

Residential Aged Care - A Current Perspective

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Abstract

The Residential Aged Care industry in Australia faces an interesting dynamic with demographics driving increased opportunities; however the degree of government regulation adds a layer of complexity, which impacts on operators and the premises they occupy.

Keywords

Residential Aged Care

Nursing Hostels

Nursing Homes

Acronyms

ACAT Aged Care Assessment Team

CACP Community Aged Care Packages

EACH Extended Aged Care at Home

HACC Home and Community Care

RCS Resident Classification Scale

Introduction

This paper is a companion piece to “Retirement Villages A Sunset Industry in a Sunrise Situation”, which was published in The Australian Property Journal (Vol38 No.5) in February 2005.

Along with most OECD countries Australia’s population is ageing giving rise to issues such as funding of aged care, workforce participation across the age spectrum, anticipated health care concerns and business opportunities, especially those that involve accommodation for the elderly. Notwithstanding this, the property based opportunities face a complex market with differing levels of government regulation and funding.

Aged Accommodation

Accommodation for the elderly comprises two main components.

- Retirement Villages - are for those that can still care for themselves (cook, clean) but want the facilities and security that can be provided by such a complex. They are operated under State Government Legislation.
- Residential Aged Care - previously called Nursing Homes and Hostels and is now called High Level and Low Level Cared Accommodation; it is for those that require assistance to perform daily tasks. Residential Aged Care is under the Federal Government Aged Care Act 1997.

This divide is somewhat simplistic as even the elderly may elect to receive care under the private sector or may receive some form of assistance while still living in their own home.

Types of Care

Aged care can be separated firstly between the Government funded sector and the privately funded sector and then between whether this care is received in a Residential Aged Care centre or the recipients own home (Figure 1).

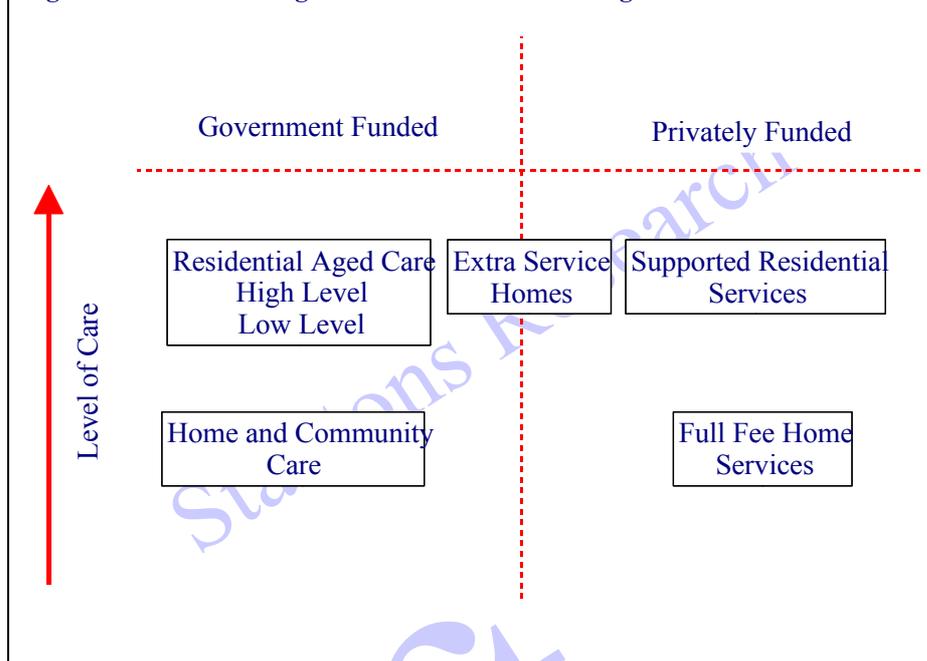
The Government funded sector comprises the following.

- **High Level Residential Aged Care** - this is the Resident Classification Scale (RCS) categories 1-4.

- **Low Level Residential Aged Care** - this is the RCS categories 5-8.

These different levels of care receive varying levels of Government funding. A resident is assessed on a series of factors including, communication, mobility, assistance with eating, personal hygiene, bladder and bowel management, understanding and undertaking living activities, wandering, disruptive or aggressive behaviour, emotional dependence, medication, required nursing procedures and therapy. The score for all these factors is calculated and the total determines the level of care required. Facilities can contain either High Level Care, Low Level Care or a combination of both referred to as **Ageing in Place**.

Figure 1 - Residential Aged Care - Source of Funding and Level of Care



- **Home and Community Care** (HACC, also referred to as Home Care and District Nurses). This was developed in 1985 whereby funding from the Federal Government is matched by the State and the allocated to services to assist the elderly (and the disabled). These services enable the recipients to remain in their own home. Respective State governments further allocate funding to organisations such as the Carers Association, Community Options, Meal Services, Local Councils and other aged care service providers including both the for-profit and the not-for-profit sectors. Many of these other service providers operate Residential Aged Care centres and utilise their infrastructure and staff to provide HACC.

Services offered by these HACC funded organisations include the following.

- Community nursing (dispensing medication, changing dressings)
- Meals (Meals on Wheels or in community centres)
- Allied Health Services (counselling, occupational therapy, physiotherapy)
- Personal Care (bathing, dressing, feeding)
- Home Modification and Maintenance (putting in ramps and handrails, repairs, changing light bulbs)
- Home Help (cleaning, cooking)
- Equipment and Aids
- Respite Care

This range of services provided is designed to allow the elderly to remain in the community, consequently in localities where a wide range of services are provided will mitigate the demand by the elderly for Residential Aged Care.

