Australian Government

Aged Care Financing Authority

# Sixth report on the Funding and Financing of the Aged Care Sector

July 2018

# Contents

# Glossary

| Term | Definition |
|---|---|
| Accommodation supplement | The accommodation supplement is payable on behalf of residents receiving permanent residential aged care who do not have the capacity to contribute to all or part of the cost of their accommodation. |
| Aged and Community Services Australia (ACSA) | A national peak body for not-for-profit providers of aged and community care in Australia. |
| Aged Care Act 1997 (the Act) | The primary legislation governing the provision of aged care services. |
| Aged Care Approvals Round (ACAR) | A competitive application process that enables prospective and existing approved providers of residential aged care to apply for a range of new Australian Government funded aged care places and financial assistance in the form of a capital grant. |
| Aged Care Assessment Team (ACAT) | ACATs are teams of medical and allied health professionals who assess the physical, psychological, medical, restorative, cultural and social needs of frail older people and help them and their carers to access appropriate levels of support. |
| Aged Care Financial Report (ACFR) | A reporting template introduced for the 2016-17 reporting year that consolidates prudential and financial reporting information that was previously separately reported. The ACFR consolidates information previously reported through the Annual Prudential Compliance Statement, the Survey of Aged Care Homes, the Home Care Financial Report and the Short Term Restorative Care Financial Report. |
| Aged Care Financing Authority (ACFA) | ACFA is a statutory committee that provides independent advice to the Australian Government on funding and financing issues, informed by consultation with consumers, and the aged care and finance sectors. |
| Aged Care Funding Instrument (ACFI) | The classification instrument used to calculate subsidies to residential aged care facilities. |
| Aged Care Pricing Commissioner | The Aged Care Pricing Commissioner is an independent, statutory office holder appointed under the Aged Care Act 1997 and reports to the Minister for Aged Care. |
| Aged Care Sector Committee (ACSC) | The ACSC is a representative committee of the aged care sector appointed by the Minister for Aged Care that provides advice to Government on aged care policy development and implementation and helps to guide future reform of the aged care system. |
| Agreed accommodation price | Accommodation prices agreed between providers and prospective residents prior to entry, as reported by providers through the Aged Care Entry Record. |
| Approved provider | An approved provider of aged care is an organisation that has been approved by the Secretary of the Department of Health to provide residential care, home care or flexible care under the Aged Care Act 1997. |

| Term | Definition |
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| Assistance with Care and Housing for the Aged (ACHA) | ACHA is a program which provides a range of supports for eligible clients, who are at risk of becoming homeless or are homeless, to remain in the community through accessing appropriate, sustainable and affordable housing and linking them to community care. From 1 July 2015 the ACHA program was incorporated into the new Commonwealth Home Support Programme. |
| Australian Bureau of Statistics (ABS) | The Government agency responsible for the production and dissemination of statistics in a range of key areas. |
| Australian Nursing and Midwifery Federation (ANMF) | The ANMF is the union for registered nurses, enrolled nurses, midwives, and assistants in nursing doing nursing work in every state and territory throughout Australia. |
| Bed days | The number of days for which a residential care place was available to be occupied by care recipients. |
| Bond Asset Cover | Provides an indication of the extent to which the accommodation bond liability is covered by assets. It is calculated as Total Assets/Total Accommodation Bonds. |
| Brownfield site | Site where an extension to an existing aged care operation is possible. |
| Care days | The number of days for which care was actually provided to a care recipient in an aged care place. |
| Catholic Health Australia (CHA) | Catholic Health Australia is a large non-government provider grouping of health, community and aged care services in Australia, nationally representing Catholic health care sponsors, systems, facilities and related organisations and services. |
| Commonwealth Home Support Programme (CHSP) | This program provides entry-level support services designed to help frail older people stay in their homes. It was introduced on 1 July 2015, consolidating four former programs: Commonwealth Home and Community Care (HACC); the National Respite for Carers Program (NRCP); Day Therapy Centres (DTC); and Assistance with Care and Housing for the Aged (ACHA). |
| Community Aged Care Package (CACP) | A package of services provided to a person in their own home. This type of care was replaced on 1 August 2013 when the new home care package levels 1-4 were introduced. A CACP package is generally consistent with the level of care provided in a level 2 home care package. |
| Consumer Directed Care (CDC) | Consumer Directed Care in home care gives consumers greater choice over their own lives by allowing them to decide what types of care and services they access and how those services are delivered. |
| Consumer Price Index (CPI) | CPI measures the changes in the price of a fixed basket of goods and services, acquired by household consumers who are resident in the eight state and territory capital cities. |
| Council on the Ageing (COTA) | COTA Australia is the peak national organisation representing the rights, needs and interests of older Australians. |
| Culturally and Linguistically Diverse (CALD) | Consumers who have particular cultural or linguistic affiliations due to their:<br>• place of birth or ethnic origin;<br>• main language other than English spoken at home; or<br>• proficiency in spoken English. |

| Term | Definition |
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| Current Ratio | Represents the ability to meet short term debt through current assets. A current ratio of more than one indicates that an organisation's current assets exceed its current liabilities. It is calculated as Current Assets/Current Liabilities. In the aged care context, current ratio needs to be interpreted with caution given all accommodation deposits (bonds pre 1 July 2014) held by providers are treated as current liabilities. |
| Daily Accommodation Contribution (DAC) | An amount paid by a partially supported resident as a contribution toward their accommodation costs in a residential aged care facility, calculated on a daily basis and paid periodically. |
| Daily Accommodation Payment (DAP) | An amount paid by a non-supported resident towards their accommodation costs in a residential aged care facility calculated on a daily basis and paid periodically. |
| Day Therapy Centres Program (DTC) | The DTC program provides a wide range of therapy and services to eligible frail, aged people living in the community and to residents in Commonwealth funded residential aged care facilities. It assists them to regain or maintain physical and cognitive abilities which support them to either maintain or recover a level of independence. As of 1 July 2015 the DTC program became part of the new Commonwealth Home Support Programme. |
| Department of Health | The department that administers the Aged Care Act 1997 and regulates the aged care industry on behalf of the Commonwealth. |
| Earnings Before Interest, Taxes, Depreciation and Amortisation (EBITDA) | Net profit after tax with interest, taxes, depreciation, and amortisation added back to it, and can be used to analyse and compare profitability between companies and industries because it eliminates the effects of financing and accounting decisions. |
| EBITDA margin | EBITDA margin shows the average net profit after tax (with interest, taxes, depreciation and amortisation added back into it) generated for each $1 of revenue earned. It's calculated as EBITDA/total revenue. |
| Extended Aged Care at Home (EACH) | Services previously provided to a person in their own home, who required a high level of care. This type of care was replaced on 1 August 2013 when the new home care package levels 1-4 were introduced. An EACH package was generally consistent with the level of care provided in a level 4 home care package. |
| Extended Aged Care at Home Dementia (EACH-D) | Services previously provided to a person in their own home, with dementia, who required a high level of care. This type of care was replaced on 1 August 2013 when the new home care package levels 1-4 were introduced. An EACH-D package was generally consistent with the level of care provided in a level 4 home care package, with the additional Dementia and Cognition supplement also being paid. |
| Facility | A residential aged care facility, approved under the Aged Care Act 1997 to provide government subsidised accommodation and care. |
| Financial Accountability Reports (FARs) | FARs were non-audited financial statements submitted by approved providers of home care services up until 2014-15 when they were replaced by the new Home Care Packages financial reports. |
| Flexible care | For those in either a residential or home care setting, that may require a different care approach than that provided through mainstream residential and home care. |

| Term | Definition |
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| General Purpose Financial Report (GPFR) | An audited financial report that is submitted by providers with their unaudited Aged Care Financial Report (ACFR). While the ACFR provides a greater level of detail the GPFR is the only audited report and is used to verify information provided. |
| Government provider | In the context of this report, the term references a provider that is owned by a local, state or territory government. |
| Greenfield site | Site where an aged care operation is built for the first time. |
| Gross Domestic Product (GDP) | GDP is the market value of all officially recognised final goods and services produced within a country in a year, or over a given period of time. |
| High care facility | A facility where over 80 per cent of residents were classified as 'high care'. The distinction between high care and low care in permanent residential care was removed from 1 July 2014. |
| Higher accommodation supplement | A higher maximum accommodation supplement was introduced on 1 July 2014 for aged care homes that have been built or significantly refurbished since 20 April 2012. |
| Home and Community Care (HACC) | A previous program that provided basic support and maintenance to people living at home to help avoid premature or inappropriate admission to long-term residential care (WA only in 2016 17). Note: the former Commonwealth HACC program was consolidated into the new CHSP from 1 July 2015. |
| Home care | Home based care provided through a home care package to help older Australians to remain in their own homes. Home care is provided through the Home Care Packages Programme. |
| Home care package | A package of services, delivered though the Home Care Packages Programme, tailored to meet the care needs of a person living at home. The package is coordinated by an approved home care provider, with funding provided by the Australian Government (with some contributions from the consumer). Home care packages range from level 1 to 4 depending on the care needs of the consumer. |
| Home Care Packages Programme | An Australian Government funded programme which has as its objectives to assist people to remain living at home and enable consumers to have choice and flexibility in the way that care and support is provided at home. The Home Care Packages Programme commenced on 1 August 2013. |
| Homeless supplement | A supplement paid to better support aged care homes that specialise in caring for people with a history of, or at risk of, homelessness. This funding is in addition to the funding provided under the viability supplement. |
| Increasing choice in home care | From 27 February 2017, funding for a home care package followed the consumer, replacing the former system where home care places were allocated to individual approved providers to deliver services in a particular location or region. |
| Interest Coverage | Shows the number of times that EBITDA will cover interest expense. Indicates an organisation's ability to service the interest on its debt. It is calculated as EBITDA/Interest Expense. |
| Leading Age Services Australia (LASA) | LASA is a peak body for aged service providers. |

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| Location | Indicates where a provider, service or consumer is located based on whether they are metropolitan or regional areas. Metropolitan is all major cities and regional is any area outside of a major city. A provider is classified as metropolitan if more than 70 per cent of its services are located in metropolitan areas and similarly classified as regional if more than 70 per cent of its services are located in regional areas. |
| Low care facility | A facility where over 80 per cent of residents were classified as 'low care'. The distinction between high care and low care was removed from 1 July 2014. |
| Maximum accommodation price | Maximum accommodation prices set by residential providers for a room (or bed in a shared room) and published on My Aged Care. These are maximum prices (providers and residents may agree lower amounts), that apply to residents who are not eligible for support with their accommodation costs. |
| Maximum Permissible Interest Rate (MPIR) | The MPIR is the rate used to calculate the equivalent daily payment of a Refundable Accommodation Deposit (RAD). The RAD is multiplied by the MPIR and divided by 365 days. The MPIR is determined in accordance with Section 6 of the Fees and Payments Principles 2014 (No. 2).The MPIR is available on the Department of Health website and is updated every three months. |
| Mixed care facility | A facility where less than 80 per cent of residents were high care residents and more than 20 per cent were low care residents. The distinction between high care and low care was removed in permanent residential care from 1 July 2014. |
| My Aged Care | The main entry point to the aged care system in Australia. My Aged Care aims to make it easier for older people, their families, and carers to access information on ageing and aged care, have their needs assessed and be supported to find and access services. |
| National Disability Insurance Scheme (NDIS) | The NDIS offers support for Australians who are under 65 years of age with a significant and permanent disability, their families and their carers. |
| National Respite for Carers Program (NRCP) | The NRCP aims to support caring relationships between carers and their dependent family members or friends by facilitating access to information, respite care and other support appropriate to their individual needs and circumstances and those of the people for whom they care. The NRCP was integrated into the CHSP from 1 July 2015. |
| National Prioritisation Queue | The order in which people are placed for being assigned a home care package, with each person's place on the queue based on the time and date of their approval for home care and their priority for service (medium or high). |
| Net Profit Before Tax (NPBT) | The NPBT is determined by revenue minus expenses for the period except for taxes. |
| Net Profit (Before Tax) Margin | Shows the average profitability generated on each $1 of total revenue. It is calculated as Net Profit Before Tax / total revenue. |
| Non-supported residents | Residents who have been assessed (based on a means test) as able to pay the full cost of their accommodation and contribute toward their care costs. Non-supported residents pay a basic daily fee, accommodation payment and means-tested care fee (may still receive some assistance with care costs). |

| Term | Definition |
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| Offline residential care places | Previously operational places that are currently not being used due to renovations or rebuilding of facilities or pending sale to other providers. Providers do not receive Australian Government subsidies while places are offline. |
| Operational places | Operational place refers to a residential care place that was allocated to a provider and has since become available for a person to receive care. |
| Partially supported residents | Residents who have been assessed (based on a means test) as eligible for full government assistance with their care costs, but able to make a part contribution to their accommodation costs. Partially-supported residents pay a basic daily fee and accommodation contribution. |
| Pay as you go (PAYG) | Pay as you go (PAYG) instalments is a system for making regular payments towards an employee's expected annual income tax liability. |
| Per consumer per annum (pcpa) | An annual average financial figure relating to home care consumers. |
| Per consumer per day (pcpd) | A daily average financial figure relating to home care consumers. |
| Per resident per annum (prpa) | An annual average financial figure relating to residential aged care residents that converts service financial data to daily amount per resident. |
| Per resident per day (prpd) | A daily average financial figure relating to residential aged care residents. |
| Provisionally allocated places (PA) | Residential care places allocated through Aged Care Approval Rounds that are not yet operational. |
| Refundable Accommodation Contribution (RAC ) | An amount paid as a lump sum by a partially supported resident as a contribution toward their accommodation costs in a residential aged care facility. |
| Refundable Accommodation Deposit (RAD) | An amount paid as a lump sum by a non-supported resident for their accommodation costs in a residential aged care facility. |
| Regional | Geographic region outside of a major city and classified by the Australian Bureau of Statistics as inner regional, outer regional, remote and very remote. |
| Regional Assessment Services (RAS) | RAS provides in home, face to face assessments of new and existing clients/carers to assess their eligibility to access CHSP services. |
| Report on the Operations of the Aged Care Act 1997 (ROACA) | A legal requirement under the Act, the ROACA is tabled in Parliament in November each year and presents an annual snapshot of facts and figures on Commonwealth funded aged care services in Australia. |
| Resident Classification Scale (RCS) | The basic tool for residential aged care funding prior to 20 March 2008, when it was replaced by the ACFI. A very small number of residents who entered care before 20 March 2008 are still classified using the RCS through grand-parenting arrangements. |
| Residential aged care | A program that provides a range of care options and accommodation for older people who choose not to continue living in their own homes. |

| Term | Definition |
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| Restorative care | Care focusing on enhancing the physical and cognitive function of people who have lost or are at risk of losing condition and independence. The Short-Term Restorative Care (STRC) Programme, which commenced in February 2017, is a flexible care program to provide restorative care to older people to improve their capacity to stay independent and living in their own homes. |
| Retained earnings | Refers to the percentage of net earnings not paid out as dividends, but retained by the company to be reinvested in its core business, or to pay debt. This is recorded under shareholders' equity on the balance sheet. |
| Retention amounts | An amount that an approved provider is allowed to deduct per month from an accommodation bond for up to five years. The maximum retention amount is set by the Australian Government. Retentions are no longer permitted for residents entering residential aged care on or after 1 July 2014. |
| Return on Assets | Indicates the productivity of assets employed in the organisation. It is calculated as EBITDA/total assets. |
| Return on Equity/ Return on Net Worth | Indicates the productivity of equity/net worth employed in the organisation. It is calculated as EBITDA/net worth. |
| Scale (providers) | Refers to the number of services operated by a provider. |
| Size (providers) | Refers to the number of beds operated by a specific residential aged care service. |
| Supported residents | Residents who have been assessed (based on a means test) as eligible for full government assistance with their care and accommodation costs. Supported residents only pay a basic daily fee. |
| Survey of Aged Care Homes (SACH) | Each year SACH seeks information on accommodation payments and planned and actual building activity during the previous financial year for each operating residential aged care service. |
| Target provision ratio | The Australian Government target of subsidised operational aged care places. These targets are based on the number of persons for every 1,000 people aged 70 years or over. The population-based provision formula ensures that the supply of services increases in line with the ageing of the population. |
| Transition care | For those requiring time-limited, goal-oriented and therapy-focused packages of services after a hospital stay. |
| Viability supplement | The viability supplement aims to improve the financial position of smaller, rural and remote aged care services that incur additional costs due to their location and are constrained in their ability to realise economies of scale due to smaller numbers of care recipients. The viability supplement also provides additional funding for residential care providers who specialise in services to Indigenous people, or people who are homeless or who are at risk of becoming homeless, in recognition of the often higher costs associated with providing care to these people. |
| Working Capital | Defined as current assets less current liabilities. |

# Foreword

I am pleased to present the Aged Care Financing Authority's (ACFA) 2018 Report on the funding and financing of the aged care sector. This is ACFA's sixth annual report.

ACFA was established in 2012 following significant reforms to the aged care sector by the Australian Government and was given the task of providing independent advice to the Government on funding and financing issues in the aged care industry. Consistent with past reports, the 2018 report examines developments, issues and challenges confronting the aged care industry in Australia. It includes analysis of financial data for 2016-17, supplemented by more recent data sources when available. It also comments on developments in 2017-18 and looks at some of the issues likely to be confronting aged care sector in the future.

This is my first report as chair of ACFA and I was very pleased to have been appointed to this position from 1 May 2018. I would like to acknowledge and thank on behalf of the members of ACFA the enormous contribution of my predecessor, Lynda O'Grady. Lynda was the inaugural chair of ACFA and served from 1 August 2012 until 30 April 2018. Through Lynda's leadership she helped establish ACFA as an important contributor to developing aged care policy, helping all stakeholders gain a better understanding of the sector and its dynamics, and providing high quality advice on aged care funding and financing. An example of this is the significant input ACFA had to David Tune's comprehensive report on the *Legislated Review of Aged Care 2017*.

The aged care sector is vital to the comfort and wellbeing of older Australians as well as being an important contributor to the Australian economy, representing 1 per cent of Gross Domestic Product and directly employing over 366,000 people. It is also one of the fastest growing industries in Australia. The ageing of the population and longer life expectations will result in a significant increase in the number and proportion of Australians needing aged care. The demographic trends are such that aged care is arguably one of the most important industries in Australia.

The aged care sector remains in a process of significant transition, with the Australian Government progressively implementing a major program of reform aimed at improving the affordability, sustainability and quality of aged care services, including by moving towards a more consumer-driven and market-based aged care industry where consumers and their families have greater choice and control over the services they receive. Many of the changes have only relatively recently been introduced, such as giving home care consumers choice of service provider and choice of services. The industry is still in the process of adjusting to these changes. The 2018-19 Budget also contained a number major measures relating to aged care.

In addition, there are a number of reviews underway or recently completed, that will likely have an important bearing on the future direction of the industry, such as the Review of the Aged Care Funding Instrument and the report from the Aged Care Workforce Strategy Taskforce. In this dynamic environment, ACFA will continue to focus on assessing and advising the Government and other stakeholders on the implications for funding and financing of the aged care sector and the implications for access to aged care services.

In this year's report, ACFA has included a new chapter (Chapter 11) which provides some observation on the challenges and pressures facing the Government, providers and consumers in the residential aged care sector.

ACFA will continue to perform its role not only through its annual report but also through other projects it is commissioned to undertake by the Minister responsible for aged care.

ACFA continued to consult widely over the past year and I would like to acknowledge and thank the aged care providers, peak bodies, financial institutions, other firms and consumers for their contribution. This involved not only informal discussions but also submissions to the range of projects that ACFA undertook over the past year. ACFA also held forums with representatives from the investment and finance sectors, providers and consumers. ACFA will continue with a very active program of consultation with all stakeholders for this is critical to its understanding of the issues, developments and challenges that are not only confronting aged care providers but also consumers.

ACFA looks forward to continuing and enhancing its role in advising the Government and informing other stakeholders of the funding and financing issues confronting the aged care sector, and to work towards ensuring its sustainability and viability and better access by consumers to quality aged care.

**Mike Callaghan AM PSM**
Chairman
Aged Care Financing Authority

# Executive Summary

## Aged care in Australia

The aged care sector in Australia provides services to over 1.3 million Australians and generates annual revenues totalling around $22 billion. The sector makes a significant contribution to the Australian economy, representing 1 per cent of Gross Domestic Product (GDP).

Total Australian Government expenditure on aged care in 2016-17 was $17.1 billion, up from $16.2 billion in 2015-16. Funding for aged care included:

- $2.4 billion for home support
- $1.6 billion for home care
- $11.9 billion for residential care
- $1.3 billion for flexible and other aged care

Australian Government expenditure is expected to be $18.6 billion in 2017-18, and increase to $22.2 billion by 2020-21.

Consumer expenditure on aged care was around $4.8 billion in 2016-17 (excluding accommodation deposits).

## Aged care workforce

As noted in ACFA's annual report last year, the 2016 National Aged Care Workforce Census and Survey reported that:

- there are over 366,000 paid workers in aged care with a further 68,000 volunteers;
- more than half of all workers are in residential care;
- the residential care workforce is relatively stable with 25 per cent of workers having been in the sector for over 14 years;
- aged care workers have high levels of job satisfaction, but have concerns regarding remuneration, time available to provide care and a perception that aged care is not valued highly by the general community; and
- reported times to fill vacancies are not indicative of a tight labour market, though some providers, particularly in remote areas, have difficulties in recruiting appropriately qualified staff.

The Aged Care Workforce Taskforce was established in 2017 to develop an Aged Care Workforce Strategy. The Taskforce undertook consultation over the period November 2017 to May 2018. Taskforce delivered its Strategy to the Minister for Aged Care on 29 June 2018.

## Aged care reforms

ACFA has previously concluded that the 2014 funding and financial reforms strengthened the viability and sustainability of the sector, although more recent developments suggest the sector is facing increased financial pressures. ACFA also notes that some of the consumer focussed reforms resulted in challenges for consumers and providers. Some of ACFA's observations on the impact of the changes include:

- the pool of lump sum accommodation deposits held by providers continues to grow ($24.8 billion[1] at 30 June 2017, up from $21.9 billion at 30 June 2016 and $15.6 billion when the reforms began on 1 July 2014);
- for the first time since the reforms of July 2014, refundable accommodation deposits (RADs) were not the preferred method of accommodation payment, with daily payments being slightly more popular during 2016-17;
- means testing arrangements in residential care and income testing in home care have not affected overall access to care, although proportionally less self-funded retirees and part-pensioners are accessing home care package levels 1 and 2 compared with levels 3 and 4.

The significant reforms in home care included the commencement on 27 February 2017 of packages following consumers. Packages are now assigned to consumers who are able to select the provider of their choice. The 2016-17 financial data will only start to reflect the impact of these reforms. ACFA will continue to provide commentary on the effect of this change on consumers and providers in future annual reports.

1 This differs from the figure of $24.7 billion in Chapter 10 of this report and section 10 of the short-form report as $24.8 billion is the lump sum deposits held by all residential care providers whereas $24.7 billion is the total held by the 99 per cent of residential care providers who submitted their ACFRs.

The 27 February 2017 reforms also introduced the National Prioritisation Queue which made the potential extent of demand for home care packages transparent for the first time. ACFA considers that further analysis is required to better understand the extent to which the queue represents unmet need for aged care.

ACFA also notes that with the changes of February 2017, home care providers are holding a high level of unspent funds on behalf of consumers ($329 million at 30 June 2017) which is required to be returned to the Commonwealth and the consumer (proportional to their respective contributions) when a consumer leaves care. The level of unspent funds could increase substantially in the medium term. ACFA considers that a review of policies concerning unspent package funds and the implications for the home care package program is warranted.

## Access to aged care

The overall aged care provision target ratio is being adjusted to progressively increase from 113 operational places (packages in home care) per 1,000 people aged 70 and over in 2012 to 125 by 2021-22. Over the same period the target for home care packages will increase from 27 to 45, while the residential care target is to reduce from 86 to 78. The remaining two places are for the STRC Programme.

In 2016-17:

- 239,379 older Australians received services through permanent residential care and 59,228 received residential respite care, compared with 234,931 and 56,852 in 2015-16;
- The provision ratio achieved for residential care at 30 June 2017 was 77.9;
- 97,516 consumers were in receipt of a home care package at some stage during 2016-17. 151,500 home care packages will be required by 2021-22 in order to meet the target ratio of 45; and
- 722,838 consumers received services through the Commonwealth Home Support Programme (CHSP), and 62,089 older Australians received services through the Western Australian Home and Community Care (HACC), compared with 640,000 CHSP consumers and 285,432 HACC consumers in Victoria and Western Australia in 2015-16.

Usage of aged care increases significantly with age. Thirty-three per cent of people aged 70 and over access some form of subsidised aged care and this rises to 70 per cent for people aged 85 and over.

Admissions to both home care and residential care have been broadly stable since the reforms of 1 July 2014. ACFA's observations regarding admissions and occupancy for residential care in 2016-17 are:

- the proportion of admissions to residential respite care continued to increase compared with permanent care; and
- average occupancy in residential care dropped to 91.8 per cent from 92.4 per cent after being stable in recent years;

On-going demographic changes will see a continuing increase in demand for aged care, as the proportion of people aged 85 and over grows to nearly 5 per cent of the population by 2055, compared with just over 2 per cent today.

During 2016-17, across all residential care, the average proportion of supported residents (excluding residents receiving extra services) was 48.5 per cent compared with 46.8 per cent in 2015-16 and 47.0 per cent in 2014-15.

ACFA notes that one measure that has been used for monitoring access to aged care services relative to the ageing of the population is progress towards achieving population-based operational provision ratios. Since the February 2017 reforms which introduced assigning packages to consumers instead of allocating packages to providers, it is no longer possible to calculate provision ratios for home care packages using the methodology used prior to the February 2017 reforms. ACFA considers that the provision ratios need to be recalibrated to allow trends in access to continue to be monitored.

## Home support

In 2016-17, the Australian Government provided total home support funding of $2.4 billion. CHSP services were provided to 722,838 consumers and a further 62,089 in the Western Australian HACC. There were 1,523 CHSP providers and 98 HACC providers in Western Australia.

The Victorian HACC program transitioned into the CHSP on 1 July 2016, followed by the Western Australian HACC program on 1 July 2018.

## Home care – operational performance

Home care providers received an estimated $1.85 billion in revenue in 2016-17, incurred around $1.65 billion in expenses and generated $201 million in profit. Total Commonwealth funding was $1.68 billion.

Consumers of home care contributed around $150 million toward the cost of their care through basic daily fees and income tested fees.

The financial performance of home care providers continued to be relatively strong in 2016-17 but reported a slight decrease in profits compared with 2015-16.

- 75 per cent of home care providers generated a net profit, the same as 2015-16.
- The average EBITDA per consumer per annum was $2,989, down slightly from $3,055 in 2015-16.

## Residential aged care – characteristics of the sector

In 2016-17, there were 902 residential care providers who operated 200,689 places. The residential aged care sector is continuing to consolidate, with the number of residential care places increasing while the number of providers continues to decrease gradually.

## Residential aged care – operational performance

Residential care providers generated revenue of $17.8 billion in 2016-17, equating to $269.55 per resident per day, an increase of 2.1 per cent from 2015-16. Total expenses were $16.8 billion, equating to $254.29 per resident per day, an increase of 2.7 per cent from 2015-16.

Residents contributed around $4.5 billion toward their living expenses, care and accommodation (excluding lump sum accommodation deposits).

ACFA notes that the financial performance of residential care providers in 2016-17 was broadly stable, although notes concerns from the sector regarding declining results in 2017-18.

In 2016-17:

- 68 per cent of residential providers achieved a net profit compared with 69 per cent in 2015-16 and 68 per cent in 2014-15;
- Average EBITDA per resident per annum increased from $11,134 to $11,481, an increase of 3.1 per cent; and
- Total profit for the sector was $1,006 million, a 5.4 per cent decrease compared with 2015-16.

ACFA notes that the changes to the Aged Care Funding Instrument (ACFI) and an indexation pause appear to be reflected in reduced financial results in 2017-18, as reported by the sector and through financial surveys conducted by StewartBrown. The 2017-18 financial results for residential care providers are likely to show a decline compared with 2016-17.

## Residential aged care – capital investment

At 30 June 2017, compared with 30 June 2016, the industry as a whole had:

- total assets of $45.0 billion, up from $40.7 billion. This includes:
  - $8.2 billion of cash and other current financial assets
  - $23.0 billion of fixed assets;
  - $5.5 billion of intangible assets;
  - $4.3 billion of related party loans;
  - $1.4 billion of receivables;
  - $1.4 billion of non-current financial assets; and
  - $1.3 billion of other assets.
- total liabilities of $33.7 billion, up from $29.8 billion, including $24.7 billion in accommodation deposits (including bonds) up from $21.9 billion. It also includes:
  - $1.9 billion in bank borrowings;
  - $2.6 billion in related party loans;
  - $1.3 billion in employee provisions; and
  - $3.2 billion in other liabilities.
- net assets of $11.3 billion, up from $10.9 billion.

In 2016-17:

- average return on equity was 18.3 per cent, up from 17.7 per cent in 2015-16; and
- average return on assets was 4.6 per cent, down from 4.9 per cent in 2015-16.

As noted in recent annual reports, investment in residential care has been strong since the 1 July 2014 reforms. In 2016-17, $2.1 billion of new construction work was completed, compared with $1.6 billion in 2015-16. However, the proportion of providers who reported they are planning to rebuild or upgrade facilities over the next 12 months dropped significantly compared with recent years.

It is estimated that the residential care sector will need to build an additional 88,110 places over the next decade in order to meet the provision target of 78 operational places per 1,000 people aged 70 and over. The estimated investment requirement of the sector over the next decade is in the order of $54 billion.

## Residential aged care – funding and financing challenges

Against the background of the financial developments canvassed in this report, and in particular the apparent decline in the financial performance of the residential aged care sector in 2017-18, this year's report includes a new chapter (Chapter 11) that highlights that all stakeholders – Government, providers and consumers – have a role to play in delivering a residential aged care sector that is financially viable, stable, efficient, effective, responsive and sustainable.

Specifically, ACFA highlights that some of the specific challenges confronting stakeholders include:

For Government – there is a need for a more stable, more contemporary, more efficient and more effective funding tool and system which provides greater financial stability to both the residential aged care sector and the Government. The Government also has the continuing challenge of ensuring ongoing equity of access for all consumers and that its funding arrangements do not incentivise outmoded or inefficient care practices and use of resources. The current review of the Aged Care Funding Instrument (ACFI) is timely and it would be desirable to consider indexation settings alongside the review of funding options.

For providers – there is an increasing need to look at their internal operations to ensure they are delivering quality care in the most efficient and effective way. The changes taking place in the sector as it moves towards a more consumer driven and market based system will continue to challenge traditional business and workforce models. Providers will need to be increasingly responsive and flexible. Under the current funding system, there are very diverse financial outcomes. The top quartile of providers, in terms of profit continue to achieve significantly better results than the lowest quartile. This very wide variation in financial performance across the sector suggests there is scope for many providers to pursue greater efficiencies and improve their results.

For consumers – there is a need for wider recognition that sustainable aged care funding arrangements will require those consumers who can afford to do so making a greater financial contribution towards their everyday living expenses and care costs, complemented by greater choice of higher quality services.

# The Aged Care Financing Authority and the 2017 Annual Sector Report

# 1

## This report

# 1. This report

## 1.1 Aged care in Australia

The aged care sector in Australia provides services to over 1.3 million Australians and generates annual revenues totalling around $22 billion. The sector makes a significant contribution to the Australian economy, representing 1 per cent of Gross Domestic Product (GDP).

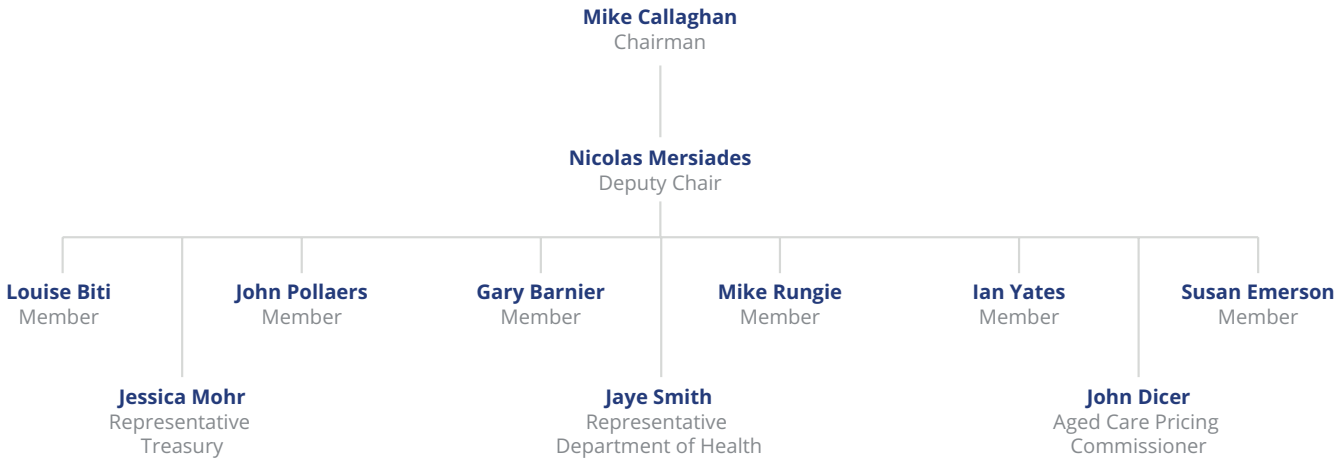
The sector remains heavily reliant on taxpayer funding, receiving $17.1 billion in Commonwealth funding in 2016-17, an increase of 8.1 per cent from 2015-16. Almost 70 per cent of total funding ($11.9 billion) was for residential care. Given the amount of taxpayer funding, objective and thorough analysis of the funding and financing of the sector is of central importance to the Government, aged care consumers and providers.

## 1.2 About the Aged Care Financing Authority

The Aged Care Financing Authority (ACFA) is a statutory committee whose role is to provide independent, transparent advice to the Australian Government on funding and financing issues in the aged care sector. ACFA considers issues in the context of maintaining a viable and sustainable aged care industry and accessible services that balance the needs of consumers, providers, the workforce, taxpayers, investors and financiers.

ACFA is led by an independent Chairman (Mike Callaghan[2]) and Deputy Chair (Nicolas Mersiades) complemented by six members with aged care or finance sector expertise. Figure 1.1 shows the ACFA membership and structure. Further details about each member are provided in Appendix A. There are three non-voting Australian Government representatives on ACFA, who are also detailed in Appendix A.

**Figure 1.1: ACFA membership**




2 Mike Callaghan commenced as ACFA chairman in May 2018. Prior to this, Lynda O'Grady held the position of chairman since ACFA's inception in 2012.

## 1.3 The Annual Report on the Funding and Financing of the Aged Care Sector

Each year ACFA is required to provide the Minister responsible for aged care with a report on the funding and financing of the aged care sector. The objective of the annual report is to provide advice to the Minister regarding the impact of funding and financing arrangements on:

- The viability and sustainability of the aged care sector;
- Consumer access to aged care services; and
- The aged care workforce.

Over time, each annual report builds upon the last, producing a substantial body of in-time as well as trend data on the funding and financing of the aged care sector. This is the sixth annual report published.[3]

### 1.3.1 Methodology

The 2018 annual report mainly presents and analyses 2016-17 data, although this is supplemented by more recent data sources in some cases when available.

The principal data sources are financial and administrative data collected by the Department of Health:

- From Commonwealth Home Support Programme providers (CHSP) (Home and Community Care providers in WA):
  - CHSP Data Exchange; and
  - HACC Minimum Data Set (WA).
- From home care providers:
  - Aged Care Financial Reports (ACFR).
- From residential care providers:
  - Aged Care Financial Reports (ACFR);
  - General Purpose Financial Reports (GPFR);
  - Annual Survey of Aged Care Homes (SACH); and
  - Published aged care accommodation prices (My Aged Care website).
- Other general data:
  - The 2016-17 Report on the Operation of the *Aged Care Act 1997* (ROACA);
  - The 2016 National Aged Care Workforce Census and Survey; and
  - Relevant supplementary information from industry analysts, including StewartBrown.

In addition to these listed data sources, ACFA consults widely with the sector, with relevant financiers and other key stakeholders. A list of organisations that ACFA has consulted is provided at Appendix C.

When discussing the financial performance of providers in this report, Earnings Before Interest, Taxes, Depreciation and Amortisation (EBITDA) is the main measure used to analyse profitability. This is because EBITDA excludes items such as interest (both income and expense) and tax expenditures, which can vary depending on the financing decisions of an organisation; and non-cash expenses, such as depreciation and amortisation which can vary greatly based on the size and age of facilities and other assets, and on ownership type and depreciation methods.

EBITDA therefore can be used to compare organisations with each other and against industry averages and is a good measure of core profit trends because it eliminates some of the extraneous factors mentioned above. This is particularly important when analysing aged care given the diversity of ownership and capital structures. EBITDA helps to smooth out these factors.

This report also refers to Net Profit Before Tax (NPBT). Both NPBT and EBITDA exclude tax, which can assist in making comparison between organisations subject to different tax treatments.

The financial analysis and commentary in this report does not include National Aboriginal and Torres Strait Islander Flexible Care Program providers, providers operating Multi-Purpose Services or providers under the Short Term Restorative Care Programme.

As discussed in previous annual reports, it is important to be mindful of the sector composition and the varying objectives of providers when interpreting the data. The sector continues to be dominated by not-for-profit providers. Traditional profit-based measures are not always consistent with the mission and objectives of not-for-profit providers.

**Considerations and limitations**

As reforms in aged care continue, some forms of service delivery, and therefore data collection, are changing. For this reason, analysis in the 2018 annual report is not always directly comparable with analysis contained in previous reports. Where this is the case it is noted.

The majority of financial data available to ACFA regarding residential and home care is at the approved provider level. Because many providers have services in multiple locations, ACFA is

3 Previous ACFA annual reports can be accessed at https://agedcare.health.gov.au/aged-care-reform/aged-care-financing-authority

constrained in its ability to analyse performance at facility or service level or the impact of locational factors on funding, financing and financial performance of services.

In 2016-17, the Aged Care Financial Reports (ACFR) were used by residential care providers to report financial data to the Department for the first time. While the ACFR provides ACFA with greater detail for analysis, it does not allow comparisons with previous years in some instances.

### 1.3.2 Navigating the 2018 annual report

The 2018 annual report is structured as follows:

- **Chapter 2 Aged care in Australia.** Provides an overview of the aged care sector in Australia.
- **Chapter 3 Aged care workforce.** Provides an overview of the aged care workforce, based mainly on the 2016 National Aged Care Workforce Census and Survey.
- **Chapter 4 Aged care reforms.** Discusses on-going reforms in aged care.
- **Chapter 5 Access to aged care.** Discusses the supply of, and access to, subsidised aged care in Australia.
- **Chapter 6 Home support.** Provides an overview of home support through the Commonwealth Home Support Programme and the Home and Community Care program in Western Australia.
- **Chapter 7 Home care: operational performance.** Discusses the provision of home care through the Home Care Packages Programme and a summary of financial performance of providers in 2016-17.
- **Chapter 8 Residential aged care: characteristics of the sector.** Discusses residential aged care, focusing on the scale, ownership and locational characteristics of residential aged care providers and their facilities.
- **Chapter 9 Residential aged care: operational performance.** Provides information on the financial performance of residential aged care providers in 2016-17.
- **Chapter 10 Residential aged care: capital investment.** Provides discussion pertaining to provider balance sheets and capital investments.
- **Chapter 11 Residential aged care: funding and financing challenges.** Provides an outline of issues facing the residential aged care sector as financial performance declines in 2017-18 compared with previous years.

Analysis of providers in this report is generally presented in four ways:

- Whole of sector (refers to all providers operating a particular type of care);
- Ownership type (not-for-profit, for-profit or government-owned);
- Location (metropolitan, regional (all areas outside of major cities), mix of metropolitan and regional); and
- Scale (number of services[4] operated by a home care provider or number of facilities operated by a residential care provider).

When referring to a facility 'size' the report is referring to the number of beds operated by a single residential aged care facility.

When referring to 'government owned', the report is referring to services owned and operated by state, territory and local governments. The Australian Government does not own or operate aged care facilities or services.

4 A home care service is a location to which a consumer goes to interact with an approved home care provider regarding their package of services.

# 2

# Aged care in Australia

# 2. Aged care in Australia

**This chapter provides an overview of the Australian aged care sector.**

**This chapter discusses:**

- types of subsidised aged care in Australia
- the regulation of the supply of aged care services
- Commonwealth and consumer expenditure on aged care

**This chapter reports that:**

- Australian Government total expenditure on aged care was $17.1 billion in 2016-17, up from $16.2 billion in 2015-16;
- total expenditure is expected to be $18.6 billion in 2017-18, and increase to $22.2 billion by 2020-21;
- services were provided to over 1.3 million[5] people in 2016-17; and is estimated to increase to 1.5 million by 2020-21;
- services were provided by:
  - 1,523 Commonwealth Home Support Programme providers (which includes the Victorian HACC providers which transitioned as of 1 July 2016), compared with 1,160 CHSP providers plus 421 HACC providers in Victoria in 2015-16;
  - 98 providers of HACC in Western Australia (105 in 2015-16);
  - 702 home care providers (496 in 2015-16); and
  - 902 residential care providers (949 in 2015-16).
- During 2016-17, 71 per cent of Australians aged 65 years and over lived at home without accessing Government subsidised aged care services, 22 per cent accessed some form of support or care at home, while 7 per cent accessed residential aged care[6].

## 2.1 Overview

The aged care system is continuing to undergo reform so that it more effectively and efficiently supports older people to live in their homes and communities for as long as possible, and enables people to make informed decisions about their care, while remaining sustainable for taxpayers and service providers. Older Australians can access a spectrum of aged care, ranging from home based support through to care provided in residential settings.

Many aged care services are subsidised and regulated by the Australian Government. Figure 2.1 illustrates the Commonwealth subsidised Australian aged care system.

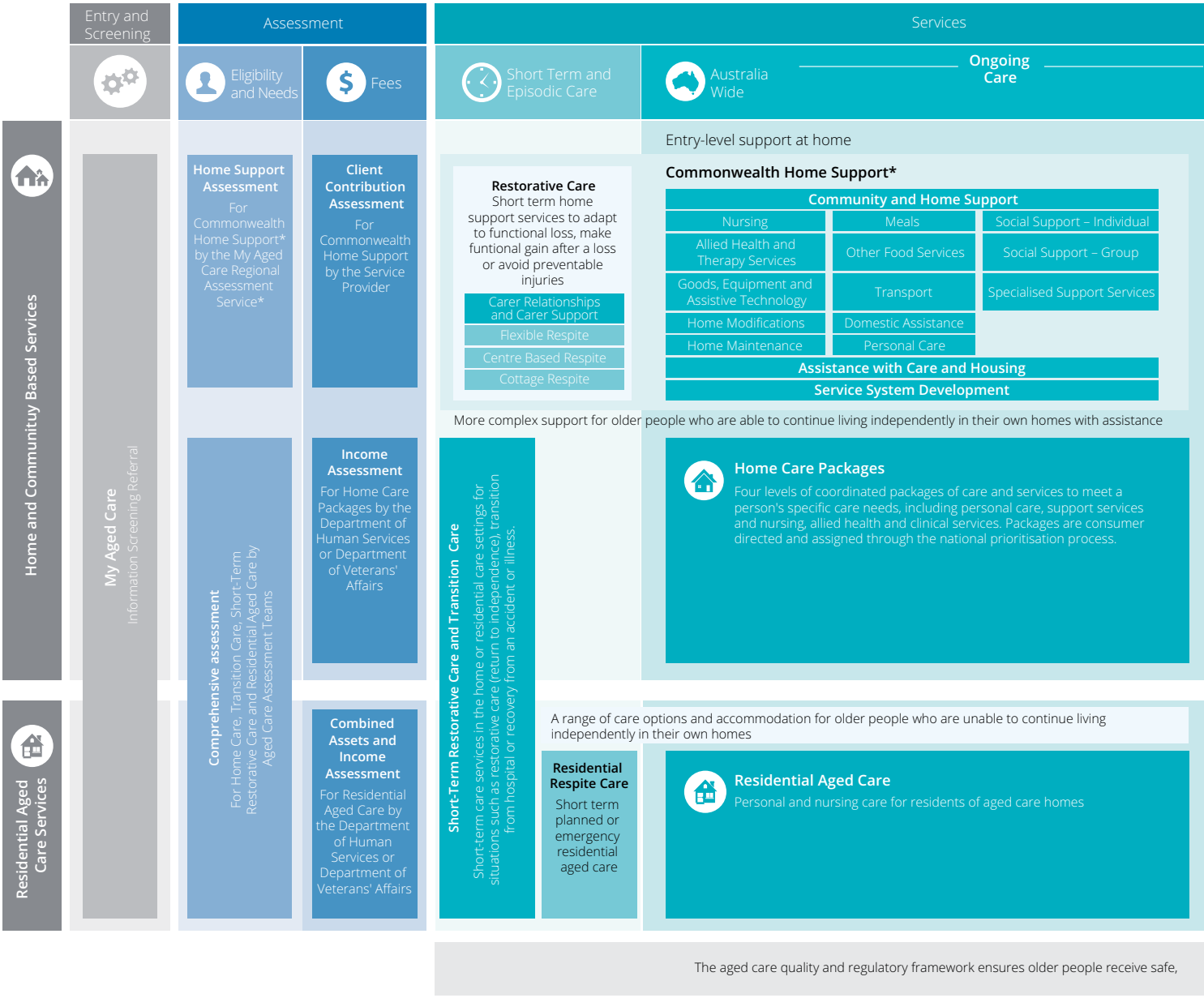
My Aged Care, administered by the Department of Health, is responsible for arranging an assessment of a person's eligibility for Commonwealth funded aged care services. The assessment determines the level of care and support for which the individual may be eligible.

Means testing conducted by the Department of Human Services determines whether an individual is required to make a contribution towards the cost of their care and accommodation, and the amount of the contribution.

5 The figure of 1.3 million consumers includes all consumers of Government funded aged care. Much of this report discusses only home support, home care and residential care and therefore total consumers reported may not always match.

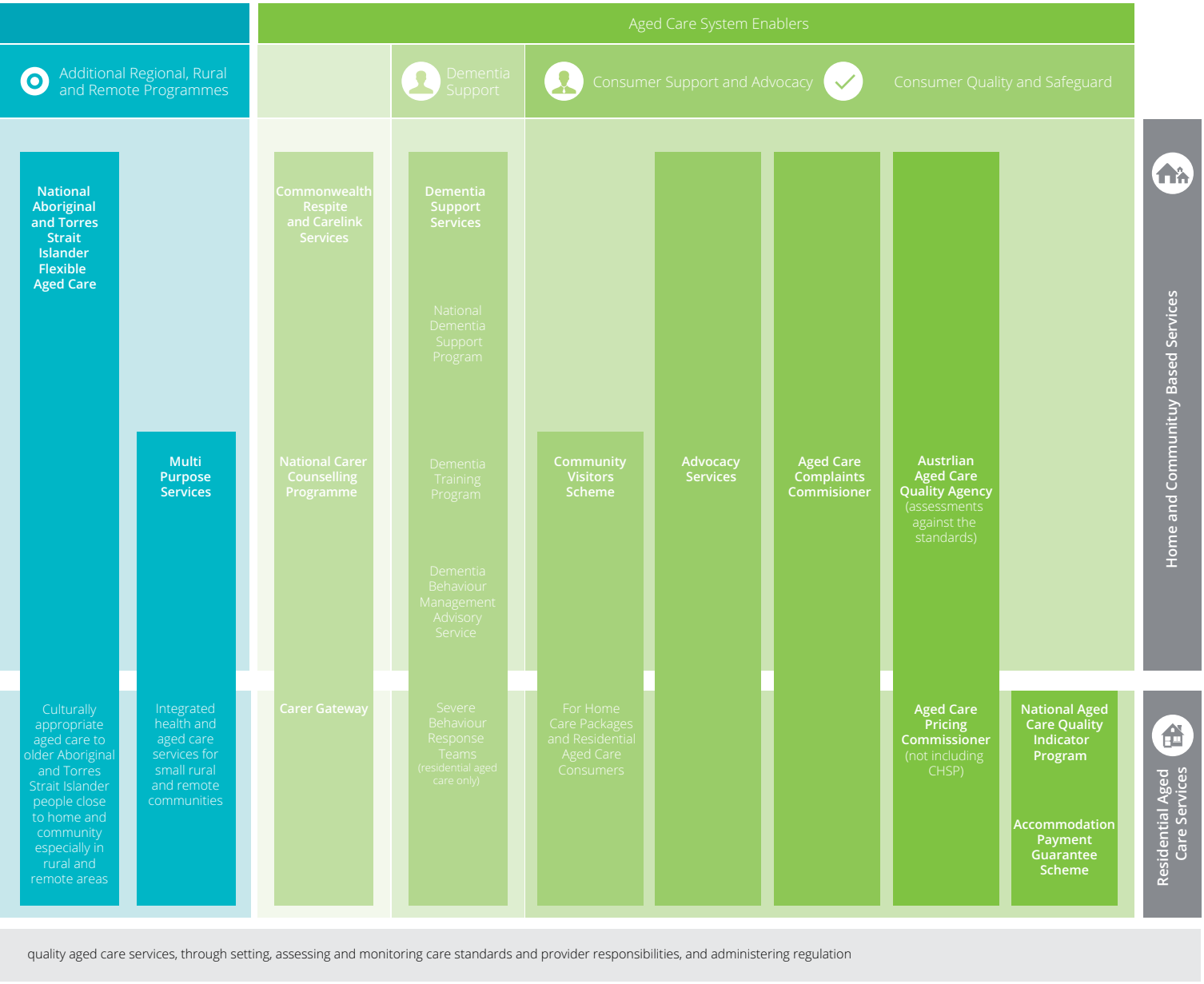
6 In ACFA's 2015-16 report, the proportion of people aged 65 and over living at home while accessing home support and care was reported as 25 per cent, compared with 22 per cent in this report. The difference is primarily due to the counting methodology employed for CHSP consumer data being different in 2015-16 compared with 2016-17.

**Figure 2.1: Australian aged care system – guide to Australian Government subsidised aged care services, as at February 2018**




* Home support assessment and some home support services may be different in Western Australia as these services are still administered by the Western Australian state government.
Home support services for older people in Western Australia will transition to the Commonwealth from 1 July 2018. My Aged Care can assist older people in Western Australia to access state specific home support assessment and these services.

The Department of Veterans' Affairs also provides Australian Government subsidised aged care services. The Department of Social Services has responsibility for carers policy and service delivery.




quality aged care services, through setting, assessing and monitoring care standards and provider responsibilities, and administering regulation

## 2.2 Current aged care

In this report, the aged care sector is mainly discussed in terms of three programs:

- **Commonwealth Home Support Programme (CHSP) (Home and Community Care (HACC) in Western Australia):** Provides services for those who require basic services to assist with remaining in their own homes. On 1 July 2015, the CHSP was implemented, combining the previous Commonwealth HACC program[7], the National Respite for Carers Program, Day Therapy Centres and Assistance with Care and Housing for the Aged. On 1 July 2016, the HACC Program in Victoria transitioned to the CHSP and on 1 July 2018 HACC services in Western Australia were also incorporated into the CHSP so that all states and territories now operate under the CHSP.
- **Home Care Packages Programme:** Provides services for those who have greater care needs and wish to remain living at home. Care and support is provided through a package of home care services.
- **Residential care:** Provides accommodation and 24 hour care for those who have greater care needs and choose or need to be cared for in an aged care facility. Care can be provided on either a temporary (respite) or permanent basis.

Table 2.1 shows the number of providers, services, places, consumers and Commonwealth and consumer funding for each of the three care types for the five years to 2016-17.

In addition there are care types about which, due to a lack of financial data, ACFA does not provide analysis or commentary. These are:

- **Flexible care:** Services in either a residential or home care setting, that, due to difficulties in delivering services in some communities, are delivered using different care approaches than that provided through mainstream residential and home care. Examples of flexible care include Multi-Purpose Services in rural and remote locations and Aboriginal and Torres Strait Islander flexible care.
- **Restorative care:** Services that focus on enhancing the physical and cognitive function of people who have lost or are at risk of losing condition and independence. The Short-Term Restorative Care (STRC) Programme, which commenced in February 2017, aims to reverse and/or slow 'functional decline' in older people and improve their wellbeing through the delivery of a time-limited, goal-oriented, multi-disciplinary and co-ordinated range of services. The Transition Care Programme seeks to optimise the functioning and independence of older people after a hospital stay, enabling them to return home rather than enter residential care.

7 The Commonwealth Home and Community Care program was created on 1 July 2012 following agreement to the transfer of all formerly joint Commonwealth-state/territory HACC programs, except Victoria and Western Australia.

**Table 2.1: Aged care in Australia 2012–13 to 2016-17**

| | 2012–13 | | | 2013–14 | | | 2014-15 | | | 2015-16 | | | 2016-17 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Home support | Home care | Residential care | Home support | Home care | Residential care | Home support | Home care | Residential care | Home support | Home care | Residential care | Home support | Home care | Residential care |
| Number of providers | 1,636 | 504 | 1,034 | 1,676 | 504 | 1,016 | 1,628 | 504 | 972 | 1,686 | 496 | 949 | 1,621 | 702 | 902 |
| Numbers of services | N/A | 2,131 | 2,720 | N/A | 2,212 | 2,688 | N/A | 2,292 | 2,681 | N/A | 2,099 | 2,669 | N/A | 2,367 | 2,672 |
| Number of places | N/A | 60,308 | 186,278 | N/A | 66,149 | 189,283 | N/A | 72,702 | 192,370 | N/A | 78,956 | 195,825 | N/A | N/A[8] | 200,689 |
| Number of consumers | 756,148 | 82,895 | 226,042 | 775,959 | 83,144 | 231,515 | 812,384 | 83,838 | 231,255 | 925,432 | 88,875 | 234,931 | 784,927 | 97,516 | 239,379 |
| Commonwealth funding ($ billion) | $1.6b | $1.2b | $9.2b | $1.7b | $1.3b | $9.8b | $1.9b | $1.3b | $10.6 b | $2.2b | $1.5b | $11.4b | $2.4b | $1.6b | $11.9b |
| Consumer contribution | N/A | $84m | $3.8b | N/A | $87m | $4.0b | N/A | $136m | $4.2b | N/A | $142m | $4.5b | $204m | $150m | $4.5b |

**Notes:**

1. This table only shows data for the three main types of Government funded aged care: CHSP (and Vic/WA HACC), home care and residential care. Therefore total consumers of aged care does not match the 1.3 million stated at the beginning of this chapter as that figure includes all other types of Government funded aged care.
2. Home support for the years 2012-13 to 2014-15 comprises Commonwealth HACC as well as Vic and WA HACC, in 2015-16 comprises CHSP as well as VIC and WA HACC and in 2016-17 comprises CHSP as well as WA HACC.
3. Commonwealth funding for home support in 2015-16 and 2016-17 includes funding for My Aged Care and Regional Assessment Service (RAS) to support the CHSP ($148 million in 2015-16 and $123 million in 2016-17).
4. The number of consumers of home support in 2015-16 (925,432) includes 285,432 for Vic and WA HACC and an estimate of over 640,000 in the CHSP as accurate data was not available. Due to the lack of accurate data and differences in counting methods the CHSP consumers for 2015-16.
5. The amounts shown for home care consumer contributions in last year's ACFA report ($147m in 2014-15 and $160m in 2015-16) were incorrect.

8 Since the changes in February 2017, packages are no longer allocated to providers. Instead packages are assigned to consumers who choose their preferred service provider.

## 2.3 Australian Government expenditure on aged care

The Australian Government spent $17.1 billion on aged care in 2016-17, up from $16.2 billion in 2015-16. In 2017-18, total Australian Government funding is expected to be $18.6 billion with $22.2 billion budgeted for 2020-21. Chart 2.1 shows total Commonwealth funding in aged care since 2012-13 and budgeted expenditure to 2020-21.

Funding for residential care is by far the largest proportion of Commonwealth expenditure at 66.2 per cent. The proportions of Commonwealth funding across the sector are illustrated in Chart 2.2.

Australian Government expenditure on aged care is projected to nearly double as a share of the economy from 1 per cent currently to around 1.7 per cent of GDP by 2055[9]. Costs of care will continue to rise on account of growth in input costs (e.g. wages) and the increasing complexity of chronic health conditions in ageing populations.

Table 2.2 shows the total Australian Government expenditure on home support, home care and residential care in terms of cost per consumer.

In previous annual reports, ACFA noted that the shift in the balance of care in favour of home care over residential care is expected to improve affordability for taxpayers over the long term. This is because the costs of accommodation associated with residential care are not incurred with home care, and because, on average, higher care subsidies apply in residential care. It should be noted, however, that there are many home care consumers with higher care needs who are in receipt of a lower level package until a package suitable to their needs becomes available. This would mean that the average expenditure per consumer for home care would be higher if all consumers had packages matched to their assessed care needs. This is discussed in chapter 7.

**Chart 2.2: Australian Government total budgeted aged care expenditure, 2017-18**

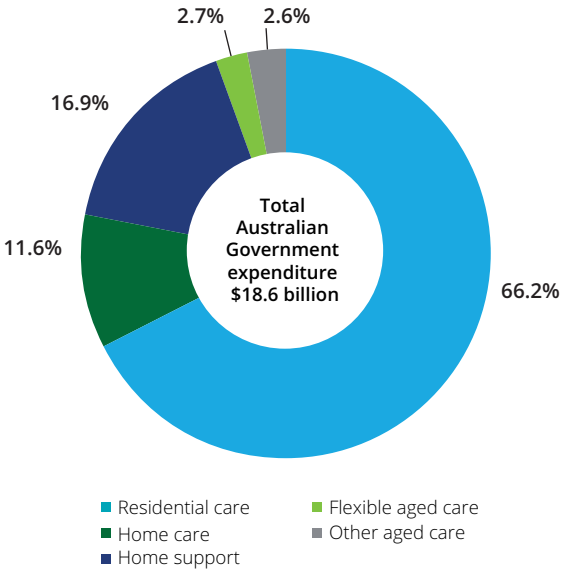
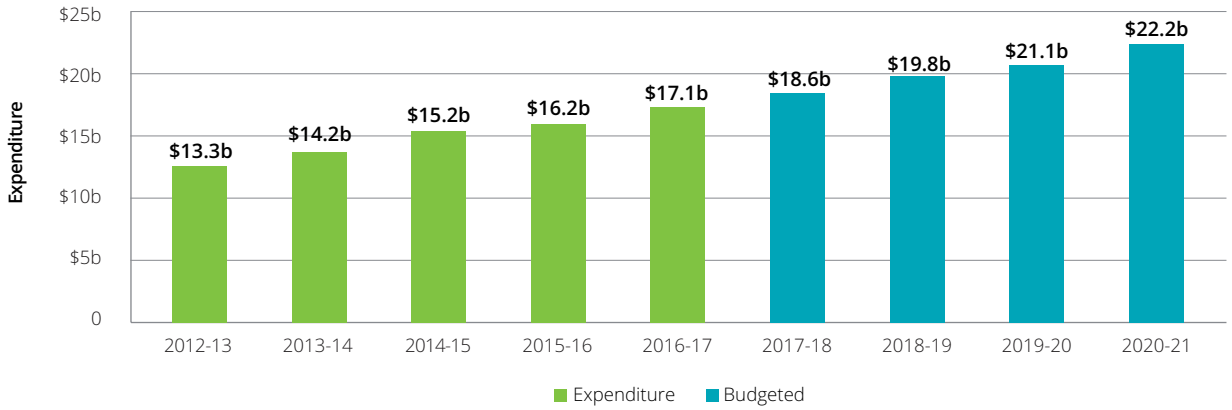



**Chart 2.1: Australian Government total aged care expenditure, 2012–13 to 2016–17 and total budgeted aged care expenditure, 2017–18 to 2020–21**




9 Department of the Treasury *Intergenerational Report, 2015*.

**Table 2.2: Australian Government expenditure, per consumer, 2016-17**

| | Commonwealth expenditure | Consumers | Average expenditure per consumer |
|---|---|---|---|
| Home support | $2,271m | 784,927 | $2,893 |
| Home care | $1,586m | 97,516 | $16,264 |
| Residential care | $11,903m | 239,379 | $49,724 |

**Notes**

1. Residential care consumers includes permanent residents only.
2. Does not include Commonwealth expenditure for flexible aged care and 'other' aged care.
3. The figure for home support includes $188m for HACC in Western Australia which is not part of the CHSP.

## 2.4 Consumer contributions

Most aged care consumers contribute to the cost of their care.

In residential care, consumers contribute 85 per cent of the single age pension towards their living expenses and, subject to means testing, may be required to contribute towards their accommodation and care costs. In 2016-17, residents contributed $3.1 billion towards their living expenses, $753 million towards accommodation costs (excluding lump sum deposits) and $547 million towards care costs.

Consumers of home care packages in 2016-17 contributed around $150 million to their care costs in 2016-17, while Commonwealth Home Support Programme consumers contributed $204 million.

Consumers may also choose to pay additional amounts to a provider to access additional levels of care or services (e.g. to 'top-up' funding available under a home care package, or to purchase additional lifestyle-related services in residential care).

## 2.5 Aged care providers

While the majority of providers operate only one type of aged care service, some operate two or all three types. Chart 2.3 shows the number of providers providing only one type, two types and all three types of services.[10]

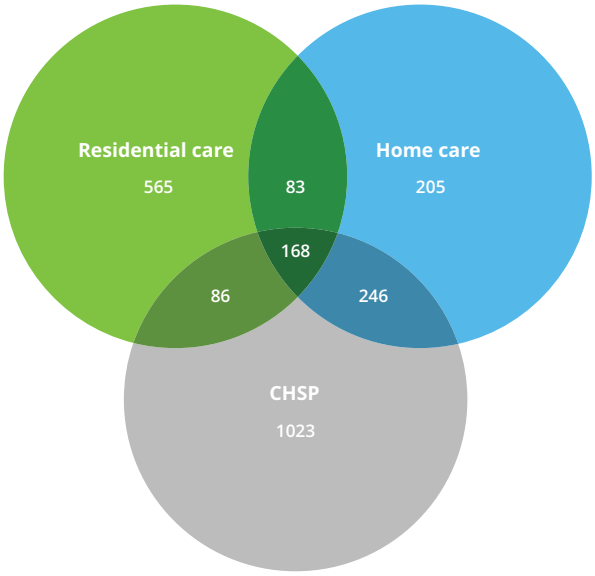
Of total providers:

- 7 per cent provide all three types of services (6 per cent in 2015-16).
- 17 per cent provide two service types (16 per cent in 2015-16).
- 76 per cent of providers provide one type of service only (78 per cent in 2015-16).

As these figures show, there appears to be a high degree of specialisation in terms of service types offered by providers (although 2016-17 shows a slight increase over 2015-16 in terms of providers offering multiple types). ACFA does however suspect there may be more occurrences of providers providing more than one service than reported here, however separate provider registration in the three different sub-sectors means this is not always apparent, as providers often have different ABNs and different trading names.

As was the case in previous ACFA Reports, this analysis excludes Western Australia HACC providers as information on whether these providers also provide residential or home care is not available. However, for the first time, the analysis does include the former Victorian HACC providers as they were incorporated into the CHSP on 1 July 2016. While the inclusion of Victorian HACC providers increased the number of providers in each service type, the overall level of specialisation regarding service types has not changed.

**Chart 2.3: Number of providers, by service type, 2016-17**




10 ACFA notes that some aged care providers, especially not-for-profit providers, also provide disability services and seniors' housing.

## 2.6 Regulation of supply

The Australian Government regulates the supply of services offered through the Commonwealth Home Support Programme (CHSP) through a capped funding amount that is indexed annually. Similarly, the Commonwealth contribution toward the joint Commonwealth-state funded Western Australian Home and Community Care (HACC) program was also capped and indexed. The Western Australian HACC program transitioned to the CHSP from 1 July 2018 making CHSP a national program. The funding for CHSP and HACC is discussed in Chapter 6.

The Australian Government regulates the supply of residential aged care places and home care packages it funds by specifying targets. These targets, known as the aged care target provision ratios, are based on the number of people aged 70 and over for every 1,000 people.

Until 2016, new aged care places in both residential and home care were made available for allocation to approved providers each year through a competitive process known as the Aged Care Approvals Round (ACAR). The number and geographic distribution of new places allocated through the ACAR has regard to the target provision ratios, population projections, current level of service provision, estimated lead times to commission new services and the quality of applications from providers.

Changes implemented in February 2017 mean that home care packages are no longer allocated to home care providers through the ACAR process. Instead, eligible older Australians are assigned a home care package that they can direct to their preferred provider. However, the Australian Government continues to control the supply of home care packages through the target provision ratio. Residential care places are still allocated through the ACAR with consideration to the target provision ratios.

The aged care target provision ratios are discussed further in Chapter 5.

In last year's annual report, ACFA noted the results of the 2016-17 ACAR, which were announced in May 2017. An ACAR was not conducted for 2017-18. The 2018-19 ACAR will see 13,500 new residential aged care places, 775 short-term restorative care places and up to $60 million in capital grants available to successful approved providers, following a competitive application process.

## 2.7 Sector viability and sustainability

Population ageing means that there is growing demand for aged care. This requires significant investment in the sector, particularly in the capital intensive residential sector. The viability and sustainability of residential care and the expansion of services that will be required will be dependent on ongoing investment. The industry needs to generate rates of return on capital that are appropriate for the risk involved and are competitive with returns in other sectors.

Viable and well run providers are best placed to attract the financial capital, experienced management and quality staff required to deliver long term industry sustainability and growth. To be viable, a provider, whether not-for-profit, for-profit or government owned, must have access to sufficient funds to repair and replace their capital stock, be able to maintain working capital to support their operations, and use capital efficiently relative to the other purposes to which it could be deployed.

Investment activity requires equity investor and debt provider confidence in the capacity of providers to deliver sustainable returns on capital and of the sector overall. The amount of (and change in) invested capital is one key metric of sustainability.

While home support and home care providers do not require the same level of capital investment as residential care providers, there is also a requirement for ongoing investment to meet growing demand. This is discussed in Chapter 5.

## 2.8 Changing population

Demographic factors are the primary driver of increasing demand for aged care. It is recognised that Australia's population is not only ageing but Australians are also living longer, and many with chronic health conditions. This is bringing significant challenges and opportunities for the aged care system both now and in the years ahead.

In 2016-17, 10.6 per cent of Australians were aged 70 years and over and 2 per cent were aged 85 years and over. By 2028, an estimated 13.1 per cent of the population will be aged 70 years and over and 2.4 per cent will be 85 years and over.

The future demand growth for aged care services and the ageing of Australia's population profile is discussed in Chapter 5.

### 2.8.1 Independence

The majority of people aged 65 and over continue to live active, independent lives in the community, and go on contributing to their communities and the economy for many years. Where required and possible, the Australian Government provides support and assistance to help people remain living independent and active lives.

During 2016-17, 71 per cent of Australians aged 65 years and over lived at home without accessing Government subsidised aged care services, 22 per cent accessed some form of support or care at home, while 7 per cent accessed residential aged care.

Around 85 per cent of older people living in the community who require help with self-care, mobility or communication, receive assistance from the informal care network of family, friends and neighbours. Informal carers perform an essential role in caring for older people, especially in supporting older people living at home.

The Productivity Commission[11] has previously predicted that there are likely to be fewer informal carers relative to the growing older population and that the ability and willingness to provide informal care may also be declining. These trends may add to pressures on the aged care sector in the future.

11 Productivity *Commission, Caring for Older Australians* 2011.

# 3

# Aged care workforce

# 3. Aged care workforce

**This chapter provides an overview of the aged care workforce, as presented in the 2016 National Aged Care Workforce Census and Survey, and as summarised in last year's ACFA report.**

**This chapter reports that:**

- there are over 366,000 paid workers in aged care with a further 68,000 volunteers;
- more than half of all workers are in residential care;
- overall the personal care workforce in residential care, and in home support and home care, is more qualified when compared with the previous Census;
- the aged care workforce is relatively stable, with 25 per cent of workers having been in the sector for over 14 years;
- the average age of workers in residential care has decreased in recent years, with the average age in 2016 being 46 compared with 48 in 2012. By contrast, in home support and home care, the average age is two years older at 52 compared with 50 in 2012;
- overseas born workers continue to make up a significant proportion of the aged care workforce, with 32 per cent in residential care and 23 per cent in home support and home care; and
- some aged care providers, particularly in more remote areas, continue to report difficulties in recruiting appropriately qualified staff.

