Residential Aged Care policy in Australia – are we learning from evidence?

Introduction

Over the next decade, the predicted expansion in the Australian population aged older than 70 years will substantially increase demand for aged care in Australia and require decisions by the Australian Government on the nature and structure of the aged care industry. The Australian Government subsidises care for older people needing high and low levels of residential care (formerly called nursing homes and hostels) and for those still living at home; and these services are complementary. While the proportion of those aged over 70 years in residential aged care decreased by about 10% between 1999 and 2012 the number of older people living in residential care increased substantially over this period (Betts 2014, p. 30). This percentage decline may be a factor of improved morbidity and disability in older people over time (Betts 2014, p. 29) and/or an increase in the number of home based care services over the past decade (Australian Government Department of Social Services 2013a). This reduction in demand is reflected in successive predictions of the impact of ageing on health and aged care costs (Australian Treasury 2003, 2007, 2010). Despite the proportional use of residential care, the expanding number of people over the age of 70 will continue to increase demand for residential aged care. For Australia to meet the anticipated demand, provider organisations will need to make substantial investments, the Australian Government will need to increase expenditure and consumers can expect to make higher proportional contributions for their care. However, changes to the current policy parameters may alter the proportion of these respective financial contributions.

The Australian Government's expenditure on aged care in 2012/13 was $13.3 billion of which $9.2 was spent on residential aged care (Australian Government Department of Social Services 2013b). The Productivity Commission (2011) predicted the need for an additional 105,000 beds over 15 years to 2027. At approximately $250,000 to construct a new residential aged care bed in 2013 (Stewart Brown 2013) this predicted expansion will require an investment of about $26 billion across

Australia over this period (Gates & Grayson 2012). The Aged Care Financing Authority (2013, p. 10) has separately reported that 74,000 new residential aged care beds will be needed by 2013 at a cost of $25 billion. In addition to the replacements of existing beds, one new 140 bed residential aged care facility will need to open somewhere in Australia every week for the next ten years to achieve this growth, which is approximately twice that of the past decade. This growth will most likely result in changes to the structure of the industry, such as the distribution, size and ownership of services.

Aged care has been subsidised by Australian governments since the 1960s and over this period there have been numerous incremental legislative and regulatory changes some of which reversed previous policy (Cullen 2003; Le Guen 1993). The current regulatory and quality system has in origins in the reforms introduced in the 1980s, which were intended to control government spending, reduce the then relative oversupply of aged care beds compared with other countries at the time and monitor quality (Cullen 2003; Fine 2007). These reforms introduced planned control over the supply of funded beds based on geographical distribution and mandated minimum standards of care as a condition of funding. The most recent package of policy changes commenced in 2013 with the passage of legislation to enact the reforms outlined in *Living Longer. Living Better* announcement of the previous government (Australian Government Department of Social Services 2014a, 2014b) and is expected to continue to be incrementally introduced until 2015/16. These reforms were introduced as part of the Government's response to the findings of the Productivity Commission's inquiry into the industry (Productivity Commission 2011). Both the Productivity Commission's report and the Government's reforms focused on the issues of capital investment, industry sustainability, competition and consumer choice. Neither the Productivity Commission's report nor the Government's response made more than a passing reference to what the industry will look like in the future. What is missing in the public debate is the potential impact that the current and proposed reforms will have on structural factors such as ownership, size and location of services and the effect these structural changes will have on resident outcomes over the long term. This lack of public debate is of interest given the often unfavourable experiences from other countries where there has been similar structural change in the provision of social services (Meagher & Cortis 2009).

This paper examines the evidence on current industry trends with the aim to stimulate wider debate on government policy that is changing the residential aged care sector in Australia. A review of the research literature on the relationship between structural factors and performance (financial performance, regulatory compliance and efficiency) and quality outcomes for aged care residents is reported. The paper then examines trends in the structure of the residential aged care industry over the past 10 years. The paper concludes with a recommendation for more evidence-based decision making.

