Aged Care Financing Authority

Third report on the Funding and Financing of the Aged Care Sector

July 2015

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Contents

Glossary

Term	Definition
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 Act is the legislation upon which the Australian Government funded aged care system is based.
Aged Care Approvals Round (ACAR)	The ACAR is an annual competitive assessment process for releasing and allocating aged care places to approved aged care providers. The number of places released is governed by the Commonwealth's population-based aged care service provision target ratio.
Aged Care Assessment Team (ACAT)	ACATs help older people and their carers work out what kind of care will best meet their needs when they are no longer able to manage at home without assistance. ACATs provide information on suitable care options and can help arrange access or referral to appropriate residential or home care services (including HACC). An ACAT assessment and approval is required before people can access residential aged care or a home care package.
Aged Care Financing Authority (ACFA)	ACFA 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)	Used for determining the level of care subsidies for residents in aged care homes based on the assessed care needs of each individual.
Aged Care Sector Committee	The ACSC provides advice to the Government on aged care policy development and implementation and helps to guide the future reform of the aged care system.
Allocated Places/Packages	The amount of subsidised aged care that an approved provider can deliver depends on the number of aged care places allocated to it under Part 2.2 of the Act. Under these arrangements, an approved provider can receive payment for care on behalf of approved care recipients only up to the specified number and type of aged care places allocated through the Australian Government's ACAR process or acquired from a provider who was previously allocated places through the ACAR process.

Assistance with Care and Housing for the Aged (ACHA)	ACHA is a programme which provides a range of services for financially disadvantaged older people to meet both their accommodation and support needs so that they can remain living independently and in the community.
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 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)	From 1 July 2015 the existing Commonwealth HACC Programme, the National Respite for Carers Programme, the Day Therapy Centres Programme and the Assistance with Care and Housing for the Aged Programme, were combined under a single streamlined Commonwealth Home Support Programme to provide basic maintenance, care, support and respite services for older people living in the community, and their carers.
Community Aged Care Package (CACP)	Care consisting of a package of services provided to a person who lives in their own home and is not in residential care. 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.

Conditional Adjustment Payment (CAP)	Introduced as part of the Australian Government's initial response to the Report of Professor Warren Hogan's Review of Pricing Arrangements in Residential Aged Care. The CAP was intended to provide medium term financial assistance to providers while encouraging them to become more efficient through improved management practices. Consequently, residential aged care providers were only eligible to receive the CAP if they achieved certain business outcomes such as providing staff training, making audited accounts available each year to the department and taking part in a periodic workforce census. The CAP was rolled into the basic care subsidy rates as of 1 July 2014.
Consumer Directed Care (CDC)	Consumer Directed Care gives older people and their carers greater choice and control over the types of care services they receive and the delivery of those services.
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/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)	CALD refers to people whose first language was not English.
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.
Daily Accommodation Payment (DAP)	An amount paid by a care recipient towards their accommodation costs in a residential aged care facility calculated on a daily basis and paid periodically.
Day Therapy Centres Programme (DTC)	The DTC Programme provides a wide range of therapy and services to frail, aged people living in the community and to residents in Commonwealth funded residential aged care facilities within an eligible resident classification range. It assists them to regain or maintain physical and cognitive abilities which support them to either maintain or recover a level of independence, allowing them to remain either in the community or in residential aged care. As of 1 July 2015 the DTC Programme became part of the new Commonwealth Home Support Programme.
Department of Social Services (The Department)	The Australian Government Department that administers the Act and regulates the aged care industry on behalf of the Australian Government.
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.

Extended Aged Care at Home (EACH)	Flexible care consisting of a package of care services, including nursing and other personal assistance provided to a person who lives in their own home and not in residential care, who requires 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 is generally consistent with the level of care provided in a level 4 Home Care package.
Extended Aged Care at Home Dementia (EACH-D)	Flexible care consisting of a package of care services, including nursing and other personal assistance provided to a person who lives in their own home with dementia and not in residential care, who requires 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 is 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.
Financial Accountability Reports (FARs)	FARs are non-audited financial statements that are submitted by the Approved Providers of Home Care services delivering care to clients in all four levels of care. Under the Accountability Principles 2014 and Home Care Packages Programme Guidelines, the submission of FARs is a mandatory requirement in a form approved by the Secretary of the Department.
Financial Planners Association (FPA)	The FPA represents the interests of the public and Australia's professional community of financial planners.
General Purpose Financial Report (GPFR)	A financial report intended to meet the information needs common to users who cannot command the preparation of specific reports for their own purposes.
Government provider	In the context of this Report, the term references a provider that is owned by a local or state 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 are classified as 'high care'.
Higher accommodation supplement	A higher maximum accommodation supplement was introduced on 1 July 2014 for significantly refurbished and new facilities. The higher level of the accommodation supplement is available to services that are identified as newly built or have completed a significant refurbishment since 20 April 2012.

Home and Community Care (HACC)	A programme of basic maintenance and support services for frail older people, younger people with disabilities and the carers of these people to prevent premature admission to Residential Care Services. It includes home nursing, home help, respite care and assistance with meals and transport. As of 1 July 2015 the Commonwealth HACC programme will become part of the new Commonwealth Home Support Programme.
Home Care	Home based care and support to help older Australians to remain in their own homes. Home care is provided in a Home Care Package in the Home Care Packages Programme (see below).
Home Care Package	A coordinated package of services tailored to meet a person's specific care needs. The package is coordinated by an approved home care provider, with funding provided by the Australian Government. Home Care Levels 1 and 2 help people with basic or low level care needs, whilst Levels 3 and 4 help people with intermediate to high care needs. This programme commenced 1 August 2013 and replaced the Community Aged Care Programme.
Home Care Packages Programme (HCPP)	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 HCPP commenced on 1 August 2013, replacing the former packaged care Programmes – Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH) packages and Extended Aged Care at Home Dementia (EACH-D) packages.
Homeless Supplement	The Homeless Supplement commenced from October 2013, to better support aged care homes that specialise in caring for people with a history of, or at risk of, homelessness.
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.
Low care facility	A facility where over 80 per cent of residents are classified as 'low care'.
Maximum Permissible Interest Rate (MPIR)	The MPIR is the rate used to calculate the equivalent daily payment of a refundable deposit. The refundable deposit 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 Social Services website and is updated every three months. As at 1 July 2015 it was 6.15 per cent.
Mixed care facility	A facility where less than 80 per cent of residents are high care residents and more than 20 per cent are low care residents.

My Aged Care	A service provided by the Department of Social Services to assist older people, their families and carers to access aged care information and services via the My Aged Care website and national phone line.
National Disability Insurance Scheme (NDIS)	The NDIS offers support for Australians 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.
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.
Net Profit Before Tax	The NPBT is determined by revenue minus expenses except for taxes.
Operational Places/Packages	Operational Place refers to a place that was allocated and has since become available for a person to receive care.
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.
Per Resident Per Day (prpd)	A daily average financial figure relating to Residential aged care residents.
Provision target ratio	The Australian Government regulates the supply of subsidised residential aged care and home care packages by specifying a national provision 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, known as the aged care *provision target ratio.* The population-based provision formula ensures that the supply of services increases in line with the ageing of the population, while capping the number of places limits the fiscal risk associated with aged care.
Refundable Accommodation Deposit (RAD)	An amount paid as a lump sum by a care recipient for their accommodation costs in a residential aged care facility.
Regional	Geographic reference to areas classified by the Australian Bureau of Statistics as inner regional, outer regional, remote and very remote.
Regional Assessment Services	Services that are responsible for conducting face-to-face assessments of older people needing entry-level support (low intensity, basic support at home) through the Commonwealth Home Support Programme. The services are delivered within 52 pre-specified regions across Australia excluding Victoria and Western Australia.

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 Aged Care Funding Instrument (ACFI). The RCS is based on a resident's classification assessed on a scale from 1-8, with levels 1-4 being classified as high care and levels 5-8 as low care. A small number of residents, who entered care before 20 March 2008 are still classified using the RCS though grand-parenting arrangements.
Residential Aged Care	A programme that provides a range of supported accommodation services for older people who are unable to continue living independently in their own homes.
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 not permitted for new residents entering residential aged care 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.
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.
Transitional Business Advisory Service (TBAS)	TBAS was a free financial advice service for providers on the 1 July 2014 accommodation payment reforms. It was provided by KPMG and funded by the Australian Government to assist with transition during the implementation of the aged care reforms. It ceased operation on 30 June 2015.
Viability supplement	The viability supplement for residential and home care is a payment made under the Act to assist aged care services in rural and remote areas with the extra cost of delivering services in those areas.
Weighted Average Cost of Capital (WACC)	The average cost of financing the assets of the entity weighted by the use of its debt and equity.
Working Capital	Defined as current assets less current liabilities.

Foreword

I am pleased to present the Aged Care Financing Authority's (ACFA) 2015 Report on the Funding and Financing of the Aged Care Sector. This is the third annual report of ACFA.

ACFA commenced in July 2012, following the announcement of the Australian Government's significant reforms of aged care. ACFA's annual report on the aged care sector examines the developments, issues and challenges affecting the industry, and provides a range of statistics and analyses of the provision of aged care in Australia. This report includes analysis of financial data collected from the 2013-14 year. It also examines issues and trends emerging since 1 July 2014, when significant funding and financing reforms were implemented. This report is timely given the significant impact the reforms are having on the sector, from consumer, provider and investor perspectives.

It is well documented that aged care is one of the fastest growing sectors in Australia, due to the ageing population and longer life expectancies.

Financial sustainability into the future is one of the key themes in the ongoing reform of the aged care sector and through these reports, ACFA is able to inform and advise the Government, the sector and other key stakeholders on funding and financing developments and issues in the sector.

I should like to acknowledge the contribution of the many providers, peak bodies, bankers and other institutions that ACFA has consulted during the year. During 2013-14, ACFA held meetings and forums with representatives from the investment and financing sectors, providers and consumers. These meetings and forums have been critical to ACFA's understanding of the key issues, developments and challenges facing the industry, particularly the impact of the 1 July 2014 reforms on all stakeholders. These consultations have greatly assisted in the understanding and analysis of the sector.

I should also like to pay special tribute to the late Professor Graeme Hugo, AO, the founding Deputy Chairman of ACFA, who sadly passed away in January 2015. Graeme made a significant contribution to ACFA's major project reviews with his lasting legacy being his research on "The Demographic Facts of Ageing in Australia", which was published in June 2014.

ACFA looks forward to its continuing role advising Government and working with and informing other stakeholders on the financing and funding of the Aged Care sector to ensure its long-term sustainability and viability.

Lynda O'Grady

Chairman

Aged Care Financing Authority

Executive Summary

- The Aged Care Sector is one of Australia's largest service industries:
    - Services are delivered to over one million people;
    - Delivered by over 2,000 providers;
    - Employs over 350,000 people; and
    - Represents 3.6 per cent of government expenditure.
- The Australian Aged Care Sector is currently undergoing a significant transformation as it moves towards a more consumer driven and market-based system.
- ACFA considers the financial and funding impacts of the reform to date have been positive:
    - Increased lump sum accommodation pool; and
    - Significant investment activity and interest in the residential care sector.
- However, there have been some challenges for some providers and consumers through transition, which will continue to be closely monitored by ACFA.
- The financial performance of home and residential providers in 2013-14 was relatively strong:
    - 66 per cent of home care providers achieved net profit. The average EBITDA per package, per annum was $1,973;
    - 66 per cent of residential care providers achieved net profit. The average EBITDA per resident, per annum was $9,224, an increase of 6.5 per cent from 2012-13;
        - Results continue to vary across the sector.
    - Net assets in the residential sector were up 10 per cent on the previous financial year to $11.2 billion; and
    - A total of $1.5 billion of new work was completed in 2013-14 – an increase of 69 per cent on the previous year.
- Strong interest from providers in new residential and home care places with both sectors being oversubscribed in the 2014 Aged Care Approval Round.
- The Sector is on a positive path, however it faces a period of substantial demographic change and systemic reform.
- ACFA will continue to monitor the sustainability and viability of the Sector closely and critically.

The Aged Care Sector is undergoing a significant transformation, which will shape the experience and delivery of aged care for future generations.

The Sector itself is one of Australia's largest – and fastest growing – service industries. Aged care services are delivered to over one million people. The Sector employs over 350,000 people. Representing 3.6 per cent of Australian Government expenditure, the Sector contributes 1 per cent of Gross Domestic Product in Australia.

In this time of change, objective, transparent and critical analysis of the financial underpinnings of the Sector is of central importance. Not only to those who provide or consume services today, but to the whole Australian community.

What this report tells you:

- The structure and operation of the Australian Aged Care Sector and its key characteristics;
- Early observations on the impact of recent reforms;
- Funding and financial performance of the sector based on 2013-14 data; and
- The emerging opportunities and challenges for the Sector as significant reforms continue.

1 The Aged Care Financing Authority and the 2015 Annual Sector Report

The Aged Care Financing Authority (ACFA) is an independent statutory committee, charged with the role of providing independent and transparent advice to the Australian Government on the sustainability and viability of the Aged Care Sector.

ACFA is required to provide an annual report on the impact of funding and financing arrangements on the viability and sustainability of the sector taking into account impacts on access to quality care and the aged care workforce.

This is ACFA's third Annual Report on the Funding and Financing of the Aged Care Sector.

2 Aged Care in Australia

Table i provides an overview of the aged care sector as at 2013-14.

Table i: Aged Care in Australia, 2013-14

	HACC	Home Care	Residential Care
Number of providers	1,676	504	1,016
Number of services	n/a	2,212	2,688
Number of places	775,959[1]	66,149	189,283
Total revenue	$1.8 billion[2]	$1.3 billion[3]	$14.8 billion
Commonwealth contribution to total revenue	*95%*	*92%*	*65%*
Consumer contribution to total revenue	*5%*	*7%*	*27%*
Other contribution to total revenue[4]	-	*1%*	*8%*
Total Expenditure	n/a	$1.1 billion	$14.1 billion
Total net profit before tax	n/a[5]	$120 million	$711 million

[1] Number of HACC consumers during 2013-14
[2] Derived from Government funding plus an estimated 5 per cent national average of consumer contribution
[3] Scaled up from the 88 per cent of providers' 2013-14 HCPP financial reports that were in a useable form. The analysis in Chapter 5 uses data from the 88 per cent only.
[4] 'Other' revenue includes interest income, asset revaluations and trust distributions
[5] Analysis of profit for HACC providers is not appropriate for this report as it is funded on a grants acquittal basis.

Aged care providers

In 2013-14, there were over 2,214 providers supplying aged care in Australia, some of whom provide more than one type. Together, they provided Home and Community Care (HACC), home care and residential care. Of the total providers across all three programmes, 957 offered HACC services only, 177 Home Care only and 753 residential care only. There were 347 providers that offered more than one type of service.

- **HACC (1,676 providers)** Home and Community Care refers to the range of services provided under the Commonwealth Home and Community Care (HACC) programme and the Victorian and Western Australian Home and Community Care programmes, to which the Commonwealth contributes funding. These programmes provide basic support services which are distinct from the more structured Home Care Packages programme.
- **Home Care (504 providers)** The new Home Care Package Programme (HCPP) commenced on 1 August 2013, replacing the former packaged care programmes – 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 (HCPs) are categorised into four levels.
- **Residential care (1,016 providers)** Residential aged care provides support and accommodation for those who choose to have their care provided within residential aged care accommodation. It can be provided on a permanent or a respite (temporary) basis.

The majority of providers in all three sectors are not-for-profit providers.

Providers across the sector range in size from those that operate a single service to those that operate multiple services. Of Home Care providers, 48 per cent operate a single service business and 15 per cent operate seven or more services. Similarly, the majority of residential care providers (64 per cent) operated only a single home while 2 per cent of providers operated more than 20 homes.

In 2013-14, 49 per cent of home care providers predominantly operated in metropolitan areas. A further 5 per cent operated services in both metropolitan and regional locations. A total of 46 per cent of providers predominantly operated in regional locations.

In the residential care sector, 58 per cent of providers predominantly operated in metropolitan areas. A total of 39 per cent of providers predominantly operated services in regional locations. The remaining 4 per cent of providers operated services in both metropolitan and regional locations.

The aged care workforce totals over 350,000 workers with around 61 per cent working in residential aged care and 39 per cent working in home care and home support. In addition, informal carers and volunteers perform a critical role in caring for older people, especially in supporting older people living at home.

Supply of aged care

The Australian government regulates the supply of home care packages and residential care by specifying a national provision target of subsidised operational aged care places for every 1,000 people aged 70 years or over, known as the aged care provision ratio.

As part of the reforms which commenced in 2012-13 the aged care provision ratio is set to grow from 113 places for every 1000 people aged over 70 to 125 places by 2021-22. As the number of places increase, the mix of residential and home care will concurrently change. The target for home care packages will increase from 27 to 45 and the residential target will reduce from 86 to 80.

The change in mix between home care and residential care from 25:88 to 45:80 is intended to respond to the reported consumer preference to stay at home where possible.

The Government allocates home care packages and residential care places through an annual competitive process, the Aged Care Approval Rounds (ACAR). In 2014, the Aged Care Approval Round made available 11,196 residential care places and 6,653 home care places. In addition, $103 million in capital grants were provided to build new or renew existing residential services.

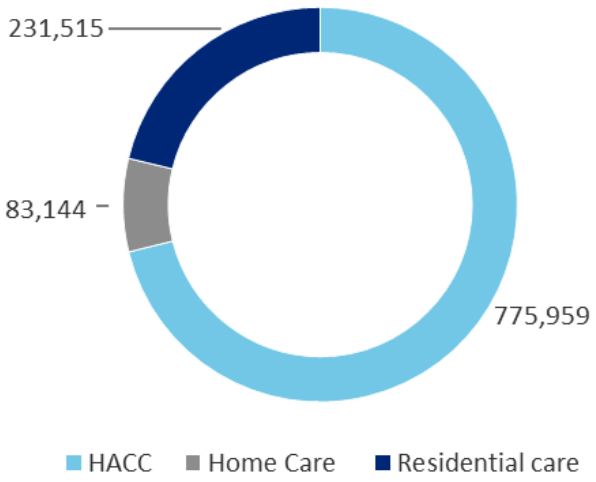
Competition for both residential and home care places was strong. Applications for over 19,000 residential places and 108,281 home care places were received.

Commonwealth HACC and the Victorian and Western Australian HACC programmes operate through grant funding arrangements and as such the number of consumers is not directly regulated by Government though is affected by overall funding.

Consumers of aged care

Over one million people accessed Aged Care services at some point in 2013-14. The largest proportion of these people accessed care through HACC and the Victorian and Western Australian HACC providers (Chart i).

Chart i: Consumers of aged care, by service type, 2013-14



Note. HACC includes Commonwealth HACC and Commonwealth contribution to Victorian and Western Australian HACC

The number of people in residential care at 30 June 2014 was 176,816 including 2,842 who were receiving respite care.

The average age of people accessing each of the three types of care in 2013-14 was 80.3 for HACC recipients, 82.3 for home care recipients and 84.5 for residential care recipients. In general, this pattern reflects the increasing need for more substantial care as people age.

Aged care workforce

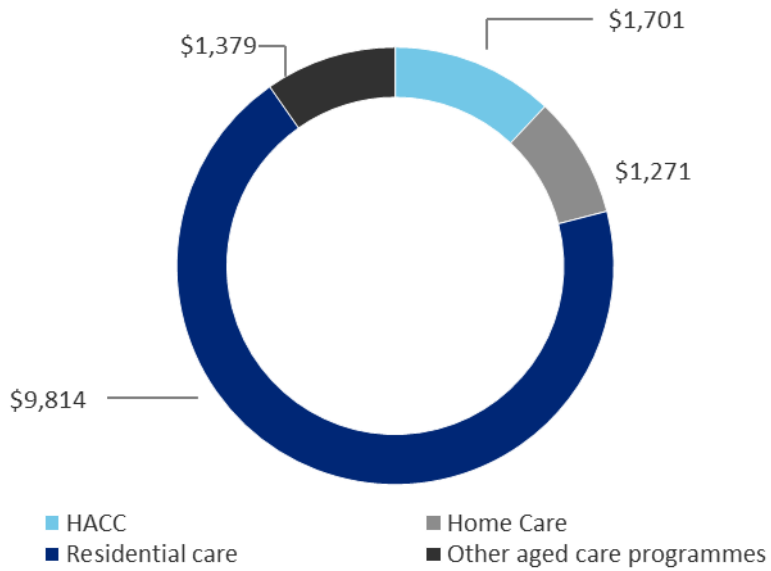
As a labour intensive industry, the growth of the sector will be mirrored in growing requirements for workforce:

- **Increasing demand:** The Productivity Commission (2011) noted that to meet ever increasing demand, the aged care workforce would be required to quadruple by 2050.
- **Increased competition in labour markets:** Workforce shortages may potentially be exacerbated as sectors competing for the same workforce, such as disability services, simultaneously grow.
- **Diverse and increasingly complex need:** Increasing rates of complex chronic conditions and a mismatch between the native language of some older Australians requiring care and the current workforce presents some challenges in keeping pace with the diversity and skills required to care for the ageing population.

Funding and financing in 2013-14

The Australian Government is the principal funder of the aged care sector. In 2013-14, the Australian Government contributed $14.2 billion to Aged Care. Chart ii shows the split of Commonwealth funding in 2013-14.

Chart ii: Distribution of Commonwealth funding, by service type, 2013-14 ($m)



Note. HACC includes Commonwealth HACC and Commonwealth contribution to Victorian and Western Australian HACC

Australian Government expenditure on aged care is projected to nearly double as a share of the economy by 2055. This increase is mainly driven by the growing number of people in older age groups but also by increasing care needs as Australians live longer with more complex care needs.[6]

Consumers also made a significant contribution to the cost of their care in 2013-14. Consumers in residential aged care contributed approximately $4.1 billion in fees (mainly towards their living expenses and accommodation costs - not including accommodation bonds). Consumers of home care packages contributed approximately $87 million. The 1 July 2014 reforms to means testing in residential care and income testing in home care packages are expected to see the share of consumer contributions to aged care funding grow over time. A more constant framework for fees in the CHSP is also expected in the future.

[6] Department of Treasury (Australia), 2015 Intergenerational Report: Australia in 2055.

Ongoing aged care reforms

The aged care sector is engaged in substantial reform which will shape the sector of the future. Government has indicated a reform direction which will result in a more consumer-driven and market based aged care system. Central to the recent reforms have been significant changes to the funding and financing arrangements for the sector introduced on 1 July 2014.

ACFA considers the funding and financing reforms implemented to date strengthen the viability and sustainability of the sector.

ACFA's monitoring of reform impacts to date has observed noticeable increases in the lump sum accommodation pool, improvements in financial performance and significant increase in investment and mergers and acquisition activity in the residential care sector.

In particular, ACFA considers the following benefits will flow from the reforms to funding and financing of the residential care sector:

- Market-based accommodation payment arrangements for non-supported residents will facilitate higher revenue flows (from the removal of caps on daily charges in high care) and an increased pool of lump sum accommodation payments (by allowing lump sums to be paid by high care residents);
- A higher Government accommodation supplement for supported residents living in new or significantly refurbished facilities will both increase revenue for eligible providers and, in conjunction with the accommodation payment changes, boost investment in the sector;
- Stronger means testing arrangements will improve long term sustainability by better balancing Government and consumer contributions.

Reform impacts to date

The reforms have had a noticeable impact in a range of areas.

ACFA notes that the overall sector is diverse and that there is also great diversity among providers within the residential and home care sectors. Reform impacts will thus vary across the sector and between providers. It will take some time for the full impacts to be assessed. ACFA will continue to monitor the impacts of reform.

Improved financial results in residential care sector since the reforms.

The improved financial results likely reflect the accommodation payment reforms and the 2.4 per cent increase to subsidies from 1 July 2014.

Consumer choice of method of accommodation payments favours Refundable Accommodation Deposits (RADs).

Consumer[7] choice of form of accommodation payment in residential care favours lump sum RADs at 41 per cent over rental style Daily Accommodation Payments (DAPs) at 35 per cent and combination payments at 24 per cent.

The total lump sum pool has increased significantly.

The total lump sum accommodation pool has increased significantly and is expected to have grown by around $3 billion by the end of 2014-15.

The average actual prices for RAD/DAP was $333,000/$58.02 at 30 June 2015, compared with average new bonds of $296,000 during 2013-14 with prices higher in city areas.

A significant increase in investment activity in the residential care sector.

There has been a significant increase in investment activity in the residential care sector, encouraged by accommodation payment reforms and the higher Government accommodation supplement. A total of $1.5 billion of new work was completed in 2013-14 – an increase of 69 per cent on the previous year. Approximately 12 per cent of services are now eligible for the higher supplement.

Reduced profitability of some Home Care providers as they adapt to CDC.

The introduction of CDC into home care will bring greater consumer focus and greater transparency to the sector. While a stronger consumer focus is desirable, it is reported that there are additional costs for providers to adjust, build capability and implement new systems. To date, there has been reduced profitability evident among some Home Care providers as they adapt to CDC requirements. There is likely to be a significant transitional factor in these impacts.

[7] For non-supported and partially supported residents. Supported residents' accommodation payments subsidised by the government are price regulated.

Admissions to home care have remained relatively stable.

In Home Care, admissions over the period have remained relatively stable. There was a spike around June 2014 followed by a decline but admissions have returned towards levels similar to pre-June 2014.

Transitional impacts have been observed in admissions to residential care

In residential care, there was a noticeable increase in permanent admissions in the period immediately preceding 1 July 2014, and a noticeable decline in the period following this date. In recent months, admission rates have seen a return to the longer-term trend. There was an observable increase in the use of respite care in residential care immediately after 1 July 2014. While this has returned closer to normal trends, use of respite care remains higher than pre 1 July 2014.

There has also been an increase in the number of providers relinquishing extra service places.

Administrative system difficulties.

There have been problems with the Department of Human Services administrative system implementation of new means and income testing arrangements causing transitional difficulties for both providers and consumers.

Home Support

Home support refers to the range of services provided under the Commonwealth Home and Community Care (HACC) programme and the Victorian and Western Australian Home and Community Care programmes which are not administered by the Commonwealth. These programmes provide basic support services which are distinct from the more structured Commonwealth Home Care Packages Programme.

Providers

In 2013-14, there were 1,110 providers of Commonwealth HACC services, up from 1,041 in 2012-13. There were also 566 HACC providers in Victorian and WA HACC, a slight decrease from 595 in 2012-13. HACC providers are predominantly not-for-profit organisations.

Consumers

In 2013-14, the Commonwealth HACC Programme provided services to 500,615 older consumers, and the Victorian and Western Australian programmes provided services to 275,344 older consumers. This totals 775,959 consumers across Australia.

Funding and financing

In 2013-14, the Australian Government provided funding of:

- $1,161 million to the Commonwealth HACC Programme ($1,113 million in 2012-13); and

- $539 million to the jointly funded HACC Programmes in Victoria and Western Australia ($501 million in 2012-13).

Fees paid by consumers currently vary across states and territories though they have been estimated at about 5 per cent of total funding, which brings the total revenue of the sector to around $1.8 billion in 2013-14.

Developments and challenges

The Commonwealth Home Support Programme (CHSP) commenced on 1 July 2015 combining the Commonwealth HACC and other Commonwealth home support programmes such as Day Therapy Centres into one programme.

The ACFA also notes that the 2015-16 budget decision to reduce annual real growth in home support funding from 6 per cent to 3.5 per cent from 1 July 2018 will improve the sustainability of aged care services for the community. Through this measure the Government is also aiming to ensure that Commonwealth Home Support funding is broadly aligned with the growth in the population of people aged 65 and over.

As part of the 2015-16 Budget, the Government announced its intention to integrate the CHSP with the Home Care Packages Programme by 1 July 2018 to create an integrated home care and support programme.

This change will raise a number of challenges in implementation for service providers as well as Government, including applying a fees policy that can operate across the currently distinct programmes.

Home Care Packages

The new Home Care Package Programme (HCPP) commenced on 1 August 2013, replacing the former packaged care programmes – 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 (HCPs) are categorised into four levels:

- Home Care Level 1 (HCL1). To support people with basic care needs;
- Home Care Level 2 (HCL2). To support people with low care needs (previously CACPs);
- Home Care Level 3 (HCL3). To support people with intermediate care needs.
- Home Care Level 4 (HCL4). To support people with high care needs (previously EACH and EACH-D).

Providers

In 2013-14, there were 504 home care providers that operated 2,212 services and 66,149 packages. Former CACP packages became level 2 and former EACH and EACH-D packages became level 4. Hence, these package levels are highest in number with levels 1 and 3 only first becoming available in 2013-14.

The majority of Home Care providers are not-for-profit providers (68 per cent).

The proportion of for-profit providers has been slowly increasing as a proportion of all Home Care providers. It will be of interest to observe for-profit providers in this market as reforms that increase consumer choice continue to unfold.

Consumers

In 2013-14, there were 83,144 individuals who accessed a home care package.

Occupancy was 88.4 per cent across all package types:

- Occupancy rates were lowest for the new HCL1 and HCL3 packages (both of which were new packages of care levels).
- Occupancy rates were highest in Tasmania and Victoria and lowest in Western Australia.

Funding and financing

Commonwealth payments on behalf of consumers are the primary source of funding for Home Care Package providers, increasing from $1.16 billion in 2012-13 to $1.27 billion in 2013-14.

Key observations on financial performance in 2013-14[8]:

- Total sector revenue of $1.3 billion;[9]
- Total sector profit of $120 million;[10]
- 66 per cent of providers achieved a surplus in Net Profit Before Tax;
- On a per package basis the average Earnings Before Interest Tax Depreciation and Amortisation per package per annum was $1,973;
- Commonwealth funding represented 92 per cent of revenue and consumer fees 7 per cent;
- Staff remuneration was the most significant expense comprising 61 per cent of total expenses; and
- From 1 July 2014, providers will benefit from a 2.4 per cent increase in package funding levels, on top of indexation, and a 20 per cent increase in the viability supplement (where applicable), though they may face additional costs as they transition to the new Consumer Directed Care system.