The Aged Care Workforce Taskforce was established by the Government in 2017 to develop an Aged Care Workforce Strategy. The Taskforce undertook consultation over the period November 2017 to May 2018.

On 29 June 2018, the Taskforce delivered its Strategy to the Minister for Aged Care.

## 3.1 Workforce

The National Aged Care Workforce Census and Survey is conducted approximately every four years. In last year's annual report, ACFA provided a summary of the findings of the 2016 Survey[12]. Another census will not be conducted until around 2020-21.

The Census only counted PAYG employees and did not include non-PAYG staff such as temporary and agency staff.

As noted in last year's ACFA annual report, the census was completed by 76 per cent of residential care providers, compared with 96 per cent in 2012.

In home support and home care, the census response rate was 42 per cent. Census results reported were scaled up to represent the whole sector.

### 3.1.1 Aged care workforce composition

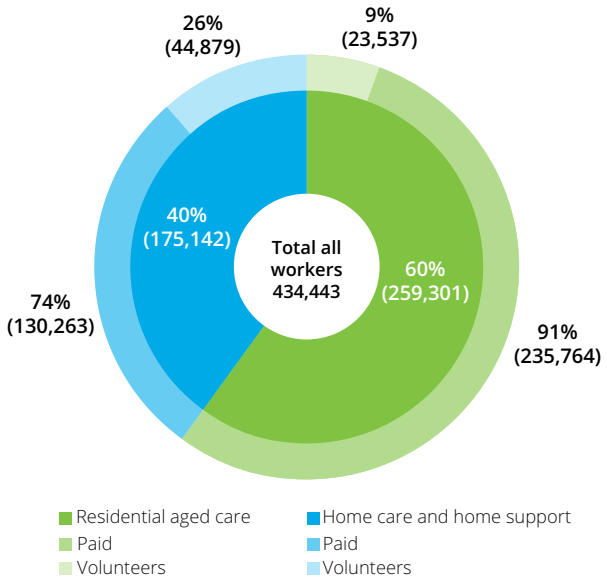
The 2016 census reported the number of paid workers in the aged care industry was around 366,000, with an additional 68,000 volunteers. When the census was conducted in 2012, the number of paid workers was 240,000. According to the Productivity Commission, the workforce is expected to grow to over 800,000 by 2050.

Total paid workers in residential care in 2016 was estimated at 235,764, of which 153,854 were direct care workers. Total paid workers in home support and home care were estimated at 130,263, of which 86,463 were in direct care roles.

Of the reported 434,443 people working in aged care in 2016, 60 per cent were in residential care. The remainder of the workforce were in home support and home care. Chart 3.1 shows the composition of the aged care workforce as reported in 2016.

12 https://agedcare.health.gov.au/news-and-resources/publications/2016-national-aged-care-workforce-census-and-survey-the-aged-care-workforce-2016

**Chart 3.1: Aged care workforce composition, 2016**




## The residential aged care workforce

The residential care workforce saw significant growth in the four years between the 2012 and 2016 Census. In 2016, the total paid workforce in residential care was estimated to number 235,764. This is an increase of 17 per cent from 2012. There also seemed to be a move toward more secure tenure within this sub-sector, with 10 per cent of the pay as you go (PAYG) residential care workforce being casual or contract employees in 2016, significantly less than the 19 per cent in 2012.

The number of registered nurses (RNs) increased by 4.5 per cent since 2012, which reverses the trend of declining numbers of RNs reported in 2007 and 2012 census compared with 2003. The number of nurse practitioners also increased, from 190 in 2012 to 293 in 2016. Table 3.1 shows the fulltime equivalent direct care employees in the residential care workforce, by occupation, since 2003.

Residential care continues to rely heavily on personal care attendants (PCAs), with PCAs increasing as a proportion of direct care employees from 68 per cent in 2012 to 72 per cent in 2016. In 2003, PCAs represented 57 per cent of direct care employees.

The 2016 Census reports a significant up-skilling of PCA workers in recent years, measured by the proportion of care workers holding Certificate III and IV in Aged Care. The proportion of facilities with more than three-quarters of PCAs holding a Certificate III rose from 47 per cent in 2007 to 62 per cent in 2012 and to 66 per cent in 2016.

In terms of stability, the residential care workforce showed some positive results. Forty-two per cent of direct care employees had worked in the sector more than nine years, and approximately 25 per cent had worked in the sector more than 14 years. Ten per cent of workers were actively seeking new employment.

**Table 3.1: Full-time equivalent (FTE) direct care employees in the residential aged care workforce, by occupation: 2003, 2007, 2012 and 2016 (estimated FTE and per cent)**

| Occupation | 2003 | 2007 | 2012 | 2016 |
|---|---|---|---|---|
| Nurse practitioner | n/a | n/a | 190 | 293 |
| Registered nurse | 16,265 | 13,247 | 13,939 | 14,564 |
| Enrolled nurse | 10,945 | 9,856 | 10,999 | 9,126 |
| Personal care attendant | 42,943 | 50,542 | 64,669 | 69,983 |
| Allied health professional | 5,776 | 5,204 | 1,612 | 1,092 |
| Allied health assistant | | | 3,414 | 2,862 |
| **Total number of employees (FTE)** | **76,006** | **78,849** | **94,823** | **97,920** |
| **As a % of total employees** | | | | |
| Nurse practitioner | n/a | n/a | 0.2% | 0.3% |
| Registered nurse | 21.4% | 16.8% | 14.7% | 14.9% |
| Enrolled nurse | 14.4% | 12.5% | 11.6% | 9.3% |
| Personal care attendant | 56.5% | 64.1% | 68.2% | 71.5% |
| Allied health professional | 7.6% | 6.6% | 1.7% | 1.1% |
| Allied health assistant | | | 3.6% | 2.9% |

### The home support and home care workforce

The home support and home care workforce reported a significant reduction in its paid workforce in 2016 compared with 2012, according to the census results (Table 3.2). This is despite significant growth in the number of consumers during this period. The 2016 Census showed a 13 per cent drop in total paid workers between 2012 and 2016 (149,801 to 130,263). ACFA notes it is unlikely the total home support and home care workforce could have decreased between 2012 and 2016 given the increase in consumers. A possible reason in the reported number of workers overall dropping may be greater use of non-PAYG workers (eg temporary and agency staff).

In home support and home care, 14 per cent of the paid workers were casual employees, which is a very considerable reduction from 41 per cent in 2012.

**Table 3.2: Size of the home support and home care workforce, all PAYG employees and direct care employees: 2007, 2012 and 2016**

| Occupation | 2007 | 2012 | 2016 |
|---|---|---|---|
| All PAYG employees | 87,478 | 149,801 | 130,263 |
| Direct care employees | 74,067 | 93,359 | 86,463 |

The estimated proportion of RNs has declined from 13.2 per cent in 2007 to 10.5 per cent in 2016 (Table 3.3). Allied health employees increased from 6 per cent to 8 per cent. Community Care Workers (CCWs), whose composition of the direct care workforce remained relatively stable, provide the bulk of the direct care in home support and home care.

**Table 3.3: Direct care employees in the home support and home care workforce, by occupation: 2007, 2012 and 2016 (estimated FTE and per cent)**

| Occupation | 2007 | 2012 | 2016 |
|---|---|---|---|
| Nurse practitioner | n/a | 55 | 41 |
| Registered nurse | 6,079 | 6,544 | 4,651 |
| Enrolled nurse | 1,197 | 2,345 | 1,143 |
| Community care worker | 35,832 | 41,394 | 34,712 |
| Allied health professional | 2,948 | 2,618 | 2,785 |
| Allied health assistant | | 1,581 | 755 |
| **Total number of employees (FTE)** | **46,056** | **54,537** | **44,087** |
| **As a % of total number of employees** | | | |
| Nurse practitioner | n/a | 0.1% | 0.1% |
| Registered nurse | 13.2% | 12.0% | 10.5% |
| Enrolled nurse | 2.6% | 4.3% | 2.6% |
| Community care worker | 77.8% | 75.9% | 78.7% |
| Allied health professional | 6.4% | 4.8% | 6.3% |
| Allied health assistant | | 2.9% | 1.7% |

In terms of qualifications in home support and home care, the proportion of direct care workers with post-secondary school qualifications has increased to 88 per cent in 2016, almost the same as in residential care (90 per cent). However, the proportion holding certificate level qualifications is lower than in residential care, with 51 per cent and 12 per cent of CCW's holding a Certificate III and Certificate IV in Aged Care, compared with 67 per cent and 23 per cent respectively for PCAs in residential care.

Fifty-one per cent of home support and home care outlets reported using volunteers.

In terms of stability, as was the case in residential care, there were positive signs in the home support and home care sectors. A high proportion (64 and 71 per cent respectively) of RNs and Enrolled Nurses (ENs) had been working in the sector for more than nine years. Nine per cent of direct care employees were actively seeking alternative employment.

### Workforce profile

The average age of the residential care workforce decreased from 48 to 46 between 2012 and 2016. In contrast, the average age of the workforce in home support and home care increased from 50 in 2012 to 52 in 2016.

In 2016, overseas born workers continue to make up a very significant proportion of the aged care workforce. The proportion in residential care was highest with 32 per cent of workers born overseas, while in home support and home care the proportion was 23 per cent. This compares with 35 per cent in residential care and 28 per cent in home support and home care in 2012.

Although aged care remains a female dominated sector, the proportion of males in the workforce is continuing to grow, albeit slowly and from a small base. In residential care, 13 per cent of workers were male (compared with 11 per cent in 2012). In the home support and home care sector, men represented 11 per cent of all workers (10 per cent in 2012).

### Skills shortages

Sixty-six per cent of residential care facilities reported skills shortages in at least one direct care occupation, with RNs being the most common. Skills shortages are most common in remote areas. In home support and home care, 49 per cent of services reported skills shortages.

### 3.1.2 Aged Care Workforce Taskforce

As announced in the 2017-18 Budget, the Australian Government created an industry-led Aged Care Taskforce to develop an Aged Care Workforce Strategy. In September 2017, Professor John Pollaers was appointed chair of the Taskforce. The Terms of Reference and membership of the Taskforce were announced in November 2017[13].

The Taskforce was established to develop a strategy for growing and sustaining the workforce providing aged care services and support for older people, and to meet their care needs in a variety of settings across Australia. The Taskforce was guided by five strategic imperatives:

- Why the Aged Care Industry Matters
- Industry Leadership, Mindset and Accountability
- Industry Workforce Organisation and Education (Current and Future)
- Industry Attraction and Retention
- Translating Research and Technology into Models of Care and Practice

The Taskforce undertook consultation over the period November 2017 to May 2018. The Taskforce placed particular emphasis on workforce planning, covering workforce size and structure, managing growth and changes in service requirements, mix of occupations, workforce roles and distinct workforce needs in different care settings and market catchments.

In March 2018, the Australian Government announced the establishment of an Aged Care Industry Reference Committee (IRC). The Aged Care IRC will be responsible for reforming national training package qualifications and skill sets needed by the aged care industry.

On 29 June 2018, the Taskforce delivered its Strategy to the Minister for Aged Care.

13 The terms of reference can be found at https://agedcare.health.gov.au/reform/aged-care-workforce-strategy-taskforce

# 4

# Aged care reforms

# 4. Aged care reforms

**This chapter summarises reforms in aged care since 1 July 2014 and discusses current and future reforms.**

ACFA concluded in previous annual reports that 2014 funding and financial reforms had strengthened the viability and sustainability of the sector. Reforms are continuing to be implemented and the effect of some of these is yet to be fully seen.

February 2017 saw significant reform in home care with the implementation of packages following consumers. Home care packages are now assigned directly to consumers who are able to select the provider of their choice.

In May 2017, ACFA provided its assessment of the aged care reforms[14] to date to the *Legislated Review of Aged Care 2017*. The Review was presented to the Government in July 2017 and it, along with the Aged Care Roadmap[15], is expected to inform the next stages of aged care reforms.

**This chapter reports that:**

- the pool of lump sum accommodation deposits held by providers continues to grow ($24.8 billion[16] at 30 June 2017, up from $21.9 billion at 30 June 2016);
- for the first time since the reforms of July 2014, Daily Accommodation Payments were slightly more popular than Refundable Accommodation Deposits; and
- means testing in residential care and income testing in home care have not impacted negatively on consumers access to care.

## 4.1 Description of reforms to date

The aged care sector has undergone substantial change in recent years with a view to improving the sustainability of aged care services and increasing consumer choice and control. This change includes a suite of reforms that have had a phased implementation since first being announced in April 2012 and further reform announcements in subsequent Budgets.

Figure 4.1 presents a timeline of reforms in aged care since 2013.

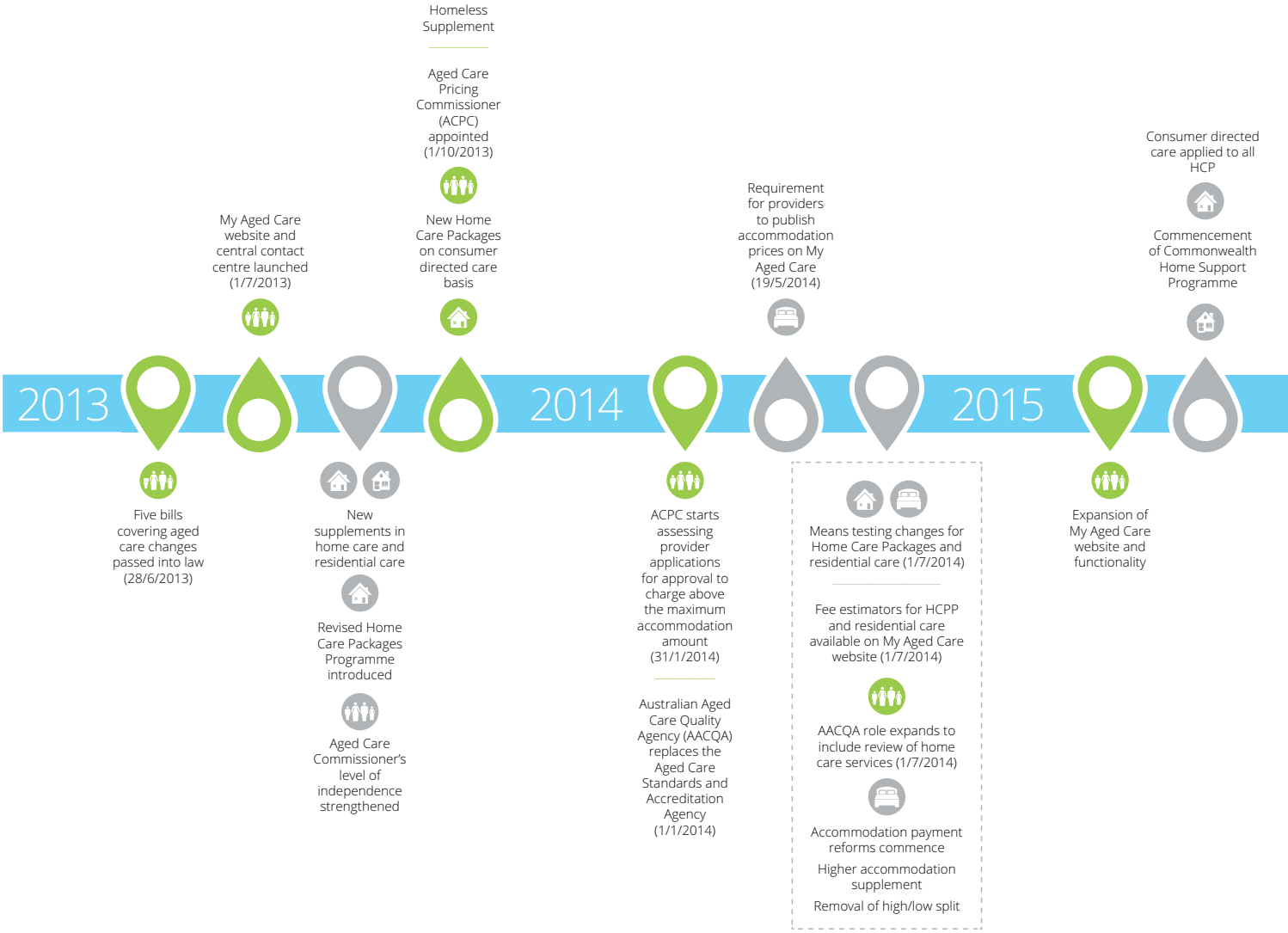
Table 4.1 summarises the reforms based on the care type they relate to, that is, CHSP, home care or residential care.

14 ACFA's Report to Inform the *2016-17 Review of Amendments to the Aged Care Act 1997*, Part One – Analysis and Observations, available at https://agedcare.health.gov.au/aged-care-reform/aged-care-financing-authority

15 The Aged Care Roadmap available at https://agedcare.health.gov.au/aged-care-reform/aged-care-roadmap

16 This differs from the figure of $24.7 billion in Chapter 10 of this report and section 10 of the main report as $24.8 billion is the lump sum deposits held by all residential care providers whereas $24.7 billion is the total held by the 99 per cent of residential care providers who submitted their ACFRs and GPFRs.

## Figure 4.1: Timeline of aged care reforms



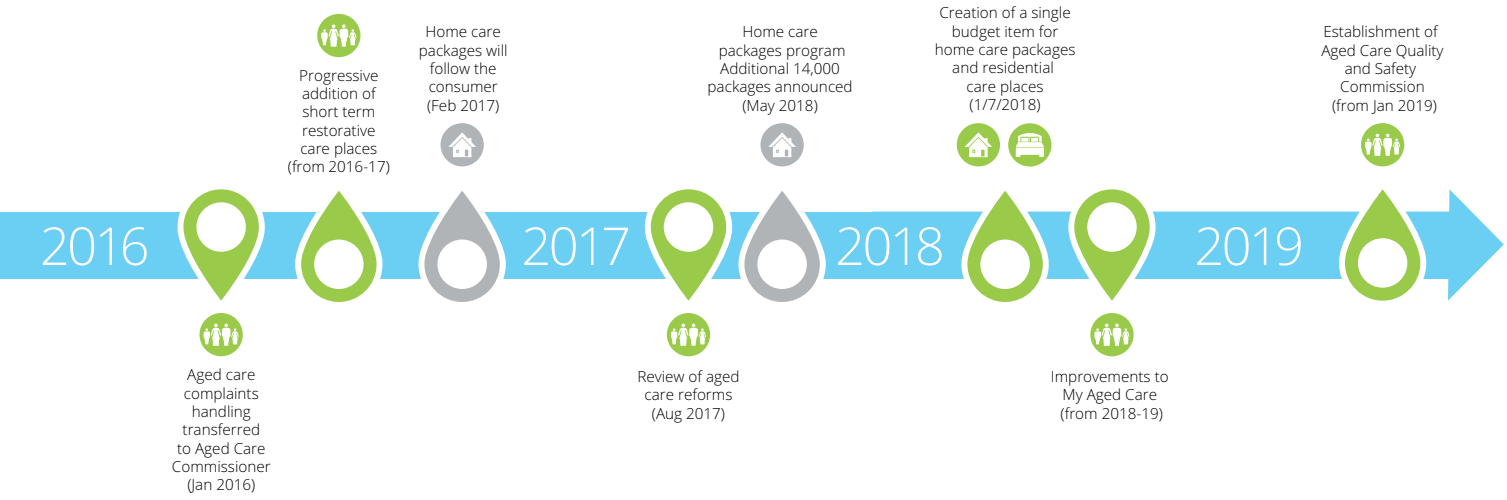

2016
2017
2018
2019
Aged care complaints handling transferred to Aged Care Commissioner (Jan 2016)
Progressive addition of short term restorative care places (from 2016-17)
Home care packages will follow the consumer (Feb 2017)
Review of aged care reforms (Aug 2017)
Home care packages program Additional 14,000 packages announced (May 2018)
Creation of a single budget item for home care packages and residential care places (1/7/2018)
Improvements to My Aged Care (from 2018-19)
Establishment of Aged Care Quality and Safety Commission (from Jan 2019)

**Table 4.1: Major reforms by program**

| Commonwealth Home Support Programme (CHSP) |
|---|
| • From 1 July 2015, the CHSP commenced by combining the former Commonwealth-State Home and Community Care (HACC) programs in all states and territories except Victoria and Western Australia, and the Commonwealth National Respite for Carers, Day Therapy Centres and Assistance with Care and Housing for the Aged programs; and<br>• Victoria transitioned their HACC services to the CHSP on 1 July 2016 and Western Australia transitioned to the CHSP on 1 July 2018. |
| **Home Care Packages Programme** |
| • new home care packages (levels 1-4) commenced 1 August 2013;<br>• formalised income testing with subsidy reduction, including annual and lifetime caps, commenced on 1 July 2014;<br>• all packages required to be CDC, with individualised budgets, from 1 July 2015;<br>• home care packages assigned to the consumer rather than allocated to the provider from 27 February 2017; and<br>• 14,000 additional higher level home care places announced in the 2018-19 Budget. |
| **Residential aged care** |
| • new means testing (combining income and assets test), including annual and lifetime caps, commenced on 1 July 2014;<br>• new accommodation payment arrangements from 1 July 2014 which allow market-based accommodation prices for all non-supported residents, accompanied by consumer choice to pay by lump sum, daily payment or a combination of both;<br>• requirements for providers to publish the maximum price they charge for accommodation and extra services;<br>• higher accommodation supplement payable for supported residents in residential aged care homes that were newly built or significantly refurbished since 20 April 2012;<br>• appointment of the Aged Care Pricing Commissioner in October 2013; and<br>• Rental income from the former home assessable for all residents who enter care from 1 July 2016 (formerly exempt for residents who made a daily payment for their accommodation). |
| **Cross-program** |
| • overall target provision ratio for Government subsidised aged care places to increase from 113 places for every 1,000 people aged 70+ to 125 places between 2012–13 and 2021–22;<br>• creation of a single budget item for home care packages and residential aged care places from 1 July 2018 that will allow flexibility to direct available funding to home care or residential care in response to consumer preferences;<br>• establishing the Aged Care Quality and Safety Commission from January 2019 and the commencement of a single set of quality standards across all aged care from 1 July 2019; and<br>• further improvements to My Aged Care in 2018-19 and 2019–20. |

## 4.2 Reform monitoring

ACFA monitored the impact of the 1 July 2014 funding and financing changes on the aged care sector, including the impact of the new accommodation payment arrangements, consumer choice of payment method, and the new means testing arrangements. ACFA provided monthly reports to the end of 2014 then quarterly in 2015.

The reports can be found on the ACFA web page.[17]

In May 2017, ACFA also provided its *Report to Inform the 2016-17 Review of Amendments to the Aged Care Act 1997*, including funding, financing and pricing issues. This can also be found on the ACFA web page.

## 4.3 Accommodation payment changes

The reforms of 1 July 2014 saw a number of significant changes to the way that accommodation was priced and paid for in permanent residential care[18].

A major change was the removal of controls over daily accommodation prices for non-supported residents receiving a high level of care. In addition, regulations preventing the payment of lump sum accommodation deposits by residents receiving high levels of care were removed. Lump sum deposits were also made fully refundable by removing providers' capacity to deduct retention amounts.

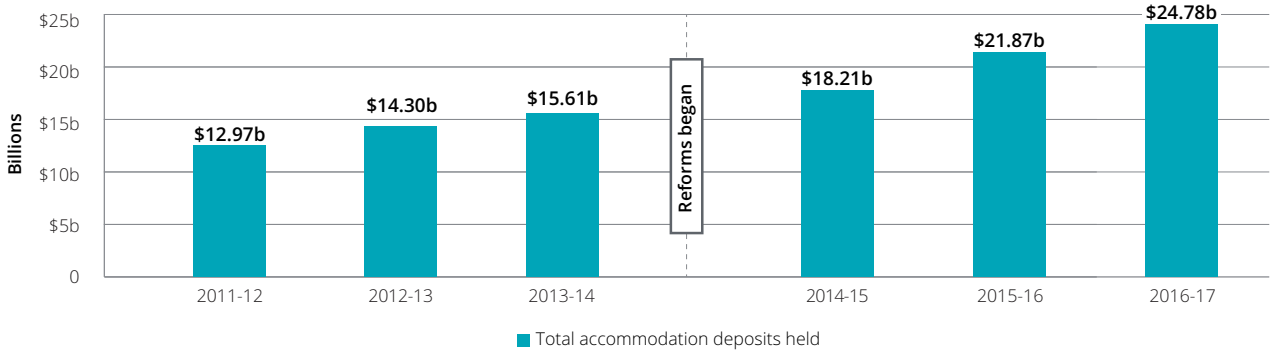
Residents were also given complete choice in their method of payment, supported by a standard formula using the Maximum Permissible Interest Rate (MPIR) – a market-based interest rate, updated quarterly – to calculate 'equivalent' Daily Accommodation Payments (DAP) based on a given Refundable Accommodation Deposit (RAD) amount. Residents are informed by transparency in prices introduced through the publication of accommodation prices. A maximum accommodation payment determined by the Minister, above which providers need to apply for approval from the Aged Care Pricing Commissioner, was set as a consumer protection mechanism[19].

There was also a significant increase in the accommodation subsidy paid by Government on behalf of supported residents who cannot meet all their accommodation costs, and who live in aged care facilities that have been built or significantly refurbished since 20 April 2012.

### 4.3.1 Choice of payment options for accommodation

When the reforms were introduced, there was some concern in the sector that there would be a move away from lump sum accommodation payments by consumers. As shown in Chart 4.1, the total pool of accommodation deposits held by providers has continued to grow in 2016-17.

**Chart 4.1: Total pool of accommodation deposits held, 2011–12 to 2016–17[20]**




17 https://agedcare.health.gov.au/aged-care-reform/aged-care-financing-authority

18 Accommodation payments apply in permanent residential care, where residents are subject to a means test. They do not apply in residential respite care.

19 The maximum price above was set at $550,00 (non-indexed)

20 The figure of $18.21 billion presented for 2014-15 in Chart 4.1 differs from the June 2015 figure of $19.84 billion in Chart 3.1 of ACFA's 2016 annual report. This is because the latter figure from the monitoring surveys includes lump sums held and receivable, whereas figures in Chart 4.1 are sourced from the Annual Prudential Compliance Statement returns of those providers who submitted their GPFR, and do not include lump sums receivable.

Residents who are assessed as having low financial capacity are eligible for Commonwealth assistance with their accommodation costs as either a partially supported or fully supported resident.

Partially supported residents may be asked to contribute towards the cost of accommodation, depending on their means. They can choose to pay their accommodation contribution by a lump sum refundable accommodation contribution (RAC), a daily accommodation contribution (DAC), or a combination of the two.

Fully supported residents cannot be asked to make a contribution and have their accommodation costs met in full by Government.

Residents who are not eligible for Commonwealth assistance with their accommodation costs agree an accommodation price with their provider and then can choose to pay by a lump sum refundable accommodation deposit (RAD), a daily accommodation payment (DAP) or a combination of the two.

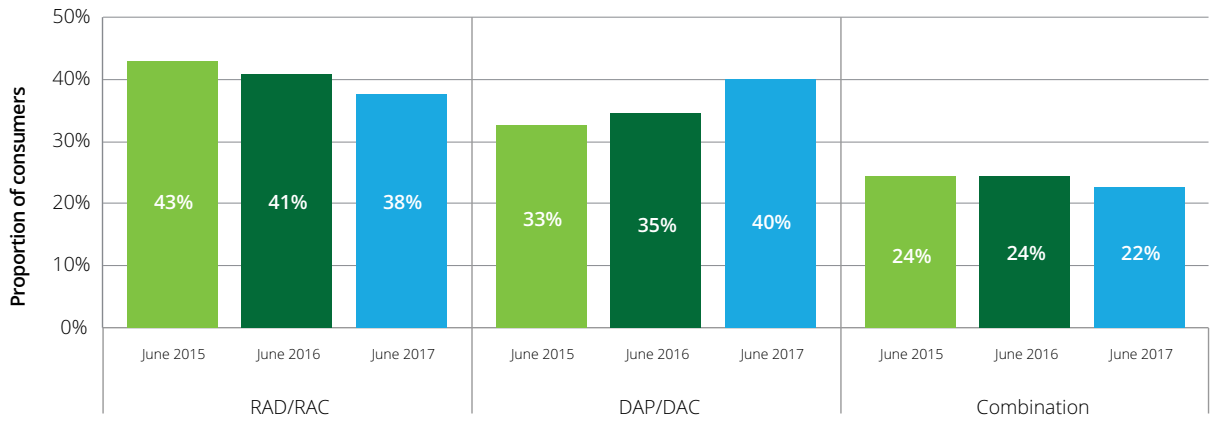
Chart 4.2 shows that in 2016-17, for the first time since 1 July 2014, DAP/DACs were slightly more popular than lump sum RAD/RACs. The proportion of people choosing RAD/RACs dropped for the second year, from 43 per cent and 41 per cent in 2014-15 and 2015-16 respectively, to 38 per cent in 2016-17. The proportion of people choosing DAP/DACs increased from 33 per cent in 2014-15 to 40 per cent in 2016-17.

Providers were concerned about a possible flight from lump sum accommodation payments following the changes of 1 July 2014. While the impact of the changes to date is not significant, ACFA will continue to monitor developments to see whether a trend may be emerging.

ACFA notes there are a number of factors that a consumer might take into consideration when determining how to pay the accommodation payment; for example, the rate of the MPIR[21] (if interest rates fall, equivalent DAPs will fall and vice versa), expected length of stay and/or personal financial circumstances. There is the potential for movement from lump sums to daily payments if the equivalence rate is set too low. If, all other things being equal, consumers were able to achieve a better return, they may be inclined to invest the lump sum and pay the daily payment out of investment earnings. On the other hand, some residents see daily payments as interest on the outstanding lump sum. From this perspective, some residents see the MPIR as a punitively high rate of interest.

The MPIR is market based and given the number of factors that might influence a consumer's decision, it is difficult to determine a particular reason for any shift towards daily payments. For a full discussion on the MPIR and its impact on residents and providers see page 46 of ACFA's *Report to inform the 2016-17 review of amendments to the Aged Care Act 1997*.

**Chart 4.2: Resident method of accommodation payment, June 2015 to June 2017**




21 The MPIR is the rate used to calculate the equivalent daily payment of a RAD. The RAD amount is multiplied by the MPIR and divided by 365 days. The MPIR is determined in accordance with Section 6 of the *Fees and Payments Principles 2014 (No. 2)*. The MPIR is available on the Department of Health website and is updated every three months.

The decrease in the proportion of RAD/RACs was across not-for-profit and for-profit providers, who both recorded a decrease of two percentage points since 2015-16 (Chart 4.3). Government providers had slightly more RAD/RACs in 2016-17, with 29 per cent compared with 27 per cent in 2015-16. Another noticeable change was a sharp drop in residents of not-for-profit providers choosing combination payments (22 per cent down from 27 per cent), seemingly choosing daily payments instead (44 per cent up from 37 per cent).

When analysed in terms of location, lump sum payments dropped to 41 per cent (from 45 per cent) in metropolitan areas (Chart 4.4). There was a lesser decrease (1 percentage point and 3 percentage points respectively) in regional and remote areas.

In last year's annual report ACFA noted there was a very significant difference in choice of payment between non-supported residents and partially supported residents. This trend continued in 2016-17, as shown in Chart 4.5.

Refundable deposits were again the dominant method of payment for non-supported residents in 2016-17 with almost half paying by lump sum.

A significant majority (84 per cent) of partially supported residents paid daily contributions only, with only 11 per cent paying by lump sum only. The proportion of residents paying by lump sum may include residents who had commenced to pay full or partial daily payments, and then paid a lump sum during the year. Similarly, residents paying a daily payment may subsequently pay a lump sum (e.g. once their house is sold).

**Chart 4.3: Resident choice of payment method, by ownership type, June 2015 to June 2017**

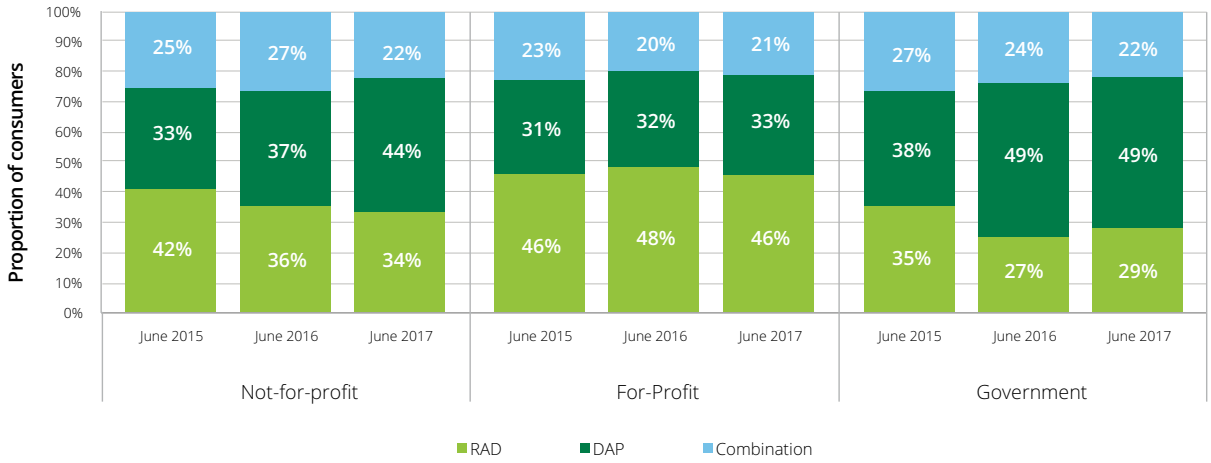



**Chart 4.4: Resident choice of payment method, by location, June 2015 to June 2017**

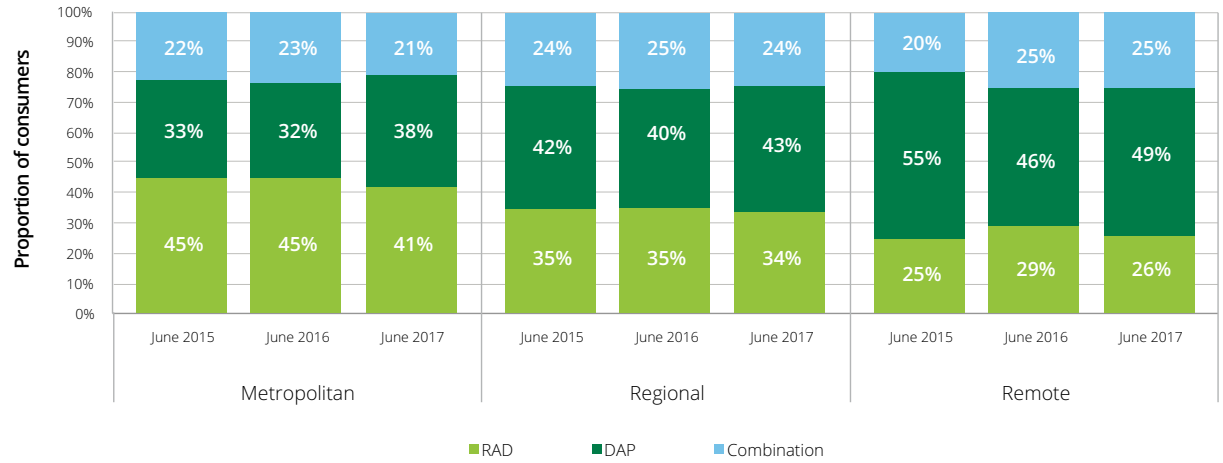
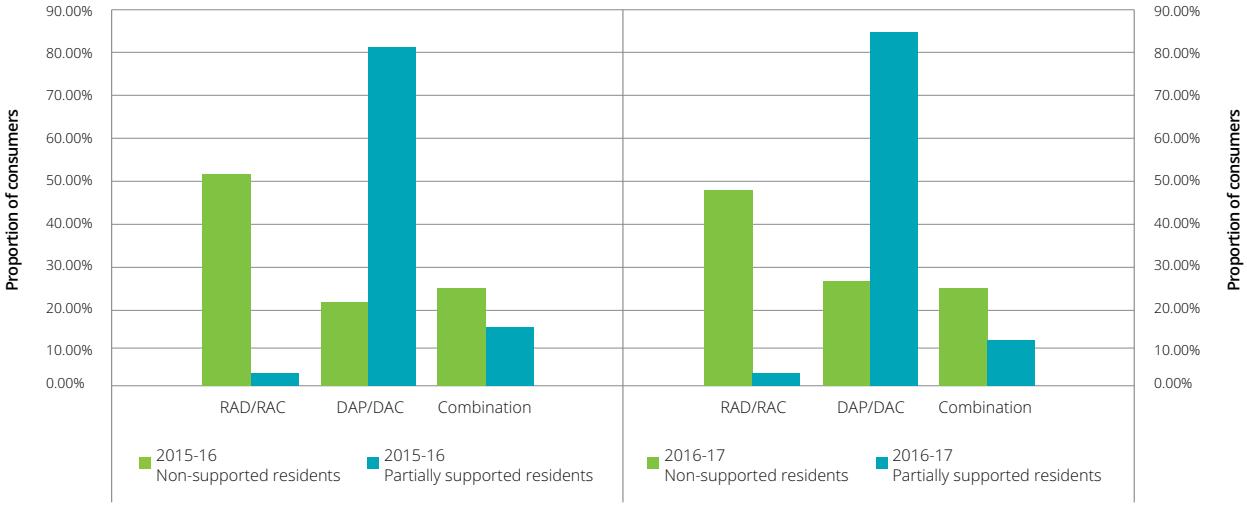


**Chart 4.5: Resident choice of payment method, 2015-16 and 2016-17**




## 4.3.2 Accommodation prices

As part of the accommodation reforms in residential care, approved providers are required to publish the maximum accommodation prices and descriptive information for rooms in their aged care facilities. Maximum prices are required to be published as RADs, equivalent DAPs and an example combination price of both RAD and DAP. A resident cannot be charged more than the published maximum price, but residents may negotiate a lower amount, referred to as the agreed price.

**Published maximum prices**

At 3 April 2018, the average maximum RAD/DAP published on My Aged Care was $411,000/$64.97, compared with $355,000/$65.06 at 29 July 2014 when prices were first published. ACFA notes that while average RAD amounts have increased over the four year period since July 2014, average DAP amounts have decreased because the MPIR, used to calculate equivalent DAP prices, has declined from 6.69% to 5.77% over the same period.

Table 4.2 provides a summary of published prices by ownership type and location, and is presented by average and percentile. A precise average is unable to be calculated as data is not available on the number of rooms in a facility at a particular price point. As a result, it is assumed that the number of price points are distributed evenly within the facility.

As was the case in previous annual reports, for-profit providers had higher average published prices than not-for-profit providers, with government providers recording the lowest. Also, as in previous years, the average published prices were significantly higher in major cities than in regional and remote areas.

The threshold above which prices must be approved by the Aged Care Pricing Commissioner remained unchanged during 2016-17 at a RAD of $550,000 or equivalent daily payment of $87.09. At 3 April 2018, 6 per cent of published prices were higher than the threshold, consistent with the previous two years.

**Table 4.2: Average maximum published RAD prices, by ownership type and location, as at 3 April 2018**

| | Average | 5th percentile | Quartile 1 | Median | Quartile 3 | 95th percentile |
|---|---|---|---|---|---|---|
| Overall | $411,000 | $225,000 | $300,000 | $375,000 | $475,000 | $715,000 |
| **Ownership type** | | | | | | |
| Not-for-profit | $400,000 | $225,000 | $300,000 | $375,000 | $475,000 | $650,000 |
| For-profit | $442,000 | $220,000 | $300,000 | $390,000 | $500,000 | $874,000 |
| Government | $332,000 | $250,000 | $280,000 | $320,000 | $350,000 | $502,000 |
| **Location** | | | | | | |
| Major cities | $443,000 | $229,000 | $320,000 | $400,000 | $525,000 | $800,000 |
| Regional areas | $347,000 | $200,000 | $280,000 | $345,000 | $400,000 | $550,000 |
| Remote areas | $297,000 | $200,000 | $250,000 | $280,000 | $320,000 | $420,000 |

### Agreed prices

While residential care providers are required to publish maximum prices, each resident can negotiate a lower actual price. This is the agreed price.

Providers are required to report agreed prices through the Aged Care Entry Record. Agreed prices are useful in understanding the way the industry is operating, particularly in pricing accommodation. Whilst the key findings on agreed prices are similar to those for maximum prices, published accommodation prices can be the average of a variety of room types, whereas average agreed accommodation prices are based on amounts agreed with individual residents for a particular room, and as such, averages for published and agreed prices cannot be compared on a like-for-like basis.

Table 4.3 provides a summary of agreed prices for the 12 months from 1 April 2017 to 31 March 2018 by provider ownership type and location, shown by average and percentile.

The results for average agreed prices are similar to those for average published prices, generally between $10,000-$30,000 lower. As was the case last year, for-profit providers recorded the highest agreed prices followed by not-for-profit and government providers. Major cities continued to have significantly higher agreed prices than regional and remote areas.

There is no data available to determine the extent to which consumers may be actively negotiating lower accommodation prices. However, given that the average agreed price is lower than the average published price, this suggests that some consumers are successfully negotiating lower prices in some instances.

It should be noted however that published prices are maximum prices, so some providers may publish higher prices by default in anticipation of charging a range of potential prices below this maximum.

## 4.4 Means testing and sustainability

On 1 July 2014, new means testing arrangements were introduced in both home care and residential care. One of the intentions of these reforms was to improve the long term sustainability of aged care in terms of affordability for Government and taxpayers.

In home care, an income test with subsidy reduction was introduced, and in residential care a new means test that combined formerly separate income and assets tests came into effect. Both the income test in home care and the means test in residential care are administered by the Department of Human Services.

Annual and lifetime caps were also introduced for both home care and residential care to limit the amount consumers can be asked to contribute each year, and over their lifetime, towards their care costs. The caps do not apply for fees paid under the Commonwealth Home Support Program, or to home care packages that commenced before 1 July 2014 or permanent residents who were in residential care before 1 July 2014 and who are still under the pre-1 July 2014 rules.

Basic daily fees continued to apply in both home care and residential care as well as fees for extra and additional services[22], all of which are payable by the consumer.

**Table 4.3: Average agreed prices, by provider ownership type and location, 1 April 2017 to 31 March 2018**

| | Average | 5th Percentile | Quartile 1 | Median | Quartile 3 | 95th Percentile |
|---|---|---|---|---|---|---|
| Overall | $393,000 | $172,000 | $299,000 | $375,000 | $475,000 | $695,000 |
| **Ownership type** | | | | | | |
| Not-for-profit | $385,000 | $160,000 | $299,000 | $375,000 | $460,000 | $650,000 |
| For-profit | $413,000 | $180,000 | $300,000 | $390,000 | $500,000 | $750,000 |
| Government | $357,000 | $155,000 | $275,000 | $350,000 | $425,000 | $550,000 |
| **Location** | | | | | | |
| Major cities | $424,000 | $188,000 | $310,000 | $400,000 | $525,000 | $750,000 |
| Regional areas | $329,000 | $136,000 | $250,000 | $330,000 | $395,000 | $500,000 |
| Remote areas | $279,000 | $150,000 | $235,000 | $300,000 | $320,000 | $420,000 |

22 Extra service and additional service fees only apply to residential care.

### Home care

In home care, prior to 1 July 2014, there was no reduction in subsidy paid by Government if the provider did not charge the income tested fee. If collected, any fee would be additional to the value of the package. ACFA has previously noted that many providers therefore did not charge the fee.

Under the post 1 July 2014 income testing arrangements, the amount of Government subsidy is reduced by the amount of the income tested fee and providers are still required to provide services to the full value of the package should they choose not to charge this fee.

All consumers (both pre and post 1 July 2014) can be asked to pay a basic daily fee of up to 17.5 per cent of the single basic age pension (currently $10.32 a day/$3,767 per annum). This fee is not subject to an income or assets test and does not impact on the Government subsidy. Providers are only required to provide services in relation to the basic daily fee if they actually charge the basic daily fee.

One of the aspects ACFA was asked to monitor following the reforms of 1 July 2014 was whether access to aged care was affected. In last year's report, ACFA noted that the number of part pensioners and self-funded retirees accessing lower level home care packages was significantly lower when compared with higher level packages. This trend has continued in 2016-17 as shown in Table 4.4. Twenty-nine per cent of level 4 package holders were part pensioners or self-funded retirees in 2016-17, with the proportion decreasing significantly with each lower level package.

In last year's report, and in ACFA's input to the *Legislated Review of Aged Care 2017*, ACFA noted this is likely because the level of consumer contributions, both through the basic daily fee and income tested fees, is not affected by the level of a home care package. Put another way, the proportion of the package value that the consumer is expected to pay is higher in lower level packages compared with higher level packages, as shown in Table 4.5. This may act as a deterrent for part-pensioners and self-funded retirees from accessing lower level packages. The income thresholds as they are applied to income testing in home care are shown at Appendix E.

ACFA notes Recommendation 12(d) of the *Legislated Review of Aged Care 2017* is to "make the value of the basic care fee proportionate to the value of the home care package, retaining an upper limit relating to the value of the single age pension."

Consistent with the observation in last year's ACFA report, the income-tested care fees are still not providing a significant improvement to fiscal sustainability from a Government or taxpayer perspective. This is because the vast majority of home care consumers continue to be full pensioners (77 per cent during 2016-17), who are not required to contribute any care fee, or part pensioners (19 per cent during 2016-17), who can be charged only a limited care fee.

**Table 4.4: Proportion of consumers who are part pensioners or self-funded retirees, 2015-16 and 2016-17**

| Package level | Proportion of consumers who were part pensioners or self-funded retirees, 2015-16 | Proportion of consumers who were part pensioners or self-funded retirees, 2016-17 |
|---|---|---|
| Level 1 | 15% | 14% |
| Level 2 | 21% | 21% |
| Level 3 | 24% | 25% |
| Level 4 | 27% | 29% |

**Table 4.5: Split of maximum consumer contribution (including Basic Daily Fee) and Government subsidy, by home care package level (March 2018 rates)**

| | | Level 1 | | Level 2 | | Level 3 | | Level 4 | |
|---|---|---|---|---|---|---|---|---|---|
| | Source | $ | % | $ | % | $ | % | $ | % |
| Pensioner | Consumer | $3,766.80 | 31% | $3,766.80 | 20% | $3,766.80 | 10% | $3,766.80 | 7% |
| | Government | $8,270.90 | 69% | $15,045.30 | 80% | $33,076.30 | 90% | $50,286.05 | 93% |
| Part Pensioner | Consumer | $9,159.71 | 76% | $9,159.71 | 49% | $9,159.71 | 25% | $9,159.71 | 17% |
| | Government | $2,877.99 | 24% | $9,652.39 | 51% | $27,683.39 | 75% | $44,893.14 | 83% |
| Self-funded retiree | Consumer | $12,037.70 | 100% | $14,552.65 | 77% | $14,552.65 | 39% | $14,552.65 | 27% |
| | Government | $0 | 0% | $4,259.45 | 23% | $22,290.45 | 61% | $39,500.20 | 73% |
| | **Total package value** | **$12,037.70** | | **$18,812.10** | | **$36,843.10** | | **$54,052.85** | |

**Residential care**

The changes of 1 July 2014 in residential care saw the previously separate income and asset tests, applied to care and accommodation contributions respectively, combined into one means test. This was to ensure consistency of assessment of wealth irrespective of whether it is in the form of assets or income. All residents can also be asked to pay a basic daily fee for their living expenses, which is set at a maximum of 85 per cent of the basic single aged pension. As at 1 July 2018[23], 85 per cent of the basic single aged pension was $50.16 per day ($18,308.40 annualised).

Whether a resident is required to contribute toward their accommodation and/or care costs is subject to the means test. The income and asset thresholds as they are applied to means testing in residential care are shown at Appendix E.

ACFA considers that the changes to means tested fees in residential care have generally improved the equity in the treatment of different forms of wealth among residents of aged care, but have made little difference to the sustainability of residential aged care services.

## 4.5 The higher accommodation supplement

A higher maximum accommodation supplement was introduced on 1 July 2014 for significantly refurbished and new facilities to:

- improve the quality and amenity of existing residential aged care accommodation; and
- encourage investment and thus increase the sector's accommodation capacity.

The higher accommodation supplement is available to facilities that have been built or significantly refurbished since 20 April 2012. As at 1 July 2018, the higher accommodation supplement was $56.14 per day compared with $36.59 for the standard accommodation supplement.

**Uptake and expenditure**

As at 31 December 2017, 986 facilities (representing 34.8 per cent of all facilities) qualified for the higher accommodation supplement. Of these, 854 were significantly refurbished and 132 were newly built facilities. This is a significant increase from 31 December 2016 when 686 facilities (25.5 per cent) were receiving the higher accommodation supplement.

As at 31 December 2017, the estimated completed refurbishment expenditure per facility averaged $3.4 million, with a median spend of $1 million and total expenditure of $3.4 billion across the sector. This compares with 31 December 2016, where the average spent was $3.8 million per refurbishment, median of $1.7 million and total expenditure of $2.7 billion.

## 4.6 Extra service

Providers with extra service status are able to charge an extra service fee for residents occupying an extra service place for the duration of their stay. Extra service status involves the provision of a higher than average standard of services, including accommodation, range and quality of food, and non-care services such as recreational and personal interest activities.

To be eligible for extra service status, providers must first seek approval from the Department. Providers that have been granted extra service status by the Department must apply to the Aged Care Pricing Commissioner for approval of proposed extra service fees, including proposed increases to current Extra Service fees.

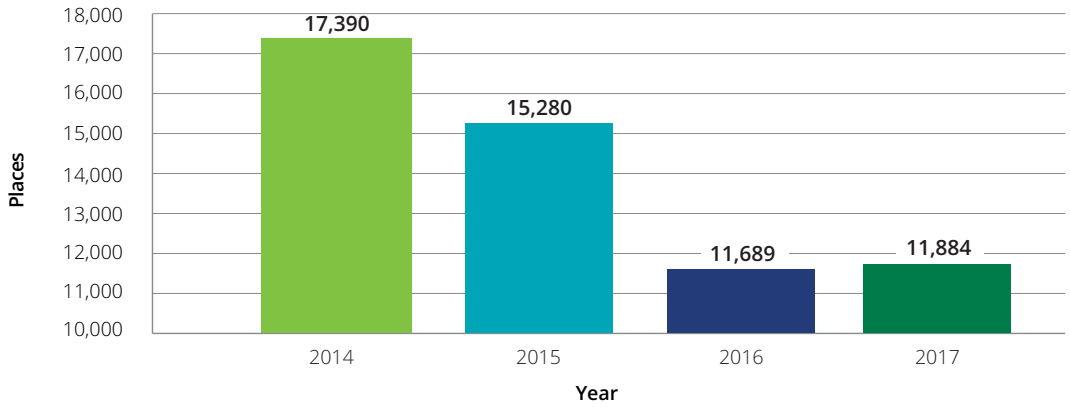
For extra service status places that are occupied by a resident who was in care prior to 1 July 2014 and who is covered under the pre-reform fee arrangements, then the care subsidy is reduced by 25 per cent of the approved extra service fee for that place. This is known as the Extra Service subsidy Reduction. The provider can charge a continuing care recipient an amount equal to the extra service fee plus the extra service reduction for receiving extra service. Extra service subsidy reduction does not apply to residents entering care on or after 1 July 2014.

Since the reforms began in July 2014, there has been a significant decrease in the total number of places with extra service status (Chart 4.6). This is likely because changes made to accommodation pricing on 1 July 2014 reduced the need and motivation for providers to have extra service status, partly because:

- lump sum accommodation payments can now be made for all care types – previously they were restricted to low care or high care with extra service;
- market-based prices determined by the provider apply for all new non-supported residents; and
- providers can offer additional care and services for additional fees outside the extra service framework.

23 Pension rates are indexed on 20 March and 20 September each year so the rate as at 1 July 2018 was set on 20 March 2018.

**Chart 4.6: Number of active extra service places, 30 June 2014 to 30 June 2017**




This has led many providers to reconsider their extra service status, with many offering residents 'additional service' arrangements (discussed in the next section).

## 4.7 Additional services

Providers operating places that do not have extra service status may also charge a resident for additional services (e.g. hairdressing, wine with dinner), which the resident has asked the provider to provide. The amount of any charge for additional services must be agreed with the resident before services are delivered, with an itemised account given to the resident once the service has been provided. These additional charges may be deducted from a refundable deposit paid by the resident, if they request it and if the provider agrees (unlike daily accommodations payments, which providers must deduct at the residents request).

Additional fees cannot be charged where:

- they do not provide a direct benefit to the individual;
- the resident cannot take up or make use of the services; or
- the activities or services subject to the fee are part of the normal operation of an aged care facility and fall within the scope of specified care and services.

ACFA notes a recent Federal Court ruling (March 2018) confirming previous advice from the Department that residential care providers cannot charge the additional service fees that are known variously as 'asset replacement charges' or 'capital refurbishment fees', or fees with another name but having the same nature.

The decision was not appealed and all residents who were charged an 'Asset Replacement Charge' or similar have received refunds. ACFA further notes that other providers have subsequently reviewed their fee arrangements, announcing that they will be refunding similar charges.

## 4.8 More choice in home care

Since February 2017, home care packages have been assigned directly to consumers rather than allocated to providers. This allows consumers to direct their package to the provider of their choice as well as change providers. Older Australians assessed as requiring home care are placed on the National Prioritisation Queue based on how long they have been waiting for care and their individual needs and circumstances, regardless of where they live.

Data from the Department shows that as at 31 March 2018 there were 108,463 people on the queue. ACFA notes that unmet demand for home care is long standing, but was not able to be quantified until the implementation of the National Prioritisation Queue for assigning packages directly to consumers.

ACFA also notes that around half the people on the queue are in receipt of an interim lower level home care package pending the availability of a higher level package consistent with their assessed needs. Additionally, the data shows that of those people not currently in a lower level interim package, around half are accessing services through the CHSP.

While a large proportion of consumers in the queue are receiving some level of support, the availability of the queue data has made transparent for the first time that the distribution between lower level and higher level packages is not in line with assessed consumer care needs. Prior to the introduction of individual budgets, providers had some flexibility to use cross-subsidisation to direct care resources where they were most needed.

As part of the 2018-19 Budget, the Australian Government announced an additional 14,000 higher level home care packages, most of which will be released in 2018-19 and 2019–20. A further 6,000 higher level packages have been released, as part of the 2017-18 Mid-Year Economic and Fiscal Outlook (MYEFO), by converting lower level packages. Taken together with the growth in higher level packages that had already been budgeted for as part of increasing the home care provision ratio to 45 by 2021–22, the proportion of higher level packages is estimated to comprise 50 per cent of total packages by 2021–22.

The creation of a single budget item for home care packages and residential care places will also provide some flexibility to direct available funds to meet the emerging demand for home care packages.

**Unspent funds**

In last year's report, ACFA discussed the significant amounts of unspent package funds held by providers on behalf of consumers of home care.

Prior to the February 2017 changes, if a consumer ceased receiving a home care package from a provider, the provider retained the unspent funds. However, since the February 2017 changes, any unspent package funds (less any agreed exit amount) must be transferred to the new home care provider, or returned to the Commonwealth and the consumer (or their estate) according to their respective contributions.

The issue of unspent funds is discussed in Chapter 7.

## 4.9 Review of Alternative Residential Aged Care Funding Options

As noted in ACFA's 2016 annual report, the Government announced in the 2016-17 Budget that it would review alternative residential care funding options to ensure sustainability and to reduce the funding volatility experienced under ACFI, including the possibility of using independent external assessment.

In addition, pending the outcome of the review of funding options, the Government made changes to the ACFI in order to reduce the rate of growth of care claimed under ACFI. This included changes to some questions and weightings used in the Instrument, mainly targeting complex health care, and indexation pauses.

As part of the review, the Department engaged the University of Wollongong to develop options and recommendations to help inform the design of future residential aged care funding models. The final report, 'Alternative Aged Care Assessment, Classification System and Funding Models', was released on 19 April 2017 and is available on the Department of Health's website at https://agedcare.health.gov.au/reform/residential-aged-care-reform.

The Department also engaged Applied Aged Care Solutions (AACS) to examine how the ACFI can be strengthened further to reduce subjectivity, including an examination of the feasibility of external assessment of the ACFI. The final report *Review of the Aged Care Funding Instrument Report* was released on 19 October 2017, and is also available on the Department's website.

Following the release of the University of Wollongong and AACS reports, the Department has commissioned a residential care Resource Utilisation and Classification Study to inform consideration of reform options. The study will examine the characteristics of residents that drive residential care costs and how those costs are distributed within the scope of services currently funded by the Commonwealth. The study is expected to be completed in December 2018. This report will be the first systematic study of relative care costs in residential aged care since the 1990s.

ACFA notes that no decisions have been made by the Government on the reform options, and any future changes will involve extensive consultation with the sector. However, the Government has announced that any new funding model would have to be funded from within existing Budget forward estimates.

## 4.10 Review of National Aged Care Quality Regulatory Processes

In May 2017, the Australian Government announced an independent review to examine Commonwealth aged care accreditation, monitoring, review, investigation, complaints and compliance processes. The Review was led by Ms Kate Carnell, AO, and Professor Ron Paterson, ONZM.

The report was released in October 2017 and made 10 recommendations. The Review found that the Commonwealth quality regulatory system in residential aged care generally works effectively, however there are improvements that could be made to address some shortcomings. The Government announced that it generally supported the broad direction of the report and subsequently has replaced announced re-accreditation site audits with unannounced site audits, effective from March 2018. The new arrangement applies to all re-accreditation applications made from 1 July 2018.

In response to this Review, the Government announced in April 2018 that a new independent Aged Care Quality and Safety Commission will be established to oversee the approval, accreditation, assessment, monitoring, complaints handling and compliance of Commonwealth funded aged care providers. From 1 January 2019, the functions of the Australian Aged Care Quality Agency and the Aged Care Complaints Commissioner will transition to the new Commission, with the regulatory functions currently undertaken by the Department of Health transitioning from 1 January 2020.

Additional initiatives were announced in the 2018-19 Budget *Better Quality of Care* measures to support the new Commission and strengthen regulation of aged care.

# 5

# Access to aged care

# 5. Access to aged care

**This chapter outlines access to subsidised aged care in Australia for older Australians.**

**This chapter discusses:**

- access to subsidised aged care for older Australians
- the supply of subsidised aged care
- usage of aged care and impacts of a changing population
- demand for aged care services

**This chapter reports that:**

- average occupancy in residential care is down from 92.4 per cent in 2015-16 to 91.8 per cent in 2016-17, continuing a recent trend towards declining occupancy rates;
- the number of residents in residential care increased from 181,048 at 30 June 2016 to 184,077 at 30 June 2017, even though the provision ratio declined, as planned, from 79.7 at 30 June 2016 to 77.9 at 30 June 2017;
- the number of consumers of home care increased from 88,875 in 2015-16 to 97,516 in 2016-17 and will continue to rise as the Government seeks to reach the target of 151,500 packages assigned to consumers by 2021-22;
- a population that is continuing to age will see an increase in demand, as the proportion of people aged 85 and over is growing to nearly 5 per cent of the population by 2055, compared with just over 2 per cent today; and
- The *Legislated Review of Aged Care 2017* notes that "robust measures of unmet demand are still a way off, and there is still a degree of uncertainty around gauging unmet demand for aged care services into the future."

## 5.1 Access to aged care

Ensuring access to appropriate quality care remains a fundamental policy objective for the Australian Government in the funding and financing of aged care. However, access to care needs to be balanced by affordability for both consumers and taxpayers.

To this end, the Australian Government applies population based target provision ratios to control the number of older people accessing subsidised home care and residential care, and requires contributions from consumers based on an assessment of their capacity to pay. The Australian Government also controls the supply of home support under the CHSP by applying a cap on annual funding.

### 5.1.1 Supply of aged care

An overall aged care target provision ratio was first set in 1985 at 100 operational residential care places per 1,000 people aged 70 and over. The overall provision ratio was increased to 108 in 2004, further increased to 113 in 2007, and in 2012 was adjusted to increase progressively to 125 by 2022. Home care packages were first introduced into the ratio in the early 1990s and since then successive Governments have gradually increased home care as a proportion of the overall provision ratio.

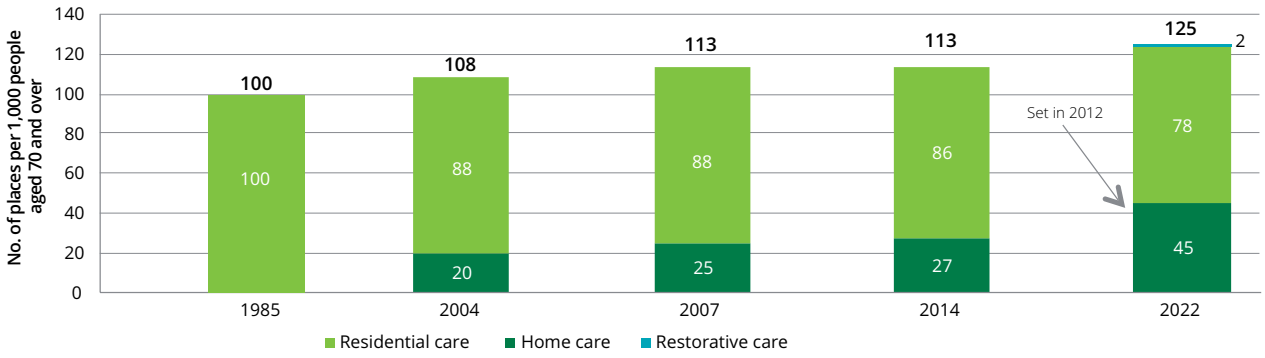
This population-based target provision formula is designed to ensure that the overall supply of services increases in line with the ageing of the population, while also defining the total number of places/packages and, thereby, helping control the Commonwealth's expenditure on aged care.

Within the current overall target provision ratio of 125, the mix of home care and residential care is being significantly altered. Over the period 2012 to 2022 the target for home care is increasing from 27 to 45, while the residential care target is to reduce from 86 to 78. The remaining two places are for the Short Term Restorative Care Programme (STRC).

Appendix D details the total operational aged care places in residential care and ratios achieved in each aged care planning region as at 30 June 2017.

Chart 5.1 shows the changes in the target ratios since 2004 and the planned increase through to 2022.

**Chart 5.1: Increase in target provision ratios, 1985–2022**

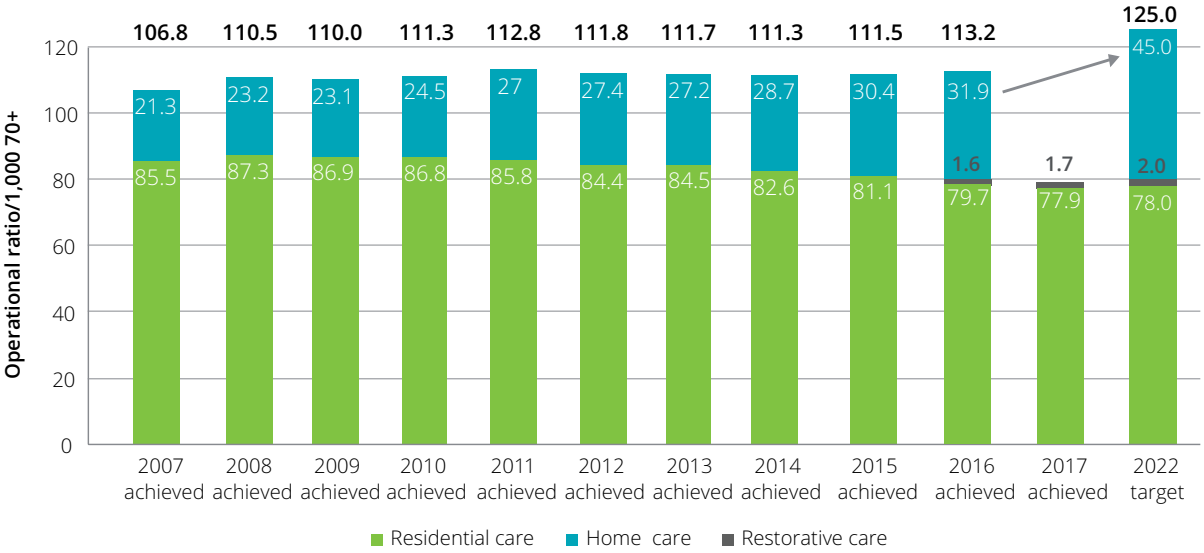



Implementation of the current target provision ratio will achieve an overall increase in the supply of home care packages and residential care places. However, the changes see the proportion of home care packages increasing at a faster rate than that of residential care places, which reflects the Government's response to the increasing number of consumers wishing to remain in their own homes.

In previous reports, ACFA has commented on the achieved ratio of operational places compared with the target operational ratio. While the calculation of this ratio is still possible for residential care (Chart 5.2), since 2016-17 an operational home care provision ratio can no longer be calculated in a way that is comparable with pre 2016-17 ratios. This is because the calculation of operational places pre 2016-17 includes places allocated to providers, and available to be used, that are not being used (i.e. vacant) whereas, since February 2017, home care packages are no longer allocated to providers but are instead assigned to consumers, i.e. there is no vacancy factor for inclusion in the calculation of the ratio. Therefore a ratio using only occupied places would, in effect, be based on consumers, not on places available to be used, and would be a lower ratio.

Chart 5.2 shows the achieved operational ratio of residential care places for the 10 years to 30 June 2017 and records the achieved operational ratio of home care until 30 June 2016. ACFA notes that the achieved residential ratio of 77.9 as at 30 June 2017 has already reached the target for 2021-22, which is 78 places per 1000 people aged 70 and over.

**Chart 5.2: Residential and home care achieved ratios, 2007–2016 and residential care achieved ratio, 2017**



ACFA notes that the home care target provision ratio is now used by the Government to work out the number of packages to be assigned to consumers. However, ACFA also notes that there is currently no official way of measuring performance against the target. ACFA considers that target provision ratio for the supply of home care packages needs to be re-calibrated in order to provide a basis for measuring performance. One option to measure relative supply in future is a population-based ratio using the number of consumers receiving care, instead of operational places.

Because there is currently no method to track progress against the target of 45 operational home care packages per 1000 people aged 70 and over by 2021-22, Chart 5.3 has been prepared as an interim measure. Chart 5.3 shows the number of consumers of home care in a package as at 30 June for each of the previous five years, as well as the target number of allocated packages published in the Department of Health's 2018-19 Portfolio Budget Statement. While the historical and forward estimates numbers are not comparable, the chart gives some indication of the increase in home care packages that is planned to be released.

The target ratio approach applied to home care packages and residential care places does not apply to the supply of care through the Commonwealth Home Support Programme (CHSP). Instead, CHSP funding is subject to an annual capped funding allocation, and CHSP providers are grant funded to provide contracted home support services. Consumers who are assessed as eligible through their Regional Assessment Service (RAS) to receive CHSP services can then access those services through a provider that is funded under the CHSP who provides the services for which they have been assessed.

The CHSP is discussed in Chapter 6.