BACKGROUND

The Aged Care Act 1997 and it Regulations empowers the Minister to control both prices charged by providers and the number of funded beds. The regulations establish the maximum amount providers can charge residents for care (except for some classes of beds) and accommodation (Australian Government Departmernt of Social Services 2014). The legislation restricts government funding to 'approved places' (beds or community care places), restricts the allocation of 'approved places' to 'approved providers' (licensees) and 'approves' the sale of approved places between providers (Australian Government Department of Health and Ageing 2012a). Before allocating new places to approved providers (at no cost to providers), the Department follows an annual planning process. This process estimates the number of new places to be allocated to each planning region, based on the number of persons in that region over the aged of 70 years, and recognises special needs groups in some locations (Australian Government Department of Social Services 2013b). Following the advertising of the new allocations, the Department invites approved providers to bid for the newly available 'approved places' (beds). The Australian Government's allocation policy is focused almost solely on location and it is silent on other structural factors that may influence the access to and the quality of residential care services.

In 2010 the Australian Government requested that the Productivity Commission (inter alia)

> *'systematically examine the social, clinical and institutional aspects of aged care in Australia … develop regulatory and funding options for residential and community aged care … [and] recommend a path for transitioning from the current regulatory arrangements to a new system' (Productivity Commission 2011, p. vii).*

In its report to the Government the Commission found that the aged care system was difficult to navigate, services and choice were limited, quality and coverage of needs were variable, pricing, subsidies and user co-contributions were inconsistent or inequitable (Productivity Commission 2011, p. xxii). In addition to the Commission's findings, a number of recent industry reports have suggested that the aged care system was not sustainable in the long term under the structural and financial parameters in place prior to the introduction of reforms in 2013 and 2014 (Deloitte Access Economics 2011; Grant Thornton 2011). The Commission made a number of recommendations that included, (inter alia), phasing out the current limits on the number of residential beds a provider can provide by removing the government's control on supply (Productivity Commission 2011, p. xxii). However, there was no recommendation made on the preferred future structural features of the residential aged care sector in relation to the size of facilities or type of providers that should emerge from this liberalisation of the controls on supply.

The Australian Government has continued to implement the reforms commenced by the former Government; for example, major changes to the financial contributions consumers make for residential aged care commended on 1 July 2014. While these policy reforms have adopted a number of the Productivity Commission's recommendations, neither the former nor the current Government have, as yet, announced any relaxation of the control on supply of residential aged care beds. However, the current Government has foreshadowed a continuing pathway towards a more market based approach to the distribution of residential aged care services (Fifield 2014).

As discussed below, the structural factors of interest reported in the international research literature include the size of facilities, the size of the organisation providing aged care services and the type of provider (for-profit, not-for-profit or government). This interest in structure is consistent with

Donabedian's (1966) conceptual model of the relationship between structure (and other inputs), process and outcomes in relation to quality in health care. This framework articulates the relationship between structural factors (such as funding, size and ownership) with processes factors (such as systems of care) and the outcomes for consumers (Donabedian 1966, 1988, 2005) and is widely used when investigating health and aged care system operations and outcomes (Asmus-Szepesi et al. 2011; Comondore et al. 2009; Fancott et al. 2010; Massoud et al. 2001; Peacock et al. 2001; World Health Organisation 2007).

The impact of different types of ownership of aged care services has been the subject of a robust and growing research literature for over two decades (Davis 1991; Pearson et al. 1993) and is focused mostly on the difference between the performance and outcomes for residents of for-profit and not-for-profit facilities (Castle & Engberg 2007; Comondore et al. 2009; Harrington 2007; Harrington, Hauser, et al. 2011; Hillmer et al. 2005; Spector & Takada 1991). While this evidence is dominated by studies from the USA, research of a similar nature has been published from Australia (Baldwin et al. 2014; Ellis & Howe 2010; Martin 2005; Pearson et al. 1993), Canada (McGregor et al. 2006), England (Gage et al. 2009), Israel (Clarfield et al. 2009) and Italy (Garavaglia et al. 2011). The general message from the literature from both Australia and overseas is that there are examples of excellent and poor aged care service providers to be found in the for-profit, not-for-profit and government sectors and that most providers in all sectors meet minimum quality standards. Although the findings are not universal, and there are limitations in methods across the research, there have been continuing and consistent findings to suggest that residents in not-for-profit facilities have better outcomes than those in for-profit facilities. The evidence on indicators of financial performance tends to favour the for-profit sector.