[8] Scaled up from the 88 per cent of providers' 2013-14 HCPP financial reports that were in a useable form

[9] Scaled up from the 88 per cent of providers' 2013-14. HCPP financial reports that were in a useable form.

[10] Scaled up from the 88 per cent of providers' 2013-14. HCPP financial reports that were in a useable form.

Developments and challenges

Significant reforms have commenced or are planned for the Home Care Packages sector.

Under the Government's planning ratios [11], there will be a continued increase in the supply of home care places with the total number of packages increasing from around 66,000 to 100,000 by 2017. An additional 40,000 packages are expected to be available over the following five-year period, bringing total places to 140,000 by 2021-22.

From 1 August 2013, all new Home Care Packages were required to be offered by providers on a CDC basis, and from 1 July 2015 all Home Care Packages were required to be provided on a CDC basis. This is a significant shift for the sector which will result in a greater focus on the consumer and greater transparency of funding and expenditure. The shift to CDC will, however, present some implementation challenges as it requires providers to reassess current business models and realign them with changing consumer needs and position themselves for the future.

As noted in the Home Support section, the Government has also announced that it intends to integrate the Commonwealth Home Support Programme and the Home Care Packages Programme from 1 July 2018.

Increasing choice, attaching funding to the consumer

The Government has announced that from February 2017 funding for Home Care Packages will be attached to the consumer.

As a result, providers will no longer bid for and be allocated Home Care Packages through the Aged Care Approvals Round (2015 will be the last ACAR for home care packages) and consumers will no longer be limited to finding a provider with a 'vacant' package. Instead, consumers will be allocated a package assessed appropriate to their needs. Providers will compete on their service offering for consumers. Once a consumer has chosen a provider, the package funding will be paid to that provider. As funding is 'attached' to the consumer, each consumer can also choose to change provider and their funding will follow. The Government will still control the overall number of funded packages available.

This will be a significant change to the dynamics of the Home Care Packages sector. Providers will need to have competitive service offerings that are responsive to consumer needs and preferences in order to succeed in this new more market-based environment.

6 Residential aged care: access to care

Residential aged care provides support and accommodation for those who choose to have their care provided within residential aged care accommodation.

[11] Home care places increasing from 27 places for every 1000 people aged 70 and over in 2012-13 to 45 places by 2021-22

Providers

In 2013-14 there were 1,016 residential care providers who operated 2,688 services with 189,283 places. The majority of residential aged care places are operated by not-for-profit providers (52 per cent of providers and 57 per cent of places). For-profit providers account for 37 per cent of providers and places with state and local government owned providers accounting for 11 per cent of providers and 5 per cent of places.

There continues to be a significant number of single home providers (64 per cent of all residential providers) though they only account for 24 per cent of places.

As the residential aged care sector matures, providers have tended to increase the scale of their business through consolidation.

The ten largest providers account for approximately 18 per cent of all operational residential care places at 30 June 2014. Over the last seven years the number of for-profit providers operating in the residential aged care sector has remained stable but the number of places held by for-profit providers has increased. For-profit providers are increasing the size of their operations over time.

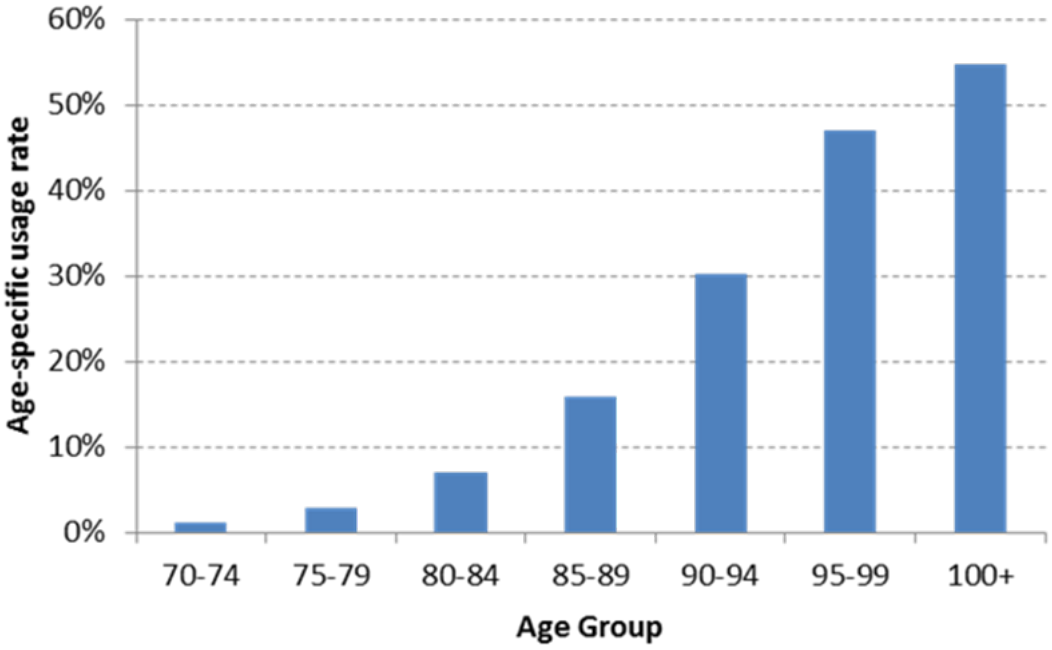
Most providers operate predominantly high care facilities (70 per cent of providers and 85 per cent of places). The remaining places are mostly operated by mixed care providers with very few providers operating predominantly low care facilities (4 per cent of providers and 1 per cent of places).

Residents

Between 2012-13 and 2013-14, the number of permanent residents increased by 3 per cent from 168,968 to 173,974, and average occupancy remained stable at 93 per cent. In addition there were 2,842 respite residents. The make-up of residents in aged care is changing. High care residents as a proportion of residents are increasing, from around 70 per cent at June 2010 to 82 per cent at June 2014. The cohort of residents in aged care is also changing with the number of residents aged over 85 growing at an average of 3 per cent over the past 5 years, whereas the number of residents aged between 70 and 85 has remained the same. 59.5 per cent of residents in care as at 30 June 2014, were aged 85 years or over. By comparison 34.2 per cent of residents were between 70 and 85 years of age.

Chart iii illustrates the proportion of total population accessing residential care, by age group.

Chart iii: Proportion of each age group in residential care, 30 June 2014



Residential aged care: operational performance

Key observations on financial performance in 2013-14 (compared with 2012-13)

- Revenue:
  - $14,826 million, an increase of 6.2 per cent; and
  - equating to $237 per resident per day, an increase of 5.3 per cent.

- Expenditure:
  - Total expenses were $14.1 billion, an increase of $0.7 billion (5.6 per cent).

- Profit:
  - Earnings before interest, taxes, depreciation, and amortization (EBITDA) was $1,581 million, up from $1,473 million (an increase of 7.3 per cent);
  - Net Profit Before Tax (NPBT) was $711 million, up from $594 million (an increase of 19.7 per cent);
  - EBITDA per resident per annum was $9,224, up from $8,660 (an increase of 6.5 per cent); and
  - NPBT per resident per annum was $4,150, up from $3,492 (an increase of 18.8 per cent.

The Australian Government's contribution to residential care was $9.8 billion in 2013-14, up from $9.2 billion in 2012-13.

Commonwealth funding represented 65 per cent of revenue, residents fees around 27 per cent and other income the remainder.

The profitability of providers varied greatly across the sector. Those with performance results in the top quartile of providers achieved an average EBITDA of $21,889 per resident. Providers in the bottom quartile averaged an EBITDA of negative $8,866 per resident.

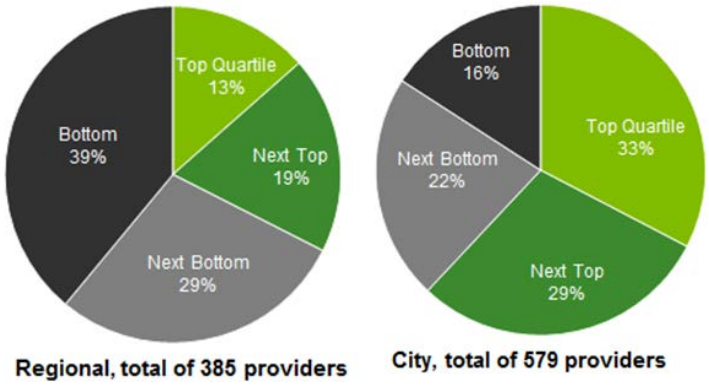
On average, financial performance continued to vary based on ownership type (for-profit generally outperformed not-for-profit), location (city generally outperformed regional) and care type (high care generally outperformed low care). However, reasonable numbers of not-for-profit and regional providers were also found in the top quartile which indicates that in most cases, providers with any mix of ownership, location and care type can achieve a sound level of financial performance.

Providers operating predominantly in city locations comprised the highest proportion of those within the top two quartiles of EBITDA per resident, whereas providers operating predominantly in regional locations were over-represented in the bottom two quartiles.

The May 2015 Report on Factors Influencing the Financial Performance of Residential Aged Care Providers found multiple factors may be at play for regional providers - particularly those in more sparsely populated, remote areas – which impact upon financial performance.

Specifically, regional providers are more likely to operate smaller facilities; receive lower resident accommodation revenue due to lower house values; have a higher proportion of low care residents; and, be significantly more dependent upon non-operating revenue for their viability (such as donations). Further, they are more likely to be not-for-profit or government providers which operate services where they may not otherwise exist, reflecting mission objectives and community service obligations.

Chart iv: Residential aged care provider distribution of average EBITDA per resident per annum, 2013-14, provider location



The box which follows provides a summary of the *Report on Factors Influencing the Financial Performance of Residential Aged Care providers.*

Summary: Report on factors influencing the financial performance of residential aged care providers

ACFA provided a separate report to Government in May 2015 on factors influencing the financial performance of residential aged care providers. Overall, ACFA's analysis found that, in most cases providers with any mix of ownership, location and size can achieve a sound level of financial performance, though further analysis was recommended on rural and remote providers. The following attributes were identified as being associated with higher financial performance:

- **Strong disciplined management** facilitates better financial performance**;**
- **Scale of facility** with providers with higher numbers of beds performing better;
- **Location of facility** with 'city' locations outperforming 'regional';
- **Ownership can be linked to financial performance with for-profit providers generally performing better than not-for-profit and government providers**;
- **Providers classified as 'high' care were associated with higher financial performance than those classified as 'low' care;**
- **Higher performing providers have higher levels of revenue**, both from subsidies and accommodation payments by residents;
- **Higher performing providers have lower liquidity, use more debt and manage it better;**
- **Regularly refurbished facilities were associated with better performers**; and
- **Greater use of outsourcing** was more evident in the better performing groups.

ACFA noted that its findings did not identify constraints that would prevent many lower performing providers adopting strategies to improve their financial performance. In this regard the report identified the following strategies that the lower performing providers could consider, noting that not all strategies would fit all providers:

- Stronger governance – including consideration of skill sets of boards and more regular review of risk, financial and strategic plans;
- Improved financial management – including clear financial goals and regular review of budgets and management and understanding of revenue and expenses;
- Stronger asset management – including investment in and refurbishment of facilities, consideration of appropriate size of facility and consideration of best approaches to debt and liquidity management; and
- Administration efficiencies – including use of outsourcing and shared or pooled services.

Source. link to website for DSS

Developments and challenges

As noted earlier, there have been significant changes since 1 July 2014:

- Reforms to accommodation payment arrangements should improve both revenue flows and holdings of lump sum accommodation payments in the sector;
- In addition, the 2.4 per cent increase in the basic care subsidy (on top of indexation) will increase revenue for all providers, and, a 20 per cent increase in the viability supplement will increase revenue for eligible rural and remote and homeless services;
- Some providers will be affected by the removal of the Payroll Tax Supplement from 1 January 2015 and cessation of the Dementia and Severe Behaviours Supplement;
- New means testing arrangements will impact on overall sector sustainability by increasing consumer care contributions but they will not affect actual care revenue for providers as increased consumer contributions will be matched by an offsetting reduction in Government care payments.

ACFA considers the net impacts of these reforms and changes will be beneficial overall for the sector though notes the impacts will vary from provider to provider.

Responding to ACFA's report on factors influencing the financial performance of providers the Government has asked the ACFA to investigate further and report on the operating circumstances of rural and remote residential and home care services, including Multi-Purpose Services and Aboriginal and Torres Strait Islander Flexible services.

Residential aged care: capital investment

Key observations on capital investment as at 30 June 2014 (compared with 30 June 2013):

- Total assets of $33.7 billion, up from $30.9 billion;
- Total liabilities (including accommodation bonds) of $22.5 billion, compared with $20.7 billion;
- accommodation bonds of $15.6 billion, compared with $14.3 billion, accounting for 71 per cent of total liabilities, unchanged, and accounting for 48 per cent of total assets compared with 48.5 per cent; and
- Net assets of $11.1 billion up from $10.2 billion, a 10 per cent increase.

Looking forward: investment challenges and trends

The sector also faces an ongoing challenge and opportunity to meet the demand for residential care going forward.

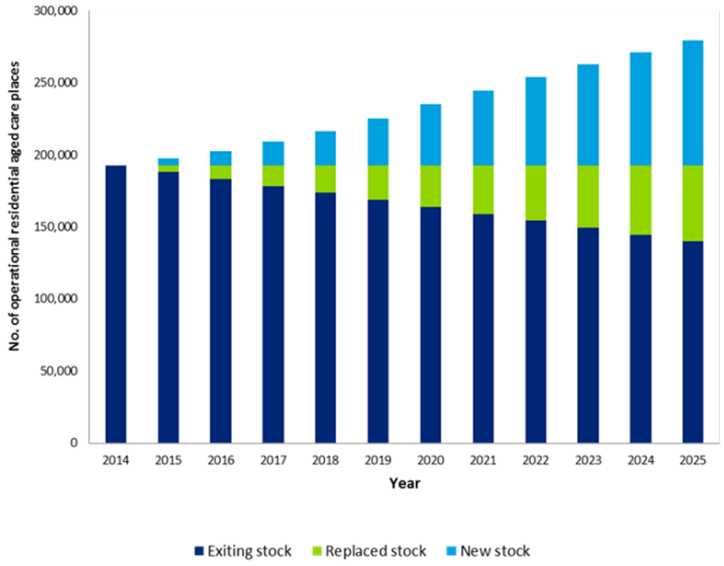
Our population is ageing. By 2054-55, the 2015 Intergenerational Report projects the number of Australians aged over 65 will more than double compared with this cohort today. Both the number and

proportion of Australians aged 85 and over will grow to represent nearly 5 per cent of the population compared with 2 per cent of the population today, an increase of close to 1.5 million people.

Underlying this are demographic factors related to the ageing of the population. The impact of population ageing will become most apparent in ten to fifteen years' time, however, impacts are already occurring and increased investment activity now and in future years is necessary to meet these challenges given the long lead times in developing and building new facilities.

For the Aged Care Sector, where lags in development times require a significant level of forward planning, this means the time to plan for change is now. Chart v illustrates the requisite path for development over the next ten years in the residential care sector alone.

Chart v: Operational residential aged care places required, 2014 to 2025



As noted previously, ACFA has observed strong positive trends in investment activity in the Aged Care sector following the initiation of the reform process:

- A total of $1.5 billion of new work was completed during 2013-14, an increase of 69 per cent.
- The proportion of providers planning to rebuild or upgrade facilities was also up as shown in below.
- During 2012-13 and 2013-14 three companies operating aged care providers floated their companies on the Australian Stock Exchange with a combined total market capitalisation of $1.7 billion. As at 30 June 2015 the combined market value was $3.3 billion. These providers in total were operating 8,681 places as at 30 June 2014.

These developments are encouraging as there is a significant investment challenge for the sector going forward.

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1 The Aged Care Financing Authority and the 2015 Annual Sector Report

1.1 About the Aged Care Financing Authority

The aged care sector in Australia provides services to over 1 million Australians, generates annual revenues totalling around $20 billion and employs over 350,000 people. As such, the sector makes a significant contribution to the Australian economy, representing approximately 1 per cent of GDP.

The sector is heavily dependent on taxpayer funding, receiving an estimated $14.2 billion in Commonwealth funding in 2013-14, or 3.6 per cent of Government expenditure. Objective, transparent and thorough analysis of the funding, financing and financial performance of the sector is therefore of central importance not only to aged care consumers and providers, but the broader Australian economy and community.

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

ACFA is led by an independent Chairman (Lynda O'Grady) and Deputy Chairman (Graeme Hugo until 20 January 2015) complemented by seven Members with aged care sector expertise. Further detail about each member and representative is provided in Appendix A.

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

The *Committee Principles 2014* require that ACFA provides the Minister with a report on the funding and financing of the aged care sector (the Annual Sector Report) each year. The objective of the Annual Sector Report is detailed in the box below.

Objectives of the Annual Sector Report

The *Committee Principles 2014* state that ACFA is to provide advice to the Minister each year on the **impact of funding and financing arrangements** on:

- The viability and sustainability of the aged care sector;
- The ability of aged care recipients to access quality aged care; and
- The aged care workforce.

Over time, each Annual Sector Report will build upon the last, producing a substantial body of in-time as well as trend data on the funding and financing of the aged care industry. To date, there have been two Annual Sector Reports published.[12]

1.2.1 Method

The 2015 Annual Sector Report analyses and presents 2013-14 financial and funding data collected from aged care service providers. Analysis of financial performance and operations of providers is primarily based on 2013-14 data, although this is supplemented by more recent data sources in certain areas for example - Chapter 3 - Ongoing aged care reforms. The principal data source is financial and administrative data collected by the Department, including:

- Residential care providers:
  - General Purpose Financial Reports (GPFRs);
  - Annual Survey of Aged Care Homes; and
  - Published aged care accommodation prices (My Aged Care Website).
- Home care providers:
  - Home Care Packages Programme (HCPP) 2013-14 Financial Reports; and
  - Financial Accountability Reports (FARs) for 2012-13 data.
- Home and community care providers:
  - Home and Community Care Minimum Data Set.
- Other general data:
  - ACFA's survey of aged care providers as part of its ongoing reform monitoring;
  - The 2012 National Aged Care Workforce Census and Survey;
  - The 2013-14 Report on the Operation of the Aged Care Act (ROACA); and
  - The 2014-15 Survey of Aged Care Homes.

In addition to the above listed data sources, ACFA has consulted widely with the sector, relevant financiers and other key stakeholders in developing this report. A list of organisations consulted in the development of the 2015 Annual Sector Report is provided in Appendix C.

2013-14 financial data has been analysed by sub-sector (Home and Community Care (Commonwealth and Victorian and WA), Home Care Packages and Residential Aged Care) to draw out key insights relating to funding and financial performance.

The financial reports do not provide detailed information on workforce issues. Information on these issues has been drawn from the 2012 Aged Care Sector Workforce Census and Survey and from administrative data held by the Department.

Considerations and limitations

As part of reform, the form of service delivery as well as data collection is necessarily changing. For this reason, the 2015 analysis is not always in a format that is directly comparable with preceding ACFA annual reports, particularly in the case of home care where new package levels were introduced in 2013-14. Where this is the case, it is signalled in the report, and the reader is asked to exercise caution in interpreting year-on-year trend data.

[12] Previous ACFA Annual Sector Reports can be accessed <https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/aged-care-reform/reforms-by-topic/aged-care-financing-authority>.

In addition, workforce data is limited in this report as the Aged Care Workforce Survey has not been updated since 2012. The next national Aged Care Workforce Census and Survey will be conducted in late 2015 with data to be published in mid-2016. The results of this survey will be discussed in ACFA's 2016 annual report.

The financial data available to ACFA is at the approved provider level. Because many providers have services in multiple locations, ACFA is constrained in its ability to analyse by-facility level performance or the impact of locational factors on funding, financing and financial performance by facility.

1.2.2 Navigating the 2015 Annual Sector Report

The 2015 Annual Sector Report is structured as follows:

- Chapter 2 **Aged care in Australia.** This chapter provides an overview of the current aged care sector in Australia, including supply, usage, sustainability and workforce.
- Chapter 3 **Ongoing aged care reforms.** This chapter discusses and analyses the impact of recent reforms in aged care.
- Chapter 4 **Home Support.** This chapter provides an overview of the Commonwealth and the Victorian and Western Australian Home and Community Care Programmes and a brief overview of the introduction of the Commonwealth Home Support Programme.
- Chapter 5 **Home Care Packages.** This chapter provides an overview of the provision of home care through the Home Care Packages Programme and a summary of revenue, expenditure and profit for providers in this sub-sector in 2013-14.
- Chapter 6 **Residential aged care: access to care.** This chapter provides an overview of residential aged care, focusing on the supply and demand for residential aged care.
- Chapter 7 **Residential aged care: operational performance.** This chapter provides information on the revenue, expenditure and profit of residential care providers in 2013-14.
- Chapter 8 **Residential aged care: capital investment.** This chapter provides discussion pertaining to provider balance sheets and capital investments.

Where relevant, links are provided to allow easy navigation between related analysis and appendices.

2 Aged care in Australia

This chapter provides an overview of the Australian Aged Care sector.

This Chapter provides an overview of:

- the supply of aged care, including the number of providers and places in different sub-sectors and how supply is set and managed by government
- usage of aged care and impacts of a changing population
- sustainability and affordability
- the aged care workforce.

This Chapter reports that:

- Aged care is one of Australia's largest service industries:
    - services provided to over 1 million people
    - provided by over 2,000 providers
    - employs over 350,000 people
    - comprises 3.6 per cent of Government expenditure.

2.1 Overview

Older Australians access a spectrum of aged care on a needs basis, ranging from home and community based services through to services provided in residential settings. Figure 1.1 illustrates the Australian aged care service system.

Older people have the option to access a single portal, My Aged Care, **for information** on aged care services. Older people are also able to ask their carers, family, friends, health practitioners and hospitals to access the My Aged Care portal for information on their behalf. Various other organisations also provide information and support for consumers.

From 1 July 2015, My Aged Care arranges an **assessment of the person**. This assessment is usually face-to-face and serves to determine the person's individual care needs, plan their goals, and identify their preferences for support. The planning component is important, and can also be developed with a service provider.

The outcome of this determines which of the **three services types** (Commonwealth Home Support, Home Care Packages or Residential Aged Care) is most suitable, and the supports provided.

Each person's care and support needs are thereafter monitored and periodically re-assessed and their services changed as necessary.

This system has evolved over many years and aims to support people living in their homes and communities for as long as they wish to, and to enable people to have a greater role in decisions about their care.

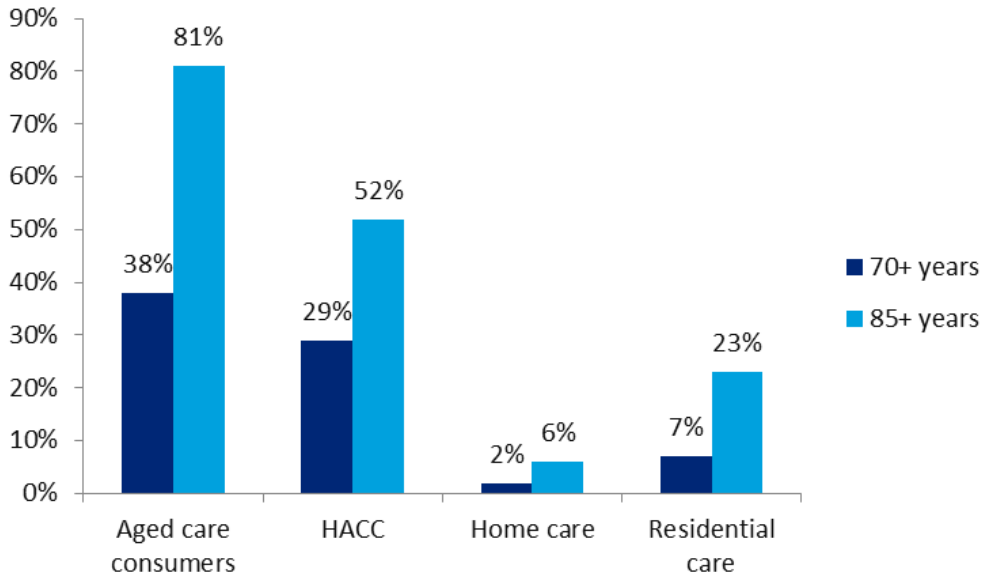
2.2 A sustainable system

To achieve a sustainable aged care system, demand for aged care must be effectively and efficiently matched to the supply of aged care services. A sustainable aged care system also needs to consider affordability to government and consumers of delivering aged care as well as the quality of care provided. This is an ongoing challenge.

The aged care target population definition adopted by the Australian Government in allocating residential and community care packages is the population aged 70 years and over – as specified in the *Aged Care Act 1997*. For reporting purposes this is combined with the population of Aboriginal and Torres Strait Islander Australians aged 50-69 years. It should be noted, however, that some comparable sources to this Report – such as the Report on Government Services produced by the Productivity Commission – instead - utilise the definition specified under the *National Health Reform Agreement,* that is, the whole population aged 65 and over and Aboriginal and Torres Strait Islander Australians aged over 50.

As at 30 June 2014, there were 2.3 million people aged over 70 living in Australia and 456,533 people aged over 85. The patterns of use of aged care services appear to change with age. As Chart 2.1 illustrates, at this point, 29 per cent of people aged 70 years and over were receiving Government subsidised aged care services (HACC and home care) while living at home and 9 per cent were utilising residential aged care. These proportions increased when focused on the over 85 cohort – notably, the proportion of people accessing residential care.

Chart 2.1: Proportion of people 70+ and 85+ accessing aged care at 30 June 2014



2.3 Current aged care supply

For the purposes of this report, the aged care sector is discussed in terms of three programmes:

- **Home and Community Care (HACC).** For those who require only a few services to assist in home living. As of 1 July 2015 the Commonwealth HACC Programme was included in the new

Commonwealth Home Support Programme (CHSP). HACC in Victoria and Western Australia will continue to operate separately.

- **Home care.** For those who require a package of services to assist in living at home, care and support is provided through an appropriate package of home care services.
- **Residential care.** For those who require 24 hour care in a residential setting, care can be provided either on a temporary/casual or permanent basis within a residential aged care home.

Across all three programmes, providers are either not-for-profit (63 per cent), for-profit (30 per cent) or government (7 per cent).[13] Table 2.1 below provides a snapshot of the number of providers, services, residential places and home care packages, consumers and funding for each of these three programmes in 2013-14.

[13] A 'government provider' is a term used in this Report to refer to providers that are owned by a local or state government. There are no Commonwealth providers.

Table 2.17: Aged care in Australia, 2013-14

	Home and community care	Home care	Residential care
Number of providers	1,676	504	1,016
Number of services	N/A	2,212	2,688
Number of places	N/A	66,149	189,283
Occupancy/number of consumers	775,959	88.4%	93.0%
Commonwealth funding ($million)	$1,701	$1,271	$9,814

Note: The number of providers, services and places in Residential Care and Home Care are all as at 30 June 2014, whereas the number of HACC consumers is during the year. Commonwealth funding for Home and Community Care above includes Commonwealth HACC as well as the Commonwealth contribution of funding to the Victorian and WA HACC.

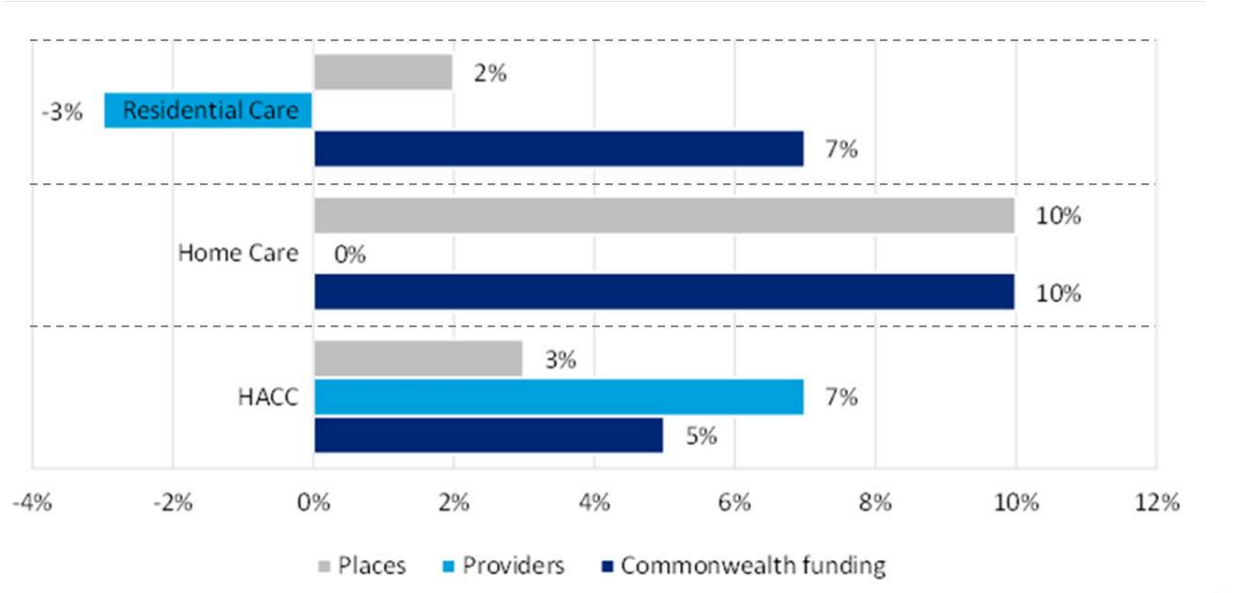
Some providers offer more than one of these types of services. Of all providers, 2.2 per cent provide all types of services and 13.3 per cent provide two service types. Over three quarters of providers either only provide HACC (42.8 per cent) or residential aged care services (33.7 per cent). 14.7 per cent of providers are home care providers only.