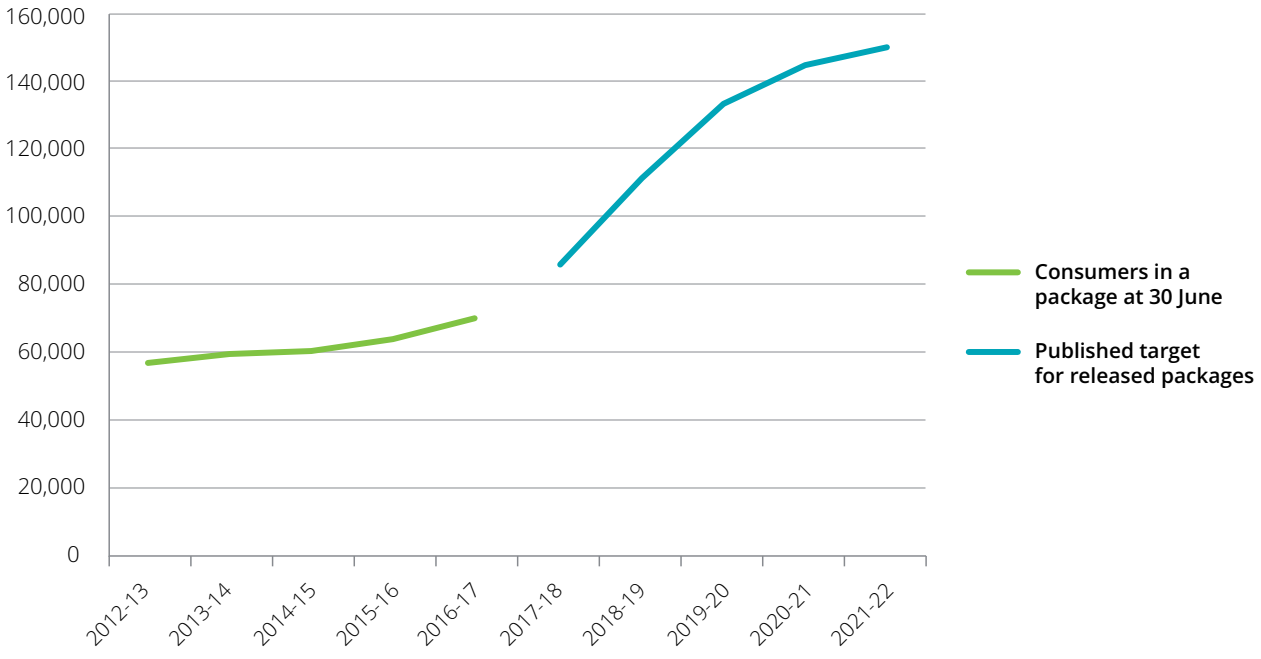
Australia is a large, sparsely populated country so providing services where people want them (that is, near their home or family) can be challenging. Rural and remote areas will always be challenged by smaller population and workforce catchments, whereas urban areas are often challenged by the lack of available and appropriate sites in areas where older Australians live.

It is important to ensure that aged care services are distributed appropriately across the country in order to achieve equitable access. Some aged care facilities specialise in services for special needs groups including Cultural and Linguistically Diverse, Aboriginal and Torres Strait Islander people, people living with dementia and the homeless.

### 5.1.2 Affordability for consumers

For the consumer, cost alone should not be a barrier to access to aged care services because the Australian Government subsidises services for those who cannot afford to pay the full price. The Commonwealth takes capacity to pay into account when formulating fee policies and applies annual and lifetime caps on care contributions in home care and residential care.

**Chart 5.3: Home care consumers and published target packages to be released**



However, there can be service gaps if the funding does not meet enough of the cost of care to attract investment in services to meet the needs of certain segments of the public, or consumers in some locations.

## 5.2 Age profile across care types

As consumers of aged care get older, the types of care they access changes. Chart 5.4 shows the proportion of older Australians in home support, home care and residential care as at 30 June 2017. It shows that the proportion of the population accessing aged care services increases as people get older. The proportion using home care and residential care, increases more than three-fold in the 85 and over bracket compared with those aged 70 and over.

In home care, the average age of consumers was 81.6 years, compared with 84.6 years in residential care. The proportion of people aged 85 and over in residential care was 59 per cent compared with 42 per cent using home care.

Chart 5.5 shows the age profile for consumers of home care over the five years to 30 June 2017. The proportion of consumers aged 65-74 has increased over this time while the 75-84 age bracket was generally decreasing, until 2016-17 when it increased again. The proportion of those aged 85 and over decreased in 2016-17, as it also did in 2015-16.

**Chart 5.4: Proportion of the population 70+ and 85+ accessing aged care, at 30 June 2017**

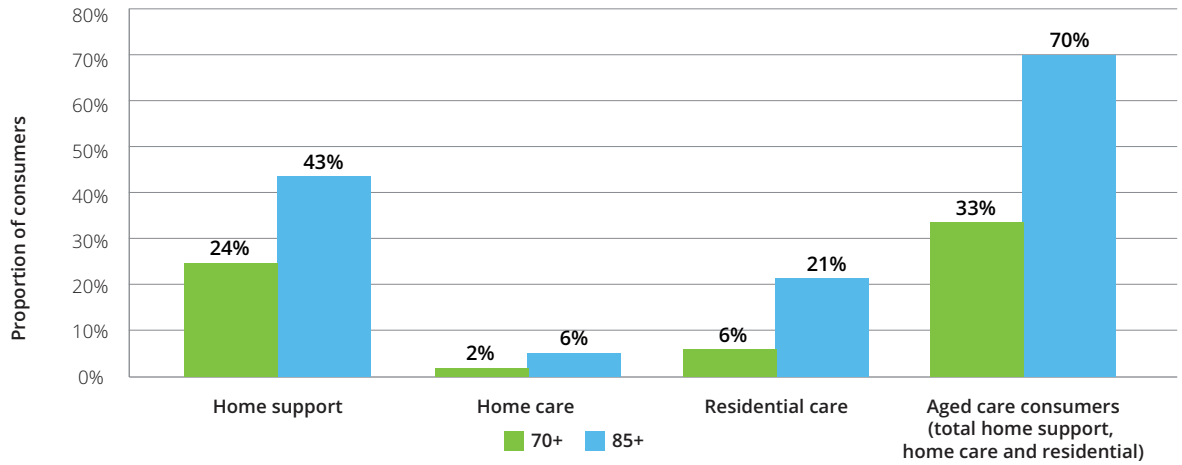



**Chart 5.5: Age profile of people in home care, 30 June 2013 to 30 June 2017**

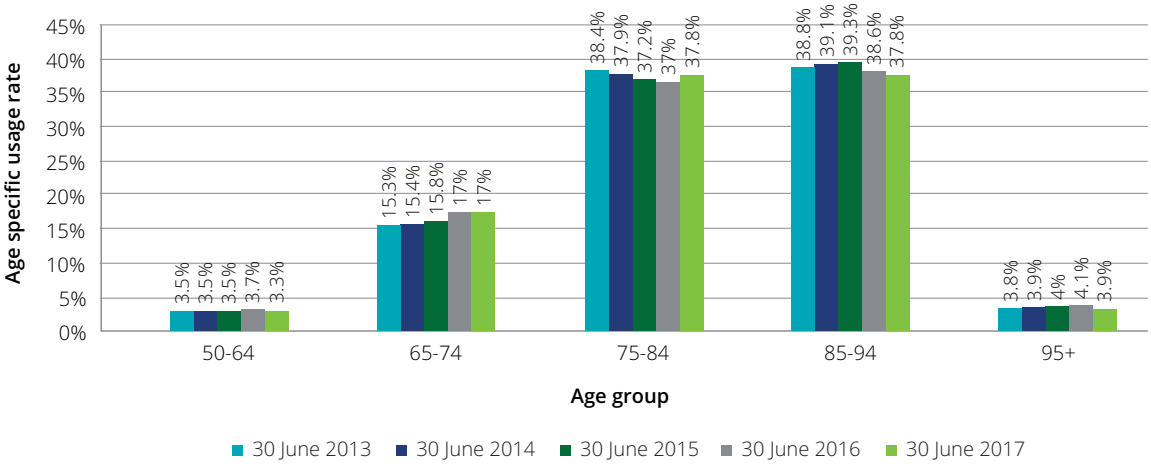


**Chart 5.6: Age profile of people in residential care, 30 June 2013 to 30 June 2017**

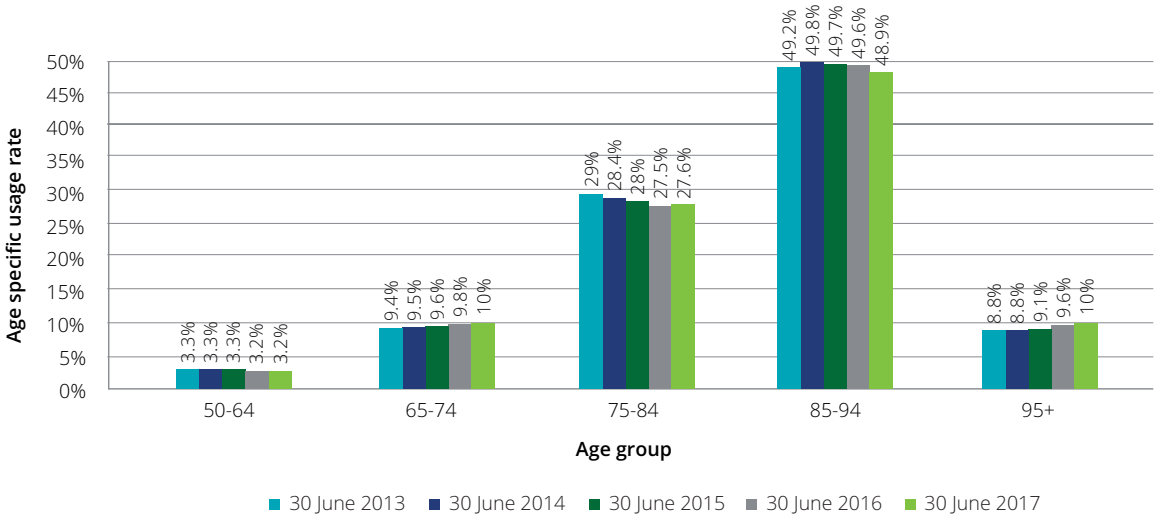



Chart 5.6 shows the age profile of consumers of residential care for the five years to 30 June 2017. The proportion of people aged 65-74 in residential care has slowly increased over the five years while the proportion of those aged 75-84 has dropped.

The proportion of those aged 95 and over has increased every year over the five years but those aged 85-94 has dropped in the last three years.

Detailed data regarding the age of consumers in CHSP is not readily available for the same level of analysis as it is for home and residential care. However, the overall average age of consumers in CHSP is 79.6 years.

## 5.3 Access by Culturally and Linguistically Diverse and Indigenous Australians

### 5.3.1 Culturally and Linguistically Diverse Australians

There is significant cultural diversity among Australians and many people from culturally and linguistically diverse (CALD)[24] backgrounds are seeking culturally appropriate aged care. While many of these people have come from European countries, recent years have seen larger numbers of people from a number of Asian countries. This is an area where aged care is changing and will continue to change as providers respond to the cultural needs of consumers.

To assist this, the Australian Government provides aged care website information for people who do not speak English, or for whom English is a second language. The My Aged Care website provides translated material in 18 languages. In 2016-17, there were 19,248 visits to the translation pages.

Throughout 2016-17, older people from CALD backgrounds could also access home support services funded through the CHSP and the WA HACC program.

There were 17,641 older Australians from CALD backgrounds in a home care package as at 30 June 2017, representing almost 25 per cent of total home care consumers. This is stable from 30 June 2016.

Table 5.1 shows the number of CALD Australians accessing home care over the last five years.

In residential care, as at 30 June 2017, there were 34,808 older Australians from CALD backgrounds in permanent or respite care, which represents around 19 per cent of all residents. This is the same proportion as at 30 June 2016. The proportion of CALD people in residential care has generally increased over the last 10 years from 15 per cent in 2007. Of the overall population of Australians aged 65 and over, as at 30 June 2017 around 20 per cent are from a CALD background.

The proportion of CALD people accessing residential care as at June 2017 was significantly less than home care (19 per cent compared with 25 per cent).

Table 5.2 shows the number of CALD consumers in residential aged care over the last five years.

In 2016-17, 146,571 consumers from a CALD background accessed CHSP (Chart 5.7). Data for previous years is not available.

24 CALD status is derived from self-reported information provided by consumers.

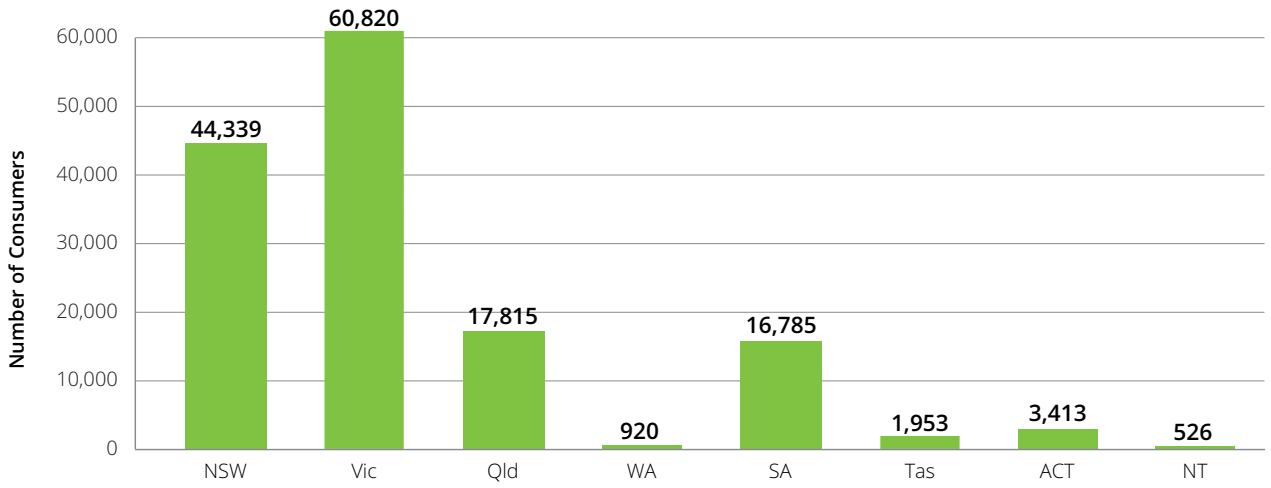
**Table 5.1: CALD consumers in home care, by state and territory, 30 June 2013 to 30 June 2017**

| State/territory | 30 June 2013 | 30 June 2014 | 30 June 2015 | 30 June 2016 | 30 June 2017 |
|---|---|---|---|---|---|
| New South Wales | 4,436 | 4,804 | 5,118 | 5,416 | 5,926 |
| Victoria | 4,439 | 4,967 | 5,460 | 5,905 | 6,594 |
| Queensland | 1,443 | 1,534 | 1,574 | 1,557 | 1,784 |
| Western Australia | 1,486 | 1,515 | 1,485 | 1,497 | 1,646 |
| South Australia | 947 | 951 | 994 | 1,042 | 1,116 |
| Tasmania | 161 | 162 | 194 | 211 | 213 |
| Australian Capital Territory | 220 | 240 | 248 | 229 | 275 |
| Northern Territory | 90 | 88 | 131 | 85 | 87 |
| **Total** | **13,222** | **14,261** | **15,204** | **15,942** | **17,641** |

**Table 5.2: CALD consumers in residential aged care, by state and territory, 30 June 2013 to 30 June 2017**

| State/territory | 30 June 2013 | 30 June 2014 | 30 June 2015 | 30 June 2016 | 30 June 2017 |
|---|---|---|---|---|---|
| New South Wales | 10,942 | 11,592 | 11,971 | 12,466 | 12,939 |
| Victoria | 10,142 | 10,650 | 11,049 | 11,634 | 11,953 |
| Queensland | 2,969 | 3,108 | 3,162 | 3,326 | 3,451 |
| Western Australia | 2,566 | 2,676 | 2,696 | 2,683 | 2,692 |
| South Australia | 2,713 | 2,836 | 2,833 | 2,886 | 2,904 |
| Tasmania | 290 | 281 | 309 | 291 | 306 |
| Australian Capital Territory | 390 | 380 | 406 | 475 | 504 |
| Northern Territory | 61 | 59 | 57 | 61 | 59 |
| **Total** | **30,073** | **31,582** | **32,483** | **33,822** | **34,808** |

**Chart 5.7: CALD consumers in the Commonwealth Home Support Programme, by state and territory, 2016-17**



## 5.3.2 Indigenous Australians

As at 30 June 2017, 2,020 Indigenous Australians[25] were accessing home care. This is up from 1,705 at 30 June 2016. Table 5.3 shows the number of Indigenous Australians accessing home care over the last five years.

As at 30 June 2017, there were 1,743 Indigenous Australians in residential care (permanent and respite) compared with 1,602 at 30 June 2016.

Table 5.4 shows the number of Indigenous Australians in residential care since 2013.

In 2016-17, 21,246 Indigenous Australians accessed CHSP (Chart 5.8). Data for previous years is not available.

**Table 5.3: Indigenous Australians in home care, by state and territory, 30 June 2013 to 30 June 2017**

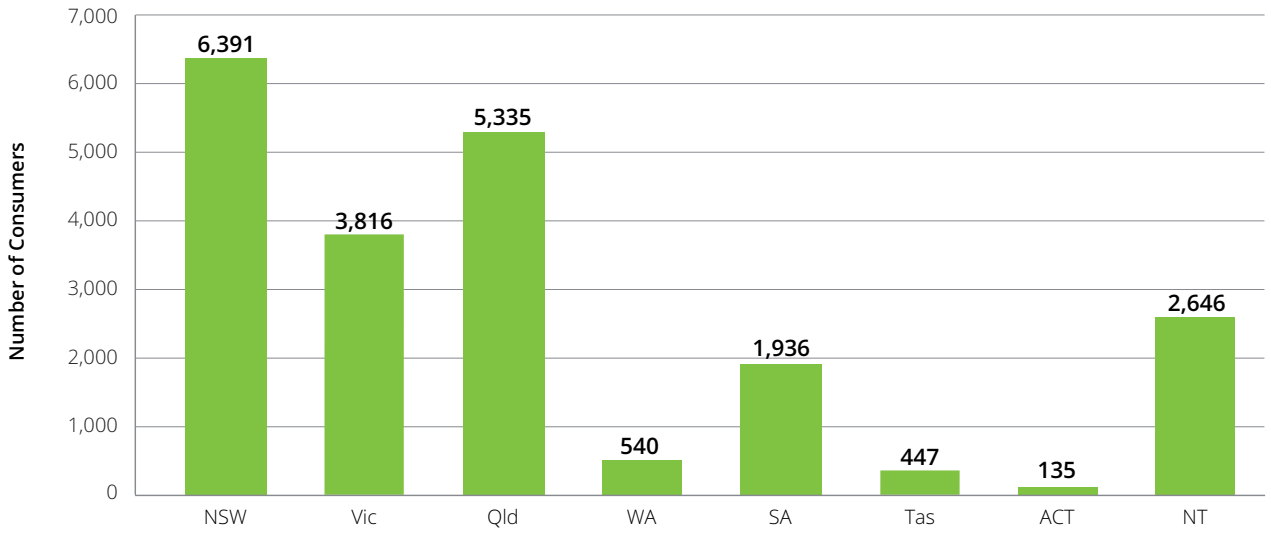
| State/territory | 30 June 2013 | 30 June 2014 | 30 June 2015 | 30 June 2016 | 30 June 2017 |
|---|---|---|---|---|---|
| New South Wales | 497 | 506 | 443 | 431 | 611 |
| Victoria | 390 | 393 | 385 | 372 | 373 |
| Queensland | 344 | 332 | 320 | 303 | 385 |
| Western Australia | 224 | 206 | 171 | 170 | 189 |
| South Australia | 81 | 77 | 72 | 65 | 94 |
| Tasmania | 26 | 22 | 23 | 21 | 27 |
| Australian Capital Territory | 48 | 43 | 29 | 27 | 40 |
| Northern Territory | 425 | 384 | 353 | 316 | 301 |
| **Total** | **2,035** | **1,963** | **1,796** | **1,705** | **2,020** |

**Table 5.4: Indigenous Australians in residential care, by state and territory, 30 June 2013 to 30 June 2017**

| State/territory | 30 June 2013 | 30 June 2014 | 30 June 2015 | 30 June 2016 | 30 June 2017 |
|---|---|---|---|---|---|
| New South Wales | 324 | 376 | 420 | 445 | 513 |
| Victoria | 106 | 109 | 102 | 110 | 124 |
| Queensland | 384 | 423 | 456 | 482 | 520 |
| Western Australia | 277 | 282 | 289 | 271 | 287 |
| South Australia | 66 | 71 | 74 | 76 | 78 |
| Tasmania | 26 | 23 | 26 | 25 | 30 |
| Australian Capital Territory | 3 | 4 | 7 | 11 | 8 |
| Northern Territory | 161 | 164 | 161 | 182 | 183 |
| **Total** | **1,347** | **1,452** | **1,535** | **1,602** | **1,743** |

25 Indigenous status is derived from self-reported information provided by consumers.

**Chart 5.8: Indigenous Australians in the Commonwealth Home Support Programme, by state and territory, 2016-17**




## 5.4 Access to home care

### 5.4.1 Consumers

The number of older Australians who received home care during 2016-17 was 97,516, an increase of 9.7 per cent from 88,875 in 2015-16.

### 5.4.2 Release of home care packages

Since the changes to home care on 27 February 2017, home care packages are periodically released to be assigned directly to consumers by the Department of Health through the National Prioritisation System within My Aged Care. Home care packages are assigned to those consumers who have reached the top of the National Prioritisation Queue according to time on a waiting list and urgency of need.

The number of packages released at each level takes into account the number of new packages that are available having regard to the phased increase in the target home care provision ratio, as well as the number of packages that consumers have exited or not accepted in previous weeks. While the total number of packages will increase each year, the number of packages at each funding level will continue to be capped in line with the aged care target provision ratio and the available budget.

As ACFA noted in last year's report, there are indications that the changes to income testing and fee arrangements for home care packages that commenced on 1 July 2014 may be impacting how consumers take up home care packages.

The relatively high level of consumer contribution for level 1 and 2 packages and the availability of CHSP at no or lower cost, compared with higher level packages, may be influencing consumers' decisions to not take up these packages.

### 5.4.3 Demand for home care packages

Since the February 2017 changes, the Department can no longer use occupancy data for the Home Care Packages Programme as a proxy measure for demand as occupancy was a measure of whether a provider's allocated packages were being occupied or not.

ACFA has also previously noted that until the changes of February 2017, data had not been available to allow an estimate to be made of the extent to which supply of home care packages was falling short of total demand.

As part of the changes that were implemented in February 2017, all older Australians who are assessed as eligible for a home care package are now placed in the National Prioritisation Queue to receive a home care package as soon as one becomes available. This queue provides a better indication of unmet demand for home care packages, including the extent to which the availability of packages at the different funding levels align with assessed consumer needs. In addition ACFA notes that the Department is seeking to obtain additional data regarding the average time to accept packages and packages that are offered but not taken up by consumers.

As noted in Chapter 4, there were over 108,000 people in the queue as at 31 March 2018. However data from the Department indicates that just under half have a lower level package assigned to them and are receiving some level of service while they wait for a higher level package. Additionally, the data shows that of those people not currently in a lower level interim package, around half are accessing services through the CHSP.

ACFA also notes that some people who are still in the queue may no longer require services, or do not wish to access services at the level for which they have been assessed. ACFA considers that further analysis is required of the composition of the queue to determine to what extent it represents a robust measure of unmet need for services. Depending on the level of demand, further consideration will be required as to how the additional demand will be funded.

### 5.4.4 Home care admissions

Chart 5.9 shows admission numbers for the four home care package levels from July 2014 to September 2017. While there are peaks and troughs, admissions continue to be overall steady, noting the number of level 4 package admissions is increasing faster than the other package levels, in line with the increasing proportion of level 4 packages being released. The significant and sudden trough followed by a sharp increase around February/March 2017 was the result of the transition to the new prioritisation system implemented in February 2017. Overall admissions during this two month period were stable.

### 5.4.5 Length of stay in home care

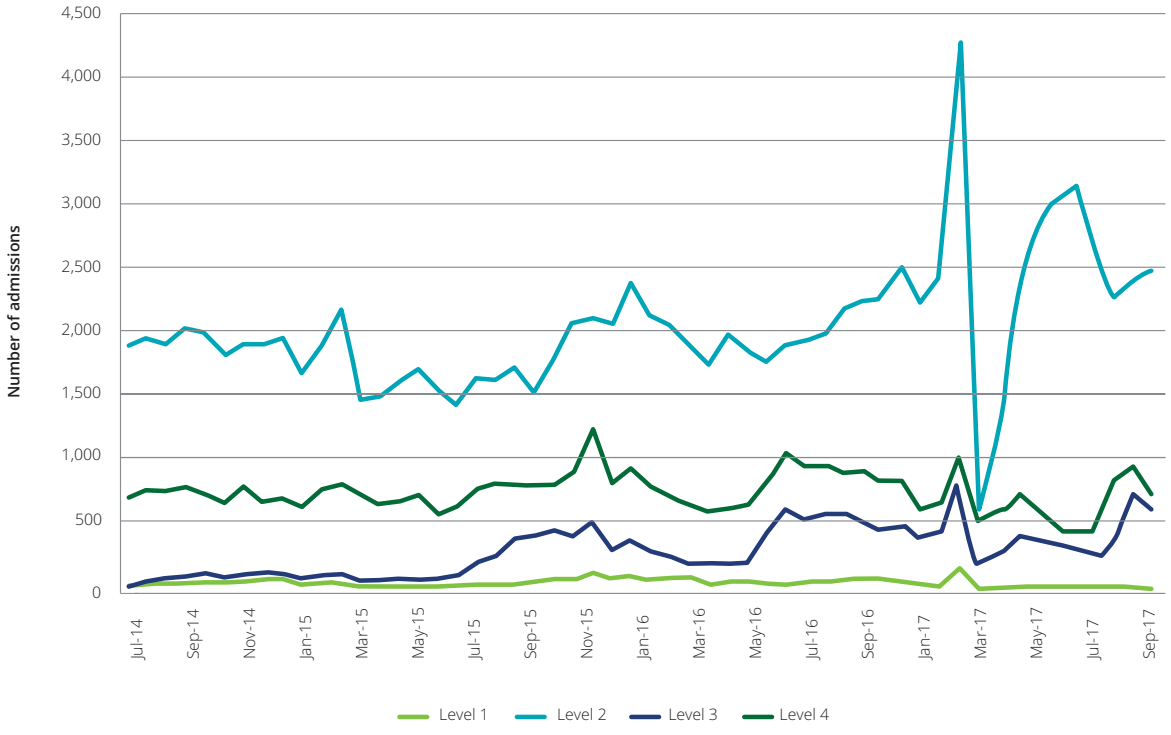
ACFA noted in last year's report that length of stay in home care differs between package levels.

For people who entered home care in 2013–14, around half the recipients of level 2 packages stayed at their package level at least 13 months and around a quarter stayed over 28 months. By contrast, for those people entering a level 4 package, around half leave care within 10 months and a quarter remain in care for over 20 months.

For people that entered home care in 2016-17, around half the recipients of level 2 packages stayed at their package level at least 16 months and over 40 per cent are still in care. By contrast, for those people entering a level 4 package, around half leave care within 13 months and less than 40 per cent were still in care as at May 2018. This suggests that length of stay in home care is increasing in more recent years irrespective of care level.

For package levels 1 and 3, of those people that entered care in 2014-15, around a quarter of level 1 package holders had left within around four months of care while level 3 recipients left after three months in care.

**Chart 5.9: Home care admissions, by package level, July 2014 to September 2017**



Insufficient data is available to assess the impact of the February 2017 changes. ACFA will expand its length of stay analysis for home care in future reports, including taking into account the impact on length of stay at lower level packages as the proportion of higher level packages is increased, noting that many consumers are currently occupying lower level packages on an interim basis. Understanding these impacts and the interactions with residential care will be important as the Australian Government expands the number of home care packages.

## 5.5 Access to residential care

### 5.5.1 Residents

The number of older Australians who received permanent residential care during 2016-17 was 239,379, an increase of 1.9 per cent from 234,931 in 2015-16.

As has been the case in recent years, the number of people accessing residential respite care is increasing proportionally faster than those accessing permanent residential care. The number of people who accessed respite care in 2016-17 was 59,228, an increase of 4.2 per cent, from 56,852 in 2015-16 and 53,021 in 2014-15. Residential respite care usage is discussed in Section 5.7 of this chapter.

## 5.6 Demand for residential aged care

While there is data on demand being met, as noted in previous reports, data is not available to allow an estimation of unmet demand for residential care. Only data pertaining to resident admissions and occupancy rates (met demand) is reported. Occupancy is measured as the total number of days an allocated place is occupied by a resident, divided by the total number of days an allocated place was available to be occupied.

### 5.6.1 Occupancy rates

Occupancy rates reflect both demand and the number of places available. In 2016-17 the occupancy rate across all residential care places was 91.8 per cent, down from 92.4 per cent in 2015-16, and 92.5 per cent in 2014-15. ACFA notes some providers are reporting the decline in the occupancy rate evident in 2016-17, has continued in 2017-18.

The overall average occupancy rate in residential care peaked at 97.1 per cent in 2003-04.

Not-for-profit providers continue to have the highest occupancy at an average of 93.1 per cent in 2016-17, down from 93.6 in 2015-16 and 94.0 per cent in 2014-15. For-profit providers achieved an average occupancy of 90.1 per cent for 2016-17, down from 90.8 per cent for 2015-16 and 90.6 per cent in 2014-15.

As noted in previous annual reports and shown in Table 5.5, there are variations in occupancy by state and territory, with the highest occupancy in 2016-17 being the Northern Territory (as it was in 2015-16) with 95.4 per cent and the lowest being the ACT with 90.1 per cent, which also had the lowest occupancy in 2015-16.

**Table 5.5: Occupancy in residential aged care by state/territory, 2015-16 and 2016-17**

| State/territory | Occupancy (%) 2015-16 | Occupancy (%) 2016-17 |
|---|---|---|
| New South Wales | 92.3 | 91.1 |
| Victoria | 91.7 | 91.1 |
| Queensland | 92.2 | 92.3 |
| Western Australia | 94.5 | 93.8 |
| South Australia | 93.7 | 93.5 |
| Tasmania | 91.0 | 91.2 |
| Australian Capital Territory | 88.6 | 90.1 |
| Northern Territory | 95.0 | 95.4 |
| **Australia** | **92.4** | **91.8** |

The greatest variation in occupancy rates continues to be by location. In 2016-17 the occupancy in very remote areas was significantly less than in all other locations, as was the case in 2015-16. ACFA also notes that the occupancy in remote areas increased in 2016-17 (91.7 per cent up from 89.7 per cent in 2015-16), while in very remote areas it decreased further compared to 2015-16 (77.4 per cent compared with 80 per cent).

Table 5.6 shows occupancy in residential care by location during 2016-17.

**Table 5.6: Residential aged care occupancy, by location, 2015-16 and 2016-17**

| Provider location | Occupancy (%) 2015-16 | Occupancy (%) 2016-17 |
|---|---|---|
| Major cities | 92.4 | 91.4 |
| Inner regional | 92.5 | 92.7 |
| Outer regional | 92.0 | 92.2 |
| Remote | 89.7 | 91.7 |
| Very remote | 80.0 | 77.4 |

Occupancy by location suggests the greatest demand pressures on average may be in metropolitan areas, with somewhat less demand in more remote areas. ACFA notes however that occupancy in major cities declined by 1 per cent in 2016-17 after being stable in previous years.

The variation in occupancy by location is more likely to reflect the supply of aged care places as distributed through the ACAR planning process, rather than characteristics of the aged population.

## 5.6.2 Admissions in residential care

As Chart 5.10 indicates, elapsed time between when a resident is assessed as eligible for residential care and entering permanent care continues to increase. This trend has been evident since 2011–12, however has become more obvious since 2013–14. In 2016-17:

- 8 per cent of people entering care did so within a week of being assessed by an ACAT (18 per cent in 2011–12);
- 24 per cent did so within a month (44 per cent in 2011–12); and
- 67 per cent within nine months (89 per cent in 2011–12).

However, elapsed time statistics need to be interpreted with caution as the delay between an eligible assessment and a person entering care could be due to consumer choice and not necessarily delays in the system.

The increasing availability of home care and the increased usage of residential respite care could also be contributing to the longer time between assessment and someone entering permanent care.

**Consumers transitioning from home care to residential care**

Chart 5.11 shows the proportion of consumers who enter permanent residential care after leaving home care. The proportion entering residential care was relatively stable at around 60 per cent for the years leading up to the introduction of the Aged Care Funding Instrument (ACFI) in 2008, when it increased to around 63 per cent. Since the start of the major reforms in 2014, the proportion has dropped to below 60 per cent and continued to decrease slightly in 2016-17.

ACFA will continue to monitor trends to see if the increased availability of higher level home care packages, and home care packages overall, impacts on the proportion of package holders transferring to residential care.

**Chart 5.10: Elapsed time between assessment and entering permanent residential care, 2011–12 to 2016-17 (%)**

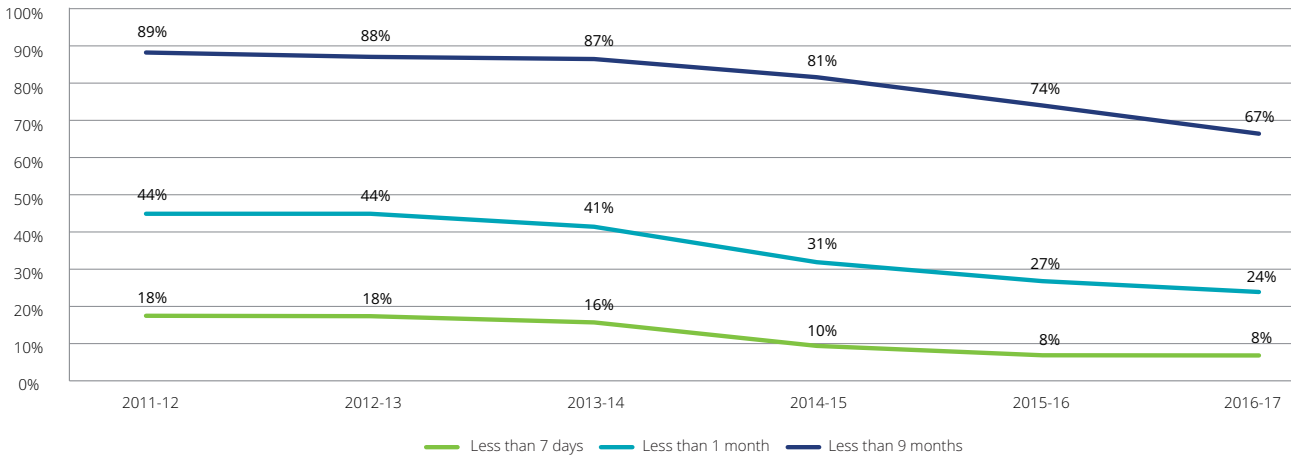
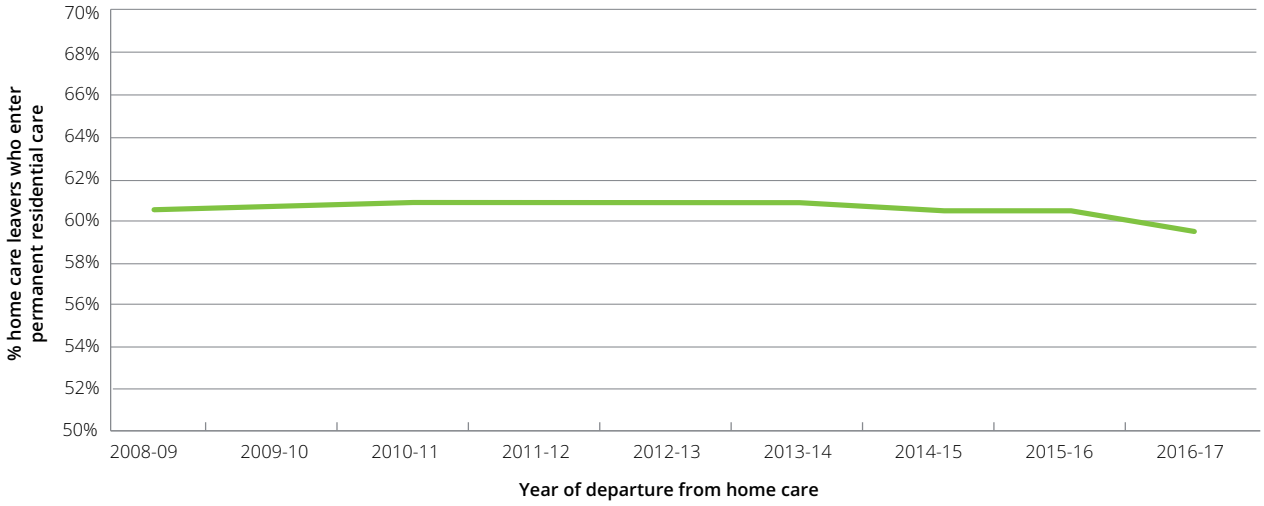


**Chart 5.11: Proportion of consumers entering permanent residential care after leaving home care, 2008–09 to 2016–17**




## 5.6.3 Length of stay in residential aged care

The average length of time between first admission and final discharge in permanent residential care has been decreasing gradually since 2003. This decrease in length of stay (LOS) of aged care residents is shown in Chart 5.12, with the average LOS decreasing from 3.3 years in 2003 to just under 3 years in 2017.

Two drivers of this decrease in LOS have been an increasing average age of entry and an increasing proportion of male residents. Older residents and male residents have shorter average LOS, so increasing proportions of these residents result in a shorter average LOS. Chart 5.13 shows both of these indicators, with the proportion of male entrants increasing from 36 per cent in 2003 to 41 per cent in 2017, and the average age of entry increasing from 82.7 to 84.1 over the same period although noting a slight dip in 2017.

**Chart 5.12: Average length of stay in residential care, by gender and year of entry, 2003 to 2017**

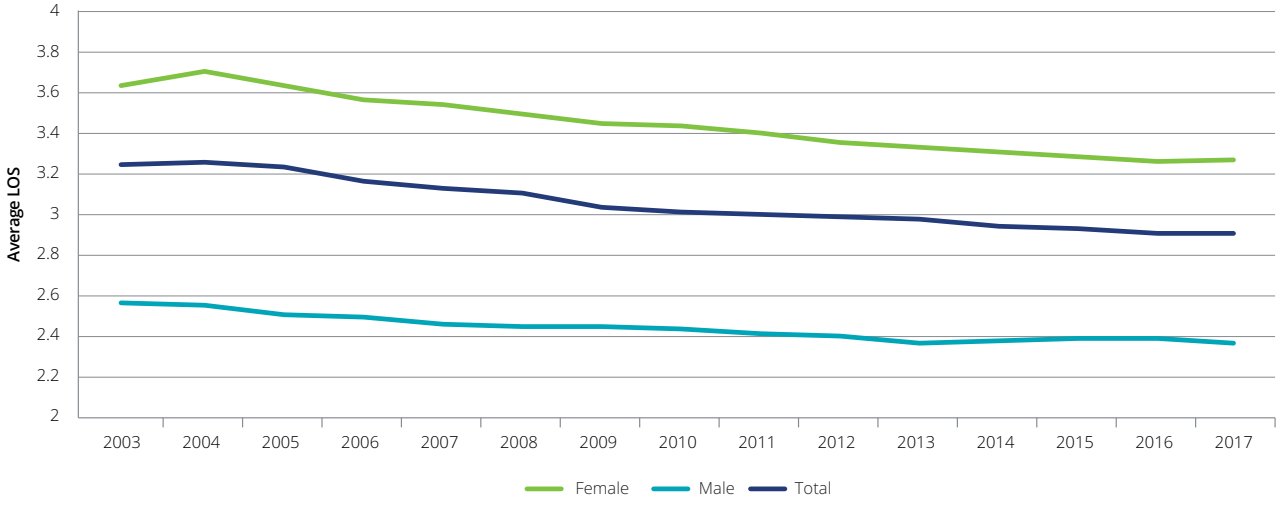
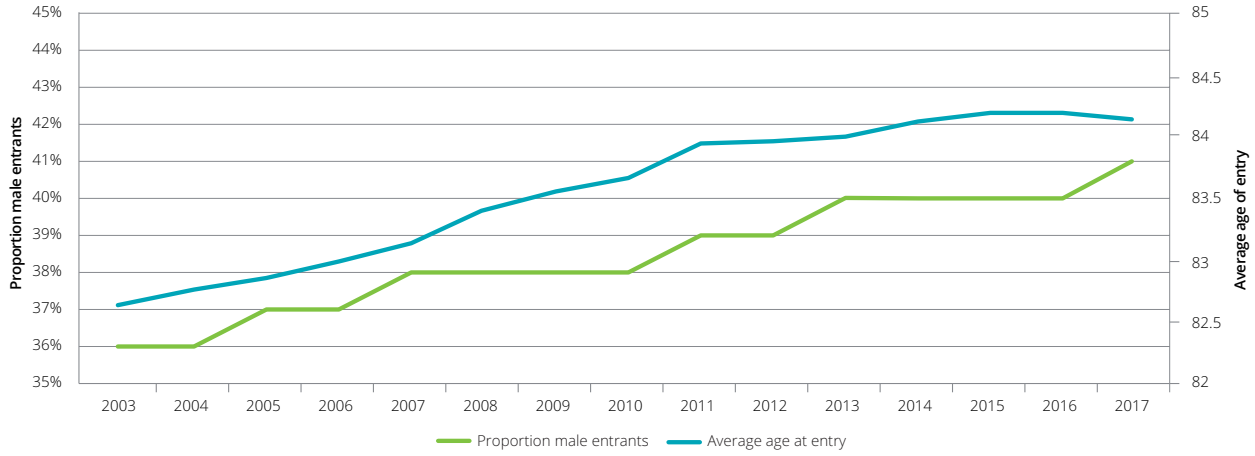


**Chart 5.13: Changes in age and gender distribution, 2003 to 2017**




### Change since 1 July 2014

The proportion of permanent residents that leave within three, six or 12 months of first entry increased from 2003–04 to 2013–14, which is in line with a decreasing average LOS (Chart 5.14). However, since 1 July 2014, this proportion decreased in 2014-15 and 2015-16, which would have an upwards impact on average LOS. However 2016-17 saw people leaving within three or six months increase by one percentage point.

### Dementia

Since 2008-09, the proportion of people entering residential care with a diagnosis of dementia has been consistently between around 43 per cent and 45 per cent of all permanent residents entering care, and the average age at admission for people with dementia was around six months older than for those without a diagnosis of dementia.

Chart 5.14 shows the proportion of people still in care over time by dementia status (diagnosis of dementia recorded within first 28 days of admission). It shows that half of the people entering without a dementia diagnosis died or left care within one year and 10 months; this compares with around two years and one month for people with an initial diagnosis of dementia. People with dementia are less likely to die or leave care in the initial period after entry, however in the longer-term, proportionally fewer people with dementia have longer lengths of stays when compared with those that do not.

**Chart 5.14: Proportion of permanent residents that leave within 3, 6 or 12 months of first entry, 2003–04 to 2016–17**

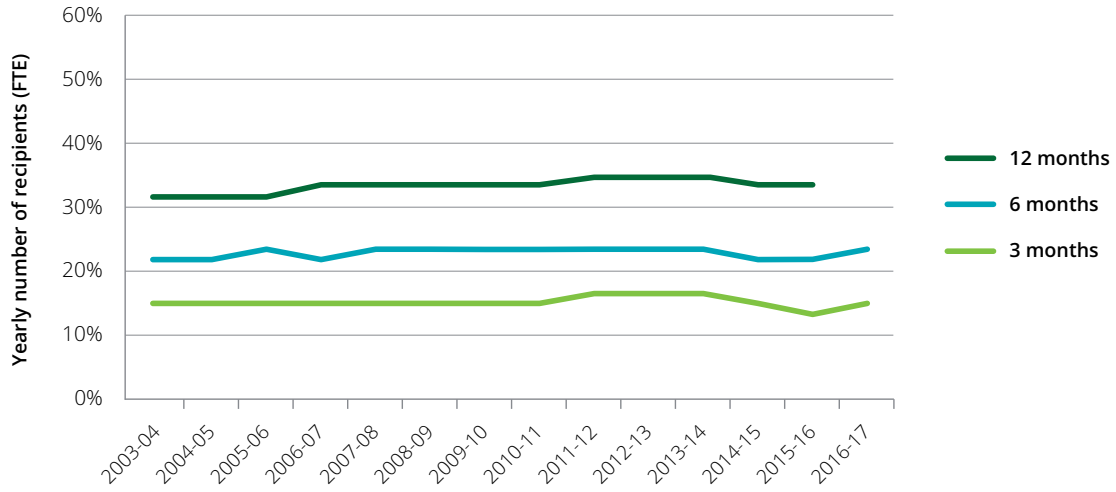
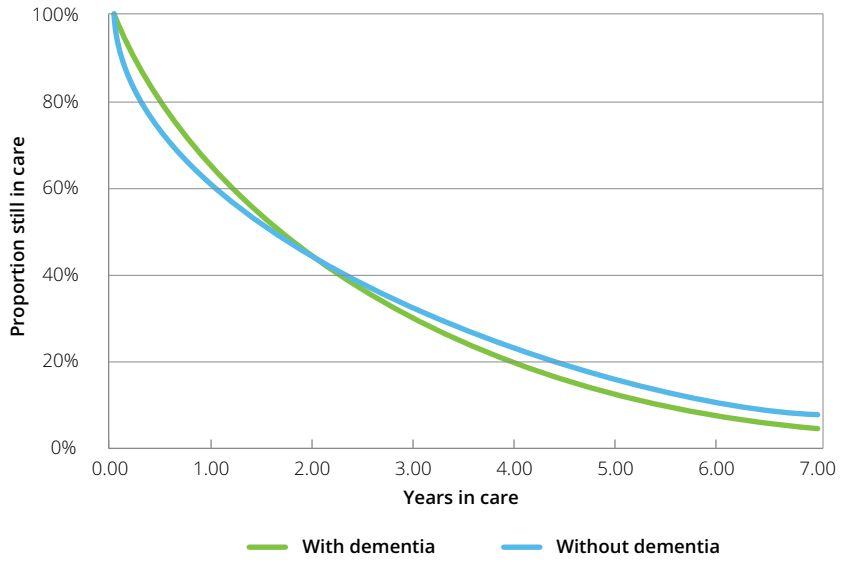


**Chart 5.15: Proportion of residents in care over time, with and without dementia**




## 5.7 Residential respite care

In its 2017 annual report, ACFA discussed the increasing use of residential respite care since the 1 July 2014 reforms. Following the release of ACFA's report, the Minister for Aged Care asked ACFA to examine the increasing use of residential respite care in recent years and provide a report as to whether the arrangements for provision and funding of residential respite, as well as other forms of respite care, remains appropriate for consumers and providers or could be improved. This report is to be provided to the Government by 31 October 2018.

Residential respite care is short-term care delivered within an aged care facility[26] on either a planned or emergency basis. People are assessed for eligibility by an ACAT, who will approve someone for high care respite and/or low care respite. The distinction between high and low care was not removed from respite care when it was removed from permanent residential care on 1 July 2014. A consumer can access residential respite for up to 63 days per financial year, with extensions possible when an Aged Care Assessment Team considers it necessary.

A noticeable difference in respite care compared with permanent residential care is that respite residents do not make any means-tested accommodation or care contributions. They can however be asked to pay the basic daily fee for living expenses, which is at the same rate as permanent residents. Respite residents can also purchase additional services, in the same manner as a permanent resident.

Providers of residential respite care do not have a separate allocation of residential respite places. Rather, a portion of each permanent allocation of residential care places may be used for the provision of respite care and it is up to the provider what mix of permanent care and residential respite care that they provide. Access to respite services will depend on a person's need/choice to access this type of care and on an approved providers willingness and ability to provide such care at that point in time.

### Number of respite care consumers

The residential care reforms introduced on 1 July 2014 made no changes to residential respite care, yet, as detailed in last year's report, the usage of respite care has increased noticeably in the three years following those reforms.

The number of people receiving respite care in 2016-17 increased by 4.2 per cent, from 56,852 in 2015-16 to 59,228 in 2016-17.

The full time equivalent (FTE) number of respite care consumers has increased by around 20 per cent over the three years since the reforms of 1 July 2014 (Chart 5.16).

Chart 5.17 shows the average number (FTE) of respite care consumers by month. As was the case last year, there is a strong seasonal pattern to the use of respite care, with the peak generally occurring in August/September. As can also be seen, the average monthly number (FTE) of respite care consumers increased significantly after 1 July 2014.

26 Other types of respite care can be accessed through the CHSP or through a home care package

**Chart 5.16: Number of full time equivalent respite care consumers, 2012–13 to 2016-17**

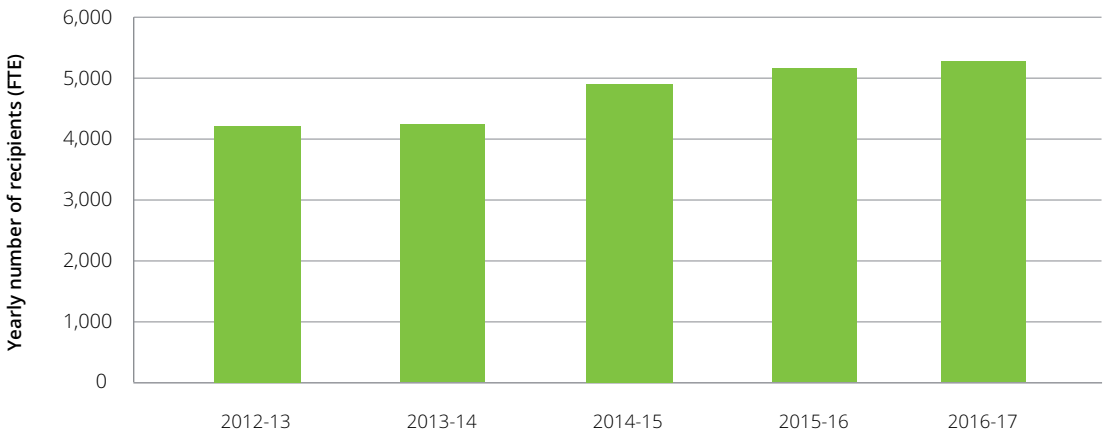



**Chart 5.17: Monthly number of full time equivalent respite care consumers, June 2012 to June 2017**


## 5.7.1 Length and frequency of stay in residential respite care

59,228 people received residential respite care during 2016-17. Of these, on average each person had 1.4 respite care stays[27] with each stay being an average of about 26 days. The average length of stay has increased slightly from around 24 days since 1 July 2014 (Chart 5.18). For home care package consumers who access residential respite care, the average length of stay is significantly shorter, at around 22 days and has remained stable since 2014-15.

A high proportion of the consumers of residential respite care have only one episode of respite care per annum (75 per cent). This trend has remained relatively stable over the past few years.

As was the case in 2015-16, a clear pattern of respite care use is that it is most often for stays of whole weeks at a time (Chart 5.19). A fortnight is by far the most common residential respite care length of stay. One, three and four weeks are the next most common lengths of stay. Around 2,300 consumers (3.9 per cent) used the maximum of 63 days in one stay. These usage trends have been stable in recent years.

### Transfers to permanent residential care

One of the factors that has driven the increased usage of respite care is that people are entering respite care in higher numbers within a week prior to assuming permanent resident status. As shown in Chart 5.20 this trend has continued in 2016-17. This is one aspect of the usage of residential respite care that ACFA will be examining in its report to Government.

27 A residential respite 'stay' refers to a single stay and is from when they enter to when they exit, no matter the duration.

**Chart 5.18: Average length of stay (days) in residential respite care, 2012–13 to 2016-17**

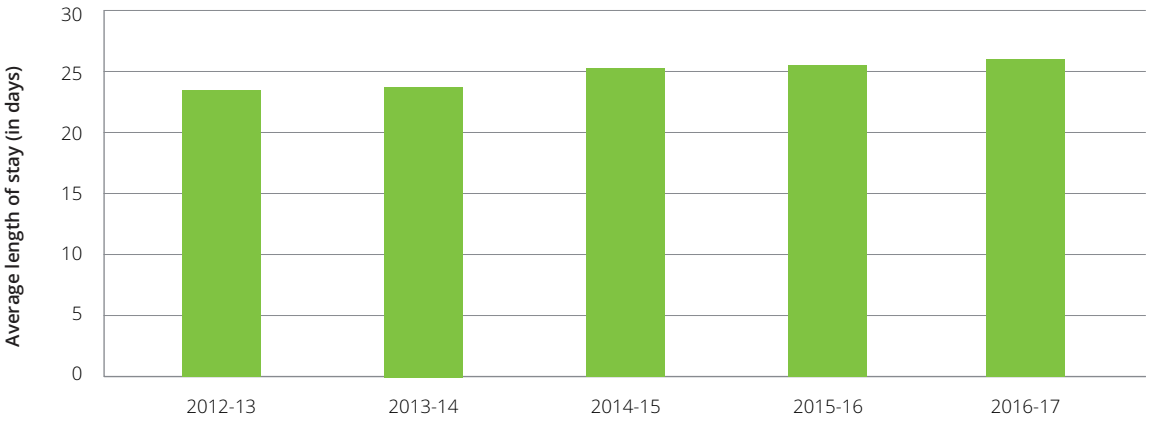



**Chart 5.19: Frequency of length of respite care stays, 2016-17**

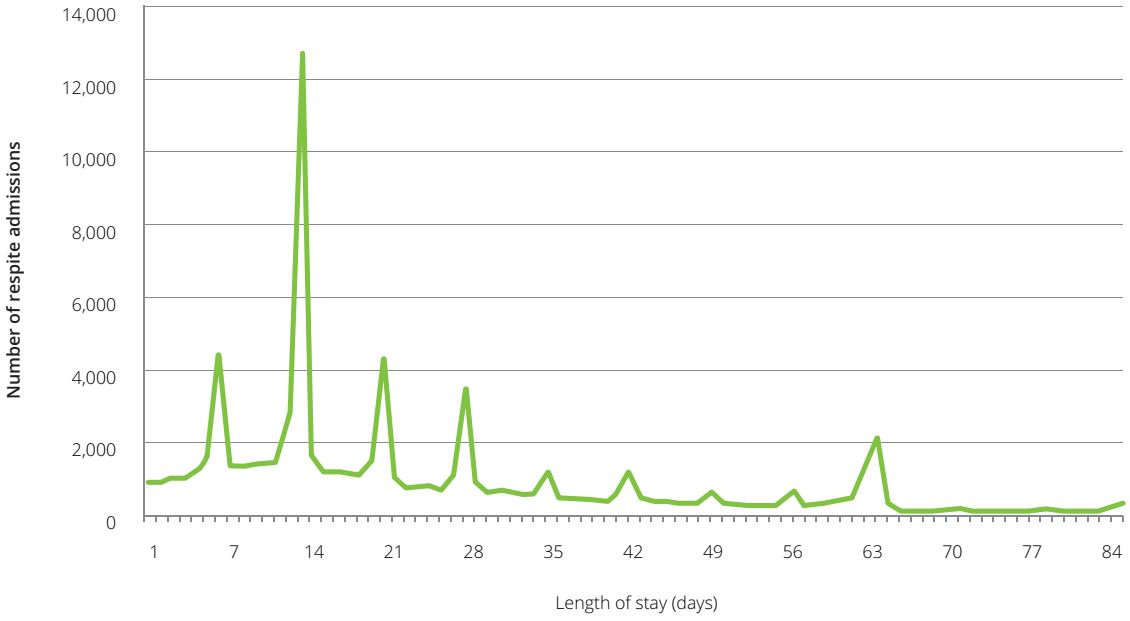
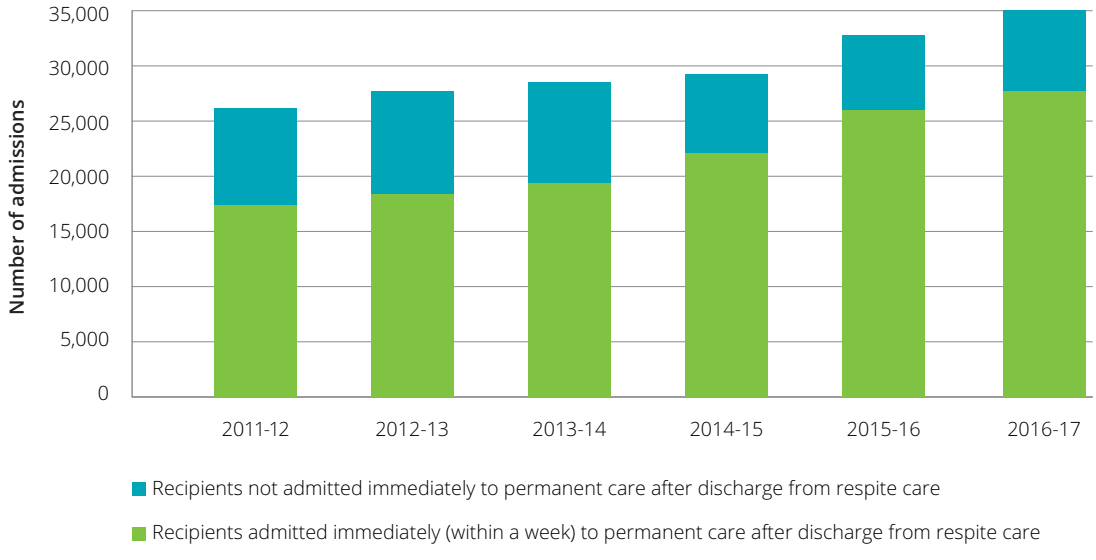



**Chart 5.20: Residents transferring into permanent care within a week of discharge from respite care, 2011–12 to 2016-17**



## 5.8 Supported residents

The Australian Government supports access to permanent residential care by consumers who are assessed as not being able to meet all or part of their own accommodation costs by paying providers an accommodation supplement on their behalf. These residents are known as supported residents.

Since the aged care reforms of 1 July 2014, eligibility for a full or partial accommodation supplement is determined by a combined assessment of an individual's income and assets. The cohort of supported residents also includes some residents who have had the value of their home excluded from the combined assets and income means test because it is occupied by a protected person (such as their partner).

The amount of accommodation supplement received by a provider on behalf of a supported resident depends on:

- the outcome of the resident's means tested assessment;
- whether the aged care service has been built or significantly refurbished since 20 April 2012; and
- whether the aged care service provides more than 40 per cent of its eligible care days to supported residents.

Providers have discretion to determine the proportion of supported residents in their facilities. However providers with 40 per cent or fewer supported residents (excluding those residents receiving extra services) in a facility have the accommodation supplement they receive for all supported residents in that facility reduced by 25 per cent.

As shown in Table 5.7 and Table 5.8, the proportion of supported residents increased across almost the entire sector in 2016-17 compared with 2015-16. Supported residents increased in all three locations and also increased in both the not-for-profit and for-profit providers. The analysis used in Tables 5.7 and 5.8 is based on claims submitted by providers on behalf of their residents.

**Table 5.7: Proportion of claims for supported residents, by location, 2014-15 to 2016-17**

| Location | 2014-15 | 2015-16 | 2016-17 |
|---|---|---|---|
| Metropolitan | 46.0% | 45.8% | 47.3% |
| Regional | 48.3% | 48.9% | 50.6% |
| Remote | 61.8% | 63.5% | 65.4% |

**Table 5.8: Proportion of claims for supported residents, by ownership type, 2014-15 to 2016-17**

| Ownership type | 2014-15 | 2015-16 | 2016-17 |
|---|---|---|---|
| Not-for-profit | 47.4% | 48.0% | 50.8% |
| For-profit | 45.2% | 44.3% | 45.3% |
| Government | 50.9% | 52.8% | 50.1% |

In December 2016, ACFA provided a report to Government regarding access by supported residents to residential care. The key findings of the report were:

- The 1 July 2014 reforms of accommodation payment arrangements have not had a negative impact on access to care for supported residents.
- The 40 per cent supported resident rule provides an important incentive for providers to accept supported residents.
- The regional supported resident ratios are being consistently exceeded by an average of around 20 to 30 percentage points in the great majority of cases.
- It is unlikely the regional ratios are significantly affecting provider behaviour. Instead the clear financial incentive of the separate 40 per cent ratio seems to be more effective in influencing provider behaviour.
- Regional ratios constitute unnecessary regulation and could be repealed with minimal, if any, impact on access to care by supported residents.

ACFA's submission to the *Legislated Review of Aged Care 2017* reported similar findings, that the changes to means testing and accommodation payments have not impaired access to residential care by people with low means. This conclusion is also supported by the proportions of supported residents in residential care in 2016-17, which were generally higher than 2015-16.

In last year's report ACFA noted that the higher accommodation supplement paid by the Australian Government on behalf of supported residents residing in newly built or significantly refurbished facilities was broadly in line with the average accommodation prices agreed between providers and non-supported residents. This indicates that, on average, the accommodation price the Government has set for supported residents is comparable with market-based prices paid by non-supported residents.

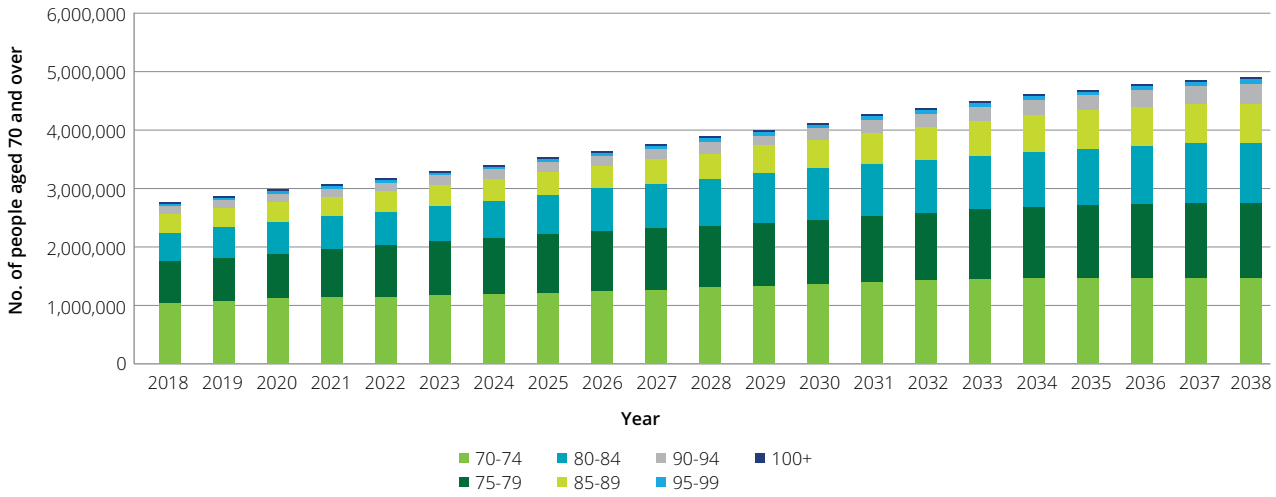
## 5.9 Future demand growth for aged care

The demand for aged care services will expand with the ageing of the population. This section considers the structural ageing of the population and the resulting growth in the demand for residential care and home care services.

The structural ageing of the Australian population over the next 20 years will see the size of the 70 years and over cohort increase by around 1 million people each decade (Chart 5.21); this is on a base of 2.7 million people. Underneath this, the older age groups will more than double over this period; for example, the 85 years and over cohort will increase from just under 500,000 people in 2018 to just over 1 million people by 2038.

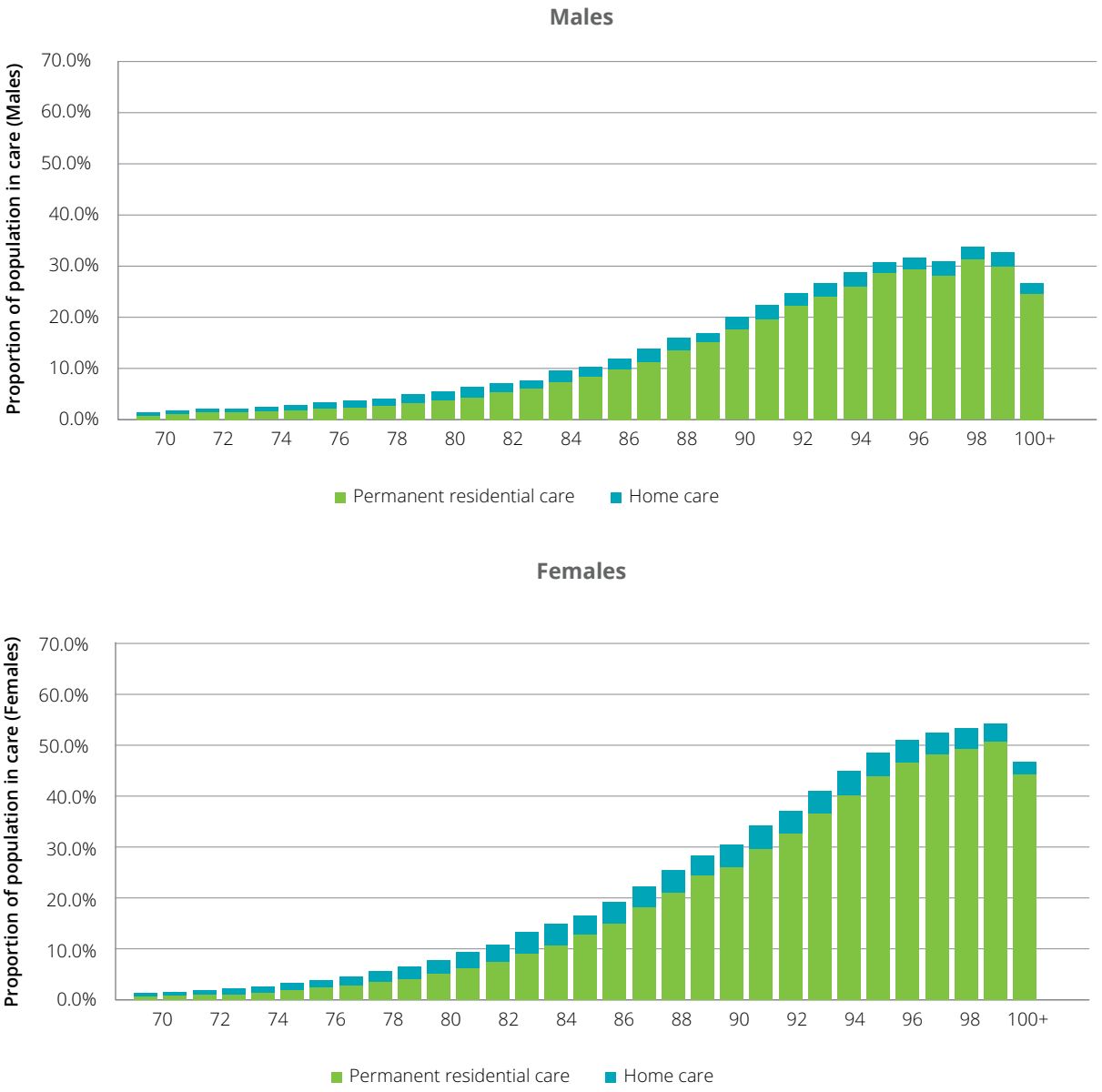
This rapid expansion in the number of older people, particularly in the oldest age groups, will result in a marked increase in demand for aged care services. As shown in Chart 5.22, the proportion of each age group who use aged care services increases dramatically with age. By age 80, the proportion of people using either permanent residential care or a home care package is around 7 per cent; this doubles by aged 85; and more than doubles again by aged 90 years.

**Chart 5.21: Number of people aged 70 years and over, by 5 year age cohort, 2018 to 2038[28]**




28 Source: ABS population projections, 2012

**Chart 5.22: Proportion of people of each age using residential care and home care, by gender and age, 2017**

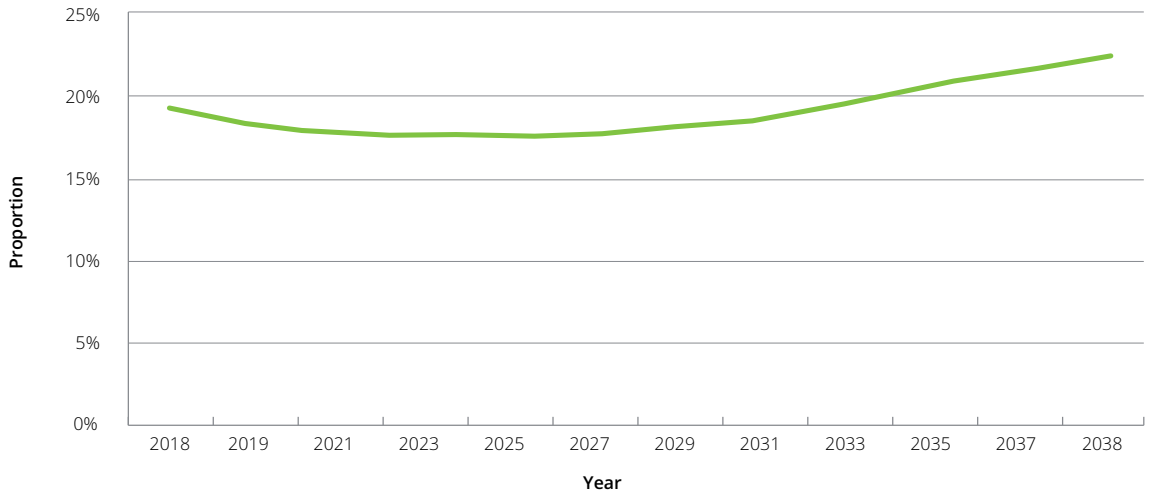



Because the baby boomers are such a large group compared with the pre-war generation, the proportion of the 70 and over population who are aged 85 and over will actually reduce over the next decade before subsequently increasing, as shown in Chart 5.23. This implies that the challenge of ensuring there is sufficient aged care supply to meet demand arising from the baby boomer generation is more likely to be felt in 10-15 years (from the late 2020s) rather than over the next decade.

