verhogen de winst in verpleeghuizen.
P_2: Private equity firma's verbeteren de efficiency in verpleeghuizen.
P_3: Private equity firma's hebben geen invloed op de innovatie in verpleeghuizen.
P_4: Private equity firma's verminderen de inzet van personeel.
P_5: Private equity firma's zorgen voor verslechterde arbeidscondities.
P_7: Het 'conflicterende uitkomsten' perspectief is van toepassing op de organisatieprestaties versus medewerkers- en cliëntenwelzijn.[3]

P_8: Het 'wederzijdse opbrengsten' perspectief is van toepassing op medewerkers- en cliëntenwelzijn.[iii]

Private equity firma's lijken voornamelijk succesvol vanuit het *shareholder* perspectief, omdat ze de financiële prestaties van organisaties over het algemeen verbeteren. Verder gaat private equity samen met de inzet van minder personeel, wat een signaal is van een arbeidsproces dat zo efficiënt mogelijk is ingericht. Cliënten ervaren naar verwachting geen consequenties of hooguit enige negatieve consequenties van private equity eigendom. De voordelige uitkomsten voor eigenaren en werkgevers gaan samen met verslechterde uitkomsten voor medewerkers (en soms ook cliënten) – wat past bij het uitgangspunt van 'conflicterende uitkomsten'.

HOOFDSTUK 4. OP WINST GERICHTE VERPLEEGHUIZEN IN NEDERLAND: WELKE FACTOREN VERKLAREN HUN OPKOMST?

Achtergrond en vraagstelling

Het marktaandeel van commerciële verpleeghuizen varieert per land[17] en neemt in verschillende Westerse landen toe.[18] Onderzoek naar factoren die de opkomst van dergelijke commerciële instellingen verklaren is beperkt.[19] De Nederlandse verpleeghuissector biedt een uitgelezen kans om zulke factoren te identificeren: deze verpleeghuissector bestond tot voor kort vrijwel uitsluitend uit non-profit instellingen,[20] maar ondergaat momenteel een verandering met de opkomst van commerciële verpleeghuizen. Deze verkennende studie *beschrijft hoe de huidige commerciële verpleeghuissector in Nederland er uitziet en analyseert welke factoren de opkomst ervan verklaren.* De studie put uit theorie over sectoren waarin zowel commerciële als non-profit organisaties opereren ('mixed-form' markets)[21] en uit economische theorie over non-profit organisaties[22] voor mogelijke verklaringen voor de entree en groei van commerciële verpleeghuizen.

Methode

Het onderzoek combineert kwantitatieve en kwalitatieve methoden:

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iii Het idee van 'conflicterende uitkomsten' versus 'wederzijdse opbrengsten' kwam eerder aan bod in de introductie van deze samenvatting.

- Er is een dataset samengesteld, op basis van (semi)publieke datasets van de Patiëntenfederatie Nederland en van het Zorginstituut Nederland, aangevuld met data van het Sociaal Cultureel Planbureau, het Centraal Bureau voor de Statistiek, en Bureau van Dijk. Daarnaast werden data opgenomen uit openbare inspectierapporten, nieuwsberichten, websites van de organisaties zelf en e-mailcontact met de organisaties. Met t-tests zijn verschillen tussen commerciële en non-profit verpleeghuizen getoetst.
- Ook werden 25 doelgericht geselecteerde respondenten geïnterviewd. Interviewdata zijn thematisch geanalyseerd met behulp van Atlas.ti.

Resultaten en conclusies

Het aantal commerciële verpleeghuizen in Nederland is in de afgelopen jaren substantieel gegroeid, resulterend in een marktaandeel van 12% (gemeten naar het aantal locaties). In vergelijking met non-profit instellingen zijn commerciële verpleeghuizen vaker kleinschalig. Bijna 12% van de commerciële verpleeghuislocaties is in handen van private equity. De relatief makkelijke toegang tot privaat kapitaal (waaronder private equity) draagt bij aan de groei van commerciële verpleeghuizen.