- Where the recipient would normally move into Low Level Residential Aged Care accommodation this HACC is referred to as **Community Aged Care Packages** (CACP's). Recipients are assessed as eligible for this care in the same manner as being eligible for Low Level Residential Aged Care. CACP's are essentially a bundle of care services which the operator is accredited to provide.
- Where the recipient would be eligible for High Level Residential Aged Care accommodation HACC is referred to as **Extended Aged Care at Home** (EACH). This is a relatively new service consequently it is not available in some areas. The same eligibility assessment procedures apply to recipients as for receiving High Level Residential Aged Care

The privately funded sector comprises the following.

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- **Supported Residential Services** are centres that have the same facilities and services as Residential Aged Care centres but as they receive no Government assistance they cannot be called Residential Aged Care. The level of care varies, along with the fee paid by the resident.
- **Full Fee Home Services** are the same as HACC services but there is no Government assistance. To further confuse the matter some of the organisations that provide HACC also provide Full Fee Home Services.

Residential Aged Care	189,929	Permanent Residential Care (several people may consecutively occupy a place during any single year)
	34,794	Residential Respite Care, including 16,282 who were later admitted to Permanent Residential Care
Community Aged Care Packages	39,721	
Home and Community Care	661,062	Reported in 2002-03 (latest data available) including 485,000 aged 70+
Source: Australian Health and Ageing System: The Concise Factbook		

As always there is an exception to this division, namely.

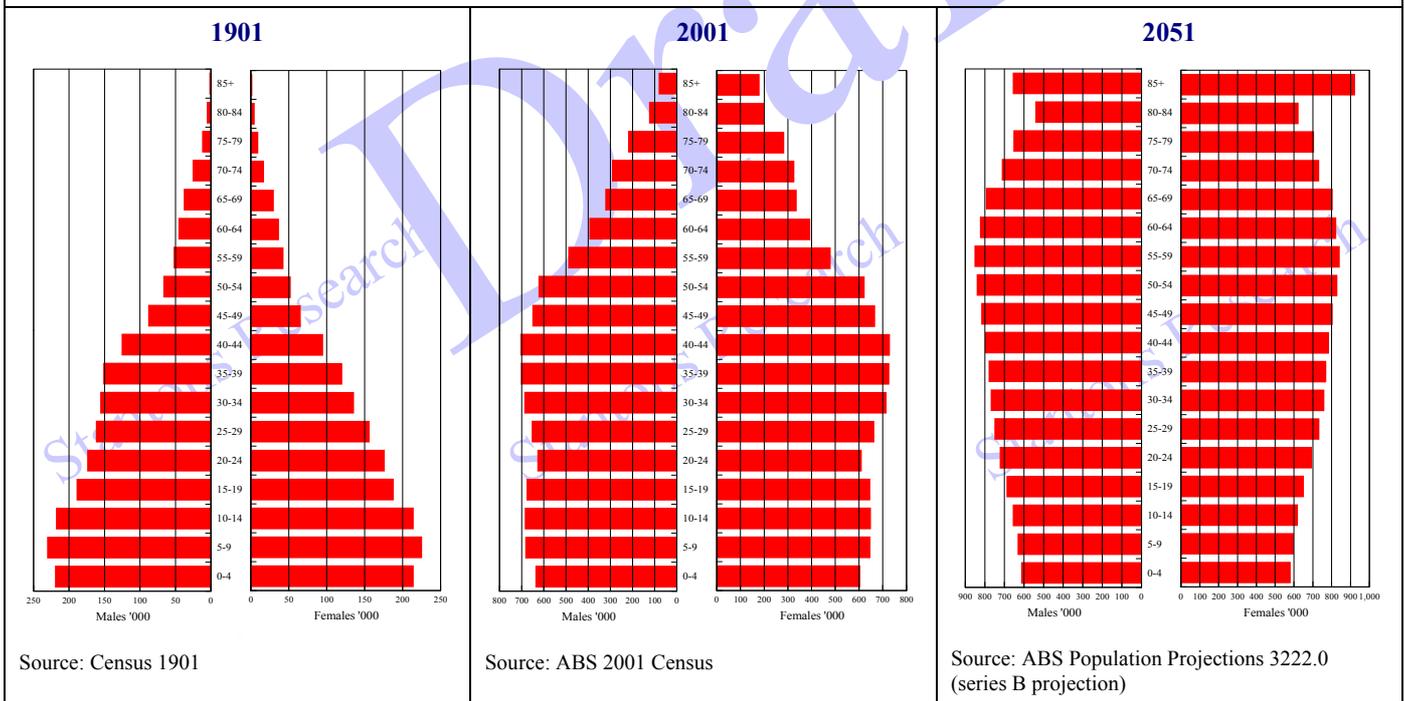
- **Extra Service Homes/Places** these are Residential Aged Care centres (Low and High Level) and places within centres that receive Government assistance for the Residential Aged Care component however they offer additional services (better quality meals, more luxurious rooms, use of additional facilities) which the resident pays for.

Group	Age
Younger Old	65-74
Middle Old	75-84
Older Old	85+

Demographic Issues

Notwithstanding the complexity of the aged care industry, strong growth is anticipated into the 21st century based on demographic factors. The ageing of Australia's population is resulting in an anticipated population increase of elderly of 4.0%pa between 2001 and 2051 (ABS Population Projections 3222.0 (series B projection)).

Chart 1 - How Australia's Population profile has changed and will change further



Australia's population increased considerably over the last century like many other industrialising ex-colonies. In 1901 the population of the Commonwealth was 3.77 million (excluding Aborigines but including 2,000 half castes), 100 years later the population (including Aborigines) had increased to 19.387 million. This is expected to increase further to 26.422 million by 2051.

Within this increase there has been a significant change in the population profile notably an ageing of the population, which is in line with other OECD countries. The proportion of those aged 65+ has increased from 4.0% in 1901 to 12.6% in 2001, and this is expected to increase further to 27.1% in 2051.