When looking at the future demand for aged care, there are a number of uncertainties. The most pressing is the level of unmet demand in the population. Since residential care is supply-capped, it is difficult to ascertain directly whether demand is being met, or how close it is to being met. This was also the case with home care (which is also supply-capped), until the changes of February 2017, which included the implementation of a National Prioritisation Queue which now allows demand to be, in part, measured. However as separate supply caps are in operation it is difficult to ascertain whether the current spread of usage across residential care and home care would be the case if these separate supply caps did not apply.

Last year ACFA noted that there seemed to be evidence that home care demand is not being met, at least at the level 3 and level 4 end of the spectrum. The advent of the National Prioritisation Queue for home care packages since last year's ACFA report has provided further evidence that the demand for home care packages is not being met. As noted earlier in this report, further analysis is required to better understand the composition of the queue, and the extent and nature of unmet demand for home care.

**Chart 5.23: Proportion of 70 years and over age group who are aged 85 and over, 2018 to 2038**



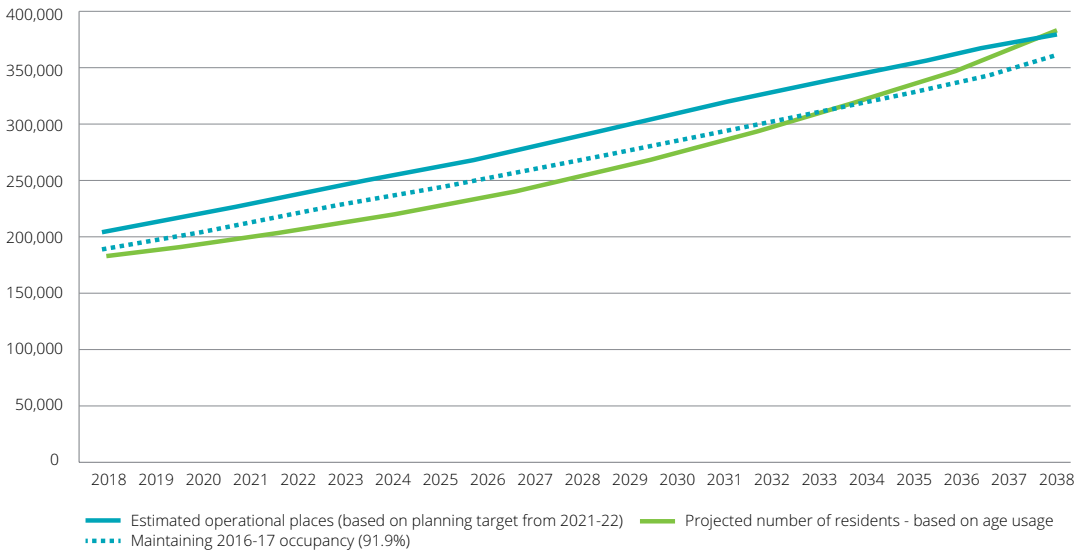

On the other hand, there appears to be some evidence for demand being met in residential care with current provision ratio targets. For example, average occupancy rates were previously stable at about 93 per cent and have decreased in 2016-17 as discussed earlier in this chapter.

Previous annual reports have reported that as the number of home care packages has increased, the proportion of people in each age group using residential care has decreased; this may indicate substitutability of service types. If this apparent trend is correct, then the Government's planned expansion of home care over the next four years is likely to further reduce demand for residential care.

Given that residential care is the most likely care type having demand met, and that the planned expansion of home care packages may further reduce this demand, it is worth considering what residential care demand may look like over the next two decades compared with the current target ratio.

The solid blue line in Chart 5.24 is the expected number of operational places; this grows at the same rate as the size of the population aged 70 years and older (i.e. the target provision ratio formula). The green line uses the current age usage of residential care, both permanent and respite care, and projects this forward with population growth in each age group; this provides an estimate of demand. As can be seen, a gap widens, which indicates that the expansion in the number of planned residential care places is in excess of the likely growth in demand. However, from about 2027, this gap starts to reduce as the baby boomers start to enter their 80s; this indicates that demand will start to grow at a faster rate than the target provision ratio is allowing for. The dashed blue line is 91.9 per cent of the solid blue line; this would be the usage of residential care if recent occupancy levels were maintained.

**Chart 5.24: Projected demand for residential care, 2018 to 2038**



ACFA notes however, that historical age-related usage rates will not necessarily apply in a more consumer-driven market-based system. Accordingly, close monitoring, analysis and reporting of occupancy rates as supply is expanded and re-balanced towards home care will be important for understanding future access to and demand for aged care services. The flexibility introduced by the 2018-19 Budget decision to create a single budget line for home care and residential care to direct available funding in line with consumer demand will also make an important contribution to understanding future demand.

ACFA notes that *the Legislated Review of Aged Care 2017* recommended changing the aged care planning ratio after 2022 to reflect numbers of consumers over age 75 rather than age 70. The above analysis however is based on the target provision age of 70 and over. ACFA will seek to have updated analysis in future reports for the possible change.

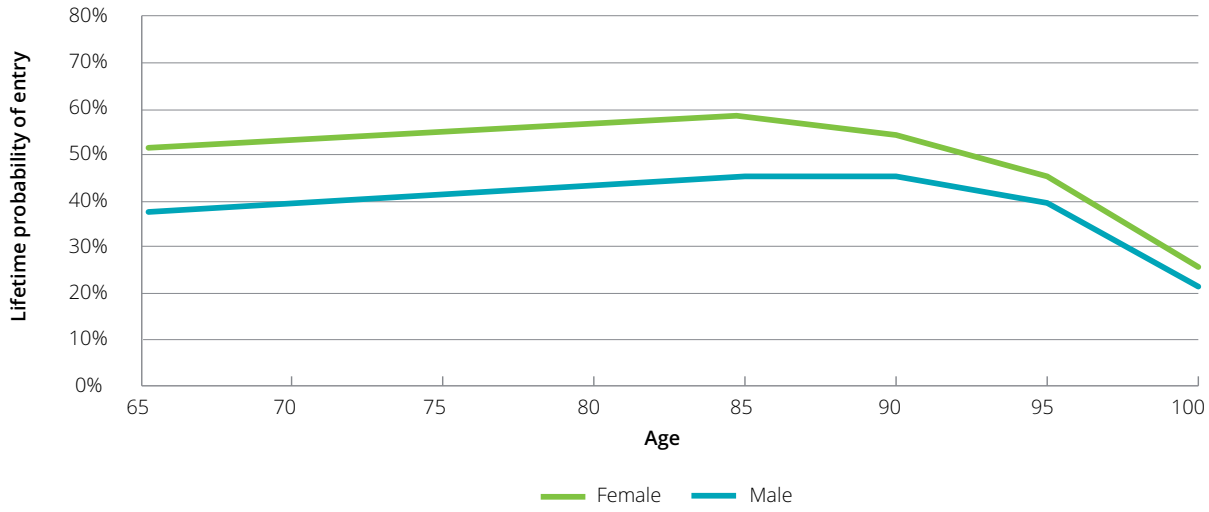
### 5.9.1 Probability of entering permanent residential aged care

Chart 5.25 shows the probability of entering permanent residential care. Females have a higher chance of entering care than males, though the difference between males and females reduces in older age. At age 70, the probability of an individual entering residential care in their lifetime is around 54 per cent for females compared with around 40 per cent for males.

The probability of a person entering residential care gradually increases up to around age 85 as people experience more immediate aged care needs. After this age, the chance of someone dying before entering permanent residential care starts to increase and the probability of entering care therefore decreases.

A major factor in future entry rates will be the continuing expansion of home care, which is expected to result in proportionally fewer people entering permanent residential care.

**Chart 5.25: Probability of entering permanent residential aged care**



# 6

# Home support

# 6. Home Support

**This chapter provides an overview of the Commonwealth Home Support Programme (CHSP) and Western Australian Home and Community Care (HACC) Program.**

**This chapter discusses:**

- the operation of the CHSP
- the supply and usage of CHSP and the Western Australian HACC
- the funding of CHSP and the Western Australian HACC

**This chapter reports that in 2016-17[29]:**

- the Commonwealth funded 1,621 providers to deliver CHSP and HACC services (1,523 CHSP providers and 98 HACC providers in Western Australia);
- the CHSP provided services to 722,838 older Australians;
- the Western Australian HACC services provided services to 62,089 older Australians; and
- the total number of older Australians that received home support services was 784,927[30].

**The Australian Government contributed $2.4 billion to home support, in 2016-17 comprising:**

- $2.1 billion for CHSP (including $115 million of growth funding);
- $123 million for My Aged Care and Regional Assessment Service (RAS) and other initiatives to support the CHSP; and
- $188 million in payments to the Western Australian government to support the jointly funded HACC program.

## 6.1 Introduction

Home support generally provides small amounts of services (entry-level services) designed to help older Australians continue living in their own homes for as long as they can and wish to do so, and delay the need for higher level care, including residential care, through early intervention. The home support programs discussed in this chapter are the Commonwealth Home Support Programme (CHSP) and the Home and Community Care (HACC) program in Western Australia.

## 6.2 Commonwealth Home Support Programme

The Commonwealth Home Support Programme (CHSP) provides entry-level support services for frail, older people aged 65 years and older (or 50 years and older for Aboriginal and Torres Strait Islander people) who need assistance to keep living independently at home and in their community. CHSP entry level support is underpinned by a 'wellness approach', which is about building on older people's strengths, capacity and goals to help them remain independent and to live safely at home.

The CHSP also supports homeless people, or people at risk of homelessness, to access care and housing. To be eligible for assistance with care and housing services through the CHSP, a person must be: prematurely aged; 50 years and over (45 years and over for Aboriginal and Torres Strait Islander people); on a low income; and be homeless or at risk of homelessness as a result of experiencing housing stress or not having secure accommodation.

My Aged Care is the Australian Government's single entry point for aged care services. Access to CHSP services is coordinated through My Aged Care and Regional Assessment Services.

Table 6.1 sets out the types of services that may be accessed through the CHSP. Data from the Department shows that about half of CHSP consumers use one type of service and about 6 per cent use five or more. On average, CHSP consumers receive services to the value of $2,600 a year.

29 There has been a change to the counting methodology used for 2016-17 due to more comprehensive reporting by CHSP providers through the Department of Social Services' Data Exchange reporting system.

30 Total home support consumers, for 2015 16 was reported as 925,432. This total is likely overstated due to lack of accurate data and differences in counting methods used for the new CHSP.

**Table 6.1: CHSP services: by sub-program and service type**

| Sub-program | Community and home support | Care relationships and carer support | Assistance with care and housing | Service system development |
|---|---|---|---|---|
| Objective | To provide entry-level support services to assist frail, older people to live independently at home and in the community. | To support and maintain care relationships between carers and clients, through providing good quality respite care for frail, older people so that regular carers can take a break. | To support those who are homeless or at risk of homelessness, to access appropriate and sustainable housing as well as community care and other support services, specifically targeted at avoiding homelessness or reducing the impact of homelessness. | To support the development of the community aged care service system in a way that meets the aims of the CHSP and broader aged care system. |
| Service types funded | • Meals<br>• Other food services<br>• Transport<br>• Domestic assistance<br>• Personal care<br>• Home maintenance<br>• Home modifications<br>• Social support-individual<br>• Social support-group (formerly centre-based day care)<br>• Nursing<br>• Allied health and therapy services<br>• Goods, equipment and assistive technology<br>• Specialised support services | Flexible respite:<br>• In-home day respite<br>• In-home overnight respite<br>• Community access – individual respite<br>• Host family day respite<br>• Host family overnight respite<br>• Mobile respite<br>• Other planned respite<br>• Centre-based respite<br>• Centre based day respite<br>• Residential day respite<br>• Community access-group respite<br>• Cottage respite (overnight community) | Assistance with care and housing (a person must be: prematurely aged; 50 years and over (45 years and over for Aboriginal and Torres Strait Islander people); on a low income; and be homeless or at risk of homelessness as a result of experiencing housing stress or not having secure accommodation). | Sector support and development activities |

## 6.3 Home and Community Care — Western Australia

The HACC program in Western Australia provided similar services for older people to those provided under the CHSP, but also provides support for younger people with a disability.

During 2016-17, Western Australian HACC services were delivered through the jointly funded HACC program under the *HACC Review Agreement 2007*. Consumers continued to be assessed for HACC services through the HACC program assessment arrangements.

Since 1 July 2018, Western Australia HACC services for older people have been incorporated into the CHSP.

## 6.4 Sector overview

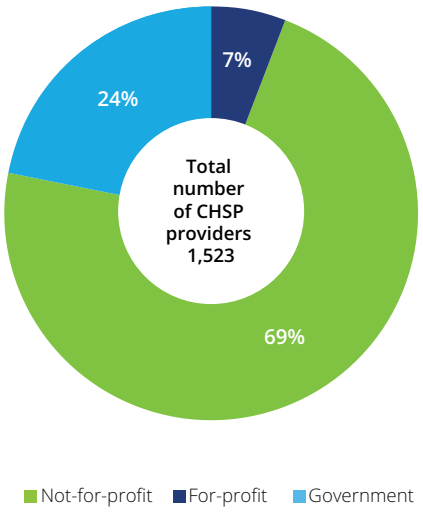
### 6.4.1 Providers of home support

In 2016-17, there were 1,523 providers of home support under the CHSP. In Western Australia, there were 98 providers of HACC. This compares with 2015-16 where there were 1,160 CHSP providers as well as 421 HACC providers in Victoria[31] and 105 HACC providers in Western Australia.

CHSP services are predominately provided by not-for-profit organisations (69 per cent), as shown in Chart 6.1. In last year's annual report ACFA reported that not-for-profit providers represented 77 per cent of CHSP providers. The reported significant drop in not-for-profit providers in 2016-17 and commensurate increase in government-owned providers (24 per cent up from 18 per cent in 2015-16) is due to a large number of Victorian local government HACC providers, who were incorporated into the CHSP in 2016-17.

31 Victorian HACC services for older people were incorporated into the CHSP as of 1 July 2016.

**Chart 6.1: CHSP providers by provider ownership type, 2016-17**




## 6.5 Funding for CHSP and HACC

In 2016-17, the Commonwealth contributed funding of $2.2 billion to the CHSP, which included $123.2 million for My Aged Care, the Regional Assessment Service and other initiatives to support the CHSP. Also included in the $2.2 billion was approximately $115 million of growth funding announced for 2016-17 and 2017-18 which targeted priority groups such as CALD, Indigenous Australians, rural and remote and homeless older Australians. A further $187.9 million was provided to the joint Commonwealth-state funded HACC program in Western Australia, bringing the total Commonwealth expenditure on home support to $2.4 billion in 2016-17.

Chart 6.2 shows total expenditure on home support since prior to the introduction of the CHSP, along with budgeted expenditure to 2020-21.

**Chart 6.2: Government expenditure and budgeted expenditure of CHSP[32] and Victorian and Western Australian HACC programs, 2012-13 to 2020-21**

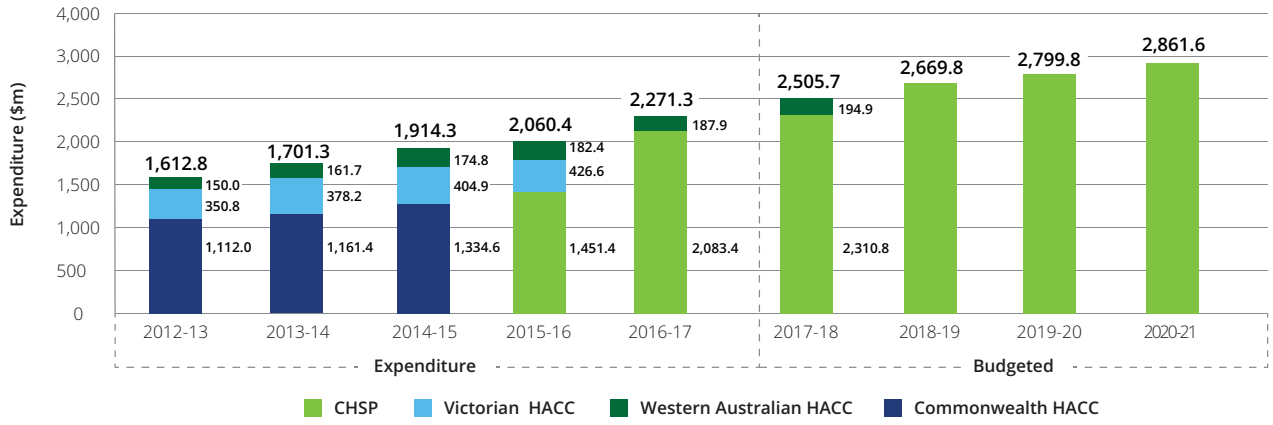
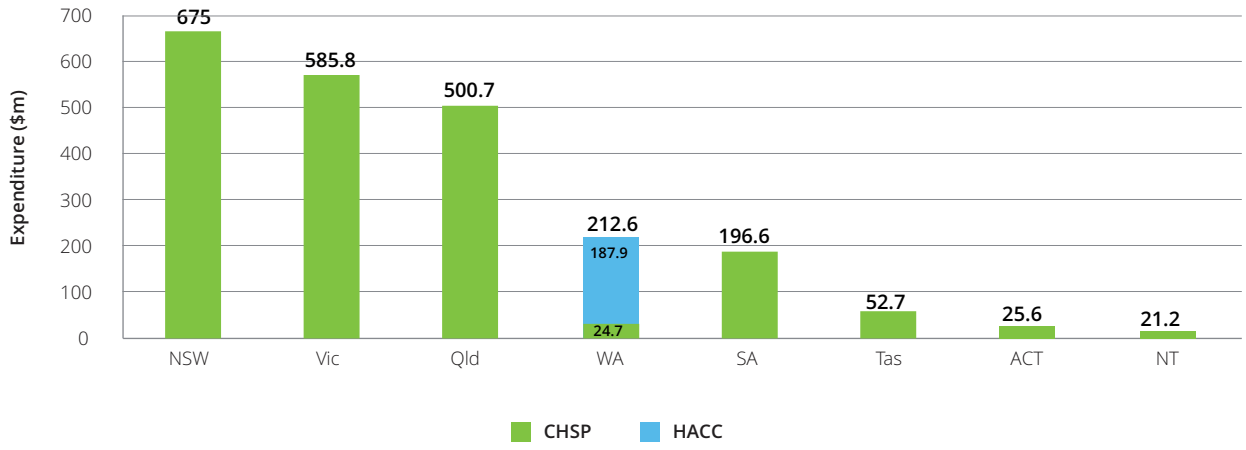



**Chart 6.3: Commonwealth expenditure on CHSP and WA HACC services during 2016-17, by state and territory[33]**




32 CHSP expenditure shown here excludes the expenditure on RAS and My Age Care support services of $148 million in 2015-16 and $123 million in 2016-17 as they were not for services to consumers.

33 The former non-HACC components of the CHSP all transferred to the CHSP from 2015-16. The $24.7 million identified under the CHSP in 2016-17 for Western Australia relates to the non-HACC components.

As part of the 2014-15 Budget, the Australian Government announced a reduction in the annual real rate of growth for the CHSP from 6 per cent to 2.8 per cent in 2015-16, 1.5 per cent in 2016-17 and 2.4 per cent in 2017-18. In 2018-19 the growth rate is 3.5 per cent which aligns with the annual growth in the population aged 65 and over. Real growth is in addition to annual indexation.

The reduction of the rate of growth did not affect the level of service delivery to clients. Because growth is aligned with growth in the aged population, consumer access to CHSP services should not be affected.

Table 6.2 shows a breakdown of the size of grants provided through the CHSP in 2016-17 by organisation type. Results for 2016-17 are similar to 2015-16. The vast majority (76 per cent) of providers receive less than $1 million and of those, almost 80 per cent receive less than $500,000.

**Table 6.2: CHSP grants provided in 2016-17, by size of grant and organisation type**

| Grant size | Not-for-profit | For-profit | Government |
|---|---|---|---|
| Less than $500,000 | 693 | 67 | 157 |
| $500,000 - $1 million | 138 | 22 | 83 |
| $1-10 million | 195 | 20 | 118 |
| $10-50 million | 15 | 1 | 7 |
| Over $50 million | 3 | 1 | 1 |

### 6.5.1 Consumer contributions

In the CHSP, the *Client Contribution Framework* and the *National Guide to the CHSP Client Contribution Framework* set out principles to guide CHSP providers in setting and implementing their own consumer contribution policy.

The principles are designed to introduce fairness and consistency, with a view to ensuring that those who can afford to contribute do so, whilst protecting the most vulnerable.

Recommendation 16 of the *Legislated Review of Aged Care 2017* recommended that mandatory consumer contributions based on an individual's financial capacity be introduced for services under the CHSP. This would bring the CHSP fees policy more in line with those under other aged care programs. The Government has not yet responded to this recommendation.

## 6.6 Looking forward

In the 2017-18 Budget, the Australian Government extended funding agreements with CHSP providers by two years, which means that the Home Care Packages Programme and CHSP will continue to operate as separate programs until at least mid-2020. In the 2015-16 Budget, the Australian Government had announced an intention to integrate the CHSP with the Home Care Packages Programme into a single home care and support programme by July 2018.

The Australian Government negotiated an agreement with the Western Australian government to transition existing Western Australian HACC services for older people aged 65 years and over (and 50 years and over for Aboriginal and Torres Strait Islander people) to the CHSP, from 1 July 2018. This now enables the Commonwealth to have full funding, policy and operational responsibility for the delivery of home and community support services for older people nationally for the first time.

Following the establishment of the CHSP as a program with full national coverage, the Department issued a new Program Manual that sets out service provider's responsibilities, including a new emphasis on a wellness approach to service delivery. From October 2018, providers will be required to submit a report outlining service level information regarding the implementation of a wellness approach within their organisation. These reports will be submitted annually and used to measure overall progress towards embedding a wellness approach in the CHSP.

# 7

# Home care: operational performance

# 7. Home care: operational performance

**This chapter provides an overview of the Home Care Packages Programme and the financial performance of home care providers.**

**This chapter discusses:**

- the operation of home care
- the funding of the sector
- the financial performance of home care providers in 2016-17

**The chapter reports that:**

- there were 702 home care providers as at 30 June 2017, up from 496 as at 30 June 2016 (data available shows there are likely to be over 800 providers by 30 June 2018);
- the sector continues to be predominately not-for-profit with 65 per cent of providers and 81 per cent of consumers as at 30 June 2017;
- home care providers received an estimated $1.85 billion in revenue in 2016-17, paid around $1.65 billion in expenses and generated $201 million in profit[34];
- services were provided to 97,516 consumers, up from 88,875 in 2015-16;
- 75 per cent of home care package providers achieved net profit in 2016-17, the same result as in 2015-16;
- average EBITDA of $2,989 per consumer, compared with $3,055 in 2015-16, a 2 per cent decrease;
- EBITDA margin of 11.3 per cent, compared with 10.9 per cent in 2015-16; and
- As at 30 June 2017 home care providers held $329 million in unspent funds, an increase of 26 per cent from 2015-16.

## 7.1 The Home Care Packages Programme

The Home Care Packages Programme commenced on 1 August 2013, replacing the former home care programs – Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH) packages and Extended Aged Care at Home Dementia (EACH-D) packages.

Home care packages allow consumers to purchase a range of services and equipment which assist them living in their own home. Packages are required to be delivered on a Consumer Directed Care (CDC) basis, including that each consumer has an individualised budget which allows them to decide what type of care and services they purchase and who delivers the services.

Consumers may purchase the following:

- **Personal services.** Examples include help with showering or bathing, dressing and mobility;
- **Support services.** Examples include help with washing and ironing, house cleaning, gardening, basic home maintenance, home modifications related to care needs, transport to help with shopping, doctor visits or attending social activities;
- **Clinical care.** Examples include nursing and other health support including physiotherapy (exercise, mobility, strength and balance), services of a dietitian (nutrition assessment, food and nutrition advice, dietary changes) and hearing and vision services; and
- **Care coordination and case management.**

Home care packages are categorised into four levels with level 1 being for people with lower level care needs through to level 4 which supports people with high care needs.

For many consumers, home care packages offer an opportunity to remain living at home instead of entering residential aged care.

34 The total revenue, expenses and profit noted here are estimates of all providers based on the 85 per cent of providers who submitted their Aged Care Financial Reports.

To obtain access to a home care package, individuals are first assessed by an Aged Care Assessment Team (ACAT) which determines eligibility for a home care package. Some people assessed as eligible to receive a package would also be eligible for residential care. Once assessed as eligible for home care, an individual is placed on the National Prioritisation Queue and is assigned a package from this queue when one becomes available. The National Prioritisation Queue is discussed in Chapter 5.

### 7.1.1 Measuring financial performance of home care

The discussion of financial performance in this chapter predominantly relates to Earnings Before Interest, Taxes, Depreciation and Amortisation (EBITDA). As discussed in Chapter 1, EBITDA is the commonly used metric for analysis and comparison of the profitability of providers and the sector. Net Profit Before Tax (NPBT), which takes interest, depreciation and amortisation into the calculation, is also used.

Financial information reported in this chapter has been collected through the 2016-17 Aged Care Financial Report (ACFR). The Accountability Principles 2014, made under Section 96-1 of the *Aged Care Act 1997*, require each provider to submit a financial report in a form approved by the Secretary of the Department of Health. It should be noted however that the ACFR is not required to be audited and should not be considered a General Purpose Financial Report.

ACFA notes that in previous years' reports, financial performance of home care providers was largely summarised on a 'per package' basis as the packages were previously allocated to approved providers after a competitive tender through an ACAR. Analysis on this basis included the provider's packages that were not fully utilised for whatever reason in a financial year. The reform changes of February 2017 have resulted in packages being assigned to consumers and as a result, the analysis is now calculated on a 'per consumer' basis. EBITDA calculated on a 'per consumer' basis is generally higher when compared with EBITDA calculated on a 'per package' basis as unutilised packages are excluded. When trend data is analysed, previous years have been re-calculated on the 'per-consumer' basis to allow for direct comparison between years.

Eighty-three per cent of home care providers submitted their 2016-17 financial reports to the Department in a usable form. Therefore, the financial performance analysis is based on this sample. However, where appropriate, the sample data has been scaled up to estimate totals for all home care providers.

## 7.2 Providers of home care

In this chapter, home care providers are discussed in four ways:

- **By whole-of-sector.** All home care providers are considered together.
- **By provider ownership type.** Providers are considered by their ownership type, that is, not-for-profit, for-profit or government.
- **By provider location.** Providers are considered by their location, that is, metropolitan, regional or both metropolitan and regional combined (as providers can operate multiple services in different locations).
- **By provider scale.** Providers are considered by the number of services they operate, one, two to six, and seven or more services.

Table 7.1 provides an overview of the number of home care providers, services operated and consumers over the last five years to 30 June 2017. Table 7.2 presents a breakdown of home care providers by ownership type, location and provider scale for all home care providers in 2016-17.

**Table 7.1: Provider numbers, number of services and number of consumers, 30 June 2013 to 30 June 2017**

| | 30 June 2013 | 30 June 2014 | 30 June 2015 | 30 June 2016 | 30 June 2017 |
|---|---|---|---|---|---|
| No. of providers | 504 | 504 | 504 | 496 | 702 |
| No. of services | 2,131 | 2,212 | 2,292 | 2,099 | 2,367 |
| No. of consumers | 56,515 | 59,739 | 59,506 | 64,069 | 71,423 |

**Table 7.2: Provider numbers, number of services and number of consumers, at 30 June 2017**

| | | | Ownership type | | | Location | | | Scale | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 30 June 2016 | 30 June 2017 | Not-for-profit | For-profit | Government | Metropolitan | Regional | Metropolitan & regional | Single service | Two to six services | Seven or more services |
| No. of providers | 496 | 702 | 453<br>65% | 150<br>21% | 99<br>14% | 367<br>52% | 291<br>41% | 44<br>6% | 388<br>55% | 223<br>32% | 90<br>13% |
| No. of services | 2,099 | 2,367 | 1,827<br>77% | 356<br>15% | 184<br>8% | 1,177<br>50% | 526<br>22% | 664<br>28% | 334<br>14% | 592<br>25% | 1,440<br>61% |
| No. of consumers | 64,069 | 71,423 | 58,783<br>82% | 7,719<br>11% | 4,921<br>7% | 38,969<br>55% | 10,795<br>15% | 21,659<br>30% | 8,291<br>12% | 18,481<br>26% | 44,651<br>63% |

While the number of approved home care providers was stable for the previous four years, 2016-17 saw a significant increase from 496 to 702 providers as at 30 June 2017. The increase is mainly due to the changes of February 2017 which allow providers to compete in the market for consumers who have been assigned a package instead of waiting to be allocated a package through the ACAR. This change encouraged more new providers to enter the home care market.

As shown in Table 7.3, the growth in home care provider numbers mainly comprised not-for-profit and for-profit providers. However proportionally, for-profits now represent 21 per cent of the sector (up from 13 per cent) whereas not-for-profit providers dropped from 70 per cent in 2015-16 to 65 per cent. ACFA had noted in previous annual reports that the opening up of the home care market was likely to see for-profit providers seek to increase their share of home care consumers.

At 30 June 2017 there were 71,423 consumers in home care, compared with 64,069 at 30 June 2016. The number of services operated by all providers also increased in 2016-17 compared with 2015-16 (2,367 up from 2,099). The majority of the increase in services was due to new single service providers entering the market. At 30 June 2017 there were 388 single service providers (55 per cent of all providers) compared with 223 (45 per cent) at 30 June 2016.

Throughout 2016-17, 97,516 older Australians were in receipt of a home care package at some time (up from 88,875 in 2015-16). In 2016-17, level 2 packages once again comprised the majority of all home care packages (66 per cent), followed by level 4 (23 per cent). Level 3 and level 1 packages comprised 10 per cent and 2 per cent respectively (Table 7.4).

Despite the significant increase in the number of for-profit providers, not-for-profit providers continued to provide the majority of home care packages across all levels in 2016-17, as illustrated in Chart 7.1 and Table 7.4.

However, as was the case last year, for-profit providers had a proportionally larger share of level 1 and level 3 package consumers than they did for level 2 and level 4, with 25 and 16 per cent compared with 9 and 13 per cent. This is likely a result of for-profit providers having greater success in more recent ACARs, coinciding with the recent introduction of level 1 and 3 packages. Overall, the total share of consumers receiving care from for-profit providers increased from 10.1 per cent in 2015-16 to 11.6 per cent in 2016-17. This continues the trend noted in previous reports of for-profit providers gradually increasing their share of the home care market.

**Table 7.3: Increase in providers, 2015-16 to 2016-17**

| | Total at 30 June 2016 | Proportion of total | Increase in 2016-17 | Total at 30 June 2017 | Proportion of total |
|---|---|---|---|---|---|
| Not-for-profit | 347 | 70% | 60 | 407 | 65% |
| For-profit | 65 | 13% | 135 | 200 | 21% |
| Government | 84 | 17% | 11 | 95 | 14% |
| **Total** | **496** | **100%** | **206** | **702** | **100%** |

**Chart 7.1: Home care consumers, by package level and provider ownership type, at 30 June 2017**

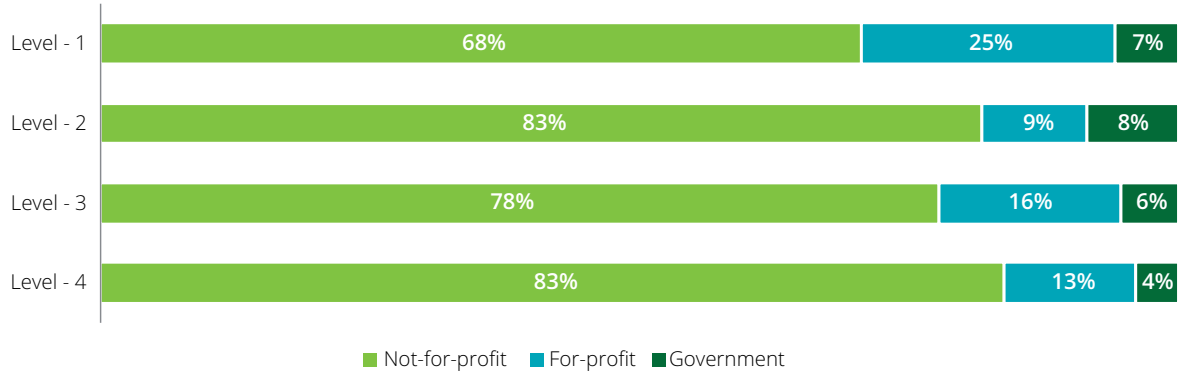



**Table 7.4: Home care consumers, by package level and ownership, at 30 June 2017**

| Level | Not-for-profit | For-profit | Government | Total |
|---|---|---|---|---|
| Level 1 | 795 | 289 | 84 | 1,168 |
| Level 2 | 38,763 | 4,691 | 3,814 | 47,268 |
| Level 3 | 5,235 | 1,115 | 400 | 6,750 |
| Level 4 | 13,390 | 2,219 | 628 | 16,237 |
| **Total** | **58,183** | **8,314** | **4,926** | **71,423** |

In previous years, the share of packages held by ownership type reflected previous ACAR allocations. However due to the February 2017 changes that allow consumers to direct their package to their provider of choice, providers' market shares will no longer be determined by the ACAR but by consumer choice. The February 2017 changes would only be starting to have an impact in 2016-17. ACFA will monitor the implications of this more competitive environment on provider market shares.

Table 7.5 shows all consumers in packages as at 30 June 2017 by ownership type, state and territory and by package level.

Across Australia, almost 69 per cent of home care consumers are in major cities with just under 21 per cent in inner regional locations. Around 8 per cent of consumers are in outer regional locations, and the remaining 2 per cent in remote and very remote areas.

**Table 7.5: Number of consumers in packages, by provider type and state/territory, at 30 June 2017**

| State/territory | Not-for-profit | For-profit | Government | Total |
|---|---|---|---|---|
| New South Wales | 19,449 | 3,331 | 623 | 23,403 |
| Victoria | 14,278 | 1,255 | 3,008 | 18,541 |
| Queensland | 11,645 | 1,401 | 247 | 13,293 |
| Western Australia | 5,152 | 1,315 | 285 | 6,752 |
| South Australia | 4,742 | 354 | 513 | 5,609 |
| Tasmania | 1,578 | 319 | 10 | 1,907 |
| Australian Capital Territory | 940 | 201 | 0 | 1,141 |
| Northern Territory | 399 | 138 | 240 | 777 |
| **Australia** | **58,183** | **8,314** | **4,926** | **71,423** |
| **% of Total** | **81.5%** | **11.6%** | **6.9%** | **100.0%** |

## 7.3 Analysis of 2016-17 financial performance of home care providers

In 2016-17, home care providers submitted their financial performance reports to the Department of Health using the Aged Care Financial Reports (ACFR). The ACFR incorporates the home care financial report, which was introduced in 2013-14.

Table 7.6 provides an overview of the 2016-17 financial performance of home care providers whose ACFRs were submitted in a useable form. Further analysis is then presented by ownership type, location and scale. While much of the analysis and commentary regarding the profitability and financial performance of providers relates only to those who submitted their useable financial reports, where possible and appropriate, the results have been scaled up to represent all home care providers.

### 7.3.1 Home care funding sources

Home care funding sources predominantly comprise Commonwealth subsidies and supplements paid on behalf of consumers, and a lesser contribution from consumers.

In 2016-17, total Commonwealth expenditure on home care subsidies and supplements was $1.68 billion, comprising of $1.64 billion in subsidies and $41 million in supplements, an increase of 12.8 per cent on $1.49 billion in 2015-16.

Consumer contributions in 2016-17 totalled around $150 million compared with around $140 million in 2015-16.

Commonwealth subsidy and supplement revenue, consumer contributions and other revenue sources reported by home care providers who submitted their financial reports for 2016-17 totalled $1.73 billion.

It is estimated that the total home care sector generated $1.85 billion in revenue in 2016-17. This has been derived by scaling up the $1.73 billion that was reported by those providers who submitted their ACFRs to the Department.

**Commonwealth funding**

Commonwealth funding is determined per consumer based on the level of package accessed. It is calculated on a daily basis and paid monthly. Each package level has a fixed maximum amount of annual funding set by the Commonwealth (Table 7.7). Supplements can also be paid in circumstances where the consumer requires additional care and/or services.

Prior to the changes that occurred in home care in February 2017, when consumers moved between home care providers or exited care (often to enter residential care), unspent package funds could be retained by the former home care provider. As part of the changes introduced in February 2017, unspent package funds now follow the consumer to their new home care provider or are returned to the Commonwealth and the consumer (based on their respective proportions) when the consumer leaves care.

**Table 7.6: Summary of financial performance of home care providers who submitted their ACFRs, 2016-17**

| | Whole sector 2015-16 | Whole sector 2016-17 | Not-for-profit | For-profit | Government | Metropolitan | Regional | Metropolitan & regional | Single service | 2 to 6 services | Seven or more services |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Total revenue ($ m) | $1,390.0 | $1,733.6 | $1,397.2 | $239.5 | $96.8 | $1,042.2 | $250.0 | $441.4 | $169.4 | $441.2 | $1,123.0 |
| Total expenses ($ m) | $1,248.3 | $1,548.4 | $1,264.3 | $195.7 | $88.5 | $917.6 | $222.1 | $408.8 | $152.5 | $385.7 | $1,010.3 |
| Profit ($ m) | $141.7 | $185.1 | $132.9 | $43.8 | $8.3 | $124.7 | $27.9 | $32.6 | $16.9 | $55.5 | $112.7 |
| EBITDA ($ m) | $151.6 | $195.2 | $141.7 | $44.8 | $8.7 | $130.6 | $29.7 | $34.9 | $18.7 | $58.0 | $118.5 |
| Average EBITDA per consumer | $3,055 | $2,989 | $2,621 | $6,767 | $1,883 | $3,431 | $2,960 | $2,026 | $2,803 | $3,420 | $2,843 |
| Average NPBT per consumer | $2,854 | $2,832 | $2,460 | $6,617 | $1,803 | $3,274 | $2,778 | $1,891 | $2,533 | $3,267 | $2,705 |
| EBITDA margin | 10.9% | 11.3% | 10.1% | 18.7% | 9.0% | 12.5% | 11.9% | 7.9% | 11.0% | 13.2% | 10.6% |
| NPBT margin | 10.2% | 10.7% | 9.5% | 18.3% | 8.6% | 12.0% | 11.1% | 7.4% | 10.0% | 12.6% | 10.0% |

The unspent home care amount is the total amount of each consumer's individual budget (comprising home care subsidy, supplements and home care fees) that has not been spent or committed for the consumer's care, less any agreed exit amount. The steps and requirements for calculating a consumer's unspent home care amount is detailed in the User Rights Principles 2014. Unspent package funds will not generally, and should not, be recognised as income until the funds have been spent or are committed for the consumer's care.

**Table 7.7: Maximum home care subsidy payments per annum, 2016-17**

| Package level | 2016-17 annualised subsidy |
|---|---|
| Level 1 | $8,045 |
| Level 2 | $14,633 |
| Level 3 | $32,171 |
| Level 4 | $48,906 |

**Home care supplements**

Supplements in home care are paid in addition to the amount of basic subsidy applicable at each package level. Supplements are paid if a consumer is eligible due to a specific care need or circumstance. The supplements that apply to home care are set out below. The amount of expenditure on each supplement in 2016-17 is at Appendix L. All supplements payable are included in the consumer's individualised budget.

Supplements in home care include:

**Dementia and Cognition supplement:** provides additional funding in recognition of the extra costs of caring for people with cognitive impairment associated with dementia and other conditions. This supplement is available across all levels of home care packages. The supplement is payable at a rate of 10 per cent of the basic subsidy payable for the level of home care package.

**Veterans' supplement:** provides additional funding for veterans with a mental health condition accepted by the Department of Veterans' Affairs (DVA) as related to their service.

**Oxygen supplement:** provides additional funding for consumers who have a specified medical need for the continual administration of oxygen.

**Enteral Feeding supplement:** provides additional funding for care recipients with a specified medical need for enteral feeding.

**Viability supplement:** is paid in recognition of the higher costs of providing services in rural and remote areas.

**Hardship supplement:** is available to home care consumers who are having difficulty paying their aged care fees for reasons beyond their control.

**Consumer contributions**

Consumers may be asked to pay a basic daily fee up to 17.5 per cent of the single basic age pension ($10.32 a day/$3,766 per annum as at 1 July 2018). The basic daily fee is not subject to an income or asset test and all consumers can be asked to pay unless they prove financial hardship, in which case the Commonwealth pays the provider on their behalf. The basic daily fee, when charged by the service provider, must be included in the individualised budget for the consumer.

Additionally, consumers may be asked to make a contribution towards the cost of their care through an income tested fee. The amount paid by the Commonwealth on behalf of a consumer is reduced by the amount of the income tested fee regardless of whether the fee is collected by the provider or not.

## 7.3.2 Revenue

In 2016-17, total sector revenue for all home care providers is estimated at approximately $1.85 billion, up from an estimated $1.75 billion in 2015-16, an increase of 6 per cent. Commonwealth contributions represent more than 80 per cent of the total revenue received by home care service providers in 2016-17, about the same as in 2015-16.

Total revenue for home care providers consists of Commonwealth contributions in the form of subsidies and supplements, contributions from consumers (the basic daily fee and income tested fees) and other revenue sources (such as consumer contributions for non-home care related services, interest income and state and territory government payments).

The average income per consumer per day in 2016-17 for home care providers who submitted their ACFRs was $72.71 ($26,539 per consumer for the year) down from $76.70 in 2015-16, a decrease of 5 per cent. Table 7.8 shows provider income per consumer per day for the two years to 2016-17 split by the major types of income. ACFA is not able to compare 2015-16 and 2016-17 with 2014-15 as some providers operated on a CDC basis, while others did not, which resulted in differences in the treatment of some revenue items.

**Table 7.8: Home care provider income, 2015-16 to 2016-17**

| Income type | 2015-16 | % of total | 2016-17 | % of total |
|---|---|---|---|---|
| Provision of care / services charged to consumers | $47.15 | 61.5 | $44.71 | 61.5 |
| Management fees charged to consumers | $11.12 | 14.5 | $10.27 | 14.1 |
| Administration of packages charged to consumers | $13.63 | 17.8 | $12.88 | 17.7 |
| Unspent funds and exit amounts deducted | $3.64 | 4.7 | $2.98 | 4.1 |
| Other revenue | $1.16 | 1.5 | $1.87 | 2.6 |
| **Total** | **$76.70** | **100** | **$72.71** | **100** |

1. Provision of care/services charged to consumers includes income recognised from consumers' packages and private home care consumers as care and services are provided. This amount will include Government subsidies and supplements, consumer contributions in the form of the basic daily fee, income tested care fees, top-ups and private contributions as well as funds transferred in with a consumer when they transfer from another home care provider (after the February 2017 changes).
2. Management fees charged to consumers is the amount of income recognised for on-going management and coordination of the consumers' packages and care requirements. This will include both Commonwealth funded home care package consumers and private consumers.
3. Administration fees charged to consumers is the amount of income recognised for on-going administration of consumers' packages. This will include both Commonwealth funded home care package consumers and private consumers.
4. Unspent package funds reflect income remaining from a consumer's care package when a consumer leaves the home care service (prior to the February 2017 changes). After this date, unspent package funds follow the consumer to their new home care provider or are returned to the Commonwealth when the consumer leaves care. Exit amounts deducted by the approved provider when ceasing to provide home care to a consumer may also be charged after this date.
5. Other revenue include other sources of income generated from running the home care services such as State and Territory payments, consumer payments for non-home care services, trust distribution, donations and bequests, interest earned on investments, insurance and work cover compensations and gains from the sale of assets.

As shown in Table 7.8, there was a significant amount charged in 2015-16 and 2016-17 for management and administration costs, which coincided with CDC and portable packages taking full effect. This is likely due to consumers having full choice on what they spend their funds on, and providers being required to provide consumers with full transparency regarding their packages, including negotiating an individualised budget and providing monthly expenditure statements, as well as having to administer unspent funds in a prudentially appropriate way. Conversely, there has been a decrease in charges to the package for care and service delivered.

### 7.3.3 Expenditure

Total sector expenditure in 2016-17 is estimated to be around $1.65 billion for all home care providers. This figure has been scaled up to cover all providers based on those that provided their ACFRs.

In 2016-17, the average expenditure per consumer per day was $64.94 ($23,703 per consumer for the year), down from $68.88 in 2015-16, a decrease of around 6 per cent.

As Table 7.9 shows, the main drivers behind the decrease in expenses in 2016-17 compared with 2015-16 were a 4.5 per cent decrease in care costs and an 11 per cent decrease in administration and other costs.

Within the overall decrease in care costs in 2016-17, there was an increase in care-related expenses of 12 per cent and an increase in sub-contracted and brokered customer services of 9 per cent, offset by the drop in care staff costs of 11 per cent. This suggests that the reduction in wages and salaries for staff costs in 2016-17 was due to greater use of sub-contracted or brokered services. This could reflect the change in provider operating models, where providers seek to employ a more flexible workforce that can adapt and respond to changing demand levels following both the CDC and packages following the consumer reforms. Given the increase in competition with more providers entering the market this trend is likely to continue.

Care-related salary costs (the first two line items in Table 7.9) are the main expense item for providers at 60 per cent. Other care related expenses and administration salaries and management fees make up 8 and 31 per cent respectively.

Table 7.10 provides a breakdown of expenditure according to ownership type, location and scale. Overall, there are some notable differences.

In terms of ownership type, government providers incurred the lowest level of expense per consumer per day with $52.43, compared with $80.93 for the for-profit providers and $64.05 for the not-for-profit providers. In 2015-16, the expenses for the not-for-profits and the for-profits were similar.

**Table 7.9: Home care expenditure per consumer per day, 2014-15 to 2016-17**

| Expenses | 2014-15 | 2015-16 | 2016-17 |
|---|---|---|---|
| **Care costs** | | | |
| Wages and salaries – care staff | $29.08 | $31.98 | $28.78 |
| Subcontracted or brokered customer services | $7.07 | $9.44 | $10.30 |
| Care related expenses | $4.43 | $5.01 | $5.64 |
| **Total care costs** | **$40.58** | **$46.43** | **$44.72** |
| **Administration costs** | | | |
| Wages and salaries – administration staff | $7.10 | $8.77 | $8.00 |
| Administration costs and management fees | $10.08 | $10.55 | $10.18 |
| Depreciation and interest costs | $0.54 | $0.55 | $0.42 |
| Other expenses | 1.53 | $2.57 | $1.62 |
| **Total administration costs** | **$19.25** | **$22.44** | **$20.22** |
| **Total costs** | **$59.84** | **$68.88** | **$64.94** |

**Table 7.10: Expenditure per consumer per day, by ownership type, location and scale, 2016-17**

| | Care related salaries | Admin and Mgmt Fees | Other care related expenses | Other expenses and non-direct costs | Total |
|---|---|---|---|---|---|
| | ($) | ($) | ($) | ($) | ($) |
| **Ownership** | | | | | |
| Not-for-profit | $35.91 | $10.40 | $15.65 | $2.09 | $64.05 |
| For-profit | $52.91 | $10.95 | $14.67 | $2.40 | $80.93 |
| Government | $23.84 | $6.41 | $21.17 | $1.02 | $52.43 |
| **Location** | | | | | |
| Metropolitan | $35.91 | $10.47 | $17.82 | $1.85 | $66.05 |
| Regional | $33.11 | $9.54 | $15.33 | $2.66 | $60.65 |
| Metropolitan & regional | $40.84 | $9.90 | $12.14 | $2.13 | $65.01 |
| **Scale** | | | | | |
| Single service | $39.45 | $7.92 | $12.01 | $3.22 | $62.60 |
| 2 to 6 services | $36.35 | $9.01 | $14.13 | $2.74 | $62.24 |
| 7 & more services | $36.53 | $11.01 | $17.30 | $1.58 | $66.42 |
| **Total sector** | **$36.78** | **$10.18** | **$15.94** | **$2.05** | **$64.94** |

Provider expense per consumer is also influenced by location. Similar to last year, regional providers had the lowest expenses per day on average. Providers who operated in both metropolitan and regional areas had lower expenses than providers operating only in metropolitan areas, largely driven by lower care related expenses.

Scale of a provider's operations appears to have a small bearing on average expenses per consumer per day with providers operating seven or more services surprisingly recording average expenses of around 6 per cent higher than smaller providers.

Care related salaries comprise the greatest proportion of expenditure across all ownership types, location and scale of provider. However there are also differences within these sub-groups.

While the not-for-profit providers reported $35.91 per consumer per day in care costs, for-profit providers reported $52.91 and government providers reported $23.84. In terms of location, regional providers had care related staffing costs of around $33.11 per consumer per day, compared to $35.91 for metropolitan providers and $40.84 for providers who provide services in both regional and metropolitan areas.

Care salary costs also vary depending on the scale of provider. Single service providers across all ownership types reported the highest salary costs, $39.45 per consumer per day, with providers operating more than one service reported care salary costs just above $36 per customer per day.

Providers operating seven or more services reported administration and management costs of $11 per consumer per day compared with single service providers reporting only $7.92. The 2016-17 administration and other care related results for the largest providers suggests there are limited opportunities for economies of scale in staffing, administration and management for multiple service providers or each of the services are sub-scale to absorb centralised overheads.

## 7.3.4 Profit

In 2016-17, after scaling up the results from the ACFRs submitted, total profit for all home care providers is estimated at $201 million, up from $183 million in 2015-16 (an increase of 10 per cent).

The increase in total revenue, NPBT and EBITDA has resulted in an improvement in both the NPBT and EBITDA margins. There was a significant increase in consumers in 2016-17 which contributed to a slight drop in the average EBITDA and average NPBT on a per consumer basis (Table 7.11). This suggests that despite tighter profit margins derived for each consumer, providers were able to derive higher total revenue and NPBT levels when compared with 2015-16 through providing services to an increased number of consumers.

As shown in Table 7.11, home care providers recorded an average NPBT per consumer per year of $2,832 compared with $2,854 in 2015-16 (a decrease of 0.8%).

**Table 7.11: Summary of financial performance of home care providers, per consumer, 2014-15 to 2016-17**

| | 2014-15 | 2015-16 | 2016-17 |
|---|---|---|---|
| Average EBITDA per consumer | $2,854 | $3,055 | $2,989 |
| Average NPBT per consumer | $2,657 | $2,854 | $2,832 |

Approximately 75 per cent of home care providers achieved a net profit before tax in 2016-17, the same level as was reported in 2015-16, and up from 72 per cent in 2015-16. This continues the recent trend since 2013-14 of a higher proportion of providers recording a profit.

As was the case with NPBT when calculated on a consumer per year basis, the average EBITDA in 2016-17 ($2,989) decreased slightly by $66 or 2.2 per cent when compared with 2015-16 ($3,055).

As reported in previous annual reports and shown in Chart 7.2, EBITDA varies considerably across the sector with the top quartile of providers performing substantially better than the rest of the home care sector. The average EBITDA per consumer per year for the top quartile was $11,242 compared with the next top quartile returning only $3,464.

**Chart 7.2: Provider average EBITDA per consumer 2016-17, by quartile (number of providers in parentheses)**

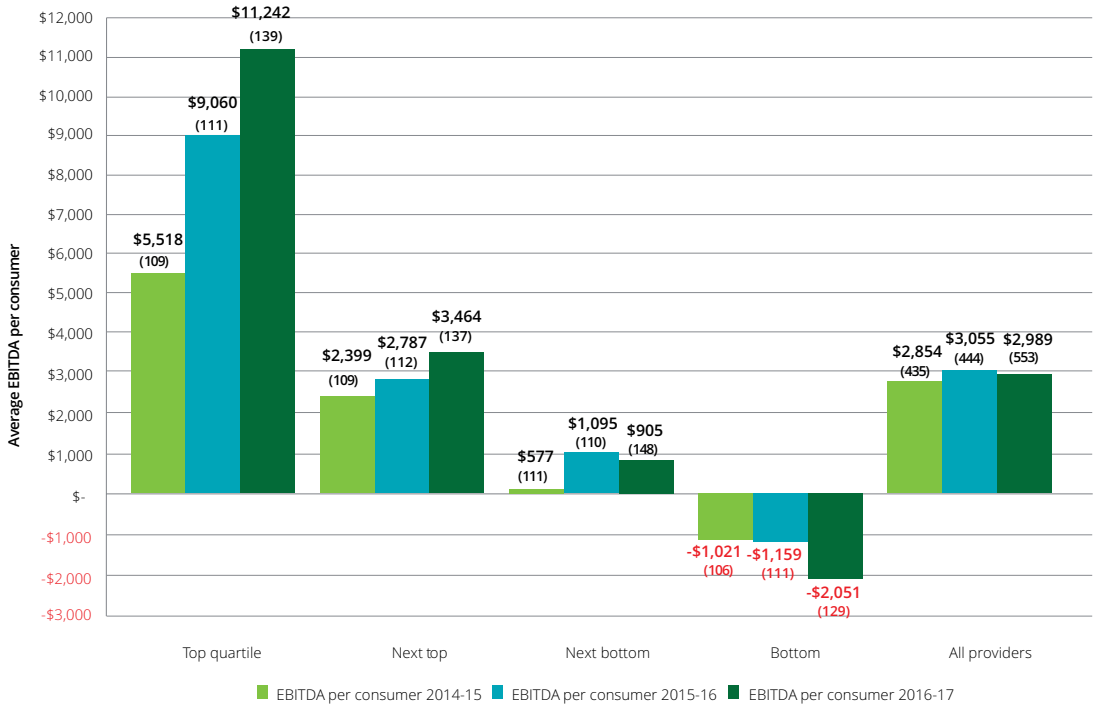


Chart 7.2 also shows that EBITDA for providers in the top two quartiles increased in 2016-17, however results of providers in the bottom two quartiles decreased.

The following analysis examines profit based on ownership type, location and scale of provider.

In 2016-17, for-profit providers continued to report the strongest results with an average EBITDA of $6,767, down from $7,481 in 2015-16, a 10 per cent decrease (Charts 7.3 and 7.4). The for-profit providers significantly outperformed not-for-profit and government providers in terms of EBITDA with the latter recording average EBITDA of $2,621 and $1,883 respectively. The not-for-profits recorded a decline of around 2 per cent while government providers had the largest decrease from $2,789 to $1,883, a 32 per cent reduction.

The largest difference in terms of ownership is in the top quartile where for-profit providers reported average EBITDA of $17,089 compared with the not-for-profit providers in the top quartile who reported $9,727, and government providers who reported $9,461.

**Chart 7.3: Provider average EBITDA per consumer per annum, by quartile and ownership type, 2016-17 (number of providers in parentheses)**

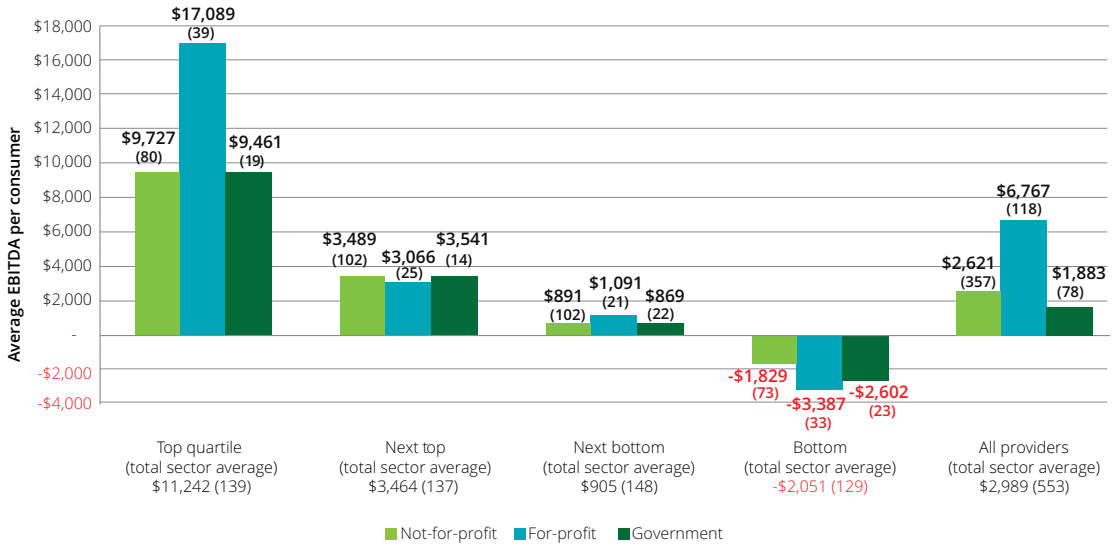
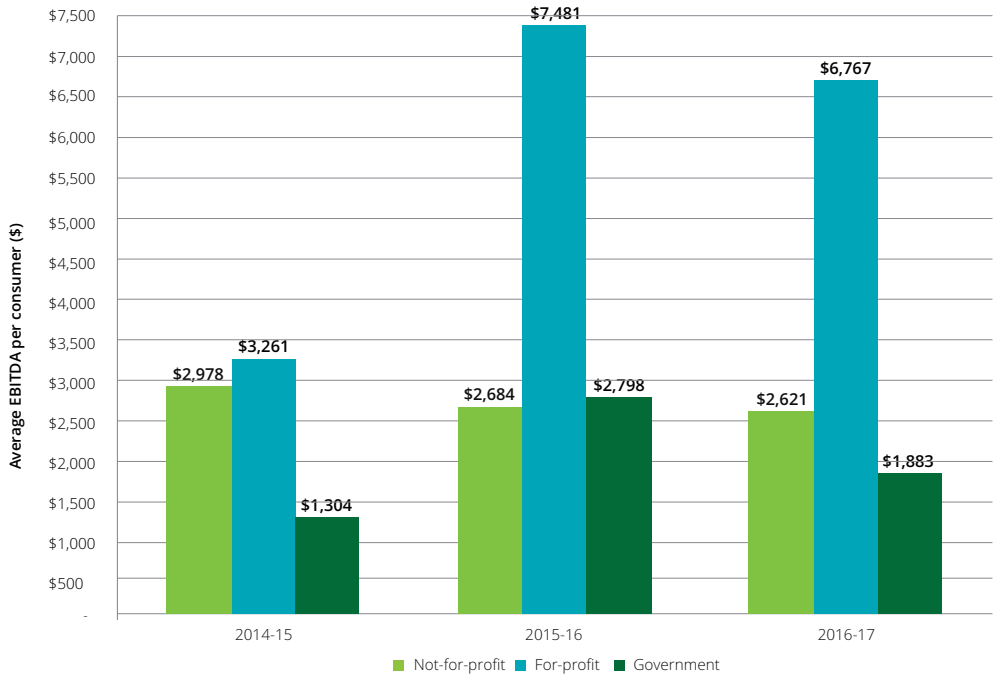



**Chart 7.4: EBITDA per consumer, by ownership type, 2014-15 to 2016-17**



As ACFA noted last year, commentary from the not-for-profit sector indicates that the generally lower operating financial results may be consistent with their mission objectives. They may fulfil their charters in a range of ways that might be difficult or inappropriate in a more commercial environment where investors are seeking returns. Specifically, not-for-profit providers may choose to invest in or expend funds on amenities and services for which they are not funded through regulated sources. Not-for-profit providers may be able to do this through a range of funding pathways and tax benefits, including payroll tax relief, fringe benefit tax benefits, income tax exemptions and tax deductible donations. However, where these costs are not covered by such incremental revenue, the comparatively lower EBITDA for many not-for-profit organisations may be the product of the delivery of additional "community benefits" or "social impacts" or returns which are not recognised in the annual financial accounts.

Similarly government providers have traditionally generated lower financial results as they often provide home care services in areas of the market where other providers may not operate. In 2016-17, government providers derived a 1.3 per cent increase in total revenue earned yet expenditure increased by 4.6 per cent, resulting in a decline in the net profit before tax of 24.5 per cent.

For government providers, total income per consumer per claim day decreased by about 35 per cent, down from $62.40 in 2015-16 to $40.37 in 2016-17. Total expenditure also declined by about 33 per cent, down from $55.20 per consumer per day to $36.89 in 2016-17.

When performance in 2016-17 is considered by location, providers who operated their services in metropolitan areas achieved the highest level of average EBITDA per claim year of $3,431, compared with $2,960 for regional providers and $2,026 for providers in both regional and metropolitan areas (Chart 7.5). This is in contrast to 2015-16 when regional providers slightly outperformed metropolitan providers (Chart 7.6).

The largest difference in performance is in the top quartile where metropolitan providers reported average EBITDA of $13,005 compared with the not-for-profit providers who reported $10,804, and government providers who reported $6,063.

Despite the large differences in the top quartile, the average EBITDA's across the other quartiles remained relatively similar across locations.

**Chart 7.5: Provider average EBITDA per consumer per annum 2016-17, by quartile and provider location (number of providers in parentheses)**

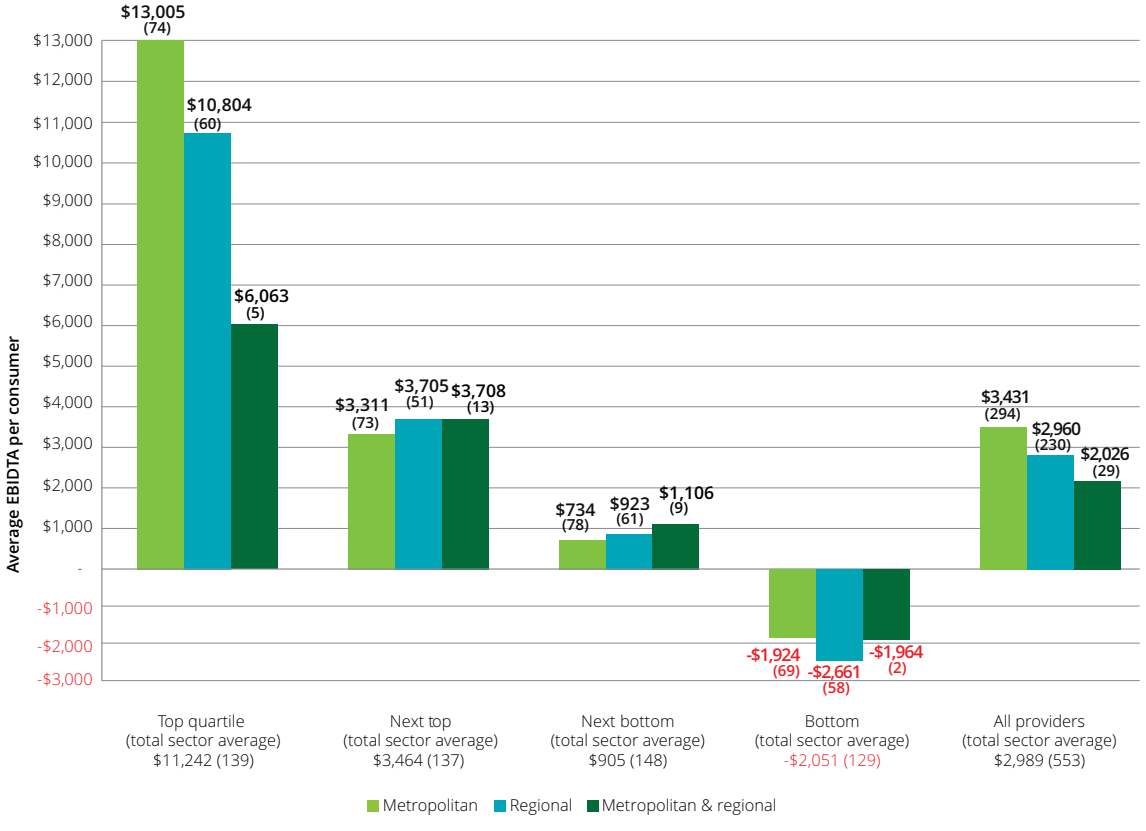
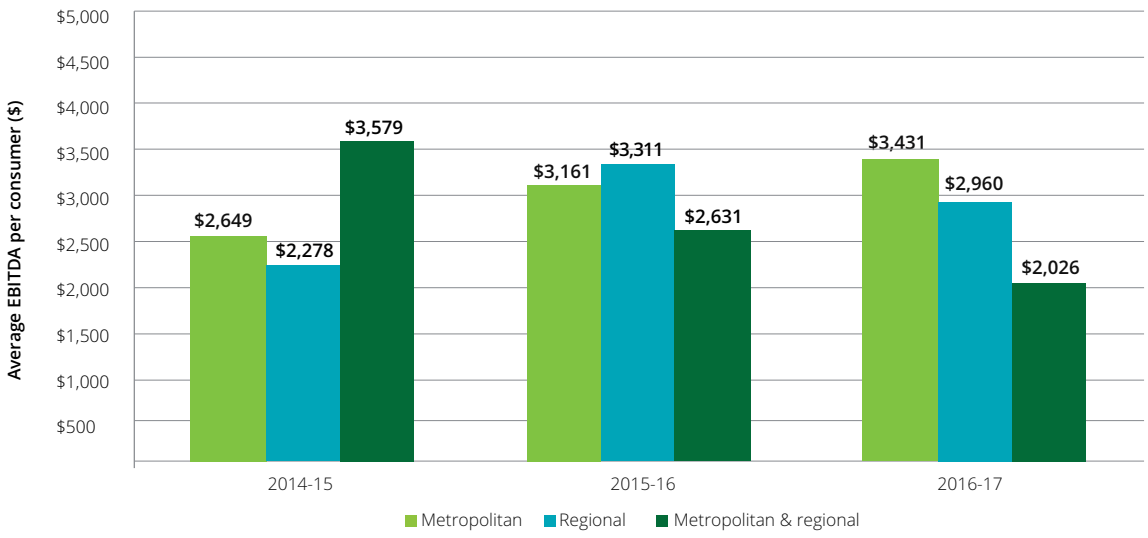


**Chart 7.6: EBITDA per consumer, by provider location, 2014-15 to 2016-17**




When performance is considered by scale, providers who operated two to six services achieved the highest level of average EBITDA per claim year of $3,420, compared with $2,843 for providers with seven or more services, and $2,803 for single service providers (Chart 7.7). This result reflects the trend over recent years of providers with two to six services closing the gap on the larger providers to now exceed them in performance. While single service providers continue to perform the worst in terms of EBITDA, 2016-17 saw a significant improvement in their performance compared with the larger providers, to the point where they recorded EBITDA almost the same as providers with seven and more services (Chart 7.8).