Een samenhangende set van factoren verklaart verder de opkomst van commerciële verpleeghuizen. Ten eerste blijkt nieuwe regelgeving – gericht op meer extramurale (zorg thuis) in plaats van intramurale zorg (zorg in een instelling) – doorslaggevend. Commerciële verpleeghuizen gebruiken de extramurale financieringsmogelijkheden om het winstverbod in intramurale zorg te omzeilen; zij bieden extramurale zorg in een geclusterde vorm aan. Ten tweede speelt de non-profit sector onvoldoende in op de groeiende vraag en de behoefte aan een welzijns- in plaats van een medisch perspectief. De nieuw opgerichte commerciële instellingen stemmen hun organisaties juist af op deze behoefte, wat samengaat met een hogere cliënttevredenheid. Ten derde maken commerciële verpleeghuizen gebruik van mogelijkheden voor ‘cream-skimming’, door zich voornamelijk te richten op een draagkrachtige clientèle. Ten slotte leunen commerciële verpleeghuizen op het bredere zorgsysteem voor meer specialistische zorg, waarmee ze de kosten voor hun medische staf relatief laag houden. De substantiële financiële bijdragen van cliënten voor services en huur maken het bovendien mogelijk om extra (‘hospatality’) personeel in te huren; dat maakt ze vervolgens relatief aantrekkelijke werkgevers in een context van arbeidstekorten.

HOOFDSTUK 5. WAT GEBEURT ER ALS EEN VERPLEEGHUISKETEN IN HANDEN KOMT VAN EEN PRIVATE EQUITY FIRMA? EEN LONGITUDINALE CASE STUDIE

Achtergrond en vraagstelling

De rol van private equity firma's in zorgorganisaties is het duidelijkst zichtbaar in Amerikaanse verpleeghuisketens.[23] Onderzoek naar de impact van private equity in deze verpleeghuizen toont wisselende resultaten.[24] Dergelijke uiteenlopende resultaten scheppen de behoefte aan case studies die gedetailleerd laten zien wat er gebeurt als een private equity firma een organisatie overneemt.[25] De longitudinale case studie in dit hoofdstuk zoomt daarom in op de strategie[26] en prestaties van een verpleeghuisketen die in handen komt van een private equity firma. De centrale onderzoeksvraag is daarbij: *Wat gebeurt er als een verpleeghuisketen in handen komt van een private equity firma?*

Methode

De longitudinale case studie betreft een Amerikaanse verpleeghuisketen die in 2006 werd overgenomen door een private equity firma. De verpleeghuisketen heeft ruim 300 locaties en circa 42.000 medewerkers (in 2012). Resultaten worden zowel gerapporteerd door de tijd heen (periode 2000-2012), als ook in relatie tot de strategieën en prestaties van vergelijkbare verpleeghuisketens. De case studie put uit een scala aan databronnen. Kwalitatieve databronnen waren Providers Magazines, berichtgeving via LexisNexis en vijf diepte-interviews met sleutelfiguren. Kwantitatieve databronnen waren een dataset van verpleeghuizen in Californië (circa 1.200 locaties) en nationale data over overtredingen van kwaliteitsrichtlijnen (circa 14.700 locaties).

Resultaten en conclusies

De strategie van de verpleeghuisketen over de periode 2000-2012 toont zowel continuïteit als verandering. Het afstoten van verlieslatende verpleeghuizen is een doorgaande strategie voor en na de overname in 2006. Dat geldt ook voor de inzet op diversificatie door het ontwikkelen van meer winstgevende zorgactiviteiten in groeimarkten, voor de geïntensiveerde sturing door het verlagen van de 'span of control' per manager en voor de strikte beheersing van de ratio professional-cliënt. Nieuwe strategieën, die worden ingezet ná de overname door de private equity firma, zijn onder meer een juridische herstructurering die

toezicht op de verpleeghuisketen complexer maakt, 'rebranding', investeringen in ICT en het inzetten van relatief meer hoger opgeleid personeel. Veel van deze strategieën zetten andere verpleeghuisketens overigens ook in, die *niet* in handen zijn van een private equity firma.[27] De verpleeghuisketen conformeerde zich grotendeels aan andere grote verpleeghuisketens, in lijn met institutioneel isomorfisme.[28] Een bijzondere strategie is wel de oprichting van nieuwe bedrijven, waarbij de verpleeghuisketen als 'platform voor lancering' fungeert. Zo wordt een farmaciebedrijf opgericht, waarbij de 300 verpleeghuislocaties verplicht diensten afnemen.

De financiële prestaties van de verpleeghuisketen verbeteren na 2006 wat betreft winstmarges en het netto inkomen per cliënt per dag; de schuldenlast neemt ook toe. Voor cliëntenwelzijn geldt dat het aantal overtredingen van kwaliteitsrichtlijnen vergelijkbaar is met die van andere verpleeghuisketens na de private equity overname, terwijl dit aantal significant lager was vóór de overname. Verder blijven rechtszaken van/namens cliënten regelmatig voorkomen.

