Honourable Intentions? Analysing the Interests of Private Equity in the Aged Care Sector[1]

Marie dela Rama

Centre for Corporate Governance, University of Technology, Sydney

Email: marie.delarama@uts.edu.au

Melissa Edwards

School of Management University of Technology, Sydney

Email: Melissa.edwards@uts.edu.au

Dr. Bronwen Dalton

School of Management University of Technology, Sydney

Email: bronwen.dalton@uts.edu.au

Dr Jenny Green

School of Management University of Technology, Sydney

Email: jenny.green@uts.edu.au

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ABSTRACT *The Australian aged care industry was once dominated by non-profit organisations but recently ownership has changed significantly with the entry of for profit and in particular private equity investment. This paper provides an overview of the main players in the Australian aged care sector The analysis is framed within the literature which examines the relationship between ownership type and the quality of community services. This paper contributes to existing literature by providing evidence to the theoretical underpinnings behind the encroachment of market provision of formerly non-profit oriented services We present results from a wider study which suggest that a change of ownership from non-profit to private equity may have significant consequences for the quality of service provision. The ownership changes in the aged care sector are symptomatic of the challenges facing Australian policymakers in coping with its ageing population.*

Keywords: Ownership and control, governance, non-profits, private equity, aged care.

INTRODUCTION

The proportion of the Australian population aged 65 and over has increased in all regions over the last 20 years, from 11.0% in June 1989 to 13.3% in June 2009 (Australian Bureau of Statistics 2009). According to both Australian Treasury and Productivity Commission estimates, this trend is about to significantly accelerate as the baby boomer generation retires. This development poses major policy challenges as state and federal governments face the difficult and urgent task of finding the most effective way to meet the inevitable soaring demand for aged care services. This paper discusses current policy approaches to address the issue, in particular those directed at increasing the level of corporatisation and marketisation in human services. The paper briefly discusses these policies in the broader context of successive governments' commitment to neo-liberalism and its faith in the capacity of markets to solve significant social and economic challenges. The paper then looks at some of the effects of this approach and in particular how a move from supply side to demand side subsidies has created a lucrative market in aged care provision which has lured more and more commercial entities into sector. This in turn has resulted in a pronounced shift in the ownership of aged care services in Australia away from the once dominant non-profit organisations to for profit and in particular private equity run businesses. We investigate this development, in particular the entry of private equity into the aged care industry. We then discuss some of the possible implications changes in ownership may have for the management and sustainability of service provision for the elderly. To conclude we point out several possibilities in the future direction of research in this area and we question the potential of profit-making motivations to undermine and cloud the task of providing quality aged care.

The policy challenge and the government's neoliberal inspired response

In 2000 the Productivity Commission found that government spending on long term aged care in Australia was just over 1 percent ($6 billion) of GDP per year. In 2007 the Treasury projected that this will increase by an average 2 per cent a year over the next 40 years (Australian Treasury 2007).

Insert Figure 1: Projections of Australian Government spending by category

Government has approached this serious challenge to fund aged care into the future through providing incentives for greater use of "managed" markets. The underlying principle is the

belief that competition results in improved outcomes such as greater efficiency, higher quality of service, a clearer focus on customers and better value for money. This is part of a broader international trend with similar policy approaches being adopted throughout the developed world for example Harris (2003) and Jordan (2000) on Britain, Reichard & Wollmann (199) on Germany, and Reisch & Gambrill (1997) on USA. These policies are inspired by a worldview generally referred to as neo-liberalism.

Neo-liberal perspectives have increasingly dominated the economic theories that inform the political and social policies of developed nations (Murray, 1984; Marsland, 1996; Jamrozik, 2006, p. 7). Since the Global Financial Crisis there has been much criticism of neo-liberalism but little change in terms of the 'free market' approach (Pusey, 2009).

The fundamental position of neo-liberalism is small government and market solutions. Its main features are:

- deregulated markets and workforces that should allow free enterprise to flourish and thereby increase economic growth which ultimately should benefit all;
- reduced public expenditure on social services such as health, education and welfare;
- privatisation of state-owned enterprises, utilities and services which in the hands of the 'market' should be run more efficiently and effectively free from the potential corruption and divisive influences of political pressure groups; and
- the reframing of concepts such as 'the public good' and 'community' into ideas that involve individualism', 'individual responsibility' and 'mutual obligation' (Robbins, 1999, Martinez & Garcia, 2000).