Table 2.2: Number of providers by sub-sector at 30 June 2014

Type of provider	HACC	Home Care	Residential	Number of providers
All three	•	•	•	49
Home Care and Residential only		•	•	194
HACC and Home Care only	•	•		84
HACC and Residential only	•		•	20
Residential only			•	753
Home Care only		•		177
HACC only	•			957
Total				**2234**

Chart 2.2 shows that the number of places in both Residential aged care and Home Care increased from 2012-13 to 2013-14, as did the number of recipients of HACC services. The number of HACC providers increased and the number of home care providers remained the same however there was a decrease in the number of residential care providers.

Chart 2.2: Growth in aged care places, providers and Commonwealth funding 2012-13 to 2013-14[14]



2.3.1 Regulation of supply

The Australian Government regulates the supply of subsidised residential aged care and home care packages by specifying national and regional provision targets 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, known as the aged care provision ratio. The population-based provision formula ensures that the supply of services increases in line with the ageing of the population, while capping the number of places limits the fiscal risk associated with aged care.

The Australian Government also regulates the supply of services offered through the Commonwealth HACC programme through a capped funding amount that is indexed annually. Similarly, the Commonwealth Government contribution toward the Victorian and Western Australian HACC programmes is a capped and indexed contribution.

The provision ratio was first set in 1985 at 100, increased to 108 places in 2004-05, further increased to 113 in 2007, and further increased to 125 in 2012 (to be achieved by 2022).

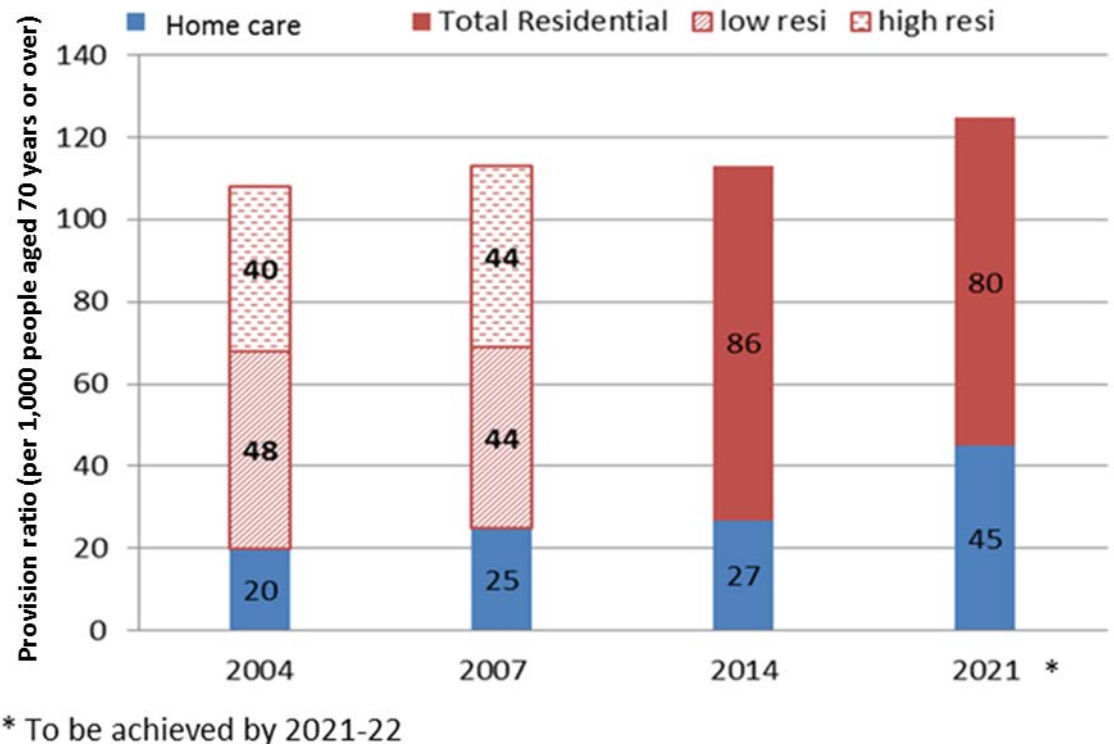
The proportion of different types of care places offered was also adjusted in 2007 from 40 to 44 places for high level residential care, from 48 to 44 places for low level residential care and from 20 to 25 places for home care for every 1,000 people aged 70 years or over. Successive adjustments to the overall target have seen a steady increase in the target for home care places.

Under the recent reforms, the overall aged care ratio was further increased from 113 operational places per 1,000 to 125 places by 2021–22. Within this overall provision ratio, the target for home care packages will increase from 25 to 45, and the residential target will reduce from 88 to 80. Additionally, from 2016-17, 2,000 new short-term restorative care places will be introduced to build on the current 4,000 transition care places to provide 6,000 short-term restorative care places by 2021. These new places will be included in the aged care provision ratio from 1 July 2015. The low care/ high care

[14] HACC places is calculated based on the total number of consumers

distinction for residential places has been removed from 1 July 2014. Chart 2.3 shows the changes in the provisional ratio since 2004 and the planned increase between now and 2021. Appendix D details the aged care provision ratio by care type and region.

Chart 2.3: Increase in provision ratio, 2004-2021 (per 1000 people aged 70 and over)



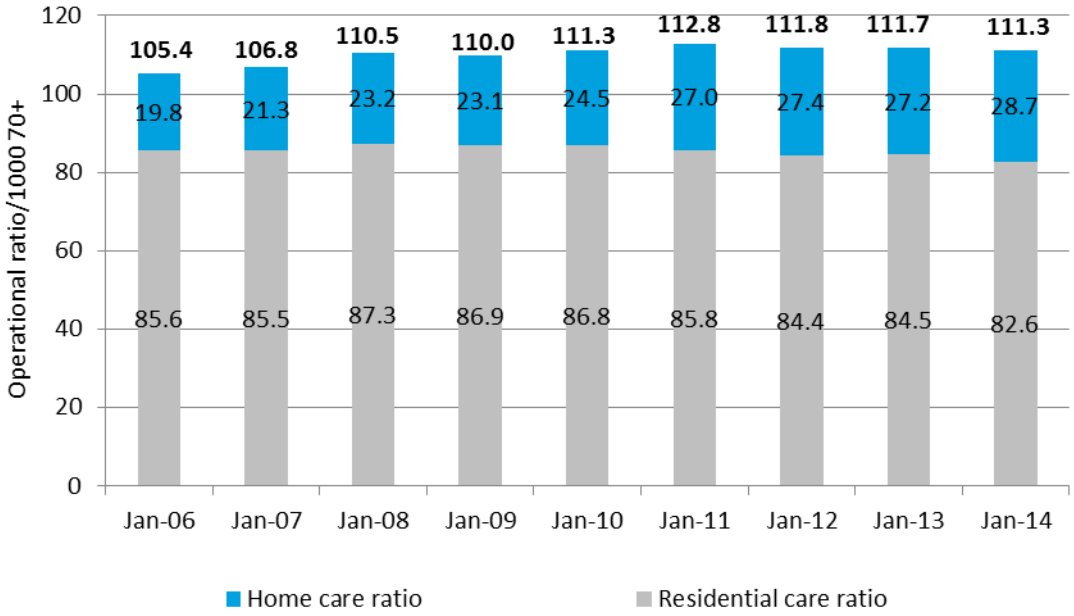
Each year, new aged care places for residential and home care are made available for allocation through the Aged Care Approval Rounds (ACAR), having regard to the service provision target ratios, population projections provided by the Australian Bureau of Statistics, and the current level of service provision. The allocation of new places seeks to achieve a balance in the provision of services between metropolitan, regional, rural and remote areas, as well as between people needing different levels and types of care.

In 2014, the ACAR allocated 11,196 new residential aged care places and 6,653 home care places. This represents a 44 per cent increase in residential care places and a 14 per cent increase in home care places, over the allocation of places in the 2012-13 ACAR. The 2015 ACAR is expected to be the last time that home care places are allocated through the ACAR process. Following this, home care places will be allocated to the consumer who will then choose their preferred service provider. However the Government will still limit the number of places available in accordance with the provision ratio.

The Government's current population-based service provision target (which is increasing from 113 places to 125 aged care places to be achieved by 2021-22) is intended to ensure an overall increase in the supply of home and residential care places. However, there is a risk of a shortage of services if there is under-investment (though recent investment trends are encouraging), and a mismatch between the location of aged care and people requiring aged care. The detailed demographics will need to be examined further by both government and providers, potentially during the legislated 2016-17 Review of Aged Care Reforms.

Chart 2.4 shows the overall aged care operational ratio, the residential care operational ratio and the home care operational ratio. The residential care ratio has decreased slightly since 2009-10 which is explained by the substitution from residential care to home care, which is also shown by the increasing home care ratio.

Chart 2.4: Aged care operational ratio, 2006 to 2014 (total aged care ratio is in bold)



2.3.2 Sector viability and sustainability

Growing demand for aged care as the population ages will require significant further investment in the sector, particularly in the capital intensive residential sector. A viable residential aged care industry needs to provide rates of return on capital that are appropriate for the risk involved. 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 for-profit or not-for-profit, 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.

The viability and sustainability of the residential sector is dependent on ongoing investment. For example, investment in new facilities with extra places and upgrading of older facilities to maintain the standard of existing homes. Investment activity requires equity investor and debt provider confidence in the viability of specific providers to deliver sustainable returns on capital. The amount of (and change in) invested capital is one key metric of sustainability. Another key sustainability metric is the growth in the capital value of aged care providers.

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

A sustainable aged care industry will meet three key principles relating to providers:

- **Existing providers –** current providers will be viable enough to continue to maintain a quality service for consumers and replace their capital stock as needed;

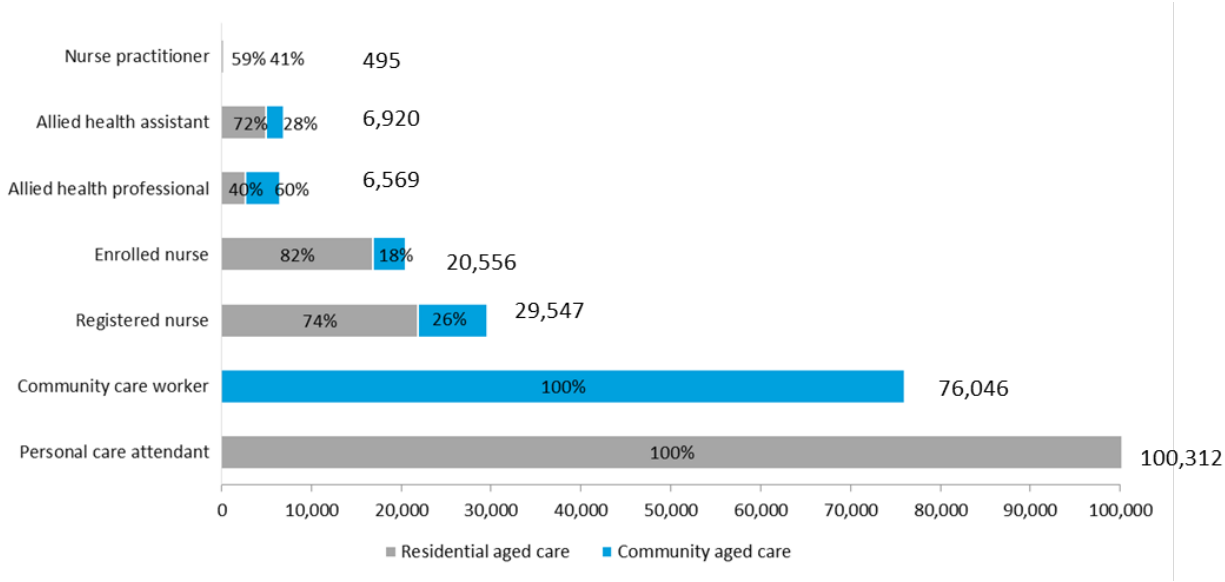
- **Growth –** well run providers who wish to grow to help meet the increasing demand for aged care will be able to attract the finance, equity and staff needed to enable them to expand;
- **New investors and providers –** new investors and providers will be attracted to the industry.

These general principles apply across residential aged care, home care packages and home and community care. The viability of each of these is discussed in more detail in relevant sections of the report.

2.3.3 Workforce

The sustainability and quality of the sector relies on sufficient numbers of appropriately skilled staff, including nurses, personal care or community care workers, support staff (such as chefs) and allied health professionals. The aged care workforce currently numbers over 350,000. Chart 2.5 shows the proportions of care workers by occupation and care setting as per the 2012 National Aged Care Workforce Census and Survey.

Chart 2.5 Care workers in aged care by occupation, 2012 (total in bold)



Ensuring there is a sufficient workforce to meet increasing demand in aged care services is a major challenge for the sustainability of the sector in the future. Increasing demand is predominantly driven by two factors - an ageing population and the increased prevalence of dementia and the associated need for higher levels of support and care (Deloitte Access Economics, 2010, see section 2.5). To meet the increased demand it is estimated the workforce needs to triple by 2050. This is at a time when the overall employment to population ratio will be reducing.

Volunteers contribute significantly to the delivery of some aged care services in both residential and community settings. Volunteers provide a range of support and services to older Australians such as helping with food shopping, providing transport, companionship, entertainment and assistance with social activities which complement the formal workforce and improve the quality of life for older people. Volunteering activities may also reduce the need for formal aged care. The 2012 survey found that 51 per cent of aged care services have one or more volunteers. The distribution of volunteers is fairly consistent except in remote areas where only 34 per cent of services had one or more volunteer. In Home Care, there are on average 27 volunteers per outlet, with each volunteer averaging 4.6 hours per fortnight. In residential care services, there are up to 10 volunteers per facility, with each volunteer contributing an average of 4.8 hours per fortnight.

The challenge also extends to informal care, where there is evidence that social and demographic factors are reducing the availability of informal carers relative to the growth in the older population. The Productivity Commission's Caring for Older Australians Report predicts a relative decline in the number of informal carers over the period 2011-2031. Because aged care currently relies so heavily on the availability of informal care, especially to support home care, an important challenge will be to ensure that policies support informal carers.

Providing quality aged care services means an appropriately skilled workforce. The 2012 workforce survey found that aged care workers are more likely to have post-secondary qualifications compared with the national average. However increasing rates of complex chronic conditions and the mismatch between the language skills of older Australians requiring care and the workforce demonstrates some difficulties in keeping pace with the skills required to care for the ageing population. Access to appropriately skilled staff is also critical for dementia care and end of life/palliative care. For example, the 2012 workforce survey found that three quarters of aged care homes and half of community services reported skill shortages in one or more occupations, with the three main reasons being a lack of specialist knowledge, slow recruitment, and geographical location. In rural and remote areas, providers reported difficulty in filling positions across all occupations.

Competitive remuneration is a challenge for the sector, which may lead to difficulties in attracting and retaining staff. For instance the 2012 aged care workforce survey found that job satisfaction is high across all areas except for pay. Remuneration is often lower in aged care than alternative settings, making it difficult to attract and retain staff.

This is exacerbated by other caring sectors potentially competing for the same pool of staff. For instance aged care and disability services often draw on the same pool of workers. Preparing the disability sector workforce for the full implementation of the National Disability Insurance Scheme (NDIS) will require a national effort across all aspects of workforce development and coordination with similar sectors such as aged care. There is also traditional competition from the health sector, especially for nursing care staff.

The 2012 workforce survey found that the median age of the direct care workforce in home care is 50 years and in residential care 48 years. However, the proportion of new hires aged 34 years or younger increased from 29 per cent in 2003 to 36 per cent in 2012.

Diversity in the workforce is important. For home care workers, the proportion of the workforce who identify as an Aboriginal or Torres Strait Islander person is similar to the broader population. For residential care workers, the number is slightly less than the broader population. Between 2003 and 2007 there was growth in the proportion of residential care workers born outside of Australia from 25 per cent to 33 per cent, which has stabilised at 34 per cent between 2007 and 2012.

It is challenging to ensure this diversity aligns with consumer preferences. For example, many older people with dementia may revert back to their mother tongue, and the growth in workers born outside Australia does not align with the language requirements of the current CALD consumer profile and poses some difficulties with language barriers (2012 workforce survey). While earlier migrants largely came from European countries, nine Asian countries are among the countries that have been the largest source of immigration since the mid-1970s. Many of these people are now seeking culturally appropriate aged care information and services.

These factors have implications for aged care service providers. Firstly, it means providers are essentially competing for scarce resources to deliver their services. Providers who place an appropriate level of importance on the recruitment and retention of staff – for instance, through competitive wages, working conditions or development opportunities – will be best placed to succeed in this environment.

Second, one of the key sustainability challenges for the sector will be accessing a suitably skilled workforce that is responsive to consumer preferences and needs.

2.4 Changing population

An increase in demand is driven by two factors – an ageing population structure and dementia prevalence.

Currently, over 15 per cent of Australia's population is aged 65 years or more (3.5 million people); this is projected to rise to 19 per cent by 2034. Some 1.9 per cent of the population (455,000) is aged 85 and over, rising to 3 per cent (955,000) by 2034. The Government's 2015 Intergenerational Report projects this will increase to nearly 2 million by 2054-55 (representing around 5.2 per cent of the total population). Similarly, the numbers of centenarians are projected to rise from 4,600 currently to 15,700 by 2054-55, predominantly among women.

The Australian Institute of Health and Welfare[15] estimates that the prevalence of dementia is expected to grow from 342,000 in 2015 to over 891,000 by 2050.

In 2014, ACFA released an information paper following an examination of the demographics of older Australians over the next 20 years by the late Professor Graeme Hugo. The paper highlights the significant difference between the ageing population of baby boomers entering the retirement stage of their life cycle and the previous generation. The paper specifically noted how they differ economically, socially and in their values, attitudes and expectations. [16]

One of the most important differences between generations relates to health. Baby boomers are eight times more likely than the previous generation to have three or more health problems – a difference which will have a significant impact on their demand for health services. The increasing prevalence of co-morbidities amongst baby boomers may also have implications for their aged care and support needs.

Another key factor identified by Professor Hugo is the spatial distribution of the older population, with Australians aged over 65 years being the least residentially mobile group in Australia. This is important as older Australians' local areas are usually where their main social contacts and services, or urban villages, are located and they will be generally reluctant to leave these areas in order to access residential aged care services.

Age-specific usage of aged care has been highly stable between 1997 (tan lines) and 2014 (dark green), with a slight decrease in age-specific usage for people aged 80 to 90 years old. As the supply of home care has increased, there has been a shift from residential care to home care. This trend reflects international experience within the OECD. It is anticipated that demand for home care will continue to increase as more people substitute this for residential care.

[15] Australian Institute of Health and Welfare 2012. Dementia in Australia.

[16] Hugo G, 2014, The demographic facts of ageing in Australia.

2.5 Access to quality aged care

Ensuring access to appropriate quality care is a fundamental policy objective in the funding and financing of aged care. The Australian Aged Care Quality Agency has responsibility for quality review of aged care services.

Australia is a large, sparsely populated country so providing services where people want them (that is, near their home or family) can be challenging. Remote and some rural areas will always be challenged by small population and workforce catchments, whereas urban areas will be 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 fairly across the country in order to achieve equitable access. Aged care services are also targeted to ensure equitable access by special needs groups including CALD, Aboriginal and Torres Strait Islander people, people living with dementia and the homeless.

For the consumer, cost alone is unlikely to be a significant barrier to access because the Australian Government subsidises services for those who cannot afford to pay the full price. The Government takes capacity to pay into account when formulating fee policies and applies annual and lifetime caps on care contributions in Residential Care and Home Care Packages.

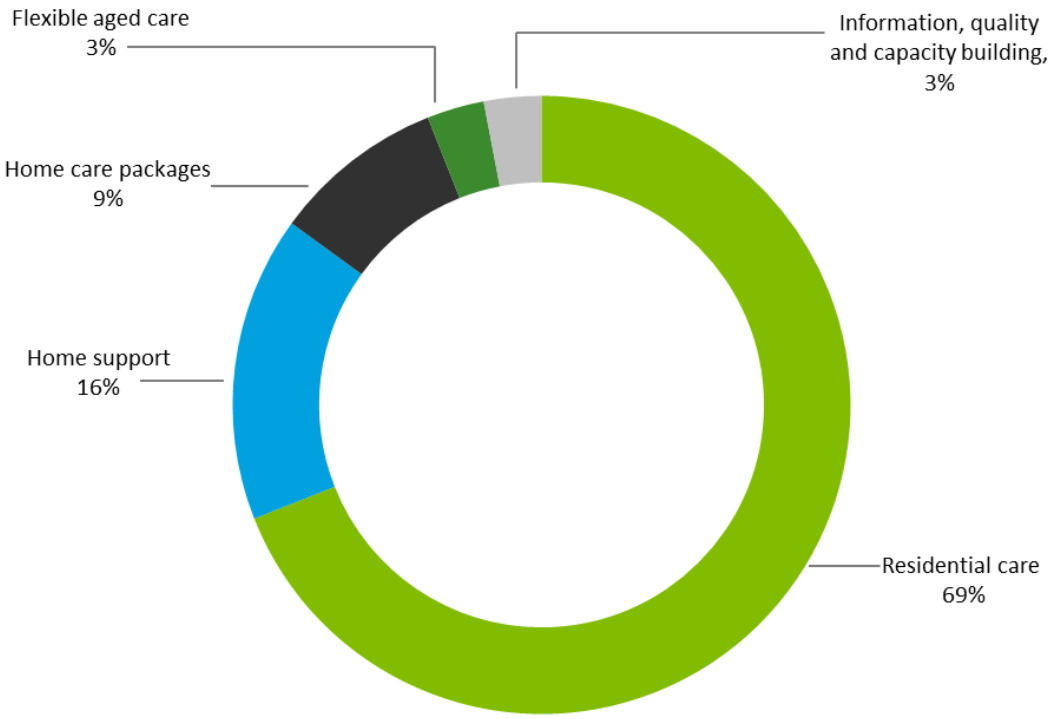
Access to care – including unmet demand – is discussed further in the following chapters:

- Chapter 4 Home Support
- Chapter 5 Home Care Packages
- Chapter 6 Residential Aged Care: access to care.

2.6 Affordability of aged care

The sector received $14.2 billion in Commonwealth funding in 2013-14. It was estimated to receive approximately $15.4 billion in Commonwealth funding in 2014-15. For 2015-16, the Government has budgeted $16 billion in aged care expenditure. The proportions of funding across the sector is illustrated in Chart 2.6.

Chart 2.5: Australian Government total budgeted aged care expenditure 2015-16



Note. 'Home support' includes HACC, NRCP, DTC and ACHA

Australian Government expenditure on aged care is projected to nearly double again as a share of the economy by 2055, as a result of the increase in the number of people aged over 70. As outlined in the 2015 Intergenerational Report, expenditure is projected to increase from 0.9 per cent of GDP in 2014-15 to 1.7 per cent of GDP in 2054-55 (see **Error! Reference source not found.**). The costs of care rise on account of growth in input costs (e.g. wages), advances in technologies and the increasing complexity of illnesses prevalent in ageing populations.

As also noted in the Intergenerational Report, spending on aged care would have reached 2.1 per cent of GDP. The lower 1.7 per cent projection largely reflects the decision to reduce the annual real growth of the CHSP from 6 per cent to 3.5 per cent.

The shift in the balance of care in favour of home care is expected to improve affordability for taxpayers over the long term, given the higher cost of funding residential care. In 2013-14, the average amount of Government payments for permanent residents in residential aged care was $56,100. By way of comparison a level 4 package in home care in 2013-14 was worth $45,607 in 2013-14.

Aged care consumers also make a significant contribution to the cost of their living expenses, care and accommodation. In 2013-14, aged care residents contributed some $4.4 billion to these costs and it is estimated consumers of home care packages contributed around $84 million to their care costs. The level of consumer contributions will increase as a result of changes to means testing arrangements in residential care and income testing in home care that commenced on 1 July 2014.

The current aged care reforms are a major step towards improving the future sustainability of the aged care system in the face of the steadily increasing demand resulting from our ageing population. The key reforms in this area are:

1. Removal of restrictions on accommodation pricing in residential care;
2. Means tested consumer contributions; and
3. Focus on home care places in preference to residential care.

The current aged care reforms are discussed in further detail in chapter 3.

3 Ongoing aged care reforms

This chapter provides an overview of the ongoing reforms to the Aged Care Sector.

The Australian Aged Care Sector is undergoing a phase of significant transformation as it moves toward an increasingly consumer led, market-based system.

This Chapter discusses:

- impacts of changes to accommodation payment arrangements, including the effect of choice of payment on the lump sum pool
- agreed and published accommodation prices
- trends in admissions to care
- the new Higher Accommodation Supplement
- initial impacts of CDC
- Implementation challenges.

ACFA considers the funding and financing reforms implemented to date strengthen the viability and sustainability of the sector.

ACFA's monitoring of reform impacts to date has observed noticeable increases in the lump sum accommodation pool, improvements in financial performance and significant increases in investment and mergers and acquisition activity in the residential care sector.

There have been some implementation challenges for some providers and consumers in transition and these will continue to be monitored by ACFA.

ACFA notes that the overall sector is diverse and that there is also great diversity among providers within the residential and home care sectors. Reform impacts will thus vary across the sector and between providers. It will take some time for the full impacts to be assessed. ACFA will continue to monitor the impacts of reform.

3.1 Description of reforms

The aged care sector is undergoing a period of substantial change. Not only is the number and preferences of consumers changing, the provider and funding landscape is also undergoing significant reform. This change includes a suite of reforms that have undergone phased implementation since being announced in April 2012, and further reform announcements in the 2015-16 Budget. These reforms can broadly be considered in four phases:

- **Phase 1 (2012-13 – 2013-14). Initial Aged Care Reform.** This phase saw the announcement of the *Living Longer Living Better* reforms, including: a phased increase in the service provision target ratio and an increased proportion of home care places; the introduction of the new home care package levels; commencement of Consumer Directed Care for new Home Care packages; and accommodation price publishing. The My Aged Care website and Contact Centre and the

Australian Aged Care Quality Agency and the Aged Care Pricing Commissioner were also introduced, along with the Aged Care Financing Authority.

- **Phase 2 (2014-15). Financing reforms.** This phase included reforms to accommodation payment arrangements, new means testing arrangements and a higher maximum accommodation supplement for new and significantly refurbished homes.
- **Phase 3 (2015-16). Consumer choice.** This phase will see further enhancement to the My Aged Care functionality to include standardised assessment and a central record that underpins assessment, referral and service provision, extension of Consumer Directed Care to all existing Home Care Package recipients and the formation of the Commonwealth Home Support Programme.
- **Phase 4 (2016-17– 2021-22). Further consumer choice, sustainability and review.** Implementation of 2015-16 Budget measures including allowing home care package recipients full choice of preferred provider, the intention to combine the Home Care Package Programme and Commonwealth Home Support Programme into a single program, and the extension of short-term restorative care places. In addition, an independent review of the reforms already introduced is scheduled to table a report in Parliament by August 2017, and further reform is likely to ensure continued sustainability, growth and quality care for older Australians.

An Aged Care Sector Statement of Principles was developed by the Aged Care Sector Committee and was endorsed in November 2014 to guide the future direction of aged care reform and to ensure a shared vision for aged care in Australia. The Statement of Principles was developed by representatives of aged care consumers, providers and workers through the Aged Care Sector Committee.[17]

The Statement of Principles envisages:

- consumers who are empowered, able to exercise responsibility, make decisions, and drive competition and quality;
- a market-based approach enabling services to be responsive to the diversity of older people, innovative, competitive, and where funding follows consumers; and
- a viable and sustainable system for all where a fit-for-purpose regulatory approach allows flexibility for innovation and Government intervention focuses on areas of potential market failure and consumer protection, including through a strong safety net.

The Aged Care Sector Committee is developing a 'roadmap' for future reform to help guide the future reform agenda.

[17] The Aged Care Sector Committee provides advice to the Government on aged care policy development and implementation and helps to guide the future reform of the aged care system. The Committee also acts as a key mechanism for consultation between the Australian Government and the Aged Care Sector. Membership of the Committee is representative of the sector and Committee members consult broadly within their own memberships and constituencies to ensure that stakeholder views inform the policy development process.