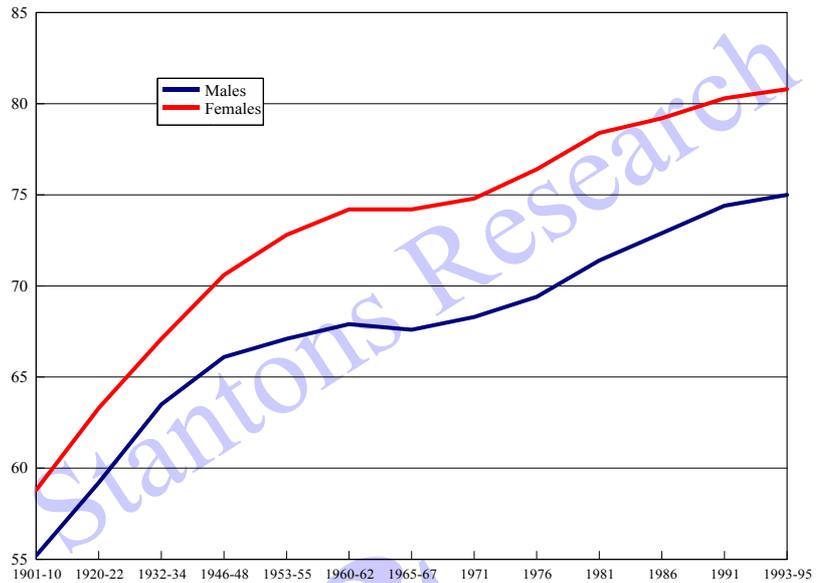
The flipside of the ageing trend is the realisation by governments that there will be a decreasing proportion of workers funding an increasing proportion of aged persons and many governments are looking at ways of overcoming this issue. One way would be to increase the numbers of workers in the workforce by increasing participation rates, especially female participation rates. However if more of the women are in the workforce then they will not be available to look after elderly parents further fuelling demand for residential aged care.

While there has been focus in the media on declining birth and immigration rates as a source of this ageing, the greatest influence has been in the increase in life expectancy that has happened over this period. Both sexes have increased their average life expectancy by between 20 to 25 years over the last century. Life expectancy at birth increased in the early part of last century with a reduction in infant and maternal mortality from improved pre and post natal care, diet, sanitation and birth conditions, reduced unplanned fertility and development of medical techniques to deal with premature births. In the later part of last century life expectancy increased with improvements in medical care for many previously fatal conditions, coronary heart disease, stroke and cancer.

This increase in average life expectancy has resulted in an increasing proportion of older old over this time frame; a trend that is expected to continue over the new century. This group will have the greatest impact on demand for residential aged care.

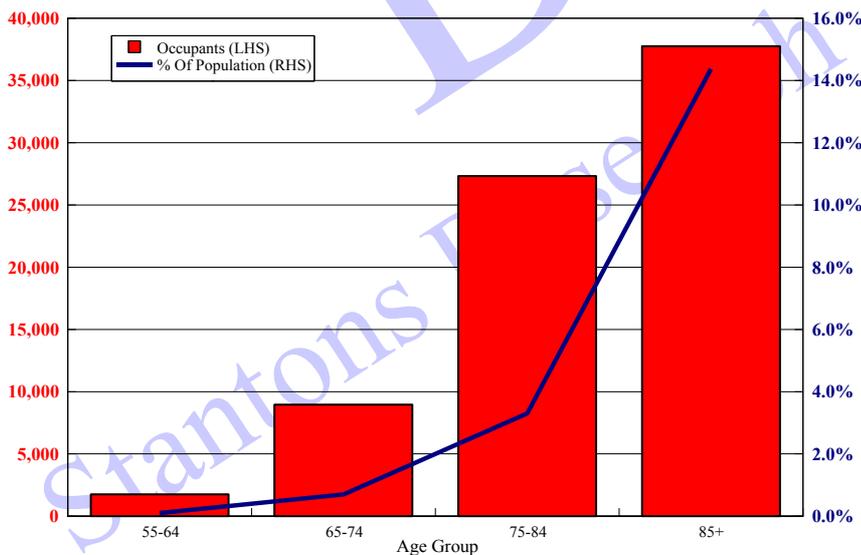
Living Arrangements

Chart 2 - Australian Life Expectancy at Birth



Source: ABS Australian Demographic Trends 3102.0

Chart 3 - Residents in Residential Aged Care



Source: ABS 2048.0 - 2001 Census Numbers

The increase in the older old is anticipated to drive a significant degree of growth in the demand for residential aged care into the new century. This anticipation is modified by predictions that this group will have better health than previous generations due to improved diet, better health and sanitation and the absence of world wars and major economic depressions; however the very improvements in medical technology have the capacity to increase life expectancy even further (provided expensive care is provided).

Notwithstanding this, projections of demand for residential aged care can be made by considering current proportions of people receiving care with the anticipated increase in the population of elderly into the century.

While ABS Census 2001 recorded the number of those in Residential Aged Care (Chart 3) these totals do not

immediately correlate with the Department of Health and Ageing numbers of people receiving aged care through 2003-04 year (Table 1). This is due to one number being a snapshot at a particular point in time and the other being a total number of those