Since the first neoliberal policies were foreshadowed, fierce debate has arisen regarding their consequences. Essentially, proponents believe that the market is 'the only legitimate allocator of goods and services in society at large' (Battin, 1991: 296) and should be 'the major coordinating mechanism in the Australian economy' (Norton, 1995: 228). Whilst the central concern of neoliberal critics is its effects on wealth distribution and the consequent social fallout. The common observation is that 'the rich grow richer and the poor grow poorer' (Battin 1991: 302; Pierri, 2004).

Governments have long touted the benefits of competition between service providers stating that it was improving responsiveness and client focus (Lewis et al 1996). However, in terms of social and community welfare, strong arguments can be stated against the benefits of competition. In the first instance there is no genuine competitive market. Instead the markets are purely a construct of the government departments funding and consequently and are more accurately described as 'quasi markets' (Ashton & Press, 1997; Shackley & Healey, 1993). Moreover, because competition for limited government funds occurs between service organisations such competition has a negative impact on some of the longstanding cooperative and transparent practices that have existed among some community services. Such cooperation is often itself a factor in cost saving and capacity building in the sector (Bergman, 1998; Council on the Ageing [COTA] 1997; Morrow, Bartlett & Silaghi, 2007). Finally, a more general observation is that the effects of the 'quasi market' have contributed to an increasing lack of 'human-ness' in caring for people and communities (Allen & Potten, 1998; Keating, 1997).

To mitigate against these negative effects there is a case for governments to foster and fund non-profit community services over for profit organisations. This is because of the absence of distributional and opportunistic profit making constraints that often occur in for-profit care and which can result in a lower quality of service (Hansmann, 1980, 1987 and more recently Comondore et al 2009). This is especially pertinent in aged care provision, where the relatives and friends of elderly clients are unable to closely monitor the level of care quality clients receive. In the language of economics this market is characterised by a high level of information asymmetry. According to Hansmann:

> *"The non-profit producer, like its for-profit counterpart, has the capacity to raise prices and cut quality in such cases [of informational asymmetries] without much fear of customer reprisal; however, it lacks the incentive to do so because those in charge are barred from taking home any resulting profits. In other words, the advantage of a non-profit producer is that the discipline of the market is supplemented by the additional protection given the consumer by another, broader 'contract', the organization's legal commitment to devote its entire earning to the production of services."* (1980:844)

Comondore et al (2009) tabulated previous studies that compared private for-profit and private not-for-profit nursing home quality of care (2009: 4-5) and their own study found:

> *"…systematic review and meta-analysis of the evidence suggests that, on average, not-for-profit nursing homes deliver higher quality care than do for-profit nursing homes. Many factors may, however, influence this relation in the case of individual institutions."* (2009: 1)

This situation notwithstanding, State and Federal Governments continue to pursue policies directed at the marketisation of community services, particularly in aged care services.

Corporatisation of Australian aged care provision

Traditionally the bulk of aged care in Australia was provided by families, with the principal carer in the vast majority of cases being female, usually the daughter or daughter-in-law of the aging person (NATSEM, 2004). There were also some formal aged care providers and prior to 1956 all of these were non-profit organisations (Braithwaite 2001).

In recent decades the aged care landscape has changed significantly. Fine and Stephens (1998) describe the change as a major shift in the locus of care responsibilities from informal family based care to formal aged care services. Demographic changes have been key drivers in this shift. Since World War II, changes in attitudes, lifestyle and the presence of women in the paid workforce have affected the supply of informal family based care arrangements. At the same time the demand for care from qualified professionals has continued to grow due to the aging of the population.

In response Australian governments have created an aged care market to resolve shortfalls in the supply of aged and related community services. In this context the provision of incentives in the form of government subsidies was partially based on a desire to encourage private investment in the provision of care services. As a result governments have adopted an extensive demand-side subsidy regime where governments move away from subsidising supply to subsidising demand aged care inputs. The demand-side subsidy regime has promoted corporatisation of the sector by creating an Australian aged care market that offers private investors the prospect of healthy returns. For example according to Australian investment banking house, Macquarie Bank, around 70% of the operating income in aged care comes from the Commonwealth government (MCAG 2007). Thus, this strategy has lead to the increased involvement of for-profit players in aged care and more recently the entry of private equity , that is investment vehicles generally owned by institutional investors and where the shares of

these vehicles are not publicly traded on a stock exchange and are therefore not subject to statutory disclosure requirements. METHODOLOGY