To a lesser extent, independent researchers have also examined the impact of facility size and organisation size on performance and resident outcomes (Amirkhanyan, Kim & Lambright 2008; Garavaglia et al. 2011; Sojourner et al. 2012; Zinn et al. 2009). Facilities with fewer than 100 beds tend to produce more favourable resident outcomes, than larger facilities (Amirkhanyan, Kim & Lambright 2008; Ellis & Howe 2010; McGregor et al. 2006; Pearson et al. 1993; Riportella-Muller &

Slesinger 1982), although there is variation in the research findings reported (Bravo et al. 1999; Li et al. 1996). The relationship between the size of provider organisations with service quality and performance has been studied primarily in the USA, where a number of large providers failed regulatory compliance during the last two decades. These studies found that homes owned by the largest aged care providers (those with 10,000 beds or more) tended to attract a higher rate of quality regulation violations per home and these violations tended to be more serious than those of smaller organisations. Secondly, homes owned by private equity organisations were more likely to have regulatory violations when compared with other ownership types (Harrington, Olney, et al. 2011). Larger organisations have also been found to focus on profit maximisation, rather than on quality outcomes, and to provide lower nursing staff to resident ratios than do smaller providers (Banaszak-Holl et al. 2002; Harrington, Hauser, et al. 2011; Kitchener et al. 2008). While there are limitations to the application of research findings from one country to another, these findings may be relevant for Australia as past policy setting have allowed for the emergence and growth of large aged care providers.

OBJECTIVES OF THIS RESEARCH

The purpose of this paper is to encourage discussion on the issue of the changing shape of the residential aged care industry in Australia and the policy parameters that drive these changes. It aims to inform the debate by identifying the trends in the structural features of the residential aged care sector in Australia and compare these trends with evidence from the international literature.

METHOD

Each year, at 30 June, the Australian Government's Department of Health and Ageing undertakes a census of aged care services. The census includes data on a number of structural features of funded residential and community aged care services. We merged and analysed the data from ten separate census files obtained from the Department, one for each year, between 2002-03 and 2011-12. Consistent with the international literature described above, three organisational classes were used to define providers – not-for-profit, government and for-profit. The census data revealed there are three

not-for-profit organisational types (charitable, religious and community based), two government organisational types (local and state), and three for-profit organisational types (private incorporated, private non-incorporated and publicly listed). The Australian Government Department of Health and Ageing allocates these organisational types in the original data.

Prior to analysis the data required considerable cleaning to remove duplicates, fill gaps, ensure consistency in the naming of services and providers across years, and to ensure services owned by the same organisation were correctly coded. Consequently, a unique data base was created whereby the totals of aged care beds and providers reported in Table 1 will vary in some respects from results published by others (Aged Care Financing Authority 2014). Details of the protocols followed in the cleaning process are available from the principal author. Following data cleaning, codes were created for 'service name', 'approved provider', 'care type', 'organisation type' and 'remoteness'. Analyses were undertaken with the statistical package SPSS (IBM 2013).

FINDINGS

Table 1 summarises the major changes across the Australian aged care industry between 2003 and 2012. Over this period there was a 27% increase in the number of operational residential aged care beds across Australia. Although the number of beds has increased substantially, the number of services has decreased from 2885 in 2003 to 2865 (<1%) in 2012. (A *service* is the aged care home funded by the Department under the Act; one provider may operate more than one service.) There have also been changes in the distribution of beds between ownership classes. In 2003 not-for-profit providers operated 62% of all services, state and local governments 12% and for-profit providers 26%. By 2012 the proportion of not-for-profit providers had declined to 60% and government services to 10%, but for-profit providers had increased to 30%.

