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Liquid home? Financialisation of the built environment in the UK's "hotel-style" care homes

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This paper combines the political economy of financialisation with feminist care ethics and sociocultural geographies of home. Together, these perspectives explain why and how real estate is converted into liquid financial assets, and expose the implications for embedded relationships. The argument is developed through a case study of UK care homes, with particular attention to the role of real estate investment trusts. Investors in care companies have sought to render their real estate assets more calculable and profitable, by standardising the assets themselves into hotel-like spaces. In effect, the work of translating between liquid finance and particular homes is transferred – from investors to those creating relationships in hotel-like spaces. Yet the fundamental illiquidity of residents, relationships, and "home" constrain and destabilise financialisation. The paper concludes by discussing the implications of "liquid home" for economic, urban, and welfare geographies, and recommends that policy pay more attention to the financing of spaces for care.

KEYWORDS
care, care homes, financialisation, real estate, REITs, UK

1 | INTRODUCTION

> They're like hotels really. They're all very nicely furnished, but […] the reason it's nicely furnished is that they've cut [carers'] wages by £2 an hour so they can afford to do it. […] They are much better I'd say. Whether the residents feel that, I wouldn't know. It's not very cosy. When I say hotel, I'm probably talking about a Travelodge! It's comfortable but honestly when you're in one you wouldn't know which one you're in, they're all so similar. […] And [the company] made this huge thing about how they've got cinemas. Well, I've never seen anybody in the cinema. Usually that's where they shove us [from the union] when we go and visit because nobody ever uses it! (Regional union organiser describing new care homes built by a private equity-backed company in England in the 2010s, which replaced publicly run homes.[1])

In the UK, more than 400,000 older people live in care homes, where they receive support with the activities of daily life and, in some cases, nursing care (CMA, 2017). Austerity has dominated research and public debate over recent years, as means-tested state support for the cost of care has been cut back (Hall, 2020; Power & Hall, 2018). Financialisation has also received growing attention: investment funds control most of the major care chains, accounting for approximately a

fifth of the total market (Burns et al., 2016). Such investors introduced risky, extractive business models – using high levels of debt to buy care homes and counting on a mass market of publicly funded residents. Private equity firms dominated large transactions of care companies in the 2000s and early 2010s, but their business models proved unsustainable and have since faced heavy losses (Horton, 2019). Newer entrants and their impacts also require scrutiny. More recent investment has been geared towards those paying for their own care privately at a higher rate. The business model is based largely on individual property wealth, converted into care fees, as well as the returns from care companies' real estate assets. Key to rolling out this model have been real estate investment trusts (REITs). The paper shows that REITs have emerged as a leading developer, major landlord, and significant lender for care homes. The number of care homes owned by REITs rose by 80% from 2016 to 2019, housing tens of thousands of residents. Alongside other investors, REITs have exerted increasing influence on the market categorisation, design, and charging structure of care homes. Each of these elements is modelled explicitly on that of hotels – in particular, large, purpose-built chain hotels offering standardised accommodation, geared towards profiting from economies of scale, which informants likened to a Travelodge or Holiday Inn Express. The paper identifies the implications for care and reflects on the relevance of this process of "hotel-ification" for wider urban forms, including student accommodation and co-living spaces.

Theoretically, this paper speaks to debates in economic geography, urban studies, and sociocultural conceptualisations of care and home. Together with urbanists, financial geographers have documented how financial methods have made capital that was fixed in the built environment available for continuous trading. Yet the work and risks inherent in this transformation from fixity to liquidity have also prompted investors to seek greater control over the built environment itself so that it better matches the standardised financial securities that represent it (Crosby & Henneberry, 2016; Guironnet et al., 2015). An appreciation of these dynamics is crucial to understanding contemporary landscapes of care. Methodologically, however, research must go beyond state actors and policy, investor logics, and practices – to include those working and dwelling in the new spaces. Such analysis can be enriched by engaging with sociocultural geographies of care and the home (Blunt & Dowling, 2006; Milligan, 2005). A radical reading of care ethics offers a normative framework for evaluating the physical and social infrastructure of welfare provision (Clement, 1996; Held, 2005; Raghuram, 2019). It provides tools to analyse how investment and the changing built environment interact with the embodied and spatially embedded relationships of care.

To capture the tensions between financialised spaces and situated relationships, I develop the concept of "liquid home": a standardised space designed for tenants who are themselves "liquid," that is, financially solvent and sufficiently mobile to move to the increasingly centralised, large-scale care homes. The work of translating between finance and relational places is transferred – from those responsible for the marketisation of real estate securities to the care workers and residents who have to do more to create relationships and a sense of home in "hotel-like" spaces of care. However, caring relationships and personalised home environments are embedded and particular. That fundamental illiquidity of residents, carers, relationships, and "home" constrains and destabilises the financialisation of home.

The paper first sets out this conceptual framework, drawing on theories of financialisation, home, and care. It then explains the research methods. The analysis considers in turn the financing, design, costs, exclusions, and risks of new care homes in the UK. The conclusion discusses the implications of the blurring of finance, home, and hotel, and offers some recommendations for an alternative approach to the provision of care.