HOOFDSTUK 6. WAT GEBEURT ER ALS PRIVATE EQUITY HAAR INTREE DOET? TWEE CASE STUDIES IN MAATSCHAPPELIJKE ZORGORGANISATIES

Achtergrond en vraagstelling

In de neoliberale beweging naar meer commerciële aanbieders van maatschappelijke zorg[29] is ook het pad geëffend voor private equity partijen. Dit hoofdstuk beschrijft de resultaten van twee case studies van maatschappelijke zorgorganisaties in Nederland: een thuiszorgorganisatie en een kinderopvangorganisatie, die beide vanaf 2006 in handen kwamen van een private equity firma. De centrale vraag is *hoe organisaties die maatschappelijke zorg verlenen presteren als zij in handen zijn van private equity firma's*. Daarbij is zowel in kaart gebracht *hoe* private equity firma's te werk gaan (strategie), als *wat* private equity betekent voor de organisatie als geheel, de medewerkers, en de cliënten.

Op basis van beschikbare literatuur over zowel private equity als commerciële thuiszorg en kinderopvang start het hoofdstuk met enkele globale verwachtingen. Zo beschrijft private equity literatuur twee ideaaltypische strategieën. In de 'neergaande' strategie focust de private equity firma op het verlagen van kosten en het intensiveren van de inzet van mensen en middelen. Bij de 'opgaande'

strategie zet de private equity firma juist in op investeren en groei.[30] De gecombineerde literatuur over private equity en commerciële thuiszorg of kinderopvang wijst – voorzichtig – op verbeterde financiële prestaties,[31] uiteenlopende resultaten ten aanzien van medewerkerswelzijn,[32] en verminderd cliëntenwelzijn.[33]

Methode

De twee case studies combineren kwantitatieve en kwalitatieve data uit negen verschillende databronnen. Triangulatie wordt toegepast bij het formuleren van de bevindingen. Waar mogelijk is een longitudinale benadering toegepast. De case studies zijn gestart met een systematische analyse van mediaberichtgeving (via Lexis Nexis) en publiek toegankelijke bedrijfsinformatie (jaarverslagen, inspectierapporten, rechtbankverslagen en faillissementsverslagen). Daarna zijn publieke datasets geraadpleegd voor financiële informatie en kwaliteitsinformatie. Verder werden in totaal 20 diepte-interviews afgenomen met doelgericht geselecteerde respondenten.

Resultaten en conclusies

In beide cases zijn enkele aspecten van de 'neergaande' private equity strategie zichtbaar. Zo is er een focus op het efficiënt organiseren van management en overhead; ook wordt strikter toegezien op kosten via verbeterde financiële informatieprocessen. De dominante strategie van de private equity firma's in beide cases is er echter één van groei. Die groei zet door als de zorgorganisatie (vanwege verkoop of faillissement) in handen komt van een nieuwe eigenaar.

In tegenstelling tot wat op basis van de literatuur werd verwacht, verbeterden de financiële prestaties in de cases niet noemenswaardig. In de context van overheidsbezuinigingen presteerden de onderzochte organisaties eerder slechter in vergelijking met andere organisaties in hun sector. De grote financiële afhankelijkheid van overheidsbijdragen was onvoldoende ingecalculeerd door private equity partijen. Voor medewerkers en cliënten werd de invloed van de private equity firma pas merkbaar toen het financieel slechter ging en er noodgedwongen werd geïntervenieerd op de werkvloer.

HOOFDSTUK 7. CONCLUSIES EN DISCUSSIE

Beantwoording van de onderzoeksvragen

Op basis van voorgaand beschreven studies zijn de onderzoeksvragen als volgt beantwoord:

1. *Wat is er bekend over de prestaties van commerciële zorgorganisaties, in het bijzonder zorgorganisaties die in handen zijn van private equity firma's?*

Hoofdstuk 3 beredeneert waarom de aard van zorg fundamenteel verschilt van veel andere producten en diensten. Daarmee vraagt de rol van commercieel (in het bijzonder private equity) eigendom in zorgorganisaties om specifiek onderzoek.

De systematische analyse van zowel literatuur over commerciële zorgorganisaties als literatuur over de impact van private equity in het bedrijfsleven leidt tot een aantal proposities. Zo wordt verwacht dat private equity in zorgorganisaties samengaat met meer winst en efficiency (organisatieprestaties). Daarnaast lijkt private equity gekoppeld aan minder inzet van personeel en verslechterde arbeidsvoorwaarden (medewerkerswelzijn), en geen of beperkt negatieve invloed op zorgkwaliteit (cliëntenwelzijn).