This piece of research was conducted as part of a wider study investigating the ownership, management and structure of organisations in the aged care sector. The data presented here are based on two stages of data collection. The first stage consisted of a collection and analysis of secondary sources based on organisation websites, annual reports, Australian Stock Exchange (ASX) announcements, the Dun&Bradstreet business database and Who's Who in Business in Australia. The second stage consisted of conducting phone and email interviews with representatives from aged care organisations. Discourse analysis was used to draw out the main themes of the written and verbal text (Silverman, 2000) in relation to the change in ownership and for the drivers for involvement in the industry. The bulk of the data was collected over a period of six months in late 2006 with subsequent changes in ownership of aged care organisations noted until 2009.The following section describes the analysis from the data collection.

RESULTS

Ownership in the Aged Care Sector

In 2007 there were sixteen significant aged care providers in Australia. They are identified in Table 1.

Insert TABLE 1 here

The providers of aged care services outlined in this table cover the main types of ownership of aged services in this country. From this table, three distinct ownership types for aged care organisations can be recognized. Firstly, the **traditional non-profit organization** which are usually faith-based with a long history and presence in the industry. Secondly, the **traditional for-profit organization** of which there are only three. This is due to the rapid acquisitions that have occurred whereby some of the traditional for-profit organisations have become part of the third type of organisation, **the private equity owners**. These organisations have emerged over the last 5 years to become important players in the aged care industry.

The Traditional Non-profit Organization: Charity and Religious Based

From Table 1, seven organisations were identified as fitting the traditional non-profit category of organization. All are charitable and faith based organisations. Two of the organisations are affiliated with the Catholic Church. One of the Uniting Church's subsidiaries is Frontier Services, which is the main aged care operator in rural Australia. This is illustrated in Table 2 below.

Insert Table Two about here

These organisations were founded on the Christian precept of charity. The following email excerpt from a Uniting Church representative explains this responsibility:

> *Caring for people has been a principal Christian activity for 2,000+ years. Churches ran the world's first orphanages, hospitals, schools, universities and hotels. In the 20th Century, Churches pioneered the care of older people. The first services provided specifically for older people were accommodation-type services for homeless older men or women. The development of these services primarily came from action at the local congregation or parish level. The services represented the efforts of local faith communities to respond to the needs that they saw around them in their local communities, in acting out their Christian ministry. (personal correspondence, 10 January 2007).*

In 2004, the Salvation Army as an organisation faced a triage situation selling fifteen of its nineteen aged care homes to Retirement Care Australia, part of the Macquarie Group, due to the increased financial costs of operating in the sector:

> *"…the need in aged care, while being great and very demanding, is not as great as the desperate need for those living below the poverty line (Knight 2004).*

In late 2006, the St. Vincent de Paul Society announced their intention of selling eighteen of their twenty aged care homes, citing:

> *The shortage of both high- and low-care places in many areas, coupled with the cessation of capital grants and an emphasis on user pays has resulted in a lack of available services in regions that the Society has identified as having significant numbers of people with little or no assets and who are in need of residential aged care (Vinnies, 2007).*

It is evident that the increased competition in the industry is causing the traditional values-based operators from the non-profit sector to relinquish their involvement in aged care to the private equity players.

The Traditional For-Profit Organization

The three companies in table 1 designated as traditional for-profit organisations have been in the aged care sector for the last 30 years. Two are listed on the Australian Stock Exchange – Aevum and Ramsay. The other, the Moran Healthcare Group, is unlisted and is family owned. Table 3 (below) provides an overview of these companies according to their current asset valuation.

Insert Table Three about here

Ramsay Healthcare

Ramsay Healthcare (RHC) was founded in 1964 by Paul Ramsay and is now the biggest private hospital provider in the country and the largest market-listed corporation in this industry. Ramsay Healthcare acquired 4 aged care facilities from Ellis Aged Care at a cost of $38.5M in April 2005. In March 2005, Ramsay Healthcare acquired Gracedale Private Nursing Home for $9.8M. Lastly, Home Care Services (HCS) was acquired by Ramsay in April 2005 for $1.5M. HCS is one of the largest commercial residential homecare businesses operating out of Adelaide.