INSERT TABLE 1 HERE

This pattern varies when examined by organisational types. In 2003 services operated by religious organisations were more numerous than other types but by 2012 the number of services operated by private incorporated bodies was highest. Over the period under review there was a 20% decline in the number of services operated by religious organisations, a seven per cent decline in those operated by community based services but a 12% increase in the number of services operated by charitable entities. There was a 40% decline in local government operated services and a 12% decline in the number of services operated by state government bodies. These changes are balanced by a 12% increase in the number of services operated by charitable organisation.

Despite the decline in the number of services operated by charitable, community-based and religious organisations there has been an increase of 48%, 28% and 3% respectively in the number of beds they operate. The number of beds provided by private incorporated organisations has increased by 40% and by publicly listed companies by 1,788%, albeit from a small base. (While beds operated by publicly listed companies remain only a small percentage of all beds they are included separately in this analysis as they are the fastest growing ownership type and the majority of this growth occurred in the three years to 2012). Conversely, beds provided by local government providers declined by 33% and by state governments by 7%.

As a consequence of the growth in residential aged care beds and a decline in the number of services the mean size of residential aged care services in Australia has increased by 27.6% over the ten years to 2012. This growth varies across organisational types, size categories and locations. Services operated by state and local governments have been the smallest and second smallest services consistently over the ten year period and remain markedly smaller, on average, than those operated by for-profit or not-for-profit providers in 2012. Charitable, community-based, religious and private incorporated bodies all increased in average size by more than the mean for the whole of the residential aged care industry.

The number of services with fewer than 60 beds has declined since 2003 and the number of services with more than 60 beds has increased. The size category of 21 to 40 beds shows the steepest

decline and the size category of over 100 beds the steepest increase. Private incorporated bodies and publicly listed companies operate the largest and second largest services on average in 2012. The average size of residential aged care services increased in all locations during the period under review, except for services in very remote locations, which had a 38% decline in the mean size of services. By contrast, there was an increase of 34% in the average size of services in major cities. There appears to be a close relationship between percentage change in size and location category as illustrated in Figure 1.

INSERT FIGURE 1 HERE

Also of interest is the location of services provided by organisational types. As Figure 2 illustrates there has been a decline in the number of services operated by not-for-profit organisations in major cities and in inner and outer regional locations. Only major cities experienced an increase in the number of services provided by for-profit organisations. In 2012 for-profit providers were virtually absent from remote and very remote locations and provide fewer services than both not-for-profits and government providers in regional locations.

INSERT FIGURE 2 HERE

The ten largest providers of both residential and community aged care services in Australia are listed in Table 2. The Victorian Department of Health is the owner of the largest number of aged care beds in Australia (although the services are operated by local health authorities). Next in size are the Uniting Care NSW and Uniting Care Queensland. Five (50%) of the largest providers are for-profit. If all the providers affiliated with the Catholic Church were to be combined as one organisation it would be, by far, the largest provider in Australia; however, these providers operate as separate organisations. None of these single providers exceeds 10,000 places.

INSERT TABLE 2 HERE

DISCUSSION

Analyses of the census data reveals a 27%, increase in the number of residential aged care beds in Australia over the past ten years despite a slight fall in the proportion of older Australians living in residential care (Betts 2014). These 40,000 new beds represented a substantial investment by both the for-profit and not-for-profit sectors. This steady growth may be attributed to the application of the bed allocation formula used by the Department, described above, which assumes that the population age profile of a planning region largely drives demand. As the Australian Government has maintained its control on the number of approved aged care bed and used the planning formula to fuel growth in the industry (Australian Government Department of Health and Ageing 2012b) the current structure of the industry can be attributed to government policy and actions. In addition, the Government's projected growth increase could be expected to continue the current trends in growth and the shape of the sector over the short to medium term.

The sector remains dominated by not-for-profit providers of aged care beds, however, there are changes occurring in the mix of aged care providers with the steady increase in the percentage of services and the number of beds operated by for-profit organisations. There is also growth in the average size of facilities. These patterns of provision also differ significantly by location. Trends in rural and remote locations are the opposite of trends in the major cities. The number of government owned services are declining in most locations but increasing in remote locations and the average size of services in large cities is increasing while it is declining in remote locations.