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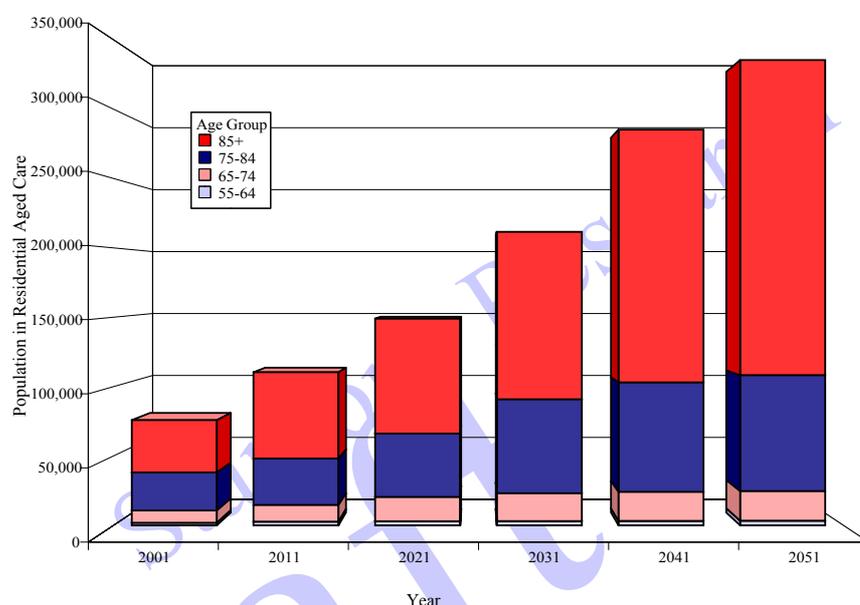
in care throughout the year. Whereas some residents may spend several years in residential aged care a significant proportion spend considerably less time in this type of accommodation, thus freeing up their place to new residents.

As at the ABS 2001 Census the number of residents in Residential Aged Care was approximately 75,000. While this as a percentage is less than 2.0% of those aged 55 and over, this proportion increases in the older age groups. Applying this current proportion of the population in Residential Aged Care to projections of the population some forecast of future demand for Residential Aged Care can be determined [(Chart 4) (ABS population projections 3222.0 series B projection)].

The total number of residents in Residential Aged Care is anticipated to rise as the proportion of elderly rises into this century. These projections have a total number of those in Residential Aged Care rising by an annual average of 3.5% to 4.5% over the next forty years. This rate of increase will start to taper off as the increase in ageing tapers off in the middle of the century.

However projecting demand for Residential Aged Care is further “muddied” by the impact of Federal Government policies. Demand for Residential Aged Care was reduced in the 1980’s by the introduction of HACC, which saw an increase in elderly remaining in their own home. If there were further significant changes in this type of assistance to the elderly this could notably impact on any forecast for Residential Aged Care places.

Chart 4 - Current and Projected Demand for Residential Aged Care



Source: ABS 2001 Census of Population and Housing, Population Projections 3222.0 (series B projection) & ABS 2048.0

Legislative Framework

Residential Aged Care is under the Commonwealth Aged Care Act 1997; this act has control over all Residential Aged Care facilities, their operators and the residents.

The act is designed to address the following.

- Provide funding for aged care both in residential care facilities and within the recipients own home.
- To provide diverse, flexible and responsive aged care services that facility choice.
- Protect the health and well being of residents in Residential Aged Care.
- To maintain the quality of care and accommodation for residents and recipients of aged care services.
- To facilitate access and equity to aged care services.

Approval/Assessment of Residents

As Residential Aged Care is funded by the Federal government, in order to be eligible a recipient must first be assessed as needing Residential Aged Care. This assessment is performed by an Aged Care Assessment Team (ACAT), which comprises health professionals who provide a thorough assessment of care requirements and then provide advice on possible options.

The assessment ensures that the person has medical, physical, social or physiological needs that can only be met by care and that these needs cannot be more appropriately met through community care.

The government subsidy is only available to those who have been approved as needing care (Residential/Community/Flexible) and the level of funding for residents is dependent on their relative care needs. Each resident is classified according to the RCS. Furthermore on entering a Residential Aged Care centre a resident is then assessed by the operator

Allocation of Places

Residential Aged Care is not a matter of “build it and they will come” an Approved Provider can only receive subsidies for providing Residential Aged Care in respect of places that have been allocated. The allocation of places is handled by the

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Federal government, and this allocation is firstly planned on a regional basis then on the types of subsidies (these subsidies account for special needs, respite and levels of care).

The aim is for 100 places (40 high level, 50 low level residential and 10 CACP) per 1000 of the population aged 70+.

The decision to allocate further places is made firstly by the Minister on a State basis, then by the Secretary on a regional basis. Following this decision the Secretary then invites applications to provide aged care services. The allocation can only be made to an Approved Provider.

There are conditions attached to all Allocated Places, these conditions may include.

- The proportion of concessional residents to be provided with care
- The proportion of respite care
- Preventing the discharge and readmission of a resident to facilitate the charging of an accommodation payment
- Where a Residential Aged Care centre relocates preventing discriminating against existing residents in the original centre

The allocation of places may involve specific conditions; these conditions include the location, the number of different places and the proportion of places that are for special needs groups.

Allocation also includes extra service places, which are places that have a higher level of food, accommodation, and services. Operators of centres with extra service places can charge higher fees from residents however lower levels of government subsidy are paid.

Approval of Operators

In order for an operator to have allocated places and to receive funding for Residential Aged Care the operator must be an approved provider. Operators (and their key personnel) are assessed on a range of criteria, including the following.

- Ability and experience
- Record of financial management
- Conduct as a provider
- General conduct

The approval is for one or more types of care (residential, community, flexible).

Accreditation of Residential Aged Care Facility

Not only must an operator be approved but also the business must be accredited in order to receive government funding (generally). This accreditation is handled by the Aged Care Standards and Accreditation Agency and is intended to ensure that the business is operating accordance with the Aged Care Act 1997 and that high quality care (with continuous improvement) is being provided.

The Accreditation Standards have four main areas.