Figure 3.1: Timeline of aged care reforms

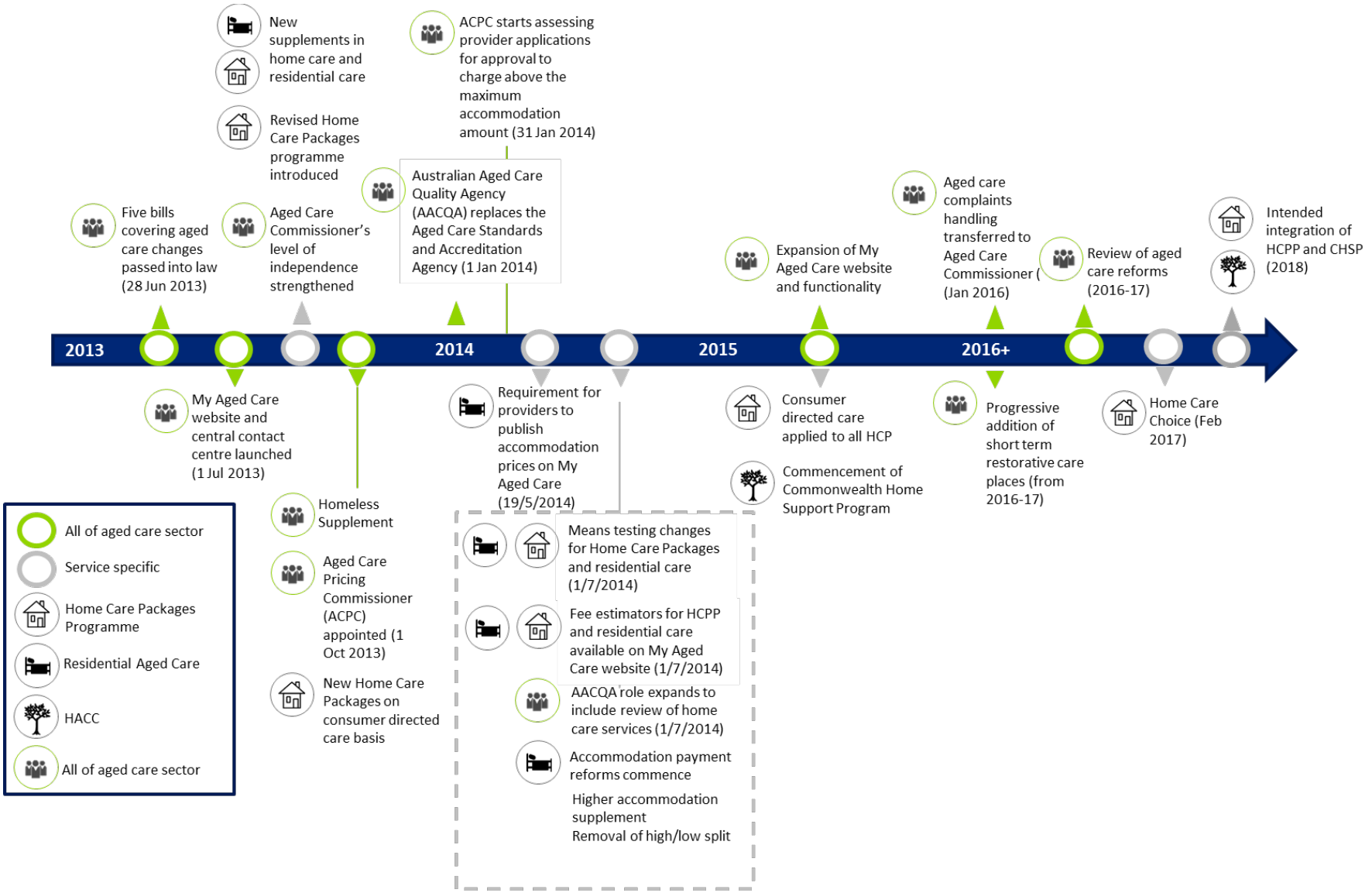


Table 3.1: Reforms by Programme

Commonwealth Home Support Programme

From 1 July 2015, the Commonwealth Home Support Programme (CHSP) commenced. The CHSP brings together the:

- HACC program;
- National respite for carers program;
- Day therapy centres program; and
- Assistance with care and housing for the aged program.

The transition period for this occurring is from 1 July to 31 October 2015. New clients will be eligible for the CHSP following a My Aged Care Regional Assessment Service assessment.

Under My Aged Care there will be new assessment and referral arrangements and a central client record.

From July 2018, the Government intends to integrate the Home Care Packages Programme and the CHSP.

A principles based policy on fees for the CHSP is being developed with further consideration likely as part of the intended 1 July 2018 reforms.

Home Care Packages Programme

From 1 August 2013, a new four level Home Care Packages Programme was implemented to replace the former:

- Packaged care programmes (Community Aged Care Packages (CACPs);
- Extended Aged Care at Home (EACH) packages; and
- Extended Aged Care at Home Dementia (EACH-D) packages.

Stronger income testing arrangements have been implemented from 1 July 2014, along with protections such as fee caps and hardship arrangements.

A significant change is the transition to consumer directed care, which commenced applying to new packages from 1 August 2013 and all packages from 1 July 2015.

Future changes for Home Care Packages from February 2017 include:

- packages will not be allocated first to providers but instead to consumers, who will then choose their provider; and,
- funding will be paid to the provider of their choice. Packages will be portable, allowing consumers to change their service provider when they choose, including when they move to another location. As a consequence, home care packages will not be allocated through the ACAR beyond 2015.

From July 2018, the Government intends to integrate the Home Care Packages Programme and the Commonwealth Home Support Programme into a single care at home programme.

Residential aged care

A number of changes have occurred in relation to the residential aged care system, primarily in relation to funding and financing. Reforms that have been implemented include:

- a new combined income and assets test;
- new accommodation payment arrangements which allow market-based accommodation prices for all non-supported residents, accompanied by consumer choice to pay by lump sum, daily payment or combination of both;
- requirements for providers to publish the maximum they charge for accommodation and extra services;
- establishment of the Aged Care Pricing Commissioner;
- Higher Accommodation Supplement payable for new or significantly refurbished homes;
- removal of high and low care distinctions; and
- implementation of the Transitional Business Advisory Service to assist providers in relation to the

Commonwealth Home Support Programme
accommodation payment changes.

In addition, there have been a number of other changes implemented including:

- a Veterans' supplement in residential care;
- a Veterans' supplement and a Dementia and Cognition supplement for Home Care Packages;
- a 20 per cent increase to all Viability supplement payments;
- a Homeless supplement in residential care;
- new assessment and referral arrangements under My Aged Care and a central client record; and,
- the Government has also announced an expansion of flexible care initiatives. The number of short-term restorative care places will be increased from 2016-17.

3.1.1 Consumer directed care

A key tenet of the reforms in home care is consumer directed care (CDC). CDC allows individuals and their carers greater discretion to influence the design and delivery of services they receive. In practical terms, CDC based care means that:

- individuals are more involved in determining their care needs and goals, and in choosing what services they receive, how they are delivered and by whom.
- individuals have greater discretion in and oversight of how their package is expended.

More information on CDC is provided in chapter 5, Home Care.

The Government has flagged a long-term agenda to increase consumer choice further which envisages a move to a less regulated, more market based system and possibly includes consideration of the removal of supply restrictions in home care and residential aged care.

3.2 Reform monitoring

ACFA has been tasked with monitoring 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, new means testing arrangements and the transitional business advisory services. This chapter describes:

- ACFA's monitoring process;
- the impact of the new accommodation payment arrangements on residential care;
- impact on access to care for residential and home care;
- impact of the higher accommodation supplement; and
- impact of other reforms on residential and home care.

3.2.1 Monitoring process

ACFA was required to provide monthly reports to the Minister from July 2014 to December 2014 and then quarterly reports through 2015. ACFA consulted with the sector peak organisations and jointly developed a survey to monitor the choice of payments and the amount of lump sum accommodation payments held and receivable. The survey collected information on:

- the number of accommodation bonds held and their value as at the end of each survey period;
- the number of bonds/Refundable Accommodation Deposits (RAD) held and their value at the end of each survey period; and

- the number of RADs, number of Daily Accommodation Payments (DAP) and number of combination payment options chosen by residents during the previous period.

From August 2014, providers were sent the survey on a monthly basis for six months. The survey is now sent after the end of the quarter, with the most recent for the January to March 2015 quarter.

In addition to the survey, ACFA's monitoring reports also include administrative data on the changing levels of occupancy and the use of residential respite care.

In addition, the ACFA Chair and members have had regular discussions with the peak organisations and other key stakeholders to gather anecdotal intelligence of the impact of the reforms.

The monitoring reports that have been provided to the Minister can be found on the ACFA web page.[18]

3.2.2 Overview of impact

ACFA considers the reforms have had and will continue to have a positive impact on the sector and will improve long term sector viability and sustainability. Monitoring of reform impacts supports this view. Nevertheless it will take some time for full impacts to flow through the system and impacts will vary across the sector. It is also important to distinguish between transitional and longer term systemic changes.

Key reform observations to date are described in the box below.

Key reform observations to date

- Consumer choice over accommodation payment in residential care favours lump sum Refundable Accommodation Deposits (RADs) at 41 per cent over rental style Daily Accommodation Payments (DAPs) at 35 per cent and combination payments at 24 per cent.
- The total lump sum accommodation pool has increased significantly and is expected to have grown by around $3 billion in 2014-15.
- Average actual prices for RAD/DAP of $333,000/$58.02 at 30 June 2015, with prices higher in city areas.
- A significant increase in investment activity in the residential care sector, encouraged by accommodation payment reforms and the higher accommodation supplement (with about 12 per cent of services now eligible for the higher supplement).
- Improved financial results in the residential care sector since the reforms.
- Reduced profitability of some Home Care providers as they adapt to Consumer Directed Care (CDC) requirements.
- Transitional impacts on access to care including an increase in admissions to residential care pre 1 July 2014, a decline post 1 July 2014, with admissions now returning closer to trend.
- Greater use of respite care in residential care.
- An increase in the number of providers relinquishing extra service places.
- Admissions to home care relatively stable.
- Problems with administrative implementation of new means and income testing arrangements caused transitional difficulties for both providers and consumers.

[18] See This is a weblink to the DSS website: www.dss.gov.au/ACFA

3.2.3 Impact of accommodation payment changes

Lump sum payments

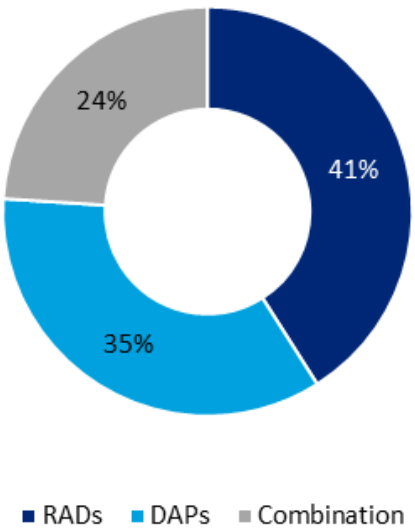
The reforms to residential care introduced on 1 July 2014 saw a number of changes to the way that accommodation is priced and paid for. Controls over daily accommodation prices for non-supported residents in high care were substantially removed, as were regulations preventing lump sum accommodation payments in high care. Residents were also given complete choice in their method of payment, regardless of the level of care they receive, complemented by the transparency in prices introduced through the publication of accommodation prices. A maximum accommodation payment, above which providers need to apply for approval from the Aged Care Pricing Commissioner (the Pricing Commissioner), was set by the Assistant Minister for Social Services as a consumer protection mechanism. As a consequence of these changes, the same accommodation payment arrangements now apply across all residential care.

Between June quarter 2014 and March quarter 2015, survey results indicate that lump sums held and receivable increased by $1.84 billion. These results show that concerns prior to the changes coming into effect that residents' capacity to choose their method of payment may result in a net outflow of lump sums held by providers have not materialised. Geographical analysis further indicates that all geographic segments (major city, inner regional and outer regional/remote) have recorded an accumulated positive growth in lump sums held and receivable between June quarter 2014 and March quarter 2015. Lump sums held and receivable increased by $1.4 billion in major city services, $0.4 billion in inner regional services, and $75 million in outer regional and remote services.

The reforms provide accommodation paying residents with choice on how they make their payments (whether by refundable deposit, daily payment or a combination of both). The reforms also ensure residents security of tenure irrespective of their choice of method of payment. Previously, residents entering into bonded places could have been requested to decide how they paid prior to entering.

Findings show that accommodation payment methods have been relatively stable for the period covering 1 July 2014 to 31 March 2015. Chart 3.1 shows the selected method of payment by residents.

Chart 3.1: Preferred method of payment, July 2014 – March 2015



Preferred method of payment by category

Location

- Major cities show a preference towards RADs.
- Inner regional areas have fluctuating preference.
- Initially post 1 July 2014, outer regional, remote and very remote areas had a preference for DAPs (55 per cent in July 2014, and 44 per cent in March 2015), however, preference for combination payment (RAD/DAP) has been increasing since 1 July 2014 (20 per cent in July 2014 compared with 32 per cent in March 2015).

Ownership type

- RADs continue to be preferred in the for–profit sector, with over half of all post 1 July 2014 residents choosing this method.
- The proportion of residents in Government facilities choosing to pay by RAD has increased to 36 per cent in March 2015 compared with 25 per cent in July 2014

Facility size

- The proportion of residents choosing to pay by RADs has increased consistently among residents of small size services.
- RADs continue to be the preferred method of payment among all providers for July 2014 to March 2015.

Care level

- RADs are the preferred method of making accommodation payments across all care levels and are significantly preferred in extra service places.

Published maximum prices

On 19 May 2014, approved providers began publishing the maximum accommodation prices and descriptive information for rooms which would apply from 1 July 2014.[19] Accommodation prices are required to be published as RADs, equivalent DAPs and a combination price of both RADs and DAPs. A person cannot be charged more than the published maximum price, but they may negotiate a lower amount.

The average published RAD/DAP price was $368,000/$64.12 at 30 June 2015 compared with $355,000/$65.06 at 29 July 2014 (note that while the average published RAD on 30 June 2015 is higher, the average published DAP is lower due to a decrease in the MPIR). Table 3.2 provides a summary of published prices by different categories. Available data does not allow a precise average to be calculated as data is not available on the number of rooms in a facility at a particular price point. As a result assumptions are made that the number of price points are distributed evenly within the facility.

The threshold in 2014-15 above which prices must be approved by the Pricing Commissioner was $550,000/$95.83. Eighty-seven per cent of **published** prices are less than this amount, 7 per cent exactly this amount and the remaining 6 per cent higher than this threshold (Chart 3.2).

Chart 3.2 Published prices and 2014-15 threshold

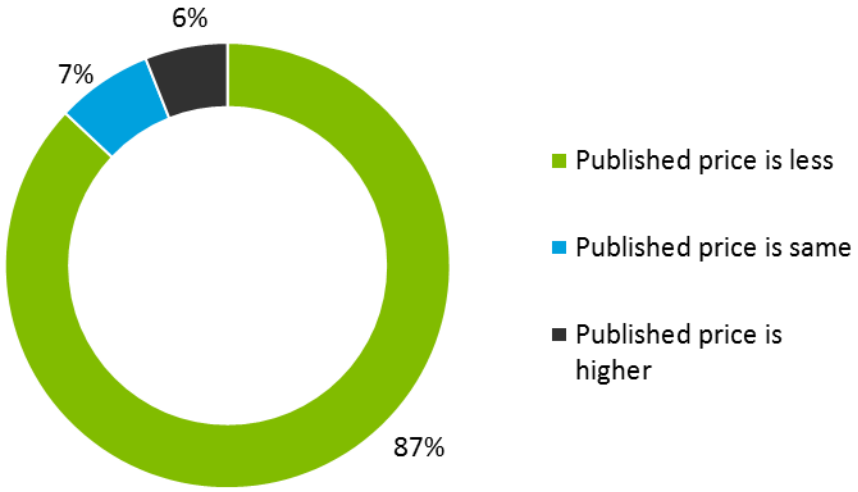


Table 3.2: Average published price by category

- **Location** – average prices published for homes in major cities ($381,000/$66.38) are higher than those in regional areas ($332,000/$57.84) and remote areas ($301,000/$52.44). The same pattern was evident in bond prices before 1 July 2014.
- **Ownership type** – for-profit and government homes have a lower average published RAD/DAP price ($355,000/$61.85 and $360,000/$62.72 respectively) than not-for-profit homes ($381,000/$66.38).

[19] Approximately 98% of providers have published room prices and descriptive information. Note that not all providers are required to publish, as the requirements only apply to those providers that intend to charge an accommodation payment.

- **Facility size** – homes with 100 or more places have a higher average published RAD/DAP price ($376,000/$65.51) than homes with between 50 and 99 places ($367,000/$63.94), and homes with fewer than 50 places ($336,000/$58.54).

Table 3.3: Average published RAD prices as at 30 June 2015, by ownership, location and jurisdiction

	Average	5th Percentile	Quartile 1	Median	Quartile 3	95th Percentile
Overall	$368,000	$195,000	$250,000	$350,000	$450,000	$550,000
Ownership type						
Not-for-profit	$381,000	$200,000	$291,000	$355,000	$450,000	$550,000
For-profit	$355,000	$180,000	$235,000	$300,000	$440,000	$650,000
Government	$360,000	$200,000	$300,000	$350,000	$450,000	$475,000
Location						
Major cities	$381,000	$195,000	$250,000	$350,000	$450,000	$650,000
Regional Areas	$332,000	$200,000	$250,000	$310,000	$400,000	$530,000
Remote Areas	$301,000	$220,000	$228,000	$320,000	$320,000	$420,000
Jurisdiction						
NSW	$347,000	$190,000	$250,000	$300,000	$400,000	$573,000
VIC	$413,000	$225,000	$300,000	$380,000	$495,000	$690,000
QLD	$339,000	$195,000	$250,000	$320,000	$400,000	$550,000
WA	$374,000	$200,000	$290,000	$375,000	$430,000	$550,000
SA	$383,000	$200,000	$291,000	$380,000	$450,000	$545,000
TAS	$321,000	$200,000	$250,000	$300,000	$395,000	$540,000
ACT	$483,000	$200,000	$350,000	$500,000	$550,000	$950,000
NT	$297,000	$228,000	$228,000	$320,000	$320,000	$420,000

Table 3.4 shows the percentage of services, by location, size, ownership type and jurisdiction that offer at least one room in a particular price range.

Since some services offer room types across a range of price bands, tables will sum to more than 100 per cent. Since the reforms, there has been a decrease in the proportion of government providers that report a RAD less than $250,000, with increases in the next two price brackets. Similarly, there has been an increase in for-profit facilities publishing prices in the $300,000-$400,000 range, from 54.3 per cent in July 2014 to 63.3 per cent in June 2015.

Table 3.4: Distribution of published RAD prices at 30 June 2015

RAD	≤ $250,000	$250,001 - $300,000	$300,001 - $400,000	$400,001 - $500,000	$500,001 - $550,000	$550,001 - $750,000	$750,001 - $1 million	> $1 million
DAP	**≤ $43.56**	**$43.56 - $52.27**	**$52.27 - $69.69**	**$69.69 - $87.12**	**$87.12 - $95.83**	**$95.83 - $130.68**	**$130.68 - $174.24**	**>$174.24**
Ownership type								
Not-for-profit	31.3%	34.0%	51.1%	24.5%	17.8%	4.1%	1.4%	0.3%
For-profit	41.5%	44.3%	63.3%	34.2%	25.4%	7.2%	4.3%	2.3%
Government	28.2%	37.2%	52.6%	16.5%	8.6%	0.0%	0.0%	0.0%
Location								
Major cities	31.7%	34.1%	55.5%	33.7%	24.9%	7.4%	3.6%	1.5%
Regional	36.4%	43.2%	55.5%	16.2%	10.6%	0.4%	0.0%	0.0%
Remote	72.5%	39.2%	33.3%	7.8%	7.8%	0.0%	0.0%	0.0%
Service size								
1-19	30.3%	26.9%	38.7%	9.2%	14.3%	0.0%	0.0%	0.0%
20-49	35.0%	34.3%	44.5%	16.4%	12.1%	1.7%	1.3%	0.5%
50-99	33.6%	38.7%	57.9%	27.7%	20.5%	4.0%	1.4%	0.8%
100+	35.0%	41.5%	66.2%	41.4%	26.9%	10.5%	5.3%	1.8%
Jurisdiction								
NSW	37.6%	42.5%	47.5%	22.3%	16.6%	5.8%	2.9%	1.2%
Vic	18.7%	29.8%	58.1%	30.4%	27.7%	6.6%	3.3%	1.5%
Qld	39.8%	37.9%	60.0%	26.3%	12.6%	2.1%	0.7%	0.0%
WA	35.2%	30.5%	57.5%	29.2%	22.7%	3.4%	1.3%	1.3%
SA	47.9%	45.3%	62.2%	29.6%	10.1%	1.5%	0.0%	0.0%
TAS	65.4%	58.0%	58.0%	19.8%	18.5%	0.0%	0.0%	0.0%
ACT	16.7%	20.8%	33.3%	54.2%	45.8%	12.5%	8.3%	0.0%
NT	63.6%	9.1%	54.5%	18.2%	9.1%	0.0%	0.0%	0.0%

Note: Rows may total to greater than 100% since some services offer room types across a range of price bands.

Agreed prices

The average price agreed between providers and residents since implementation of the 1 July 2014 reforms was $333,000/$58.02.[20] This is 12.5 per cent higher than the average accommodation bond agreed with new residents in 2013-14 ($296,000) and 10 per cent lower than the average published price of $368,000/$64.12.

There are three plausible explanations for this. Firstly, published prices are maximums only so consumer negotiating may lead to lower actual prices than the maximum reported. Second, retention payments can no longer be taken from the lump sum by providers as they previously were from bonds; in 2013-14 retention amounts were capped at $340.50 per month, equivalent to a RAD of $64,000. Finally, the average published price does not take into account the number of rooms offered at each price (i.e. weighted average), for example, if a home has three price points but only a

[20] Agreed prices come from the Aged Care Entry Records completed by providers and submitted to the Department of Human Services when a resident enters care.

small number of rooms at the highest price the estimated average will be higher as it assumes all price points are evenly spread.

As stated, the threshold in 2014-15 above which prices must be approved by the Pricing Commissioner is $550,000/$95.83. Ninety-two per cent of **agreed prices** are less than this amount, 4 per cent exactly this amount and the remaining 4 per cent higher than this threshold.

0 provides findings on the actual prices since the reforms by ownership, location and jurisdiction.

Agreed prices findings by category

- **Location** – average agreed prices were higher in major cities ($354,000/$61.68), compared with those agreed in regional areas ($287,000/$50.00) and in remote areas ($230,000/$40.07)
- **Ownership type** – government homes ($319,000/$55.58) have the lowest average agreed price , while for-profit homes ($335,000/$58.37) and not-for-profit homes ($334,000/$58.19) are effectively the same, despite not-for-profit homes having a significantly higher average published price ($381,000/$66.38) than for-profit homes ($355,000/$61.85).
- **Facility size** – homes with 100 or more places had the highest average agreed price ($352,000/$61.33), followed by homes with between 50 and 99 places ($325,000/$56.63), while homes with fewer than 50 places had the lowest average agreed price ($303,000/$52.79). Higher average agreed prices in larger homes could also reflect the increased likelihood that larger homes will be located in major cities, which have higher average agreed prices than regional or remote locations due to higher house values. This suggests that the size of the home is probably less significant in determining agreed prices than the location of the home.

Table 3.5: Average agreed prices as at 30 June 2015, by ownership, location and jurisdiction

	Average	5th Percentile	Quartile 1	Median	Quartile 3	95th Percentile
Overall	$333,000	$120,000	$240,000	$320,000	$400,000	$550,000
Ownership type						
Not-for-profit	$334,000	$104,000	$250,000	$325,000	$400,000	$550,000
For-profit	$335,000	$150,000	$230,000	$300,000	$400,000	$550,000
Government	$319,000	$95, 000	$248, 000	$310,000	$400,000	$550,000
Location						
Major cities	$354,000	$147, 000	$250,000	$350,000	$450,000	$565, 000
Regional Areas	$287,000	$90, 000	$219,000	$299, 000	$350,000	$450,000
Remote Areas	$230,000	$66, 000	$188,000	$220,000	$299,000	$390,000
Jurisdiction						
NSW	$332,000	$125, 000	$230,000	$300,000	$400,000	$598, 000
VIC	$352,000	$113, 000	$269, 000	$350,000	$450,000	$550,000
QLD	$321,000	$102, 000	$250,000	$322, 000	$395,000	$500,000
WA	$320,000	$97, 000	$200,000	$320,000	$400,000	$550,000
SA	$330,000	$150,000	$240,000	$320,000	$400,000	$510,000
TAS	$286,000	$175,000	$230,000	$290,000	$350,000	$400,000
ACT	$379,000	$156, 000	$250,000	$400,000	$510,000	$550,000
NT	$316,000	$44, 000	$200,000	$300,000	$320,000	$550,000

3.2.4 Impact of reforms on access to care

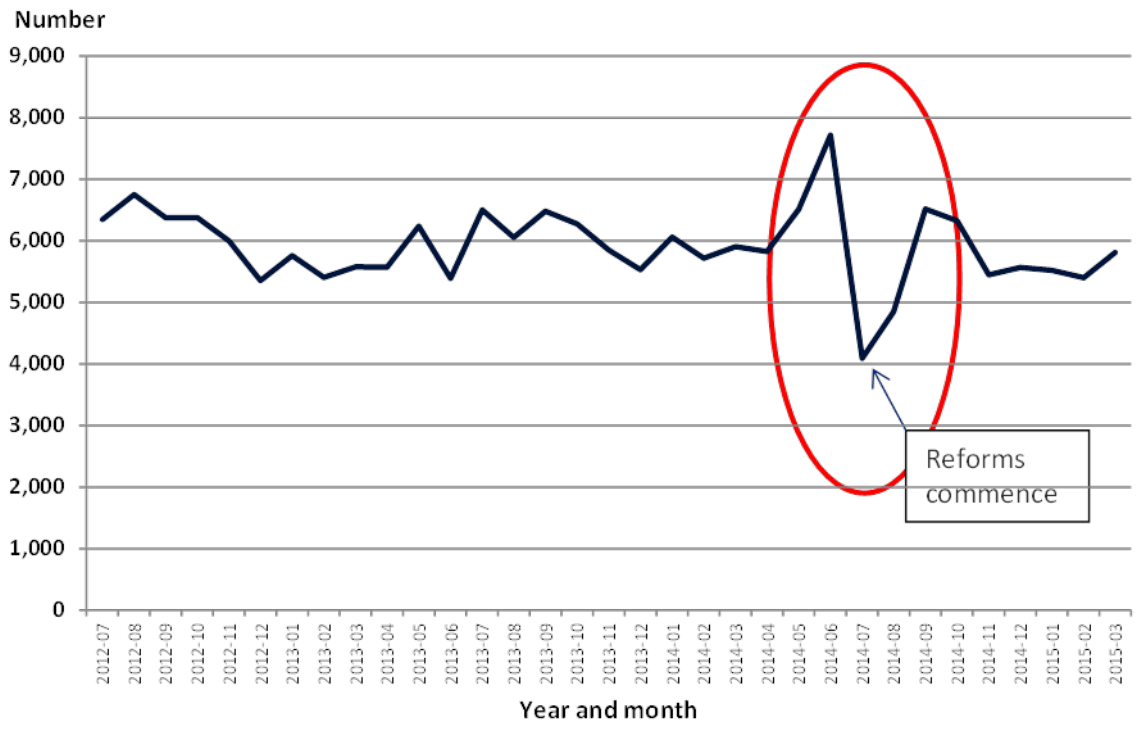
Permanent Residential Care

Admissions and occupancy rates for residential care changed upon implementation of the 1 July 2014 reforms, but have since returned towards prior trends. There was an upsurge in admissions to permanent care pre 1 July 2014 reform, followed by a dip in admissions in July 2014 (see Chart 3.3). This reflected residents moving into care before 1 July 2014 to lock in capped accommodation charges in residential care and avoid higher means tested consumer contributions that could apply from 1 July 2014.

This rise in admissions likely impacted occupancy rates, which declined between July and October 2014 after peaking in June 2014, before returning to trend levels after October 2014.

There was also a higher than usual shift toward increasing use of respite care between July and October 2014, with respite admissions exceeding permanent care admissions between July and September 2014. This may be as a result of new residents being accommodated in respite care until their means testing results were received.

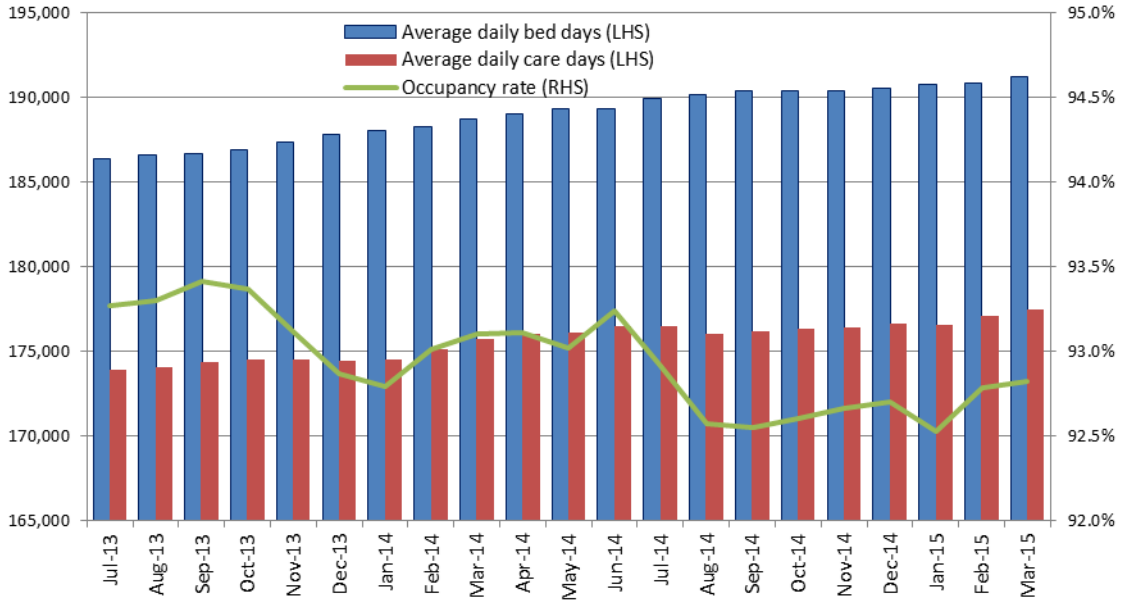
Chart 3.3: Admissions to permanent care, July 2012-March 2015



The occupancy rate slightly decreased following the reforms from 93.2 per cent in June 2014 to 92.5 per cent in January 2015 before increasing to 92.8 per cent in March 2015, while the number of care days used has remained stable (see Chart 3.4). Despite an initial decline in occupancy levels after 1 July 2014, rates increased so that by March 2015 there were over 1,000 more people in residential care compared with June 2014.

The overall annual occupancy rates for permanent residents for the past five years have been between 92 per cent and 93 per cent. At a national level, there has been very little change in occupancy, with less than 0.3 percentage point difference in any two successive years.