2 | FINANCIALISATION, GEOGRAPHIES OF HOME, AND CARE ETHICS

2.1 | Property investment: homes as liquid assets

Despite the eruption of the 2007–2008 financial crisis in American mortgage markets, global real estate investment subsequently rebounded to far surpass pre-crisis levels (Cushman & Wakefield, 2019). In the UK, returns from property have come to play a dominant economic role (Christophers, 2018), amounting to a "finance- and real estate-driven regime" of accumulation (Hofman & Aalbers, 2019). This has required the development of ways to release capital from the built environment into circulation. Conventionally, investing in property meant leaving capital "locked up" over a long period in fixed, physical form – and when it re-entered the market, transactions were complicated by the difficulty of valuing specific properties: unique geographical locations, built forms, and local markets make different property assets fundamentally incommensurable commodities (Gotham, 2009).

A vibrant literature in economic geography and urban studies has identified various strategies developed by investors, governments, and other actors to render real estate more liquid. Various methods transform idiosyncratic properties into quantified, comparable, and tradeable financial assets (Gotham, 2006; van Loon & Aalbers, 2017). A key actor in this

process of securitisation has been the real estate investment trust (REIT). Long established in the USA, more recent regulation has enabled the creation of REITs in dozens of other countries, including the UK in 2007 (Waldron, 2018, p. 209). REITs own property portfolios and sell publicly traded shares to investors, who receive dividends based on rental income, as well as share price gains where real estate values rise (Haslam et al., 2015). REITs offer several significant benefits to shareholders: they enable highly liquid investment in a diversified property portfolio, are required to pay out 90% of their rental income to investors, and are not liable for capital gains or corporation tax (Hale, 2014). In the context of rapidly, though unevenly, rising property values, returns to investors have been high (The Economist, 2016). Technological developments have also helped to make even highly fragmented property markets into commensurable financial assets: for example, investors have built large portfolios of individual, foreclosed homes in the USA by using big data to value these highly diverse properties (Fields, 2018). However, realising markets for such heterogeneous assets involves extensive work: they only become calculable through complex assemblages of goods, measuring devices, and shared understandings (Callon & Muniesa, 2005; Fields, 2018). Moreover, the underlying assets remain locally embedded and particular (Gotham, 2006), producing destabilising tensions: "the housing finance sector is permeated by significant contradictions and irrationalities that reflect the disruptive and unstable financial process of transforming illiquid commodities into liquid resources" (Gotham, 2009, p. 357).

Investors have therefore sought to reduce the difficulty and instability of marketisation, which emerge from differences between properties and the standardised financial securities into which they are translated. One strategy involves defining and standardising real estate developments themselves. Put simply: form follows finance (Willis, 1995). Urban scholars have shown how investor expectations have come to exert a growing – though uneven and contested – influence over the precise form of urban development (Crosby & Henneberry, 2016; Guironnet et al., 2015). Financial requirements can be "translated into physical form" through an "institutional specification" for building design (Crosby & Henneberry, 2016, p. 1435). Investors and developers strongly pursue such specifications in negotiations with planners (Guironnet et al., 2015). The performativity of investor expectations is mediated by particular contexts (Svetlova, 2012), but is likely to be stronger where austerity and infrastructure funding deficits promote reliance on private investment (Halbert & Attuyer, 2016). Under such conditions, financial requirements have tended to exert a homogenising influence on the urban fabric, producing generic commercial property in city centres and redevelopment zones, and limiting local governments' capacity to foster economic diversity, innovative designs, and non-standard uses of space (Crosby & Henneberry, 2016; Guironnet et al., 2015). Thus they can "create a more homogenous and commodified urban environment" (Waldron, 2018, p. 216).

Moreover, the closer integration of real estate with financial markets gives rise to a series of risks. Volatility arises from speculation, high debt levels, and over-accumulation (Gotham, 2009; van Loon & Aalbers, 2017). Such volatility fails to provide stable returns for the "ultimate" individual investors – including pension holders – and also provides a shaky foundation for long-term planning for the urban environment and welfare services by governments, business, and households (Halbert & Attuyer, 2016). Even outside periods of intense volatility and crisis, the financialisation of the built environment can have detrimental effects. In both the commercial and residential sectors, investment funds' debt costs and expectations of profit have driven rent increases, underinvestment in maintenance, and the harassment of lower-income tenants. These are linked to a faster rate of tenant turnover, producing geographies of exclusion and displacement (Fields & Uffer, 2016; Waldron, 2018). For example, Fields (2017) explored the social, emotional, and embodied impacts of private equity ownership of New York rental housing: it has led to deteriorating living conditions and displacement, as well as illness and weakened relationships within the home and community. She concludes that "housing made precarious contradicts the very ontology of home" (2017, p. 592). However, most research has focused on investor activities and their relations with states, particularly in the commercial property sector. A fuller appreciation of the implications of the financialisation of the built environment can be gained through engagement with feminist ethics of care and sociocultural geographies of home.