De reviews van de literatuur bieden zo behulpzame richtingen voor de invloed van private equity in zorgorganisaties, maar roepen tegelijkertijd ook de vraag op waar verschillen (die ook zichtbaar worden in beschikbare studies) vandaan komen. De studie in de Nederlandse verpleeghuissector (hoofdstuk 4) suggereert verder dat commerciële aanbieders juist beter presteren op sommige indicatoren van cliëntenwelzijn dan non-profit verpleeghuizen. Er is daarom behoefte aan meer diepgaand inzicht in hoe de impact van commercieel eigendom tot stand komt.[34] Dit proefschrift heeft, via drie longitudinale case studies, uitdrukkelijk ook aandacht voor de strategieën en multidimensionale prestaties van zorgorganisaties die in handen zijn van private equity firma's.

2. *Welke strategieën passen private equity firma's toe in zorgorganisaties?*

In alle drie de case studies in dit proefschrift ligt de focus van de private equity eigenaar op groei. De private equity firma's passen een 'buy-and-build' strategie toe. Daarbij gebruiken ze de zorgorganisaties als platform om andere zorgorgani-

saties aan te koppelen ('add-ons'). In één van de cases wordt groei ook zichtbaar doordat de private equity partij de zorgorganisatie gebruikt als springplank ('launch customer') voor de oprichting van nieuwe, andersoortige organisaties. De zorgorganisatie wordt daarbij ingezet als gegarandeerde afnemer van die nieuwe organisatie. Verder gaan de onderzochte zorgorganisaties bij de 'exit' van de private equity firma op in nog grotere (internationale) zorgconglomeraten. Dat laatste wordt zichtbaar in de case studies en komt ook naar voren in de studie naar commerciële Nederlandse verpleeghuizen. Meerdere Nederlandse verpleeghuisketens die in handen waren van een private equity partij werden doorverkocht aan internationaal opererende ketens.

Een andere strategie die in alle cases terugkwam was het stroomlijnen van de topstructuur, via het reorganiseren van management en overhead en het inzetten op verbeterde financiële informatiestromen.

3. *Hoe presteren zorgorganisaties die in handen zijn van private equity firma's wat betreft financiën (organisatieniveau)?*

Hoewel de systematische reviews van de literatuur wijzen op verbetering van financiële prestaties door private equity, laten de drie case studies uiteenlopende resultaten zien – ook door de tijd heen. In alle drie de cases is een toename van schulden zichtbaar. Verder valt het in twee van de drie cases op dat zij relatief slecht bestand zijn tegen veranderingen in de (beleids)context; de zorgorganisaties worden relatief hard geraakt door bezuinigingen en wijzigende regelgeving.

4. *Hoe presteren zorgorganisaties die in handen zijn van private equity firma's wat betreft het welzijn van medewerkers en cliënten?*

In alle drie de cases blijkt regulering een barrière voor private equity partijen om te reorganiseren op de werkvloer; directe private equity interventies op de werkvloer zijn beperkt. In twee cases is er (uiteindelijk) wel degelijk impact op het niveau van medewerkers, maar die impact is niet zozeer ingegeven door het *directe* ingrijpen van private equity partijen. Impact voor medewerkers volgt eerder uit reorganisaties vanwege financiële problemen; problemen die deels veroorzaakt worden door de relatief slechte voorbereiding op beleidswijzigingen en/of economische teruggang. Op het niveau van cliënten lijken de gevolgen van private equity grotendeels afwezig.

***Hoofdvraag**: Hoe presteren commerciële zorgorganisaties, in het bijzonder zorgorganisaties die in handen zijn van private equity firma's?*

De systematische reviews van de literatuur over commerciële zorgorganisaties en over private equity in het bedrijfsleven onderzochten het onderwerp van dit proefschrift in de breedte. Dit leidde tot een aantal proposities: verbeterde organisatieprestaties, indicaties voor verslechterd medewerkerswelzijn en geen of weinig gevolgen voor cliënten. In case studies in vervolgens meer diepgaand onderzocht hoe private equity impact kan hebben, door ook rekening te houden met strategie en context. Dan wordt zichtbaar dat de private equity firma's in zorgorganisaties zich voornamelijk focussen op groei. Financiële prestaties variëren tussen de cases en door de tijd heen, al nemen de schulden wel in alle gevallen toe. Op de werkvloer is de invloed van de private equity eigenaar beperkt merkbaar, maar dit verandert op het moment dat de financiële situatie nijpend wordt. Voor cliënten lijkt de impact nagenoeg afwezig.