Given these trends, older people living in major cities may see a reduction in their capacity to choose between provider types as, if current trends continue, for-profit providers become the dominant provider of care in major cities. In addition, the increase in the average size of services in major cities will result in a reduction in the number of small services from which consumers can choose. The establishment of larger, better-resourced for-profit services may result in high quality of care but could also result in a reduction in the quality of life for those residents who would prefer a

smaller, more intimate, not-for-profit service. It is beyond the scope of this paper to explore in any depth the consequences for the quality of care and quality of life that will result from these trends but this remains an important area for study and community discussion.

Aged consumers outside of major cities will continue to have very limited choice if they want to choose a for-profit provider and those living in remote/very remote locations will be increasingly dependent on state government service providers. The size of services in remote locations is trending downwards and these small services may struggle in the future to maintain financial viability without additional government funding. Should these trends continue we may see the emergence of a two tiered system in Australian aged care based on economic and geographical factors, whereby there is one sector operating in major cities and inner regional locations and a different sector operating in outer regional and remote locations. In fact the current Assistant Minister for Social Services, the Hon Mitch Fifield, has suggested that the system for aged care in rural and remote areas in the future may be different from the market-based system that will emerge from current reforms and operate in the rest of Australia (Fifield 2014). These comments were made while clarifying the Government's intention to continue to pursue a more market based approach to the administration of the residential aged care sector, however, he made no mention of the policy implications of a two tiered system for aged care in Australia,

Recent government commissioned Australian reports have questioned the financial viability of small aged care services, particularly those in remote locations (Hogan 2004; Productivity Commission 2011). Hogan also made some observations about the relative efficiency of not-for-profit providers (2004, p. 74). Therefore it is, interesting, that having made these observations, neither Hogan nor the Commission made recommendations for the preferred mix of ownership type, the size of services, or the size of provider organisations. In addition, despite the substantial international literature, neither report addressed the issue of service quality in relation to structural variables other than the capacity of most services to meet minimum standards. Recent industry-funded benchmark research and other investigative reports (Ansell, Dovey & Vu 2012; Stewart Brown 2013) suggest that some residential aged care services may be too small to be financially viable and recommend facilities

have more than 60 beds to maximise profits and viability. A 60 bed facility is currently above the average size of Australian residential aged care services in all locations (Ansell, Dovey & Vu 2012; Stewart Brown 2013). None of these reports address the impact on quality of care or quality of life arising from an increase in the size of services.

The short review of the international literature summarised above suggests that there are differences in outcomes for residents between services operated by not-for-profit and for-profit providers (not-for-profit providers deliver higher quality of care) and services of different sizes (smaller services produce better quality). The extent to which these findings apply in Australia is unclear, since there has been little similar research in Australia. The evidence suggests that for-profit residential aged care services have a lower nurse to resident staffing ratio than not-for-profit services (Martin 2005) and this is consistent with international evidence (Castle & Engberg 2007). There is also evidence to suggest for-profit services are more at risk of failing to achieve minimum standards in Australia (Baldwin et al. 2014; Ellis & Howe 2010), which is also consistent with overseas findings (Comondore et al. 2009). Australia has a different structural patter to other countries, which may limit comparability. It also lacks a national database of quality indicators, which could be used to monitor changes in outcomes related to changes in structure. In view of the limited available evidence in Australia, policies that will significantly change the structure of the aged care industry should be approached with caution least a different structure, which may be difficult to reverse, results in less desirable outcomes.