2.2 | Recuperating home through geographical ethics of care

Processes of financialisation are thus entangled with wider patterns of precariousness, displacement, and "domicide" – "the deliberate destruction of home that causes suffering to its inhabitants" (Porteous & Smith, 2001, p. ix). In some senses, scholarship on these themes has sought to recuperate the concept of home, amid critiques by feminist, queer, critical race, and disability studies perspectives that have highlighted the oppressive and exclusionary relations operating within and around home (Blunt & Dowling, 2006; Lowe & Deverteuil, 2020; McDowell, 1983). Such problematic relations can be especially acute in the case of care homes, where residents with a range of disabilities, diseases, and vulnerabilities may be deprived of privacy, autonomy, and mobility (Hyde et al., 2014). These concerns are not unique to the current regime, but date back to critiques of large-scale, publicly run care homes in the 1980s and have resurfaced in recent carceral

geographies of institutional care (Fairhurst, 1999; Repo, 2019). The lack of a sense of home here can arise from different pressures: bureaucratic and regulatory concern with safety and rational design; institutional routine; austerity and commercial imperatives to reduce costs; or efforts to create exclusive, "mall-like" spaces of luxury consumption (Bromley, 2012; Kenkmann et al., 2017; Peace & Holland, 2001). Geographies of care must be attentive to these diverse forces that can undermine the potential for home.

However, it is equally necessary to identify the enabling structures for home as a place of safety and selfhood that is not entirely continuous with "dominating, exploiting, commercial or bureaucratic social structures" (Young, 2005, p. 149). Instead, home should offer material "anchors" for radical relationships of care that extend out into the community (hooks, 1990). In care homes, requirements include autonomy for residents and visitors, the creation of a sense of community through shared activities, and links to relatives and others outside (Kenkmann et al., 2017; Milligan, 2005). Homeliness then is a matter of power, practice, and relationships. These are shaped by both the broader organisation of welfare and by the particular spaces in which care takes place. As Imrie and Kullman argue, care "involves acknowledging the transforming character of the social and material environment"; therefore producing the environment is a matter of "folding values into the physicality of space" (2016, pp. 3, 6). Design should support the "precarious attachments between bodies, materials and spaces that compose built environments" (Imrie & Kullman, 2016, p. 1), guided by ethics of care.

Care ethics offer a valuable framework for evaluating the infrastructural and relational spaces produced by financialisation. While social reproduction theory helps to illuminate the relations between financialised capitalism and the reproduction of labour and society (Kofman, 2012; Pollard, 2012; Roberts, 2013), care ethics go further in offering a critique of the (neo)liberal subject and suggesting alternative propositions for social relationships (Tronto, 2013). This critique is particularly useful given the dominant policy model of individual consumers exercising choice within care markets (Held, 2005; Power & Hall, 2018). In contrast, care ethics insist that subjects are interdependent, implying a shared responsibility to promote the relationships and conditions that enable subjects to live as well as possible (Clement, 1996). Also crucial to this approach is the recognition of subjects as embodied and emotional – unlike narrowly rational, purely cerebral, and mutually indifferent neoliberal subjects (Dyer et al., 2008; Held, 2005). Caring interactions must be responsive to the differing needs of subjects on their own terms, rather than following universalising, abstract templates lacking a basis in personal knowledge or negotiation (Tronto, 1993). Furthermore, radical care ethics are alert to the power relations within care, including the ways in which structures, practices, and spaces of care can control or oppress carers and those they care for (Raghuram et al., 2009). In the context of financialisation, care ethics are a useful framework for exploring the impacts of ownership and corporate business models, and the distribution of resources and risks.

Geographical theorisations of care have also emphasised the spatially extensive nature of caring relations, which stretch beyond the direct site of care (Lawson, 2007). This insight needs to be paired with careful attention to how care is shaped by place, including the material environment in which it is practised. As Kenkmann et al. observe, the latter does not exert a determining force on care:

> Space in [care] homes is not simply the product of neutral design but is experienced and lived-in and thus becomes actively imbued with value, meaning and potential for exercising power. These values and meanings are continuously re-negotiated … by residents, staff and visitors. (2017, p. 4)

Nevertheless, the built environment expresses specific relations of power, with important implications for vulnerable residents and poorly valued care workers.

In summary, the paper asks how a standardised, financialised built environment interacts with ideas of home as a material foundation for relational selfhood, from the perspective of care ethics, which centre interdependence among emotional and embodied subjects.

3 | METHODS

This research sought to identify changing patterns of care home ownership and financing; to explore the implications for the built environment and access to good care; and to examine the potential risks associated with dominant business models. Industry data showed that private equity firms dominated large transactions in the 2000s (Horton, 2019). By the mid-2010s, REITs had also come to play a remarkably important role – as creditors, developers, and landlords – according to reports from major care companies, specialist consultancies, and industry press. Data on REITs' portfolios of care homes in the UK were collected from their websites in 2016 and 2019, showing the number of properties and, in some cases,

locations. At both points, specialist consultancies' reports on "alternative" property investments, including care homes, provided market data and analysis based on their extensive work advising investors.