**Chart 7.7: Provider average EBITDA per consumer per annum 2016-17, by quartile and provider scale (number of providers in parentheses)**

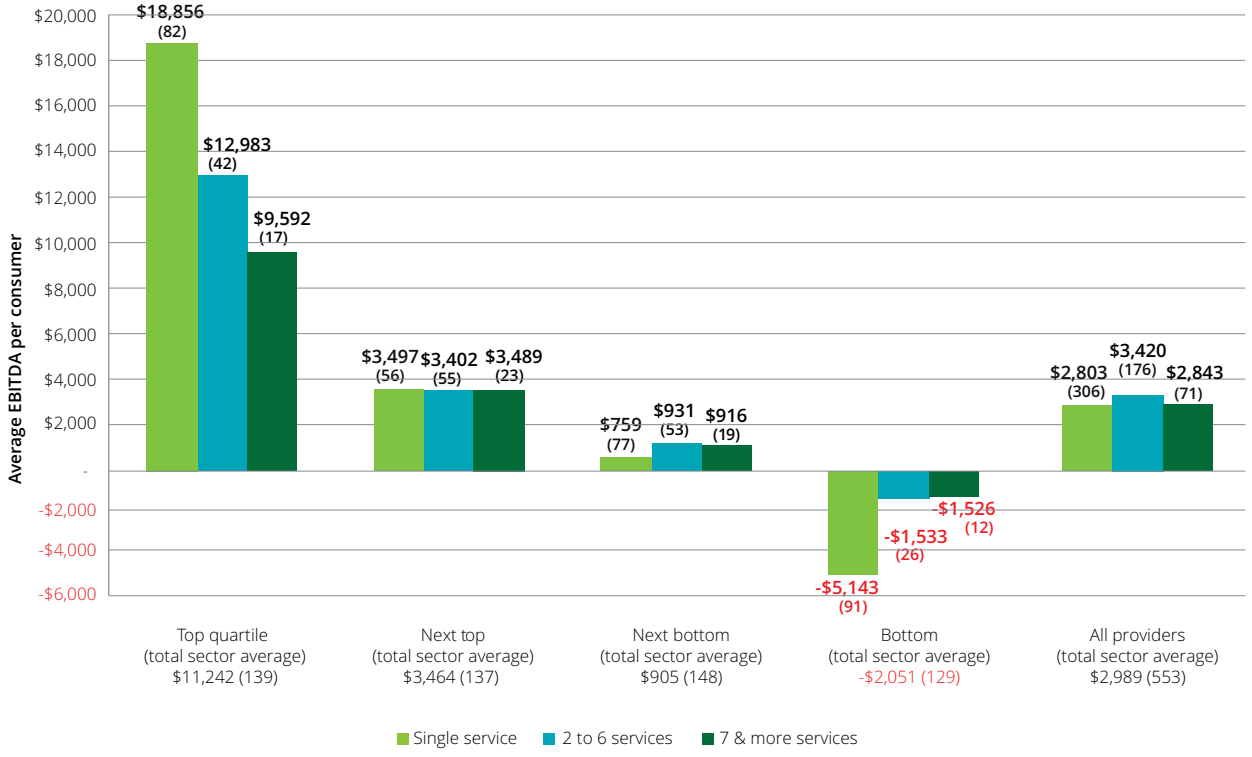
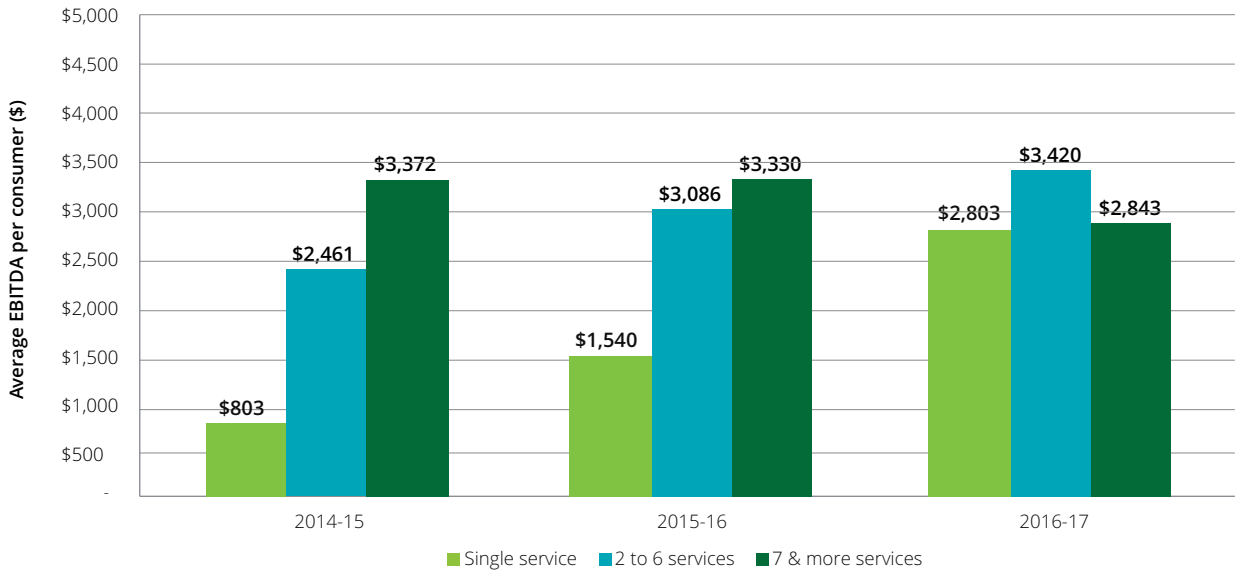


**Chart 7.8: EBITDA per consumer per annum, by provider scale, 2014-15 to 2016-17**




## 7.3.5 Financial performance analysis 2017-18

The major recent reform in the home care sector, the introduction of packages following consumers, only took effect from February 2017. Consequently only the initial impact of the reform will be evident in the financial analysis in this chapter which is based on data for the 2016-17 financial year.

Given that the majority of the financial analysis in this report is based on 2016-17 data, ACFA has reviewed StewartBrown's more recent Aged Care Financial Performance Surveys[35] to gain an insight as to developments in the home care sector in 2017-18, a period when the impact of the more recent reforms to the sector are likely to be more evident. It is not possible, however, to directly compare results presented for 2016-17 in this report with the results from the StewartBrown survey for the nine months to March 2018 given collection methods and coverage vary considerably. Nevertheless, the StewartBrown surveys are likely to broadly reflect the developments in the sector as a whole.

The StewartBrown survey indicates that for the nine months to March 2018, average revenue per client day declined by 2.5 per cent ($1.87 per client per day) compared with levels achieved for the 12 months to 30 June 2017. StewartBrown has suggested that this reduction has been driven by increased price competition as providers compete for business. ACFA notes that consumers will benefit from price competition and that some disruption was to be expected following the introduction of consumer choice of provider until the sector and individual providers adjusted to the new competitive operating environment. Among the issues to consider, especially during the transition, is the impact on the quality of care and services.

In terms of overall financial performance, the StewartBrown survey indicates that Earnings Before Tax (EBT) per client per day in the home care sector declined from an average for all providers of $5.37 for the 12 months to June 2017 to $4.39 for the nine months to March 2018.

## 7.3.6 Unspent funds

In last year's report, ACFA identified the significant amount of unspent package funds held by providers on behalf of consumers. At 30 June 2017, those providers who submitted their financial reports to the Department reported unspent funds of around $329 million. This equates to holding average unspent funds per consumer of $4,613 at 30 June 2017, an increase of $946 (26 per cent) from the unspent funds balance of $3,667 per consumer, at 30 June 2016.

If current consumer behaviour continues, and there is no indication that it will change, the level of unspent package funds will increase substantially to well over $500 million over the next few years, as the number of packages is expanded and a much larger proportion is at the higher levels.

35 StewartBrown collects detailed financial and operational data from providers who service approximately 25 per cent of home care packages in their quarterly Aged Care Performance Surveys. StewartBrown's survey participants are predominantly not-for-profit entities.

This level of unspent funds represents a large amount of funds not being used for care services. Unspent may accumulate as a result of consumer choice to save a proportion of their budget for future events, or because the consumer does not require all the funds allocated to them. In the latter case, the funds could be used more effectively elsewhere, including unmet demand. There are also prudential issues because the unspent funds held by providers need to be available should the consumer transfer to another provider or, if they leave home care, in which case the funds have to be returned to the Government and the consumer in proportion to their contribution. Providers should hold unspent funds securely for the consumer which may add to the administrative costs of managing and accounting for individual budgets.

ACFA considers that a review of policies concerning unspent funds and the implications for home care package funding is warranted.

## 7.4 Looking forward

The home care sector is continuing to undergo significant change to its operations with providers and consumers still adjusting to packages following the consumer.

These changes give consumers greater control over their own lives by enabling them to make choices about the types of care and services they purchase and from whom they are purchased. However while these changes are a positive step for consumers in terms of greater choice and flexibility, consumers need to be better supported in order to exercise informed choice. The 2018-19 Budget responded to this need by providing funding for the development and piloting of system navigators to guide consumers. Additional funding was also provided to improve the accessibility and quality of information about services on MyAgedCare. This includes consideration of options to improve the comparability of home care service prices.

# 8

# Residential aged care: characteristics of the sector

# 8. Residential aged care: characteristics of the sector

**This chapter provides an overview of the operational characteristics of residential care providers and their services.**

**This chapter discusses:**

- the operation of residential care
- the ownership, locational and scale characteristics of residential care providers
- the supply of residential care

**This chapter reports that:**

- at 30 June 2017 there were 200,689 operational places, up from 195,825;
- during 2016-17 residential aged care was provided to 239,379 older Australians;
- at 30 June 2017 there were 902 providers, down from 949 in 2015-16;
- the residential aged care sector is continuing to consolidate with the number of residential care places increasing while the number of providers continues to gradually decrease;
- not-for-profit providers continue to represent the largest proportion of ownership type in residential care, with 56 per cent of providers and 56 per cent of places, but the proportion of places operated by the for-profits continues to slowly increase; and
- as at 30 June 2017 there were 39,294 provisionally allocated places and an additional 7,924 formerly operational places that were off-line pending refurbishment or redevelopment, or pending sale to another provider.

## 8.1 Sector overview

Residential care provides care and support for eligible older Australians who choose not to, or are unable to live independently in their own homes. Services provided in residential care include:

- day-to-day services such as meals, cleaning, laundry;
- personal care such as assistance with dressing, grooming, toileting; and
- 24-hour nursing care such as nursing assessment, pain management, wound care and catheter care.

Residential care is provided on a permanent or respite basis. The majority of residential care places are occupied by permanent residents who have security of tenure. Residential respite provides short-term care on a planned or emergency basis. In doing so, it provides carers with a break from their caring duties as well as being used by some consumers to transition into permanent residential care.

## 8.2 Supply of residential care

The Australian Government uses a population based planning ratio (target provision ratio) to determine the number of subsidised operational residential care places. This is detailed in Chapter 5.

Table 8.1 shows the number of providers, facilities[36], places and residents since 2012-13. As can be seen, the number of providers has decreased each year through consolidation, while the number of places and residents continues to increase.

36 In residential care, a 'facility' refers to an aged care home or service.

**Table 8.1: Number of providers, facilities, places and residents, 30 June 2013 to 30 June 2017**

| | 30 June 2013 | 30 June 2014 | 30 June 2015 | 30 June 2016 | 30 June 2017 |
|---|---|---|---|---|---|
| Providers | 1,048 | 1,016 | 972 | 949 | 902 |
| Facilities | 2,718 | 2,688 | 2,681 | 2,669 | 2,672 |
| Allocated places | 216,477 | 217,006 | 228,024 | 238,843 | 247,907 |
| Operational places | 186,278 | 189,283 | 192,370 | 195,825 | 200,689 |
| Achieved residential care ratio | 84.5 | 82.6 | 81.1 | 79.7 | 77.9 |
| Provisionally allocated places | 24,232 | 21,047 | 28,000 | 35,124 | 39,294 |
| Provisionally allocated places as proportion of allocated places | 11.2% | 9.7% | 12.4% | 14.7% | 15.9% |
| Occupancy | 92.7% | 93.0% | 92.5% | 92.4% | 91.8% |
| Total residents | 173,094 | 176,816 | 177,820 | 181,048 | 184,077 |
| – Permanent | 168,968 | 173,974 | 172,828 | 175,989 | 178,713 |
| – Respite | 4,126 | 2,842 | 4,992 | 5,059 | 5,364 |

1. The achieved residential care ratio reflects the target provision ratio for 2021-22 of 78 residential places.
2. This table excludes flexible care places.

Table 8.2 shows a breakdown of residential care providers as at 30 June 2017, presented by ownership type, location and scale.

**Table 8.2: Number of providers, facilities, places and residents in residential care, 2016-17**

| | | | Ownership type | | | Location | | | Scale | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Total sector 2015-16 | Total sector 2016-17 | Not-for-profit | For-profit | Government | Metropolitan | Regional | Metropolitan & regional | Single home | 2 To 6 homes | 7 To 19 homes | 20 & more homes |
| Providers | 949 | 902 | 505 | 301 | 96 | 457 | 355 | 90 | 572 | 256 | 53 | 21 |
| Facilities | 2,669 | 2,672 | 1,549 | 880 | 243 | 740 | 592 | 1,340 | 572 | 738 | 589 | 773 |
| Operational places | 195,825 | 200,689 | 112,142 | 79,758 | 8,789 | 61,327 | 30,296 | 109,066 | 43,040 | 50,400 | 45,697 | 61,552 |
| Occupancy | 92.4% | 91.8% | 93% | 90% | 90% | 91% | 92% | 92% | 91% | 91% | 93% | 92% |
| Total residents | 181,048 | 184,077 | 104,541 | 71,552 | 7,984 | 55,534 | 28,039 | 100,504 | 39,239 | 45,664 | 42,474 | 56,700 |
| Permanent | 175,989 | 178,713 | 101,916 | 69,026 | 7,771 | 53,777 | 27,068 | 97,868 | 37,889 | 44,220 | 41,422 | 55,182 |
| Respite | 5,059 | 5,364 | 2,625 | 2,526 | 213 | 1,757 | 971 | 2,636 | 1,350 | 1,444 | 1,052 | 1,518 |

This table does not include MPS and flexible care providers and places.

## 8.2.1 Residential care providers

At 30 June 2017, there were 902 residential care providers operating 200,689 residential care places in Australia. This compares with 949 providers operating 195,825 places as at 30 June 2016.

As reported in previous annual reports, some providers are seeking to expand the scale of their businesses. As a result there has been a consolidation of industry providers over a number of years. Chart 8.1 shows the decreasing provider numbers over the seven years to 2016-17, and shows the proportion of ownership across not-for-profit, for-profit and government providers.

## 8.2.2 Ownership type

As shown in Charts 8.1 and 8.2, the largest provider group remains the not-for-profit provider group (religious, charitable and community-based organisations). They represent 56 per cent of providers and operate 56 per cent of all residential aged care places. For-profit providers account for 33 per cent of providers and 40 per cent of places. The remaining providers and places are state and territory and local government-owned providers. The proportion of providers across ownership types has remained relatively stable. However, the proportion of operational residential care places held by for-profit providers has been increasing slowly in recent years (Chart 8.2). This reflects for-profit providers gradually increasing the scale of their operations through both acquisitions and greater success at gaining new allocations through the annual Aged Care Approvals Rounds (ACAR).

**Chart 8.1: Provider numbers, 2010-11 to 2016-17**

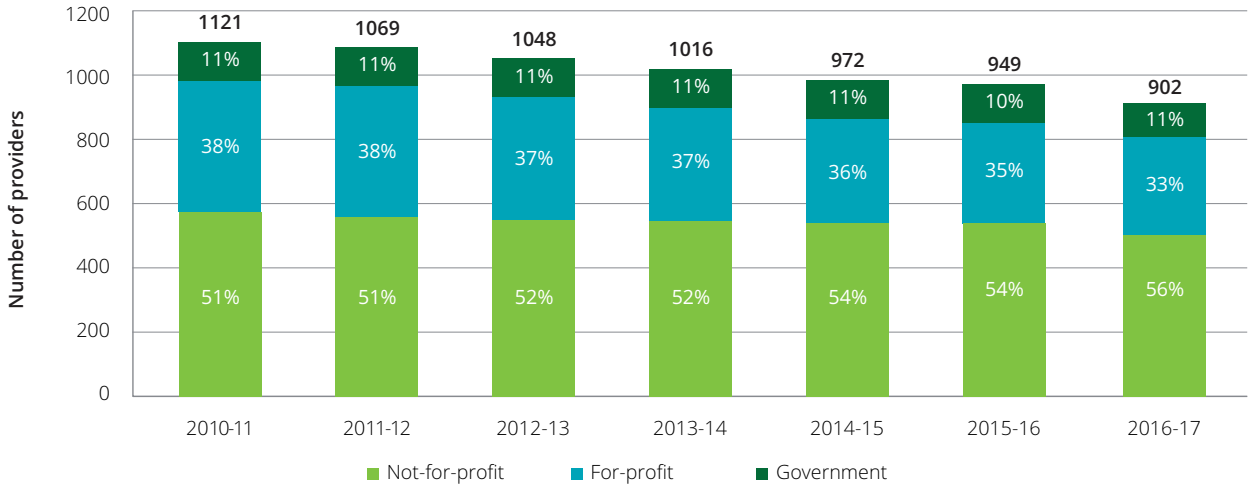
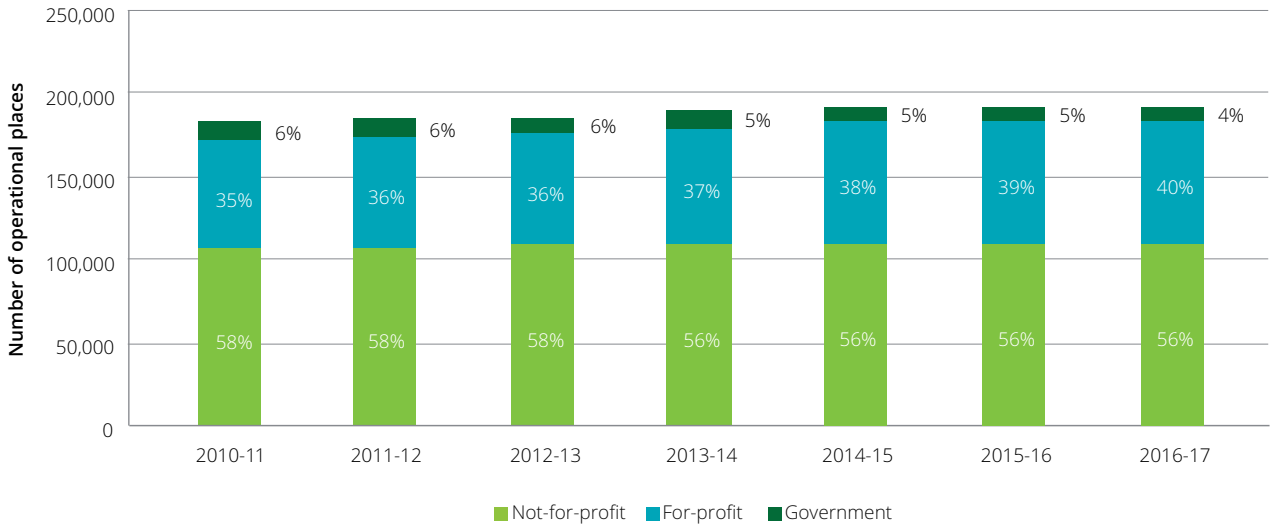



**Chart 8.2: Operational places, 2010-11 to 2016-17**



Similar to the case in last year's annual report, not-for-profits operated 56 per cent of all operational residential care places in 2016-17, although operated 66 per cent of all regional places. Conversely, and also similar to 2015-16, for-profit providers operated 40 per cent of all places in 2016-17 and only 23 per cent of regional places. Government providers operated the remaining 11 per cent of regional residential care places.

## 8.2.3 Provider scale

The majority of residential care providers (63 per cent) operate only one residential aged care home (Chart 8.3). These single aged care home providers account for 21 per cent of all operational residential care places. Conversely, only 2 per cent of providers operate more than 20 homes, but they account for 31 per cent of operational places.

ACFA notes, as shown in Table 8.3, that for-profit and not-for-profit providers have, on average, around three facilities per provider. However within those facilities, for-profit providers, on average, operate 89 residential care places per facility, compared with not-for-profit providers who operate only 35 places per facility, partly reflecting their bigger presence in regional locations

## 8.2.4 Provider location

ACFA generally categorises residential care providers as those operating only in metropolitan areas, those operating only in regional[37] areas, and those who have facilities in both metropolitan and regional areas. A provider is categorised as being regional if more than 70 per cent of their residents are in facilities in regional areas.

Chart 8.4 shows that 51 per cent of providers operate only in metropolitan areas. However, this number has decreased from 58 per cent in 2013–14 as more providers who previously only provided services in metropolitan areas expanded into regional areas. Conversely, 10 per cent of providers operate facilities in both metropolitan and regional areas, up from 4 per cent in 2013-14. The remaining 39 per cent of providers operate in regional areas only.

**Chart 8.3: Provider and operational places by provider scale, 2014-15 to 2016-17**

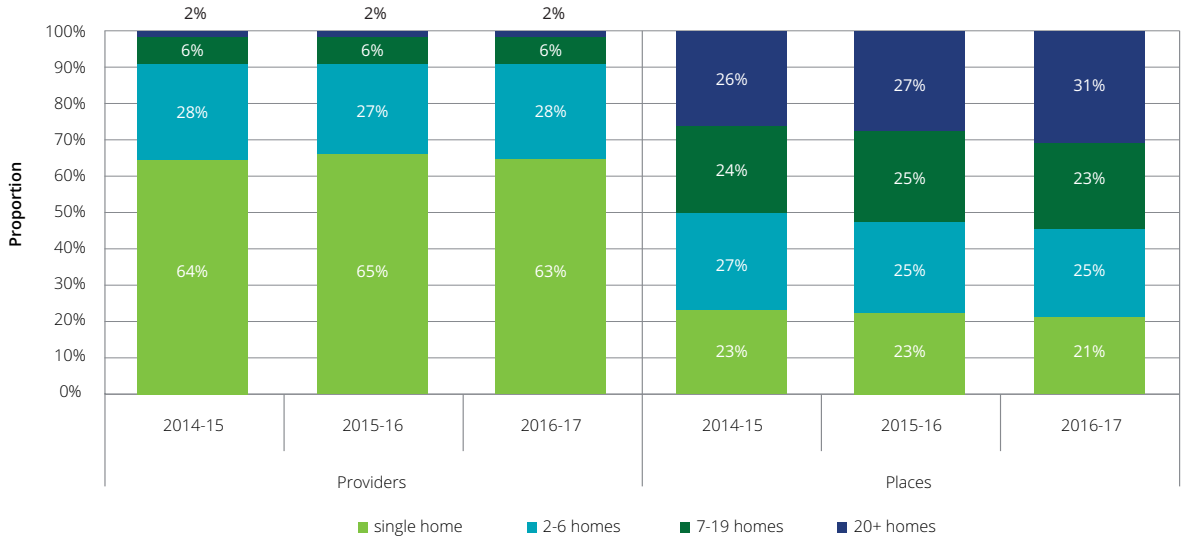
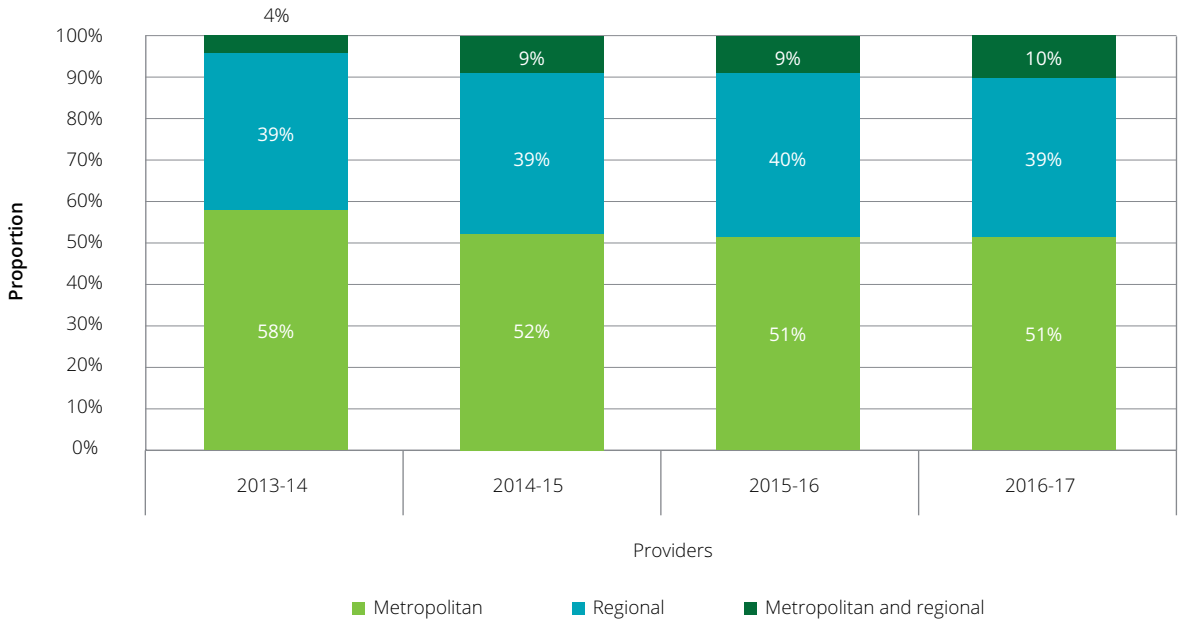



**Table 8.3: Number of facilities per provider, by ownership type, 30 June 2017**

| Organisation type | Number of providers | Number of facilities | Average facilities per provider | Total operational places | Average places per provider | Average places per facility |
|---|---|---|---|---|---|---|
| For-profit | 301 | 880 | 2.92 | 79,758 | 265 | 91 |
| Not-for-profit | 505 | 1,549 | 3.0 | 112,142 | 221 | 72 |
| Government | 96 | 243 | 2.53 | 8,789 | 92 | 36 |

37 In the aged care context, 'regional' includes rural and remote aged care areas.

**Chart 8.4: Providers location, 2013–14 to 2016-17**




## 8.2.5 Residential care room configuration

The predominant room configuration for residential aged care facilities is a single room with an ensuite. Based on current data provided to the Department by residential care providers, it is estimated that around 77 per cent of rooms are single rooms with an ensuite and around 5 per cent are shared rooms with an ensuite. Around 18 per cent of residents are in rooms that could be considered 'ward style rooms' which are shared and have a common shared bathroom.

## 8.2.6 Provisionally allocated places

The Commonwealth releases residential aged care places through the annual ACAR. After a place is allocated to an approved provider, there is usually a period during which the place is considered 'provisional' while the provider constructs the facility or extends the current facility. Once the place is available to be occupied by a resident, it becomes 'operational'. The average time it takes providers to bring places online is around four years.

At 30 June 2017, there were 39,294 provisional residential care places reflecting the carryover of allocated places from previous ACARs which are yet to become operational. This represents around 16 per cent of all allocated places, which compares with 14 per cent at 30 June 2016 and 12 per cent at 30 June 2015. ACFA notes however that 9,911 new residential care places were allocated in May 2017 following the 2016-17 ACAR, which would have contributed to the increase at 30 June 2017, as the majority of these would not have become operational in such a short time.

The provisional allocations relate to around 610 aged care facilities, which represent around 23 per cent of all facilities.

Queensland, Western Australia and the ACT have the highest proportion of provisionally allocated places, all having over 20 per cent. The next highest proportion is Victoria with 15 per cent. As was the case last year, South Australia and Tasmania have by far the lowest with 4 and 5 per cent respectively (Table 8.4).

ACFA also notes that the not-for-profit providers, who have 56 per cent of operational places, only have 50 per cent of provisionally allocated places, whereas the for-profit providers, who have 36 per cent of operational places, have 43 per cent of the provisionally allocated places.

In addition, there were also 7,924 formerly operational places at 30 June 2017 that were offline pending refurbishment or redevelopment, or pending sale to another provider.

**Table 8.4: Provisionally allocated residential care places by state/territory, as at 30 June 2017.**

| State/territory | Provisionally allocated places | All allocated places | Proportion |
|---|---|---|---|
| NSW | 11,175 | 82,778 | 13.5% |
| Vic | 9,974 | 65,527 | 15.2% |
| Qld | 10,976 | 49,141 | 22.3% |
| WA | 5,333 | 22,161 | 24.1% |
| SA | 748 | 18,848 | 4.0% |
| Tas | 275 | 5,357 | 5.1% |
| ACT | 728 | 3,425 | 21.3% |
| NT | 85 | 670 | 12.7% |
| **Australia** | **39,294** | **247,907** | **15.9%** |

Table does not include flexible aged care places

ACFA notes that the Government introduced legislative changes in 2016 to encourage providers to operationalise their provisional places in a timely manner. The changes limit the provisional allocation period to four years (noting that up to two extensions of 12 months each can be granted by the Department, and further extensions in exceptional circumstances). At the end of this time, the provisional allocations lapse and the places return to the Department for redistribution in a future ACAR. This change applies to all allocations regardless of when they were made. This means that providers who had already exceeded the four years were required to justify why their places are not operational and demonstrate that steps are being taken to make them operational in order to be granted a further extension.

Tables 8.5 and 8.6 show the distribution of the ages of provisionally allocated places by location and state and territory.

**Table 8.5: Provisionally allocated residential care places by location and year of distribution, as at 30 June 2017**

| | <1 year old | 1-2 years old | 2-4 years old | 4-6 years old | 6-8 years old | 8-10 years old | 10 + years | Total |
|---|---|---|---|---|---|---|---|---|
| Metropolitan | 7,243 | 7,425 | 10,037 | 2,012 | 1,791 | 422 | 595 | 29,525 |
| Regional | 2,556 | 3,062 | 2,924 | 434 | 486 | 175 | 52 | 9,689 |
| Remote | 0 | 30 | 0 | 50 | 0 | 0 | 0 | 80 |
| **Total** | **9,799** | **10,517** | **12,961** | **2,496** | **2,277** | **597** | **647** | **39,294** |

Table does not include flexible aged care places

**Table 8.6: Provisionally allocated residential care places by state and year of distribution, as at 30 June 2017**

| | <1 year old | 1-2 years old | 2-4 years old | 4-6 years old | 6-8 years old | 8-10 years old | 10 + years | Total |
|---|---|---|---|---|---|---|---|---|
| NSW | 2,469 | 2,771 | 3,836 | 957 | 793 | 171 | 178 | 11,175 |
| VIC | 2,627 | 3,010 | 3,626 | 384 | 235 | 0 | 92 | 9,974 |
| QLD | 2,600 | 2,969 | 3,329 | 679 | 916 | 292 | 191 | 10,976 |
| WA | 1,621 | 1,217 | 1,709 | 191 | 333 | 134 | 128 | 5,333 |
| SA | 205 | 211 | 185 | 147 | 0 | 0 | 0 | 748 |
| TAS | 103 | 80 | 89 | 3 | 0 | 0 | 0 | 275 |
| ACT | 174 | 194 | 187 | 115 | 0 | 0 | 58 | 728 |
| NT | 0 | 65 | 0 | 20 | 0 | 0 | 0 | 85 |
| **Total** | **9,799** | **10,517** | **12,961** | **2,496** | **2,277** | **597** | **647** | **39,294** |

Table does not include flexible aged care places

**Transferring residential aged care places**

Residential aged care places may be transferred between providers. A transfer of operational places commonly occurs as the result of a business transaction between two approved providers where a decision has been made by the transferor to sell all or some of their residential care places. Transfers of operational places need to be approved by the Secretary of the Department of Health, or their delegate.

As a general rule, when provisionally allocated places transfer between approved providers, the location in respect of which the places are allocated does not change. These provisions, and the need for approval by the Department, are designed to discourage attempts to subvert the competitive allocation process and to maintain care delivery in the region where the places were originally allocated.

# 9

# Residential aged care: operational performance

# 9. Residential aged care: operational performance

**This chapter provides analysis of the operational performance of residential care providers in 2016-17 and discusses trends emerging in 2017-18.**

**This chapter discusses:**

- funding arrangements for residential care
- the operational performance of residential care providers in 2016-17, including revenue, expenditure and profit
- operational performance by provider ownership type, location and scale

**Key findings on financial performance in 2016-17 compared with 2015-16:**

- total revenue of $17.8 billion, equating to revenue of $269.55 per resident per day, an increase of 2.1 per cent from $263.92;
- other income of $980 million, down from $1.3 billion[38];
- total expenses of $16.8 billion, equating to $254.29 per resident per day, compared with $247.58, an increase of 2.7 per cent;
- average EBITDA per resident per annum of $11,481 compared with $11,134, an increase of 3.1 per cent;
- total profit of $1,006 million compared with $1,063 million, a decrease of 5.4 per cent;
- NPBT per resident per annum of $5,572 compared with $5,962, a decrease of 6.5 per cent; and
- 68 per cent of providers achieved a net profit compared with 69 per cent.

## 9.1 Introduction

Funding for residential aged care is made up of operational funding and capital financing. Operational funding supports day-to-day services such as nursing and personal care, living expenses and accommodation expenses. Capital financing supports the construction of new residential aged care facilities and the refurbishment of existing facilities. Capital financing is discussed in Chapter 10.

In this chapter, the performance of residential care providers is discussed in four ways:

- **All providers.** All residential care providers who reported using the Aged Care Financial Report (ACFR), accounting for around 99 per cent of providers.
- **By provider ownership type.** That is, not-for-profit, for-profit and government owned providers.
- **By provider location.** Providers with facilities located in metropolitan areas, regional areas or both metropolitan and regional areas[39].
- **By provider scale.** Scale is categorised into providers operating one, two to six, seven to 19, and 20 or more aged care facilities.

## 9.2 Operational funding

A combination of Australian Government and resident contributions provides the operational funding for residential aged care as described in Figure 9.1.

38 For this report, ACFA was able to gain additional insights on the sources of 'other income' for residential providers through the introduction of the ACFR in 2016-17. The 'other income' sources have been separately identified where possible for 2016-17, and accounts for the reduction compared with 2015-16. In addition, comparisons may not always be possible with 2015-16 due to the change in reporting methods.

39 For this report, 'regional' is any area that is outside of a major city. That is, inner and outer regional, remote and very remote are combined. A provider is classified as metropolitan if 70 per cent or more of their residents are in facilities in metropolitan locations and classified as regional if 70 per cent or more of their residents are in facilities in regional locations.

**Figure 9.1: Residential aged care services**


The Commonwealth determines its contributions on behalf of permanent residents in residential care by setting:

- a basic care subsidy for personal and nursing care;
- the rates of supplements paid to support aspects of residential care that incur higher costs to deliver; and
- the maximum rate of accommodation supplement.

With regard to respite care, the Commonwealth sets the basic respite care subsidy at two levels depending on the level of respite care the consumer is approved for by the Aged Care Assessment Team (ACAT).

The Commonwealth also sets the maximum levels for contributions made by residents for the following:

- the maximum rate of the basic daily fee for living expenses (permanent and respite); and
- the maximum means tested care fee that may be charged by providers (permanent only).

## 9.2.1 Commonwealth operational funding

Commonwealth payments for residential aged care in 2016-17 can be classified as:

- basic care subsidies
- respite care subsidies and supplements
- accommodation supplements
- viability supplements
- other supplements

A full list of subsidies and supplements is at Appendix I.

Commonwealth subsidies and supplements are generally indexed either biannually (accommodation related) or annually (care related).

The indexation applied to the basic subsidy for residential care is the Wage Cost Index 9 (WCI-9), which is a composite index constructed by the Department of Finance that comprises a wage cost component (weighted at 75 per cent) and a non-wage cost component (weighted at 25 per cent). For all Wage Cost Indices the value of the wage cost component is based on the dollar increase in the national minimum wage (as determined annually by the Fair Work Commission) expressed as a percentage of the latest available estimate of average weekly ordinary time earnings (AWOTE) published by the Australian Bureau of Statistics as at November of each year. The value of the non-wage cost component of WCI-9 is based on changes in the Consumer Price Index between March quarters each year.

Accommodation related supplements are indexed using the Consumer Price Index (CPI).

## 9.2.2 Basic care subsidies

- **The basic care subsidy** is a payment to support the costs of providing personal and nursing services for permanent residents. It is calculated based on the assessed need of each permanent resident as determined by the provider by applying the Aged Care Funding Instrument (ACFI). The Commonwealth determines the level of payments on behalf of residents by setting the prices and rules for claiming ACFI care subsidies.

- **The basic respite subsidy** is a payment intended to support the costs of providing personal and nursing services for respite consumers. Respite consumers are assessed by an ACAT as requiring either high or low level care, with payment amounts for each set by the Commonwealth.

**The Aged Care Funding Instrument (ACFI)**

The ACFI is a funding allocation tool. It assesses the care needs of permanent residents as a basis for allocating care funding by focusing the funding allocation around the main areas that differentiate relative care needs among residents.

The ACFI consists of 12 questions about assessed care needs, each having four ratings (A, B, C or D) and two diagnostic sections. ACFI is self-assessed by providers.

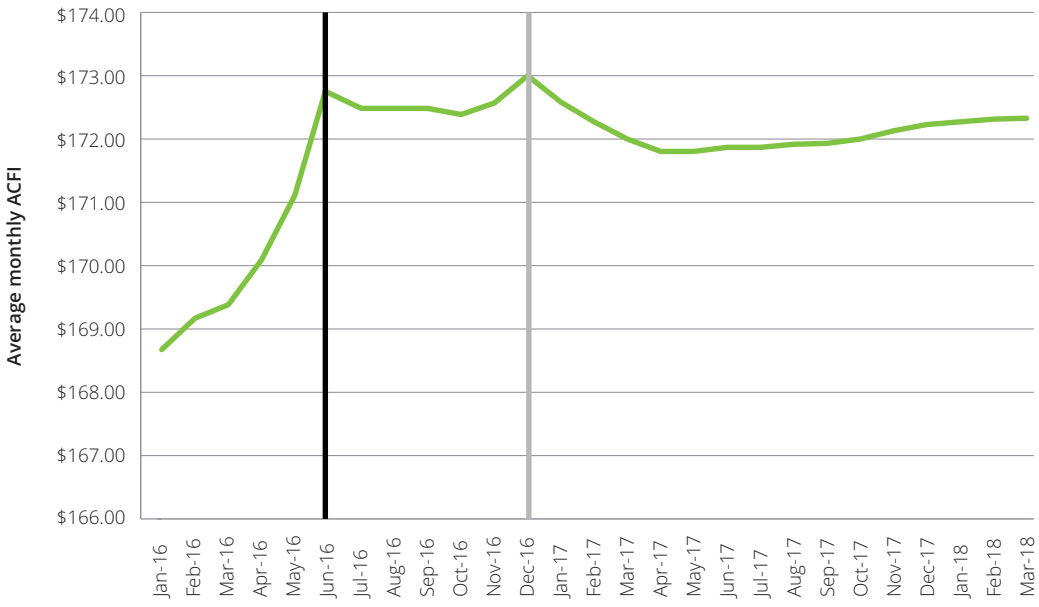
During 2015-16, real growth of expenditure per resident per day through the ACFI was 5.2 per cent, compared with a Government budgeted growth of 3.2 per cent. This resulted in an increase to the Government's forecast expenditure over four years of $3.8 billion. The Government responded by announcing changes to the ACFI and indexation following consultation with the sector. These changes took effect on 1 July 2016 and 1 January 2017. The changes to ACFI included a new matrix reducing the rating categories for medication under Question 11 of the Complex Health Care domain and changes to the scoring and eligibility requirements for certain Complex Health Care procedures. These changes were complemented by an indexation pause on all ACFI domains in 2017-18 and a partial indexation pause in 2018-19.

Annual real growth in ACFI expenditure for 2016-17 was forecast to be around 1.7 per cent (excluding 1.3 per cent indexation); the actual growth for the year was 2.1 per cent. In 2018-19, the majority of indexation for the ACFI will return, with full indexation of ACFI subsidy rates for the Activities of Daily Living and Behaviour domains, while indexation for the Complex Health care domain will be paused by 50 per cent. All domains of ACFI will be indexed in full from 2019-20.

The Department produces monthly reports regarding actual ACFI expenditure compared with Budget estimates. These reports can be found at https://agedcare.health.gov.au/tools-and-resources/aged-care-funding-instrument-acfi-reports.

Following the implementation of the measures, there was an overall reduction in the average ACFI claim, particularly following the 1 January 2017 changes, driven by lower average CHC claims and little growth in the other domains due to providers not reappraising residents. Since April 2017, the average ACFI claim has grown very slowly: there has been modest growth in the average claims for the ADL domain, which has been offset by a continued reduction in the average CHC claim. Overall growth since 1 July 2017 to March 2018 has been negative 0.2 per cent compared to the nine months from July 2016 to March 2017. As shown in Chart 9.1, there was a noticeable decline in ACFI claims following the changes of 1 January 2017, however since April 2017 they have gradually increased each month to March 2018.

**Chart 9.1: Average monthly ACFI payments, January 2016 to March 2018**



ACFA notes that the Government has commissioned a study on the relative costs of providing care for residents with differing care needs and is consulting with the sector on long-term reform options for residential aged care funding, discussed in section 4.9.

The ACFI does not apply for residential respite care. Instead, respite care funding is paid at either a low or high rate depending on the level of care for which the consumer is approved by the ACAT. Additionally, providers who use 70 per cent or more of their respite allocation over a 12-month period receive a higher payment[40].

### 9.2.3 Payments for residential respite care

The Australian Government pays the provider a residential respite subsidy and a respite supplement for each eligible respite resident.

The subsidy and supplement are paid at either a low or high rate depending on the level of respite care the consumer is approved for by the ACAT. Providers that use 70 per cent or more of their respite allocation over a 12 month period receive a higher daily respite supplement rate per eligible high care recipient. Respite subsidies are indexed on 1 July each year. Supplements are indexed on 20 March and 20 September each year in line with pension indexation. Table 9.1 shows the residential care respite rates applicable as at 1 July 2018.

The daily amount of low respite care subsidy and supplement combined is higher than the lowest daily rate of care subsidy payable in permanent residential care. The higher respite care subsidy plus supplement is $222.78, which is approximately equivalent to the highest daily rate of care subsidy payable in permanent residential care.

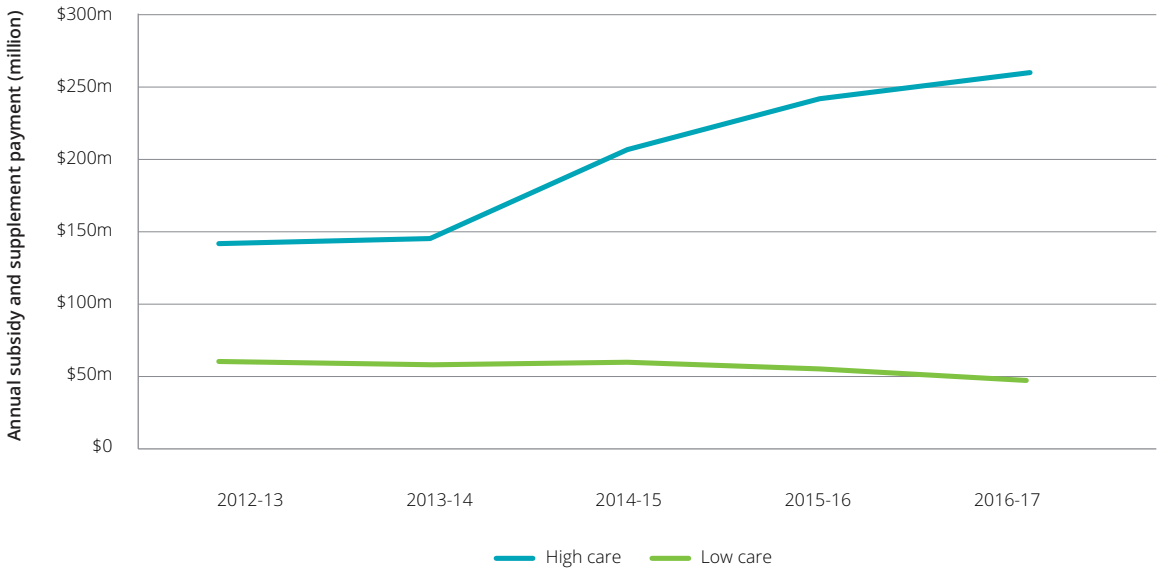
In addition, residential respite consumers can be eligible for other supplements, such as oxygen supplement, where there is a need.

**Table 9.1: Residential respite care subsidies and supplement rates, at 1 July 2018**

| | Daily Subsidy | Daily Supplement | Total paid per day |
|---|---|---|---|
| Low level respite care | $46.74 | $38.46 | $85.20 |
| High level respite care | $131.05 | $53.91 | $184.96 |
| High level respite care when a provider uses 70% or more of respite allocation | $131.05 | $91.73 | $222.78 |

Chart 9.2 shows the Australian Government payments for residential respite care since 2012-13. While payments for low care have remained stable, there has been a significant increase in payments for high care since the reforms of 1 July 2014.

**Chart 9.2: Australian Government payments for residential respite care, by care level, 2012-13 to 2016-17.**




40 An additional amount is paid to residential care providers if they use an average of 70 per cent or more of their respite care allocation during the 12 months up to and including the month providing respite care. If the 70 per cent target is met, a payment is made at the end of the month for each of the high care respite days provided during that month

### 9.2.4 Accommodation supplements

Accommodation supplements are paid by the Commonwealth to assist with the accommodation costs of permanent residents who do not have the means to meet all of that cost themselves (supported residents). These supplements include both the current accommodation supplement and grand-parented supplements under previous policies.

Accommodation supplements (or accommodation payments) do not apply for consumers accessing residential respite care.

The Commonwealth determines the amount of accommodation supplement payable by setting the maximum rate of accommodation supplement and determining the share paid by residents based on a means test.

Two significant reforms from 1 July 2014 affected accommodation payments. A new means test that combined the formerly separate income and assets tests was introduced for residents entering residential care after 1 July 2014, and the accommodation supplement paid by the Commonwealth to a provider on behalf of supported residents living in aged care homes that have been built or significantly refurbished since 20 April 2012 was significantly increased.

### 9.2.5 Viability supplement

The viability supplement aims to improve the financial position of smaller, rural and remote aged care facilities that incur additional costs due to their location and are constrained in their ability to realise economies of scale due to smaller numbers of beds. In addition, the viability supplement also supports providers who specialise in aged care services for Indigenous people, or people who are homeless or who are at risk of becoming homeless, in recognition of the often higher costs associated with providing these services.

The supplement is available to residential care facilities, home care services, Multi-Purpose Services and Aboriginal and Torres Strait Islander Flexible services. In 2016-17, on average, the viability supplement provided $8,600 per resident per annum for residential care facilities in remote and very remote areas, directly improving their financial results.

On 1 January 2017, changes were made to the way that the viability supplement is calculated. The changes included applying a more appropriate remoteness classification tool (the Modified Monash Model) as well as an overall increase in the amount of viability supplement paid ($100 million[41] over four years or a 30 per cent increase).

### 9.2.6 Homeless supplement

A homeless supplement is paid to providers for each resident of an eligible aged care home. Eligibility for the supplement is based on an aged care home having more than 50 per cent of its residents who are identified as being homeless, or at risk of being homeless. The supplement is in addition to the funding provided under the viability supplement.

As at 30 June 2017, the homeless supplement was being paid in respect of around 1,500 residents. In 2016-17 $8.3 million was paid for the supplement.

### 9.2.7 Resident operational funding

Contributions by permanent residents in 2016-17 for operational funding were made up of:

- **A basic daily fee**, which is a contribution towards living expenses such as meals, laundry services, utilities and toiletries. The price is set by the Commonwealth, and is currently set at a maximum of 85 per cent of the single basic age pension.
- **A means tested care fee**, which is a contribution some residents make towards their care costs (personal and nursing) based on their assessable income and assets. Annual and lifetime caps on care contributions apply as a consumer protection. As at 1 July 2018 the annual cap for a means tested care fee was $26,964.71, with a lifetime cap of $64,715.36 also applying.
- **Accommodation payments**, are daily payments for accommodation in an aged care facility. Lump sum accommodation deposits are not treated as revenue, but as capital financing which is discussed in Chapter 10.
- **Extra service fees**, which residents in aged care facilities with extra service status may be asked to pay for significantly higher standards of accommodation, food and non-care services. These vary from facility to facility.

41 The figure of $100 million combines $75 million for residential care and $25 million for home care and other flexible care.

- **Additional services fees**, which are for care and services in non-extra service facilities that are over and above those that providers are required to deliver, and must be agreed between the resident and provider. These vary from facility to facility.

## 9.3 Analysis of 2016-17 financial performance of residential aged care providers

As noted in previous ACFA reports, the financial performance of residential care providers is affected by variations in both revenue and expenditure. It can also vary depending on the location in which care is delivered.

Operational funding contributes to the cost of provision of services to residents. Additionally, if surpluses in any one year contribute to Retained Earnings in the balance sheet, such equity may be contributed towards capital financing for the provision of infrastructure.

The top half of Figure 9.2 maps operational funding of the residential care sector in 2016-17. The capital financing portion of the Figure is explained and discussed in Chapter 10 (Figure 10.1). The financial performance (profit and loss in the current financial year) is discussed in this section.

ACFA notes there are some reporting differences in 2016-17 which affect some comparisons between 2016-17 and previous years. In its September 2014 report, *Improving the Collection of Financial Data from Aged Care Providers*, ACFA recommended a new Aged Care Financial Report (ACFR) be introduced to consolidate the General Purpose Financial Report (GPFR), the Annual Prudential Compliance Statement (APCS), the Survey of Aged Care Homes (SACH) and the home care Financial Accountability Reports (FAR). Information obtained through the GPFRs is still used for comparisons with previous years.

The ACFR became mandatory for all residential care providers from 2016-17, and introduced a number of mandatory data items for providers with the aim of improving the consistency, quality and usability of the financial data being received.

As the ACFR provides more complete data, ACFA is able to provide enhanced analysis of the financial operations of providers. Year-to-year comparison of prior year financial data however is hampered in some cases or not possible in others, due to the different reporting requirements of the ACFR.

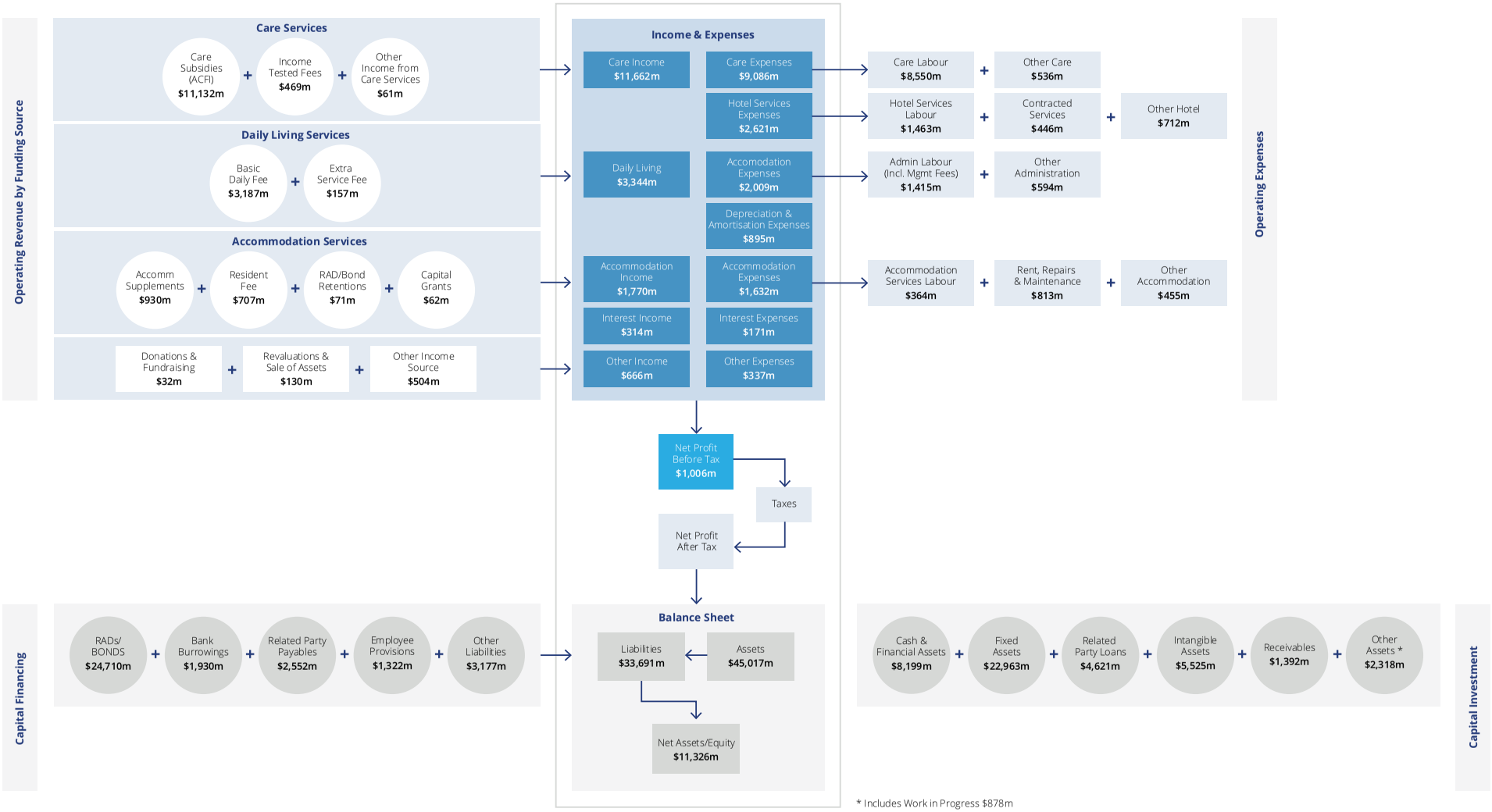
As noted, when presenting comparisons with previous years, ACFA is utilising data provided through the GPFRs. Table 9.2 shows the overall financial performance of residential care providers who submitted their GPFRs for the years up to 2015-16 and ACFR for 2016-17. The total revenue increased across each of the five years with the net profit before tax improving in the four years to 2015-16 before dropping slightly in 2016-17.

The average EBITDA per resident improved across each of the last five years. The EBITDA margin also improved across the last five years, albeit only by 0.1 per cent, to 11.7 per cent in 2016-17. The NPBT margin declined slightly in 2016-17 to 5.7 per cent, down from 6.2 per cent.

**Table 9.2: Summary of financial performance of residential aged care providers, 2012-13 to 2016-17**

| | 2012-13 | 2013–14 | 2014-15 | 2015-16 | 2016-17 |
|---|---|---|---|---|---|
| Revenue ($m) | $13,961 | $14,826 | $15,810 | $17,172 | $17,757 |
| Expenses ($m) | $13,367 | $14,115 | $14,903 | $16,109 | $16,751 |
| NPBT ($m) | $594 | $712 | $907 | $1,063 | $1,006 |
| NPBT margin | 4.3% | 4.9% | 5.8% | 6.2% | 5.7% |
| EBITDA ($m) | $1,473 | $1,582 | $1,776 | $1,985 | $2,072 |
| Average EBITDA per resident per annum | $8,660 | $9,224 | $10,222 | $11,134 | $11,481 |
| EBITDA margin | 10.6% | 10.7% | 11.2% | 11.6% | 11.7% |

## Figure 9.2: Residential aged care funding/financing sources, 2016-17




* Includes Work in Progress $878m

Table 9.3 shows the overall financial performance of providers by ownership type, location and scale in 2016-17.

There was an improvement in the overall financial performance of not-for-profit providers, with EBITDA increasing from $1,047 million in 2015-16 to $1,174 million in 2016-17, an increase of $127 million. EBITDA per resident per annum increased by $1,219 to $11,408 in 2016-17. The EBITDA of the for-profit providers dropped slightly from $938 million in 2015-16 to $928 million in 2016-17. The EBITDA per resident per annum of the for-profit providers also dropped marginally from $13,908 in 2015-16 to $13,316 in 2016-17. Government providers reported an overall loss of $30 million in 2016-17 and a loss in EBITDA per resident per annum of $3,791.

In 2016-17, the overall financial performance improved for metropolitan providers and providers operating in both metropolitan and regional locations. The EBITDA increased for metropolitan providers from $1,306 million in 2015-16 to $1,401 million in 2016-17, with the EBITDA per resident per annum improving from $11,701 in 2015-16 to $12,422 in 2016-17. For regional providers, the EBITDA decreased from $266 million in 2015-16 to $233 million in 2016-17, a decrease of $33 million, and the EBITDA per resident per annum dropped from $9,046 in 2015-16 to $8,257 in 2016-17. Providers operating in both metropolitan and regional locations improved their reported EBITDA from $413 million in 2015-16 to $439 million in 2016-17, an increase of $26 million, with the EBITDA per resident per annum, increasing from $11,081 in 2015-16 to $11,093 in 2016-17.

In terms of provider scale, in 2016-17 compared with 2015-16, the overall financial performance improved for providers operating more than 20 homes and for providers operating up to 6 homes. The EBITDA for those operating 7 to 19 homes declined from $481 million in 2015-16 to $406 million in 2016-17, with the EBITDA per resident per annum declining from $10,901 to $9,709. Providers operating single homes increased EBITDA per resident per annum, up from $12,220 in 2015-16 to $12,534 in 2016-17. Providers operating 2 to 6 homes had the biggest improvement in EBITDA per resident per annum, up from $9,072 in 2015-16 to $10,586 in 2016-17. Providers operating more than 20 homes also improved EBITDA per resident per annum from $12,325 in 2015-16 to $12,726 in 2016-17.

**Tavle 9.3: Summary of financial performance of residential aged care providers, 2016-17**

| | | | Ownership type | | | Location | | | Scale | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Total sector 2015-16 | Total sector 2016-17 | Not-for-profit | For-profit | Government | Metropolitan | Regional | Metropolitan & regional | Single home | 2 To 6 homes | 7 To 19 homes | 20 & more homes |
| Revenue ($m) | $17,172 | $17,757 | $9,737 | $7,143 | $877 | $11,089 | $2,797 | $3,870 | $3,718 | $4,268 | $4,123 | $5,647 |
| Expenses ($m) | $16,109 | $16,751 | $9,209 | $6,580 | $962 | $10,344 | $2,734 | $3,673 | $3,448 | $4,067 | $3,985 | $5,251 |
| Profit ($m) | $1,063 | $1,006 | $528 | $563 | -$85 | $745 | $62 | $198 | $270 | $201 | $139 | $395 |
| EBITDA ($m) | $1,985 | $2,072 | $1,174 | $928 | -$30 | $1,401 | $233 | $439 | $479 | $451 | $406 | $736 |
| EBITDA p.r.p.a ($) | $11,134 | $11,481 | $11,408 | $13,316 | $3,791 | $12,422 | $8,257 | $11,093 | $12,534 | $10,586 | $9,709 | $12,726 |
| EBITDA margin | 11.6% | 11.7% | 12.1% | 13.0% | -3.4% | 12.6% | 8.3% | 11.3% | 12.9% | 10.6% | 9.8% | 13.0% |
| NPBT margin | 6.2% | 5.7% | 5.4% | 7.9% | -11.5% | 6.7% | 2.4% | 5.1% | 7.3% | 4.7% | 3.5% | 7.0% |

1. Amounts presented in this table represent those providers who have given their ACFRs (98.5per cent of the sector).
2. The amount of tax and Net Profit/Loss After Tax is not given in the ACFR at the residential aged care segment level by all providers.
3. The amount of un-appropriated profit flowing to the balance sheet is not given by all providers at the residential aged care segment level.

## 9.3.1 Revenue

ACFA broadly describes revenue for residential care providers in four categories: care related, living expenses, accommodation and other. Table 9.4 provides a breakdown of the revenue reported by residential care providers in 2016-17, compared with 2015-16.

In 2016-17, care related revenue formed 65.7 per cent of the total revenue earned by residential providers ($11.7 billion) compared with 62.9 per cent in 2015-16. Living related revenue received from residents, which includes the basic daily fee and extra service fees, accounted for 18.8 per cent ($3.3 billion) of total revenue, the same proportion as 2015-16.

Accommodation payments, consisting of accommodation supplements paid by the Government and accommodation payments paid by residents, account for 9.6 per cent ($1.8 billion) of total provider revenue in 2016-17, compared with 10.4 per cent in 2015-16.

Accommodation payments made by residents totalled $778 million in 2016-17 compared with the reported amount of $851 million in 2015-16. In last year's report, ACFA noted that some anomalies in the collection of data pertaining to accommodation payments received by providers in 2014-15 and 2015-16 had resulted in greater than expected increases in reported payments in 2015-16. Addressing these anomalies in data collection is a large factor in the decline in reported accommodation payments made by residents in 2016-17, and ACFA expects that 2017-18 will see a return to average annual growth rate.

**Table 9.4: Revenue sources for residential care providers, by care, accommodation, living and 'other', 2015-16 and 2016-17[42]**

| Revenue sources | 2015-16 ($million) | 2016-17 ($million) | Change ($million) | Change (%) |
|---|---|---|---|---|
| **Care related** | | | | |
| Basic care subsidy (ACFI) | $9,991.3 | $10,741.7 | $750.4 | 7.5% |
| Respite subsidy | $287.7 | $301.4 | $13.7 | 4.8% |
| Other supplements | $72.8 | $89.3 | $16.5 | 22.7% |
| Resident means tested care fees | $456.0 | $468.9 | $12.9 | 2.8% |
| Resident other care fees[42] | $0 | $61.2 | $61.2 | N/A |
| **Total care revenue** | **$10,807.8** | **$11,662.5** | **$854.7** | **7.9%** |
| **Living related** | | | | |
| Resident basic daily fee | $3,088.9 | $3,186.7 | $97.8 | 3.2% |
| Extra service fees | $146.9 | $157.5 | $10.6 | 7.2% |
| **Total living related revenue** | **$3,235.8** | **$3,344.2** | **$108.4** | **3.4%** |
| **Accommodation related** | | | | |
| Accommodation supplement | $941.6 | $929.7 | -$11.9 | -1.3% |
| Accommodation payments from residents | $850.8 | $778.4 | -$72.4 | -8.5% |
| Capital grants | $0 | $61.7 | $61.7 | N/A |
| **Total accommodation related revenue** | **$1,792.4** | **$1,769.8** | **-$22.6** | **-1.3%** |
| **Other income** | | | | |
| Interest | $0 | $313.8 | $313.8 | N/A |
| Donations and fundraising | $0 | $32.3 | $32.3 | N/A |
| Gain on sale of assets | $0 | $29.1 | $29.1 | N/A |
| Revaluation of assets | $0 | $130.4 | $130.4 | N/A |
| Other | $1,335.8 | $474.4 | -$861.4 | -64.5% |
| **Total other revenue** | **$1,335.8** | **$980.0** | **-$355.8** | **-26.6%** |
| **Total residential provider revenue** | **$17,171.8** | **$17,756.5** | **$584.7** | **3.4%** |

1. Extra service subsidy reduction does not apply to new residents entering care from 1 July 2014, however it still applies to residents in ESS places who were in care prior to 1 July 2014.
2. Some revenue items in this table are reported as $0 for 2015-16. This is due to lack of data available for these items prior to the 2016-17 year.

42 Fees and charges received from a resident in respect of occasional care services like consultation, therapy, medication, treatment or procedure provided in addition to services required to be delivered under Schedule 1 of the *Aged Care1997*.

Interest revenue for providers may include interest earned on lump sum deposits less any interest payments made on borrowings (providers may show these separately in their balance sheets or may combine them as 'net').

Additional insights were gained on the sources of 'other income' for providers through the introduction of the Aged Care Financial Report in 2016-17. Some items previously classified as 'other revenue' have now been apportioned to more appropriate revenue items. This means that reported 'other' income is 26 per cent less in 2016-17 compared with 2015-16. Interest income comprises more than a third of the 'other income' providers received. Almost half of 'other income' reported by residential providers ($474 million) comes from unidentified other revenue sources. Total 'other income' of $980 million forms just over 5 per cent of the total revenue earned by providers in 2016-17, and forms a substantial proportion of the reported NPBT for residential service providers of $1,006 million.

Chart 9.3 shows the proportions of all revenue sources for residential providers in 2016-17.

ACFA also analyses revenue sources in terms of those sources provided by the Commonwealth compared with those provided by residents. Table 9.5 shows provider revenue sources for 2015-16 and 2016-17, split by Commonwealth, resident and other.

Overall in 2016-17, the Commonwealth contributed 68.3 per cent of total provider funding ($12.1 billion). Residents contributed 26.2 per cent ($4.6 billion) while income from other sources comprised the remaining 5.5 per cent ($980 million). This compares with 2015-16 where the Commonwealth share was 65.8 per cent, residents contributed 26.5 per cent and other income was 7.8 per cent.

Chart 9.4 shows the proportion of revenue that residential providers received in 2016-17 from the Commonwealth (68.3 per cent of total income) with ACFI subsidies comprising the vast majority of the total revenue from the Commonwealth (89 per cent).

**Chart 9.3: Proportions of total residential care provider revenue, 2016-17**

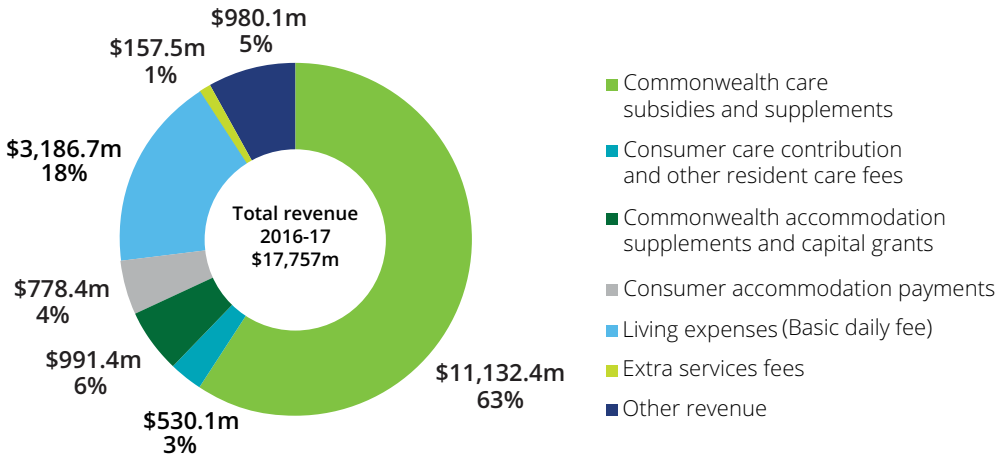



**Chart 9.4: Proportions of provider revenue from the Commonwealth, 2016-17**

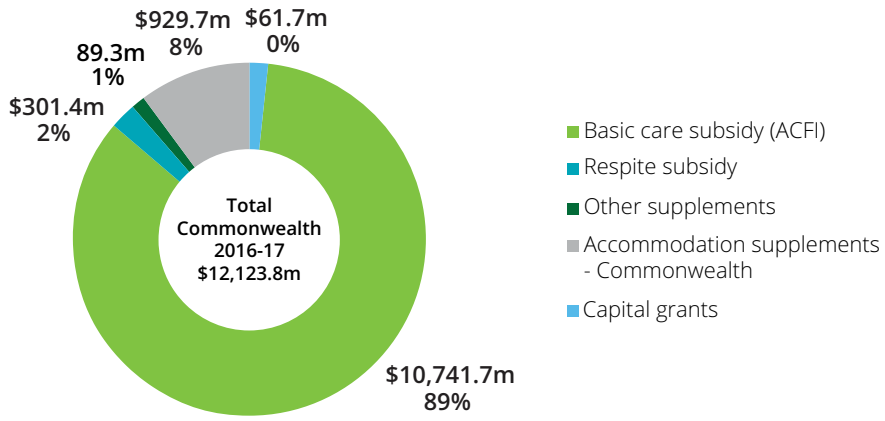


**Table 9.5: Revenue sources for residential care providers, Commonwealth, resident and 'other', 2015-16 and 2016-17**

| Revenue sources | 2015-16 ($million) | 2016-17 ($million) | Change ($million) | Change (%) |
|---|---|---|---|---|
| **Commonwealth** | | | | |
| Basic care subsidy (ACFI) | $9,991.3 | $10,741.7 | $750.4 | 7.5% |
| Respite subsidy | $287.7 | $301.4 | $13.7 | 4.8% |
| Other supplements | $72.8 | $89.3 | $16.5 | 22.7% |
| Accommodation supplements | $941.6 | $929.7 | -$11.9 | -1.3% |
| Capital grants | $0 | $61.7 | $61.7 | N/A |
| **Commonwealth funding sources** | **$11,293.4** | **$12,123.8** | **$830.4** | **7.4%** |
| **Resident** | | | | |
| Basic daily fee | $3,088.9 | $3,186.7 | $97.8 | 3.2% |
| Means tested care fees | $456.0 | $468.9 | $12.9 | 2.8% |
| Resident care fees – other | $0 | $61.2 | $61.2 | N/A |
| Accommodation payments | $850.8 | $778.4 | -$72.4 | -8.5% |
| Extra services fee | $146.9 | $157.5 | $10.6 | 7.2% |
| **Resident funding sources** | **$4,542.6** | **$4,652.7** | **$110.1** | **2.4%** |
| **Other** | | | | |
| Interest | $0 | $313.8 | $313.8 | N/A |
| Donations and fundraising | $0 | $32.3 | $32.3 | N/A |
| Gain on sale of assets | $0 | $29.2 | $29.2 | N/A |
| Revaluation of assets | $0 | $130.4 | $130.4 | N/A |
| Other | $1,335.8 | $474.4 | -$861.4 | -64.5% |
| **Other funding sources** | **$1,335.8** | **$980.1** | **-$355.7** | **-26.6%** |
| **Total revenue** | **$17,171.8** | **$17,756.5** | **$584.7** | **3.4%** |

1. Extra service subsidy reduction does not apply to new residents entering care from 1 July 2014, however it still applies to residents in ESS places who were in care prior to 1 July 2014.
2. Some revenue items in this table are reported as $0 for 2015-16. This is due to the lack of data available for these items prior to 2016-17.