- **Management Systems, Staffing and Organisational Development** - this includes: management systems compliance with regulations; education and staff development; complaints handling mechanism; appropriate levels of qualified staff, inventory levels; information systems; and the sourcing of external services.
- **Health and Personal Care** - this includes: the delivery of clinical care, specialised nursing care and other health services to residents; management of residents medication and pain control; quality of palliative care; appropriate levels of nutrition; the management of residents with continence and behavioural problems; quality of skin and dental care; and enabling residents to achieve natural sleep patterns.
- **Resident Lifestyle** - the standard focuses on maintaining a quality of life for residents including: the level of emotional support social interaction; privacy and dignity; cultural, spiritual and leisure activities; and security of tenure for residents.
- **Physical Environment and Safe Systems** - this includes occupational health and safety compliance; control of infection; ability to handle emergencies (fire); and catering, cleaning and laundry services.

Accreditation for a Residential Aged Care facility can be up to 4 years if the centre is performing exceptionally well, however if issues are noted then Accreditation is for a lesser period.

Certification of a Residential Aged Care Facility

With the introduction of the Aged Care Act a process of building improvement was introduced; this was designed to improve the physical standards of Residential Aged Care facilities. Only Residential Aged Care facilities that are certified can charge accommodation payments to residents.

To achieve certification a Residential Aged Care facility is inspected to determine whether it meets minimum standards relating to (fire) safety, hazards, privacy, access, heating/cooling, lighting/ventilation and security. Each of these components is awarded points out of a total; to pass a facility must achieve 60 out of a possible 100 points for the overall facility and 19 out of a possible 25 points for safety standards.

The introduction of certification involved a forward plan by which facilities were required to meet the requirements. This forward plan involved two main dates, 2003 - Structural Certification and 2008 - Privacy and Space Certification. The latter certification requirement is currently having the most impact on the Residential Aged Care industry. This requirement is for all existing facilities to achieve a maximum of 4 residents per room with points awarded for achieving an average of 2 - 3 residents per room across the facility. In addition there is the requirement for a maximum of 6 residents per toilet and 7 residents per shower.

These requirements become mandatory in 2008. For some older properties these certification requirements are significant, especially where the facility is on a site with little room to accommodate additional building.

How Residential Aged Care is Funded

The funding of Residential Aged Care is a combination of payments received from the Federal government plus amounts charged to residents. These amounts vary and their methods of calculation can be complex taking into account a number of factors.

Residential Care Subsidy

The residential care subsidy is a monthly payment made by the Federal government to approved operators and is determined by the number of residents within their care. The subsidy is based on the number of residents and their respective RSC levels. This subsidy is adjusted upward for Primary Supplements (concessional residents, respite residents, oxygen treatment, enteral feeding). The subsidy is adjusted downward for individual compensation entitlements (workers compensation, third party). A further downward adjustment is made for income testing of residents. Finally further supplements are added (pensioner supplement, viability supplement, for small rural centres). Division 43 and 44 of the Aged Care Act 1997 covers the method of payment and how to calculate the amount of the residential care subsidy. These rates are indexed and adjusted annually.

Residential Care (Capital) Grants

Some targeted capital funding is made available through the Residential Care (Capital) Grants programme to operators that are unable to meet the cost of necessary capital works. These grants meet the need for capital upgrading where the accommodation payments charged to residents and capital component of the residential Care Subsidy are insufficient. These grants are targeted to facilities with a majority of concessional/special needs residents and are available for land acquisition, building and purchase of capital items.

Fees

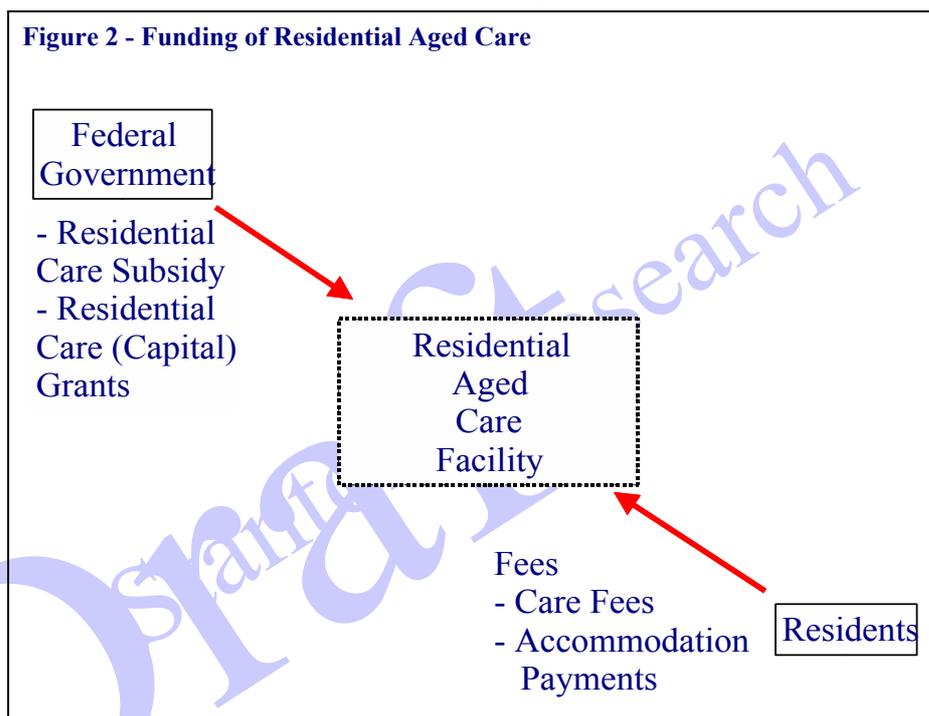
There are two main types of fees that may be charged to residents (by Accredited Providers), care fees and accommodation payments.

- **Daily Care Fees** - these are monthly payments that are a contribution toward the resident's daily living costs (nursing, care, meals, cleaning, lighting heating/cooling).

These fees are based on the following

- Basic daily care fee
- Plus any income tested amount and/or any compensation payment reduction
- Less any hardship supplements

Figure 2 - Funding of Residential Aged Care



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- Plus any additional fees for additional services (extra service place) agreed between the operator and resident (for a higher standard of accommodation, food and services but not any difference in the applicable level of care)
- Add any extra service amount and/or remote area allowance where applicable

The level of these fees is set under Division 58 and Subdivision 44E of the Aged Care Act 1997.