In-depth interviews were conducted with 25 interviewees, including investors and industry advisers, care staff, and trade union officials, between October 2015 and September 2016. The "hotel" model of care home design, charging structures, and property investment were widely mentioned and seen as an important influence on care quality. Indeed, a "homely physical environment" – including sufficient personal space over which residents have control and the avoidance of regimented, institutionalised living – is a key factor in determining quality of life in care homes, according to a systematic review of qualitative research. Another factor is residents' relationships with each other and with care staff (Bradshaw et al., 2012). This paper provides insights into environments, activities, and relationships from care workers' perspectives, who were able to compare different homes and comment on changes over time. It also draws on data from the Care Quality Commission, whose regular inspections of care homes involve speaking to residents and observing care (CQC, 2018). As the most affected group, the views of residents would be an important contribution to future research on care and homeliness under conditions of financialisation. However, there are practical and ethical challenges in conducting research with people who have dementia, which affects the majority of care home residents (Alzheimer's Society, 2016), and in advanced stages can preclude informed consent (Lepore et al., 2017). In line with relational care ethics, research can therefore also draw on insights from relatives, advocates, and care staff. For example, one experienced nurse commented that while residents with severe dementia were unable to comment on their changed surroundings, following a hotel-inspired modernisation of the facility, "you can see symptoms like they don't feel stable, they don't feel at home." Interviews were transcribed and analysed using manual thematic coding. The analysis draws on critical comparison of the documentary sources and key quotes that represent common themes and disagreements among informants, in order to present a broad-based narrative of change and tensions arising from financialisation.

4 | LIQUID HOME: CARE IN A FINANCIALISED ENVIRONMENT

4.1 | Care homes as alternative property investment

Fragmented ownership and funding have left much of the UK's care infrastructure outdated. After assuming some greater responsibility for care through the post-war welfare state, governments have retreated from the building of care homes since the late 1970s (Hamnett & Mullings, 1992); 95% are now privately owned (Knight Frank, 2020). The state has continued to fund care services on a means-tested basis but, from 2010, public funding came under significant pressure as a result of austerity programmes (King's Fund, 2019). Care home owners are diverse: 5,500 different providers run the UK's 11,000 care homes for older people. The majority have only a single site – many of these are small scale and family run (CMA, 2017). The largest chains are run by investment funds, as they are willing to take on higher levels of debt for buy-outs, capital spending, and expansion compared to more risk-averse publicly listed companies (Laing and Buisson, 2012, p. 2). In the absence of coordinated care home development, a specialist property broker estimated that "around 85 per cent of the stock is either period-converted or is over 50 years of age, so the vast majority of the stock is very aged – bad pun […] not fit for purpose, not purpose built." Such facilities may be less safe and appropriate for the increasingly acute needs of the care home population. Major capital expenditure therefore is required to provide good quality accommodation.

It is in this context that real estate investment trusts became "the major investor in UK care homes" (Grant Thornton, 2018b, p. 20). They have led the financing of new homes and major refurbishments. In 2016, US-based Welltower was the largest developer of care homes in the UK (CBRE, 2016, p. 5). In addition to their role as developers, REITs have acquired existing care homes and they are an increasingly significant landlord in the sector. In 2016, five REITs owned some 260 care homes in the UK.[2] By 2019, the number of REITs active in the sector in the UK had grown to nine, with 467 care homes in their portfolio – an 80% increase in three years.[3] The number of beds in care homes owned by REITs can be estimated at nearly 30,000.[4] Some REITs have focused on acquiring and building "prime" properties in regions with a high proportion of privately paying clients. Others have bought up large chains with a national presence, as high land prices have pushed some investors out of the most expensive locations, generating a diffuse geography of REIT-owned care homes. As well as acting as developers and landlords, REITs play a third role as lenders to their care operating company tenants or to finance leveraged buy-outs of care chains by private equity firms.

REITs' intervention in the industry followed an earlier phase of building in the 2000s by private equity firms, which used high levels of private debt to expand, restructure, and sell chains, aiming to achieve a higher return within a few years. Although private equity firms remain significant owners of care chains, their expansion has declined and

several have sought to exit major investments as profits fell – affected by unsustainable debts and the global financial crisis, as well as austerity and higher minimum wages (Horton, 2019). Meanwhile, amid strong demand for real estate investments and rising property values, REITs were able to raise cheaper capital by issuing shares rather than borrowing. Whereas private equity funds tend to lock in investors' capital for approximately five years, REITs have the advantage of offering both short-term flexibility via highly liquid shares and "future-proofed" dividends from decades-long leases. To explain the rise of REITs in financing care home development or refurbishment, an employee emphasised their specialist knowledge of the care sector, their ability to cover a greater proportion of costs than banks, and crucially their cheaper cost of capital:

> Private equity capital is too expensive – trying to get a 20% return into a building like this doesn't work. Banks are not supposed to do this job – they can [offer] 50–60% loan-to-value, so who puts in the other 35–45% of the costs? There's a lot of capital that needs to go into [building or] refurbishing these properties and there's just no one else to do it other than really the REITs. [There are] pension and insurance funds who've got a lower return expectation, but a lot of the UK insurers or pension funds don't have a dedicated team that does healthcare real estate.