Conclusies

Conclusie 1: Private equity firma's vergroten de omvang van zorgorganisaties.

Zowel de case studies als het onderzoek naar commerciële verpleeghuizen in Nederland wijzen op de groeifocus van private equity firma's in zorgorganisaties. De eerste conclusie is daarom dat private equity eigendom samengaat met de groei van zorgorganisaties. Deze conclusie wordt bevestigd door recente ervaringen met private equity in de kinderopvang in de V.S. en het Verenigd Koninkrijk, alsook in onderzoek naar private equity in diverse andere zorgsectoren.[35] De combinatie van private equity en zorgorganisaties krijgt daarmee een plek in bredere debatten over marktconcentraties.[36]

Conclusie 2: Private equity firma's verhogen financiële risico's in zorgorganisaties.

Het bedrijfsmodel dat private equity firma's toepassen maakt zorgorganisaties extra kwetsbaar in het geval van onverwachte uitdagingen.[37] Op basis daarvan wordt geconcludeerd dat private equity firma's de financiële risico's in zorgorganisaties kunnen vergroten. Eerder onderzoek in zorgorganisaties en anekdotisch bewijs bevestigen deze conclusie.[38] Onderzoek naar private equity in het bedrijfsleven stelt dat private equity inderdaad vaak samengaat met financiële problemen, maar dat dit niet leidt tot meer faillissementen.[39] Het is zeer de vraag

of dit resultaat overeind blijft in zorgsectoren. De publieke zorgcontext, en de daarmee samenhangende afhankelijkheid van overheidsregulering en -bijdragen, maken deze context fundamenteel anders dan die in het bedrijfsleven.

Conclusie 3: De zorgcontext beperkte de directe invloed van private equity firma's op welzijn; invloed op welzijn was voornamelijk indirect.

De cases tonen betrekkelijk weinig impact van private equity firma's voor medewerkers en cliënten, zolang de organisatie er financieel goed voor staat. De *publieke* context van zorg, met regelgeving over bijvoorbeeld de minimale inzet van personeel, beperkte de mogelijkheden voor grote veranderingen op de werkvloer.[40] Dit past in de theorie over institutioneel isomorfisme, die stelt dat organisaties op elkaar gaan lijken onder invloed van dezelfde beperkingen.[41]

Overigens is het de vraag of private equity firma's überhaupt veranderingen in het primaire proces van de zorgorganisaties beogen. De toenemende schulden en de financiële kwetsbaarheid van de onderzochte zorgorganisaties suggereert een focus op financiële engineering in plaats van operationele verbeteringen.[42] Consequenties voor welzijn lijken eerder een indirect resultaat van dergelijk risico-verhogend gedrag (zie conclusie 2) dan van directe interventies op de werkvloer.

Beperkingen van het onderzoek

Met de uitvoering van case studies gaf dit proefschrift gehoor aan de roep om meer diepgaand onderzoek naar private equity in portfolio organisaties[43] en de uitnodiging om niet alle commerciële zorgorganisaties over één kam te scheren.[44] Het uitvoeren van case studies bleek in de praktijk behoorlijk uitdagend. De private equity sector heeft een gesloten karakter, wat toegang tot respondenten en informatie lastig maakte.[45] Een beperking van het onderzoek is daarmee de incompleetheid van de data op sommige onderdelen. Een tweede beperking is dat – naast het type eigendom – ook andere factoren de prestaties van organisaties bepalen. Daarbij moet ook het aandeel van topmanagement in prestaties worden genuanceerd.[46] De focus van dit onderzoek op eigendom was daarmee vrij smal. Een derde beperking is dat de variabele 'staffing levels' in de verschillende hoofstukken op verschillende manieren is gecategoriseerd. Een laatste beperking is dat de verschillen in de nationale contexten (V.S. en Nederland) niet zijn meegenomen in de analyse.