Chart 3.4: Average resident, bed days and occupancy rate



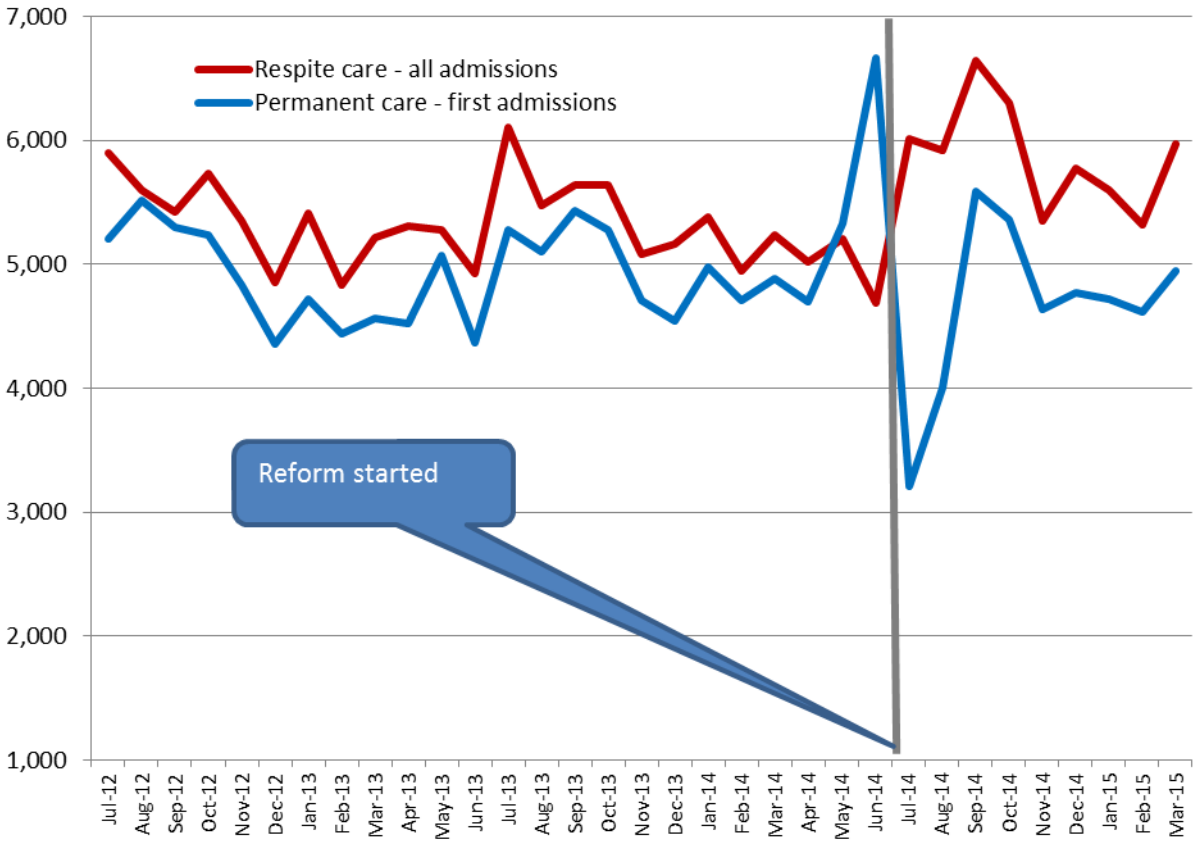
Note. 'bed days' refers to the number of days for which a place was available to be occupied by a care recipient. The term 'care days' refers to the number of days for which care was actually provided to a care recipient in an aged care place.

Residential respite care

Between July and October 2014, there was a clear shift towards an increasing use of respite care. While it is usual to see an increase in use of respite care in the July to September period each year, the increased use after 1 July 2014 was markedly higher than usual. Respite care admissions, unusually, exceeded permanent care admissions between July and September 2014. Feedback from the sector indicated that this was likely partly as a result of new residents being accommodated in respite care until their means testing assessments were received and financial arrangements settled.

Respite admissions declined in October but still remained higher than historical trend levels. In November 2014 respite admissions were lower than the previous months and by March 2015 were returning towards trend levels, possibly reflecting improved timeframes for means test assessments.

Chart 3.5: Admissions for permanent and respite care, July 2012 – March 2015

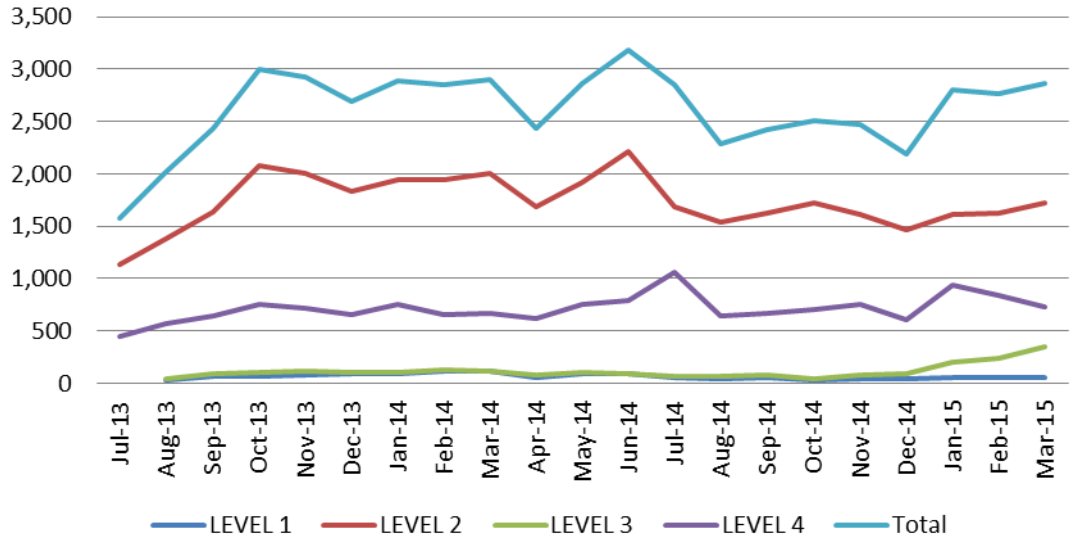


Home care

National occupancy rates in home care were relatively stable post 1 July 2014 reform implementation until November 2014, following which there was a decline. This drop in occupancy rate in December 2014 is reflected across jurisdictions, followed by a subsequent increase except for Queensland. The decrease in December 2014 reflects the release of new home care places from the ACAR increasing the denominator in the occupancy ratio and therefore reducing the ratio despite admissions continuing to increase. This situation does not apply in residential care as places allocated are not made operational (and therefore affect occupancy) until the provider advises the Department that they are ready to be occupied by a resident, which is usually well after the place is allocated.

As shown in Chart 3.6 below, despite the drop in occupancy, admissions to home care have remained relatively stable since the introduction of the new package levels in August 2013. This shows that consumers are still accessing home care. While ACFA is aware of some concerns that income tested fees may be influencing take up of home care packages by some consumers, no significant impact is noticeable in the data. There was a spike around June 2014 followed by a decline, but admissions have returned to levels similar to pre June 2014.

Chart 3.6: Admission to Home Care packages, by package type, July 2013 - March 2015



Exposure to bad debt

ACFA does not have any data to analyse whether the new arrangements have had an impact on bad debt for providers, though some providers have advised this is the case. The extent to which any changes in this area are systemic or transitory will need to be considered over the longer term. Some transitional issues, including administrative issues associated with the Department of Human Services implementation of means testing, may have contributed in the shorter term.

3.2.5 Impact of higher accommodation supplement

Higher accommodation supplement and significant refurbishment

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 level of the accommodation supplement is available to services that are identified as newly built or have completed a significant refurbishment to an existing service since 20 April 2012.

Uptake and impact

As at 31 March 2015, an estimated 13.3 per cent of all services were eligible or potentially eligible for the higher supplement – including 300 for significant refurbishment (10.3 per cent of existing services), and 87 for newly built services (3.0 per cent of existing services).

It is estimated that this will result in 4,500 additional care recipient rooms in new buildings and 3,000 additional new rooms in significantly refurbished facilities.

In addition, 120 services had submitted pre-approval applications for future refurbishments.

Expenditure

The estimated completed refurbishment spending per service averages $4.2 million, with a median of $2.5 million and total expenditure of $1.3 billion. Table 3.8 provides an overview of the expenditure based on location.

Table 3.6: Profile of eligible significantly refurbished services

Location (ABS Remoteness)	No. of significantly refurbished services	Estimated Additional beds/places derived from significant refurbishment applications only	Estimated Refurbishment Costs	Range of costs ($)
Major city	163	1,874	$710 million	292,130 – 29 million
Inner regional	84	941	$363 million	110,220 – 17 million
Outer regional	47	196	$164 million	139,357 – 26 million
Remote	4	30	$13 million	2 million – 5 million
Very remote	2	2	$7 million	2 million - 5 million
Total	**300**	**3,043**	**$1.26 billion**	

3.2.6 Impact of other reforms

Consumer directed care

All packages that have been released since August 2013 have been required to be delivered on a Consumer Directed Care (CDC) basis. Additionally, providers could choose to voluntarily transition existing packages to CDC prior to 1 July 2015, from which time all packages were required to be delivered on a CDC basis.

Analysis by Stewart Brown on the providers that participate in their benchmarking service[21] show that profitability of some CDC providers has been lower than those still delivering traditional Home Care Packages. For level 2 packages for the nine months to March 2015, CDC providers' profit per client day was $2.30 compared with $3.85 for a non-CDC provider. For the same period Level 4 CDC providers' profitability was $18.63 compared with $27.59 per day for non-CDC providers. The Stewart Brown survey includes mainly not-for-profit providers and is not necessarily reflective of the whole sector.

The above analysis points to CDC providers spending more time on administration as a significant driver in the lower profitability when compared with traditional package providers. There is likely to be a significant transitional factor. Stewart Brown expects that the administration time will decrease once processes and IT systems to manage CDC requirements are in place, but they note this benefit may not flow to smaller providers who are unable to invest in the technology.

[21] Stewart Brown survey is conducted with predominantly not-for-profit providers and is not necessarily representative of the whole sector.

Extra service

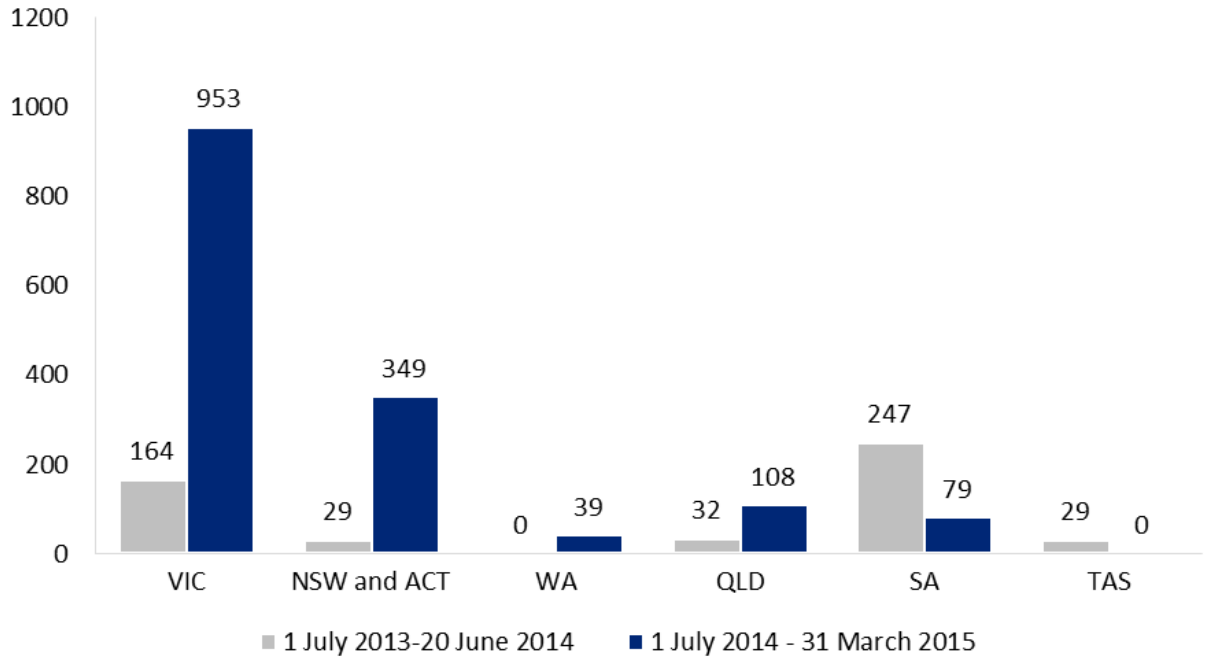
There has been a significant decrease in the total number of places with extra service status (see Chart 3.7). In the period between 1 July 2014 and 31 March 2015, providers suspended or relinquished the extra service status of 1,528 places, leaving 15,863 active extra service places. This compared with 501 places suspended or relinquished in the period 1 July 2013 to 30 June 2014.

This may be 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 extra service;
- market-based prices determined by the provider apply for all new non-supported residents;
- providers can continue to offer a higher standard of care and services on an opt in/opt out basis for an additional fee outside the extra service framework; and
- residents can request (but cannot require) that a provider draws down from the RAD to pay for optional additional services.

This has led many providers to reconsider their extra service status, with many either transitioning residents to new 'optional additional service' arrangements, or increasing their base service offerings. This means providers have a capacity to maintain their revenue streams while simplifying administration and transitioning away from extra service.

Chart 3.7: Number of places with extra service status suspended or relinquished by jurisdiction, July 2013 – March 2015



3.2.7 Administrative Implementation Challenges

Delays and errors in the Department of Human Services' administration of the new means testing system caused difficulties for some providers and consumers particularly in the first months of the reforms. These issues are a reminder of the importance of administrative implementation of new measures.

While the majority of providers were prepared for change, it would also appear that a number had not prepared as well as they could have for the new arrangements.

The Government helped industry manage the accommodation payment changes by providing free advice through the Transitional Business Advisory Service (TBAS) from 3 April 2014 to 30 June 2015. TBAS was delivered by KPMG, on behalf of the Department, to assist aged care providers prepare for and manage the transition to the new accommodation payment arrangements that commenced on 1 July 2014. Services ranged from assistance with simple queries through to the development of tailored financial and business advice. The Government also provided transitional funding to assist CDC and CHSP providers to adapt to the reforms.

3.2.8 Ongoing challenges

The success of reforms, and reform implementation is also dependant on the readiness of key stakeholders. Important factors include:

- Consumer reform readiness – consumers need to be empowered to understand and accept their rights and obligations;
- Provider responsiveness – including adopting appropriate systems and practices to reflect the new arrangements and a consumer-oriented service culture and agility and capacity to grow;
- Investors – responsiveness and readiness to meet the growing demand and mix of services; and
- Supply planning – including available aged care places, developer and builder readiness and availability of greenfield sites.

4 Home Support

This chapter provides an overview of Home Support.

This Chapter discusses:

- the operation of Home Support including recent and proposed reforms;
- the supply and usage of Home Support;
- funding of the Home Support sector; and
- developments and opportunities going forward.

This Chapter reports that:

- in 2013-14, there were 1676 HACC providers (Commonwealth and Victorian and Western Australian HACC);
- services were provided to 775,959 older consumers; and
- $1.7 billion in total Commonwealth funding for the Commonwealth HACC and Victorian and Western Australian HACC programmes.

The Chapter reports on data pertaining to the Commonwealth HACC as well as data on the Victorian and Western Australian HACC programmes where available.

Home Support in aged care comprises of several programmes which are separate to the Home Care packages programme. Home support is made up of the Commonwealth Home and Community Programme (HACC), Victorian and Western Australian Home and Community Care Programmes (not administered by the Commonwealth), the National Respite for Carers Programme (NRCP), Day Therapy Centres Programme (DTC) and the Assistance with Care and Housing for the Aged Programme (ACHA).

As of 1 July 2015 the Commonwealth Home Support Programme (CHSP) commenced, combining the Commonwealth HACC, NRCP, DTC and ACHA Programmes. Negotiations for transitioning the Victorian and Western Australian HACC services for older people into the CHSP are underway with the Victorian and Western Australian governments. HACC services for older people in Victoria and Western Australia will continue to be provided under the Commonwealth-State jointly funded HACC Programme subject to the outcome of these negotiations.

Future ACFA Annual Sector reports will include some analysis and commentary regarding all of the programmes that now make up the Commonwealth Home Support Programme

4.1 Commonwealth HACC and Victorian and WA HACC Programmes

Commonwealth HACC and Victorian and Western Australia HACC programmes target older people who are largely independent, but who may require assistance in some areas to live independently at home. It should be noted that the Victorian and Western Australian HACC programmes also target younger people with a disability, however analysis and commentary in this report will focus on the provision of services for older people.

Services provided through both the Commonwealth HACC and Victorian and Western Australian HACC programmes are basic maintenance and support services, including assessment, case management and client care coordination, centre based day care, counselling, support, information and advocacy, domestic assistance, home maintenance, nursing, allied health care, personal care and respite care, social support, meals, home modification, linen service, goods and equipment and transport.

The Australian Government has full financial and operational responsibility for HACC services for older people, except in Victoria and Western Australia where it is a joint Australian Government and State governments' program administered under the *Home and Community Care Review Agreement 2007*. For clarity, in this chapter, where referring to HACC services outside of Victoria and Western Australia, the programme will be referred to as 'Commonwealth HACC'.

Prior to 1 July 2015, to access HACC services, individuals underwent a basic assessment by a HACC service provider in relation to how they are coping with their daily living. From 1 July 2015 assessments for the Commonwealth Home Support Programme will be coordinated through the Commonwealth My Aged Care and its Regional Assessment Services. Consumers will continue to access HACC services in Victoria and Western Australia through the HACC providers.

4.1.1 Data collection

The Commonwealth HACC programme collects data through a minimum data set required to be submitted by HACC providers; however this is focused on service data. As a consequence, there are minimal details available on the financial performance of Commonwealth HACC services.

HACC providers, most of whom are not-for-profit, would generally structure their operations to maximise service within a fixed Budget allocation, rather than to achieve maximum profit, and some services rely on volunteers for much of their service provision.

The Victorian and Western Australian state governments collect data on their respective HACC programmes, including a minimum data set. Some of this data is shared with the Commonwealth through annual business reports. As with the Commonwealth HACC, there are minimal details on financial performance of Victorian and Western Australian HACC services.

4.2 Sector overview

4.2.1 Supply of HACC

In 2013-14, there were 1,110 providers of Commonwealth HACC services. This is an increase from the previous two years, with 1,041 in 2012-13 and 1,043 in 2011-12. In 2013-14 there were a total of 566 HACC providers in Victorian and Western Australian HACC, 456 in Victoria and 110 in Western Australia. The total represents a decrease from the 606 HACC providers that operated in these two states in 2012-13 (481 in Victoria and 125 in Western Australia).

Chart 4.1, below illustrates the ownership types for Commonwealth HACC providers. While data pertaining to ownership type for Victorian and Western Australian HACC providers was not available, providers in these states are predominately not-for-profit and government owned. Most Commonwealth HACC providers were not-for-profit (74.6 per cent), followed by government (17.7 per cent) and then for-profit (7.7 per cent). Not-for-profit includes religious, charitable and community based organisations. For-profit bodies include private incorporated bodies and publically listed companies. Government bodies include state, territory and local government organisations.

Chart 4.1: Commonwealth HACC providers by provider type, 2013-14

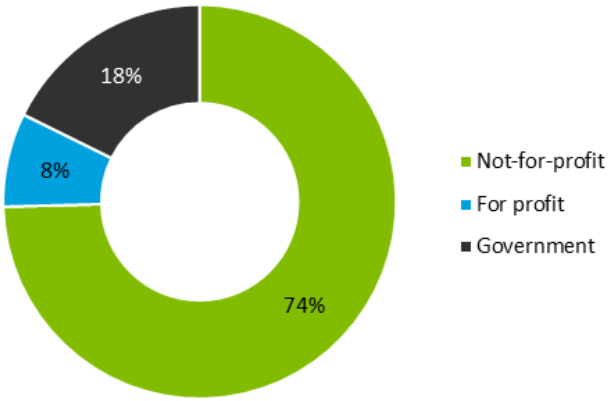


Table 4.1 below provides a breakdown of Commonwealth HACC providers by ownership type and State/Territory.

Table 4.1: Commonwealth HACC providers by ownership type and state, at June 2014

State/Territory	Religious	Charitable	Community Based	Private Incorporated Body	Publicly Listed Company	State/Territory Govt.	Local Govt.	TOTAL
NSW	17	119	227	41	1	19	74	**498**
Qld	9	79	181	23	3	14	36	**345**
SA	8	30	63	9	0	7	28	**145**
Tas	3	14	30	6	0	2	4	**59**
ACT	2	9	14	1	0	3	0	**29**
NT	3	6	14	1	0	1	9	**34**
Australia	**42**	**257**	**529**	**81**	**4**	**46**	**151**	**1110**

Table 4.2 provides a breakdown of the type and quantity of HACC services (Commonwealth and Victoria and Western Australia) delivered by service type.

Table 4.2: Services delivered to Commonwealth and Victorian and Western Australian older HACC consumers, 2013-14

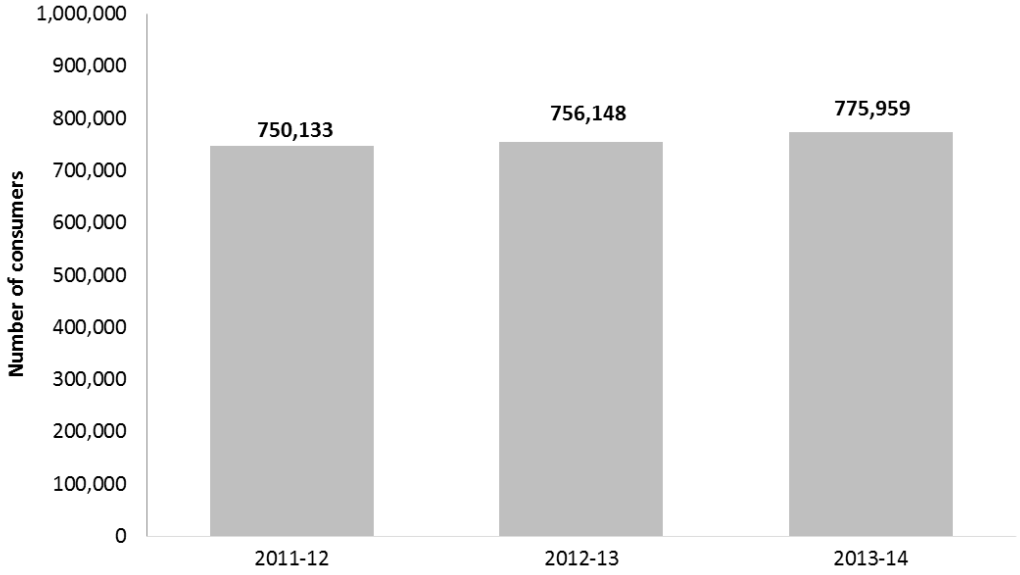
Assistance Type	Measure	Number (according to measure)
Allied Health Care (Centre)	*Hours*	693,910
Allied Health Care (Home)	*Hours*	446,527
Assessment	*Hours*	864,863
Case Management	*Hours*	418,212
Centre-Based Day Care	*Hours*	12,230,265
Client Care Coordination	*Hours*	537,535
Care Counselling Support	*Hours*	269,471
Carer Counselling Support	*Hours*	155,642
Domestic Assistance	*Hours*	7,173,489
Formal Linen Service	*Quantity*	25,216
Aids for Reading	*Quantity*	128
Car Modifications	*Quantity*	1,024
Communication Aids	*Quantity*	4,758
Medical Care Aids	*Quantity*	619
Other Goods and Equipment	*Quantity*	26,657
Self-Care Aids	*Quantity*	10,074
Support and Mobility Aids	*Quantity*	13,396
Home Maintenance	*Hours*	1,424,295
Home Modification	*Dollars*	24,358,372
Meals (Centre)	*Quantity*	1,006,638
Meals (Home)	*Quantity*	8,404,606
Nursing Care (Centre)	*Hours*	212,714
Nursing Care (Home)	*Hours*	2,290,885
Other Food Services	*Hours*	115,180
Personal Care	*Hours*	2,878,684
Respite Care	*Hours*	956,502
Social Support	*Hours*	4,239,946
Transport	*Quantity*	5,280,274

4.2.2 Supply of HACC services

In 2013-14, the Commonwealth HACC Programme provided services to 500,615 consumers, and the Victorian and Western Australian programmes provided services to 275,344 older consumers. This totals 775,959 older consumers across Australia.

Chart 4.2 illustrates the number of older consumers of both Commonwealth and Victorian and Western Australian HACC programmes over the last three years.

Chart 4.2: Consumers accessing Commonwealth and Victorian and Western Australian HACC



4.3 Access to care

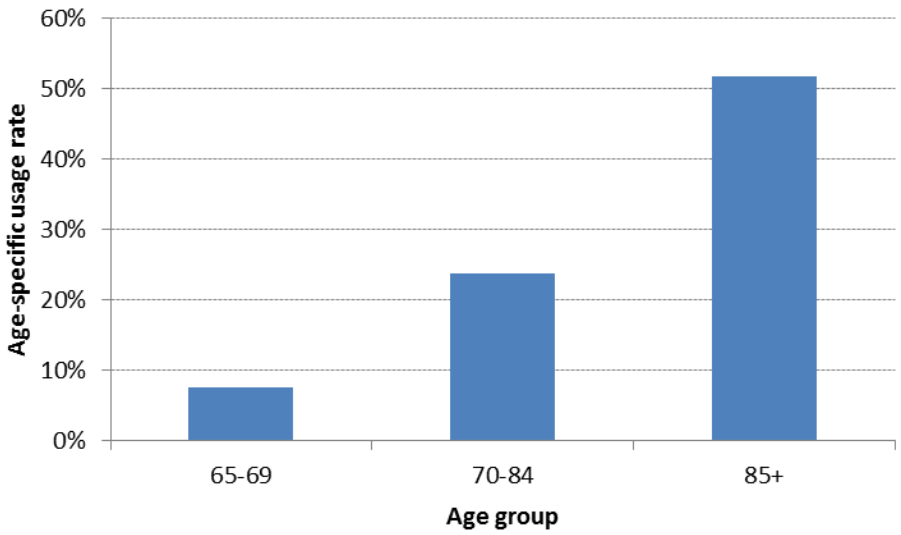
Table 4.3 provides an overview of HACC recipients across both the Commonwealth and Victorian and Western Australian HACC programmes in 2013-14 by age group and location.

Table 4.3: Commonwealth and Victorian and Western Australian older HACC Recipients, by age group and State/Territory, 2013-14

	NSW	VIC	Qld	WA	SA	TAS	ACT	NT	Total
50-64	3,995	991	1,866	788	736	129	64	409	8,978
65-69	23,337	26,740	15,679	5,408	9,301	2,633	1,318	358	84,774
70-84	128,415	128,196	87,999	33,338	47,342	13,708	6,033	1,043	446,074
85+	73,585	61,818	47,039	18,065	25,991	6,238	3,141	256	236,133
Total	**229,332**	**217,745**	**152,583**	**57,599**	**83,370**	**22,708**	**10,556**	**2,066**	**775,959**

As Chart 4.3 shows, when grouped by age, the proportion of population utilising HACC services increases with age.

Chart 4.3 Proportion of each age group utilising HACC, 2013-14



The Productivity Commission defines the target population for aged care as all individuals over the age of 65 and Aboriginal and Torres Strait Islanders over the age of 50. Using this definition, the Productivity Commission reported that, as at 30 June 2014, 21.8 per cent of the target population for aged care in Australia were accessing HACC. By comparison, 19.8 per cent of the target Aboriginal and Torres Strait Islander population were reported to be accessing HACC.

The number of consumers of Commonwealth and Victorian and Western Australian HACC consumers who identified as Aboriginal or Torres Strait Islander comprised two per cent of the total HACC consumers. The highest representation of Indigenous consumers was in the Northern Territory (Table 4.4).

Table 4.4: Commonwealth and Victorian and Western Australian HACC consumers, Australian Indigenous Status, by State/Territory 2013-14

	NSW	VIC	Qld	WA	SA	TAS	ACT	NT	Total
Indigenous	9,193 (4.0%)	1,856 (0.9%)	4,452 (2.9%)	1,753 (3.0%)	1,651 (2.0%)	371 (1.6%)	103 (1.0%)	925 (44.8%)	20,304
Non-indigenous	211,907 (92.4%)	201,997 (92.8%)	130,628 (85.6%)	53,783 (93.4%)	76,318 (91.5%)	21,094 (92.9%)	10,127 (95.9%)	1,121 (54.3%)	706,975
Not stated	8,232 (3.6%)	13,892 (6.4%)	17,503 (11.5%)	2,063 (3.6%)	5,401 (6.5%)	1,243 (5.5%)	326 (3.1%)	20 (1.0%)	48,680
Total	**229,332**	**217,745**	**152,583**	**57,599**	**83,370**	**22,708**	**10,556**	**2,066**	**775,959**

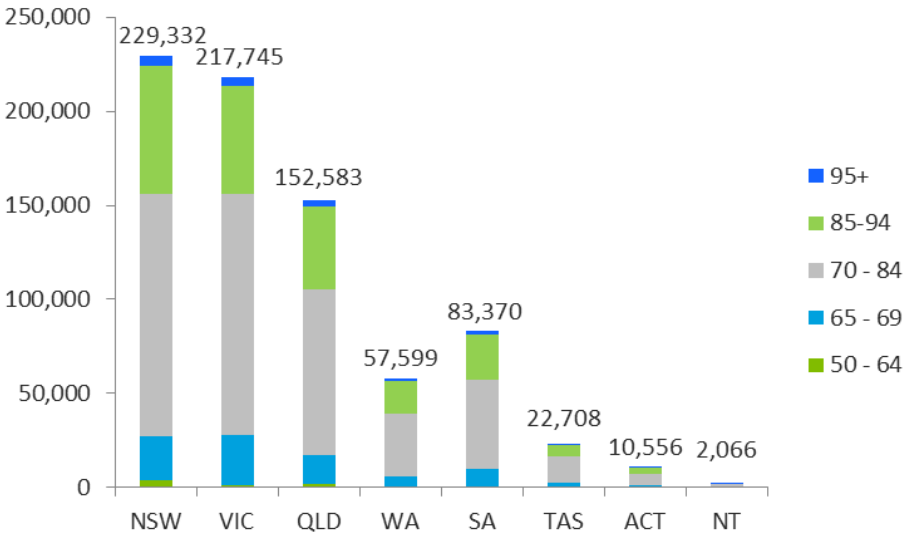
Source. Productivity Commission, Report on Government Services 2014

Older people from a CALD background made up 18.1 per cent of Commonwealth and Victorian and Western Australian HACC consumers in 2013-14.