The expansion of REITs reflects strong demand for property investment underpinned by vast pension funds and international capital, particularly from the USA (investor; Savills, 2020). UK regulation governing international REITs' activities was relaxed in 2012 and US REITs accounted for 46% of major UK care home transactions from 2013 to 2015 (Peart, 2018). Demand has spread beyond traditional commercial real estate to "alternative" sectors including care homes, hotels, and student accommodation: they were expected to provide consistent, countercyclical returns, based on longer leases than those of other commercial tenants, with rents indexed to inflation or rising automatically (Savills, 2017). In 2017, 28% of commercial property investment in the UK went into alternative property, including 8% to healthcare (Knight Frank, 2018a). As an illustration, in 2019, Impact REIT leased four care homes with annual rent rises of up to 4% (Impact Healthcare REIT, 2019). Together these factors generated high returns. For example, Target, which is based in the tax haven of Jersey, offered investors a 35% return over 2014–2017 (City Wire, 2017). "Healthcare property" – which includes care homes, as well as other private medical facilities and nurseries – outperformed all other UK property investments from 2016 to 2018 (Knight Frank, 2019a).

4.2 | Hotel-like design and ideas of home

Investor priorities contribute to the production of a specific built environment for care in financialised chains. Investors categorise care homes as a subsector of commercial real estate alongside hotels, rendering them comparable to other properties and calculable as investments. This categorisation is common in property industry publications (e.g., Knight Frank, 2019b; Savills, 2020). As one established investor, who was asked why care work is low paid, said:

> Very simple … There is a very small proportion of the market prepared to pay, say, 1.5 times minimum wage for a superior service. Same applies in the hotel, which it is after all a variant of.
> Interviewer: That's an interesting analogy. Care staff say that it's not really like a hotel.
> Investor: But it is, to a very large extent – just needs a bit more care for the inmates.

This categorisation helps to reduce investors' sense of risk by offering an alternative use for the space: if profits fall too low in residential care, some homes – the newer "Holiday Inn Express-type unit […] could be converted into low end hotels [or] student accommodation." Space is thus standardised and made convertible. Care company marketing materials likewise emphasise that facilities are "hotel-like" or "hotel-standard" (e.g., Brighterkind, n.d.). There is no sense of the particularity of place or the material and relational character of home. Care staff noted the discrepancy between care home residents and the transience and mobility of hotel visitors (see also Nowicki et al., 2019):

> They [company management] like it to be 'hotel-like' and they don't realise that the elderly people want to be in their own home, not in a hotel-like place, because a hotel-like place is not a home-like environment … What do you do in a hotel? You only sleep there, then you go out and sight-see, so if the elderly comes in a hotel-like place, that is not their home.

In addition to calculability, the design of financialised homes tends to be more driven by concern for profitability, with less consultation of staff and service users, compared to non-profit and public sector homes (Buse et al., 2017). This manifests in a focus on individual clients and their private rooms: new facilities were said to have a more atomised feel, as if residents "had a room in a hotel, rather than a home" (former carer). The rationalisation of space enables the maximisation of returns from a larger number of residents. Indeed, other researchers have found that market pressures in private homes can lead to reduced outdoor and shared spaces (Kenkmann et al., 2017). The emphasis on the individual detracts from concern for relationships between residents, staff, and the wider community, which – from the perspective of care ethics – are vital to interdependent subjects. Design also tends to follow abstract templates, rather than responding to the embodied needs of residents and the situated knowledge of staff. For example, a new facility built by a company under private equity control had four wings accommodating 15 people each; staff described the homogeneity of design as disorientating for residents with dementia: "It was hard for some of the residents to know where they should be. Their wings weren't distinctive enough, so that they knew they were in the right place." Staff had been consulted on the design and suggested that each of the wings be painted a different colour, but their views were ignored: "We all put forward lots of ideas about how these four new wings […] would look. But in the end they all looked the same anyway" (former carer). In this context, extra labour is required by residents and workers to create a sense of place and home.

Financialised chains focus on attracting new clients, such that space and resources are directed towards marketing and visitors, rather than residents and care workers. One senior corporate figure discussed the importance of technological upgrades such as fall sensors, but some changes did not appear to reflect the priorities of residents; for example, he mentioned installing broadband to satisfy younger relatives who were visiting residents: "Why should you not have that in a care home, if you have it in a hotel?" Care staff and other informants expressed some frustration with spending on inappropriate equipment and facilities, like the cinemas mentioned above or new furniture that was attractive but required more work to keep clean. While financialised providers have devoted resources to these upgrades, they have exerted strong downward pressures on labour costs, contributing to a 30% wage differential between the private and public sectors (Skills for Care, 2015, p. 63), as exemplified by the cuts mentioned in this paper's opening quotation (and see Horton, 2019). Such decisions can exacerbate staff turnover and shortages, which are acute in the sector (ONS, 2017; Skills for Care, 2016) and require additional effort by staff and residents to form the relationships that underpin care. Upgraded environments therefore do not guarantee, and may even come at the expense of, good care. For example, in one region, care services were privatised and new homes built by a private equity-owned company; after new contracts were introduced with significant cuts to pay and benefits, many staff left, vacancies rose and one informant reported this experience:

> On Father's Day this year I think it was, relatives were turning up to visit people in the home and only one person had turned up for work. And there were people in bed, still not washed or anything, and [the carer] was in tears.