- **Accommodation Payments** - these are payments by a resident for entry into a Residential Aged Care centre. There are two types of payments.
 - Accommodation Charges - these are charged to residents entering high level Residential Aged Care (but not on an extra service place). It is determined on a daily basis, is means tested and is in addition to the daily care fees. The accommodation charge is payable while the resident is in care for residents arriving after 1 July 2004, but for earlier residents it is capped for a period of up to five years.
 - Accommodation Bonds - these are charged to residents entering low level Residential Aged Care (and are means tested) or an extra service place at either level of care. The amount is agreed to by the resident and operator and the operator is entitled to deduct an amount based on the duration of the stay (capped at 5 years), the remainder of the bond is refunded when the resident leaves the centre.

These payments may be made as a lump sum or as a regular periodic payment. Where residents have less than a benchmark level of assets these Accommodation Payments are not charged.

Accommodation payments (and the interest earned on them) may be used to meet the cost of capital work, retire debt and to improve the quality and range of Residential Aged Care in the centre. The holding of Accommodation Payments by an operator is governed by prudential requirements. These requirements are to ensure that the outstanding balance of any Accommodation Bond is paid within a reasonable time to any resident who leaves a centre.

All these conditions and regulations on Residential Aged Care can make the non-government funded sector of the industry appear more attractive (Supported Residential Services and Full Fee Home Services). However this is mitigated by the reality of the older people get, the less money they have remaining. In the words of one operator "by the time they are 80 the money has run out". This is a trend that can be anticipated to continue, as while the baby boomers have shown an interest in saving for an active retirement it remains to be seen whether there are as enthusiastic about economising in order to dribble in a nursing home.

While the conditions and regulations may be considered an added complexity to the industry the flip side of these conditions and regulations is that this is an industry where the underlying income is underpinned by the government (paid in advance on a monthly basis), which gives a layer of security to investors/operators.

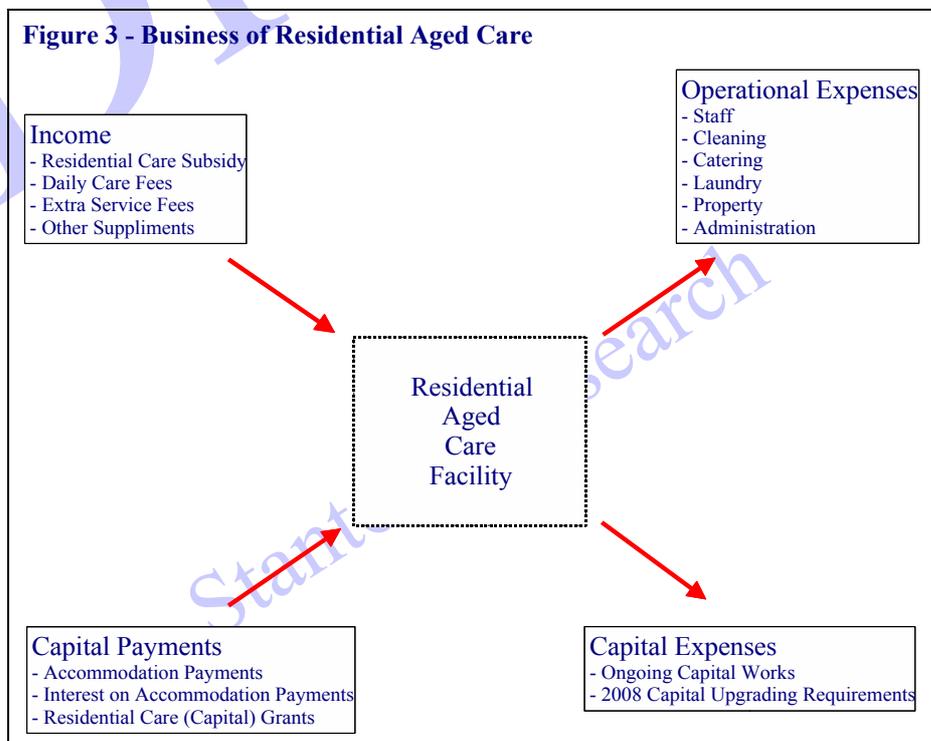
The Business of Aged Care

With any business activity that requires specialised premises it is difficult to separate the business component from the property component. Furthermore this is an industry where there is a notable line between operating income/expense factors and capital factors.

The sources of income for Residential Aged Care are government fees/subsidies and charges paid by residents. These are matched by operational expenses which include: staffing (averaging 66%, due to the labour intensive nature of the business plus the requirement for skilled nursing staff); cleaning; catering; laundry; and property costs (maintenance, rates, and utilities).

Staffing issues are anticipated to be a concern in the short to medium term, due to shortages of qualified nursing personnel. Many of the industries of the new millennium require staff with IT skills (a subject that is currently popular) or they require unskilled personnel with minimal training (students, and those retraining). Residential Aged Care however requires

Figure 3 - Business of Residential Aged Care



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staff with a particular set of skills that are only obtainable through intensive training/education; plus the general subject of nursing is currently not fashionable. Consequently the shortage of skilled staff is an issue that can be anticipated to continue.

The dominance of the industry by large numbers of smaller operators makes drawing conclusions from financial analysis difficult. The Review of Pricing Arrangements in Residential Aged Care by the Aged Care Price Review Taskforce reported significant variation in profitability across regions, types of operators and size of facility.

Average occupancy levels are reported at in excess of 96% however there is variance between regions. This high level of occupancy indicates the further need for more places, which requires capital funding.