Recent industry funded private sector consultancy reports (Deloitte Access Economics 2011; KPMG 2013) suggest that the for-profit sector is better placed than the not-for-profit sector to take advantage of the expansion of the industry and the recently introduced reforms. This proposition reflects the perception that for-profit providers are more focused on their business objective and exhibit a greater level of comfort with debt, compared with the not-for-profit sector. These factors result in the for-profit provider's easier access to capital to fund expansion. Based on this economic advantage, it is reasonable to anticipate that the number of beds and services operated by for-profit providers will continue existing trends and grow substantially over the next ten years, and faster than

the not-for-profit sector. This growth may result in for-profit providers becoming the largest type of residential aged care provider. Should for-profit providers dominate the industry in the future this would mirror the experience of the industry in comparable countries. For example, in the USA, during the last few decades of the twentieth century there was a shift from predominately not-for-profit to predominately for-profit provision of aged care (Kaffenberger 2000). In New Zealand the percentage of services operated by for-profit providers increased from 65% to 76% between 2005 and 2009 (Grant Thornton 2010), in Ireland the beds operated by for-profit providers increased from 22% in 1998 to 69% in 2013 (Hickey 2014) and in the United Kingdom between 1980 and 2005 the proportion of beds in the for-profit sector rose from 18% to 90% (Johnson, Rolph & Smith 2010). It seems reasonable to expect that if government policy articulated similar expected changes in Australia it would spark community debate.

A reason why Australia has not followed the trends in the pattern of ownership seen in other comparable countries may be a result of the continuing tight government control over the supply of beds. This system of control on supply appears to have three principal objectives: to maintain control on the growth in government financial outlays on aged care; to prevent oversupply (as occurred in the 1980s); and to achieve an equitable distribution of services geographically across Australia. The third objective has effectively been achieved (Australian Government Department of Social Services 2013b) and the expansion of community aged care services may have lessened the need for control on oversupply by reducing some of the demand for residential care. However, while the Australian Governments' policy has strictly controlled the type, number and location of newly allocated beds (Australian Government Department of Health and Ageing 2013) it appears to be indifferent to other structural factors. These factors are the size of organisations to which allocations are made, the size of the facility that is likely to result from the allocation and the profit status of the approved providers to whom the places are allocated.

The question, therefore, arises as to whether the Government has intended that the structural changes evident in current trends will emerge, given that it has control on supply. Neither the previous, nor the current, Australian Government has indicated a preference on the future mix of

service providers, the growth of large providers, or the size of facilities. This suggests that policy makers, even in the light of the available evidence, have enabled these trends to continue through their silence, or are at least comfortable with the direction in which the industry is headed.

Policy makers will argue that the Government is purchasing services from approved providers and that they are indifferent to the size of a service, or the type or size of provider, as long as the services provided meet minimum standards (Australian Government Department of Health and Ageing 2012a). This position appears to accept the proposition that the 'market place' will determine the mix of providers (Meagher & Cortis 2009). However, this position is questionable while the Government retains control over supply and, consequently, severely limits the capacity of a market to emerge. While the Government controls supply it seems reasonable to argue that the shape of the industry is a result of its policies.

The question also emerges as to the role of not-for-profit aged care providers. Government subsidies are the same for both for-profit and not-for-profit providers, but successive governments provide not-for-profit providers with favourable treatment in relation to taxation and other benefits. This suggests that the intention of this policy is that not-for-profit providers have a different role to for-profit providers; such as covering gaps in service delivery arising from market failure. For this reason, it seems reasonable to expect that the Australian Government will be able to articulate a vision for the relative mix and distribution of for-profit and not-for- profit aged care providers.

Currently, Australian based evidence to guide decisions on the shape the aged care industry is minimal and the inevitable differences between countries limits the extent to which Australia should rely solely on the research evidence from other countries. While the Australian Government cannot avoid making funding and allocation decisions, these decisions should be based on the best available evidence and where that is not available, the Government should pursue policies that will generate the evidence needed for informed policy making. What the analysis of the structural trends of Australia's aged care industry has shown is that there are clear trends in the structure of the industry and these trends are under the control of the Australian Government. While maintaining this control successive

Australian governments have remaining silent on their preferences for the future shape of the industry and there had been little community debate on what is preferred. There is clearly a need to obtain more evidence on the impact structural change will have on the quality of care and the performance of the industry. There is also a clear need for wider community debate on the future shape of the residential aged care industry in Australia.