Beyond these acute lapses, care standards can also come under pressure as a result of investors seeking to increase profitability through economies of scale, particularly in staffing: "The economics of a small care home are clearly inferior to the economics of a 60 or 70 or 80 bed home." Whereas the average care home has 40 residents (CMA, 2017, p. 35), industry analysis suggests that homes with between 80 and 99 beds are most profitable (Knight Frank, 2015, p. 10). Under financial pressure from investors and creditors, austerity, and regulatory costs, this is contributing to a significant scaling up of care homes by the large chains (Grant Thornton, 2018a). In terms of the number of residents, "new homes that opened [in 2017–18] were double the size of those that closed" (Knight Frank, 2018b, p. 3). However, care staff said that "it's very hard in a 60-bed care home to get to know the people as well as in a 30-bed care home." Larger care homes can thus place strains on caring relationships and a sense of community. Indeed, this trend is associated with lower care quality: 89% of homes with up to ten beds were rated good or outstanding by the regulator, whereas only 65% of those with 50 or more residents met these standards and did not require improvement (CQC, 2017, pp. 19–20). As the head of the care regulator warned, scaling up works "against the person-centred, homely feel and the ability of a manager to be on top of what needs to be done throughout his or her service in the way that we see in some of the smaller services;" she warned of "the luxury end of the market, focusing on presentation, of what looks good, as oppose to focusing on what is even more important, which is how it feels" (Corder, 2016). In summary, the hotel-like care home is the product of investors' categorisation of care homes as a type of calculable, convertible space geared towards profitability through the rationalisation of space and reduced staffing costs, rather than co-produced, distinctive places that support relationships and a sense of home.

4.3 | "Hotel costs," exclusion, and eviction

While the quality of care offered to residents in hotel-like care homes often falls short, a significant number of older people are denied access to these homes altogether. Exclusion is generated both by high "hotel costs" in care homes and by uneven geographies of investment in care.

The framing of care homes as hotels influences the pricing of services, with implications for access to care. Costs for accommodation and food in a care home are commonly referred to in the sector as "hotel costs" (King's Fund, 2006), separate from the costs of care services. As real estate values have risen sharply in parts of the UK, investors have sought to tap into clients' residential property wealth by charging premium hotel costs. This revenue helps to cover high land prices paid for care home sites and to achieve investors' desired return. Effectively, investors are leveraging the vulnerability, immobility, and relationships that tie residents to particular places: care is embedded rather than liquid. Fee revenue is most lucrative in the case of privately paying residents, and investors have become increasingly focused on this market. For example, Ventas REIT has aimed to have 90% self-funding residents, compared to the sector average of 40% (property broker). As a result, those without personal or family wealth face exclusion from the new generation of care homes: the financialised model is not responsive to widely distributed needs for care. Nearby alternatives may be lacking. As one employee in a private-equity-owned home explained:

> We're only accepting as much as we can private paying residents, or that can reach our rate [of £75,000 per year]. […] The company goal is to be privately funded residents really. […] When we assess [potential residents], we will see the funding. If they are social services[-funded], they will be offered that we have a lifestyle choice fee, that if you come in this home, this is our rate … so can you meet the fee or can you not?

The exclusionary cost of care can therefore result in under-occupied homes (Laing Buisson, 2018) even as the elderly population grows. This "underperformance" further threatens the stability of the care sector. Moreover, it contributes to under-provision: an estimated one in seven older people in the UK has unmet care needs (Age UK, 2019).

Investor imperatives can also result in the de facto eviction of residents in at least three scenarios. First, residents of some homes can be forced to leave if they become unable to pay the fees, according to this informant:

> When their funds finish – say for example, they have sold their house and [have] no more money, social services will come in [to pay for the care]. We don't kick people out because they're just social services[-funded]. […] There are some homes that do that, and I think it's horrible.

Second, homes have been strategically closed where local wealth is not sufficient to supply the desired proportion of privately paying residents. One investor in a major care chain explained that they were heavily focused on raising the share of privately paying clients; this required closing "homes which cannot go above say 20 per cent private mix given the local area […] We've always got to churn the estate […] to make sure you put in at the top and sort of slice off the bottom." Third, home closure can occur as a result of financial difficulties that arise from risky investor practices. The most dramatic crisis in the sector came with the collapse of the major chain Southern Cross in 2011: its properties had been sold off, leaving care homes with rising rent bills (Horton, 2019). As financial pressures had mounted, the company had cut spending on the physical environment, to the extent that several homes that had been "run down to rack and ruin" were shut by the regulator, and their residents forced to relocate (former carer). Closures have continued, notably in the struggling investor-owned Four Seasons chain (Plimmer, 2019a). These have contributed to the development of "care deserts" – local areas with insufficient care provision – in the East, North East, and South West of England (Age UK, 2019, p. 23).