The average age of Commonwealth and Victorian and Western Australian HACC consumers in 2013-14 was 80.[22] Chart 4.4 provides a breakdown of all HACC consumers by age and State/Territory of residence.

[22] This average applies to the Commonwealth HACC and Victorian and Western Australian HACC programs but only for individuals aged over 70.

Chart 4.4: Number of Commonwealth and Victorian and WA HACC consumers by age bracket and location, as at 30 June 2014



The proportion of older Aboriginal and Torres Strait Islander Commonwealth and Victorian and Western Australian HACC consumers who are aged 80 years or over is 26.9 per cent and the proportion of non-Indigenous consumers who are aged 80 years or over is 54.5 per cent.

4.4 Funding of Commonwealth HACC and Victorian and Western Australian HACC

4.4.1 Commonwealth funding

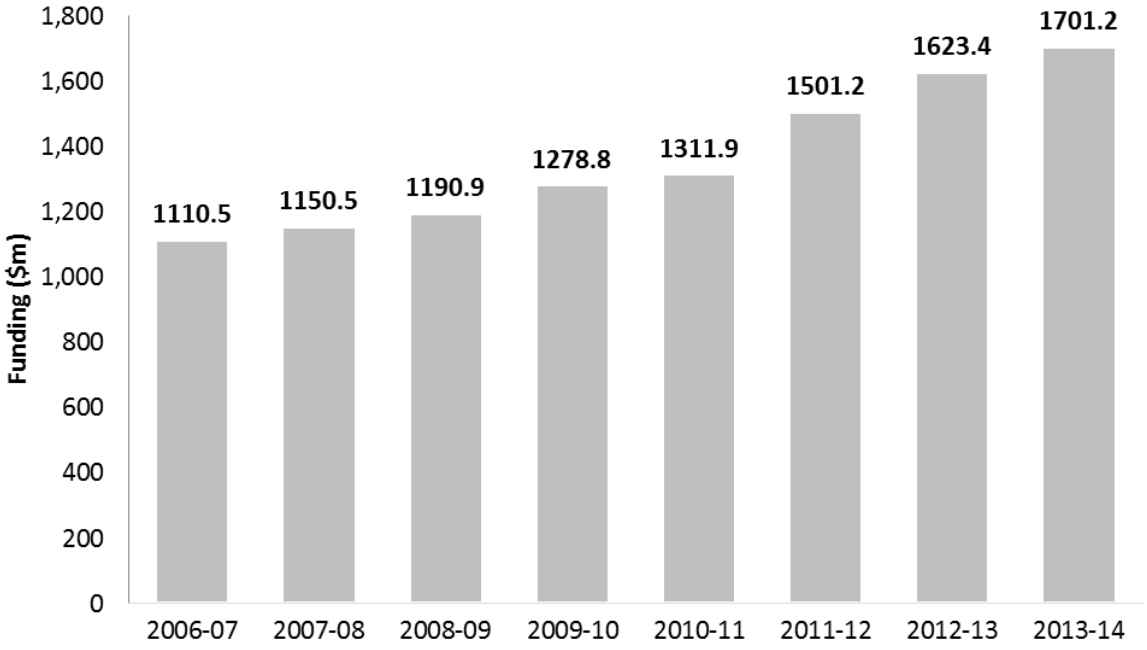
In 2013-14, The Australian Government provided funding of $1,161.4 million for the Commonwealth HACC Programme ($1.113.0 million in 2012-13) and contributed $539.8 million to the joint Commonwealth/state funded HACC Programmes in Victoria and Western Australia ($501.0 million in 2012-13).

Commonwealth HACC providers received a 2.4 per cent increase in funding on 1 July 2014, on top of indexation, as a result of the repurposing of the Workforce Supplement announced in the 2014-15 Budget, representing $31 million in 2014-15 ($183.9 million over four years).

Of the $1,161.4 million in Commonwealth funding provided to the Commonwealth HACC Programme in 2013-14, 59 per cent was provided to not-for-profit providers, 6 per cent to for-profit providers and 35 per cent to government providers.

Commonwealth funding for HACC across Australia has been increasing since around 1990 when the programme first started. Chart 4.5 shows the growth in funding since 2006-07. As part of the 2014-15 Budget, the Australian Government announced a reduction in the annual real rate of growth of funding for the Commonwealth Home Support Programme from 6 per cent to 3.5 per cent, to align funding growth with the annual growth in the population aged 65 and over. The real growth is on top of the annual indexation.

Chart 4.5: Combined funding of Commonwealth HACC and Commonwealth contribution to Victoria and Western Australia HACC Programmes



4.4.2 Consumer contributions

Fees paid by consumers for Commonwealth HACC and Victorian and WA HACC services currently vary across states and territories and across service providers. However, information collected from providers shows that currently fees collected from consumers are about 5 per cent on average across all states and territories.

Under aged care reforms announced in 2012, a nationally consistent fees policy was to be implemented by 1 July 2015 which would see fees charged in a consistent way across the entire Commonwealth Home Support Programme. However, the Commonwealth has since announced that the implementation of the nationally consistent fees policy would be delayed until 2018, to coincide with the intention to integrate the CHSP and the Home Care Packages into a single programme.

In the meantime, the Department is working with sector peak bodies to develop a principles based fees policy framework. This framework will outline principles that Commonwealth Home Support providers can adopt in setting and implementing their fees, leading to greater consistency and fairness. The Department is also working with the sector to develop a national guide for providers and consumers which describes the current varying fee arrangements in order to make them more transparent.

4.5 Looking forward: developments, opportunities and challenges

As previously outlined, the Commonwealth Home Support Programme (CHSP) commenced on 1 July 2015, with the combining of the Commonwealth HACC, NRCP, DTC and ACHA programmes. The key aim of consolidating these programmes is to increase service flexibility, reduce administrative costs and to allow greater integration with the Commonwealth's other aged care programmes to create a national aged care system.

Other features of the Commonwealth Home Support Programme include nationally consistent assessment and eligibility criteria and a focus on re-enablement and wellness.

The Commonwealth has provided $20 million in additional funding to support aged care providers in transitioning to the CHSP. The funding will assist the providers with the additional work they face to incorporate the new CHSP arrangements, including programme reclassification, new information and reporting and changes required to accept referrals from My Aged Care.

In addition, as part of the 2015-16 budget, the Government announced its intention to integrate the CHSP with the Home Care packages programme by 1 July 2018 to create an integrated care at home programme.

This will raise a number of challenges in implementation for Government and service providers, including developing policies for fees that can operate across the current distinct programmes.

5 Home Care Packages

This chapter provides an overview of the Home Care Packages Programme.

This chapter discusses:

- the operation of the Home Care Packages programme
- the supply and usage of Home Care Packages
- funding of the sector
- financial performance of the sector in 2013-14
- key reforms, opportunities and challenges looking forward.

The Chapter reports that:

- in 2013-14, there were 504 Home Care Package Providers
- they provided services to 83,144 consumers across the year
- 66 per cent of home care package providers achieved net profit in 2013-14.
    - the average EBIDTA was $1,973 per package
- Commonwealth funding was 92 per cent of revenue and consumer funding was 7 per cent
  the sector is in transition following recent – and ongoing – substantive changes to the mode of delivery. Further significant changes will take effect from 2017.

5.1 The Home Care Package Programme

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

Packages. Under the HCPP, consumers are able to gain access to Home Care Packages (HCPs) which support them to stay at home. A HCP is a coordinated package of services tailored to meet the consumer's specific care needs.

HCPs may be comprised of:

- **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; and
- **Clinical care.** Examples include nursing and other health support including physiotherapy (exercise, mobility, strength and balance), services of a dietician (nutrition assessment, food and nutrition advice, dietary changes) and hearing and vision services.

HCPs are categorised into four levels:

- Home Care Level 1 (HCL1). To support people with basic care needs;
- Home Care Level 2 (HCL2). To support people with low care needs (previously CACPs);

- Home Care Level 3 (HCL3). To support people with intermediate care needs; and
- Home Care Level 4 (HCL4). To support people with high care needs (previously EACH).

Specific funding in the form of a Dementia and Cognition Supplement can be provided for care recipients with cognitive impairment for all levels of HCPs. The supplement is paid at a rate of 10 per cent of the basic subsidy amount payable for each of the applicable HCL. This supplement recognises that people receiving any level of package could have cognitive impairment.

To obtain access to a HCP, individuals are first assessed by an Aged Care Assessment Team (ACAT), who determine eligibility for a low level (HCL1 or 2) or high level (HCL3 or 4) package.

Providers. An approved and accredited HCP provider is responsible for the provision of the package to the consumer (some components of which may be sub-contracted).

Services. HCP providers may also operate through a single service or operate through several services. Services are spread across metropolitan and regional locations across Australia.

Consumers. A consumer may only hold a single package at any time. However, a consumer can move from one package level to another if their care needs change and another package is available. The number of consumers who accessed care through a package during 2013-14 exceeds the total number of packages provided in a year as once a person stops receiving care due to changed circumstances, another person will be able to utilise that package within the same year.

This chapter provides an overview of the 2013-14 funding and financial performance of Home Care Package providers and an outlook for the future of home care. The discussion of profit in this chapter predominantly relates to Earnings Before Interest, Taxes, Depreciation and Amortisation (EBITDA). This measure is the commonly used metric for analysis and comparison of the profitability of providers and the sector.

Much of the information reported in this chapter has been collected through the HCPP 2013-14 financial report which was introduced in 2013-14 to improve data collection across all package levels. The report is required to be submitted by each provider, but in 2013-14 was completed in a useable form by 88 per cent of providers (who hold 87 per cent of packages).

This chapter does not report 2012-13 data as a point of comparison. This is because the 2012-13 data was collated using information provided through the previous reporting framework – Financial Accountability Reports (FARs). Only data pertaining to CACP services were provided in a usable format for financial reporting. Therefore, the 2012-13 data only considered information relating to CACP.

The Report finds that in 2013-14, the 444 providers of HCPP who were included as part of the financial analysis raised $1,139.5 million in revenue, paid $1,035.3 million in expenses and hence, profited $104.2 million.

5.2 Sector overview

5.2.1 Supply of home care

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

- **By whole-of-sector.** All HCP providers are considered together.
- **By ownership type.** That is, not-for-profit, for-profit and government providers.
- **By location.** Providers with services located in metropolitan areas, regional areas or both metropolitan and regional areas.

- **By provider size.** Size is categorised into providers operating one, two to six, and seven or more services.

Figure 5.1 provides an overview of the number of providers, the number of services operated and the number of packages provided in 2013-14. The table provides a breakdown of ownership type, location and provider size for all Home Care providers.

Figure 5.1: Provider numbers, number of services and number of HCPs, as at 30 June 2013 and 30 June 2014

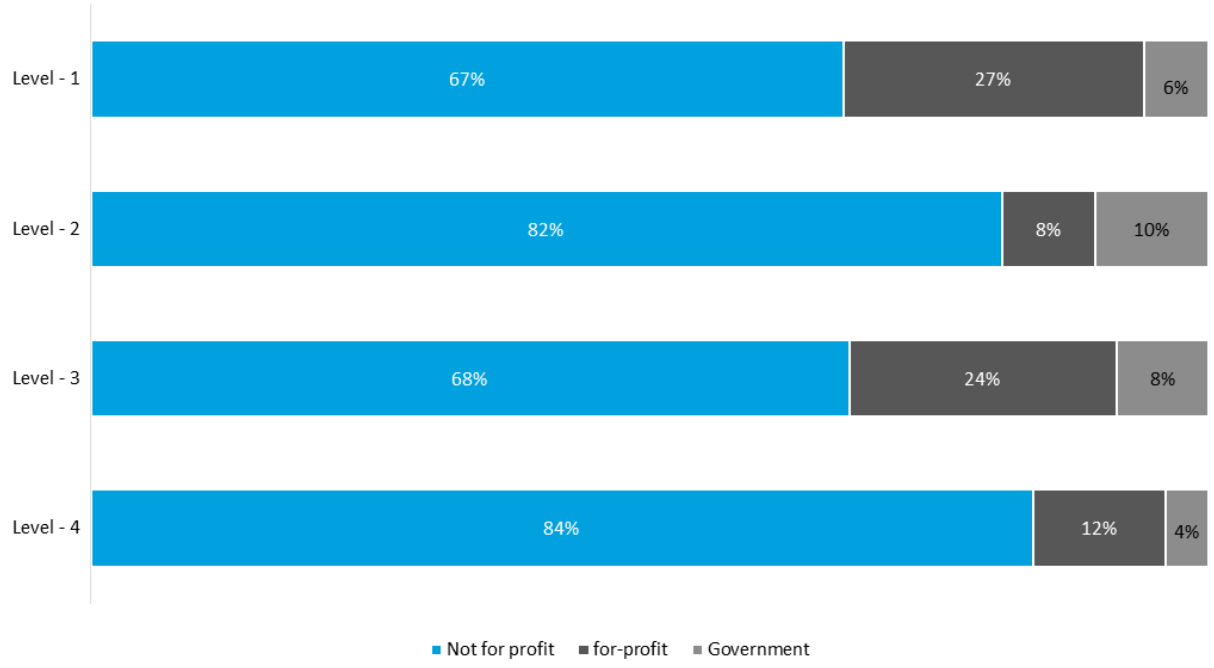
			Ownership type			Location			Provider size		
	Total sector 2012-13	Total sector 2013-14	NFP	For-profit	Government	Metropolitan	Regional	Metro and regional	Single service	Two – six services	Seven or more
Providers	504	504	345 (68%)	60 (12%)	99 (20%)	246 (49%)	234 (46%)	24 (5%)	240 (48%)	190 (37%)	74 (15%)
Services	2,131	2,212	1,755 (79%)	230 (10%)	227 (11%)	1,253 (57%)	522 (23%)	437 (20%)	240 (11%)	578 (26%)	1,394 (63%)
Packages	60,308	66,149	54,009 (81%)	6,363 (10%)	5,777 (9%)	43,162 (65%)	10,562 (16%)	12,425 (19%)	6,687 (10%)	16,494 (25%)	42,968 (65%)

As Figure 5.1 shows, in 2013-14, there were 504 providers of home care who provided 66,149 packages to consumers. There were 59,739 consumers as at 30 June 2014. The reason there were fewer consumers than packages was because the remaining packages were not occupied at that time. Over the year 2013-14 there were 83,114 consumers who received a package at some point.

In 2013-14, HCL2 packages comprised the majority (76 per cent) of all operational packages followed by HCL4 (21 per cent), HCL1 (2 per cent) and HCL3 (1 per cent). This reflects that former CACP packages became HCL2 and former EACH and EACH-D became HCL4. HCL1 and 3 only came into operation in August 2013.

As illustrated in Chart 5.1 and Table 5.1, not-for-profits provide the greatest number of packages across all levels. Government provides the fewest packages across levels, except for HCL2 in which it provides 10 per cent of packages compared with the for-profit sector's 8 per cent.

Chart 5.1: HCPs by provider type, as at 30 June 2014, ownership type (%)



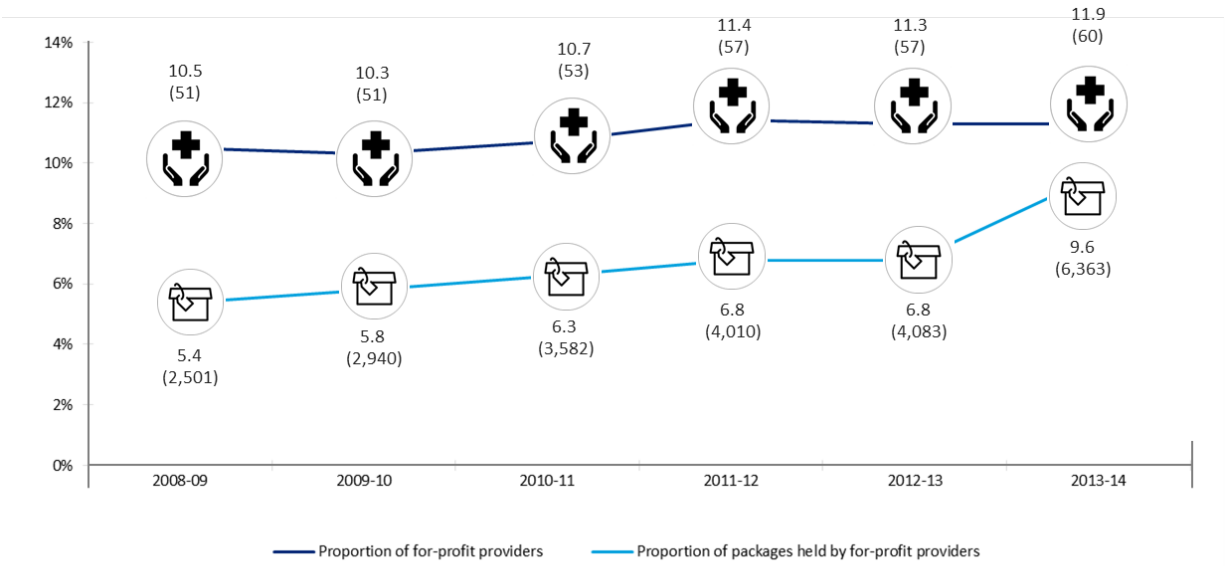
Note: The HCPs (all levels) commenced on 1 August 2013

Table 5.1: HCP by ownership type and by package level, as at 30 June 2014

Level	Not-for-profit	For-profit	Government	Total
Level 1	878	350	75	1,303
Level 2	40,917	4,143	5,097	50,157
Level 3	686	241	83	1,010
Level 4	11,528	1,629	522	13,679
Total	**54,009**	**6,363**	**5,777**	**66,149**

It is noticeable that for-profit providers have a larger share of the new HCL1 and HCL3 packages than they do of the HCL2 and HCL4 packages. This possibly indicates an increasing level of interest by for-profit providers in the HCP market. The number of packages provided by for-profit providers jumped from 7 per cent to 10 per cent between 2012-13 and 2013-14 alone (Chart 5.2). It will be of interest to see if this trend continues with the potential for for-profit providers to move into the HCP market likely to increase with the reforms for increased choice in HCP announced to take effect from February 2017.

Chart 5.2: Proportion of provider and HCPs, for-profit providers, 2008-09 to 2013-14 (%)



As a result of the recent reforms which increased the aged care ratio for home care packages from 25 to 45 packages per 1,000 people aged 70 and over, the number of operational home care packages is set to increase by about 80,000 to around 140,000 packages by 2021-22. A total of 6,653 new places were allocated in the 2014 ACAR:

- 951 HCL1 places
- 1,838 HCL2 places
- 2,850 HCL3 places
- 1,014 HCL4 places.

A breakdown of these places by state and territory can be found in Appendix K.

5.2.2 Demand for home care

Demand includes both that which is met by a service and that which is not met by a service. At present, data is not systematically collected which would allow for an estimation of unmet demand. Therefore, only data pertaining to occupancy rates (met demand) is reported in this chapter.

Occupancy is measured as the cumulative number of claim days (days where a package was actually used by a consumer) divided by the cumulative number of available package days (days where a package was operational, that is able to be used by a consumer).

The change in home care that will see the allocation of packages direct to individuals post February 2017 is likely, for the first time, to provide an accurate assessment of unmet need and demand for home care packages.

Occupancy across all home care levels during 2013-14 was 88.4 per cent compared with 92.0 per cent in 2012-13. As the results of the 2012-13 ACAR were announced on 28 June 2013, all new home care packages (Levels 1 – 4) were assumed to be operational from 1 July 2013, even though some places would not have been available to be used by a consumer until after that date. Given that occupancy is calculated by dividing the number of days a place is occupied, by the number of days it was operational, this likely contributed to the lower occupancy ratio.

Table 5.3 below provides occupancy rates by package level.

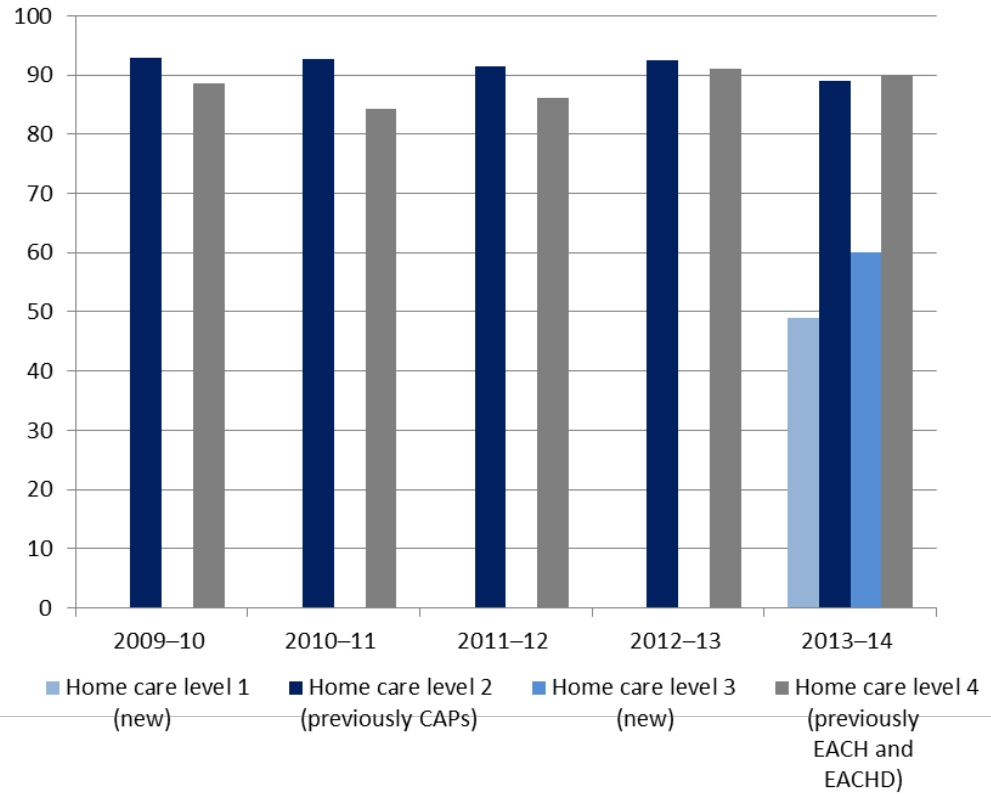
Table 5.2: HCP occupancy by HCP level

Level	Occupancy 2012-13	Number of operational packages at 30 June 2013	2012-13 ACAR allocated packages	Number of operational packages at 30 June 2014	Occupancy 2013-14
HCL1	n.a	0	1,303	1,303	48.7
HCL2	92.4[a]	47,158	2,997	50,157	88.8
HCL3	n.a.	0	1,010	1,010	59.9
HCL4	92.9[b]	13,150	525	13,679	90.1

a. CACPs only; b.EACH only

Chart 5.3 provides an overview of occupancy by package type over time. Noting that the packages have recently changed – the chart combines EACH and EACH-D packages as a comparator for HCL4 and CACPs packages are treated as a comparator for HCL2 packages.

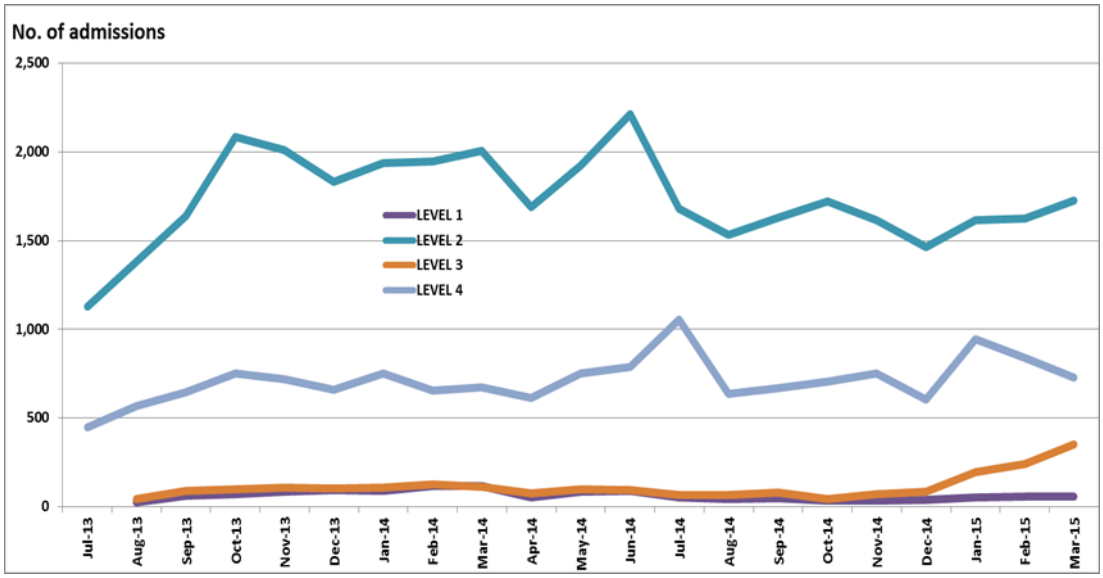
Chart 5.3 Occupancy by package type, 2009-10 to 2013-14



On average, in 2013-14, occupancy of newer HCL1 and 3 packages was 49 per cent and 60 per cent respectively, and 89 per cent and 90 per cent for HCL2 and HCL4. This mainly reflects the fact that HCL1 and HCL3 were new packages so there was some time for each package to be occupied by consumers. By contrast, the majority of HCL2 and HCL4 packages were the previous CACP and EACH package and therefore already had a consumer holding the package in the majority of cases.

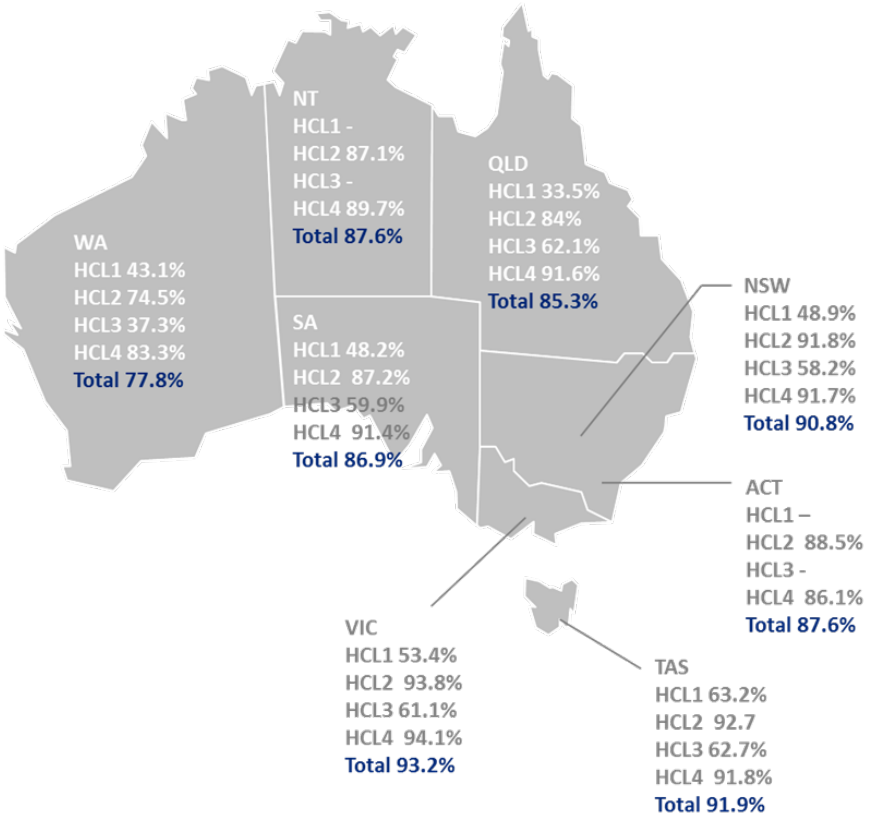
Chart 5.4 shows admissions to all four HCL packages since July 2014.

Chart 5.4: Admission to HCL packages, by package type July 2014 - March 2015



The trend of higher occupancy for HCL2 and HCL4 is consistent across all states and territories. Victoria, Tasmania and New South Wales have the highest rates of occupancy for HCP overall with the lowest overall occupancy in Western Australia (Figure 5.2).

Figure 5.2: Home Care occupancy rates across Australia, by state and package level, 2013-14



The average age of Home Care consumers in 2013-14 was 82.3. Table 5.3 provides a breakdown of consumers by age bracket and location.