Implicaties voor theorie en praktijk

Theorie

Dit proefschrift combineert inzichten uit literatuur over (A) gezondheidzorgbeleid en de bestuurskunde over commerciële publieke dienstverlening met inzichten uit (B) economische literatuur over private equity. Het onderzoek draagt zo bij aan beide onderzoeksvelden:

(A) Het proefschrift (her)introduceert het belang van het blijvend bestuderen en volgen van commercialisering in publieke dienstverlening. Zo toont deze studie van commercialisering in extreme vorm (via private equity eigendom) dat niet alleen efficiency waarden (zgn. sigma-waarden), maar ook zaken als veerkracht en risico (zgn. lambda-waarden) een rol spelen bij vergaande commercialisering van publieke dienstverlening.[47] Vervolgonderzoek zou zich kunnen richten op de relatie tussen commercialisering en risico's in publieke dienstverlening.[48] Onderzoek naar de implicaties van de toenemende omvang van zorgorganisaties is eveneens relevant.[49]

(B) Economisch onderzoek naar private equity is vooral kwantitatief van aard en put voor een deel uit dezelfde, door managers gerapporteerde cijfers. De case studies in dit proefschrift laten de sterke interactie zien tussen private equity firma's en de specifieke zorgcontext – en daarmee de noodzaak om preciezer en diepgaander naar de uitwerking van private equity te kijken. Bovendien is het analyseniveau in het huidige onderzoek vooral dat van de organisatie. Daarmee bestaat het risico dat relevante interventies door private equity partijen worden gemist in wetenschappelijk onderzoek. Private equity partijen creëren namelijk ook waarde *naast* de individuele portfolio organisatie (de 'launch customer' strategie, zie ook de beantwoording van deelvraag 2).[50]

Praktijk

De uitkomsten uit dit onderzoek hebben ook een aantal praktische implicaties.

- Ten eerste is het van belang aandacht te hebben voor de (internationale) groei van zorgorganisaties onder invloed van private equity firma's. Dergelijke groei kan negatieve consequenties hebben.[51] Mededingingsautoriteiten hebben behoefte aan nieuw instrumentarium, dat hen in staat stelt adequaat om te gaan met mogelijke risico's van (internationale) groei onder invloed van private equity.

- Ten tweede is transparantie vereist van eigendomsstructuren van zorgorganisaties.[52] Die structuren zijn soms ingewikkeld, en private equity firma's dragen geregeld bij aan die complexiteit. Transparantie kan helpen rond vraagstukken van aansprakelijkheid.[53]
- Ten derde toont dit onderzoek het belang aan van kwaliteitsregelgeving. Dergelijke regelgeving wordt soms ervaren als regeldruk, maar het invoeren en handhaven ervan is noodzakelijk bij het commercialiseren van publieke dienstverlening.[54]
- Ten slotte leidt het onderzoek tot een oproep aan de huidige eigenaren van zorgorganisaties om bij de eventuele verkoop van de organisatie aan een private equity firma goed geïnformeerd te werk te gaan, door vragen die verder gaan dan het 'financiële plaatje' in overweging te nemen.[55]

Afsluitend

De 'corporate' kangoeroe geeft er de voorkeur aan geruisloos te bewegen, zoveel mogelijk uit het zicht van het publieke debat. De doorgaande groei van de private equity sector vereist echter dat de 'corporate' kangoeroe meer in het zicht komt, vooral als kangoeroes de zorg als hun nieuwe habitat beschouwen.

EINDNOTEN SAMENVATTING

[1] Ben-Ner & Ren 2008
[2] Bain & Company 2019; Cadigan et al. 2015; Harrington et al. 2012, 2017; Holly 2018; Ivory et al. 2016; Meagher et al. 2016; Winblad et al. 2017
[3] Barron & West 2017; Cabin et al. 2014: Genet et al. 2011; Karsio & Anttonen 2013; King & Meagher 2009; Meagher & Cortis 2009; Mercille 2018, Mukamel et al. 2014; Stolt 2011; Winblad et al. 2017
[4] Crouch 2011: vii
[5] Achterhuis 2000; Crouch 2011
[6] Goddeeris & Weisbrod 1998; Maier et al. 2016
[7] Freeman et al. 2010
[8] Hillman & Keim 2001; Smith 2003
[9] Boatright 2006, Freeman 2010; Van De Voorde et al. 2012
[10] Mintzberg & Waters 1985
[11] U.S. Dept. of Health and Human Services 2013
[12] Zie eindnoot 3
[13] Duhigg 2007; Pradhan et al. 2014
[14] Bates & Santerre 2013; Baumol & Bowen 1966; Hirschman 1980; Hochschild 1983; Sandel 2000
[15] Harrington et al. 2011
[16] Vgl. Cadigan et al. 2015; Harrington et al. 2012; Pradhan et al. 2013, 2014; Stevenson & Grabowski 2008