Chart 9.5 shows the proportion of total revenue that residential providers receive from residents (26.2 per cent of total revenue), with the basic daily fee forming 69 per cent of the total revenue received from residents. Means tested care fees formed a further 17 per cent of the revenue received.

As shown in Table 9.6, total revenue per resident per day in 2016-17 was $269.55, an increase of 2.1 per cent from 2015-16 ($263.92).

**Chart 9.5: Proportions of provider revenue from residents ($m), 2016-17**

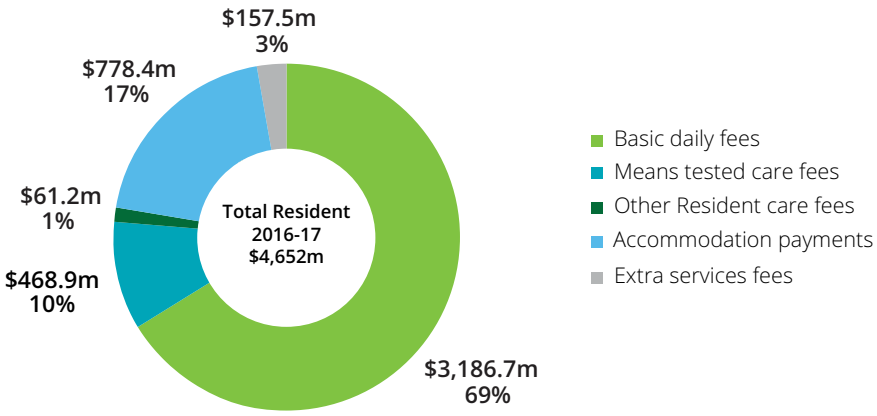


**Table 9.6: Revenue sources per resident per day, 2015-16 and 2016-17**

| | 2015-16 | 2016-17 | Change | |
|---|---|---|---|---|
| | | | $ p.r.p.d. | % |
| **Commonwealth revenue sources** | | | | |
| ACFI | $153.56 | $163.07 | $9.51 | 6.2% |
| Respite care subsidies and supplements | $4.42 | $4.58 | $0.15 | 3.6% |
| Other supplements | $1.12 | $1.36 | $0.24 | 21.4% |
| Accommodation supplements | $14.47 | $14.11 | -$0.36 | -2.5% |
| Commonwealth capital grants | N/A | $0.94 | N/A | N/A |
| **Total Commonwealth revenue** | **$173.57** | **$184.06** | **$9.54** | **5.5%** |
| **Resident revenue sources** | | | | |
| Means tested care fees | $7.01 | $7.12 | $0.11 | 1.6% |
| Accommodation payments | $13.08 | $11.82 | -$1.26 | -9.6% |
| Basic daily fees | $47.47 | $48.38 | $0.90 | 1.9% |
| Extra services fees | $2.26 | $2.39 | $0.13 | 5.8% |
| Resident care fees – other | N/A | $0.93 | N/A | N/A |
| Total resident revenue | $69.82 | $70.64 | $0.82 | 1.2% |
| **Total residential service income** | **$243.39** | **$254.70** | **$11.31** | **4.7%** |
| Other income | $20.53 | $14.88 | -$5.65 | -27.5% |
| **Total** | **$263.92** | **$269.55** | **$5.64** | **2.1%** |

1. With data collected through the ACFR in 2016-17, more accurate revenue items have been captured. This has lessened the reliance on multiple sources of data to ascertain numbers. As a consequence some new data items have been obtained such as capital grants. Some other items have been adjusted due to different collection through the ACFR, such as:
   - Subsidies and supplements were reported in accordance with Commonwealth records of payments made in previous years, as more reliable data was not available. In 2016-17 ACFA has been able to report the total subsidies received by providers captured through the ACFR.
   - Accommodation payments received (DAPs DACs etc) was collected from the Survey of Aged Care Homes (SACH) in prior years as no other source of data was available. This data appears to have been slightly overstated through this method, and going forward will be obtained from the ACFR.
2. Revenue from additional services fees, including capital refurbishment fees, asset replacement contributions and other similar fees related to accommodation charged by some providers are likely to have been included as part of extra services fees, or other income reported by providers prior to 2016-17.
3. Extra service subsidy reduction does not apply to new residents entering care from 1 July 2014, however it still applies to residents in ESS places who were in care prior to 1 July 2014.
4. The amount shown for ACFI includes a small number of residents who are grandparented under the former 'Resident Classification Scale,' which was the funding instrument in place prior to the ACFI being introduced in 2008.

## 9.3.2 Expenditure

Total expenditure in 2016-17, for those providers who submitted their ACFRs, was $16.75 billion, up from $16.1 billion in 2015-16. Chart 9.6 shows total expenses for the five years to 2016-17.

Table 9.7 shows the expenses for residential care providers in 2016-17 compared with 2015-16 and Chart 9.7 presents the expenses for 2016-17 as a proportion of total expenses.

Total expenditure increased by 4 per cent in 2016-17 to $16.75 billion. Employee costs represent 70 per cent of the total expenses incurred by providers, an increase from 2015-16 where staff costs represented 67 per cent of total expenses.

'Other' expenses represented 23 per cent of total costs, down from 27 per cent in 2015-16. 'Other' expenses include building repairs and maintenance expenses, rent, utilities and costs associated with employment support activities, cleaning and administration. Depreciation and interest costs account for the remaining 5 and 1 per cent respectively, the same as in 2015-16.

In 2016-17, $11.8 billion was expended in wages and management fees (employee expenses), an increase of $936.5 million from 2015-16. Of this increase:

- $135 million (14 per cent) is attributable to an increase in number of days of care provided (volume changes);
- $792 million (85 per cent) is attributable to a 7.3 per cent increase ($12.17 per claim day) in the average amount paid per claim day in wages and management fees. This would reflect a combination of factors including wage increases, increased hours worked per claim day, increased staffing levels, and changes in the mix of staff to cater for increased care needs; and
- The remaining $10 million (1 per cent) is due to the interaction of price/volume changes.

**Chart 9.6: Total expenses, residential care providers, 2012-13 to 2016-17**

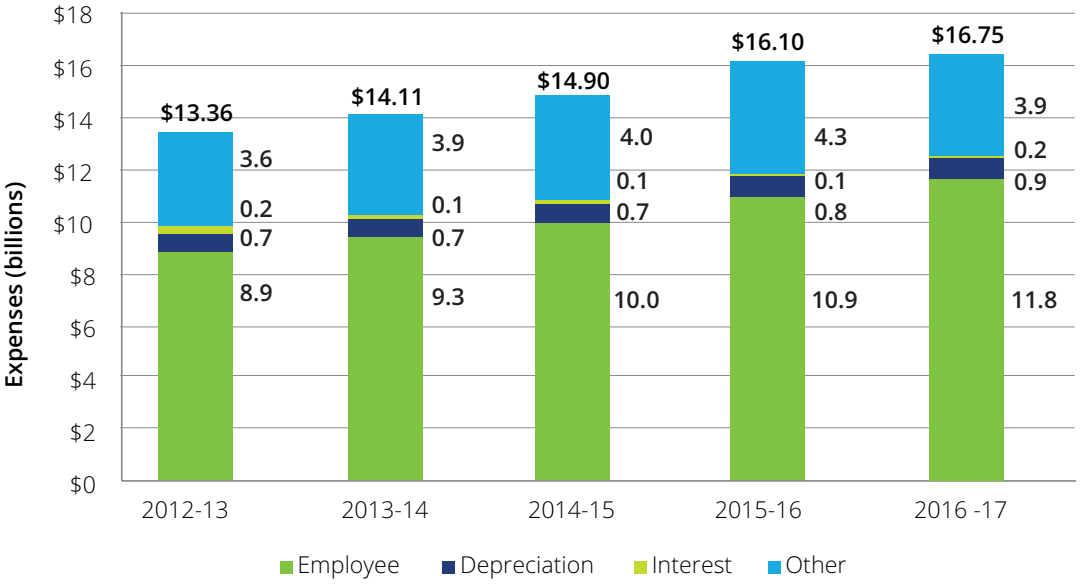
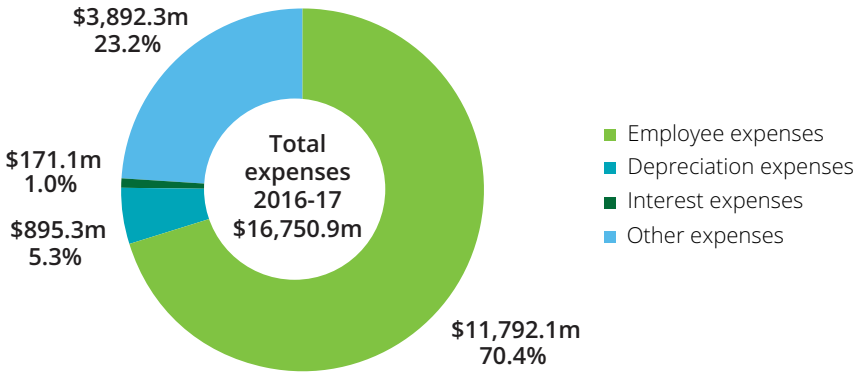



**Table 9.7: Summary of expenses, residential care providers, 2015-16 and 2016-17**

| Expenses | 2015-16 ($m) | 2016-17 ($m) | Change ($m) | Change (%) |
|---|---|---|---|---|
| Employee | $10,855.6 | $11,792.1 | $936.5 | 8.6% |
| Depreciation | $772.2 | $895.3 | $123.1 | 15.9% |
| Interest | $149.8 | $171.1 | $21.3 | 14.2% |
| Other expenses | $4,331.5 | $3,892.3 | -$439.20 | -10.1% |
| **Total expenses** | **$16,109.1** | **$16,750.9** | **$641.7** | **4.0%** |

**Chart 9.7: Proportion of total expenses, residential care providers, 2016-17**




As noted in the discussion on residential care provider revenue, the Department collected additional financial information in 2016-17 through the Aged Care Financial Reports (ACFR) not previously collected. This enables ACFA to present a more detailed analysis of expenditure for the sector. However, as this data was not collected for 2015-16 and earlier, it is not possible to provide comparative analysis with past years.

Table 9.8 shows the major expense types for providers, per resident per day, for the five years to 2016-17. Total expenses per resident per day were $254.29 in 2016-17, up from $247.58 in 2015-16.

As noted earlier, in 2016-17, a different breakdown of expenditure data was collected through the introduction of the ACFR for residential care providers. The new format for data collection has enabled the collection of more detailed expenditure information from 2016-17 onwards. Table 9.9 shows provider expenditure in 2016-17 using the new categories collected through the ACFR.

Care expenditure relates to the direct costs incurred in providing care for residents within residential care facilities. Care related employee expenses make up 94.1 per cent of total care expenses, and 51 per cent of total expenditure, making it the largest single expense for providers. Employee expenses include payments made to doctors, nursing, therapists, nutritionists, case managers, health assistants and support staff.

Other care expenses include items such as resident medication, oxygen and related equipment, treatments and procedures, incontinence aids, items that assist mobility, recreation and social activities, rehabilitation support, personal grooming and specific cultural and social events.

Accommodation expenditure relates to the costs incurred in providing accommodation to residents. Within accommodation, expenses are evenly distributed between employee (22.3 per cent), repairs and maintenance (28.8 per cent), facility rental (20.1 per cent), and other (27.9 per cent).

**Table 9.8: Summary of expenses, per resident per day, 2012-13 to 2016-17**

| Expenses | 2012-13 | 2013–14 | 2014-15 | 2015-16 | 2016-17 |
|---|---|---|---|---|---|
| Employee | $142.92 | $148.81 | $157.68 | $166.84 | $179.01 |
| Depreciation | $11.59 | $11.56 | $11.49 | $11.87 | $13.59 |
| Interest | $2.57 | $2.34 | $2.21 | $2.30 | $2.60 |
| Other | $58.24 | $62.81 | $63.67 | $66.57 | $59.09 |
| **Total expenses** | **$215.31** | **$225.52** | **$235.05** | **$247.58** | **$254.29** |

**Table 9.9: Breakdown of residential care provider expenses, 2016-17**

| | 2016-17 ($m) | % of total expenses |
|---|---|---|
| **Care** | | |
| Employee expenses | $8,549.9 | 51.0% |
| Other | $536.1 | 3.2% |
| **Total care expenses** | **$9,086.0** | **54.2%** |
| **Accommodation** | | |
| Employee expenses | $364.1 | 2.2% |
| Repair & maintenance | $470.3 | 2.8% |
| Rent | $342.1 | 2.0% |
| Other | $455.4 | 2.7% |
| **Total accommodation expenses** | **$1,631.9** | **9.7%** |
| **Hotel** | | |
| Employee expenses | $1,463.0 | 8.7% |
| Contracted services | $445.9 | 2.7% |
| Other | $712.1 | 4.3% |
| **Total hotel expenses** | **$2,620.9** | **15.7%** |
| **Administration** | | |
| Employee expenses | $922.6 | 5.5% |
| Management fees | $492.5 | 2.9% |
| Other | $594.0 | 3.6% |
| **Total administration expenses** | **$2,009.1** | **12.0%** |
| **Financing** | | |
| Depreciation | $874.5 | 5.2% |
| Amortisation | $20.8 | 0.1% |
| Interest | $171.2 | 1.0% |
| **Total financing expenses** | **$1,066.4** | **6.4%** |
| **Other** | | |
| Revaluation of assets (decrease) | $32.2 | 0.2% |
| Loss on sale of assets | $9.5 | 0.1% |
| Other | $294.9 | 1.8% |
| **Total other expenses** | **$336.5** | **2.0%** |
| **Total expenses** | **$16,750.9** | **100%** |

Other accommodation expenses include property rates and taxes, bed licence fees/allocation certification fees, utilities and waste disposal.

Hotel expenditure relates to the costs incurred in the provision of everyday living expenses to residents. Within hotel, expenses relate to employees (55.8 per cent), contracted services (17 per cent) and other (27.2 per cent).

Contracted services are payments made to external providers or internal divisions for the provision of catering, cleaning or laundry. Other expenses consist of expenses such as meals, refreshment, other food consumables, bedding materials, toiletry and sanitary goods, cleaning items, laundry items.

Financing expenditure relates to depreciation incurred on property, plant and equipment, amortisation of intangible assets, and interest paid on borrowing used to fund the capital requirements of facilities. Financing accounted for 6.4 per cent of total expenditure in 2016-17.

Other expenses relate to expenditure not covered in any of the above categories. It is of note that through the introduction of the ACFR, ACFA has been able to better identify expense items that previously were classified as 'other'. The proportion of expenses classified as 'other' was almost 30 per cent in 2015-16 but is only 2 per cent in 2016-17.

### 9.3.3 Operating position – profit

The residential aged care sector reported an overall profit in 2016-17. The 99 per cent of providers who submitted their ACFRs reported total profit (NPBT) of $1,006 million, down slightly from $1,063 million in 2015-16. Sixty-eight per cent of providers reported a net profit compared with 69 per cent in 2015-16.

As shown in Table 9.10, in 2016-17 the total EBITDA increased by 4.4 per cent compared with 2015-16. However the total NPBT decreased by 5.4 per cent. Average EBITDA per resident per annum increased by 3.1 per cent to $11,481 in 2016-17 whereas NPBT per resident per annum decreased by 6.5 per cent to $5,572. The increase in EBITDA, but decrease in net profit, is due in part to a significant increase in reported depreciation by providers, which is not included in the calculation of EBITDA but is for NPBT. Providers reported a 13.2 per cent increase in depreciation from $772 million in 2015-16 to $874 million in 2016-17.

Table 9.11 shows an overview of the operating position of providers since 2012-13. The EBITDA has improved over the five years to 2016-17. The NPBT increased each year from 2012-13 to 2015-16 but fell in 2016-17.

Chart 9.8 presents the EBITDA per resident per annum in 2015-16 and 2016-17 by provider performance quartiles. Although all but the 'next bottom' quartile had a decrease in average EBITDA in 2016-17, the average EBITDA across the sector increased by 3.1 per cent to $11,481. The biggest change was in the bottom quartile where there was negative EBITDA of $5,344, which represents a $1,731 further decline in financial performance compared with 2015-16. This change in performance follows a substantial ($2,201) improvement in 2015-16. The decrease in performance in the other quartiles of providers was less, with the top quartile recording average EBITDA of $24,751 (down from $25,254 or a 2 per cent reduction) and the 'next top' quartile recording a drop of 0.2 per cent. The 'next bottom' quartile reported average EBITDA of $6,077 per resident per annum, up 3.9 per cent from 2015-16.

ACFA notes that whilst Chart 9.8 shows decreases in 2016-17 in EBITDA per resident in some quartiles, particularly in the top, and next top quartiles, it also shows that the overall EBITDA per resident has increased. This outcome has been influenced by a significant shift of residents between providers as a result of the consolidation of providers within the sector (down from 945 to 902). The providers in the top and next top quartiles have increased their proportion of residents from 57 per cent to 63 per cent, while the next bottom and bottom quartiles have decreased their proportion of residents from 43 per cent to 37 per cent. With proportionally more residents in the higher performing quartiles, a slight increase in the overall EBITDA per resident has resulted, even though the EBITDA per resident in three of the quartiles have declined.

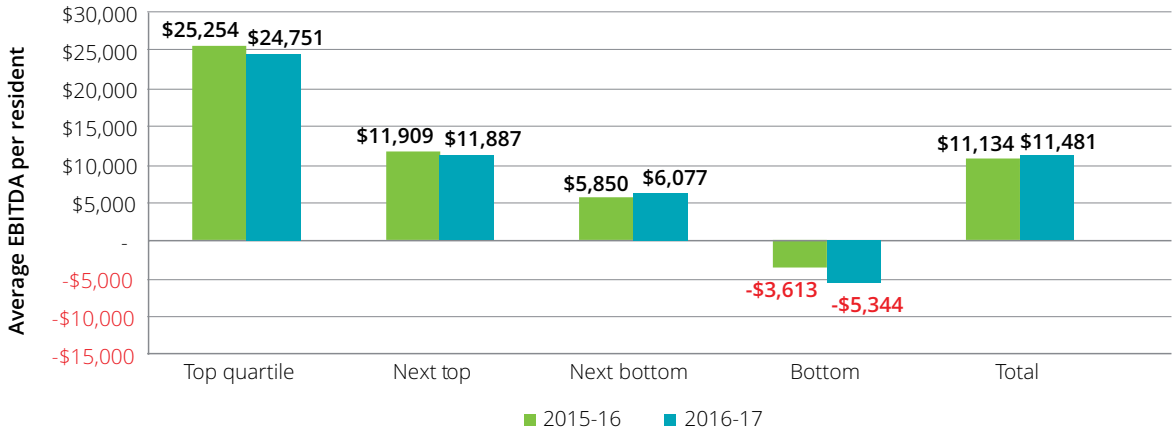
**Table 9.10: Overview of operating position of residential care providers, 2015-16 and 2016-17**

| | 2015-16 | 2016-17 | Change ($m) | Change (%) |
|---|---|---|---|---|
| Revenue | $17,172m | $17,757m | $584m | 3.4% |
| Expenditure | $16,109m | $16,751m | $642m | 4.0% |
| Total EBITDA | $1,985m | $2,072m | $87m | 4.4% |
| Total NPBT | $1,063m | $1,006m | -$57m | -5.4% |
| EBITDA p.r.p.d | $11,134 | $11,481 | $347m | 3.1% |
| NPBT p.r.p.d | $5,962 | $5,572 | -$390 | -6.5% |

**Table 9.11: EBITDA and NPBT of residential care providers, 2012-13 to 2016-17**

| | 2012-13 | 2013–14 | 2014-15 | 2015-16 | 2016-17 |
|---|---|---|---|---|---|
| Total EBITDA | $1,473m | $1,581m | $1,775m | $1,985m | $2,072m |
| EBITDA p.r.p.a | $8,660 | $9,224 | $10,222 | $11,134 | $11,481 |
| EBITDA margin | 10.6% | 10.7% | 11.2% | 11.6% | 11.7% |
| Total NPBT | $594m | $711m | $907m | $1,063m | $1,006m |
| NPBT p.r.p.a | $3,492 | $4,150 | $5,221 | $5,962 | $5,572 |
| NPBT margin | 4.3% | 4.9% | 5.8% | 6.2% | 5.7% |

**Chart 9.8: Comparative EBITDA per resident per annum, 2015-16 and 2016-17**




Operating performance continues to vary across provider ownership type, location and scale. The following commentary provides analysis across the segments of providers.

### By provider ownership type

Overall, for-profit providers have continued to outperform the not-for-profit and government providers in terms of EBITDA margin and Net Profit margin (Chart 9.9). However, this variable needs to be considered carefully because providers in the not-for-profit and government sectors often have different business motives, business models and funding sources and often operate in areas affected by the impacts of remoteness and facility size.

ACFA notes commentary from the not-for-profit sector that the generally lower operating financial results may be consistent with their community or religious missions. They may fulfil their charters in a range of ways that might be difficult or inappropriate in a more commercial environment where investors are seeking returns.

Specifically, not-for-profit providers may choose to invest in or expend funds on amenities and services for which they are not funded through regulated sources. Not-for-profit providers may be enabled to do this through a range of funding pathways and tax benefits, including payroll tax relief, income tax exemptions and tax deductible donations. However, where these costs are not covered by such incremental revenue, the comparatively lower EBITDA for many not-for-profit providers may be the product of the delivery of additional "community benefits" or "social impacts" or returns which are not recognised in the annual financial accounts.

As shown in Chart 9.10, government and not-for-profit providers reported higher interest coverage ratios than for-profit providers, likely due to their lower use of debt to fund operations and finance assets.

As was the case in 2015-16, a higher proportion (34 per cent) of for-profit providers were present in the top quartile of performance per resident (Charts 9.11 and 9.12), compared with not-for-profit (23 per cent) and government (8 per cent) providers. Interestingly however the not-for-profit providers in the top quartile recorded average EBITDA per resident of $29,206 compared with for-profit providers in the top quartile with $21,929.

**Chart 9.9: Operating performance ratios, by ownership type, 2015-16 and 2016-17**

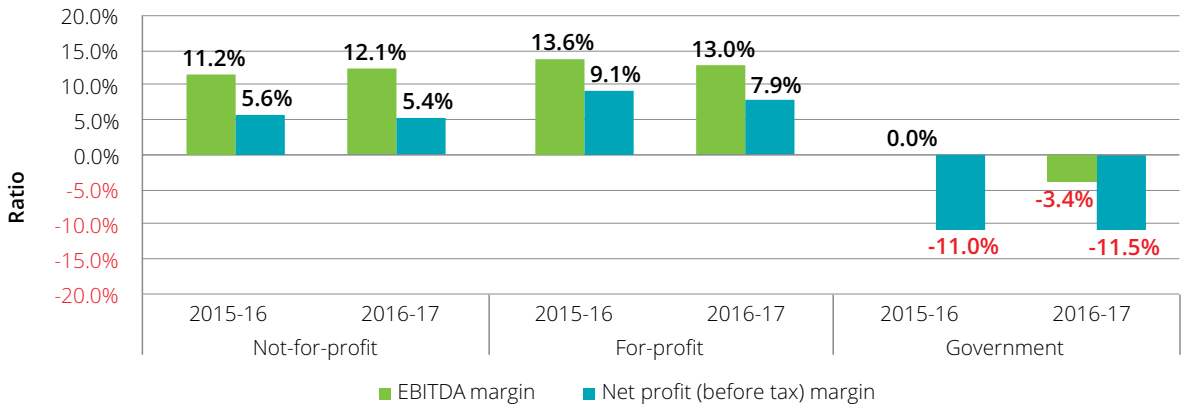


**Chart 9.10: Operating performance ratios, by ownership type, 2016-17**

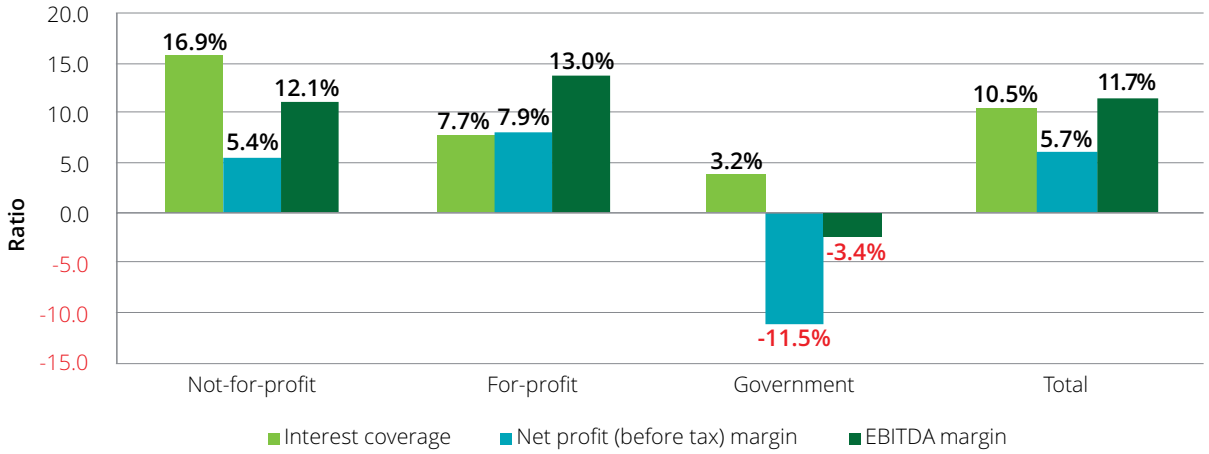



**Chart 9.11: Residential care provider average EBITDA per resident per annum 2016-17, by quartile (number or providers in parentheses) – by ownership type**

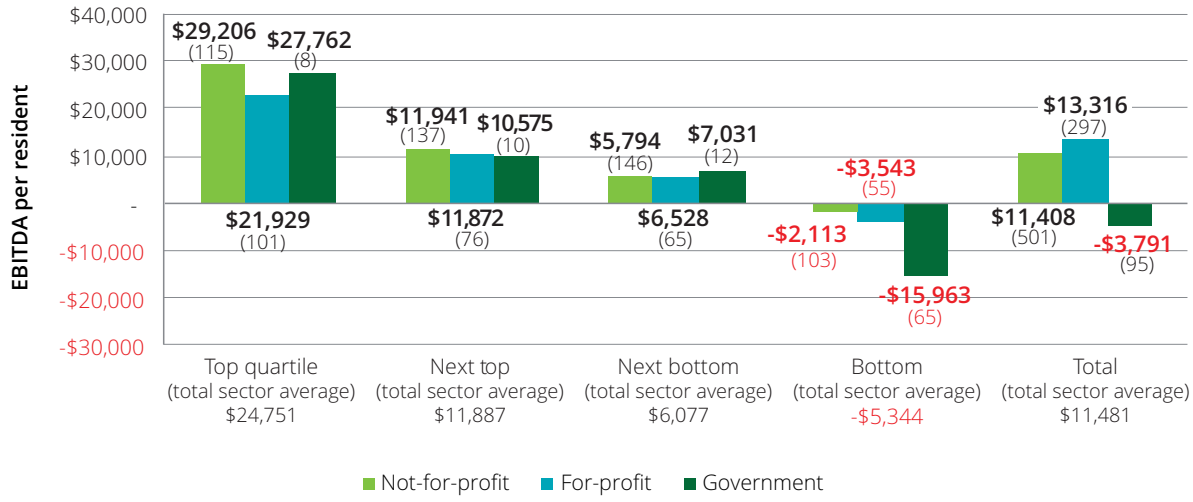
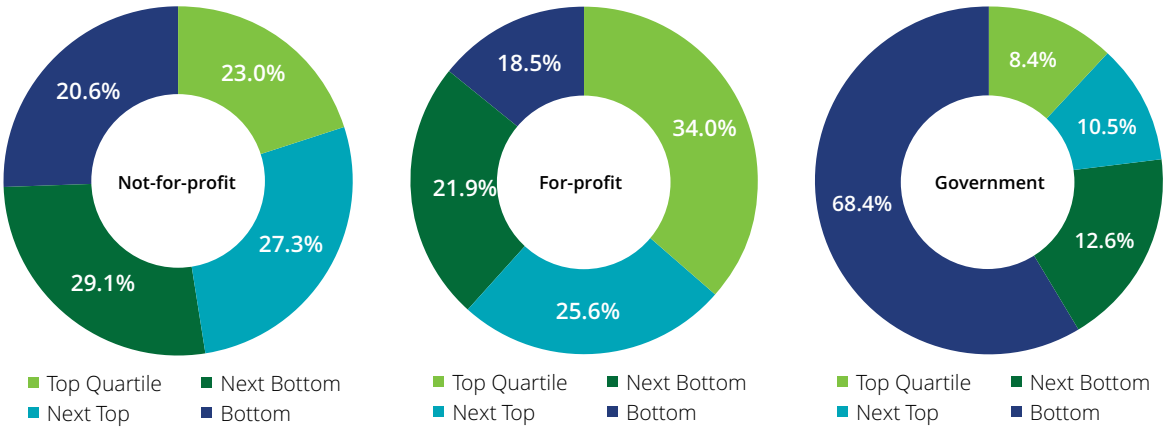



**Chart 9.12: Residential care provider distribution between quartile of average EBITDA per resident per annum 2016-17 – by provider ownership type**



As has been the case with previous years, there is some representation of all ownership types in each quartile.

ACFA noted last year that the organisational and operating structure of Government owned residential care providers, owned by state and local governments, is often quite different to that of the not-for-profit and for-profit providers. Government providers are often co-located with other health services such as hospitals and disability services and government providers often receive funding from state or local governments that affects revenue and thus profits. In addition, there are often differences in accounting practices that can distort GPFR's reporting of profitability depended on by ACFA for aggregate results of the residential care sector.

ACFA notes that without the government providers included, which represent almost 11 per cent of residential care providers, the reported EBITDA of the remaining sector would be $660 or 6 per cent higher than the $11,481 reported. In 2015-16 the difference was 5 per cent. ACFA does note however that while the majority (68 per cent) of government providers are in the bottom quartile, eight (8 per cent) are in the top quartile.

The diverse range of results for the government owned sector was also identified in ACFA's report on *Issues Affecting Rural and Remote Aged Care Providers* which was published in February 2016[43].

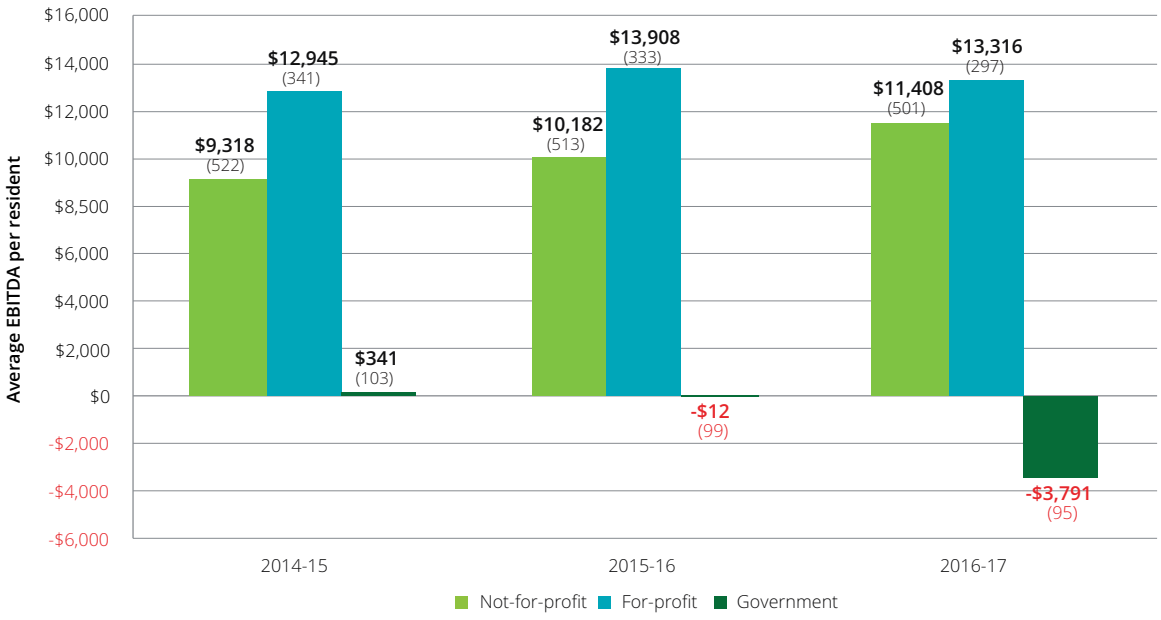
The report highlighted not only the difference in business models and accounting, but also the scale and location of these facilities. Further analysis of the financial performance of the sector with and without government providers is included at Appendix F.

Chart 9.13 shows the average EBITDA for the three years to 2016-17 by ownership type. While the not-for-profits have improved each year, the for-profits and government providers reported a decline in 2016-17 compared with 2015-16.

**By provider location**

A higher proportion (31 per cent) of metropolitan providers are present in the top quartile of ranking by EBITDA per resident compared with regional providers (17 per cent), as shown in Charts 9.14 and 9.15. Conversely, a higher proportion of regional providers were represented in the bottom quartile. Quite interestingly, those regional providers represented in the top quartile recorded average EBITDA per resident almost double that of the metropolitan providers in the top quartile.

**Chart 9.13: EBITDA per resident, by ownership type, 2015-16 to 2016-17**




43 In ACFA's *Report on the Issues Affecting the Financial Performance of Rural and Remote Providers*, it was noted that government owned facilities reported high levels of state/territory and local government subsidies. Detailed analysis on this is not able to be undertaken here.

As was the case with analysis based on ownership type, providers from all locations are present in each quartile.

As shown in Chart 9.16, the EBITDA per resident per annum for metropolitan providers improved over the three years, increasing $1,488 to $12,422 in 2016-17. The EBITDA per resident per annum for regional providers improved $2,604 between 2014-15 and 2015-16, before dropping $789 to $8,257 in 2016-17. The EBITDA per resident per annum for providers operating in both metropolitan and regional locations has remained stable in comparison, dropping $85 to $11,081 in 2015-16 before increasing $12 to $11,093 in 2016-17.

**Chart 9.14: Residential care provider average EBITDA per resident per annum 2016-17, by quartile (number of providers in parentheses) – by location**

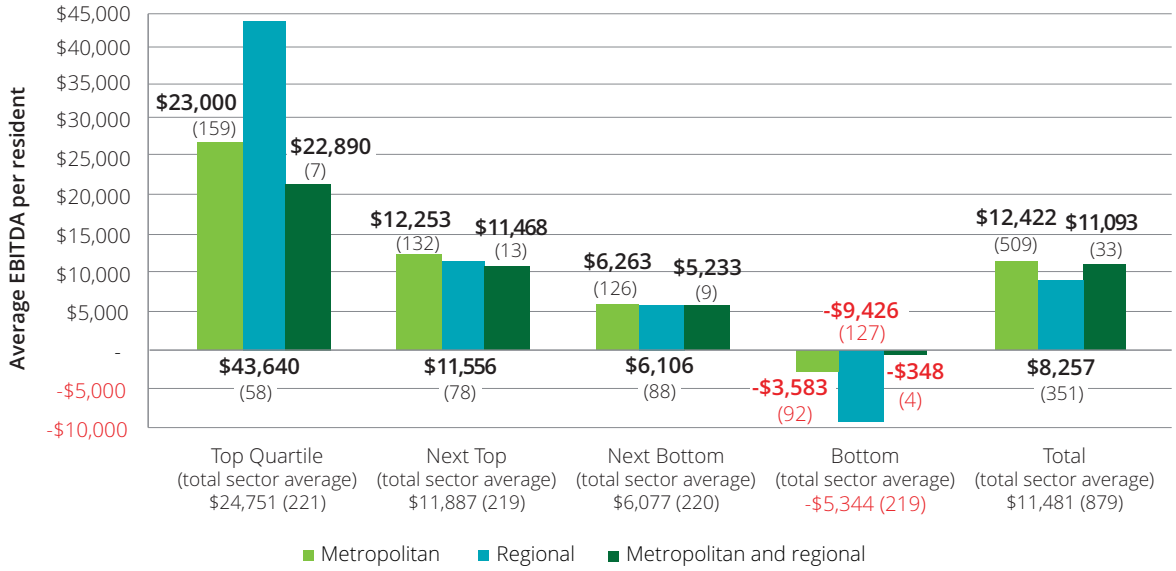



**Chart 9.15: Residential care provider distribution between quartile of average EBITDA per resident per annum 2016-17 – by location**

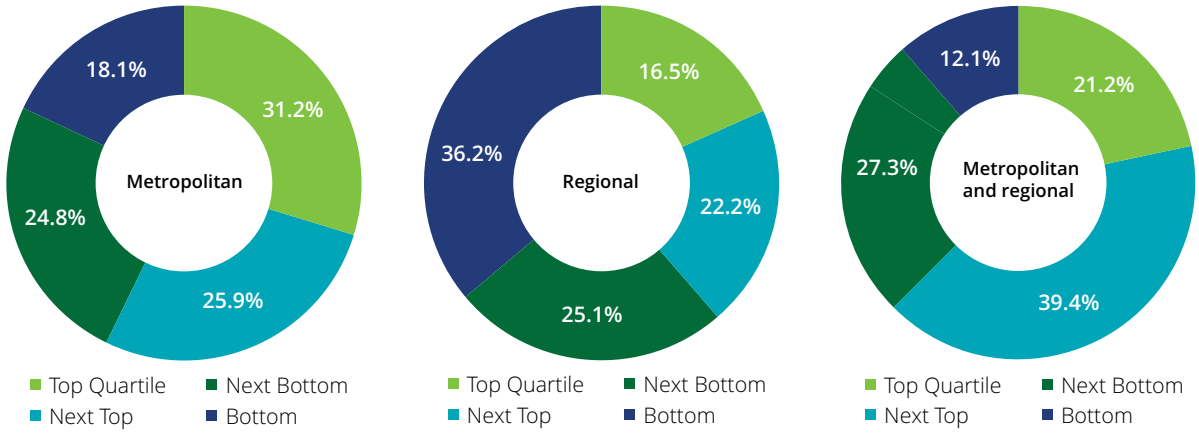
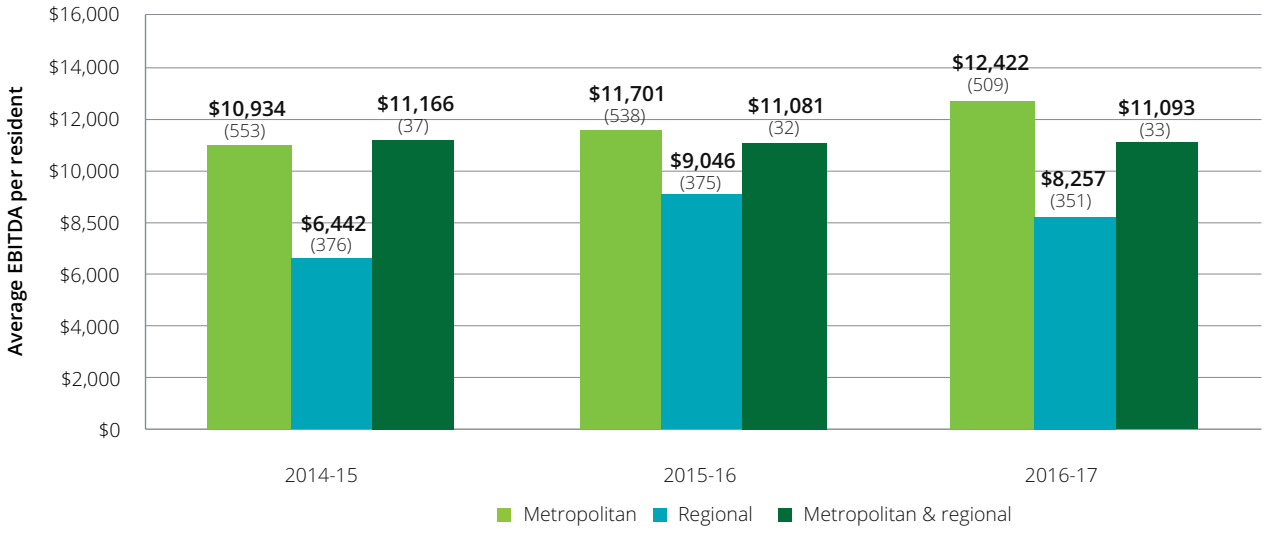


**Chart 9.16: EBITDA per resident, by provider location, 2014-15 to 2016-17**




## By provider scale

While there are only 21 providers who own more than 20 facilities, 16 of these are in the top two quartiles of ranking by EBITDA per resident per annum (Charts 9.17 and 9.18). This high proportion of the larger scale providers being in the top quartiles was also the case in previous years.

Around 63 per cent of all providers operate only one facility. In terms of financial performance, they are spread evenly across all four quartiles. This was also the case with providers who operate two to six facilities. Of the 55 providers who operate between seven and 19 facilities, 55 per cent are represented in the middle two quartiles.

Analysis over the last three years shows that in all three years single home providers and those operating 20 or more homes outperformed providers with between two and 19 homes (Chart 9.19). Single home providers and those operating 20 or more homes have shown an improvement over the last two years compared with 2014-15.

**Chart 9.17: Residential care provider average EBITDA per resident per annum 2016-17, by quartile (number of providers in parentheses) – by provider scale**

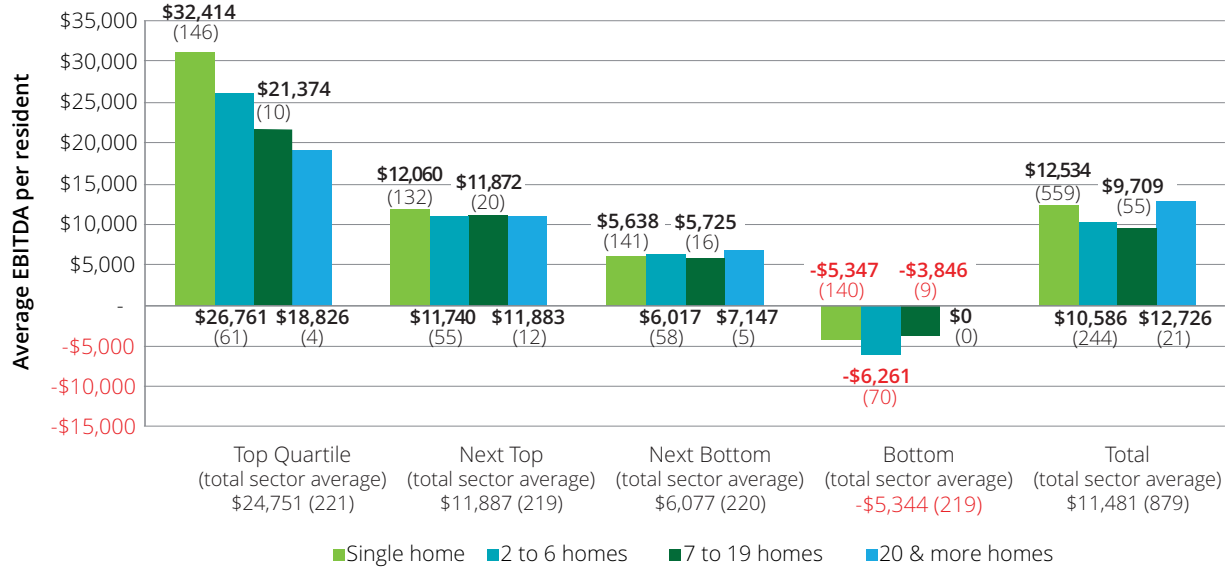


**Chart 9.18: Residential care provider distribution between quartile of average EBITDA per resident per annum 2016-17 – by provider scale**

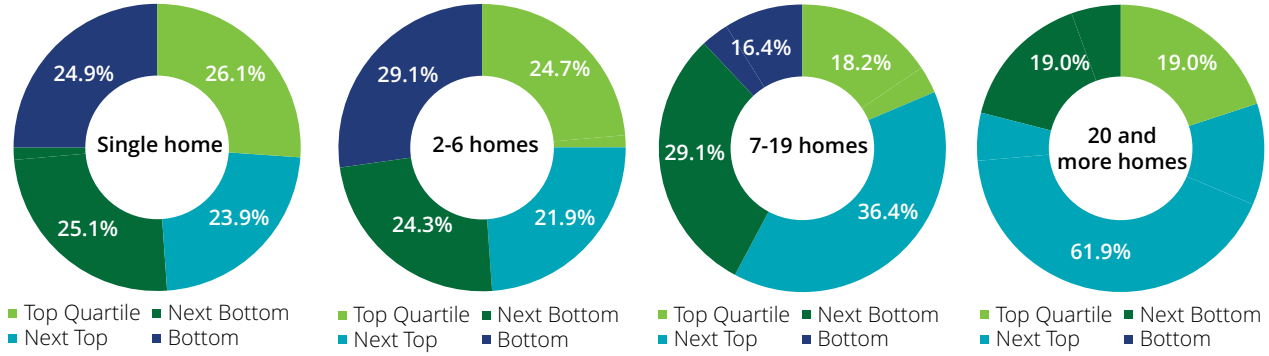
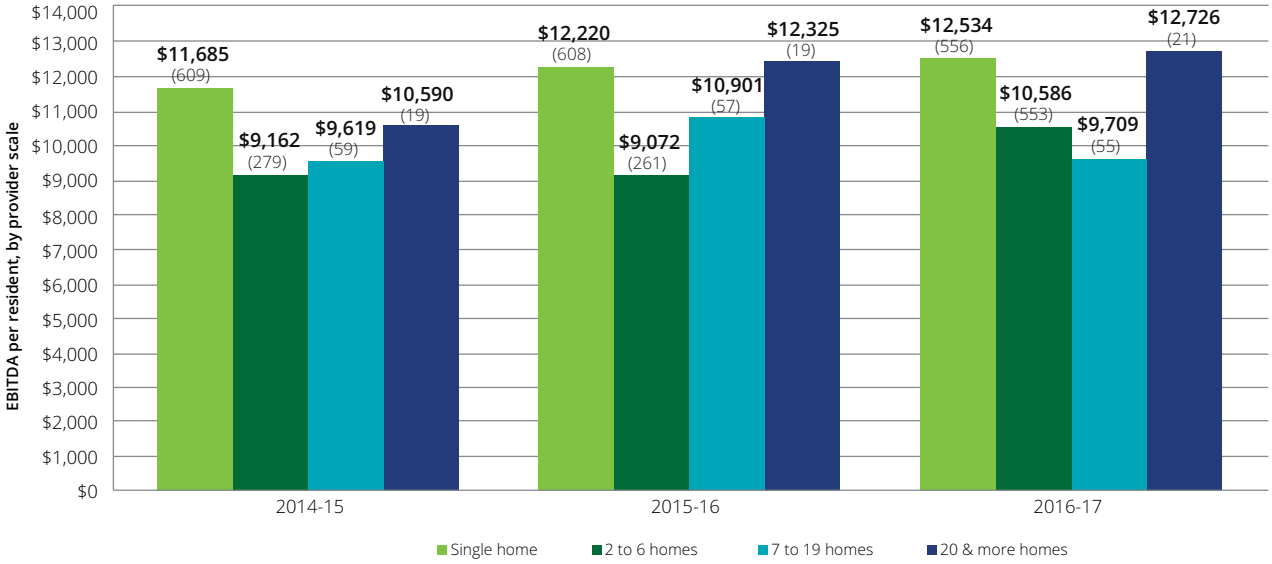



**Chart 9.19: EBITDA per resident per day, by provider scale, 2014-15 to 2016-17**




## 9.3.4 Financial performance analysis 2017-18

The majority of financial analysis presented within this report is based on the 2016-17 financial results, using the latest available Aged Care Financial Reports prepared by residential care providers.

ACFA has however received representations from members of the residential aged care sector with growing concerns about the financial pressures that may impact the sustainability of the sector. Their concern is that revenue is not keeping pace with the growth in expenditure.

With the majority of the analysis in this report based on 2016-17 data, ACFA has reviewed StewartBrown's more recent Aged Care Financial Surveys[44] to gain an insight as to recent developments in the residential aged care sector. Importantly, the data presented in this report is at the provider level whereas analysis and discussion in the StewartBrown survey is at the facility level.

It is also not possible to directly compare results presented for 2016-17 in this report with the results from the StewartBrown survey for the nine months to March 2018 given collection methods and coverage

44 StewartBrown collects detailed financial and supporting data from over 38 per cent of residential aged care facilities through its quarterly Aged Care Financial Performance Surveys.

vary considerably[45]. Nevertheless, the StewartBrown surveys are likely to broadly reflect the developments in the sector as a whole.

The results of StewartBrown's survey for the nine months to March 2018 suggest a decline in the financial performance of residential care facilities in 2017-18.

StewartBrown survey results indicate that as of 31 March 2018, 43 per cent of facilities reported a negative EBT (Earning Before Tax), up from 34 per cent at 30 June 2017, and facilities reporting negative EBITDA also increased to 21 per cent from 16 per cent at 30 June 2017. Whilst the largest proportion of facilities recording losses were in outer regional/remote and very remote areas, significant declines also occurred in inner regional and metropolitan areas.

There were significant declines in average facility EBT and EBITDA in the nine months to March 2018, with EBT decreasing from $3,236 per bed per annum (pbpa) to $1,348, and EBITDA from $8,397 pbpa to $6,884. The decrease was due in part to a significant decline in the care result from negative $0.58 pbpa to negative $7.30 pbpa[46].

The main drivers of the decrease in care results compared with the 12 months to June 2017, as suggested by StewartBrown, centred around:

- Only slight increases in ACFI subsidies, to $172.00 from $171.85 pbpd. While ACFI revenue was impacted in part by the current indexation pause (discussed in section 9.4);
- Increases in care employee costs of 4 per cent or $4.92 pbpd, largely attributable to the additional cost and hours worked in both care management and allied health staffing; and
- Increases in administration and support services of 5.2 per cent or $1.85 pbpd.

Whilst the care result has driven the overall results lower, the accommodation results[47] reported by StewartBrown have improved from $9.95 pbpd to $11.23, or 12.9 per cent, in the nine months to March 2018. The improving accommodation results are predominately due to greater significant refurbishment supplements and lower expenditure on refurbishment by survey participants.

## 9.4 Looking forward

Against the backdrop of the financial developments that have been canvassed, Chapter 11 provides some observations by ACFA on the funding and financing issues confronting the residential aged care sector.

45 Results reported by StewartBrown reflect only the operational results of the facilities they gather data from (approximately 38 per cent of facilities, predominantly in the not-for-profit sector), and thus are generally lower than the results reported through ACFA. They concentrate on care and accommodation results (metrics developed by StewartBrown for the survey) to allow their participating facilities to benchmark their operational performance. One of the larger differences to the results presented through ACFA is that StewartBrown do not include non-operational revenue and expenses, for example they do not include the interest revenue providers earn on accommodation deposits/bonds. ACFA results also include 97 per cent of the for-profit sector, which further improve the sector results.

46 Care and accommodation refer to metrics developed by StewartBrown to assist survey participants in the benchmarking of their operational facility results. Care results = ACFI result + everyday living result + administration result.

47 Accommodation result is the net of accommodation revenue (DAPs/DACs/Accommodation supplements and expenses related to depreciation, property rental and refurbishment costs.

# 10

# Residential aged care: capital investment

# 10. Residential aged care: capital investment

**This chapter provides an overview of capital investment in the residential aged care sector.**

**This chapter discusses:**

- the sources of capital financing for the residential care sector, including the role of Refundable Accommodation Deposits (bonds prior to 1 July 2014)
- key balance sheet metrics for 2016-17
- current investment trends and future requirements

**On 30 June 2017, compared with 30 June 2016, the industry as a whole had:**

- Total assets of $45.0 billion, up from $40.7 billion, which includes:
  - $13.1 billion of current assets, an increase of $1.5 billion; and
  - $31.9 billion of non-current assets, including $23.0 billion of property, plant and equipment[48] and $5.5 billion in Intangibles.
- Total liabilities of $33.7 billion, up from $29.8 billion. This includes $24.8 billion of accommodation deposits held by industry, up from $21.9 billion;
- Net assets of $11.3 billion, an increase of $300 million;
- average return on equity was 18.3 per cent, up from 17.7 per cent; and
- average return on assets was 4.6 per cent, down from 4.9 per cent.

**ACFA Notes:**

- $2.1 billion of new construction work was completed in 2016-17, compared with $1.6 billion in 2015-16; and
- the higher accommodation supplement for new and significantly refurbished facilities that came into effect on 1 July 2014 continues to provide positive incentives for investment in the sector.

48 Additional data was collected through the ACFR regarding non-current assets in 2016-17 which makes comparison with 2015 16 not possible.

## 10.1 Capital financing

Capital for residential aged care providers is comprised of:

- financing from equity investments;
- loans from financial institutions;
- interest free loans from residents in the form of lump sum Refundable Accommodation Deposits (bonds pre 1 July 2014);
- capital investment support from Government by way of capital grants for eligible projects; and
- equity investment and retained earnings.

### 10.1.1 Residents

Lump sum accommodation payments by residents contribute to funding of capital investment in residential care. Refundable Accommodation Deposits (RADs) act as an interest free loan to providers, paid by residents, and play a significant role in financing the industry. At 30 June 2017, a total of $24.8 billion of accommodation deposits (including bonds) were held by providers. Accommodation deposits provide a source of interest income that is included in the other income reported by providers in the operating statement.

As an alternative to RADs, residents may pay Daily Accommodation Payments (DAPs) or a combination of a RAD and DAP (refer to Section 4.3 for discussion on consumer choice). Prior to 1 July 2014 providers were restricted from charging an accommodation bond to residents in a high care place (unless it had extra service status). With the removal of the distinction between high and low care places on 1 July 2014, this restriction was lifted and providers can accept lump sum refundable deposits from all residents except fully supported residents.

Partially supported residents contribute towards accommodation as a Refundable Accommodation Contribution (RAC) or Daily Accommodation Contribution (DAC). In this chapter, references to RADs also include RACs and references to DAPs include DACs.

### 10.1.2 Australian Government

The Australian Government makes capital grants available for services that target communities and geographic areas where there may be insufficient access to capital from other sources. The 2018-19 ACAR is making $60 million in capital grants available to successful approved providers, following a competitive application process.

Data from the Department shows that of the $64 million in grant funding allocated through the 2016-17 ACAR, 90 per cent was allocated to approved providers servicing rural and remote Australia. The remaining 10 per cent was allocated to providers in metropolitan areas with a focus on homelessness and culturally and linguistically diverse (CALD) backgrounds. A total of $415 million was sought by providers for capital grant projects in the 2016-17 ACAR.

Additionally, the higher accommodation supplement, payable where a facility has been built or significantly refurbished since 1 April 2012, is encouraging investment in residential care. Although not strictly a form of capital for providers, it provides an increased rate of return on the capital invested.

### 10.1.3 Other sources of capital finance

Residential care providers also obtain capital finance from investors, financial institution loans and donations. ACFA does not have data across the sector on debt and equity financing, other than that reported in the aggregated balance sheets, which are discussed in this chapter.

## 10.2 Accommodation deposits

At 30 June 2017, refundable accommodation deposits (including bonds) of those providers who submitted their ACFRs, totalled $24.7 billion and comprised 55 per cent of total assets of $45.0 billion and 73 per cent of liabilities ($33.7 billion) for the aged care industry.

At 30 June 2017, there were 87,160 refundable accommodation deposits (including bonds) held by providers (82,006 in 2015-16), with an average value of $283,499 ($267,000 in 2015-16).

### 10.2.1 Accommodation deposit prices

Up until and including the 2015 ACFA report, which reported on the 2013–14 financial year, ACFA reported the average price of new accommodation bonds.

As of 1 July 2014, new accommodation pricing arrangements came into effect. These changes included the following:

- Lump sum accommodation payments became known as Refundable Accommodation Deposits (RADs);
- Providers being able to charge a RAD to any eligible resident whereas they had previously only been able to charge a bond to a low care resident, or a high care resident who had opted for extra services. However providers can no longer deduct a retention amount from the RAD;
- Residents can, at their discretion, choose to pay a RAD, a Daily Accommodation Payment (DAP) or any combination of RAD and DAP; and
- Providers being required to publish the maximum price for their rooms, or part of a room, in their aged care facilities. Residents may negotiate a lower price (known as the agreed price) but cannot be asked to pay more than the published price.

ACFA previously noted that while average accommodation bond prices prior to the 1 July 2014 changes are not directly comparable with the value of RADs following these changes, they can be compared, having regard to the differences noted above, with average and agreed prices following 1 July 2014. It should be remembered that the agreed prices can be a RAD, DAP or combination of the two, which is why there can be no direct comparison with bond prices prior to 1 July 2014.

Charts 10.1 and 10.2 show the average agreed prices since 1 July 2014 and the average new bond prices for the five years prior to 1 July 2014, presented by provider ownership type and location.

For-profit providers recorded the greatest increase in new agreed prices with an average of $402,000 compared with $362,000 in 2015-16, an increase of 11 per cent. This follows a 9 per cent rise in 2015-16 compared with 2014-15. The not-for-profit providers recorded an average new agreed price in 2016-17 of $373,000, 6 per cent higher than 2015-16. Government providers' agreed new price has remained almost the same over the last three years. ACFA notes that in 2014-15, the first year following the reforms, not-for-profit providers had a slightly higher average new agreed price than the for-profits. However, since then the for-profits' price has increased when compared with not-for-profit providers. As noted in Chapter 8, the not-for-profit and government providers operate proportionally more of the places in regional and rural locations compared with the for-profit providers, which would contribute to their lower average prices.

**Chart 10.1: Average price of new accommodation bonds: 2009-10 to 2013–14 and average agreed accommodation prices (lump sum equivalent): 2014-15 to 2016-17 (thousands), by provider ownership type**

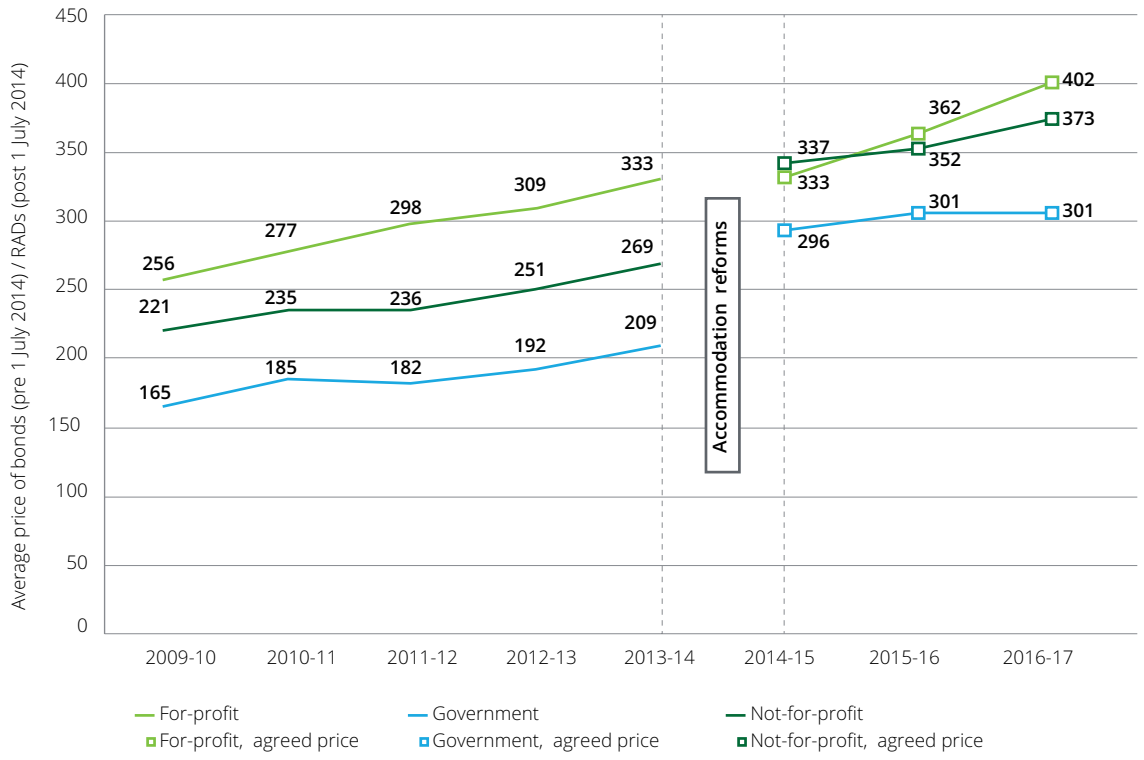
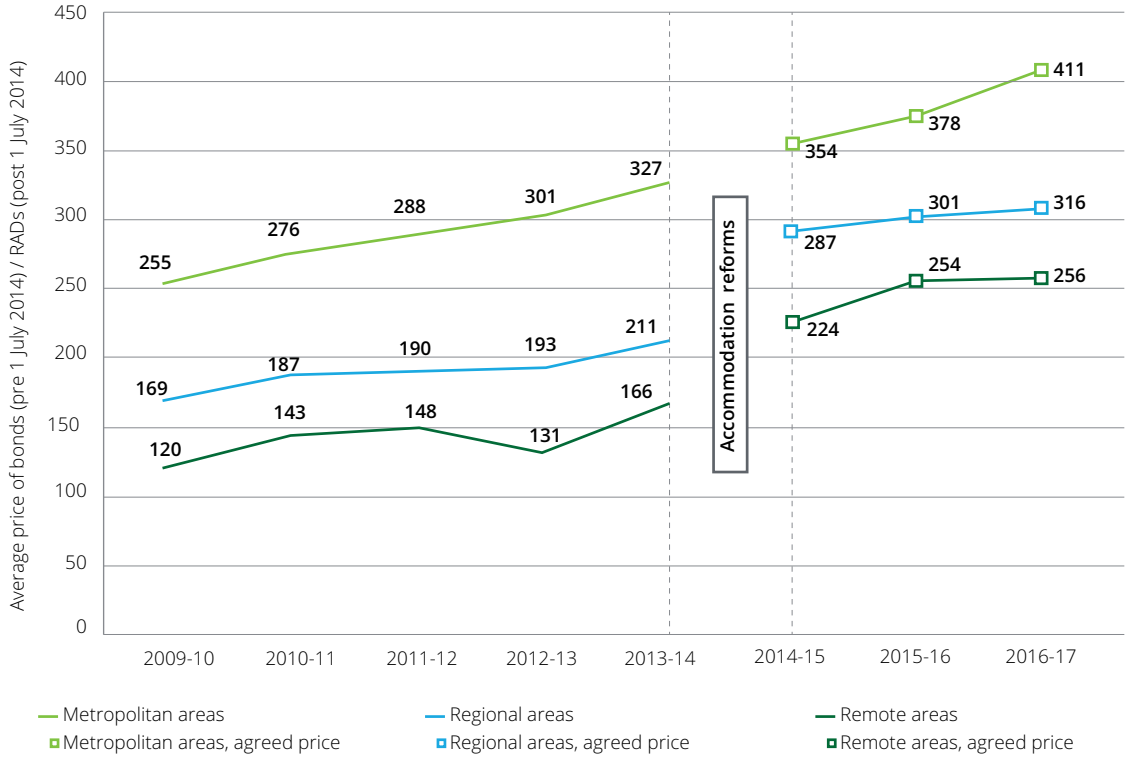



**Chart 10.2: Average price of new accommodation bonds: 2009-10 to 2013–14 and average agreed accommodation prices (lump sum equivalent): 2014-15 to 2016-17 (thousands), by provider location**



In terms of location, agreed prices are significantly higher in metropolitan areas ($411,000) compared with regional and remote areas ($316,000 and $256,000 respectively). This continues the trend which has been evident since 2009-10.

## 10.3 Financing status - balance sheet

This section focuses on the balance sheet of the residential aged care industry, showing the liabilities, assets and net assets. This is indicated in the bottom half of Figure 10.1.

With the introduction of the Aged Care Financial Report (ACFR), further disaggregation of the total assets and liabilities is possible. As this is the first year of the ACFR, comparisons with previous years is not always possible. The disaggregated financial data is presented in Figure 10.1 and Table 10.4. Tables 10.1, 10.2 and 10.3 use the previous methodology to allow for comparisons with previous years.

Using the same methodology as in previous years, Table 10.1 shows the balance sheet of residential care providers for 2016-17 compared with 2015-16. Table 10.2 shows the balance sheet for the five years since 2012-13.

At 30 June 2017, the industry as a whole had total assets of $45.0 billion (an increase of $4.3 billion since 30 June 2016). Current assets increased by 14 per cent proportionally in line with the growth in accommodation deposits. Due to some corrections in the treatment of certain items under the ACFR, there was a significant increase in fixed assets with a commensurate decrease in other non-current assets.

Total liabilities were $33.7 billion (compared with $29.8 billion in 2015-16). This includes the $24.7 billion of accommodation deposits held by industry (up from $21.9 billion in 2015-16).

The sector overall had net equity of $11.3 billion in 2016-17, up from $10.9 billion in 2015-16.

Accommodation deposits, as a proportion of total assets, is a measure that indicates an organisation's leveraging and shows the proportion of total assets that have been financed by accommodation deposits. As shown in Table 10.2, accommodation deposits as a proportion of total assets has been increasing gradually over the last five years from 46 per cent in 2012-13 to 55 per cent in 2016-17.

Other liabilities, which include secured bank and related party lenders, creditors and provisions, represent 20 per cent of total asset financing. This has been stable over the last five years.