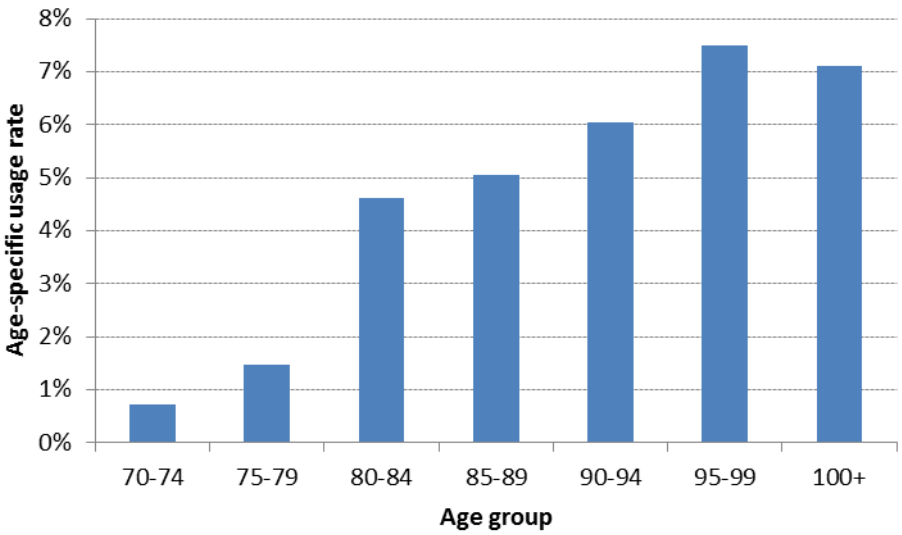
Table 5.3: Number of home care consumers by age bracket and state, as at 30 June 2014

Age	NSW	VIC	Qld	WA	SA	TAS	ACT	NT	Total
50-59	200	275	169	95	28	17	9	76	869
60-69	1,136	1,436	860	481	259	94	93	196	4,555
70-79	4,480	4,303	2,668	1,489	976	394	236	275	14,821
80-89	9,769	7,019	5,035	2,840	2,439	769	540	218	28,629
90+	3,839	2,233	1,908	1,179	1,027	273	229	50	10,738
Total	19,424	15,266	10,640	6,084	4,729	1,547	1,107	815	59,612

Note. Ages were recorded as 'unspecified' for some consumers.

Chart 5.5 provides a breakdown of home care usage by age bracket (as a proportion of age-specific population as at 30 June 2014).

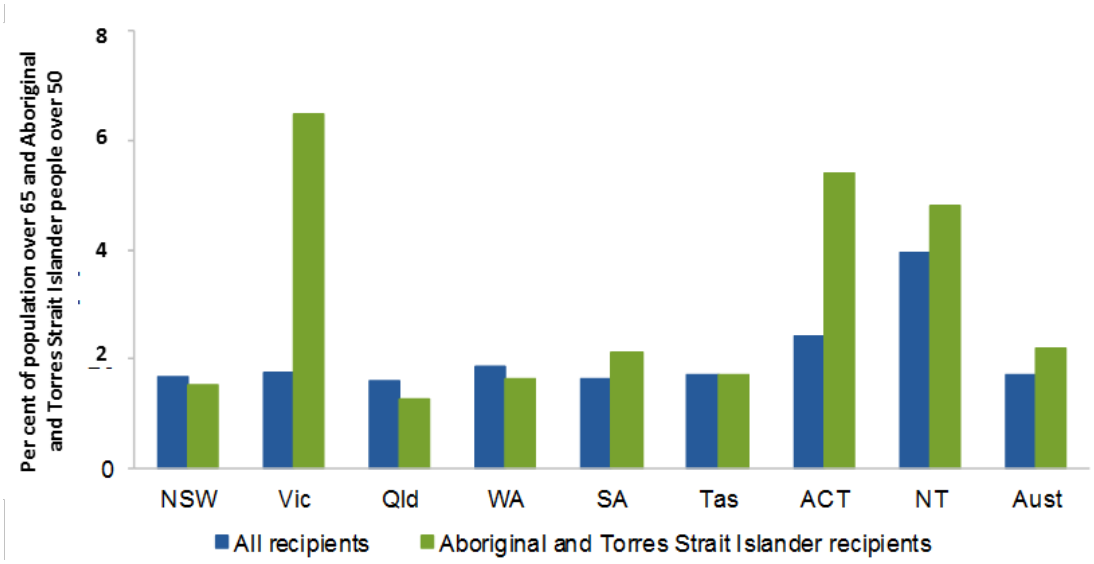
Chart 5.5 Proportion of each age group who are in home care, at 30 June 2014



The Productivity Commission defines the target population for aged care as all individuals over the age of 65 and Aboriginal and Torres Strait Islanders over the age of 50. Using this definition, the Productivity Commission reported that, as at 30 June 2014, 1.7 per cent of the target population for aged care in Australia were accessing home care. By comparison, 2.21 per cent of the target Aboriginal and Torres Strait Islander population were reported to be accessing home care.

Chart 5.6 provides the number of Home Care consumers per 1000 aged care target population as at 30 June 2014, highlighting utilisation by Aboriginal and Torres Strait Islander populations across all states.

Chart 5.6: Home care consumers as a proportion of population over 65 and Aboriginal and Torres Strait Islander people aged over 50, 30 June 2014



Source. Productivity Commission, 2015 Report on Government Services.

There were 13,481 older Australians from CALD backgrounds in receipt of a Home Care package as at 30 June 2014, which represents 22.6 per cent of the total Home Care recipients, up slightly from 22 per cent in 2012-13.

5.3 Analysis of 2013-14 Financial Performance of Home Care providers

In 2013-14, providers submitted financial performance reports to the Department using a new HCP Financial Report. The Report was introduced in 2013-14 and provides more comprehensive information that encompasses all levels of packages. This reporting format superseded all previous CACPs, EACH and EACH-D reports. The data used for analysis in this chapter is derived from that which was submitted using the new HCP 2013-14 Financial Reporting format.

In previous years, the ACFA Report has used data in the FARs which provided financial data only in relation to CACPs. Reports collected for EACH and EACH-D services did not include financial information and therefore past ACFA reports did not include financial performance analysis of EACH and EACH-D services. As a result, it is not possible to readily compare financial information across 2012-13 and 2013-14. Future ACFA Reports will provide comparative analysis going forward.

Figure 5.3 provides an overview of the 2013-14 financial performance of HCP providers as a whole, and then by ownership type, location and provider size. It is important to remain mindful of the sector composition and the varying objectives of providers when interpreting the data in Table 5.5. As noted earlier, the sector is dominated by not-for-profit providers. Traditional profit based targets are not always consistent with the mission and objectives of not-for-profit providers, many of whom seek to balance funding with expenditure rather than set profit based goals.

Figure 5.3: Summary of annual financial performance of HCP providers, 2013-14

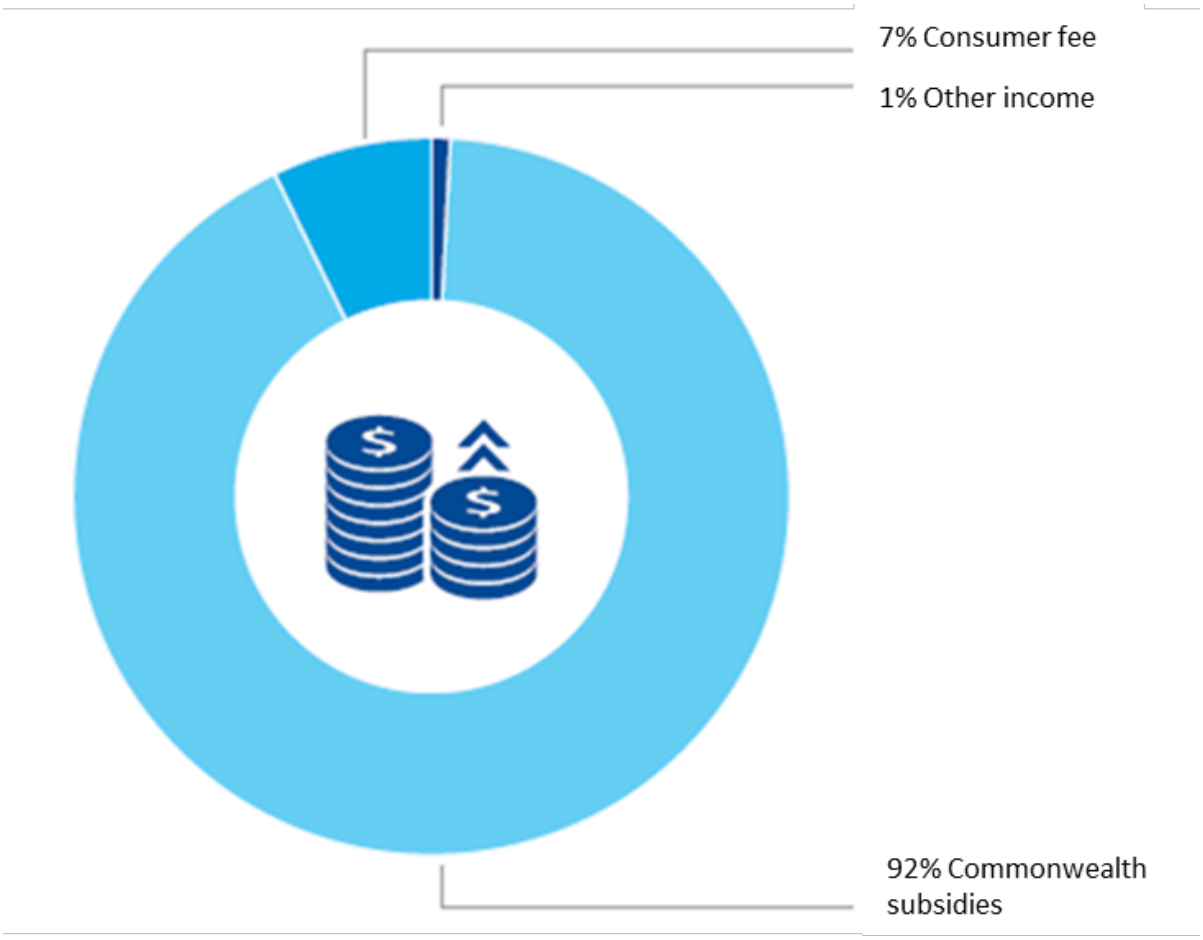
		Ownership type			Location			Provider size		
	Total sector 2013-14	NFP	For-profit	Government	Metropolitan	Regional	Metro and regional	Single service	Two – six services	Seven or more
Revenue ($m)	1,139.5	957.7	104.9	76.9	730.3	152.5	256.6	90.2	291.8	757.3
Expenses ($m)	1,035.3	867.4	90.9	77.0	659.9	146.1	229.3	87.9	271.3	676.1
Profit ($m)	104.2	90.3	14.0	-0.1	70.4	6.4	27.3	2.3	20.5	81.2
Average EBIDTA per package ($)	1,973	2,096	2,563	75	2,048	921	2,516	547	1,425	2,476

Note. All data provided in this table is data collated from the HCPP Financial Reports (2013-14). It reflects 88% of providers who provided usable data in their returns.

5.3.1 Revenue

Total revenue in 2013-14 across all providers who were included in the analysis was $1.14 billion. Chart 5.7 provides a break-down of the main sources of revenue reported by HCP providers.

Chart 5.7: Revenue sources for HCP providers, 2013-14



Note. This data refers to those services/providers who submitted their HCPP Financial Reports in a usable form.

Commonwealth funding

Commonwealth funding is the primary source of revenue for HCP providers. In 2013-14, the Commonwealth made payments of $1.27 billion to HCP providers on behalf of consumers as a contribution towards their support costs, up from $1.16 billion in 2012-13. [23] Over the period 2008-09 and 2013-14, Commonwealth contributions towards home care for older Australians have risen at an average rate of 11.5 per cent per annum. The number of home care packages has increased at an average annual rate of 7.1 per cent over the same period.

Commonwealth funding is determined per consumer based on the level of package accessed. It is calculated on a daily basis and paid monthly. Each HCL has a fixed level of annual funding set by the

[23] It is important to note that the revenue from the Commonwealth reported here exceeds what is reported as revenue for the summed value of revenue across the ($1.14 billion in 2013-14). The reason for this is that the revenue reported across the sector is collated from the HCPP Financial Reports which relates to 88% of the sector. Commonwealth Funding reported here relates to 100% of the sector.

Government. Supplements can also be paid where the consumer's circumstances require that they are provided with additional care and/or services.

The daily subsidy amounts applying to each package level in home care from 2012-13 to 2015-16 can be seen in Table 5.4. The daily amounts for all supplements applying in home care from 2013-14 to 2015-16 can be seen in Table 5.5.

In 2013-14, the Commonwealth funding of $1.27 billion comprised $1.24 billion in subsidies and the remaining $30 million in supplements.

Table 5.4: HCP Subsidies per day, 2013-14 and 2014-15

HCL	2012-13 subsidy ($)	2013-14 subsidy ($)	2014-15 subsidy ($)	2015-16 subsidy ($)
HCL1	-	20.55	21.43	21.71
HCL2	-	37.38	38.99	39.50
HCL3	-	82.20	85.73	86.84
HCL4	-	124.95	130.32	132.01
CACP	37.32	37.38	-	-
EACH	124.75	124.95	-	-
EACH-D	137.58	139.92	-	-

Note. In 2013-14, the rates for CACP, EACH and EACH-D were applicable up to 31 July 2013. As of 1 August 2013, the new HCL 1-4 rates applied.

Table 5.5: Home care supplement amounts per day, 2013-14, 2014-15 and 2015-16

Home Care Supplements	2013-14	2014-15	2015-16
Dementia and Cognition and Veterans' Supplement			
Level 1	$2.06	$2.14	$2.17
Level 2	$3.74	$3.90	$3.95
Level 3	$8.22	$8.57	$8.68
Level 4	$12.50	$13.03	$13.20
Other			
EACH-D Top Up Supplement	$2.47	$2.58	$2.62
Oxygen Supplement	$10.60	$10.84	$10.98
Enteral Feeding Supplement – Bolus	$16.78	$17.17	$17.39
Enteral Feeding Supplement – Non–bolus	$18.86	$19.29	$19.54
Home Care Viability Supplement			
ARIA Score 0 to 3.51 inclusive	$0.00	$0.00	$0.00
ARIA Score 3.52 to 4.66 inclusive	$4.21	$5.15	$5.22
ARIA Score 4.67 to 5.80 inclusive	$5.06	$6.19	$6.27
ARIA Score 5.81 to 7.44 inclusive	$7.08	$8.66	$8.77
ARIA Score 7.45 to 9.08 inclusive	$8.50	$10.39	$10.53
ARIA Score 9.09 to 10.54 inclusive	$11.89	$14.54	$14.73
ARIA Score 10.55 to 12.00 inclusive	$14.27	$17.45	$17.68

Though HCL1 and 2 packages made up 78 per cent of all packages, they are relatively lower in monetary value; hence they comprised only 51 per cent of total HCPP Commonwealth funding.

Not-for-profit providers are dominant in the sector and so receive most of the funding. Not-for-profit providers receive 83 per cent of total Commonwealth HCPP funding, comprising, on average 92 per cent of a HCP provider's income. Not-for-profit providers also received the greatest level of Commonwealth funding per provider on average ($2.9 million) compared with for-profit providers ($1.8 million) and government providers ($0.8 million).

Total funding for 2013-14 by subsidy and supplements is provided in Table 5.6 below.

Table 5.6: Commonwealth funding for Home Care, 2013-14 ($million), by ownership type

	Not-for-profit	For-profit	Government	Total
Subsidy	1,035.1	120.0	87.3	1,242.4
Supplements	22.5	2.8	3.2	28.5
Total	**1,057.6**	**122.8**	**90.5**	**1,270.9**

Note. Totals refer to whole-of-sector

Consumer contributions

In 2013-14, all consumers could be asked, at the discretion of the service provider, to pay a basic daily fee which is up to 17.5 per cent of the single basic age pension (currently $9.77 a day). Basic daily fees were not applied consistently across the sector.

Income tested fees could also be applied at the discretion of providers. As the Government subsidy was paid regardless of any income tested fee charged they were also not universally applied.

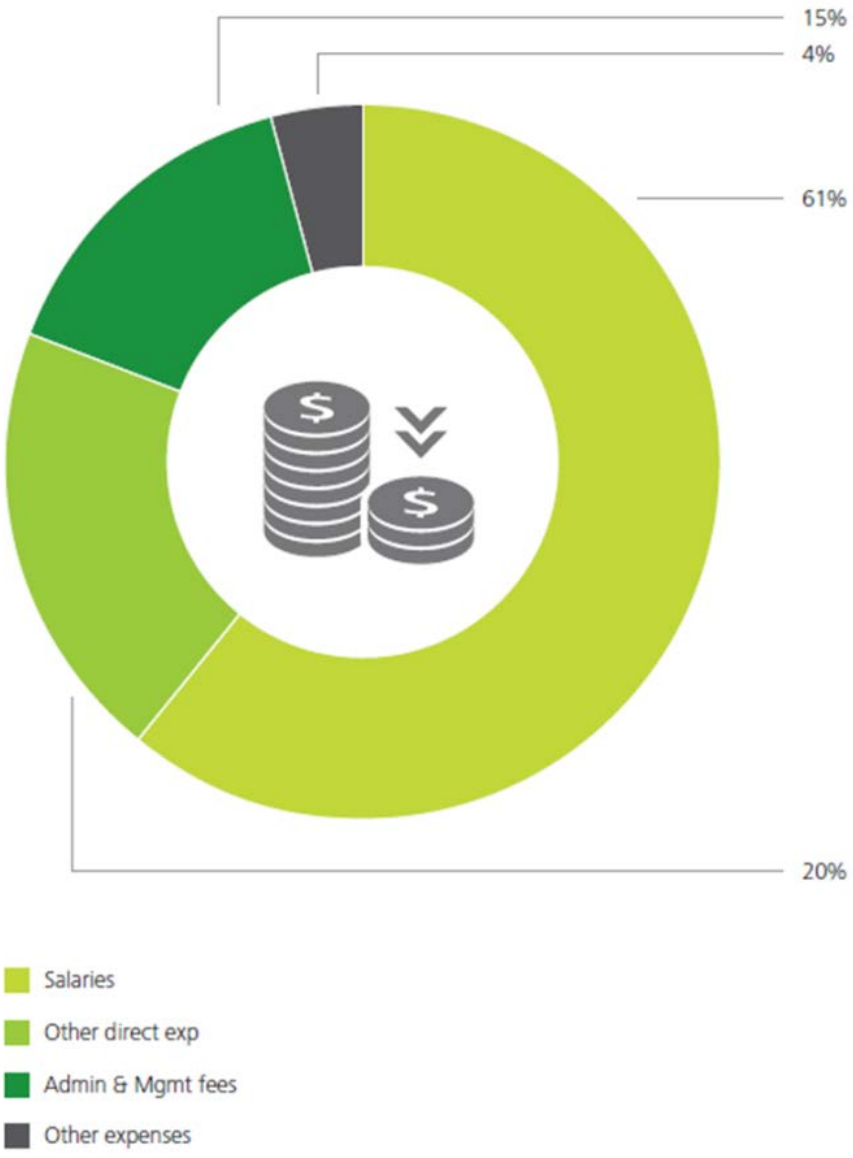
The vast majority of revenue in the sector is from Government subsidies. The amount contributed by consumers was about 7 per cent. This proportion is expected to rise following the introduction of new income testing arrangements for home care on 1 July 2014 reforms, described in Appendix E.

Both consumer and Government contributions per day were lowest among the bottom quartile of HCP providers ranked by EBITDA per consumer per day. While for-profit providers received the highest Government funding per consumer per day in the sector ($64.90 compared with $59.78, not-for-profit and $49.19, government), they received lower levels of consumer fees per consumer day than not-for-profit ($4.64 compared with $5.15). A break-down of per consumer day income, expenditure and profit by ownership type is provided in Appendix K.

5.3.2 Expenditure

Total expenditure across the sector in 2013-14 was approximately $1 billion. The average expenditure per consumer day was $58.76, that is, $21,447.40 per client for the year 2013-14. Chart 5.8 provides a break-down of expense types reported by HCP providers in 2013-14.

Chart 5.8: Expenditure for HCP providers, 2013-14



The most significant expense across the sector was staff remuneration, comprising 61 per cent of total expenses.

Table 5.7 provides a breakdown of expenditure according to ownership type, provider location and provider size. As the table shows, across all types of providers, salaries comprised the greatest proportion of expenditure. Smaller providers with only a single service incurred lower levels of expenditure per client overall compared with larger providers. For-profit providers incurred higher levels of expense than not-for-profit or government providers. Government providers incurred the lowest level of expense per client day.

Table 5.7: Expenditure per consumer day, 2013-14 by ownership type, provider location and provider size

	Salaries ($)	Other Direct Exp ($)	Admin & Mgmt Fees ($)	Other Expenses ($)	Total ($)
Ownership					
Not-For-Profit	36.33	11.31	9.03	2.48	59.15
For-Profit	39.29	8.47	9.84	3.30	60.90
Government	25.65	19.25	5.12	2.62	52.64
Location					
City	33.75	13.59	8.41	2.54	58.29
Regional	33.96	12.03	6.78	3.63	56.40
City & Regional	42.87	5.82	11.29	1.88	61.86
Size					
Single service	29.95	7.74	4.98	2.73	45.40
2 to 6 services	34.97	10.60	7.24	2.94	55.75
7 and more services	37.06	12.94	10.15	2.36	62.51
Total Sector	**35.70**	**11.72**	**8.78**	**2.56**	**58.76**

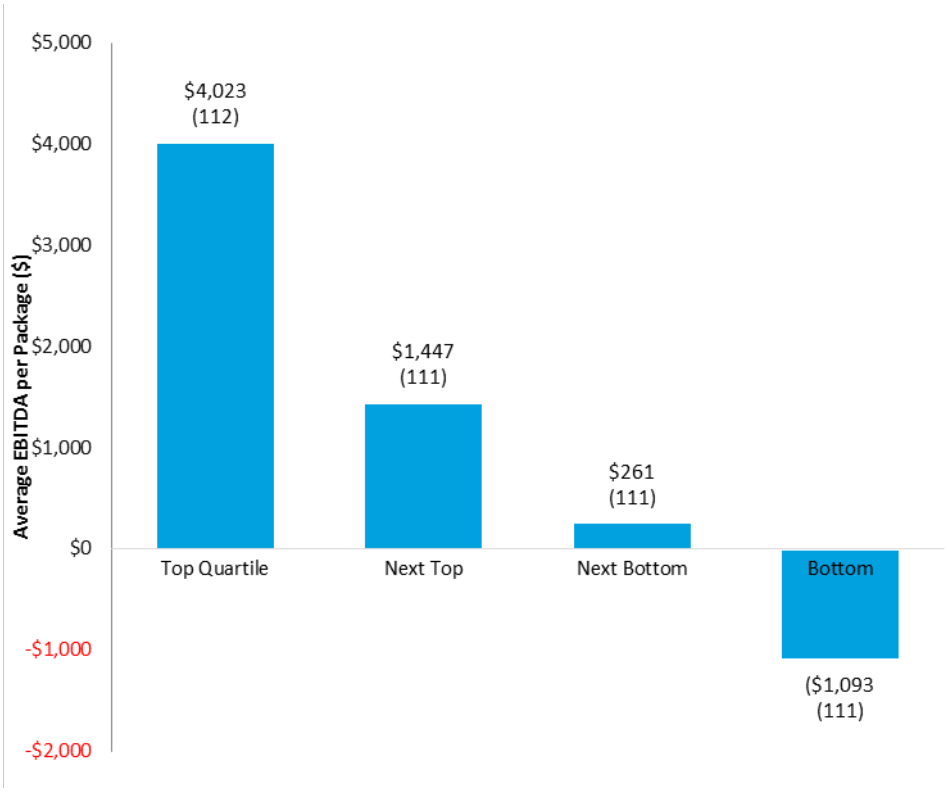
'Other direct expenditure' refers to care related expenses and sub-contracted or brokered client services.

5.3.3 Profit

In 2013-14, HCP providers generated a profit of $104.2 million in aggregate, translating to $1,810 per package. Overall an analysis of 2013-14 data shows that approximately 66 per cent of home care providers achieved a surplus in NPBT.

The average EBITDA per package was $1,973. As Chart 5.9 shows, profitability varies considerably across the sector with the top quartile (ranked according to EBIDTA) of HCP providers performing substantially better than the rest of the home care sector. The EBITDA margin for the top quartile is 18.3 per cent compared to the next top quartile returning 7.3 per cent.

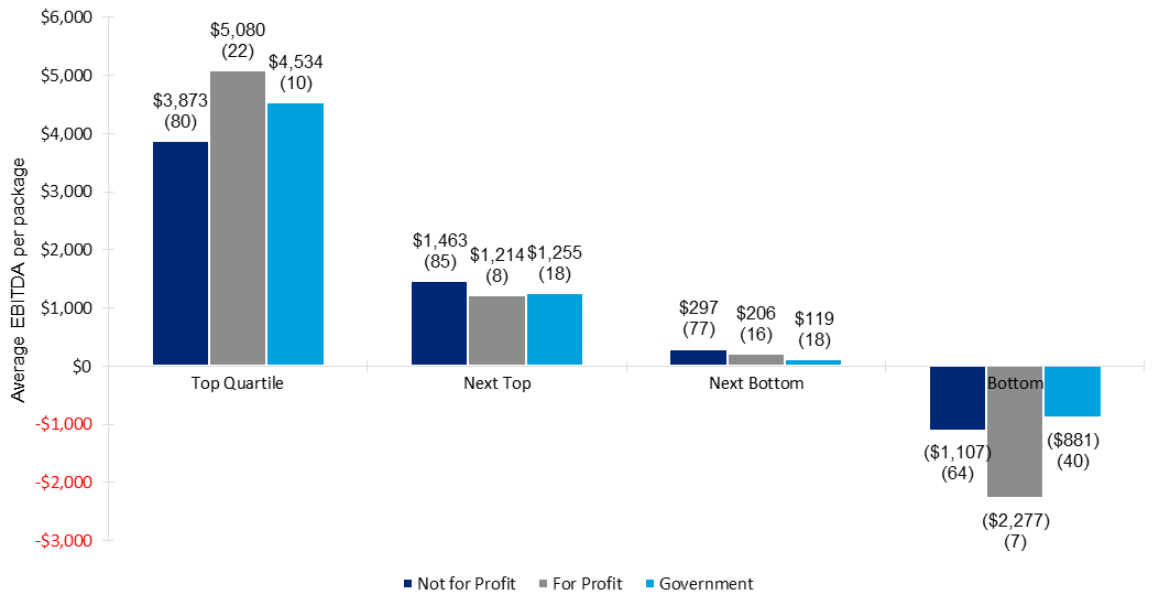
Chart 5.9: HCP provider average EBIDTA per package 2013-14, by quartile (number of providers in parentheses)



The composition of each quartile varies across ownership type, location of provider and size of provider.

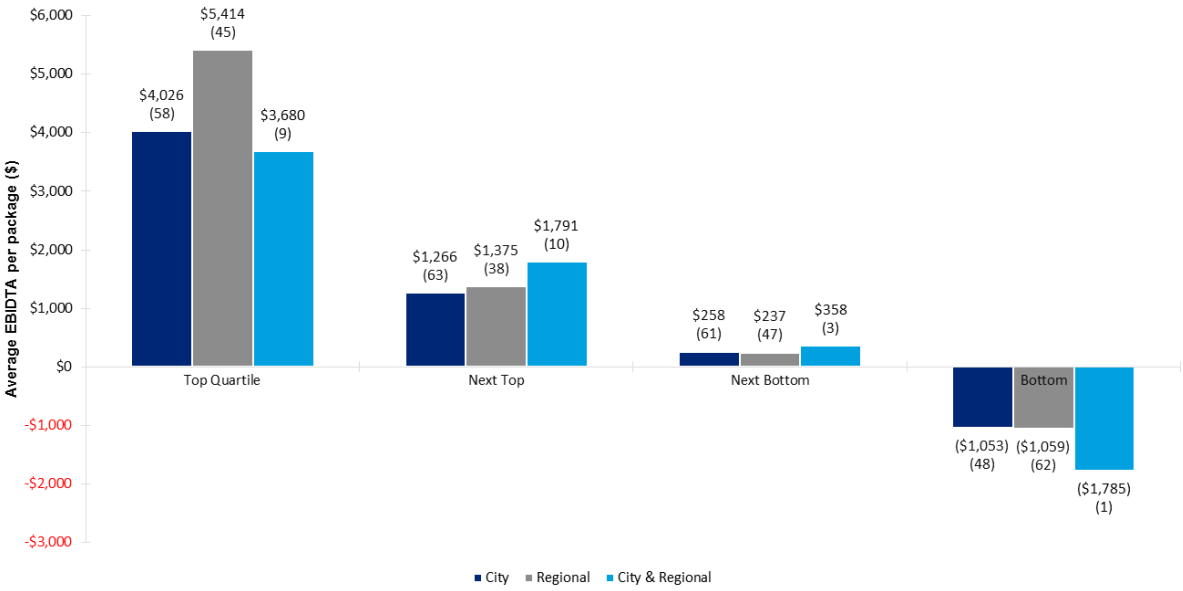
For-profit providers achieved the highest average EBITDA per package ($2,563 per package), while not-for-profit providers achieved a surplus above the sector average ($2,096 per package). Government providers had the lowest results making a loss on average per package ($75 per package). A higher proportion of total for-profit providers were present in the top quartile of ranking by EBIDTA per package Chart 5.10.