[17] Eurofound 2017
[18] Zie eindnoot 3
[19] Kingma 2003; Weisbrod 1997
[20] Jeurissen & Ginneken 2019
[21] Brown & Slivinski 2018; Rose-Ackerman 1990
[22] Anheier & Ben-Ner 2003; Ben-Ner & Van Hoomissen 1992; Hansmann 1980; Salamon 1987; Weisbrod 1988
[23] Harrington et al. 2011
[24] Cadigan et al. 2015; Harrington et al. 2012; Pradhan et al. 2013, 2014; Stevenson and Grabowski 2008; Grabowski et al. 2016
[25] Rodrigues & Child 2010
[26] Mintzberg & Waters 1985
[27] Grabowski et al. 2016; Hurley et al. 2012; Kitchener et al. 2008; Pradhan et al. 2014; Stevenson et al. 2013
[28] DiMaggio & Powell 1983
[29] Blomqvist 2004; Davidson 2009; Karsio & Anttonen 2013; Meagher & Cortis 2009; Petersen & Hjelmar 2014; Salamon 1993; Sivesind & Saglie 2017
[30] Bruining et al. 2005; Rodrigues & Child; Wright et al. 2001
[31] Blau & Mocan 2002; Cabin et al. 2014; Cadigan et al. 2015; Davis et al. 2014; Datta et al. 2013; Grabowski et al. 2009; Huang & Kim 2017; Kim & McCue 2013; Pradhan et al. 2013, Scellato & Ughetto 2013
[32] Bacon et al. 2012; Boseslie & Koene 2010; Boucly et al. 2012; Mitchell 2002; Morris & Helburn 2000; Paglia & Harjoto 2014; Scellato & Ughetto 2013; Sosinsky et al. 2007; Stevenson & Grabowski 2008
[33] Cabin et al., 2014; Cleveland 2008; Dalby & Hirdes 2008; Doran et al. 2007; Haldiman & Tseng 2010; Harrington et al. 2012; Japel 2005; Koning et al. 2007; Leviten-Reid 2012; Morris & Helburn 2000; Palcic & Reeves 2013; Pradhan et al. 2014; Rosenau & Linder 2001; Sosinsky et al. 2007; Stevenson & Grabowski 2008; Sundell 2000
[34] Rodrigues & Child 2010
[35] Chen et al. 2020; Gondi & Song 2019; Meagher et al. 2016; Resneck 2018; Roosenboom 2019
[36] Vgl. Crouch 2011; Harrington et al. 2017; Stiglitz 2019
[37] Vlg. Roosenboom 2019
[38] Gondi & Song 2019; Whoriskey & Keating
[39] Tykvová & Borell 2012; Wilson & Wright 2013; Wright et al. 2014
[40] Ben-Ner et al. 2012; Harrington & Edelman 2018; King & Meagher 2009
[41] DiMaggio & Powell 1983
[42] Appelbaum & Batt 2014
[43] Rodrigues & Child 2010; Wright et al. 2009
[44] Stevenson et al. 2013
[45] Vgl. Appelbaum & Batt 2014; Clark 2009
[46] Akgündüz & Plantenga 2013; Morris & Helburn 2000; Tolbert & Hall 2015
[47] Hood 1991: 15; Hood & Jackson 1991
[48] Vgl. Penn 2009; Gondi & Song 2019
[49] Vgl. Harrington et al. 2012; Morris & Helburn 2000; Sosinsky et al. 2007
[50] Press & Woodrow 2009; Harrington et al. 2015
[51] ACM 2018; Harrington et al. 2012; Kitchener et al. 2008; Noels 2019

[52] Vgl. Harrington et al. 2011
[53] cf. Gondi & Song 2019; Poerink 2012
[54] Vgl. Harrington & Edelman 2018
[55] Vgl. Bos & Hesselink 2018

D

Dankwoord
(acknowledgements in Dutch)

DANKWOORD

De kangoeroe dient in dit proefschrift als metafoor voor private equity in zorgorganisaties. Private equity firma's springen als bedrijfsmatige kangoeroes van de ene naar de andere organisatie. Als eigenaar van zorgorganisaties focussen ze op enorme organisatiegroei – vergelijkbaar met de snelle groei van baby kangoeroes. Daarbij bewegen de private equity firma's zich zo geruisloos mogelijk, net zoals een kudde kangoeroes. Eén in het oog springende eigenschap van de kangoeroe is minder van toepassing en heb ik bewaard voor dit dankwoord.