Aevum

Aevum was formally known as the Hibernian Friendly Society. In its previous form it was a Catholic society established to assist Irish Catholics in funeral and sickness benefits in colonial Australia. It opened its first retirement village in 1973 and is now the largest for-profit operator in NSW. The society demutualised in 2002 and listed on the Australian Stock Exchange in 2004. In 2004, a takeover bid was made by Primelife. A significant owner of Primelife is the private equity group, Babcock & Brown. This bid was rejected. In 2006, Primelife increased its shareholding in Aevum to 39%. In August 2006, Aevum bought Moran Healthcare's West Australian homes for $128M (Klan, 2006).

Moran Healthcare

This Group was established in1956 by Doug and Greta Moran and is run by members of the Moran Family. The group was Australia's largest private aged care provider. In August 2005, Macquarie Group's Retirement Care Australia acquired 12 Aged Care Facilities from Moran Healthcare for $186M (Macquarie, 2005). A year later, the Aevum transaction occurred in Western Australia. In October 2006, AMP's Principal Aged Care entered into an agreement to purchase the leases and operations of 39 residential aged care homes from Moran Health Care Group for $129.3M.

From this brief overview of the for-profit companies two trends are evident. The first is the increasing consolidation trend which is coupled with a chain-management approach. The second is the recent entry of private equity investment which has resulted in varying degrees of hybrid management arrangements.

The New Business Model For-Profit Organization or Private Equity Owners

The "new" owners in the aged care industry can be characterized by the ownership structure and investment horizon of their corporate entity: "private equity". As the name suggests, the shares of private equity entities – unlike their publicly listed counterparts – are not listed and are held in private hands - such as wealthy individuals, families and or listed/unlisted institutions. Kaplan and Schoar (2005) provide a definition:

> *Private equity investing is typically carried out through a limited partnership (LP) structure in which the private equity firm serves as the general partner (GP). The LPs consist largely of institutional investors and wealthy individuals who provide the bulk of the capital…The GP then has an agreed time period in which to invest the committed capital—usually on the order of 5 years. The GP also has an agreed time period in which to return capital to the LPs—usually on the order of 10–12 years in total. Each fund or limited partnership, therefore, is essentially a closed end fund with a finite life (2005: 1793).*

However, private equity's march up to and leading to the global financial crisis of 2008 was not without its critics. The quote below is from the global union federation, the UNI Global Union's general secretary Philip Jennings speaking to private equity's business leaders at the World Econonic Forum's annual 2007 summit in Davos, Switzerland:

"Your philosophy is buy it, strip it and flip it…At a time when we are looking for companies to be more transparent you are taking corporate governance underground. Does this mean you have abandoned any sense of broader responsibilities?"- Jennings (2007)

Due to the nature of private equity investing, aged care facilities are seen as part of a portfolio of assets. Therefore, the performance of this portfolio depends not just on the profitability of the aged care facilities but on the other assets in that same portfolio. Aged care facilities may be placed in the same portfolio as airports, roads and other 'similar-stable' assets and promoted and sold to selected investors as one 'infrastructure' fund. Ownership changes occur quickly while existing day-to-day management structures of the facilities may remain constant. Fund managers may be appointed to the board of directors. Generally, the fund managers belong to a division or subsidiary owned by a bigger organization.

Insert table 4 about here

Table 4 provides an overview of the companies listed in this category. Five of the six organisations identified in this sample are based in Australia, with the European-American consortium CVC (CAID) being the exception. All have acquired pre-existing aged care facilities from traditional non-profit and/or for-profit organisations. All six private equity owners are part of publicly listed entities.

Below is a brief overview of four of these players and their motivations for involvement in the aged care sector. Attention is then focused on the recent instability in global financial markets which raises questions about the stability of provision for community services, including aged care, if this increasing trend towards 'marketisation' continues.

Principal Care

Principal Aged Care owns 42 aged care homes around Australia. In October 2006, Principal Aged Care entered into an agreement to purchase the leases and operations of 39 residential aged care homes from Moran Health Care Group for $129.3M.