Through care home closures, financialisation can effectively lead to the eviction of some of the most vulnerable members of society. Research has found "significant" and "inevitable" distress among residents during care home closures, who experienced a sense of confusion, sadness, and loss, while staff faced stress linked to uncertainty about their jobs (Glasby et al., 2019). Home closures can destroy relationships among carers and residents based in particular homes and require additional effort to form connections in new settings; they may place strain on relatives and friends if residents move to a new home at a greater distance from their community; and the relocation of services can require care staff to commute longer distances (union officials). Ethics of care strongly value relationships, which are situated in place, and recognise interpersonal knowledge as important to good care. Yet where financialisation drives closures, relatively mobile capital induces a forced mobility among less powerful actors. The distribution of revenues to investors and creditors is prioritised over redistribution to support those needing care, based on relations of interdependence and responsibility.

4.4 | REIT risks: rents, asset values, and debt

Despite REITs' promise of low-risk financing for care infrastructure, there are several ways in which this model of funding care home development could jeopardise the homes of a large number of elderly people. First, REITs have tended to charge care homes substantially higher rents than other landlords, which reflects not only the cost of new developments, but critically, investors' expectations of strong returns. As one property specialist described:

> [REITs] are just, frankly, they are property companies that lease out care facilities and operators pay them a rent, it's no different. What is different is their tax treatment, and what is different is their rent tends to be higher – they need to get a high return to their investors […] Probably broadly 15–20 per cent higher than […] what we think is a market rent.

REITs' leases typically include annual, mechanical, upward-only rent reviews, which gives operators limited flexibility if they hit difficulties (former investor). Relatedly, care homes renting from REITs often pay a larger proportion of their profit as rent. While a care home operator would expect to have a profit of 1.7× its rental costs, for a REIT this typically drops to 1.4× (Grant Thornton, 2014), which one informant said was "a slight concern." Among US REITs operating in the UK, the ratios can be even lower (1.1×) (Knight Frank, 2016, p. 5), which one industry figure said would suggest a high level of risk. High rental costs drive care companies' efforts to maximise the hotel costs that they charge residents, deepening inequalities of access, while diverting resources away from residents and staff.

In addition to returns from high rents, investors in REITs can benefit from capital gains as real estate assets rise in value. Portfolios are typically revalued twice a year and increases tend to be reflected in the share price. These arrangements can contribute to asset price inflation. Among UK care homes, highly capitalised REITs engaged in a "buying frenzy" in the early 2010s, acquiring homes at "ridiculously high" multiples of the companies' earning that would not have been possible if capital costs were higher, according to one investment professional. He summed up the approach of most REITs as: "Buy it, don't care how much you have to pay for it, just show me the rent, lovely, bosh, done." By 2014–2015, property investors observed that US REITs acted as "the primary driver of increasing values in prime healthcare assets [including care homes]" in the UK (JLL, 2016). Where property assets are leveraged, debt imposes higher costs on care operators and potentially puts the sector at risk in a downturn.

REITs may also lend to their tenant care companies, and some of these debts have proven unsustainable. For example, the American REIT HCP has been a major lender to leading UK care companies HC-One and Four Seasons. For the private equity buy-out of Four Seasons in 2012, HCP provided £136.8 million in debt financing, with a costly annual interest rate of over 12% for the 8-year term of the loan. However, Four Seasons struggled under its huge debt burden, and in 2017, HCP sold on this debt for £53.8 million less than its initial commitment, representing a huge loss (PR Newswire, 2017). Overall, treating care homes as liquid financial assets and residents as a source of revenues to be maximised generates more exclusionary, risk-laden landscapes of care. Risks relating to high rents, extraction based on asset price inflation and excessive debts suggest a need for caution in drawing too strong a distinction between "purely speculative" private equity activities and the longer-term investment of REITs (Wijburg et al., 2018).

5 | CONCLUSIONS

This paper has traced the influence of investors, especially real estate investment funds, on a process of "hotel-ification" that runs through the market categorisation, design, and charging structure of care homes. Specific built forms are produced for maximum revenue generation from relatively wealthy, short-term residents, while the option to convert the space into related categories of accommodation is retained. Efforts to generate these forms of "liquid home" have several implications for economic geography, urban studies, and scholarship on care. These are identified by pairing the explanatory power of financialisation with the normative framework of care ethics.