Limitations of this research and notes on the data

The Australian Government Department of Health and Ageing originally collected and assembled the data accessed for this review and the authors have not validated their accuracy and reliability. A conservative approach was taken to the data cleaning procedures which removed identified duplications and errors in the original data entry and this approach may have resulted in more services and providers in the final data set than actually exists.

Conclusions

Over the ten years to 2012 the residential aged care industry in Australia has shown steady growth but also signs of a modest trend towards consolidation, evidenced by the reduction in the number of service providers and the increase in the average size of facilities. The result is fewer, but larger, services in major cities and smaller, often government-operated services in outer regional and remote locations. Continuation of these trends may result in a two-tiered system of residential aged care in Australia in the future with non-urban consumers offered a different system of care to those in major cities and inner regional areas. There has also been increased proportional provision of residential aged care beds by for-profit providers and this trend is likely to continue and may result in the for-profit sector dominating provision of care, at least in some segments of the market. The Australian Government has maintained a tight control over the supply of aged care beds over recent decades, leading to the conclusion that it is either comfortable with the current trends in the aged care industry, responsible for them, or disinterested in them. However, the international evidence on the structural factors that are most likely to lead to a residential aged care industry that provides efficient services and high quality care does not fully support these trends. A prudent future approach should be to

develop a more transparent and informed policy, introduce the routine collection of data on outcomes to inform policy and actively foster research into the structural feature that are most likely to achieve desired quality of care and outcomes for Australian residential aged care consumers.

Figure 1 Percentage changes in mean size of residential aged care services by location; Australia 2003-2012

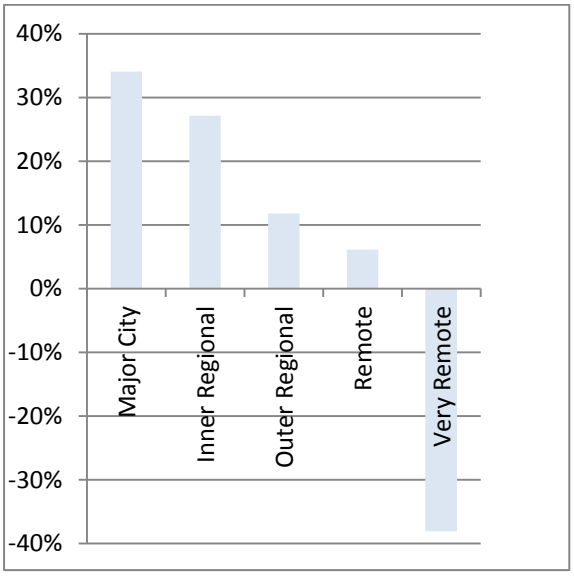

Figure 2 Number of services by organisational type and location; Australia 2003 and 2012