In January 2008, Principal bought Domain Aged Care making the group Australia's largest owner of for-profit aged care with more than 5000 operational beds in 58 facilities. AMP stated that the key investment reasons for this expansion were:

- low volatility and growing cash flows from accommodation bonds, which are attached to 60 per cent of all beds;
- stable revenues underpinned by regulated Government funding;
- substantial freehold property portfolio in Queensland, Victoria and NSW, providing development, structuring and portfolio enhancement opportunities; and
- sound track record of acquiring and developing high quality new facilities on time and on budget. (AMP 2008)

Principal Care is owned by a consortium of institutional funds, of which AMP Capital Investors manages 95.5% (Principal Care, 2006). AMP Capital Investors is the fund management arm of AMP, managing over $97B for investors. From 1995-2005, the fund delivered an average 16.3% return to investors and in 2005 the Infrastructure Equity Fund of AMP Capital had $2.6B assets under management (December 2005 figures). To participate in the fund requires a minimum investment of $10M. The fund is divided into three areas dealing with origination (establishing infrastructure deals), asset management and portfolio management. The fund invests in three key sectors; Utilities, Transport and Social Infrastructure (Principal Healthcare falls under this category). In October 2005, Chief AMP Economist Shane Oliver reported that amongst the different infrastructure project types available, Social Infrastructure Funds may expect an income yield of 8-10% with an average return of 11% for 5-10 years (Oliver, 2005).
AMP Capital has Principal Healthcare marked as a mature investment in the portfolio life cycle and it is therefore in the exit stage of the investment lifecycle. This raises serious implications for the future availability of funds for Principal Healthcare.

Craigcare / Hastings Funds Management / Westpac

Acquired by Westpac Bank in 2007, Hastings Funds Management is self-described as *'one of the largest managers of infrastructure and alternative investments in Australia'*(HFM, 2007). Hastings acquired Craigcare in 2003, a West Australian aged care operator of 16 aged care facilities since the 1970s. Craigcare became part of the Hastings Private Equity Fund. In

2006, the group triumphantly proclaimed, *"Hastings exited its investment in Craigcare in late 2006 achieving an IRR (internal rate of return) in excess of 27%"*(HFM, 2007)

Ibis Care

Ibis Care has been in the sector since 1997 operating three facilities in NSW and Tasmania. In March 2006, IBIS Care Holdings Pty Ltd was bought by ANZ Capital with the deal originating with ANZ's Aged Care Division Corporate Banking. The equity came from ANZ Capital and the debt was financed by ANZ Corporate Banking. The deal was formed under ANZ's Capital Acquisition and Development Funding. At the time of ANZ's purchase, the financial orientation of the investment was uppermost:

> *"ANZ is pleased to provide IBIS Care with access to investment-banking solutions that are historically only available for Wall Street-sized firms* (Read, 2006)

Retirement Care Australia

Retirement Care Australia (RCA) owns and operates nineteen aged care centres across the country. RCA acquired fourteen aged care facilities from The Salvation Army in July 2005. In December 2005, RCA acquired 12 aged care centres from the Moran Health Care Group. Macquarie Capital Alliance Group Ltd. (MCAG) owns 98% of RCA. Tricare owns the remaining 2%. MCAG also has a 49% shareholding in the Zig Inge Group (ZIG) which runs 16 retirement villages on the East Coast of Australia. MCAG is an arm of the investment bank, Macquarie Group. MCAG also listed on the Australian Stock Exchange. RCA and ZIG join a stable of Macquarie infrastructure assets. MCAG securities were not available to the public, instead they were offered to certain institutional investors (including offshore and onshore institutions), and existing Macquarie shareholders.

MCAG lists the aged care industry in Australia within their five most promising industries (Macquarie, 2007). The MCAG justify their investment in RCA on the basis that it is a predictable revenue stream with strong growth prospects. According to MCAG:

> *the aged care industry provides stable underlying revenue streams and predictable cash flows, primarily from government funding and subsidies" (Macquarie, 2007a).*

Additionally, they cite the long-standing management experience of the personnel gained when they acquired facilities from The Salvation Army and The Moran Group Moreover, this experience and knowledge enables them to 'participate in further consolidation and acquisitions' in the profitable aged care industry. This suggests that the primary goal for entering into the aged care industry is profit which MCAG can make all the more secure through industry domination. (Macquarie, 2007b).

Subsidising 'Private Equity' Investment?

Citing dela Rama's submission to the Senate Inquiry into Private Equity Investment, Senator Ursula Stephens (Hansard 2007: E84) noted:

> *unlike other areas where private equity investment tends to be high risk and speculative, this is an area of economic activity that is in essence underwritten by government subsidies and will continue to be because of the nature of aged care provision.*

This suggests that government is the underwriter of last resort and the taxpayer is the ultimate creditor. The global financial crisis has reinforced this view of government's role as fundamental guarantor of the excesses of the financial services sector.