The capital side of Residential Aged Care operations is an area that is receiving considerable focus. From an operator's perspective any requirement for capital outlays can be met by capital payments plus any profit from the operating side of the business. With the requirements for capital upgrading many operators require funding this difficultly would be compounded if they are also facing problematical profitability levels. Requirements for capital funding were assisted by a one off capital payment of \$3,500 per place to residential aged care operators of in 2003-04 by the Commonwealth government.

With the anticipation of consolidation within in the industry it is likely that a number of facilities will change ownership, therefore due diligence of any purchase will be in issue for the operators that are expanding. Many of the for-profit operators anticipate achieving efficiency gains with any new purchase and consider how any purchase would mesh into a larger portfolio. Another notable factor is the issue of accrued accommodation payments, while these can be paid monthly many are paid as a lump sum and the operators have access to the accrued interest on these payments. Any due diligence process needs to consider these capital sums and what proportion can be utilised by the incoming purchaser.

Types of Operators

There are three main types of groups operating Residential Aged Care centres.

- For-Profit - these include a range of operators ranging from those with one small facility to listed companies with operations in a number of states. Two subgroups within the for-profit sector are actively expanding.
 - Health Care companies (Moran Health Care, DCA/Amity Group, Ramsay Health)
 - Retirement Village companies (Primelife, Australian Retirement Homes)

The rise of these two subgroups mirrors development in North America as the largest provider organisations in that market are integrated groups (accommodation/medical focus). These groups are able to achieve economies of scale and synergies within the different divisions of the organisation.

- Not For Profit - these include the established charities and community/ethnic based organisations
- Government - State and Local

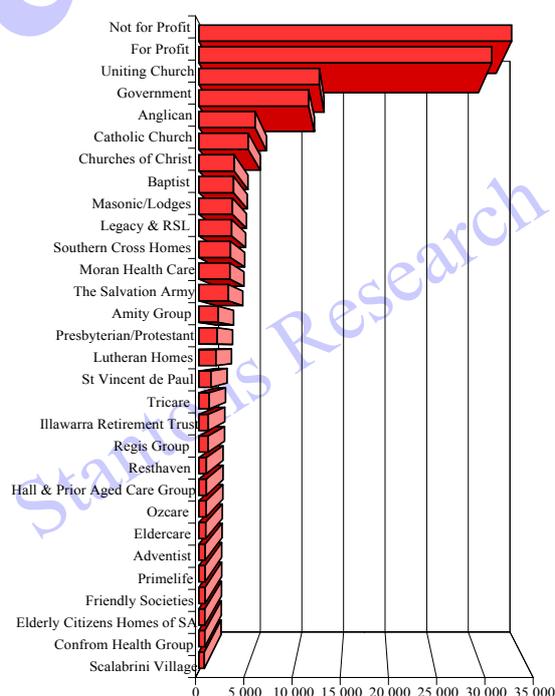
The industry is dominated by smaller operators; in a recent study of Residential Aged Care centres throughout Australia the largest group of operators was those operating less than five centres. While the smaller not for profit operators represent the largest group with 22.3% of the market, they are closely followed by the smaller for profit operators with 21.3% of the market. The government (state and local) was the next largest composite group with 7.8% of the market. Furthermore this structure is duplicated within all the states.

The largest operator groups were in the not for profit sector, lead by the Uniting Church (8.6%), Anglican Church (and Anglicare) (4.0%), the Catholic Church (3.5%), Churches of Christ (2.5%) and the Baptist Church (2.5%).

Of the for profit operators the largest group was the Moran Health Care with 2.2% of the market.

Across Australia, centres have on average 51 places (both levels of care), however few generalisations can be made regarding size of centre and type of operator. The individual not for profit operators have a smaller than average size of centre while some of the larger not for profit and the for profit operators have a larger than average size.

Chart 5 - "Top 30" Operators of Aged Care Centres in Australia (by number of places)



Source: Department of Health and Ageing & Stantons Research

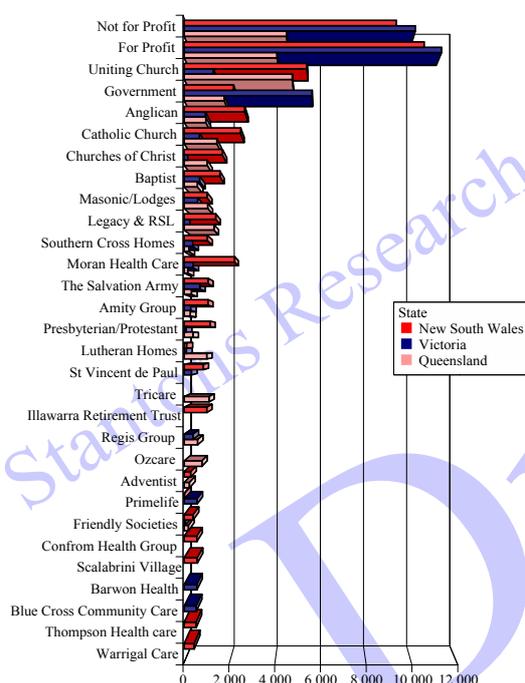
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The states present a similar ranking of operators and number of places with the composite groups comprising the bulk of the market.

Each mainland state has a locally based operator that has a significant holding in that state alone. In New South Wales this includes the Illawarra Retirement Trust, Conform Health Care, Scalabrini Village and Warrigal Care; in Victoria, Barwon Health and Blue Cross Community Care, in Queensland, Ozcare and Tricare; in Western Australia, Hall & Prior Aged Care Group, Brightwater Care Group, Aegis Aged Care Group and the Silver Chain Nursing Association; and in South Australia, Resthaven, Elderly Citizens Homes of SA and Helping Hand Aged Care. What this local focus does indicate is that many operators develop their strength in a local market (often in conjunction with Retirement Villages) and extend from this base into neighbouring regions, rather than interstate.