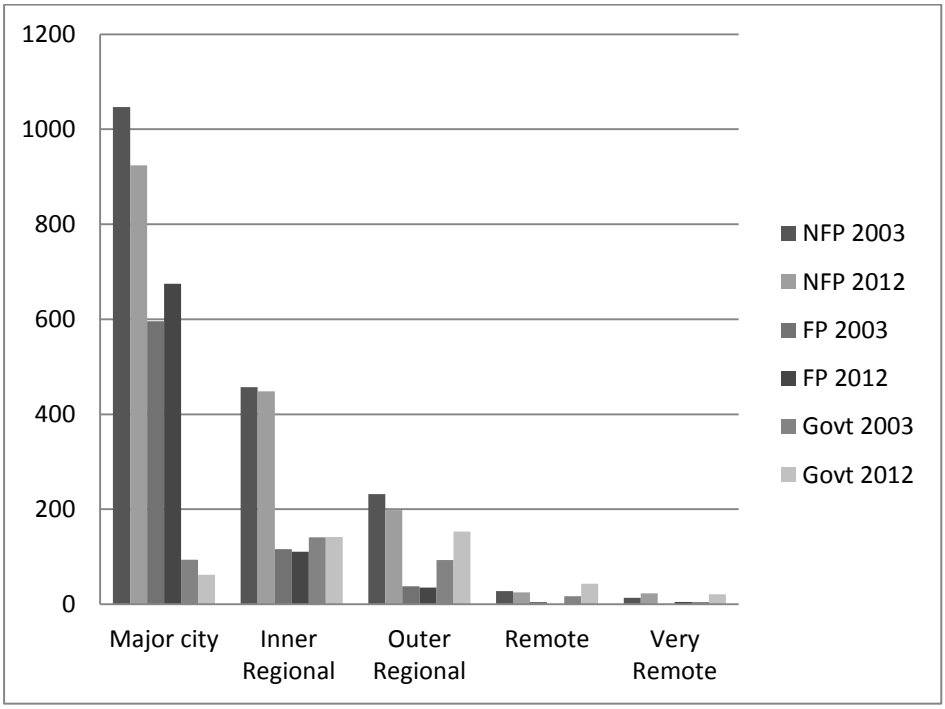

Table 1 Residential aged care beds, services and average size: Australia 2003-12

	2003		2012		% Change 2003-12
	No.	%	No.	%	
Number of residential aged care beds					
High care places	73,920		93,424		26%
Low care places	74,267		94,350		27%
Charitable	21,888		32,370		48%
Community based	19,632		25,230		29%
Religious	48,812		50,316		3%
Total not-for-profit	**90,332**	**61%**	**107,916**	**57%**	19%
Local government	2,816		1,888		-33%
State government	9,646		8,934		-7%
Total government	**12,462**	**8%**	**10,822**	**7%**	-13%
Private Incorporated and non-incorporated	45,250		63,518		40%
Publicly Listed Company	145		2,737		1,788%
Total-for-profit	**45,395**	**31**	**66,255**	**36%**	46%
Total residential aged care places	148,187	100%	187,774	100%	27%
Number of residential aged care services					
Charitable	404		454		12%
Community based	470		437		-7%
Religious	903		724		-20%
Total not-for-profit	**1,779**	**62%**	**1,612**	**60%**	**-9%**
Local government	83		50		-40%
State government	267		236		-12%
Total state government	**350**	**12%**	**286**	**10%**	**-18%**
Private Incorporated and non-incorporated	754		788		5%
Publicly Listed Company	2		38		1,800%
Total for-profit	**756**	**26%**	**826**	**30%**	9%
Total residential aged care services	2,883	100%	2,725	100%	-1%
Average size of residential aged care services by organisational type					
Charitable	53.92		70.95		32%
Community based	41.78		57.45		37%
Religious	54.06		69.53		29%
Local government	33.93		37.00		9%
State government	36.13		31.79		-12%
Private Incorporated and non-incorporated	60.08		80.74		34%
Publicly Listed Company	72.50		72.03		-1%
All residential aged care services	51.36		65.54		28%
Average size of services by location					
Major City	56.88		76.26		34%
Inner Regional	47.18		59.97		27%
Outer Regional	38.39		42.94		12%
Remote	24.30		25.79		6%
Very Remote	24.25		15.02		-38%
All residential aged care services	51.36		65.54		26%

Table 2 Largest aged care providers in Australia 2012

Service provider	Class/type	Beds	Community places	total
Victorian Department of Health (provided through local health services)	Govt/state	6,100	1735	7,835
Uniting Care NSW	NFP/religious	5,850	2,735	8,585
Uniting Care Qld	NFP/religious	5,220	2,308	7,528
Bupa	FP/private incorporated body	5,600	0	5,600
Regis group	FP/private incorporated body	4,482	45	4,527
RSL Care	NFP/charitable	3,400	973	4,373
Domain Principal	FP/ private incorporated body	4,100	0	4,100
Japara	FP/ private incorporated body	2,740	0	2,740
Allity (Archer Capital)	FP/private non-incorporated body	2,290	0	2,290
Catholic Healthcare (NSW)	NFP/religious	2,100	1,025	3,125
Catholic Church (provided through numerous separate organisations)	NFP/mixed religious and charitable	19,000	8,000	27,000

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