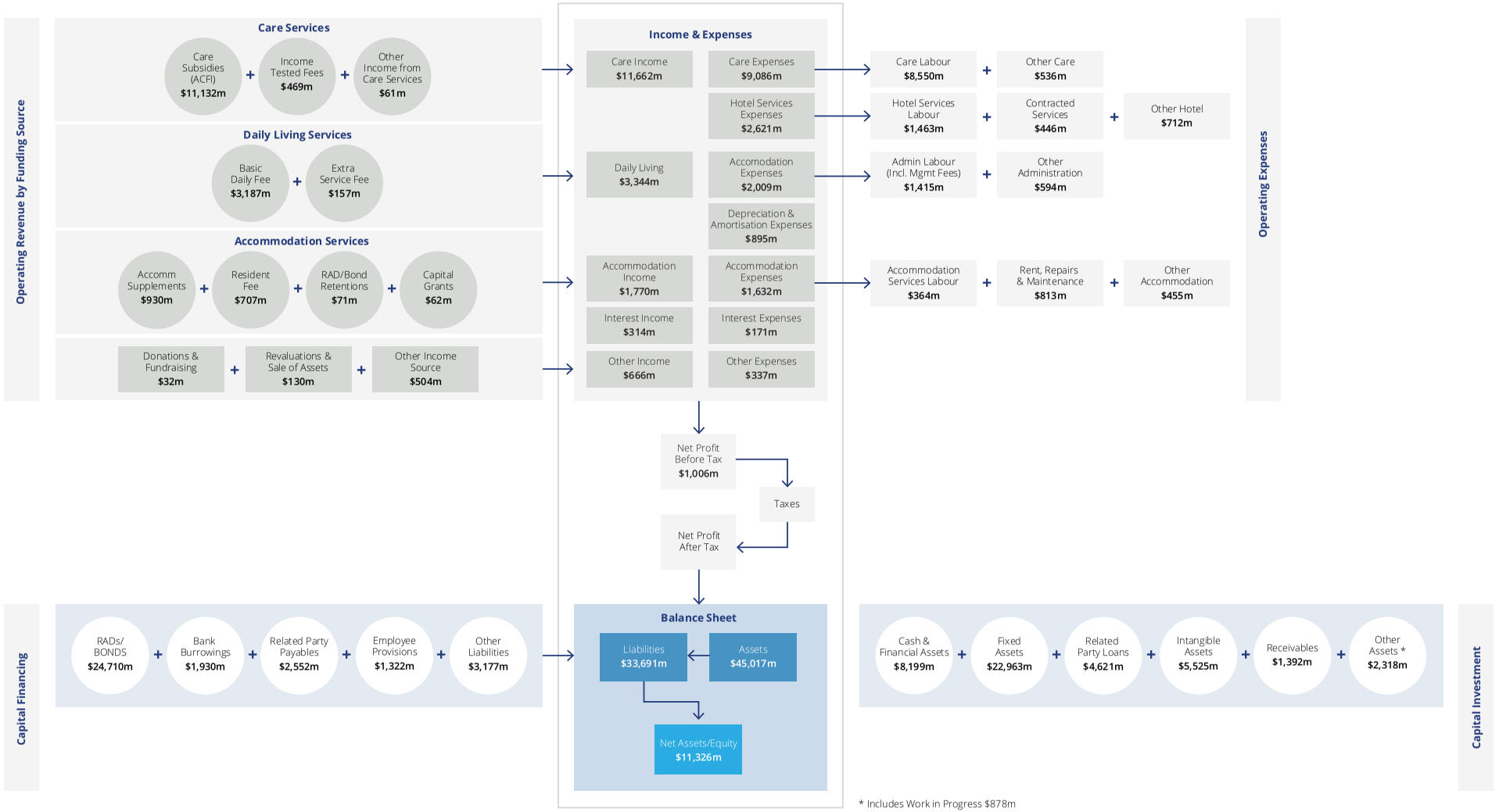
Net worth/total equity as a proportion of assets is a measure of the share of an organisation which is contributed by and held beneficially by the owners/ shareholders. Over the last five years there has been a decline from 33 per cent in 2012-13 to 25 per cent in 2016-17.

**Table 10.1: Balance sheet of residential care providers who submitted their GPFR, 2015-16 and ACFR, 2016-17**

| Assets/liabilities | 2015-16 ($million) | 2016-17 ($million) | Change ($million) | Change (%) |
|---|---|---|---|---|
| Current assets | $11,556 | $13,137 | $1,581 | +13.7% |
| Fixed assets | $11,455 | $22,963 | $11,508 | +100.5% |
| Intangible assets | $3,442 | $5,529 | $2,087 | +60.6% |
| Other non-current assets | $14,240 | $3,388 | -$10,852 | -76.2% |
| **Total assets** | **$40,694** | **$45,017** | **$4,324** | **+10.6%** |
| Accommodation deposits | $21,872 | $24,710 | $2,837 | +13% |
| Other liabilities | $7,878 | $8,982 | $1,104 | +14% |
| **Total liabilities** | **$29,750** | **$33,691** | **$3,941** | **+13.2%** |
| **Net worth/equity** | **$10,943** | **$11,326** | **$383** | **+3.5%** |

Note: One of the main reasons of the significant increase in fixed assets and commensurate decrease in 'other non-current assets' is a correction in reporting of around $9.5 billion of certain property, plant and equipment items in the balance sheet reporting between 2015-16 and 2016-17.

## Figure 10.1: Residential aged care funding/financing sources, 2016-17




* Includes Work in Progress $878m

**Table 10.2: Balance sheet of residential care providers who submitted their GPFR, 2012-13 to 2015-16 and ACFR, 2016-17**

| Assets/ liabilities | 2012-13 ($m) | 2013–14 ($m) | 2014-15 ($m) | 2015-16 ($m) | 2016-17 ($m) |
|---|---|---|---|---|---|
| Cash assets | $3,942 | $3,558 | $5,170 | $5,611 | $8,199 |
| Fixed assets | $9,372 | $10,238 | $10,674 | $11,455 | $22,963 |
| Other assets | $17,539 | $19,866 | $20,742 | $23,629 | $13,855 |
| **Total assets** | **$30,853** | **$33,662** | **$36,586** | **$40,694** | **$45,017** |
| Refundable accommodation deposits | $14,295 | $15,611 | $18,213 | $21,872 | $24,710 |
| Other liabilities | $6,369 | $6,883 | $7,472 | $7,878 | $8,981 |
| **Total liabilities** | **$20,664** | **$22,494** | **$25,685** | **$29,750** | **$33,691** |
| **Net worth/equity** | **$10,189** | **$11,168** | **$10,901** | **$10,944** | **$11,326** |
| **As % of total assets** | | | | | |
| Refundable accommodation deposits | 46.3% | 46.4% | 49.8% | 53.7% | 54.9% |
| Other liabilities | 20.6% | 20.4% | 20.4% | 19.4% | 20.0% |
| **Total liabilities** | **67.0%** | **66.8%** | **70.2%** | **73.1%** | **74.8%** |
| **Net worth/equity** | **33.0%** | **33.2%** | **29.8%** | **26.9%** | **25.2%** |

## 10.3.1 Balance sheet analysis by ownership type

Assets and liabilities have been analysed by ownership type in order to identify differences between not-for-profit, for-profit and government providers. Table 10.3 shows the balance sheets by ownership in 2016-17.

At 30 June 2017, the not-for-profit providers (who hold 56 per cent of places in the sector) had total assets of $24 billion (54 per cent of total industry assets). The for-profit providers had total assets of $19.5 billion.

As has been the case in previous years, the for-profit sector had the highest proportion of liabilities, with total liabilities being 89 per cent of total assets compared with the not-for-profit providers with 66 per cent. This significant difference is representative of the way the for-profits operate in terms of higher leveraging.

Chart 10.3 shows liabilities and net worth/equity as a proportion of total assets. Government providers again had by far the highest net worth/equity as a proportion of assets with 61 per cent followed by the not-for-profit providers (34 per cent). For-profit providers had the lowest net worth/equity as a proportion of assets with 11 per cent, which reflects both a higher proportion of accommodation deposits, greater use of debt to fund investment and greater distribution of profits. These different financing characteristics affect the ratios discussed in the rest of this section.

**Chart 10.3: Liabilities and net worth/equity as a proportion of total assets, 2016-17, by provider ownership type**

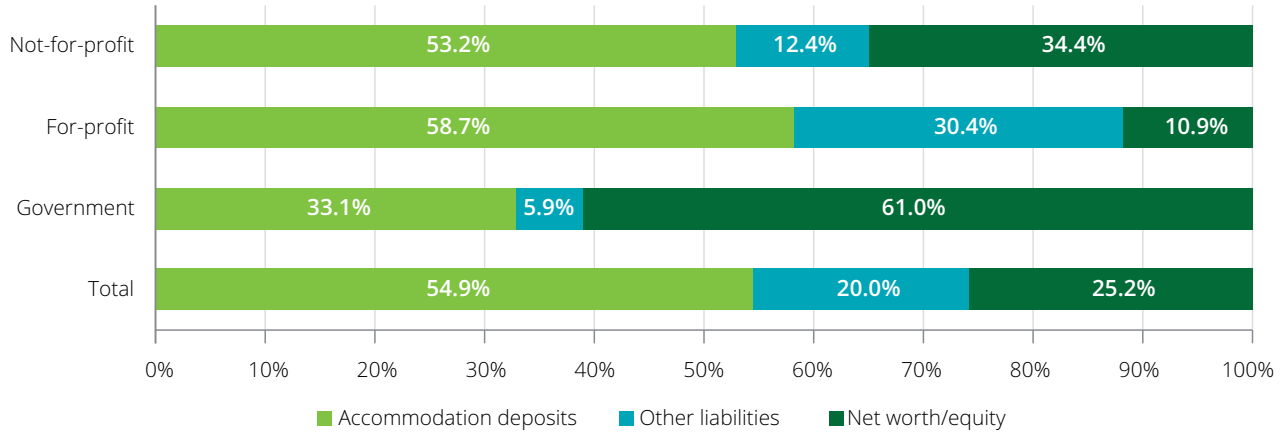


**Table 10.3: Balance sheet, by ownership type, at 30 June 2017**

| | Not-for-profit ($m) | For-profit ($m) | Government ($m) | Total ($m) |
|---|---|---|---|---|
| **Total assets** ***funded by:*** | **$24,017** | **$19,454** | **$1,545** | **$45,017** |
| Refundable accommodation deposits | $12,779 | $11,418 | $512 | $24,710 |
| Other liabilities | $2,980 | $5,911 | $90 | $8,982 |
| **Total liabilities** | **$15,759** | **$17,329** | **$602** | **$33,690** |
| **Net worth/equity** | **$8,259** | **$2,125** | **$942** | **$11,326** |
| **As a % of total assets** | | | | |
| Refundable accommodation deposits | 53.2% | 58.7% | 33.1% | 54.9% |
| Other liabilities | 12.4% | 30.4% | 5.9% | 20.0% |
| **Total liabilities** | **66%** | **89%** | **39%** | **75%** |
| **Net worth/equity** | **34.4%** | **10.9%** | **61.0%** | **25.2%** |

Table 10.4 presents the consolidated balance sheet at segment and organisation level for 2016-17. This has been presented for the first time, and disaggregates the large 'other asset' and 'other liability' categories to present a more comprehensive picture of the assets and liabilities of the sector.

An exception is government organisations, as data is not available to be disaggregated to the same level as not-for-profit and for-profit providers. In future years more detailed comparative analysis, including enhanced balance sheet ratios will be possible for not-for-profit and for-profit providers within the sector.

**Table 10.4: Disaggregated balance sheet by organisation, at 30 June 2017**

| | Total sector ($m) | Not-for-profit ($m) | For-profit ($m) | Government ($m) |
|---|---|---|---|---|
| **Assets** | | | | |
| **Current assets** | | | | |
| Cash | $5,873 | $4,096 | $1,676 | $102 |
| Financial assets | $2,004 | $1,916 | $88 | $0 |
| Trade receivables | $516 | $322 | $194 | $0 |
| RADs & RACs receivable | $876 | $513 | $363 | $0 |
| Related party loans | $2,868 | $191 | $2,677 | $0 |
| Work in progress | $193 | $153 | $40 | $0 |
| Other current assets | $808 | $297 | $132 | $379 |
| **Total current assets** | **$13,138** | **$7,486** | **$5,170** | **$481** |
| **Non-current assets** | | | | |
| Financial assets | $322 | $215 | $107 | $0 |
| Related party loans | $1,752 | $56 | $1,696 | $0 |
| Fixed assets | $22,963 | $14,506 | $7,469 | $967 |
| Work in progress | $685 | $584 | $101 | $0 |
| Intangibles - bed licences | $2,924 | $969 | $1,955 | $0 |
| Intangibles – other | $2,601 | $156 | $2,445 | $0 |
| Other non-current assets | $633 | $46 | $511 | $76 |
| **Total non-current assets** | **$31,880** | **$16,531** | **$14,284** | **$1,064** |
| **Total assets** | **$45,017** | **$24,018** | **$19,454** | **$1,545** |

| | Total sector ($m) | Not-for-profit ($m) | For-profit ($m) | Government ($m) |
|---|---|---|---|---|
| **Liabilities** | | | | |
| **Current liabilities** | | | | |
| Accommodation deposits (including bonds) | $24,710 | $12,779 | $11,418 | $512 |
| Related party loans | $1,497 | $108 | $1,389 | $0 |
| Bank borrowings | $623 | $206 | $417 | $0 |
| Employee provisions | $1,093 | $641 | $452 | $0 |
| Other current liabilities | $2,426 | $1,179 | $1,204 | $43 |
| **Total current liabilities** | **$30,349** | **$14,913** | **$14,881** | **$555** |
| **Non-current liabilities** | | | | |
| Related party loans | $1,055 | $117 | $938 | $0 |
| Bank borrowings | $1,307 | $365 | $942 | $0 |
| Employee provisions | $229 | $127 | $101 | $0 |
| Other non-current liabilities | $752 | $237 | $467 | $48 |
| **Total non-current liabilities** | **$3,342** | **$846** | **$2,449** | **$48** |
| **Total liabilities** | **$33,691** | **$15,759** | **$17,329** | **$603** |
| **Net assets** | **$11,326** | **$8,259** | **$2,125** | **$942** |

As shown in Table 10.4, fixed assets – predominantly residential aged care facilities infrastructure – are the single largest asset category held by providers ($23 billion or 51 per cent of total assets). It is also the largest asset category based on ownership type, although it is notable that for the not-for-profit providers, fixed assets represent 60 per cent of total assets whereas for the for-profit providers it is 38 per cent. The significant difference is likely explained in part by providers in the for-profit sector being more likely to rent the facilities they provide residential services in, often under arrangements where the facilities are rented from related party entities.

Cash ($5.9 billion) and financial assets ($2.0 billion current and $0.3 billion non-current) represent $8.2 billion (18.6 per cent) of total assets, and $7.9 billion (60 per cent) of current assets. Not-for-profit providers hold 80 per cent, or $7.6 billion of current assets in cash and financial assets, while for-profit providers hold 34 per cent, or $1.9 billion. This indicates that the for-profit providers are more active in investing their funds, often in categories other than fixed assets.

Intangible assets make up 12 per cent, or $5.5 billion of total sector assets. Of the $5.5 billion, bed licences make up 53 per cent, or $2.9 billion, and other intangibles of $2.6 billion, consisting mostly of goodwill held by the for-profit sector, makes up the remainder of this balance. For-profit providers hold 80 per cent, or $4.4 billion of the intangibles balance for the sector. It is of note that whilst for-profit providers hold 39 per cent of residential operational places, they account for 67 per cent of the value attributed to bed licences.

ACFA notes that the Government announced in the 2018-19 Budget that it will fund an impact analysis of allocating residential aged care places to consumers instead of providers.

Another significant area of investment is related party loans. While related party loans make up 10 per cent ($4.6 billion) of total assets, for-profit providers hold $4.4 billion of this balance. Some of this might be explained by residential facilities being held by related parties, but as 61 per cent ($2.7 billion) of related party loans are classified as current assets (receivable within 12 months), and fixed assets are non-current in nature, only a portion can be attributable to this.

Given the regulated permitted uses of RADs and bonds, the build-up of categories of assets other than fixed assets is noteworthy. A formal review of the use of RADs and bond financing is part of the annual focus of the Department of Health in their examination of Annual Prudential Compliance Statements. It is important that as RADs and their related investments continue to grow, Government regulation and oversight keep pace with the expanding sector.

In terms of total liabilities, RADs (including bonds) make up 73 per cent ($24.7 billion) of the capital funding of the sector. Fifty-two per cent of RADs are held by not-for-profit providers, 46 per cent by for-profit providers and 2 per cent by government providers. With 39 per cent of places held in the sector, the for-profit providers hold the highest proportion of RADs and bonds. Conversely the not-for-profit providers have proportionally, significantly less RADs as they hold 56 per cent of places.

Other capital funding sources include:

- Bank borrowings which make up 6 per cent, or $1.9 billion of total liabilities. The for-profit sector hold 72 per cent, or $1.4 billion, while not-for-profit providers have borrowed 28 per cent, or $0.5 billion; and
- Related party loans which make up 8 per cent, or $2.6 billion of total liabilities. The for-profit sector once again holds the majority of this funding with 91 per cent, or $2.3 billion of borrowings.

Other liabilities make up 9 per cent, or $3.2 billion of total liabilities. Other liabilities include balances that have not been disaggregated from data submitted from providers. Other liabilities include items, but not limited to; deferred revenue, trade and other payables, income tax payable, deferred tax liabilities, financial instruments such as interest rate swaps, other financial liabilities such as lease arrangements, and non-employee related provisions.

## 10.3.2 Balance sheet performance ratios

Balance sheet ratios are calculated from the financial results and performance of providers. Balance sheet ratios provide an indication of the financial health of providers across the sector through analysis of their levels of profitability, liquidity and efficiency as well as their net worth.

### Balance sheet performance ratios – definitions

**Current Ratio**

Current ratio is a measure of an organisation's ability to meet its short term obligations (current liabilities) from its current assets. The current ratio measures an organisation's liquidity and provides an indication of risk that the organisation may not be able to meet its short term obligation as and when they fall due. It is calculated by dividing current assets of an organisation by its current liabilities.

Generally, a current ratio of at least 1.0, shows that an organisation has sufficient current assets to meet its short term obligations. However the requirement to categorise accommodation deposits as current liabilities49 on the balance sheet means that the current ratio needs to be treated with some caution and considered with other financial indicators of liquidity for aged care organisations. This is because, although refundable accommodation deposits (RADs) are required to be repaid when a resident leaves care, they are more often than not, repaid after a stay of longer than one year. The average length of stay for residents is currently just over three years.

**Net Assets Value**

The net assets value provides an indication of the value of an organisation. The net assets value is determined by taking the total assets of an organisation and subtracting the total liabilities. A low net assets value or a decrease in the value over time indicates higher levels of financial risk for lenders and consumers.

**Debt Ratio**

The debt ratio is calculated by dividing an organisation's total liabilities by its total assets and provides an indication of the degree of financing of an organisation. Within the aged care sector, total liabilities will consist of an organisation's refundable accommodation deposits as well as other secured and unsecured debt balances. An organisation's total assets will include cash and asset balances to which the refundable accommodation deposits may have been applied. As total liabilities increase as a proportion of total assets, the higher levels of debt could reflect the use of additional borrowings used to fund an organisation's improvements and expansions.

**EBITDA to assets ratio**

The EBITDA to total assets ratio measures the operating return generated from an organisation's total assets. The ratio is a measure of financial performance and is calculated by taking the earnings, before interest, tax, depreciation and amortisation (EBITDA) and dividing this by the organisation's total assets. Generally, the higher the EBITDA to total assets ratio, the better the level of return generated from the organisation's total assets.

**EBITDA to total equity/net worth/net assets ratio**

The EBITDA to total equity ratio measures the operating return generated from an organisation's total equity or their net assets. The ratio is a measure of financial performance and is calculated by dividing an organisation's earnings, before interest, tax, depreciation and

49 The requirements for the presentation of financial statements is set out in AASB 101 and paragraph 69(d) relates to liabilities where there is no right to defer settlement of the liability for at least 12 months after the reporting period. The average length of stay of a resident is three years and as a result, the liability for repayment of an accommodation deposit can extend beyond 12 months after year end if the resident is still in care.

amortisation (EBITDA) by the organisation's total equity or net asset position. Generally, the higher the 'EBITDA to total equity ratio', the greater the level of return on the owners' contribution and retention of earnings over time.

As illustrated in Chart 10.4, the current ratio and EBITDA to total assets ratios decreased slightly between 2015-16 and 2016-17. This was after being stable in the previous two years. The EBITDA to Equity/net worth/net assets ratio did however increase to 18.3 per cent after increasing from 16.0 to 17.7 in 2015-16. This indicates an improvement in the level of results derived across the net assets of the sector.

Chart 10.5 shows the balance sheet ratios by provider type.

In 2016-17, the current ratio for not-for-profit providers decreased to 0.46 compared with 0.58 and 0.55 in the previous two years. Although the current ratio for the not-for-profits declined, it was still higher than the current ratio achieved by the for-profit providers which was steady at 0.35 in 2016-17. As noted, a current ratio of less than 1.0 ordinarily indicates an organisation has insufficient assets to meet their obligations when they become due and payable. However, although refundable accommodation deposits can become repayable at any time and are classified as current liabilities, in practice, the repayment period for accommodation deposit balances will vary in line with each resident's tenure. This means that the current ratio result should be used with some caution and considered with other financial indicators in the residential aged care sector.

**Chart 10.4: Balance sheet performance ratios, 2015-16 and 2016-17**

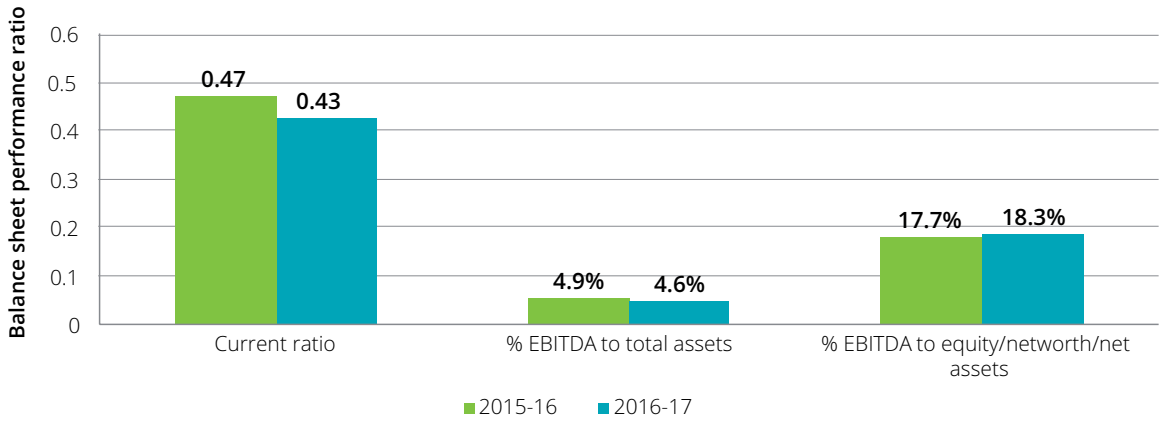
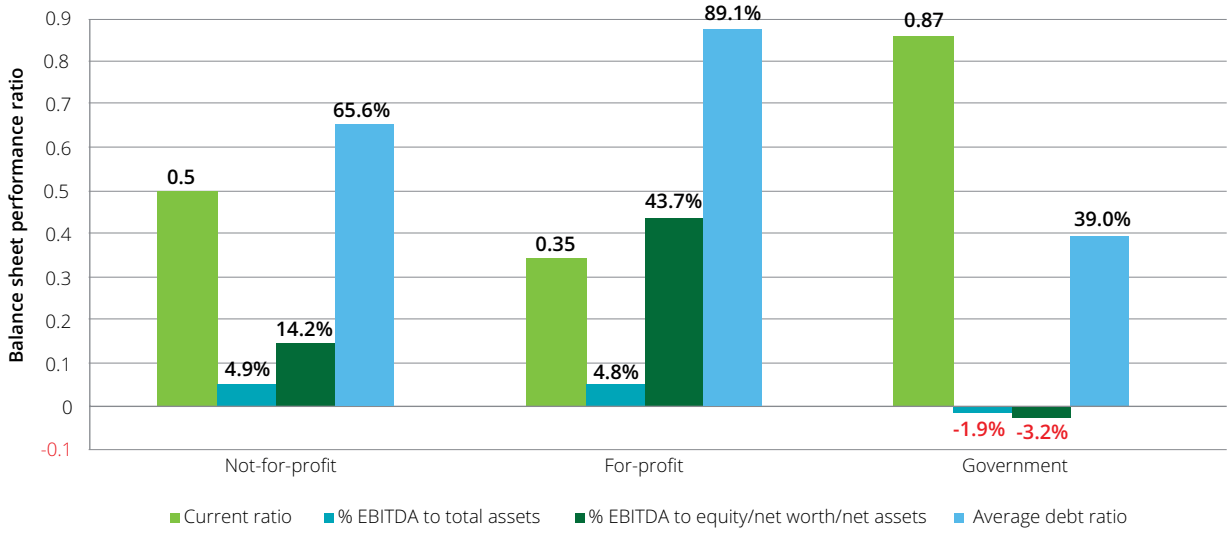



**Chart 10.5: Balance sheet performance ratios at 30 June 2017, by provider type**



The average debt ratio across the sector again increased slightly with all three ownership types recording an increase compared with 2015-16. The average debt ratio shows the proportion of organisational assets that are financed through debt. A ratio of more than 1.0 indicates that an organisation has a higher debt level than the value of its assets.

The EBITDA to total assets was almost the same for the not-for-profit providers (4.9 per cent) as it was for the for-profit providers (4.8 per cent) however there was a significant difference in terms of the EBITDA to Net Worth assets (14.2 and 43.6 per cent respectively).

Chart 10.6 shows the balance sheet metrics by ownership type in 2016-17, compared with 2015-16. For the whole of sector, the average for all accommodation deposits held increased to $283,499 per resident from $266,717 in 2015-16, an increase of 6 per cent. This metric measures the average value of all bonds (pre 1 July 2014) and accommodation deposits (post 1 July 2014) that providers hold. Net worth/equity decreased for the for-profit providers by around $5,000 (15.7 per cent) in 2016-17 whereas the not-for-profit recorded a 7.6 per cent increase.

## 10.4 Investment requirements

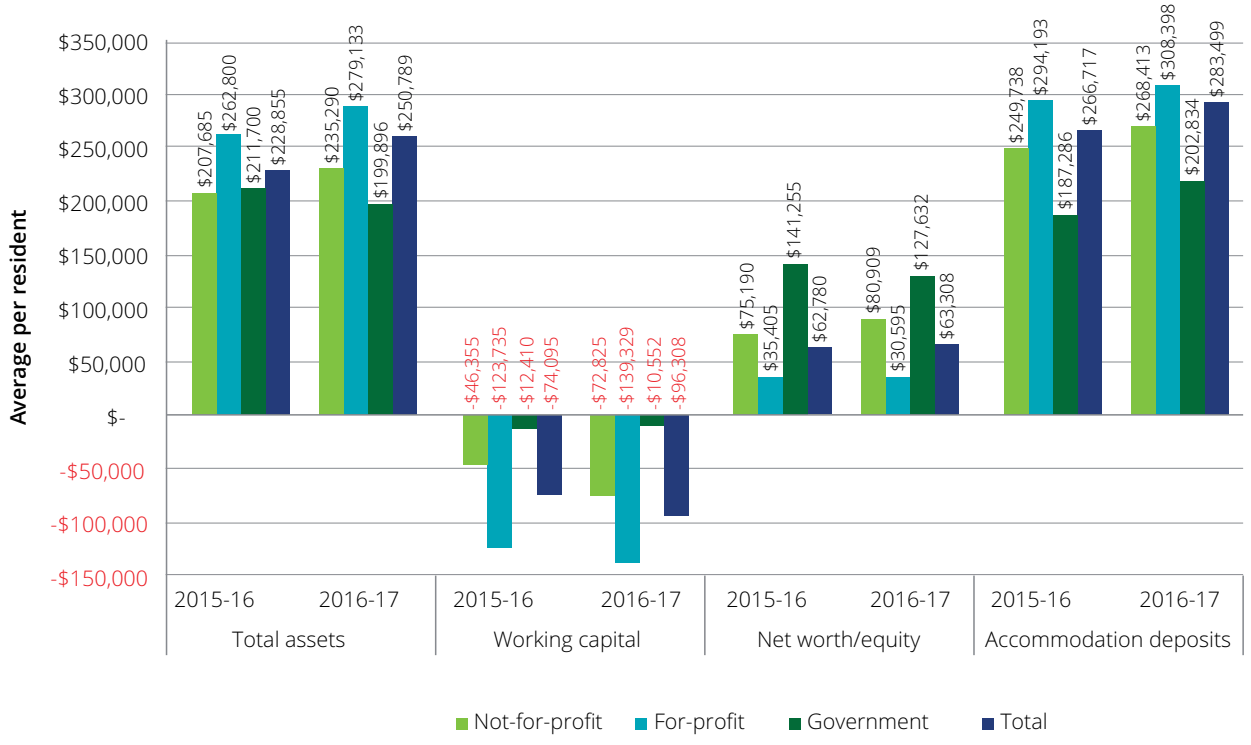
The Department maintains a model that forecasts the future requirements for investment in residential aged care based on the Government's current target provision ratios. The number of places required and the total investment requirement over the next decade have been published in previous ACFA reports. In early 2018, Deloitte Access Economics was engaged by the Department to review and redevelop the model, and provide advice on improving the reporting of the model's outputs. The following analysis is based on the model developed by Deloitte Access Economics.

The model estimates the sector's annual investment requirement for residential care over the next decade, based on the Government's current target provision ratio. These estimates are based on a number of key assumptions:

- the current service target provision ratios continue;
- the cost of construction and land continue to grow at about 2.4 per cent and 4.4 per cent each year respectively; and
- the average lifetime of an aged care building is about 40 years, so that the current stock will need to be replaced over the next four decades.

It is estimated that the residential care sector will need to build an additional 88,110 places over the next decade (Chart 10.7) in order to meet the target

**Chart 10.6: Average balance sheet metrics by resident, 2015-16 and 2016-17, by provider type**



provision ratio of 78 operational places per 1,000 people aged 70 and over.

At the same time, the sector will need to rebuild a substantial proportion of its current stock. Assuming that a quarter of the current stock of buildings is rebuilt at an even rate over the next decade, it is estimated that the investment requirement of the sector over the next decade is in the order of $54.0 billion.

In 2016-17, ACFA reported that the annual investment requirements would increase from $2.8 billion in 2016-17 to around $4.2 billion in 2026-27. The results from the revised model are considerably higher for a number of reasons:

- the model now includes annual upgrade costs, which are estimated to increase from $0.7 billion in 2017-18 to $1.2 billion by 2026-27;
- allowing for the lag in building times brings investment requirements for new places forward;
- the average cost of a new place and a rebuilt place are approximately $77,000 and $33,000 higher than the assumptions in the old model, respectively; and
- other differences, including a higher number of places and indexation, which increase the investment requirements over time – for example, land is indexed at approximately 4.4% per annum compared to 2.4% per annum in the previous calculations.

This increase in investment requirements will necessitate several inputs in order to be met, including:

- continued subsidised operational funding from the Commonwealth on behalf of supported residents;
- consumer contributions to operational funding;
- capital financing from residents (in the form of refundable accommodation deposits), providers, investors and financiers and the Commonwealth;
- industry wide access to detailed medium term demographic forecasts to ensure correct siting of future facilities; and
- availability of greenfield sites for the construction of new aged care homes in the areas needed.

Chart 10.8 shows the investment needed over the next decade to construct the new aged care places required to cater for the impact of the baby boomer generation on the number of places generated under the provision ratio. Over the next decade, there is a steep ramp up from $4.7 billion needed in 2017-18 to around $6.2 billion in 2026-27.

The pattern in annual investment, including the slight contraction in 2019, reflects the underlying growth in the 70 years and over population and most notably the large number of births in 1946.

The calculation of future annual investment requirements are predicated on achieving the current service target provision ratios in each year. The residential care planning targets apply at the national level only and there are many planning considerations that affect the relative supply of places in each location, such as local demand profiles and building costs. The investment requirements reported here for each state and territory are based on allocating places to each jurisdiction in a manner that would get that jurisdiction as close to the national target as possible while minimising variation in allocation amounts each year.

**Chart 10.7: Number of operational residential aged care places required in the next decade**

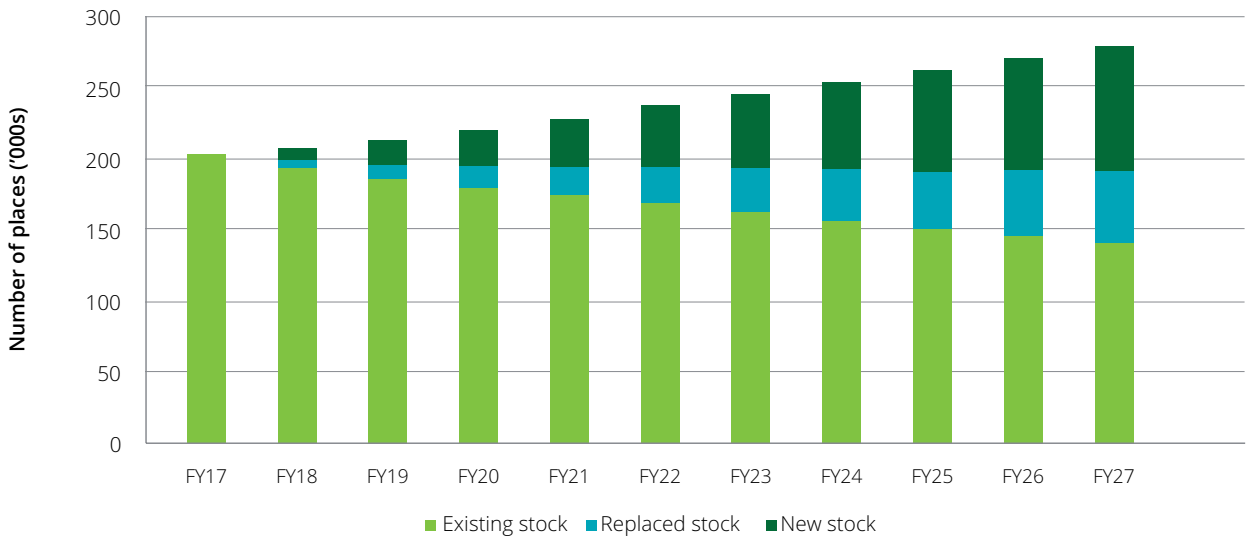


**Chart 10.8: Future annual investment requirement, 2017-18 to 2026-27**


The total estimated investment requirements for each state and territory over the next decade are broadly in line with the distribution of the older population. The notable exception to this is Western Australia which currently has 8 per cent of total places and 12 per cent of the total investment requirement. The major reason for this anomaly is that Western Australia is currently relatively undersupplied compared with what the national target would dictate and is therefore projected to be allocated a disproportionately high number of places over the next ten years. In addition, the average cost of construction in Western Australia is higher than the national average.

As noted in Chapter 5, the residential care planning targets are likely to over-estimate the places required to ensure sufficient provision levels during the short term. This is because the cohort that predominantly access residential care – the population aged 85 and over – is declining as a proportion of the 70 and over population on which the target provision ratios are based.

As at 30 June 2017 there were 39,294 provisionally allocated mainstream residential care places, meaning that they have been allocated to aged care providers but not yet made operational due to the building time required to bring a place online. In addition to the relatively large stock of provisionally allocated places in the development pipeline, demand by providers for new places was strong in the 2016 ACAR, with 45,053 places sought by providers, (a 15 per cent increase on the 2015 ACAR) compared with the 10,000 places advertised. The 2018-19 ACAR announced by the Government is seeking applications for 13,500 new residential care places.

### 10.4.1 Recent trends in investment in the residential care sector

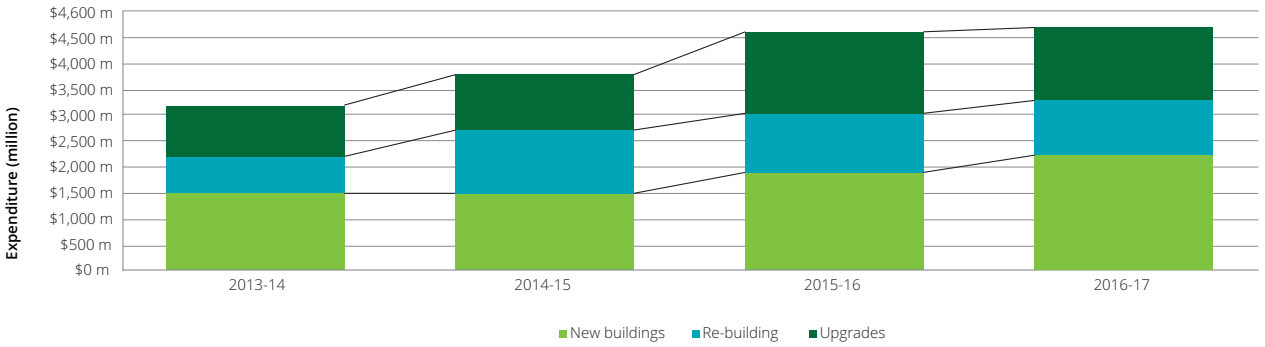
ACFA noted in its previous two annual reports that investment trends appear to have been improving since the 1 July 2014 reforms. In 2016-17 these trends generally continued with building work and building approvals improving significantly. However, the proportion of providers reporting they are intending to build reported a noticeable decline.

The 2017 Survey of Aged Care Homes estimated that a total of $2.1 billion in new building, refurbishment and upgrading work was completed during 2016-17, up from $1.6 billion in 2015-16. The amount of new building work in progress at the end of June 2017 was estimated at $2.6 billion.

ACFA notes that the total completed work in 2016-17 was $4.7 billion, compared with $4.5 billion in 2015-16 (Chart 10.9).

ACFA concludes that investors have responded positively to the 1 July 2014 reforms and are showing interest in investments that leverage the ageing demographic, although notes the drop in providers reporting building planning in 2016-17.

**Chart 10.9: Residential aged care building activity, 2013–14 to 2016-17**




## 10.4.2 Building and construction statistics

Chart 10.10 shows the proportion of homes planning to either rebuild or upgrade over the period 2013-14 to 2016-17. The proportion in 2016-17 is significantly lower than in previous years. ACFA will monitor this to see if the trend continues.

Notwithstanding the decline in planned building, upgrading and rebuilding work reported in the Survey of Aged Care Homes, building statistics data from the Australian Bureau of Statistics showed strong signs of building in the sector in 2016-17. There were 397 building approvals for aged care homes in the 12 months up to the end of February 2018, compared with 395 for the same period up to February 2017 (Chart 10.11).

**Chart 10.10: Proportion of homes planning to either upgrade or rebuild, 2013-14 to 2016-17**

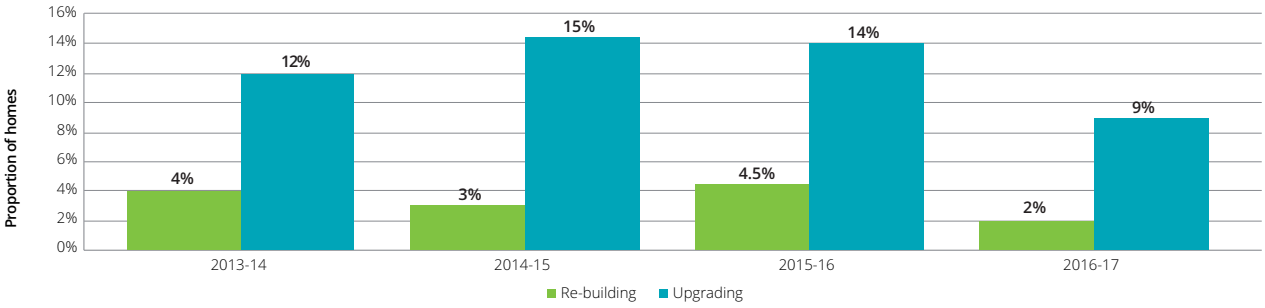
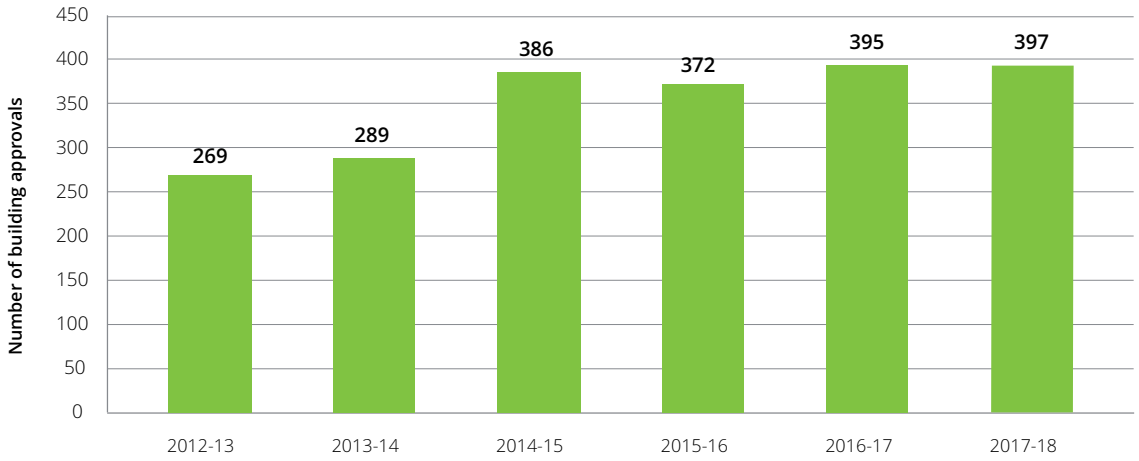


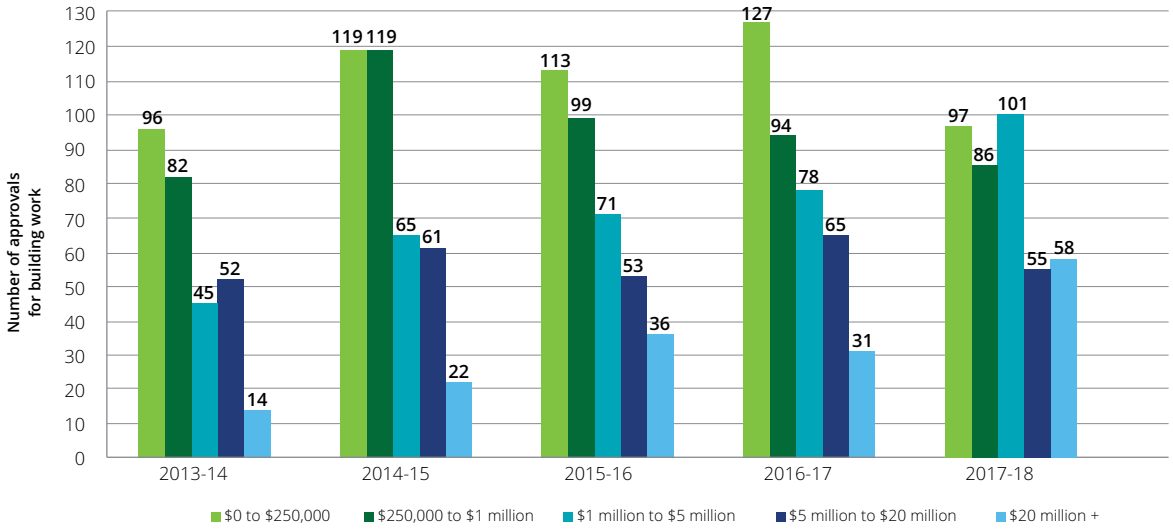

**Chart 10.11: Residential aged care building approvals, 2012-13 to 2017-18**




Note: Dates are from March to February

The value of building approvals has increased significantly in the 12 months up to February 2018, with average monthly total building approvals for aged care facilities being $232 million per month, compared with $149 million (per month) in the previous 12 months. The main driver of this increase is building approvals of $20 million and over which increased from 31 to 58 in the 12 months to February 2018, as shown in Chart 10.12.

**Chart 10.12: Number of building approvals, by value of building work, 2013-14 to 2017-18**



# 11

# Funding and financing challenges in the residential care sector

# 11. Funding and financing challenges in the residential care sector

**This chapter provides an overview of the challenges and pressures facing residential aged care providers.**

**This chapter discusses:**

- recent financial results in a historical context
- ACFI claims growth and indexation, including the views of the sector and Government
- the importance of appropriate indexation for stability and confidence in the industry
- demographics and longer term investment
- the role of consumers in funding residential aged care

**ACFA Notes:**

- The importance of a funding tool and assessment arrangements that accurately and objectively assess the funding needs of residents;
- the desirability of considering indexation settings alongside the review of residential aged care funding options; and
- while it can be challenging to balance higher contributions with protections for consumers, changes to the basic daily fee and appropriately charged additional service fees could have a significant impact on the financial viability and sustainability of providers.

## 11.1 Introduction

Detailed analysis of the financial results of the residential care sector is contained in Chapter 9, including analysis by provider type, size and location. This chapter provides ACFA's observations on the funding and financing issues and challenges facing the sector.

To deliver the care that aged consumers need and desire into the future, it is critical that the residential aged care sector is financially viable, stable, efficient, effective, responsive and sustainable.

All stakeholders – Government, providers, consumers and the aged care workforce – have key roles in contributing to this objective. Against the background of the developments in the funding and financing of the aged care sector canvassed in Chapters 7, 9 and 10, in this chapter ACFA highlights some of the specific challenges confronting stakeholders. In summary, these include:

For Government – there is a need for a more stable, more contemporary, more efficient and more effective funding tool and system which provides greater financial stability to both the residential aged care sector and the Government. The Government also has the continuing challenge of ensuring ongoing equity of access for all consumers and that its funding arrangements do not incentivise outmoded or inefficient care practices and use of resources.

For providers – there is an increasing need to look at their internal operations to ensure they are delivering quality care in the most efficient and effective way. The changes taking place in the sector as it moves towards a more consumer driven and market based system will continue to challenge traditional business and workforce models. Providers will need to be increasingly responsive and flexible. Under the current funding system there are very diverse financial outcomes, with the top quartile of providers in terms of profit continuing to achieve significantly better results than the lowest quartile. This very wide variation in financial performance across the sector suggests there is scope for many providers to pursue greater efficiencies and improve their results.

For consumers – there is a need for wider recognition that sustainable aged care funding arrangements will require those consumers who can afford to do so making a greater financial contribution towards their everyday living expenses and care costs, complemented by greater choice of higher quality services.

Before examining these issues in more detail, it is useful to highlight the key financial metrics of the sector.

## 11.2 Residential care – revenue, expenses and balance sheets

The following section provides a broad overview of some of the main financial aspects of the sector in 2016-17, though as noted in Chapters 7 and 9, there is a wide variation across providers in the sector.

### 11.2.1 Revenue and Expenses

As shown in Table 11.1, care related funding under the Aged Care Funding Instrument (ACFI) from Government, is the dominant revenue source for residential aged care providers, accounting for 60.5 per cent of revenue in 2016-17. The next main source is the basic daily fee paid by residents for living expenses (18 per cent), followed by the Government accommodation supplement for supported residents (5 per cent) and daily accommodation payments from residents (4 per cent). Other revenue sources are relatively minor in comparison.

Overall the Government provides approximately 68 per cent (based on 2016-17 data) of the revenue of providers, consumers 26 per cent and other income the remainder.

Expenses (Table 11.2) are dominated by wages at 67.5 per cent, followed by other operational expense categories of; accommodation (rent, repairs and maintenance, rates, utilities etc) at 7.6 per cent, hotel expenses (contracted hotel service, catering, cleaning, laundry etc) at 6.9 per cent, depreciation at 5.3 per cent, administration expenses at 3.6 per cent, care expenses (medication, oxygen, mobility equipment, treatment and procedures, recreational activities etc) at 3.2 per cent, management fees at 2.9 per cent, and all other expenses at 2 per cent.

**Table 11.1: Revenue sources, residential care providers, 2016-17**

| Revenue source | $m | Proportion of total revenue |
|---|---|---|
| **Government** | | |
| Basic care subsidy (ACFI) | $10,741.7 | 60.5% |
| Respite subsidy | $301.4 | 1.7% |
| Other care and accommodation supplements | $89.3 | 0.5% |
| Accommodation supplements | $929.7 | 5.2% |
| Capital grants | $61.7 | 0.3% |
| **Total Government revenue** | **$12,123.8** | **68.3%** |
| **Consumer** | | |
| Basic daily fee | $3,186.7 | 17.9% |
| Means tested care fees | $468.9 | 2.6% |
| Resident care fees – other[50] | $61.2 | 0.3% |
| Accommodation payments | $778.4 | 4.4% |
| Extra services fee | $157.5 | 0.9% |
| **Total resident revenue** | **$4,652.7** | **26.2%** |
| **Other** | | |
| Interest | $313.8 | 1.8% |
| Donations and fundraising | $32.3 | 0.2% |
| Other | $634.0 | 3.6% |
| **Total other revenue** | **$980.1** | **5.5%** |
| **Total revenue** | **$17,756.5** | **100.0%** |

**Table 11.2: Expense items, residential care providers, 2016-17**

| Expense item | $m | Proportion of total expenses |
|---|---|---|
| Wages and labour costs | $11,299.6 | 67.5% |
| Management fees | $492.5 | 2.9% |
| Care expenses | 536.1 | 3.2% |
| Accommodation expenses | $1,267.8 | 7.6% |
| Hotel expenses | $1,157.9 | 6.9% |
| Administration expenses | $594.0 | 3.6% |
| Depreciation and amortisation | $895.3 | 5.3% |
| Interest | $171.1 | 1.0% |
| Other expenses | $336.6 | 2.0% |
| **Total expenses** | **$16,750.9** | **100.0%** |

50 Fees and charges received from a resident in respect of occasional care services like consultation, therapy, medication, treatment or procedure.

### 11.2.2 The Balance Sheet

The aggregate balance sheet for residential care providers as at 30 June 2017 (Table 11.3) highlights the significant role that RADs play in the capital financing of the sector, funding 55 per cent of the value of total sector assets and representing approximately two thirds of total sector liabilities. However as noted in Chapter 10, there are significant variations in the composition of the balance sheet across providers.

**Table 11.3: Balance sheet, residential care providers, 2016-17**

| Balance sheet item | $b |
|---|---|
| **Assets** | |
| Current assets (including cash) | $13.1 |
| Fixed assets (including property, plant & equipment) | $23.0 |
| Other non-current assets | $3.4 |
| Intangibles | $5.5 |
| **Total assets** | **$45.0** |
| **Liabilities** | |
| Refundable accommodation deposits | $24.7 |
| Other liabilities | $9.0 |
| **Total liabilities** | **$33.7** |
| **Net worth/equity** | **$11.3** |

## 11.3 Financial results – a longer term context

As noted in Chapter 9, the results from StewartBrown's Aged Care Financial Performance Survey for the nine months to March 2018 indicated that there was a noticeable decline in the financial performance of residential aged care facilities[51] over the course of 2017-18. This was attributed by StewartBrown to cost pressures (mainly wages) growing faster than revenue. This is not surprising in a year in which ACFI indexation was paused and the impacts of changes to the ACFI tool have dampened growth in the value of claims (given ACFI revenue is 60 per cent of provider revenue).

While monitoring year to year financial results is important, it is also informative to take a longer term view of financial performance in order to gain a better appreciation of the possible implications of recent developments and to identify any underlying issues that may need to be addressed to ensure a viable and sustainable system.

### 11.3.1 Results over the past decade

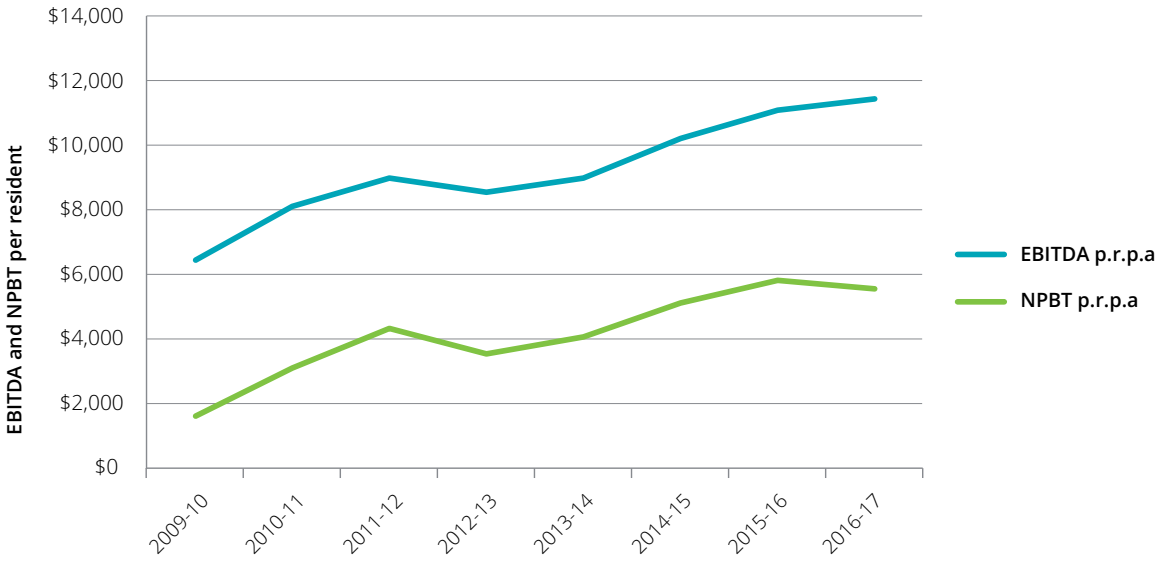
As highlighted in Chart 11.1, the overall financial results of residential aged care providers have varied over time, with an improved performance in some years followed by a lower performance in others. For example while, as noted previously, the overall financial results of the sector have weakened in 2017-18, they had improved in preceding years. StewartBrown's analysis has attributed the pause in ACFI indexation as a major contributing factor for the decline in financial performance in 2017-18.

The decline in the sector's financial performance in 2017-18 follows a pause in ACFI indexation and adjustments to the ACFI tool, and mirrors the decline in the sector's financial results following a similar pause in ACFI indexation and adjustments to the ACFI tool in 2012-13. Both occasions were a response by the Government to growth in ACFI funding it considered could not be justified by growth in resident frailty alone, but rather involved some level of over claiming by providers.

The financial performance of the sector recovered after the 2012-13 indexation pause was lifted, though this was helped by revenue friendly reforms resulting from the Living Longer Living Better package, including the 2.4 per cent real increase in ACFI prices as a result of the Workforce Supplement being rolled into the basic subsidy.

51 ACFA notes that analysis by StewartBrown is at the facility level whereas data provided by the Department, on which ACFA analysis is based, is at the provider level.

**Chart 11.1: EBITDA and NPBT per resident per annum, residential care providers, 2009-10 to 2016-17**




## 11.3.2 ACFI claims growth and indexation

ACFA has undertaken an historical analysis of growth in ACFI subsidies and compared this to changes in cost indices. This is shown in Table 11.4 and Chart 11.2. A key finding of the analysis is that the indexation applied to ACFI subsidies (Column 4) has been noticeably lower than growth in a range of cost price indices. Wages (which account for 68 per cent of total costs) have grown approximately twice as fast as ACFI prices.

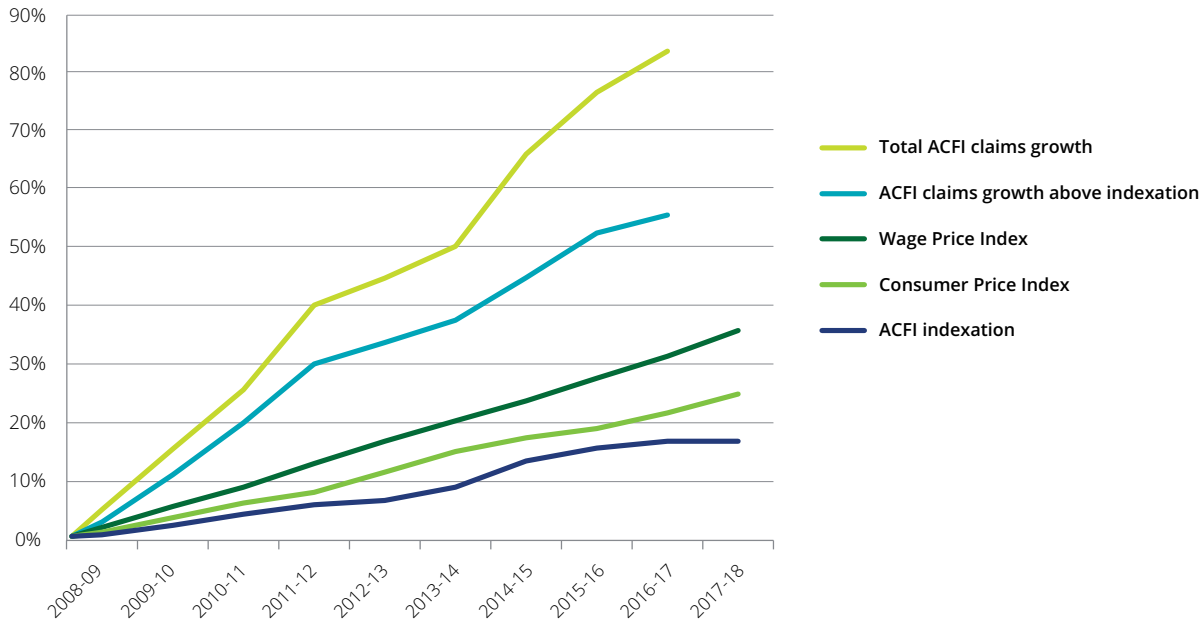
However, overall, the actual average amount of ACFI subsidy paid to providers per resident per day (Column 5) has grown at nearly three times as much as wage and price increases. This level of growth reflects claiming behaviour under the ACFI by providers.

**Table 11.4: Annual change in selected indexes, wages, and payment rates, 2008-09 to 2017-18**

| | CPI (change between March quarters) | WPI (Health Care and Social Assistance) | Age Care Award 2010 | ACFI subsidy rates | Average ACFI payment per resident | ACFI growth per resident above indexation |
|---|---|---|---|---|---|---|
| 2008-09 | 2.4% | 4.1% | - | 1.7% | 7.4% | 5.6% |
| 2009-10 | 2.9% | 3.8% | - | 1.7% | 7.7% | 5.9% |
| 2010-11 | 3.3% | 3.3% | 3.4% | 1.8% | 10.0% | 8.1% |
| 2011–12 | 1.6% | 3.0% | 2.9% | 1.9% | 9.3% | 7.3% |
| 2012-13 | 2.5% | 3.3% | 2.6% | 0.0% | 3.7% | 3.7% |
| 2013–14 | 2.9% | 2.9% | 3.0% | 1.7% | 4.6% | 2.8% |
| 2014–15 | 1.3% | 2.6% | 2.5% | 4.3% | 9.8% | 5.2% |
| 2015-16 | 1.3% | 2.6% | 2.4% | 1.3% | 6.9% | 5.5% |
| 2016-17 | 2.1% | 2.3% | 3.3% | 1.5% | 3.7% | 2.1% |
| 2017-18 | 1.9% | 2.7% | 3.5% | 0.0% | N/A | N/A |
| *Average annual change* | 2.2% | 3.1% | 3.0% | 1.6% | 7.0% | 5.1% |
| *Cumulative change* | 24.7% | 35.2% | - | 17.1% | 83.4% | 56.7% |

1. The Aged Care Award was not in effect in 2008-09 so growth can only be calculated over the period 2009-10 to 2017-18
2. ACFI subsidy rates have been adjusted to account for the Conditional Adjustment Payment that was rolled into ACFI subsidy rates in 2014–15
3. Average ACFI payment per resident includes all basic subsidy payments
4. The change to subsidies in 2016-17 did not apply across all domains of the ACFI – the CHC domain only received half indexation
5. Average ACFI payments per resident for 2017-18 are not available at the time of publication. The latest ACFI monitoring report is for March 2018 and shows growth for the period 1 July 2017 to March 2018 of negative 0.2%, compared with growth from 1 July 2016 to March 2017. Chart 9i in section 9.2 provides more detailed tracking of ACFI growth rates.
6. The average annual and cumulative change in ACFI payments are calculated to the end of 2016-17.

**Chart 11.2: Cumulative change in aged care subsidies and costs, 2008-09 to 2016-17**




Providers and the Government have differing views about the legitimacy of the increases in claims.

Providers have argued that the growth in ACFI payments per resident per day above indexation (Column 6), which they point out are subject to an audit program, has reflected a continuing increase in the acuity/frailty of residents. The Government has maintained that while it accepts and builds into its estimates an allowance for increasing frailty, the rate of growth of ACFI claims at times cannot be explained by pure growth in frailty, which would be expected to increase gradually over time. Accordingly, in 2012-13 and again in 2017-18, the Government introduced measures to slow overall growth in funding by adjusting the ACFI tool and pausing indexation.

This variability in funding is not beneficial for Government in the management of its outlays, nor the financial management and operations of the sector, and nor does it provide the stability favoured by investors.

The current ACFI arrangements cannot satisfactorily resolve the extent to which resident's care needs have been increasing over time compared with the extent to which providers have maximised the potential to use the ACFI tool to increase revenue growth (including as a response to low indexation).

ACFA considers the current ACFI tool may also suffer from no longer being contemporary (such as incentivising certain, sometimes outdated, types and modes of care delivery), it could encourage inefficiencies (through providers focusing limited resources on ACFI claiming) and appears to lack stability (with a history of cycles of high growth followed by low or no growth as higher than expected provider claiming leads to Government taking measures to reduce funding growth rates back to estimated levels).

ACFA therefore supports the Government's review of alternative residential care funding arrangements and the Resource Utilisation and Classification Study currently being undertaken to help inform consideration of funding reform options.

ACFA considers that a key element of any reform package should be a tool that accurately and objectively assesses the funding needs of residents.

A more efficient Government funding system would allow provider assessment resources to be devoted to assessment for care planning purposes. A more contemporary system would support delivery of the right types of care. A more stable system would provide greater certainty on funding levels for government, providers and investors, establishing a system that encourages investment in the sector to meet future demographic challenges as demand for aged care grows.

Growth in ACFI expenditure reflects three key drivers:

**Change in volume (numbers of residents in care).**

This is driven over the longer term by demographics and the increasing numbers of aged in the population. Shorter-medium term changes are reflected in changing occupancy levels and building development rates / places coming online. ACFI expenditure is demand driven to the extent that it is based on the assessed needs of individual residents (though the Government controls overall expenditure by limiting the supply of aged care services through population based target provision ratios).

**Change in price paid under the funding tool.**

The ACFI, administered by providers, determines the price paid to providers per resident. The Government also allows for some element of frailty growth in its estimates.

**Change in price from indexation of subsidy rates.**

Indexation is applied to subsidy rates to ensure rates move in line with the direction of changes to key cost drivers in the sector, though indexation is not designed to fully match cost changes as discussed further below.

## 11.3.3 Indexation

As noted earlier, indexation is intended to ensure the Government contribution towards care costs grows in a manner which is reflective of cost pressures on the sector. ACFA considers the rate of growth in funding needs to move with cost growth but does not need to match cost growth, in recognition that the sector would be expected to pursue productivity improvements in the same way as other sectors of the economy operating in a competitive environment. This was recognised in the Productivity Commission's "Caring for Older Australians Report" where it commented as follows:

> *"A major concern of participants to this inquiry was the appropriateness of indexation arrangements for determining the cost of care and accommodation on which government subsidies are based. The Commission considered indexation arrangements as part of its 1999 inquiry into nursing home subsidies and found that, with other sources of income for providers largely tied, inadequate increases in subsidies after allowing for efficiency improvements would, in one way or another, compromise the delivery of quality care. While not putting forward a view on the most appropriate indexation methodology, it recommended that: Basic subsidy rates should be adjusted annually according to indices which clearly reflect the changes in the average cost of the standardised input mix, less a discount to reflect changes in productivity. (PC 1999, p. 97)"*

This approach recognises the importance of both ensuring care prices accurately reflect the cost pressures faced by the aged care industry and providing an incentive for providers to look for ways to improve their productivity. ACFA supports this general principle.

The index applied to the basic care subsidy for residential care is Wage Cost Index 9 (WCI-9), which is a composite index constructed by the Department of Finance that comprises a wage cost component (weighted at 75 per cent) and a non-wage cost component (weighted at 25 per cent). For all Wage Cost Indexes the value of the wage cost component is based on the dollar increase in the national minimum wage (as determined annually by the Fair Work Commission) expressed as a percentage of the latest available estimate of average weekly ordinary time earnings (AWOTE) published by the Australian Bureau of Statistics as at November of each year. The value of the non-wage cost component of WCI-9 is based on changes in the Consumer Price Index between March quarters each year.

As the wage component is determined by expressing the growth in minimum wages as a percentage of AWOTE (which is more than double minimum wages) this works to in effect apply a discount to the actual growth in minimum wages. In line with the approach raised in the Productivity Commission report, a discount can be seen to reflect expectations of improvements in productivity/efficiency in the provider sector.

ACFA also notes that the ability for the sector to gain revenue growth through changes to ACFI claiming behaviour may be diminishing. At the end of the first full year of ACFI in 2008-09, around 7 per cent of residents with an ACFI classification were in a High-High-High classification. This has grown significantly, with 31 per cent of residents currently having the highest rating. As the scope for further increases in provider revenue through changes in ACFI claiming behaviour is reduced, this will put further pressure on the need for indexation arrangements to adequately reflect the growth in costs (while providing incentives for providers to increase productivity). Table 11.5 shows the changes in the proportion of residents classified at each ACFI domain level at the end of each year since 2012-13.

**Table 11.5: Proportion of residents by ACFI domain classification, 2012-13 to 2017-18**

| | 2012-13 | 2013–14 | 2014-15 | 2015-16 | 2016-17 | 2017-18 |
|---|---|---|---|---|---|---|
| **ADL** | | | | | | |
| High | 45.1 | 47.1 | 51.3 | 56.0 | 56.4 | 58.9 |
| Medium | 30.2 | 30.5 | 30.4 | 29.6 | 30.1 | 29.6 |
| Low | 22.7 | 20.9 | 17.2 | 13.7 | 12.9 | 11.0 |
| Nil | 2.1 | 1.6 | 1.0 | 0.7 | 0.6 | 0.5 |
| **BEH** | | | | | | |
| High | 54.2 | 55.3 | 59.4 | 62.7 | 62.6 | 64.2 |
| Medium | 23.3 | 22.8 | 22.6 | 21.8 | 22.1 | 21.8 |
| Low | 15.5 | 15.3 | 12.6 | 11.1 | 11.0 | 10.2 |
| Nil | 7.0 | 6.5 | 5.5 | 4.4 | 4.3 | 3.8 |
| **CHC** | | | | | | |
| High | 35.6 | 41.6 | 51.8 | 61.0 | 54.8 | 53.5 |
| Medium | 29.8 | 28.2 | 26.0 | 23.1 | 28.2 | 29.7 |
| Low | 27.2 | 24.1 | 18.0 | 13.0 | 15.2 | 15.9 |
| Nil | 7.5 | 6.1 | 4.2 | 2.9 | 1.8 | 0.9 |

### 11.3.4 Implication – the importance of appropriate indexation

The above analysis highlights that indexation and claiming by providers under the ACFI tool may be linked. ACFA observes that it is possible that if the rate of indexation is not adequately keeping pace with cost pressures, providers may be incentivised to strive for every opportunity to maximise their ACFI claims to compensate. This then contributes to volatility in care funding and an inefficient cycle of growth followed by measures to constrain growth.

Given these possible linkages, ACFA considers it would be timely for the Government to consider the issue of indexation settings at the same time as it is reviewing the funding tool.

## 11.4 The long term demographic pressures and the capital investment challenge

The ageing of the population will see a marked increase in the number of older Australians likely to need residential care. The proportion of people aged 85 and over, the common age for entry to residential care, is projected to grow to nearly 5 per cent of the population by 2055, compared with just over 2 per cent today. The Intergenerational report by the Department of the Treasury noted that Australian Government expenditure on aged care is projected to nearly double as a share of the economy, from almost 1 per cent currently to around 1.7 per cent of GDP by 2055[52].

The significant demographic shift will increase financial pressures for Government. While this shift is not immediate, it will build over the next decade as the 'baby boom' cohort of the population approach 85 years old.

52 Department of the Treasury, Intergenerational Report, 2015

In response to these demographic pressures, the *Legislated Review of Aged Care 2017* recommended changing the aged care planning ratio after 2022 to reflect numbers of consumers over age 75 rather than age 70, with this to be done in a way which would increase the number of places over time. Further, the Legislated Review estimated this could come at a cost to Government of around $2 billion per annum by 2031.

While demand is expected to continue to shift to home care as a result of the reforms, the number of people needing residential care is expected to also continue to grow due to the absolute increase in the number of older people. Capital investment and renewal is also important for supporting continued operations for providers. This brings into focus the need for ongoing capital investment in the sector to build new stock and regenerate older stock in a manner that meets the demands and expectations of consumers and supports providers. *The Legislated Review of Aged Care 2017 noted "While there is considerable uncertainty about the exact levels of demand, the long-term need for more aged care resulting from demographic changes is certain and will need to be addressed by government"*.

### 11.4.1 Recent history and reforms

Prior to the Living Longer Living Better reforms, concerns had been expressed in the sector about whether pricing regulations for accommodation payments (e.g. the capped daily accommodation charge for non-supported residents in high care and the low level of the accommodation supplement for supported residents) would support the investment needed to meet future demand for residential aged care. The decline in applications for places under the ACARs underlined this concern.

The 2014 reforms, which extended market-based lump sum deposits and daily payments for accommodation for all new residents and introduced the higher accommodation supplement for newly built and significantly refurbished facilities and increases in subsidies through the rolling in of the workforce supplement to general subsidies – have had a positive impact on investor sentiment. The lump sum pool has grown from $15.6 billion when the reforms began in July 2014 to almost $25 billion at 30 June 2017. The improved investor sentiment was evident in the record level of applications for places in the ACAR rounds following the reforms.