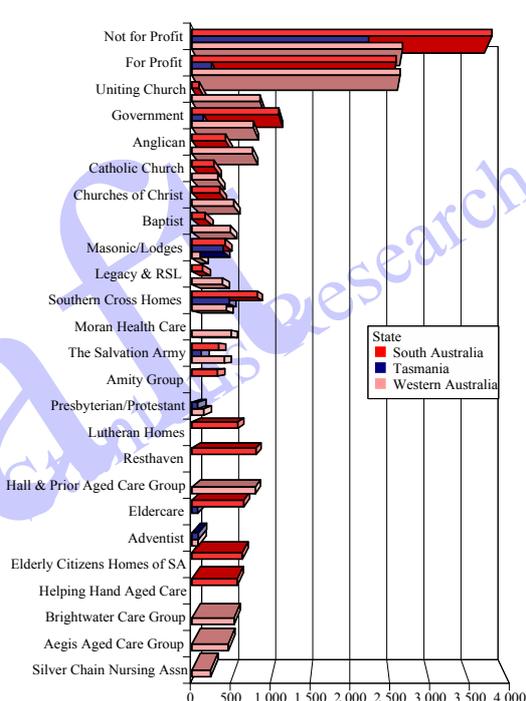
A further state focus was noted, with Moran Health Care having its main base in New South Wales plus some other operations in the other more populous states.

Chart 6 - “Top 30” Operators of Aged Care Centres in New South Wales, Victoria & Queensland (by number of places)



Source: Department of Health and Ageing & Stantons Research

Chart 7 - “Top 26” Operators of Aged Care Centres in Tasmania, South Australia & Western Australia (by number of places)



Source: Department of Health and Ageing & Stantons Research

In contrast the Territories, ACT and the Northern Territory, present a different structure due to their smaller population and individual demographic. Neither the ACT nor the Northern Territory had any government operated centres and while the ACT had 2 for profit centres the Northern Territory had no centres managed by this type of operator.

Industry Dynamics

The industry is currently in a dynamic position with further expansion, consolidation and amalgamations anticipated. The main factors encompass the following issues.

- The ageing demographic is driving demand for more places; this is facilitating expansion by existing operators and encouraging new operators to enter into the industry.
- The industry is currently dominated by the smaller operators with (those with < 5 facilities); many of these operators reportedly have low profitability levels. This is an industry where efficiency gains can be made.
- Economies of scale of operations can be achieved by all types of operators. These economies include amalgamation of administration, sales, human resources and purchases divisions. However a significant factor is the ability to share applications for a place between different facilities. Due to high occupancy levels in some areas those wishing to place a relative in Residential Aged Care must put them on a waitlist with a number of different operators. Where an operator has a number of different facilities they are able to offer the first available place.

The two main for-profit sub groups are able to achieve further economies of scale depending on their business focus.

- Health Care companies; these are able to share specialised equipment and facilities many of which may have significant capital cost; furthermore there is the ability to share specialised personnel.
- Retirement Village companies; there is the ability to achieve vertical integration, with residents moving from a retirement village to a Residential Aged Care facility often within the same complex.

Economies of scale and synergies across operations can also be achieved with regard to capital payments and expenses, especially where high level care places are supplied.

- Government regulation requires many existing premises to be upgraded; the operators of these premises may not have access to capital funding for this upgrade. These operators may be seeking to sell their facility or enter into joint venture agreements with some to the expanding/new operators.

Some of these premises that require upgrading may not have sufficient room on their site for further expansion; these facilities can be expected to sell for redevelopment, especially in localities which have experienced rising property prices.

- The government regulations (which can be anticipated to be ongoing) have increased the construction costs of new facilities; operators looking to enter the market or those looking to expand need to have access to capital funding to construct these new facilities.
- Larger operators especially those listed or with access to the listed market are better able to access funding that has more advantageous terms when compared to smaller operators with one or a few facilities.

An example of this funding arrangement has been the purchase of the Salvation Army portfolio. This involved the newly formed Retirement Care Australia acquiring a number of facilities from the Salvation Army. These facilities will be managed by TriCare, a private for-profit operator. Macquarie Bank has acted as financier to the arrangement. This arrangement involves each party bringing to the table the skills that they have the most expertise in.

- The government regulation places complexity on the industry; however the associated funding/subsidies results in an asset class where incomes are underpinned by the government. This is highly attractive especially to the listed property trust sector as it is looking for assets that can pay a regular income return. While many property investors are more used to assets with lesser levels of regulation much of the thrust of the funding framework for Residential Aged Care has been planned to attract ongoing investment and development within the sector.
- With smaller/older facilities closing and the need for further places considerable development can be anticipated. This development will occur not only on Greenfield sites but incorporate the redevelopment of existing properties. For example those in established localities that have close proximity to hospitals. Furthermore in the more populous localities this development can be anticipated to be high rise in order to obtain a better return on the site cost.

All these factors can be anticipated to result in an industry which is dominated by larger for-profit operators, with this group being responsible for the greater number of new places in recent years. Furthermore this will reflect the US situation where the industry is dominated by the large for-profit operators. In the US the 10 largest seniors housing owners are all for-profit operators (Seniors Housing Statistical Digest). In addition the 1990's saw significant growth in the numbers of listed owner/operator companies growing from 2 to over 12 by the end of the decade. A major entrant into the US seniors housing market over recent decades has been the Health Care operators as many of these operators saw operational efficiencies in expanding their activities.

Conclusion

The Residential Aged Care industry is very much in a maturation stage and is facing an interesting dynamic, while the demographics are driving the anticipated increase in size of this sector, the main threats arise from within the industry including an increased variety of home and community based care. While the complexity of government regulation can be regarded as difficulty faced by operators, it does place a barrier to entry to the industry therefore inappropriate speculative overbuilding (the bane of many other expanding sectors) is considered less likely.