The Global Financial Crisis has seen the investment banking model somewhat discredited with the spectacular collapses or organizational restructuring of the same Wall Street-sized firms. This raises questions regarding the effects of policies that have facilitated and encouraged entry of those whose usual business is speculative investments.[7]

The final column in Table 4 (above) indicates the short-term nature of the private equity investment in the aged care industry with the sale of Citigroup's aged care investment only a

[7] While it is beyond the scope of this paper, the parallels between the issues faced by the aged care sector and childcare sector are striking. With the fallout from the collapse of ABC Learning still fresh in the child care sector; those watching the aged care sector with its funding similarities are arguably entitled to ask: "What type of financial guarantee does the Government have available for rescuing aged care homes when their operational viability may be undermined by the current economic conditions?" The findings of the 2009 Senate Inquiry into Childcare are pertinent to the future of the Australian aged care sector especially deficiencies in the policy arena and belated response by government once market failure in the childcare sector had already occurred. See Senate (2009) Report into the Provision of Childcare, Department of Education, Employment and Workplace Relations [DEEWR] References Committee, Commonwealth of Australia http://www.aph.gov.au/SEnate/committee/eet_ctte/child_care/report/report.pdf accessed 13 January 2010

year after its purchase of DCA Group. Citigroup sold on this interest to BUPA for around $1.225B. By comparison, the Government budget for the whole industry is only $8.6B a year. This suggests that some of the market valuation for aged care entities is optimistic at best or at worst inflated. This again raises the following difficult and critical questions. Should multi-billion dollar entities, which have greater financial leverage and scope than the Federal Government, be allowed to continue to access subsidies in the aged care sector? Are these subsidies being used for their intended purpose of benefiting the aged or are they the means by which owners of aged care facilities can increase returns to their shareholders or unit holders? Finally and more fundamentally, who in our community really benefits from the neoliberal market policies that are applied to the funding of community services?

The reliance on government subsidies is such that in the 2007 Financial Report of Macquarie Capital Alliance Group (the parent of operator Retirement Care Australia now known as Regis) noted that such reliance is a source of credit risk:

> *At the group level, there are no significant considerations of credit risk. However certain subsidiaries have concentrations of credit exposure as follows:*
> *A significant proportion of the day-to-day receipts of Retirement Care Australia Holdings (RCAH) are sourced from the Commonwealth Government (MCAG, 2007)*

Later in the same document, MCAG's Financial Risk Management reiterated this risk for the group and made the following statement about its management.

> *In each case, the creditworthiness of the counterparties mitigates the risk associated with the concentration of exposure to one counterparty…The Group has policies in place to ensure that cash deposits are appropriately spread between counterparties with acceptable credit ratings (MCAG, 2007).*

The above excerpts suggest that according to the risk management strategies of these new entrants, there is a certain preparedness to face risk, if and when it is realized.

As a two-tiered system in aged care has now evolved with the increased marketisation, – or arguably, the commodification[8], – of the industry, then perhaps a two-tiered system of distribution of subsidies would better reflect the current commercial reality.

Private ownership

According to Young and Salaman (2002) among the reasons the non-profit sector has experienced pressures to commercialise, is the 'expanded demand' of an aging population. In the Australian Treasury's Intergenerational Report (2010), the ageing population with climate change have been highlighted as the major, immediate challenges facing the country. The increasing demands of an ageing population and the incentive of government subsidies have produced increased competition between for-profit providers for larger and larger stakes in the sector, with particularly increased activity from private equity players. There are several potential issues identified with this change in ownership. Firstly, the situation can enable instances of private profiteering from public funds. Government subsidies in the aged care industry create attractive investment opportunities for investment funds looking for a low risk venture. Secondly, there are issues regarding the effects this may have on the quality of service provision (Luksetich et al., 2000). Private equity funds require a 'return on investment' which opens the possibility that this may be valued above the 'quality of care' criteria.

Private equity is also a bull market phenomenon and the proliferation of these investment groups in the aged care sector is there as long as there is a heavily liquid market In late 2007 and 2008, the credit crisis in the USA triggered a worldwide bear market that has stemmed investment flows. Hence the fickle nature of private equity's investment horizons may be incompatible with an industry which requires long-term and sustained investment.

While some investment companies are moving in the direction of 'ethical investment' the large majority of private investment firms involved in the aged care industry in Australia are looking for a low risk, steady return investment opportunity to 'hedge' some of the higher risk ventures in their portfolios.