First, the standardisation of developments challenges claims of increasing policy- and data-driven personalisation, and instead appears to be evidence of the mass production of space by "Taylorist finance" (Martin et al., 2008). Similar rationales and aesthetics are detectable in purpose-built student accommodation and "co-living" developments that target young, professional urban renters (Harris & Nowicki, 2020; Hubbard, 2009), as well as in new "supersized," "rooming-house"-style developments for short-term rentals through platforms such as Airbnb (Alexander, 2018). Theories of care and home provide vital tools for critique, recognising the importance of embedded relationships and responsiveness to embodied needs, including through the built environment (Imrie & Kullman, 2016).

Second, standardising real estate assets reduces the work required to transform them into comparable, liquid financial assets (Crosby & Henneberry, 2016; Guironnet et al., 2015). The work of mediating between markets and particular places is shifted to those who use the spaces, who then have to do more to transform them into homely places reflecting particular needs, and to compensate for a loss of features that can support relationships, such as shared spaces. Further research is needed into how residents, relatives, and workers perform the work of making homes and forging relationships within hotel-ified, liquid real estate. How do caring relations and reproductive labour reverse or challenge the process of marketisation at different scales?

Third, these liquid spaces are designed for liquid populations, who are transient and able to pay higher rates than can generally be charged on a longer-term basis. Such exclusivity runs counter to interdependence and responsiveness to need, which are prioritised by ethics of care. It results partly from a lack of state intervention to ensure sustainable, geographically even care services. While UK governments have created favourable regulation for REITs and encouraged privatisation of care services, policy has tended to limit public intervention in care, including active support for financialisation (Horton, 2019). This weak relationship with the state hinders REITs' capacity to finance the large-scale public–private development projects seen elsewhere, where governments have exercised at least some degree of influence over plans, even if state agendas often closely match those of investors (Wijburg, 2019; Wijburg et al., 2018). Leaving real estate investors to govern care home development with virtually no democratic oversight gives rise to even more investor-oriented, exclusionary outcomes. These outcomes also reflect the particular vulnerability and constrained agency of those using, and working in, care services.

However, the fundamental illiquidity of residents, caring relationships, and situated real estate generates instabilities and constrains financialisation. Over recent years, efforts to find buyers for each of the four major care chains – even the most profitable – have failed. From early 2020, COVID-19 hit the sector: the planned sale of Barchester care to Welltower REIT for £2.5 billion collapsed; care home REITs' share prices plummeted and credit ratings agencies issued negative outlooks for the debts of several (Daly, 2020; Flynn, 2020; Plimmer, 2019b). Others appeared more stable and continued to pay out to investors: in April 2020, Target REIT reported that "confirmed or suspected cases of COVID-19 have increased, though still represent residents occupying fewer than 5% of the portfolio's beds," and announced that – underpinned by rising rents and property values – it was increasing shareholder dividends, with investors expected to receive a 6.3% return for the year (Target, 2020). Across the sector, however, protection of vulnerable residents and carers was gravely inadequate (Mitchell, 2020; ONS, 2020).

A new approach to care policy and politics is needed urgently. This research shows that space for care is a crucial part of the agenda. To provide good homes and jobs, secure long-term land tenure on an affordable basis is essential for care homes. Care facilities also need sustainable financing for capital expenditure on new developments and major refurbishments. Land and finance must be available to care providers, such as cooperatives, that operate without high-risk gambles on financial markets. These needs are opposed to recent trends of austerity, privatisation of public land at market rates, and financialised real estate ownership (Christophers, 2018). Instead, collective investment in spaces of care and support for carers should be at the heart of efforts to recover from the impacts of COVID-19. Progressively funded spending in this sector would not only expand access to quality care. It would also create good, low-carbon jobs, contributing to a "green recovery." In 2016, it was estimated that a 2% increase in public spending on care in the UK would lead to GDP growth of nearly 7% through boosting employment, incomes, and demand (De Henau et al., 2016). Spending on care supports both workers within "global care chains" and local foundational economies as an alternative to "grand, city-centre based strategies that hope to 'trickle down' to those on the geographic and demographic periphery" (Powell et al., 2017). However, democratic control of spaces of care presents particular challenges given the health conditions and short lengths of stay of many residents. The ownership, governance, design, and work of spaces for personal and nursing care therefore require genuine co-production (Hatcher, 2019), involving residents, relatives, workers, the wider community, and local government. In line with care ethics, this reflects a more distributed concept of agency, grounded in interdependence.

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DATA AVAILABILITY STATEMENT

Except for publicly available sources cited in the paper, data are confidential to protect the identities of anonymised interviewees.

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ENDNOTES

[1] The company revised most of the job descriptions, and staff were given a choice between re-employment on inferior terms and conditions or voluntary redundancy.

[2] Author's calculation based on REIT portfolio details (American Healthcare Investors, 2016; HCP, 2016; Target Healthcare REIT, 2016; Ventas, 2016; Welltower, 2016).

[3] Author's calculation based on REIT portfolio details (American Healthcare Investors, 2019; HCP, 2019; Impact REIT UK, 2019; LXI REIT, 2019; Omega Healthcare, 2019; Peart, 2019; Target Healthcare REIT, 2019; Ventas, 2019; Welltower, 2019).

[4] Based on 467 × 60, the average size of a new home (Knight Frank, 2018a).

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