De medische literatuur beschrijft namelijk 'kangaroo care' (kangoeroe zorg). 'Kangaroo care' gaat over het liefdevolle huid-op-huid contact tussen ouder en pasgeboren baby. Medisch onderzoek wijst uit dat dit contact de pijn van baby's vermindert, hun psychologische stabiliteit vergroot en bijdraagt aan hun algehele groei en ontwikkeling. Baby's zijn vol levenslust, maar tegelijkertijd ook kwetsbaar. Ze hebben altijd die ander nodig om er te komen. De parallel is snel getrokken. Dat dit proefschrift het levenslicht zag, is zeker niet alleen mijn eigen verdienste. Heel veel kundige en lieve mensen hebben ervoor gezorgd het zover kwam. Door knuffels, 'zielzorg' en het royaal delen van hun kennis en netwerk.

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Liselot (Liesje) en Benjamin (Benja). Hoeveel is ontelbaar plus ontelbaar? De som die jullie me voorhouden, waarop het antwoord dan, gek genoeg, ook weer ontelbaar is. Waar onderzoekers en private equity investeerders vaak tellen, zijn de belangrijkste zaken in het leven ‘ontelbaar’. Mama’s boekje is nu écht af. Liesje, ik denk dat ik wel weer eens een nieuw boekje ga schrijven. Kom je dan ook naast mijn bureau staan om te vragen hoeveel pagina’s ik al heb geschreven vandaag? En hoeveel ik er dan nog moet? Dat vond ik heel fijn! Benja, toen ik vijf jaar was vond ik heel veel dingen spannend, net als jij. Dat vind ik nu nog steeds. En kijk nou, dan is het soms goed om die dingen tóch te doen.

Lars, ik hoop dat één van jouw ‘koosnaampjes’ voor mij (‘Arie Stress’), minder van toepassing is in de komende jaren – al heb ik net genoeg zelfkennis om te weten dat dat niet zo zal zijn. *I love your perfect imperfections*. Ik prijs me gelukkig met de wetenschap dat dat wederzijds is.

ABOUT THE AUTHOR

Aline Bos works as a senior consultant and researcher at the Utrecht School of Governance, Utrecht University. She is contracted by a broad range of clients in the public sector. Next to her main job as a senior consultant and researcher, Aline teaches several courses in the Bachelor and Master programs of Utrecht University, School of Governance.

Aline received her Bachelor's degree in Public Administration and Organizational Science at Utrecht University with honors. Hereafter, she graduated cum laude in the Research Master in Public Administration and Organizational Science, a joint university Master of Utrecht University, Erasmus University Rotterdam and Tilburg University. She combined her master program with a consultancy internship at Berenschot. In 2010, she finished the 'Essentials in Consulting and Change' course of the interuniversity center Sioo.

Her academic work has been published in international refereed journals and books, such as *Health Care Management Review*, *INQUIRY*, and *the International Journal of Health Services*. Her paper "Barbarians in our hospital? Private equity involvement and the quality of working life of health care professionals" received the 'best paper award' at the European Group for Public Administration (EGPA)-conference in Bergen, Norway.

How do for-profit and private equity-owned care organizations perform? Private equity ownership is a particular type of for-profit ownership. Private equity firms own and trade unlisted, private companies with money from investors and banks. They seek to increase the financial value of the organizations they own, to realize a profit when they sell them in about three to seven years.

This doctoral research project analyses the strategies and performance of for-profit and private equity owned care organizations from different angles. It brings together (a) systematic reviews of the literature on for-profit care organizations and private equity ownership, (b) an analysis of the rise of for-profit nursing homes in the Netherlands, and (c) the results of three longitudinal case studies of private equity-owned care organizations.

The combined results lead to the metaphor of the 'corporate kangaroo' for private equity in health services. Just like private equity firms, kangaroos metaphorically hop from one organization to another. The metaphor is linked to the three main conclusions of the thesis: (1) The rapid growth of the baby kangaroo resembles the dominant focus of private equity firms on increasing the size of care organizations. (2) Moreover, the relatively unfamiliar 'habitat' of care narrows the corporate kangaroos' freedom of movement and increases financial risks. (3) During profitable periods, then, the 'corporate kangaroos' whoosh almost silently past the organization's work floor employees and clients – as kangaroo hopping is extremely quiet.

Aline Bos works as a senior consultant and researcher at the Utrecht School of Governance, Utrecht University.