[8] The commodification of the industry was a comment made at a Paid Care Symposium held at the University of Sydney in December 2009.

The significance of ownership

As the short-term investment horizons of some for-profit entities in recent years have shown, who owns and controls the aged care entity is as important as those who run and manage the delivery of care. The stability of ownership arrangements ultimately impacts on the stability and quality of service provision. Luksetich et.al (2000) following Weisbrod (1988) argued that ownership and the associated managerial behaviour differs between non-profit and for-profit organisations, in areas where there is asymmetry between buyers and sellers and the quality of the service is difficult to evaluate. This is the case in the aged care sector . Such views note that those in non-profit organisations are more likely to be driven by altruistic motivations whereas for-profits organisations are more likely to engage in 'opportunistic skimping' on aspects of quality not easily monitored (Morris & Helpburn, 2000). Furthermore the 'agency costs' associated with large scale chain ventures operating in many locations are situations where managers are more likely to serve their own self interests rather than those of the organisation (Luksetich, 2000).

In relation to the corporatisation and marketisation of the health care systems Wynne made the observation that in the USA corporate interests 'encourage resources to be diverted from patient care to meet market priorities' (Wynne 2004, p.4). Market obligations induce practitioners to serve business missions at the expense of their duty of care for their patients. Furthermore, Wynne (2004) cites Australian evidence where this is associated with cases of fraud, misconduct and malpractice. While Wynne is referring to the health care system, the examination of the aged care industry in this study demonstrates that there is reason for concern. The evidence suggests not only an emerging domination by the marketisation forces of private equity, but also the incorporation of these assets into portfolios whereby aged care facilities are managed as chains and valued as a stable return. It is reasonable to question the likelihood of incentive for profit maximisation at the expense of care provisions and even managerial profits due to the opportunities of agency costs.

CONCLUSIONS AND FUTURE DIRECTIONS

Private equity players have transformed and are transforming the aged care industry, as they continue to acquire non-profit providers. Those non-profits that remain must compete against corporations with significantly greater resources and arguably have greater influence in the formation of future policy agendas.

The shift in ownership in the aged care industry raises several questions requiring further investigation For example, is there a difference in service provision between those private non-listed for-profits 'new players' and the 'older' publicly listed more established for-profit organisations? Of particular interest should be understanding the way in which government subsidies act as a lure for equity investors looking for investment security and the consequent effects this orientation has on the quality of service provision.

Another area that needs scrutiny is the difference in the financial valuation of nursing homes by private equity as compared to nonprofit operators. Can a more realistic (and even a market) valuation of a nursing homes by nonprofit owners include the incorporation of intangibles and goodwill? How can the assessment of quality translate into a better financial management for a nonprofit run home for aged people?

While there has been a growth in 'hybrid' organisations that mix the profit market principles with the social values of nonprofit missions, there has been little research examining "how mission-driven business enterprise models structure themselves to allay the tension between social mission and commercial goals or the specific mechanisms of mission drift" (Cooney, 2006:144). In particular we ask: does a change in ownership impact upon the governance and practices of an aged care organisation? Furthermore, does private equity investment in aged care services in Australia lead to changes in management? And where management remains stable, but the ownership changes, how does this change impact upon the staff and their service provision for older persons?

Alternatively, could we find that variations in efficiency and quality of service provision are more likely to exist *within* ownership types and are dependent upon, managerial practices, (Morris and Helburn, 2000), or the existence of chain structures (Luksetich, 2000), or the stringency of government imposed regulation (Morris & Helburn, 2000; Luksetich, 2000)?

This paper contributes to the literature by providing evidence showing significant organisational, ideological and managerial upheavals in the sector with the encroachment of market provision of formerly non-profit oriented services,

By highlighting the issues we have raised that private ownership and private equity players

are increasingly entering the aged care field this paper, this paper should alert those concerned with the quality of service delivery to the elderly and have them view the aged care sector with continuous and close vigilance.