High growth in ACFI payments per resident per day, as well as the increase in ACFI prices as a result of the Workforce Supplement, also promoted a more positive sentiment in the sector.

### 11.4.2 Current issues and looking forward

Analysis of building approvals and building work is contained in Chapter 10. Data shows that while investment trends have been improving since the 1 July 2014 reforms, the proportion of providers reporting they are intending to build has declined noticeably. Those intending to rebuild decreased from 4.5 per cent in 2015-16 to 2 per cent in 2016-17, and those intending to upgrade decreased to 9 per cent from 14 per cent.

ACFA is aware anecdotally that investor sentiment has shifted somewhat and some providers are putting investment projects on hold and not proceeding with work previously planned while they assess the future direction of the market and reforms.

The shift in sentiment likely reflects the impact of a deterioration in financial results over the past 12 months and uncertainty over future developments. The more marginal projects in terms of either business or financing risk are likely to be delayed or abandoned first, and this may have implications for investment in rural and remote areas where profitability is generally lower. ACFA notes, however, that the Government has announced an additional $100 million in capital grants for new and refurbished facilities in rural and remote areas.

Another factor influencing the outlook for investment in the sector is that the growth in the pool of RADs held by providers since the Living Longer Living Better reforms has slowed.

In the years immediately following the reforms, the pool of RADs grew because the option to pay by lump sum deposit was extended to all new residents (partially supported and non-supported) and no longer limited to just low care residents. While the pool of lump sums could continue to grow along with any growth in the number of non-supported residents (to date non-supported residents have been more likely to choose to pay by lump sum), this largely depends on future consumers' choice of payment method. The rate of growth may be slowed if the emerging trend towards more consumers electing to pay DAPs over RADs continues.

Two other factors may dilute the rate of growth. First, new RAD paying residents are now more likely to be replacing existing RAD paying residents, whereas in the years immediately following the reforms the ratio of new RAD payers to lump sum refunds was much higher (largely due as pre 2014 residents who hadn't paid a lump sum being replaced with post 2014 residents who were more often paying a lump sum - subject to their choice of payment method). Second, the rate of growth will slow if residential occupancy rates continue to fall in response to the expansion of home care packages. These factors could present a particular challenge for those providers that currently rely heavily on RADs, and who may need to transition to alternative sources of finance.

ACFA has updated its estimates on the investment needed in the sector to support expected growing demand. This analysis is at Section 10.4 in Chapter 10.

ACFA considers that close attention needs to be given to the factors impacting on the outlook for investment in the aged care residential sector.

## 11.5 The challenge for providers

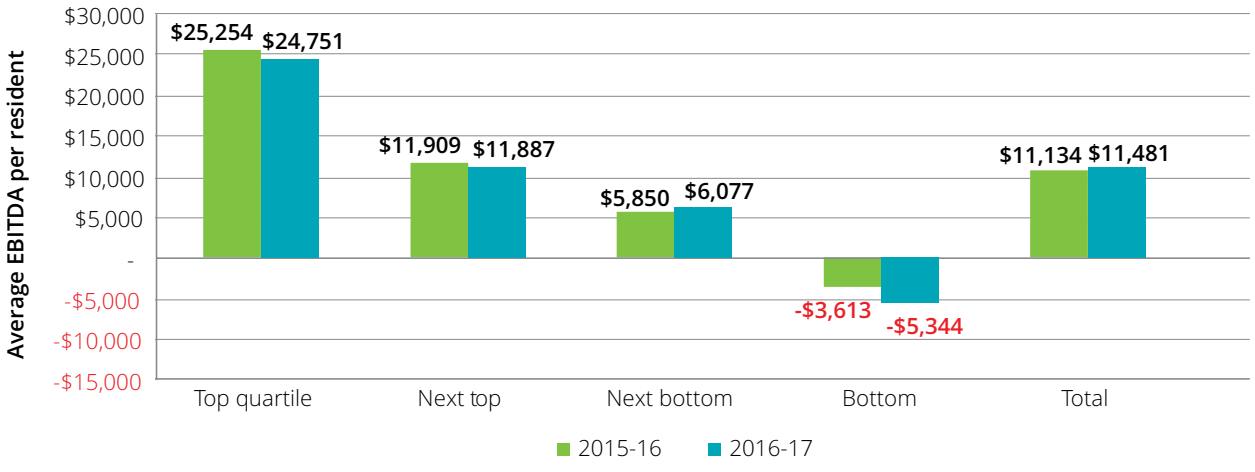
The challenge for providers is to ensure they are operating efficiently and effectively and driving productivity improvements. This will be increasingly important if the Government proceeds with proposals recommended by the *Legislated Review of Aged Care 2017* to deregulate supply controls and move towards a more consumer directed and competitive aged care sector. Providers will also need to consider if their business models and approaches of the past are the most efficient and effective for the market that may develop into the future.

The very wide diversity in the financial performance of providers has been highlighted in this report. There are providers, irrespective of size, ownership type and location, who are achieving good financial results under current funding arrangements, notwithstanding the recent ACFI changes (see analysis in Section 9.3.3 where the top 25 per cent of providers are achieving average EBITDA per resident per annum of $24,751 compared with the average of $11,481 for the whole sector). While a range of factors would be affecting the individual performance of providers, including in particular the demands facing providers operating in rural and remote areas the magnitude of the variance in financial results suggests there is scope for many providers to improve their operations and performance. Chart 11.3 shows EBITDA per resident per annum in 2015-16 and 2016-17 by quartile.

The solution to achieving a financially viable and sustainable sector does not depend solely on more Government funding. There is a role for providers to ensure they are operating in the most efficient and effective manner by having appropriate financial management and workforce policies and strong governance structures in place that deliver efficient and effective quality outcomes for residents as well as viable business and financial outcomes.

ACFA suggests that greater attention should be given to the factors that will encourage and facilitate improved performance, management and governance arrangements in the aged care residential sector. ACFA notes that the peak groups who represent the sector have a role to play in this regard, as does Government in terms of creating a more market-based and competitive sector. This would involve more consumer choice and appropriate deregulation.

**Chart 11.3: Comparative EBITDA per resident per annum, 2015-16 and 2016-17**



## 11.6 The role of consumers

A number of reviews and reports (Productivity Commission, *Legislated Review of Aged Care 2017*, Aged Care Sector Committee Roadmap) have highlighted that aged care consumers who can afford to do so should contribute to the cost of their care, and that this should be a focus of future reforms. These reports have also argued that increased contributions should be accompanied by greater consumer choice and control of aged care services.

While Government care subsidies provide the main revenue source for residential care providers, and can be expected to continue to do so, consumer fees are a significant part of provider revenue, making up 26 per cent of total revenue.

The appropriate level and types of fees that providers can charge is an important consideration in looking at the long term viability and sustainability of the residential aged care sector. The expansion of the scope of the Pension Loan Scheme announced in the 2018-19 Budget is also a relevant consideration.

It is also noteworthy that care fee policies in residential care should not be considered in isolation of care fee policy for home care packages.

### 11.6.1 Means tested care fees

The *Legislated Review of Aged Care 2017* noted that while changes made to means tested fees in 2014 have seen an increase in the contributions from consumers, the increase has been modest. The review recommended stronger means testing arrangements which would reduce pressure on Government expenditure (as Government subsidies are reduced by the means tested care fees paid by residents). ACFA notes the Government ruled out recommendations of the review for the inclusion of the full value of the former home in the means test when there is no protected person living in it and for the removal of the annual and lifetime caps on care fees.

### 11.6.2 Basic daily fee

The *Legislated Review of Aged Care 2017* recommended an increase in the basic daily fee for non-low means residents, which could provide a substantial increase in revenue flow for the sector.

The basic daily fee is already a significant source of revenue for providers, representing almost 19 per cent ($3.2 billion) of total provider revenue in 2016-17, with all fees going directly to provider revenue (there is no offset to Government subsidies as is the case for means tested fees). However, analysis by StewartBrown suggests that the cost of providing the services that the basic daily fee is expected to cover (hotel services such as food, linen, utilities etc) are closer to $75 per day than the maximum $50 currently able to be charged.

The *Legislated Review of Aged Care 2017* recommended that providers be allowed to charge a higher basic daily fee to non-low means residents, with amounts over $100 to be approved by the Aged Care Pricing Commissioner. An increase in the basic daily fee to $100 would increase the annual revenue for a 100 bed facility with 50 per cent low means residents by nearly $1 million per annum. An increase to $75 would increase revenue by nearly $500,000 per annum for the same facility.

The Government has not yet responded to this recommendation. ACFA notes that while any changes to fee arrangements would need to be carefully considered and take account of provider and consumer views, an increase in the basic daily fee charged to non-low means tested residents could have a significant impact on the financial viability and sustainability of providers.

### 11.6.3 Additional service fees

Additional service fees are fees that providers may charge for certain 'additional' services that are over and above those required to be provided under aged care legislation.

A number of providers and commentators have focused on the role of additional service fees as a potential source of increased revenue for providers. ACFA notes there is currently no data available regarding additional services fees charged by providers.

In March 2018 the Federal Court ruled that 'asset replacement' type charges are not permitted to be charged under aged care legislation. This confirmed the Department's view that additional fees are only permitted for additional services that provide some clear benefit to the resident, and that providers can continue to offer additional services fees on this basis only.

ACFA recognises and supports the need for appropriate regulation of these fees.

ACFA also recognises that appropriately charged additional services fees have a place to play in supporting provider viability and allowing providers increased flexibility to innovate and adapt their service offering to meet consumer demands.

The challenge for Government is to find the appropriate balance between allowing providers to charge appropriate additional service fees while ensuring there are adequate protections for consumers.

## 11.7 Other reform initiatives

There is a strong focus on ensuring that the sector provides quality care and recent Government reforms signal a clear intention to strengthen the regulatory framework around quality. This is welcome and appropriate, but will likely bring some added financial pressure on providers as they respond to the increased regulatory and consumer expectations for high quality care.

Other reforms are also likely to have an impact. Along with the expansion of home care services, the Government is examining the potential impacts from further deregulation by removing the ACAR for residential care. A more competitive and deregulated market is likely to ultimately be beneficial but the transition will need to be carefully managed and further consolidation of the sector can be expected. Similarly strengthening prudential standards is appropriate to protect consumers but impacts on the sector will need to be carefully considered. Ensuring an appropriately skilled workforce is also critical to meeting the care needs of residents but also presents cost challenges for the sector as it competes with other sectors for quality staff. ACFA notes that the recommendations from the Aged Care Workforce Strategy Taskforce will be an important component in the pursuit of a viable and sustainable aged care sector.

The analysis outlined in this chapter highlights the range of complex and inter-linked issues affecting the funding and financing of the residential aged care sector. Such issues as the development of a new funding tool, indexation, fees and charges, capital investment, workforce challenges, expansion of home care services and transitioning to increased consumer choice and control need to be considered together and recognise the roles and responsibilities of all stakeholders.

# Appendices

# Appendix A: ACFA Membership

### Members

| ACFA position | Name | Organisation |
|---|---|---|
| Chairman | Mr Mike Callaghan (Commenced 1 May 2018) | Non-Executive Director, Business Advisor |
| Deputy chair | Mr Nicolas Mersiades | Director Aged Care, Catholic Health Australia |
| Member | Mr Ian Yates AM | Chief Executive, COTA Australia |
| Member | Mr Gary Barnier | Former aged care executive, independent advisor |
| Member | Mr John Pollaers | Chair of the Australian Industry and Skills Committee |
| Member | Dr Mike Rungie | Former CEO, Aged Care Housing Group |
| Member | Ms Susan Emerson | Director, Helping Hand Aged Care |
| Member | Ms Louise Biti | Director, Aged Care Steps |

### Representatives

| ACFA position | Name | Organisation |
|---|---|---|
| Representative | Mr Jaye Smith | First Assistant Secretary, Ageing and Aged Care Group, Department of Health |
| Representative | Mr John Dicer | Aged Care Pricing Commissioner |
| Representative | Ms Jessica Mohr | Manager, Health and Disability Social Policy Division, Department of the Treasury |

# Appendix B: Work completed by ACFA to date

| Work | Date of completion |
|---|---|
| 2017 Annual Report on Funding and Financing of the Aged Care Sector | Provided to Minister in July 2017. Published in August 2017. |
| Application of the Base Interest Rate | Provided to Minister in May 2017. Published in June 2017. |
| Bond Guarantee Scheme | Provided to Minister in April 2017. Published in May 2017. |
| *Report to Inform the 2016-17 Review of Amendments to the Aged Care Act 1997* | Provided to Minister in May 2017. Published in June 2017. |
| Access to Residential Care by Supported residents | Provided to Minister in January 2017. Published in February 2017. |
| 2016 Annual Report on Funding and Financing of the Aged Care Sector | Provided to Minister in July 2016. Published in August 2016. |
| Report on Issues Affecting the Financial Performance of Rural and Remote Providers, Residential and Home Care | Provided to Minister in January 2016. Published in February 2016. |
| 2015 Annual Report on Funding and Financing of the Aged Care Sector | Provided to Minister in July 2015. Published in August 2015. |
| Report on Factors Influencing the Financial Performance of Residential Aged Care Providers | Provided to Minister in May 2015. Published in June 2015. |
| Report on Improving the Collection of Financial Data from Aged Care Providers | Provided to Minister in September 2014. Published in October 2014. |
| Reports on the Impact of Financial Reforms on the Aged Care Sector | First monthly report – 6 August 2014<br>Second monthly report – 9 September 2014<br>Third monthly report – 29 September 2014<br>Fourth and fifth monthly reports – 20 January 2015<br>Sixth monthly report – 13 March 2015<br>Seventh monthly report – 21 April 2015<br>First quarterly report – 18 September 2015<br>Second quarterly report – 21 December 2015<br>Third quarterly report – 26 February 2016<br>Final quarterly report – 1 June 2016. |
| 2014 Annual Report on the Funding and Financing of the Aged Care Sector | Provided to Minister in July 2014. Published in August 2014. |
| Supported Residents Data Book | Provided to Minister in April 2014. Published in May 2014. |
| Interim advice to the Minister on Improving the Collection of Financial Data from Aged Care Providers | Provided to Minister in July 2013. Published in August 2013. |
| First Annual Report (2013) on the Funding and Financing of the Aged Care Sector | Provided to Minister in June 2013. Published in July 2013. |
| Estimation of the possible impacts on revenue and balance sheet funding from changes to accommodation payment arrangements | ACFA's advice and KPMG modelling provided to Minister in May 2013. Published in May 2013. |
| The framework for setting accommodation payments in residential aged care | Final ACFA advice provided to Minister in November 2012. Government announced its position in December 2012. Further advice on the method for determining a RAD and a DAP using a MPIR provided to Minister on 17 May 2013. Government announced its position on 23 May 2013. |

# Appendic C: ACFA's stakeholder engagement

ACFA holds meetings and forums with representatives from the investment and financing industries, providers and consumers. This engagement is critical to ACFA's understanding of the key issues, developments and challenges facing the industry.

## Investors

In September and October 2017, ACFA held Roundtables in Sydney and Melbourne with members of the investment and financing community to share the findings of its 2017 annual report and to hear their views on key issues facing the sector.

Over 50 representatives from various organisations participated in the roundtables and a diverse range of issues and views were discussed regarding current and future investment in aged care, workforce issues and the availability of land and the challenges in developing that land into aged care facilities.

## Providers

ACFA liaised closely with the provider peaks including:

- Leading Age Services Australia;
- Aged and Community Services Australia;
- Catholic Health Australia;
- The Aged Care Guild; and
- Uniting Care.

## Other stakeholders

Since its last annual report, ACFA has presented at various forums including:

- The Australia's Future of Aged Care Summit;
- The 2017 Australian Palliative Care Conference;
- The Australian Assistive Technology Association;
- The Leading Age Services Australia National Congress;
- The 2017 China-Australia Aged Care Forum;
- The National Retirement Living Summit; and
- The Aged Care Workforce Forum.

# Appendix D: Aged care operational ratios

**Table D.1: Operational residential and restorative care, aged care places and ratios (places per 1000 people aged 70 years and over) by aged care planning region as at 30 June 2017**

| | | Total Operational Places | | | | | Total Operational Ratios | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| State/ Territory | Aged Care Planning Region | Residential care[1] | Home Care[2] | Total residential+ home care | Restorative care[3] | Total | Residential care[1] | Home Care[2] | Total residential+ home care | Restorative care[3] | Total (planning ratio) |
| NSW | Central Coast | 3,785 | 0 | **3,785** | 121 | **3,906** | 67.6 | 0.0 | **67.6** | 2.2 | **69.8** |
| | Central West | 2,113 | 19 | **2,132** | 45 | **2,177** | 93.1 | 0.8 | **93.9** | 2.0 | **95.9** |
| | Far North Coast | 3,619 | 21 | **3,640** | 87 | **3,727** | 77.7 | 0.5 | **78.1** | 1.9 | **80.0** |
| | Hunter | 6,303 | 0 | **6,303** | 113 | **6,416** | 80.7 | 0.0 | **80.7** | 1.4 | **82.2** |
| | Illawarra | 4,329 | 0 | **4,329** | 94 | **4,423** | 74.3 | 0.0 | **74.3** | 1.6 | **75.9** |
| | Inner West | 4,603 | 0 | **4,603** | 94 | **4,697** | 93.7 | 0.0 | **93.7** | 1.9 | **95.6** |
| | Mid North Coast | 4,225 | 6 | **4,231** | 90 | **4,321** | 76.1 | 0.1 | **76.2** | 1.6 | **77.9** |
| | Nepean | 2,304 | 0 | **2,304** | 48 | **2,352** | 72.7 | 0.0 | **72.7** | 1.5 | **74.2** |
| | New England | 1,909 | 20 | **1,929** | 38 | **1,967** | 78.7 | 0.8 | **79.5** | 1.6 | **81.1** |
| | Northern Sydney | 9,063 | 0 | **9,063** | 112 | **9,175** | 92.6 | 0.0 | **92.6** | 1.1 | **93.8** |
| | Orana Far West | 1,717 | 41 | **1,758** | 44 | **1,802** | 81.4 | 1.9 | **83.3** | 2.1 | **85.4** |
| | Riverina/Murray | 3,067 | 17 | **3,084** | 115 | **3,199** | 76.3 | 0.4 | **76.8** | 2.9 | **79.6** |
| | South East Sydney | 8,310 | 3 | **8,313** | 176 | **8,489** | 88.6 | 0.0 | **88.6** | 1.9 | **90.5** |
| | South West Sydney | 6,946 | 0 | **6,946** | 118 | **7,064** | 76.2 | 0.0 | **76.2** | 1.3 | **77.5** |
| | Southern Highlands | 2,330 | 6 | **2,336** | 63 | **2,399** | 74.0 | 0.2 | **74.2** | 2.0 | **76.2** |
| | Western Sydney | 5,427 | 7 | **5,434** | 108 | **5,542** | 68.3 | 0.1 | **68.4** | 1.4 | **69.8** |
| | **NSW** | **70,050** | **140** | **70,190** | **1,466** | **71,656** | **79.9** | **0.2** | **80.0** | **1.7** | **81.7** |
| Vic | Barwon-South Western | 4,370 | 3 | **4,373** | 101 | **4,474** | 87.7 | 0.1 | **87.8** | 2.0 | **89.8** |
| | Eastern Metro | 11,019 | 0 | **11,019** | 173 | **11,192** | 79.3 | 0.0 | **79.3** | 1.2 | **80.6** |
| | Gippsland | 3,188 | 0 | **3,188** | 47 | **3,235** | 78.2 | 0.0 | **78.2** | 1.2 | **79.4** |
| | Grampians | 2,423 | 0 | **2,423** | 73 | **2,496** | 81.4 | 0.0 | **81.4** | 2.5 | **83.8** |
| | Hume | 3,037 | 8 | **3,045** | 79 | **3,124** | 77.4 | 0.2 | **77.6** | 2.0 | **79.6** |
| | Loddon-Mallee | 3,824 | 8 | **3,832** | 109 | **3,941** | 77.5 | 0.2 | **77.7** | 2.2 | **79.9** |
| | Northern Metro | 6,926 | 69 | **6,995** | 137 | **7,132** | 78.3 | 0.8 | **79.1** | 1.5 | **80.7** |
| | Southern Metro | 13,013 | 0 | **13,013** | 237 | **13,250** | 83.6 | 0.0 | **83.6** | 1.5 | **85.2** |
| | Western Metro | 5,895 | 0 | **5,895** | 144 | **6,039** | 80.5 | 0.0 | **80.5** | 2.0 | **82.5** |
| | **Vic** | **53,695** | **88** | **53,783** | **1,100** | **54,883** | **80.7** | **0.1** | **80.9** | **1.7** | **82.5** |

| | | Total Operational Places | | | | | Total Operational Ratios | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| State/ Territory | Aged Care Planning Region | Residential care[1] | Home Care[2] | Total residential+ home care | Restorative care[3] | Total | Residential care[1] | Home Care[2] | Total residential+ home care | Restorative care[3] | Total (planning ratio) |
| Qld | Brisbane North | 4,078 | 0 | **4,078** | 141 | **4,219** | 92.0 | 0.0 | **92.0** | 3.2 | **95.2** |
| | Brisbane South | 6,214 | 0 | **6,214** | 142 | **6,356** | 89.7 | 0.0 | **89.7** | 2.0 | **91.7** |
| | Cabool | 3,307 | 0 | **3,307** | 19 | **3,326** | 70.2 | 0.0 | **70.2** | 0.4 | **70.6** |
| | Central West | 116 | 17 | **133** | 0 | **133** | 95.1 | 13.9 | **109.0** | 0.0 | **109.0** |
| | Darling Downs | 2,409 | 24 | **2,433** | 52 | **2,485** | 70.7 | 0.7 | **71.4** | 1.5 | **72.9** |
| | Far North | 1,825 | 29 | **1,854** | 50 | **1,904** | 58.1 | 0.9 | **59.0** | 1.6 | **60.6** |
| | Fitzroy | 1,532 | 27 | **1,559** | 37 | **1,596** | 84.9 | 1.5 | **86.4** | 2.1 | **88.4** |
| | Logan River Valley | 1,822 | 0 | **1,822** | 25 | **1,847** | 55.1 | 0.0 | **55.1** | 0.8 | **55.9** |
| | Mackay | 876 | 18 | **894** | 9 | **903** | 77.4 | 1.6 | **79.0** | 0.8 | **79.8** |
| | North West | 150 | 13 | **163** | 0 | **163** | 88.2 | 7.6 | **95.9** | 0.0 | **95.9** |
| | Northern | 1,781 | 0 | **1,781** | 62 | **1,843** | 77.3 | 0.0 | **77.3** | 2.7 | **80.0** |
| | South Coast | 5,117 | 0 | **5,117** | 96 | **5,213** | 85.4 | 0.0 | **85.4** | 1.6 | **87.0** |
| | South West | 257 | 16 | **273** | 0 | **273** | 77.7 | 4.8 | **82.6** | 0.0 | **82.6** |
| | Sunshine Coast | 4,052 | 0 | **4,052** | 77 | **4,129** | 75.8 | 0.0 | **75.8** | 1.4 | **77.2** |
| | West Moreton | 1,184 | 0 | **1,184** | 44 | **1,228** | 52.5 | 0.0 | **52.5** | 2.0 | **54.4** |
| | Wide Bay | 2,386 | 5 | **2,391** | 71 | **2,462** | 53.1 | 0.1 | **53.2** | 1.6 | **54.8** |
| | **Qld** | **37,106** | **149** | **37,255** | **825** | **38,080** | **74.4** | **0.3** | **74.7** | **1.7** | **76.3** |
| WA | Goldfields | 267 | 8 | **275** | 0 | **275** | 63.8 | 1.9 | **65.7** | 0.0 | **65.7** |
| | Great Southern | 514 | 38 | **552** | 10 | **562** | 57.8 | 4.3 | **62.1** | 1.1 | **63.2** |
| | Indian Ocean Territories | 0 | 0 | **0** | 0 | **0** | 0.0 | 0.0 | **0.0** | 0.0 | **0.0** |
| | Kimberley | 169 | 8 | **177** | 0 | **177** | 106.2 | 5.0 | **111.3** | 0.0 | **111.3** |
| | Metropolitan East | 2,411 | 0 | **2,411** | 40 | **2,451** | 64.8 | 0.0 | **64.8** | 1.1 | **65.9** |
| | Metropolitan North | 4,060 | 0 | **4,060** | 218 | **4,278** | 63.8 | 0.0 | **63.8** | 3.4 | **67.2** |
| | Metropolitan South East | 3,233 | 0 | **3,233** | 35 | **3,268** | 79.0 | 0.0 | **79.0** | 0.9 | **79.9** |
| | Metropolitan South West | 3,678 | 0 | **3,678** | 85 | **3,763** | 63.7 | 0.0 | **63.7** | 1.5 | **65.1** |
| | Mid West | 394 | 37 | **431** | 15 | **446** | 56.5 | 5.3 | **61.8** | 2.2 | **64.0** |
| | Pilbara | 76 | 0 | **76** | 0 | **76** | 59.0 | 0.0 | **59.0** | 0.0 | **59.0** |
| | South West | 1,217 | 12 | **1,229** | 32 | **1,261** | 64.0 | 0.6 | **64.6** | 1.7 | **66.3** |
| | Wheatbelt | 561 | 64 | **625** | 0 | **625** | 62.7 | 7.2 | **69.9** | 0.0 | **69.9** |
| | **WA** | **16,580** | **167** | **16,747** | **435** | **17,182** | **66.2** | **0.7** | **66.8** | **1.7** | **68.6** |
| SA | Eyre Peninsula | 506 | 29 | **535** | 2 | **537** | 74.5 | 4.3 | **78.8** | 0.3 | **79.1** |
| | Flinders & Far North | 238 | 22 | **260** | 1 | **261** | 118.9 | 11.0 | **129.9** | 0.5 | **130.4** |
| | Hills, Mallee & Southern | 1,648 | 8 | **1,656** | 41 | **1,697** | 69.1 | 0.3 | **69.4** | 1.7 | **71.2** |
| | Metropolitan East | 3,009 | 0 | **3,009** | 98 | **3,107** | 99.3 | 0.0 | **99.3** | 3.2 | **102.5** |
| | Metropolitan North | 3,501 | 12 | **3,513** | 109 | **3,622** | 79.4 | 0.3 | **79.7** | 2.5 | **82.1** |
| | Metropolitan South | 3,927 | 0 | **3,927** | 90 | **4,017** | 86.5 | 0.0 | **86.5** | 2.0 | **88.5** |
| | Metropolitan West | 2,817 | 0 | **2,817** | 8 | **2,825** | 98.1 | 0.0 | **98.1** | 0.3 | **98.4** |
| | Mid North | 380 | 0 | **380** | 2 | **382** | 82.8 | 0.0 | **82.8** | 0.4 | **83.3** |
| | Riverland | 450 | 7 | **457** | 2 | **459** | 77.1 | 1.2 | **78.3** | 0.3 | **78.6** |

| | | Total Operational Places | | | | | Total Operational Ratios | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| State/ Territory | Aged Care Planning Region | Residential care[1] | Home Care[2] | Total residential+ home care | Restorative care[3] | Total | Residential care[1] | Home Care[2] | Total residential+ home care | Restorative care[3] | Total (planning ratio) |
| | South East | 730 | 0 | **730** | 2 | **732** | 78.2 | 0.0 | **78.2** | 0.2 | **78.4** |
| | Yorke, Lower North & Barossa | 1,443 | 0 | **1,443** | 12 | **1,455** | 84.0 | 0.0 | **84.0** | 0.7 | **84.7** |
| | **SA** | **18,649** | **78** | **18,727** | **367** | **19,094** | **85.5** | **0.4** | **85.9** | **1.7** | **87.6** |
| Tas | North Western | 1,075 | 0 | **1,075** | 28 | **1,103** | 68.3 | 0.0 | **68.3** | 1.8 | **70.1** |
| | Northern | 1,453 | 28 | **1,481** | 33 | **1,514** | 69.9 | 1.3 | **71.3** | 1.6 | **72.9** |
| | Southern | 2,503 | 42 | **2,545** | 58 | **2,603** | 79.0 | 1.3 | **80.3** | 1.8 | **82.2** |
| | **Tas** | **5,031** | **70** | **5,101** | **119** | **5,220** | **73.8** | **1.0** | **74.8** | **1.7** | **76.5** |
| ACT | ACT | 2,538 | 0 | **2,538** | 68 | **2,606** | 73.8 | 0.0 | **73.8** | 2.0 | **75.8** |
| | **ACT** | **2,538** | **0** | **2,538** | **68** | **2,606** | **73.8** | **0.0** | **73.8** | **2.0** | **75.8** |
| NT | Alice Springs | 207 | 87 | **294** | 5 | **299** | 131.9 | 55.4 | **187.4** | 3.2 | **190.6** |
| | Barkly | 25 | 20 | **45** | 2 | **47** | 50.3 | 40.2 | **90.5** | 4.0 | **94.6** |
| | Darwin | 337 | 12 | **349** | 26 | **375** | 45.8 | 1.6 | **47.4** | 3.5 | **50.9** |
| | East Arnhem | 4 | 14 | **18** | 2 | **20** | 11.2 | 39.3 | **50.6** | 5.6 | **56.2** |
| | Katherine | 113 | 47 | **160** | 4 | **164** | 135.7 | 56.4 | **192.1** | 4.8 | **196.9** |
| | **NT** | **686** | **180** | **866** | **39** | **905** | **64.6** | **17.0** | **81.6** | **3.7** | **85.2** |
| **Australia** | | **204,335** | **872** | **205,207** | **4,419** | **209,626** | **77.9** | **0.3** | **78.2** | **1.7** | **79.9** |

**Notes:**

1. **Residential care** includes flexible residential care places in the: Multi-Purpose Service (MPS) Program, Aged Care Innovative Pool Program and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program.
2. **Home care** Following the Increasing Choices changes on 27 February 2017, places for the Home Care Packages Program are now assigned to consumers and not to services. Correspondingly, places data for the Home Care Packages Program are no longer captured in the stocktake and no longer included in the operational aged care provision ratio. These figures only include flexible home care places in the: Multi-Purpose Service (MPS) Program, Aged Care Innovative Pool Program and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program.
3. **Restorative care** includes places in the Transition Care Program and the Short-Term Restorative Care Program.

**Note:** The ratios in the above table were calcuzlated using revised population projections for June 2017 which are based on the 2012 ABS Estimated Resident Population. These population projections are customised projections prepared for the Department of Health (DoH) by the ABS, according to the assumptions agreed to by DoH. Due to rounding, individual ratios may not sum to the total.

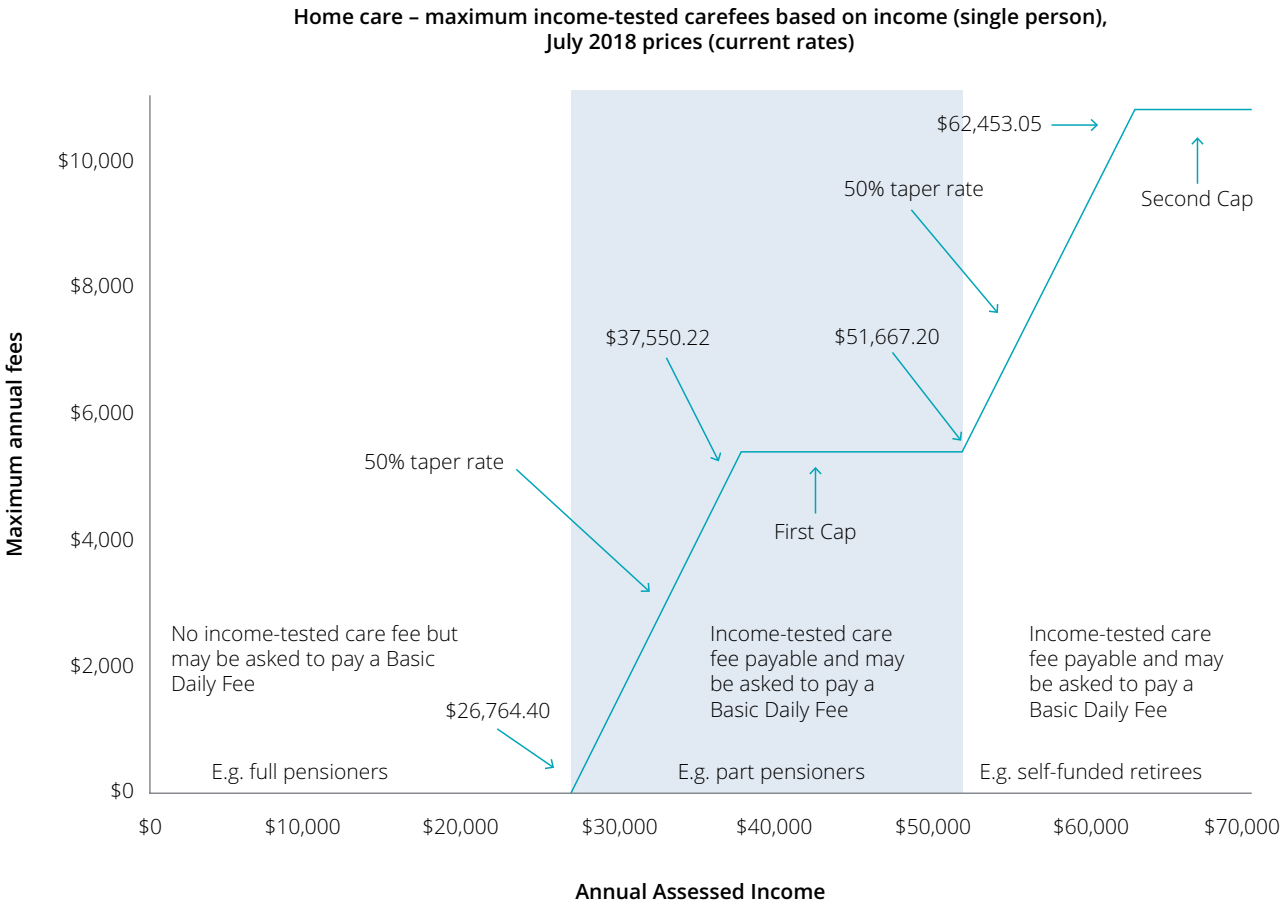
# Appendix E: Means testing arrangements

## Home care

In addition to the basic daily fee, an income-tested care fee was introduced in home care from 1 July 2014. Unlike the arrangements for the basic daily fee, the Commonwealth payment received by the provider is reduced by the amount of the income-tested care fee. Accordingly, to receive an amount equivalent to the full subsidy the provider needs to charge the appropriate income-tested care fee.

Annual income-tested care fees in home care are currently capped at $5,392.91 for part-pensioners and $10,785.85 for non-pensioners (March 2018 rate). A lifetime cap of $64,715.36 per consumer currently applies for care contributions across home care and residential care (March 2018 rate). Full pensioners are not required to contribute to their care costs and may only be required to pay the basic daily fee.

**Figure E1: Current income testing for home care (post 1 July 2014)**



## Residential aged care

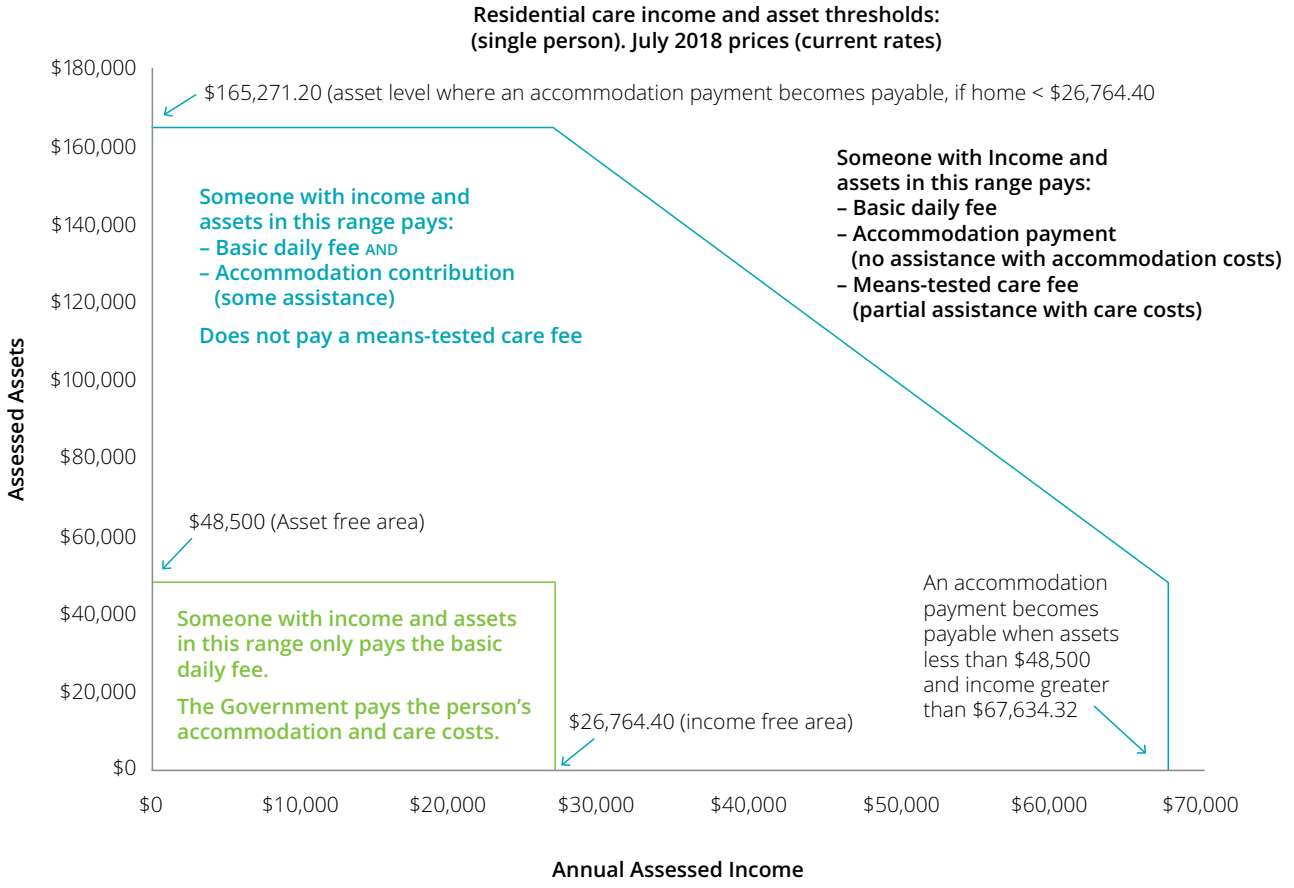
Changes to residential care from 1 July 2014 introduced more comprehensive means testing arrangements by way of a combined assets and income assessment and a new fees structure.

Annual and lifetime caps were also introduced, with an annual cap of $26,964.71 applying to the means-tested care fee and a lifetime cap of $64,715.36 for care contributions (March 2018 rate).

Figure E.2 demonstrates how the means testing arrangements created three tiers of consumer contributions in residential aged care:

- consumers with low means, who are required to pay only the basic daily fee (85 per cent of the single basic age pension) as a contribution towards their daily living expenses, while their accommodation and care costs are funded by the Australian Government;
- consumers with moderate means, who in addition to contributing towards their daily living expenses by paying the basic daily fee, also make a capped contribution towards their accommodation costs; and
- consumers with greater means, who in addition to contributing towards their daily living expenses, also pay the basic daily fee for their accommodation costs in full and make a capped contribution towards their care costs.

**Figure E2: Current means testing for residential care (post 1 July 2014)**



# Appendix F: Financial performance with government owned[53] providers included and excluded, 2016-17.

| | All providers (893) | Government providers (95) | Providers excluding government (798) |
|---|---|---|---|
| Total revenue | $17,757m | $877m | $16,879m |
| Total EBITDA | $2,072m | -$30m | $2,102m |
| EBITDA p.r.p.a | $11,481 | -$3,791 | $12,179 |
| Total NPBT | $1,006m | -$85m | $1,091m |
| NPBT p.r.p.a | $5,572 | -$10,776 | $6,319 |
| EBITDA margin | 11.7% | -3.4% | 12.5% |
| NPBT margin | 5.7% | -9.7% | 6.5% |
| # with positive EBITDA | 735 | 35 | 700 |
| # with positive NPBT | 608 | 21 | 587 |

53 Excludes Multi-Purpose Services.

# Appendix G: Financial ratios by provider ownership type

**Table G.1: Financial ratios of total sector by provider type, 2016-17**

| | Not-for-profit | For-profit | Government | Total sector |
|---|---|---|---|---|
| Total RADs | $12,779b | $11,418b | $512b | $24,710b |
| No. of providers | 500 | 298 | 95 | 893 |
| EBITDA p.r.p.a | $11,408 | $13,316 | -$3,791 | $11,481 |
| **Capital structure** | | | | |
| Assets p.r.p.a | $235,290 | $279,133 | $199,896 | $250,789 |
| No. of RADs | 47,610 | 37,025 | 2,525 | 87,160 |
| Avg RAD per resident | $268,413 | $308,398 | $202,834 | $283,499 |
| Net worth p.r.p.a | $80,323 | $30,455 | $119,438 | $62,756 |
| Working capital p.r.p.a | -$72,224 | -139,194 | -9,416 | -$95,366 |
| Non-current liabilities as % of total assets | 3.5% | 12.6% | 3.1% | 7.4% |
| RADs as % of total assets | 53.5% | 58.7% | 33.1% | 54.9% |
| Net worth as % total assets | 34.4% | 11.0% | 61.6% | 25.2% |
| **Viability** | | | | |
| Current ratio | 0.50 | 0.35 | 0.87 | 0.43 |
| Interest coverage | 22.3 times | 7.9 times | -25.5 times | 12.1 times |
| NPBT margin | 5.4% | 7.9% | -9.7% | 5.7% |
| Occupancy | 93.1% | 90.1% | 90.3% | 91.8% |
| % EBITDA to total assets | 4.9% | 4.8% | -1.9% | 4.6% |
| % EBITDA to net worth | 14.2% | 43.7% | -3.2% | 18.3% |
| RADs asset cover (T.A.) | 1.9 times | 1.7 times | 3.0 times | 1.8 times |

### Table G.2: Financial ratios for not-for-profit providers, 2016-17

| | Top | Next top | Next bottom | Bottom | Total |
|---|---|---|---|---|---|
| No. of providers | 113 | 135 | 144 | 106 | 498 |
| EBITDA p.r.p.a | $29,206 | $11,941 | $5,794 | -$2,113 | $11,408 |
| **Capital structure** | | | | | |
| T. Assets p.r.p.a | $324,680 | $213,434 | $220,868 | $231,756 | $235,290 |
| No. of RADs | 8,178 | 21,279 | 13,035 | 5,118 | 47,610 |
| Avg RAD per resident | $283,349 | $265,298 | $264,951 | $266,320 | $268,413 |
| Net Worth p.r.p.a | $149,916 | $64,739 | $69,679 | $70,867 | $80,323 |
| Working Capital p.r.p.a | -$42,616 | -$77,495 | -$73,983 | -$88,652 | -$72,224 |
| Non.Curr Liab as % of T.Asts. | 5.0% | 2.5% | 3.5% | 4.4% | 3.5% |
| RADs as % of T. Asts | 43.8% | 56.9% | 56.2% | 51.3% | 53.2% |
| Net Worth as % T.Asts | 46.2% | 30.3% | 32.4% | 30.6% | 34.4% |
| **Viability** | | | | | |
| Current ratio | 0.73 | 0.46 | 0.46 | 0.41 | 0.50 |
| Interest coverage | 49.3 Times | 27.2 Times | 9.8 Times | -4.2 Times | 22.3 Times |
| NPBT margin | 21.0% | 5.6% | 0.6% | -9.1% | 5.4% |
| Occupancy | 94.7% | 93.2% | 92.4% | 91.9% | 93.1% |
| %EBITDA to T. Assets | 9.0% | 5.6% | 2.7% | -0.9% | 4.9% |
| %EBITDA to Net Worth | 19.5% | 18.4% | 8.3% | -3.0% | 14.2% |
| RADs Asset Cover (T.A.) | 2.3 Times | 1.8 Times | 1.8 Times | 1.9 Times | 1.9 Times |

### Table G.3: Financial ratios of government providers, 2016-17

| | Top | Next Top | Next Bottom | Bottom | Total |
|---|---|---|---|---|---|
| No. of providers | 8 | 10 | 11 | 60 | 89 |
| EBITDA p.r.p.a | $27,762 | $10,575 | $7,031 | -$15,963 | -$3,791 |
| **Capital structure** | | | | | |
| T. Assets p.r.p.a | $323,246 | $187,711 | $183,532 | $195,888 | $199,896 |
| No. of RADs | 181 | 362 | 464 | 1,518 | 2,525 |
| Avg RAD per resident | $198,726 | $169,687 | $227,405 | $203,719 | $202,834 |
| Net Worth p.r.p.a | $234,775 | $143,467 | $89,331 | $107,113 | $119,438 |
| Working Capital p.r.p.a | $11,295 | $4,659 | -$1,317 | -$19,459 | -$9,416 |
| Non.Curr Liab as % of T.Asts. | 5.1% | 4.7% | 3.2% | 2.1% | 3.1% |
| RADs as % of T. Asts | 23.2% | 20.1% | 42.4% | 37.0% | 33.1% |
| Net Worth as % T.Asts | 72.6% | 77.6% | 48.7% | 57.5% | 61.6% |
| **Viability** | | | | | |
| Current ratio | 1.16 | 1.14 | 0.99 | 0.75 | 0.87 |
| Interest coverage | 1093.3 Times | 120.0 Times | 27.9 Times | -104.5 Times | -25.5 Times |
| NPBT margin | 14.4% | 2.0% | 3.6% | -22.4% | -9.7% |
| Occupancy | 92.0% | 87.4% | 92.6% | 90.5% | 90.3% |
| %EBITDA to T. Assets | 8.6% | 5.7% | 3.8% | -8.4% | -1.9% |
| %EBITDA to Net Worth | 11.8% | 7.4% | 7.9% | -14.9% | -3.2% |
| RADs Asset Cover (T.A.) | 4.3 Times | 5.0 Times | 2.4 Times | 2.7 Times | 3.0 Times |

**Table G.4: Financial ratios of for-profit providers, 2016-17**

| | Top | Next Top | Next Bottom | Bottom | Total |
|---|---|---|---|---|---|
| No. of providers | 100 | 74 | 65 | 53 | 292 |
| EBITDA p.r.p.a | $21,929 | $11,872 | $6,528 | -$3,543 | $13,316 |
| **Capital structure** | | | | | |
| T. Assets p.r.p.a | $302,525 | $250,040 | $274,603 | $302,215 | $279,133 |
| No. of RADs | 14,353 | 11,605 | 8,471 | 2,596 | 37,025 |
| Avg RAD per resident | $320,435 | $294,290 | $298,515 | $337,161 | $308,398 |
| Net Worth p.r.p.a | $25,969 | $31,692 | $42,115 | $14,310 | $30,455 |
| Working Capital p.r.p.a | -$164,919 | -$100,397 | -$164,943 | -$106,904 | -$139,194 |
| Non.Curr Liab as % of T.Asts. | 13.1% | 13.7% | 6.1% | 22.4% | 12.6% |
| RADs as % of T. Asts | 58.0% | 59.4% | 60.9% | 53.9% | 58.7% |
| Net Worth as % T.Asts | 8.6% | 12.7% | 15.3% | 4.9% | 11.0% |
| **Viability** | | | | | |
| Current ratio | 0.30 | 0.45 | 0.24 | 0.51 | 0.35 |
| Interest coverage | 9.8 Times | 7.2 Times | 7.7 Times | -2.5 Times | 7.9 Times |
| NPBT margin | 14.0% | 6.9% | 3.3% | -8.3% | 7.9% |
| Occupancy | 91.0% | 90.6% | 90.7% | 82.0% | 90.1% |
| %EBITDA to T. Assets | 7.3% | 4.7% | 2.4% | -1.2% | 4.8% |
| %EBITDA to Net Worth | 84.4% | 37.5% | 15.5% | -24.8% | 43.7% |
| RADs Asset Cover (T.A.) | 1.7 Times | 1.7 Times | 1.6 Times | 1.9 Times | 1.7 Times |

# Appendix H: Residential aged care subsidies and supplements

**Table H.1: Summary of funding amounts for subsidies and supplements in residential aged care, 2015-16 to 2016-17**

| | 2015-16 ($M) | 2016-17 ($M) |
|---|---|---|
| **Basic Care subsidies** | | |
| Permanent | 10,507.7 | 11,024.2 |
| Respite | 264.4 | 280.6 |
| **Primary care supplements** | | |
| Oxygen | 16.5 | 17.5 |
| Enteral feeding | 6.3 | 5.9 |
| Respite incentive | 29.0 | 30.1 |
| **Hardship** | | |
| Hardship | 5.2 | 4.9 |
| **Accommodation supplements** | | |
| Accommodation supplement | 845.7 | 907.5 |
| Hardship accommodation | 3.6 | 2.9 |
| Transitional accommodation Supplement | 22.3 | 15.5 |
| Concessional | 64.0 | 55.6 |
| Accommodation charge top-up | 2.1 | 1.4 |
| Pensioner supplement | 36.3 | 27.2 |
| **Viability Supplement** | | |
| Viability | 35.6 | 43.2 |
| **Supplements relating to grand parenting** | | |
| Transitional | 6.0 | 4.8 |
| Charge exempt | 3.8 | 2.0 |
| Basic daily fee | 0.6 | 0.4 |
| **Other supplements** | | |
| Veterans' | 1.8 | 1.1 |
| Homeless | 7.6 | 8.3 |
| **Reductions** | | |
| Means testing reduction | -455.7 | -560.8 |
| Other | -31.5 | -1.5 |
| **TOTAL** | **11,372.3** | **11,903.8** |

# Appendix I: Residential aged care subsidy and supplements rates

**Table I.1: ACFI rates ($ per day), 2016-17 to 2018-19**

| ACFI | 2016-17 | 2017-18 | 2018-19 |
|---|---|---|---|
| **Activities of daily living (ADL)** | | | |
| Low | $36.65 | $36.65 | $37.16 |
| Medium | $79.80 | $79.80 | $80.92 |
| High | $110.55 | $110.55 | $112.10 |
| **Behaviour (BEH)** | | | |
| Low | $8.37 | $8.37 | $8.49 |
| Medium | $17.36 | $17.36 | $17.60 |
| High | $36.19 | $36.19 | $36.70 |
| **Complex Health Care (CHC)** | | | |
| Low | $16.37 | $16.37 | $16.48 |
| Medium | $46.62 | $46.62 | $46.95 |
| High | $67.32 | $67.32 | $67.79 |
| Interim rate for new residents pending ACFI assessment | $56.22 | $56.22 | $57.01 |

| Daily residential respite subsidy rates | 2016-17 | 2017-18 | 2018-19 |
|---|---|---|---|
| Low | $45.45 | $46.09 | $46.74 |
| High | $127.46 | $129.24 | $131.05 |

**Table I.2 Residential care supplements table, 2016-17 to 2018-19**

| Residential care | 2016-17 | 2017-18 | 2018-19 |
|---|---|---|---|
| Oxygen supplement* | $11.12 | $11.35 | $11.57 |
| Enteral Feeding supplement – Bolus* | $17.62 | $17.99 | $18.33 |
| Enteral Feeding supplement – Non-bolus* | $19.79 | $20.21 | $20.59 |
| Adjusted Subsidy Reduction | $12.85 | $13.03 | $13.21 |
| Veterans' supplement | $6.88 | $6.98 | $7.08 |
| Homeless supplement | $15.72 | $15.94 | $16.16 |

* These supplements are payable in respect of eligible residential respite care recipients.

### Table I.3: Residential aged care supplements (accommodation and hotel related)

| Residential care | 20/03/17 | 20/09/17 | 20/03/18 |
|---|---|---|---|
| Higher accommodation supplement – newly built or significantly refurbished facilities | $55.09 | $55.44 | $56.14 |
| Accommodation supplement – facilities that are not newly built or significantly refurbished but do meet set building requirements | $35.90 | $36.13 | $36.59 |
| Accommodation supplement – facilities that are not newly built or significantly refurbished and don't meet set building requirements | $30.17 | $30.36 | $30.74 |
| Concessional resident supplement (concessional and assisted residents) - newly built or significantly refurbished facilities | $55.09 | $55.44 | $56.14 |
| Concessional resident supplement (concessional residents) – facilities that are not newly built or refurbished | $21.95 | $22.09 | $22.37 |
| Concessional resident supplement (assisted residents) – facilities that are not newly built or significantly refurbished | $9.03 | $9.09 | $9.20 |
| After 19 March 2008 and before 20 September 2010 | $8.22 | $8.27 | $8.37 |
| After 19 September 2010 and before 20 March 2011 | $5.48 | $5.51 | $5.58 |
| After 19 March 2011 and before 20 September 2011 | $2.74 | $2.76 | $2.79 |
| Transitional supplement | $21.95 | $22.09 | $22.37 |
| Basic Daily Fee supplement | $0.57 | $0.58 | $0.59 |
| Respite supplement – high level is equal to or greater than 70% of the specified proportion of respite care for the approved provider | $90.01 | $90.59 | $91.73 |
| Respite supplement – high level is less than 70% of the specified proportion of respite care for the approved provider | $52.90 | $53.24 | $53.91 |
| Respite supplement – low level | $37.74 | $37.98 | $38.46 |

### Table I.4: Residential aged care viability supplement

| Residential aged care viability supplement* | 2016-17 | 2017-18 | 2018-19 |
|---|---|---|---|
| 2017 Scheme Services | | | |
| Eligibility score of 100 | $53.22 | $56.09 | $56.88 |
| Eligibility score of 95 | $47.17 | $49.95 | $50.65 |
| Eligibility score of 90 | $42.35 | $45.06 | $45.69 |
| Eligibility score of 85 | $36.31 | $38.94 | $39.49 |
| Eligibility score of 80 | $30.22 | $32.76 | $33.22 |
| Eligibility score of 75 | $23.03 | $25.47 | $25.83 |
| Eligibility score of 70 | $16.74 | $19.09 | $19.36 |
| Eligibility score of 65 | $11.47 | $13.75 | $13.94 |
| Eligibility score of 60 | $9.38 | $11.63 | $11.79 |
| Eligibility score of 55 | $6.27 | $8.48 | $8.60 |
| Eligibility score of 50 | $4.18 | $6.36 | $6.45 |
| Eligibility score of 45 #<br>Eligibility score of 40 #<br>Less than a score of 40 | $0.00<br>$0.00<br>$0.00 | $0.00<br>$0.00<br>$0.00 | $0.00<br>$0.00<br>$0.00 |

Note: the Modified Monash Model classification scale was implemented on 1 January 2017

*These supplements are payable in respect of eligible residential respite care recipients.

| Residential aged care Viability supplement* | 2016-17 | 2017-18 | 2018-19 |
|---|---|---|---|
| **2005 Scheme Services** | | | |
| Eligibility score of 100 | $50.69 | $51.40 | $52.12 |
| Eligibility score of 95 | $44.92 | $45.55 | $46.19 |
| Eligibility score of 90 | $40.33 | $40.89 | $41.46 |
| Eligibility score of 85 | $34.58 | $35.06 | $35.55 |
| Eligibility score of 80 | $28.78 | $29.18 | $29.59 |
| Eligibility score of 75 | $23.03 | $23.35 | $23.68 |
| Eligibility score of 70 | $18.48 | $18.74 | $19.00 |
| Eligibility score of 65 | $12.66 | $12.84 | $13.02 |
| Eligibility score of 60 | $10.36 | $10.51 | $10.66 |
| Eligibility score of 55 | $6.92 | $7.02 | $7.12 |
| Eligibility score of 50 | $4.62 | $4.68 | $4.75 |
| Eligibility score of 45 # | $0.00 | $0.00 | $0.00 |
| Safety net – former 1997 or 2001 scheme services: viability supplement | $1.90 | $1.93 | $1.96 |

* These supplements are payable in respect of eligible residential respite care recipients.

# Appendix J: Residential care financing structures and balance sheets

**Table J.1: Distribution of average lump sum accommodation deposits by ownership and earnings before interest, taxes, depreciation and amortisation quartile, 2016-17**

| | Top | Next top | Next bottom | Bottom | Total |
|---|---|---|---|---|---|
| **Not-for-profit** | | | | | |
| No. of providers | 115 | 137 | 145 | 103 | 500 |
| No. of providers that held RADs | 110 | 133 | 141 | 94 | 478 |
| Proportion of residents that paid RADs in facilities, where RADs were held | 49.8% | 46.6% | 46.3% | 46.9% | 47.1% |
| Average RAD per resident | $283,349 | $265,298 | $264,951 | $266,320 | $268,413 |
| **For-profit** | | | | | |
| No. of providers | 101 | 76 | 66 | 55 | 298 |
| No. of providers that held RADs | 92 | 74 | 63 | 49 | 278 |
| Proportion of permanent residents that paid RADs in facilities, where RADs were held | 56.6% | 51.5% | 56.5% | 49.8% | 54.3% |
| Average RAD per resident | $320,435 | $294,290 | $298,515 | $337,161 | $308,398 |
| **Government** | | | | | |
| No. of providers | 8 | 10 | 12 | 65 | 95 |
| No. of providers that held RADs | 8 | 10 | 11 | 59 | 88 |
| Proportion of permanent residents that paid RADs in facilities, where RADs were held | 41.0% | 22.2% | 36.1% | 37.0% | 33.9% |
| Average RAD per resident | $198,726 | $169,687 | $227,405 | $203,719 | $202,834 |
| **Total** | | | | | |
| No. of providers | 224 | 223 | 223 | 223 | 893 |
| No. of providers that held RADs | 210 | 217 | 215 | 202 | 844 |
| Proportion of permanent residents that paid RADs in facilities, where RADs were held | 53.8% | 47.6% | 49.4% | 45.6% | 49.3% |
| Average RAD per resident | $306,111 | $274,377 | $277,099 | $275,947 | $283,499 |

# Appendix K: Home care revenue and expenditure

**Table K.1 Financial performance results of home care providers, by ownership type, 2016-17**

| | Top quartile | Next top | Next bottom | Bottom | Total |
|---|---|---|---|---|---|
| **Not-for-profit** | | | | | |
| Number of providers | 80 | 102 | 102 | 73 | 357 |
| Provision of care/services charged | $43.08 | $42.94 | $39.67 | $45.42 | $42.31 |
| Admin and management of packages | $27.38 | $25.41 | $21.89 | $21.09 | $23.73 |
| Unspent and exit amounts | $4.27 | $3.21 | $2.05 | $2.95 | $2.94 |
| Other income | $5.66 | $0.56 | $0.82 | $2.41 | $1.81 |
| Total expenses | $54.34 | $63.08 | $62.28 | $77.33 | $64.05 |
| Net Profit Before Tax | $26.05 | $9.04 | $2.15 | -$5.45 | $6.74 |
| **For-profit** | | | | | |
| Number of providers | 39 | 22 | 24 | 33 | 118 |
| Provision of care/services charged | $104.55 | $57.00 | $49.23 | $38.55 | $69.85 |
| Admin and management of packages | $20.55 | $29.07 | $20.43 | $21.85 | $22.31 |
| Unspent and exit amounts | $2.32 | $3.48 | $4.02 | $3.12 | $3.12 |
| Other income | $8.40 | $1.93 | $0.14 | $1.15 | $3.78 |
| Total expenses | $89.38 | $83.81 | $71.16 | $74.15 | $80.93 |
| Net Profit Before Tax | $46.43 | $7.67 | $2.65 | -$9.48 | $18.13 |
| **Government** | | | | | |
| Number of providers | 20 | 13 | 22 | 23 | 78 |
| Provision of care/services charged | $55.43 | $27.96 | $36.01 | $29.34 | $36.68 |
| Admin and management of packages | $11.05 | $16.85 | $19.66 | $19.66 | $17.64 |
| Unspent and exit amounts | $6.59 | $2.50 | $2.51 | $2.17 | $3.18 |
| Other income | $1.31 | $1.36 | $0.35 | -$2.52 | -$0.14 |
| Total expenses | $48.83 | $39.15 | $56.34 | $55.96 | $52.43 |
| Net Profit Before Tax | $25.55 | $9.52 | $2.18 | -$7.31 | $4.94 |
| **Total** | | | | | |
| Number of providers | 139 | 137 | 148 | 129 | 553 |
| Provision of care/services charged | $56.79 | $43.34 | $40.13 | $43.12 | $44.71 |
| Admin and management of packages | $24.77 | $25.36 | $21.59 | $21.01 | $23.15 |
| Unspent and exit amounts | $4.03 | $3.21 | $2.25 | $2.89 | $2.98 |
| Other income | $5.92 | $0.67 | $0.72 | $1.78 | $1.87 |
| Total expenses | $61.25 | $63.61 | $62.50 | $74.81 | $64.94 |
| Net Profit Before Tax | $30.26 | $8.96 | $2.19 | -$6.01 | $7.76 |

**Table K.2 Financial package results for home care providers, by ownership type, 2016-17**

| | Top Quartile | Next Top | Next Bottom | Bottom | Total |
|---|---|---|---|---|---|
| **Not-for-profit** | | | | | |
| Number of providers | 80 | 102 | 102 | 73 | 357 |
| Total revenue per consumer | $29,342 | $26,324 | $23,517 | $26,236 | $25,838 |
| Total expenses per consumer | $19,834 | $23,024 | $22,732 | $28,225 | $23,378 |
| NPBT per consumer | $9,508 | $3,300 | $785 | -$1,989 | $2,460 |
| **For-profit** | | | | | |
| Number of providers | 39 | 22 | 24 | 33 | 118 |
| Total revenue per consumer | $49,571 | $33,390 | $26,941 | $23,608 | $36,157 |
| Total expenses per consumer | $32,624 | $30,591 | $25,973 | $27,065 | $29,539 |
| NPBT per consumer | $16,947 | $2,800 | $967 | -$3,460 | $6,617 |
| **Government** | | | | | |
| Number of providers | 20 | 13 | 22 | 23 | 78 |
| Total revenue per consumer | $27,149 | $17,765 | $21,363 | $17,757 | $20,940 |
| Total expenses per consumer | $17,823 | $14,290 | $20,564 | $20,425 | $19,137 |
| NPBT per consumer | $9,326 | $3,475 | $796 | -$2,668 | $1,803 |
| **Total** | | | | | |
| Number of providers | 139 | 137 | 148 | 129 | 553 |
| Total revenue per consumer | $33,401 | $26,488 | $23,612 | $25,112 | $26,539 |
| Total expenses per consumer | $22,356 | $23,218 | $22,813 | $27,306 | $23,703 |
| NPBT per consumer | $11,045 | $3,270 | $799 | -$2,194 | $2,832 |

# Appendix L: Home care subsidies and supplements

**Table L.1: Home care subsidies per day, 2016-17 to 2018-19**

| Package level | 2016-17 | 2017-18 | 2018-19 |
|---|---|---|---|
| Level 1 | $22.04 | $22.35 | $22.66 |
| Level 2 | $40.09 | $40.65 | $41.22 |
| Level 3 | $88.14 | $89.37 | $90.62 |
| Level 4 | $133.99 | $135.87 | $137.77 |

**Table L.2: Home care supplement amounts per day, 2016-17 to 2018-19**

| Home care supplements | 2016-17 | 2017-18 | 2018-19 |
|---|---|---|---|
| Dementia and Cognition and Veterans' supplement (10% of basic care subsidy) | | | |
| Level 1 | $2.20 | $2.24 | $2.67 |
| Level 2 | $4.01 | $4.07 | $4.12 |
| Level 3 | $8.81 | $8.94 | $9.06 |
| Level 4 | $13.40 | $13.59 | $13.78 |
| Other | | | |
| EACH-D Top Up supplement | $2.66 | $2.69 | $2.73 |
| Oxygen Supplement | $11.12 | $11.35 | $11.57 |
| Enteral Feeding supplement – Bolus | $17.62 | $17.99 | $18.33 |
| Enteral Feeding supplement – Non–bolus | $19.79 | $20.21 | $22.91 |
| Home Care Viability supplement – Modified Monash Model classification | | | |
| MMM 1,2,3 | - | $0.00 | $0.00 |
| MMM 4 | - | $1.04 | $1.05 |
| MMM 5 | - | $2.29 | $2.32 |
| MMM 6 | - | $15.16 | $15.37 |
| MMM 7 | - | $18.20 | $18.45 |

Note: the MMM classification scale was implement on 1 January 2017

| Home Care Viability supplement – ARIA value viability supplement amount | 2016-17 | 2017-18 | 2018-19 |
|---|---|---|---|
| ARIA Score 0 to 3.51 inclusive | $0.00 | $0.00 | $0.00 |
| ARIA Score 3.52 to 4.66 inclusive | $5.30 | $5.37 | $5.45 |
| ARIA Score 4.67 to 5.80 inclusive | $6.36 | $6.45 | $6.54 |
| ARIA Score 5.81 to 7.44 inclusive | $8.90 | $9.02 | $9.15 |
| ARIA Score 7.45 to 9.08 inclusive | $10.69 | $10.84 | $10.99 |
| ARIA Score 9.09 to 10.54 inclusive | $14.95 | $15.16 | $15.37 |
| ARIA Score 10.55 to 12.00 inclusive | $17.95 | $18.20 | $18.45 |

Note: the MMM classification scale was implement on 1 January 2017

**Table L.3: Summary of Australian Government payments of subsidies and supplements of home care, 2015-16 to 2016-17**

| Supplement | 2015-16 | 2016-17 |
|---|---|---|
| Dementia and cognition supplement | $21.7m | $24.7m |
| Veterans' supplement | $0.2m | $0.2m |
| Oxygen supplement | $1.8 m | $2.4m |
| Enteral feeding supplement | $0.5m | $0.7m |
| Viability supplement | $7.2m | $11.4m |
| Hardship supplement | $0.2m | $0.2m |

# Appendix M: Residential aged care and home care financial data

- Residential Aged Care and Home Care providers financial data is obtained from Aged Care Financial Reports (ACFRs) required to be prepared and submitted by providers of residential aged care under the *Accountability Principles 2014 (Section 35, 35A, 36, 37 and 37A) made under Section 96-1 of the Aged Care Act 1997.*
- Residential and Home Care financial data and analysis given in this report includes financial information for only those services that were operational from 01 July 2016 to 30 June 2017 and whose financial information is received by the Department.
- Approximately 99 per cent of residential aged care providers and 95 per cent of the Home Care Providers submitted their ACFRs. Whilst the majority of residential data was used, only the data from 83 per cent of Home Care provider data was submitted in useable form to derive the necessary analysis and measurements.
- Financial information contained in ACFRs varies from provider to provider. Accounting standards are subject to interpretation and it is possible that interpretations may differ between providers. The Department has not verified provider's interpretation and application of the accounting standards.
- The information in the ACFR is not audited. It is however tested for reasonableness to the Approved Provider's audited General Purpose Financial Report which is also submitted annually. Whilst some verification of data is undertaken by the department, a significant portion of data submitted through the ACFR has not been verified by the Approved Providers.
- Analysis of financial data may be affected by incomplete, aggregated data provided in ACFRs. As a result, averages stated in the report may not fully represent the sector.
- Discrepancies occur in the ACFR home care income statement which can impact the overall average results of the sector. For example, there are instances where the details of the expenses are aggregated to other expenses or total expenses. There are also instances where income and expenditure through brokered services are not disclosed in their entirety thus understating revenue and expenditure. These instances result in inconsistency and limitations in deriving various metrics and measurements.
- It is apparent through home care income statement that some services have moved their carry-over previous year/future year income or expense amounts to the current year period. This accounting difference may affect the average results for the 2016-17 year.
- The ACFR home care income and expenses are aggregated for Commonwealth Government funded packaged clients and private clients. Therefore, the analysis used in this report is not interpretable for any particular group of clients who are receiving/ paying any particular funding type.
- Assets and liabilities reported in the residential aged care balance sheet contain, where not already fully verifiable, some proportional allocations based on the historical and sector trends from other sources within provider ACFRs and GPFRs. These allocations have not been verified by the Aged Care providers.

# Appendix N: References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