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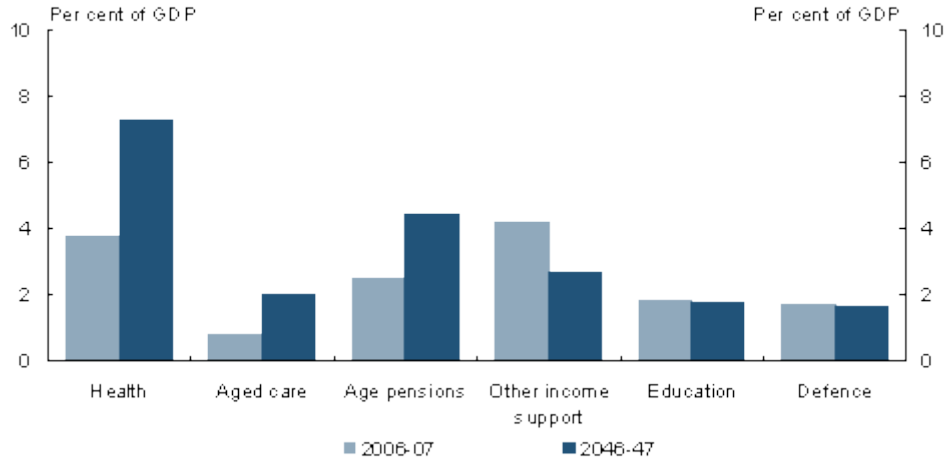
Figure 1: Projections of Australian Government spending by category



Source: Australian Treasury (2007) Projections and assumptions.

Table 1: List of 16 Aged Care Organisations studied in 2007

Organization	**Organisational Type**	**Year of Entry in Sector**
Anglicare Australia	Nonprofit	1857
Aevum	Traditional For-Profit	1868 as a Catholic charity, 1973 for first retirement village
Baptist Community Care	Nonprofit	1944
Craigcare	New Model For-profit	1970s
DCA Group	New Model For-Profit	1987
Ibis Care	New Model For-Profit	1997 (by phone)
Little Company of Mary Healthcare	Nonprofit	1885
Masonic Homes	Nonprofit	1890s
Moran	Traditional For-Profit	1956
Primelife	New Model For-Profit	1986
Principal Care	New Model For-Profit	1998
Ramsay	Traditional For-Profit	1964
Retirement Care Australia	New Model For-	2005

	Profit	
Salvation Army	Nonprofit	1900s
St. Vincent de Paul	Nonprofit	1967 in Victoria website
Uniting Care Australia	Nonprofit	1928

Table 2: Top 10 Aged Care Operators in Australia in 2002[9]

OPERATOR	SECTOR	NO. OF LOCATIONS	NO. OF BEDS	MARKET SHARE
Uniting Church (NSW)	Nonprofit	82	4,819	3.4%
Moran Health Care	Private	48	3,900[10]	2.8%
Uniting Church (QLD)	Nonprofit	57	3,021	2.1%
NSW Government	Government	20	1,718	1.2%
Anglican Retirement Villages	Nonprofit	16	1,671	1.2%
Amity/DCA Aged Care	Private	21	1,603	1.2%
Uniting Church (OLD Synod)	Nonprofit	27	1,576	1.1%
Conform Group	Private	22	1,560	1.1%
St Vincent de Paul	Nonprofit	33	1,460	1.0%
Baptist Community Services	Nonprofit	23	1,440	1.0%

Table 3: List of Traditional For-Profit Organisations in the Sector

"Traditional For-profit" Business		
Company	**Year of Listing (ASX Code)**	**Market Capitalisation (as at**

[9] Amity Group 2002 Annual Report
[10] The 2005 figure is 3,379 beds (see Operations). However, Moran Health Care is a private company and the number of beds could vary due to the paucity of information.

		9/1/07) or Revenues
Aevum	2004 (AVE)	$266M market capitalization
Moran	Unlisted	$150M estimated revenues
Ramsay	1997 (RHC)	$1.98B market capitalization

Table 4: List of 'New Business Model' For-Profit Organization

"New Business Model For-profit": Private Equity Owners			
Company	**Private Equity Owner**	**Corporate Owner**	**Year Acquired or Established (Exited)**
Craigcare	Hastings Funds Management	Westpac	2003 (2006)
DCA Group	CAID Pty Ltd	CVC & Citigroup	2006 (exited 2007 to BUPA)
Ibis Care	ANZ Capital	ANZ Bank	2006
Primelife	B&B Communities Group	Babcock and Brown (no longer exists)	2005 (exited 2008 to Lendlease and Stockland)
Principal Healthcare Group	AMP Capital Investors	AMP	2006
Retirement Care Australia/Regis	Macquarie Capital Alliance Group	Macquarie Bank	2005 (partial exit in 2008)