Chart 5.10: HCP provider average EBIDTA per package per annum 2013-14, by quartile and ownership type (number of providers in parentheses)



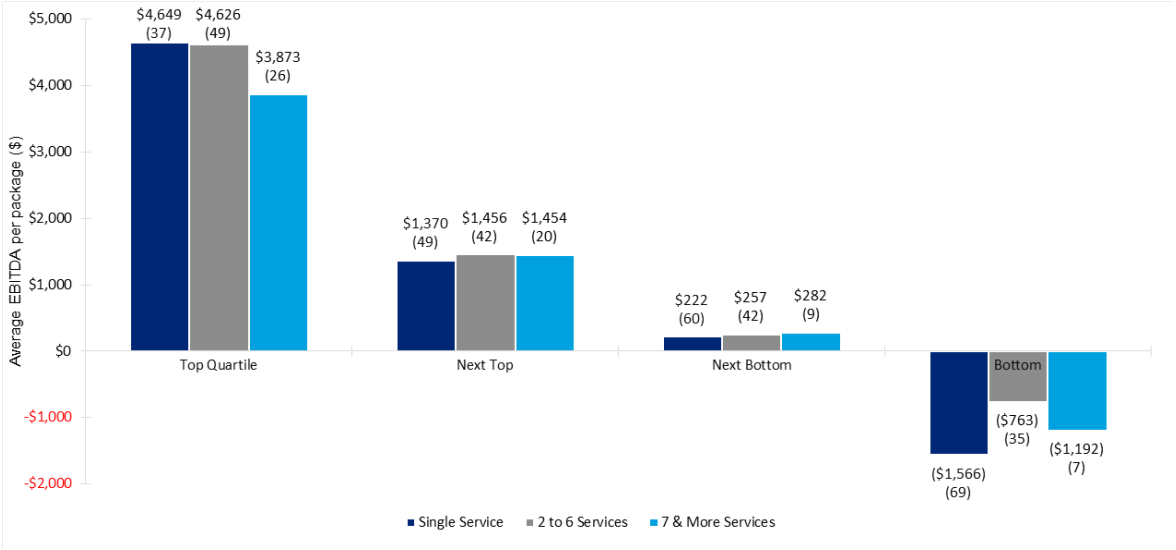
When classified on the basis of service location, providers who operated all of their services in regional locations achieved the lowest level of average EBIDTA per package ($921, compared with $2,048 for city providers and $2,516 for providers with services in the city and regional locations). On the other hand, high performing regional providers in the top quartile out-performed metropolitan providers or providers operating in both regional and metropolitan areas (Chart 5.11).

Chart 5.11: HCP provider average EBIDTA per package per annum 2013-14, by quartile and provider location (number of providers in parentheses)



Providers who only operate one service are under-represented in the top quartile (17 per cent) and over represented in the bottom quartile (32 per cent), achieving the highest and lowest average results in respective quartiles (Chart 5.12).

Chart 5.12: HCP provider EBIDTA per package per annum 2013-14, by quartile and provider size (number of providers in parentheses)



5.4 Looking forward: developments, opportunities and challenges

There are a number of changes occurring within the Home Care Packages Programme that will impact on HCP providers and the aged care sector overall. These include:

- increasing numbers of consumers being able to choose to be cared for at home with the help of a home care package delivered on a CDC basis; and
- the measures announced in the 2015-16 Budget to allow package holders greater choice over their preferred service provider from February 2017, and the intention to integrate home care packages and the CHSP into a single programme from July 2018.

5.4.1 Projected increase in package numbers

Changes in the service provision target ratios will result in an increase in the number of packages funded by the Australian Government. The Government will increase the total number of HCP from around 66,000 to around 100,000 by 2017. An additional 40,000 additional packages are expected to be available over the following five year period, from 2017-18 to 2021-22, bringing total places to 140,000. This increase is in line with the provision ratio target of 45 home care places for every 1000 people aged 70 and over by 2021-22, up from 27 places in 2012 when the reforms were announced.

The increase in the supply of home care packages will give more consumers the option to remain in their own homes, thereby increasing competition between home care and residential services.

Table 5.8: New aged care place allocations in most recent ACAR (December 2014)

Level	HCP	Residential places
HCL1	951	-
HCL2	1,838	-
HCL3	2,850	-
HCL4	1,014	-
Total	**6,653**	**11,196**

5.4.2 Consumer directed care

The Home Care Package sector is undergoing significant change to its operations with the full implementation of Consumer Directed Care (CDC). From 1 August 2013, all new Home Care Packages were required to be offered by providers on a CDC basis, and from 1 July 2015 all Home Care Packages were required to be provided on a CDC basis.

CDC gives consumers greater control over their own lives by enabling them to make choices about the types of care and services they access and how those services are delivered. In practical terms, CDC means that there is:

- greater choice and flexibility for the consumer about the types of care and services they access and how those services are delivered;
- greater transparency to consumers about what funding is available under their package of care and how those funds are spent through the use of an individualised budget and monthly income and expenditure statements;
- agreement on the level of involvement consumers want in managing their package; and
- ongoing monitoring and formal reassessment of needs to ensure the package continues to be appropriate for the consumer.

This increased involvement by consumers and transparency changes the dynamics of the relationship between the provider and consumer, empowering consumers by allowing them greater control over their individual budget with providers requiring appropriate systems for accounting for their costs and prices. The introduction of new arrangements for income tested fees in home care from 1 July 2014 has also seen consumers take a more active role in their packages as they now see part of the funding as being directly funded by them.

The main issues that emerged as a result of the implementation of CDC into the Home Care Packages Programme include:

- cultural organisational changes - some providers having to incorporate a cultural change within their organisation to embed a greater partnership approach between the consumer and provider to enable better participation of consumers;
- financial system changes - some providers having to upgrade their financial systems to incorporate the development of an individualised budget and monthly statement;
- cross subsidisation - some providers had been using funding from one consumer to ‘top up’ the care of another with more complex care needs, generally with neither being aware. This meant that not all consumers were getting the full value of their package and were missing out on services, or some consumers had an inappropriate package level for their needs. Providers can no longer cross subsidise other consumers under CDC arrangements, as all consumers are required to have an individualised budget that matches the funding. Transitioning to these arrangements has required adjustments to service levels in some cases; and
- the Department has established a CDC Transition Hotline to look at cases where a consumer has concerns about reductions to their service levels.

Supports and challenges of CDC

CDC was first trialled in 2010-11 for two years as a means of enhancing person-centred care by involving consumers more in determining their goals and service needs and in choosing services to meet their needs. While person-centred care is not a new concept, CDC does present some additional challenges for both providers and consumers who are unaccustomed to operating within what is a more consumer driven paradigm.

The Department has made various support mechanisms available to the sector and consumers to assist with the transition to CDC. The challenges and supports are detailed in Figure 5.4. The Government is also providing $20 million to assist home care providers with the costs they have already incurred in transition to CDC, through a one off grant of $274 per package held.

In addition, COTA Australia, in partnership with Aged Care Services Australia and Leading Age Services Australia, has been funded to undertake capacity building projects for providers and consumers to support the introduction of CDC. This includes the development of the 'homecare today' website and several resources for both consumers and providers which address the issues identified.[24]

CDC has required changes to how providers operate as noted in chapter 3 (see 3.2.6). Initial indications are that implementation and administration has increased provider costs, reducing profitability in 2014-15.

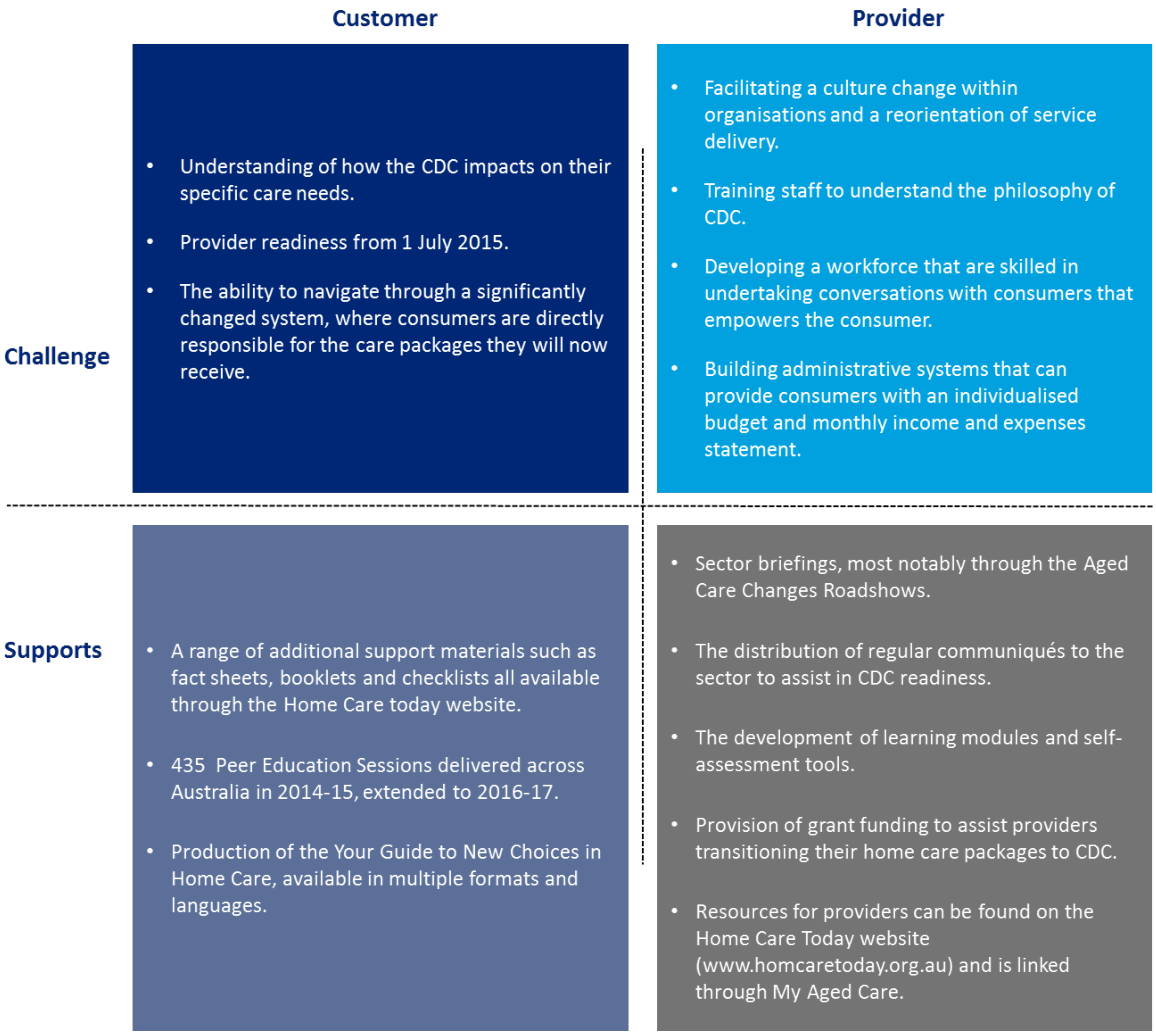
Opportunities of CDC

While the shift to CDC presents some challenges, CDC provides an opportunity for providers to reassess current business models and realign them with changing consumer needs. As business models mature post 1 July 2015 when all Home Care Packages will be offered on a CDC basis, this will allow providers to work with consumers to provide:

- increased choice and flexibility;
- better support information allowing consumers to make informed decisions about their care;
- a partnership approach and better-quality participation;
- emphasis on wellness and re-ablement; and
- greater transparency.

[24] (This is a weblink to Home Care Today: http://www.homecaretoday.org.au/)

Figure 5.4: Challenges and supports for consumers and providers



5.4.3 Budget 2015-16

From February 2017, HCPs will no longer be allocated to providers. Instead, funding for a HCP will follow the consumer, allowing eligible consumers to choose their service provider, as well as flexibility to change their provider. Once they have chosen their provider, Government subsidies will be paid to that provider.

These changes will give older Australians greater choice in deciding who provides their care and establish a consistent national approach to prioritising access to care. The changes will increase competition, and are expected to lead to enhanced quality and innovation in service delivery and reduced regulation and red tape for providers. Some rationalisation of providers could occur as the sector moves to a more competitive environment.

The 2015 ACAR will be the last to allocate HCPs to providers, though the Government will still control the total number of places it will fund.

From July 2018, the Government intends to integrate HCP and the Commonwealth Home Support Programme into a single care at home programme. These changes will represent a significant shift in how care and support is delivered to older Australians and will involve consultation with stakeholders on the implementation and transitional arrangements. This will also have implications for the separate subsidy payment and fee arrangements that currently apply in CHSP and HCP.

Residential care

Residential care is discussed across three chapters. Chapter 6 provides an overview of access to residential care. Chapter 7 provides commentary on the operational performance of aged care providers. Chapter 8 provides commentary on capital investment.

6 Residential aged care: access to care

This chapter provides an overview of the residential aged care sector – demand, supply and access to care.

This Chapter discusses:

- the operation of residential aged care.
- the supply and usage of residential aged care.

This Chapter reports that:

- the residential aged care sector is consolidating with the number of residential aged care places increasing while the number of provider's slightly reduce:
    - 189,283 places up from 186,278 in 2012-13
    - 1,016 providers down from 1,049 in 2012-13
- Not-for-profit providers represent the largest proportion of ownership type in residential aged care, with 52 per cent of providers and 57 per cent of places;
- ongoing demographic challenges will see an continuing increase in demand (people aged 85+ expected to grow to represent nearly 5 per cent of the population by 2055 compared with 2 per cent of the population today);
- occupancy has been relatively stable (93 per cent in both 2012-13 and 2013-14);
- continuing shift to provision of high care over low care services;
- ACFA has been asked to undertake a study on access for supported residents; and
- the proportion of residents in residential aged care from a CALD background is steadily increasing.

6.1 Sector overview

Residential aged care provides care and support for older Australians who are unable to live independently in their own homes. Services provided by residential aged care include:

- **Day-to-day tasks** such as cleaning, cooking, laundry
- **Personal care** such as dressing, grooming, going to the toilet
- **24-hour nursing care** such as wound care, catheter care

To obtain access to residential aged care, individuals are first assessed by an Aged Care Assessment Team (ACAT). Up until 30 June 2014, approvals for permanent residential care could be assessed as high care or low care.

- For care that was assessed as low level, the care was focussed on personal care services including help with the activities of daily living (dressing, eating and bathing), accommodation; support services (cleaning, laundry and meals); and some allied health services (such as physiotherapy). Nursing care can be given when required.
- For care that was assessed as high level, the care provided assistance with most activities of daily living with 24 hour care, either by registered nurses, or under the supervision of registered nurses. Nursing care is combined with accommodation; support services; personal care services (including toileting and moving around); and allied health services (such as physiotherapy, occupational therapy, recreational therapy and podiatry).

From 1 July 2014, the assessment by high and low care levels was removed for permanent residents in conjunction with the introduction of new accommodation payment arrangements that apply across all residential care. However, as this report examines 2013-14, some findings are still presented by care type.

Residential care is provided on a permanent or respite basis. The majority of residential aged 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 aged care homes.

- **Permanent residential aged care** is offered to older people who can no longer be supported to live in their own home.
- **Respite residential aged care** is short-term care in aged care services. It is available on a planned or emergency basis for older people who intend returning to their own home yet need residential aged care on a temporary basis. It supports older people in transition stages of health, as well as carers, to provide them with a break from their caring duties. It is also used by some older people to transition into permanent residential care. Residential respite care is provided on either a low-care or high-care basis.

This chapter provides an overview of the supply and demand for aged care and issues related to access to care.

6.2 Supply of residential aged care

The Government uses a needs-based planning framework to achieve and maintain a specified national provision level of subsidised operational residential aged care places and to achieve an equitable distribution of aged care places across Australia.

Table 6.1 provides an overview of the number of providers, the number of services operated, the number of places provided and number of residents in 2013-14.

Table 6.1: Number of Providers, services, places and residents in residential aged care, 2013-14*

			Ownership type			Location			Provider size				Care type		
	Total sector 2012-13	Total sector 2013-14	Not-for-profit	For-profit	Government	Metropolitan	Regional	Metro & regional	Single Home	2 To 6 Homes	7 To 19 Homes	20 & More Homes	High care	Low care	Mixed care
Providers	1,049	1,016	531 (52%)	377 (37%)	108 (11%)	586 (58%)	392 (39%)	38 (4%)	650 (64%)	287 (28%)	63 (6%)	16 (2%)	716 (70%)	38 (4%)	262 (26%)
Services	2,718	2,688	1,581 (59%)	842 (31%)	265 (10%)	1,495 (56%)	651 (24%)	542 (20%)	649 (24%)	805 (30%)	667 (25%)	567 (22%)	2,182 (81%)	41 (2%)	465 (17%)
Places	186,278	189,283	108,747 (57%)	70,842 (37%)	9,694 (5%)	116,698 (62%)	32,760 (17%)	39,825 (21%)	45,616 (24%)	52,204 (28%)	49,693 (26%)	41,770 (22%)	161,109 (85%)	1,252 (1%)	26,922 (14%)
Occupancy	92.7%	93.0%	94.6%	91.0%	90.0%	93.0%	92.9%	93.2%	92.7%	92.7%	93.4%	93.2%	93.0%	89.8%	93.0%
Residents	173,094	176,816	103,310	64,771	8,735	108,956	30,433	37,427	42,719	48,580	46,501	39,016	150,427	1,127	25,262
Permanent	168,968	173,974	101,820	63,564	8,590	107,297	29,767	36,910	41,891	47,810	45,816	38,457	148,136	1,089	24,749
Respite	4,126	2,842	1,490	1,207	145	1,659	666	517	828	770	685	559	2,291	38	513

Note. Totals of percentages may not add to 100% on account of rounding.

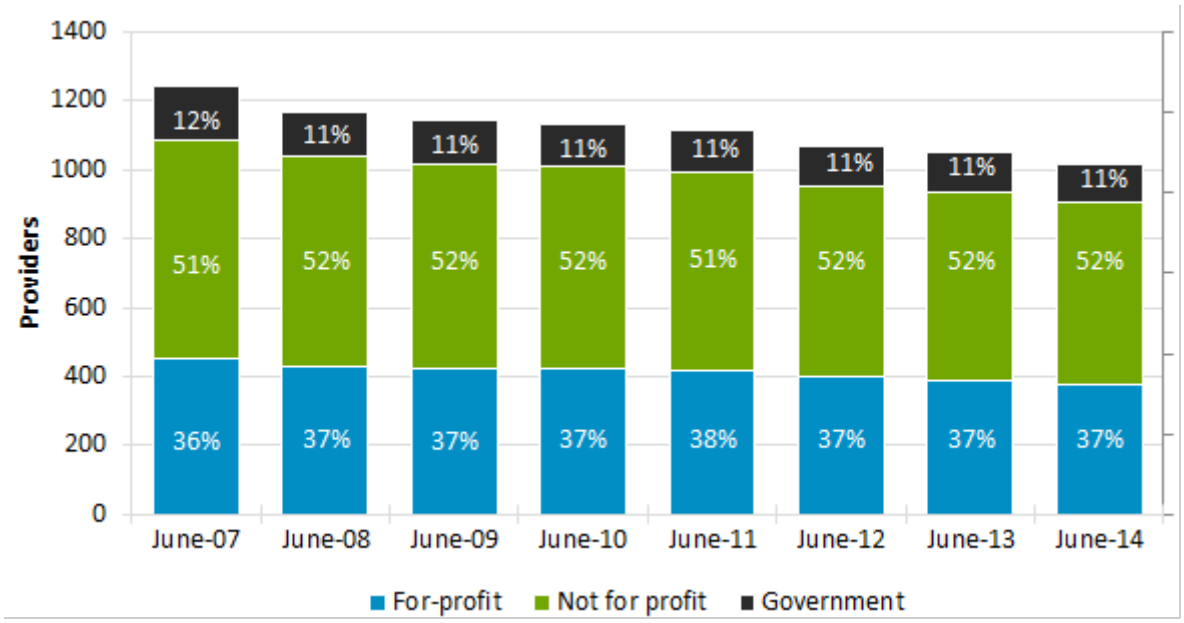
6.2.1 Number of places and providers

At 30 June 2014, there were 189,283 operational residential care places in Australia. The 1.5 per cent increase in residential operational places compares with annual average growth of 1.6 per cent over the previous five years.

At 30 June 2014, the operational ratio was 82.6 residential care places for every 1,000 people aged 70 years or over. Despite the policy to reduce the aged care provision ratio for residential care from 88 to 80 places by 2021-22, the structural ageing of the population means that the number of residential places released through the ACAR will continue to grow.

As the residential aged care industry matures, an increasing number of providers are seeking to increase the scale of their businesses. As a result there has been a consolidation of the industry providers. Chart 6.1 shows the decreasing provider numbers over the seven years to 2013.

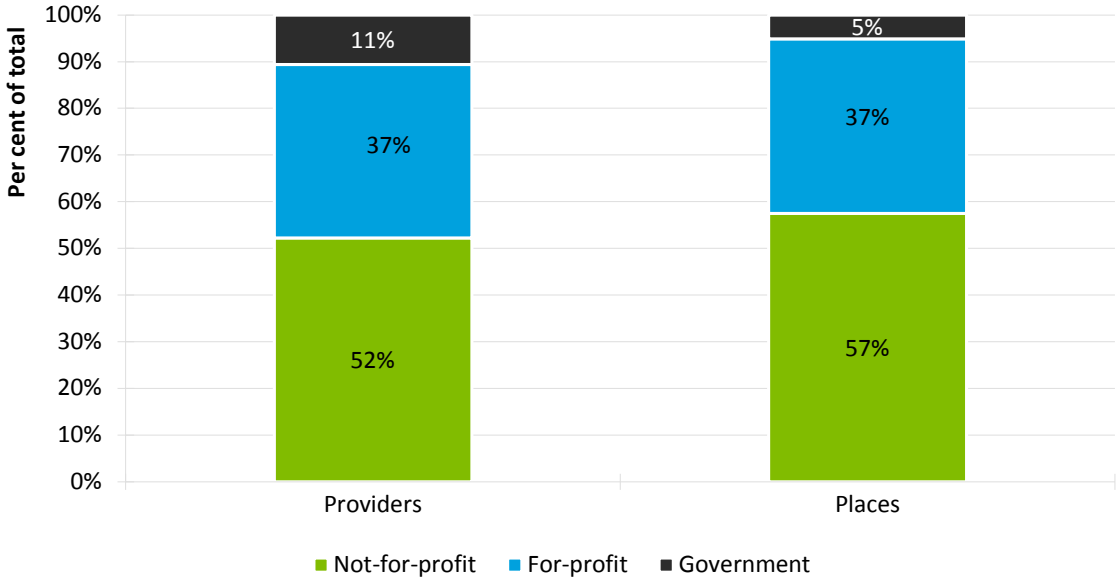
Chart 6.1: Provider numbers, 2007 to 2014



Ownership type

The largest provider group is not-for-profit providers (religious, charitable and community-based (see Chart 6.2)). They also operate the most operational residential aged care places at 57 per cent. For-profit providers account for 37 per cent of providers and 37 per cent of places. The remaining 11 per cent were operated by state/territory and local government owned providers who account for 5 per cent of the operational places.

Chart 6.2: Proportions of provider and places by provider ownership

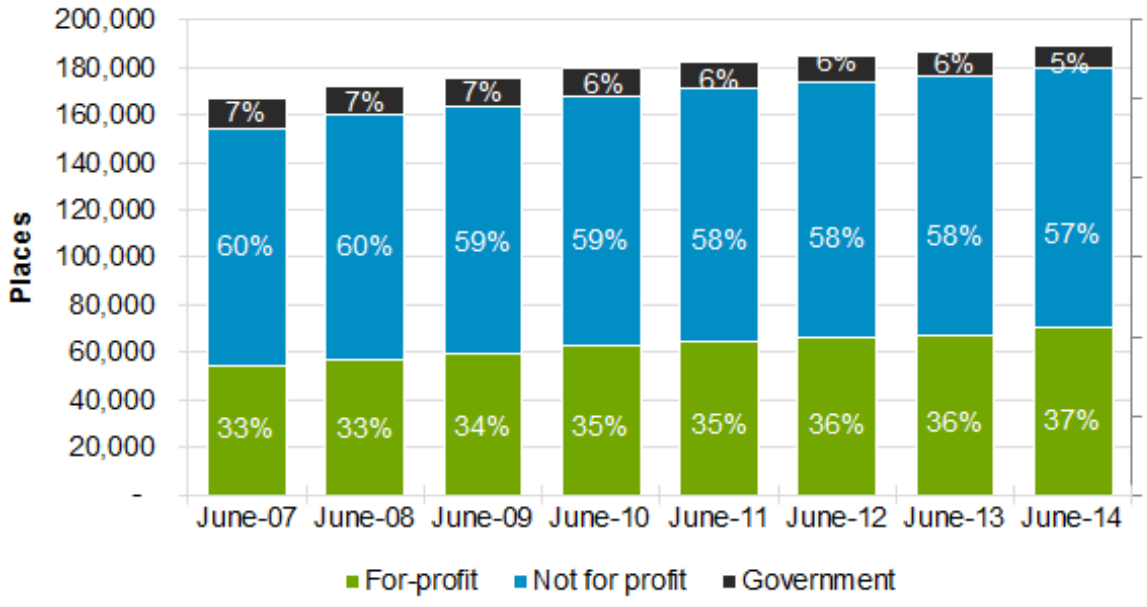


Note. Totals may not add to 100% on account of rounding

The proportion of providers across ownership types has remained relatively stable, while overall numbers of providers has slowly decreased (see Chart 6.1). However, Chart 6.3 shows that the proportion of operational residential aged care places held by for-profit providers has increased over the last 7 years despite the proportion of for-profit providers remaining stable. This reflects for-profit providers increasing the size of their operations.

An analysis of provisional allocations confirms that this trend towards for-profit providers holding an increasing proportion of residential aged care places is continuing.

Chart 6.3: Operational places 2007 to 2014

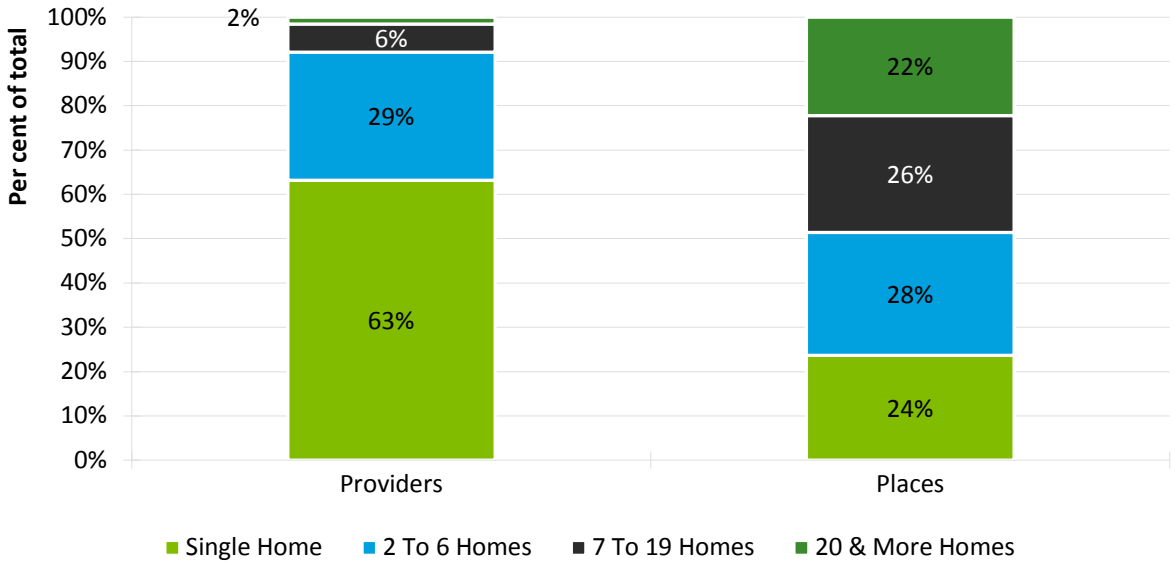


Note. Total percentages may not add to 100% on account of rounding.

Provider size

Most providers (63 per cent) only own one residential aged care home[25]. These single home providers account for 24 per cent of all operational aged care places (Chart 6.4). Conversely, providers with more than 20 homes account for only 2 per cent of all providers, however they account for 22 per cent of operational places.

Chart 6.4: Provider and operational places by provider size[1]



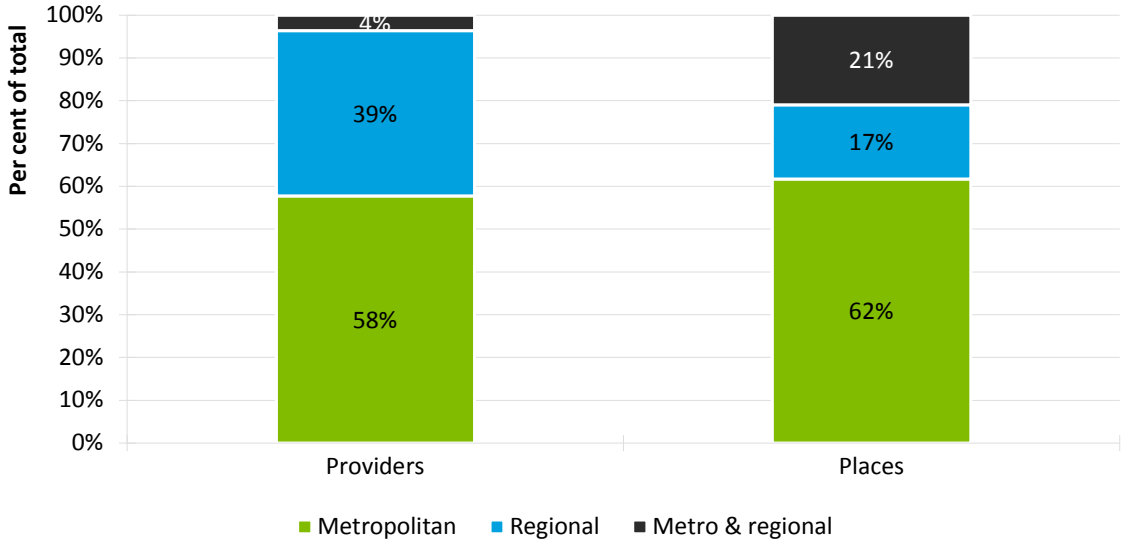
Notes: 1) The 63 per cent pertains to the GPFR sample

Location

Table 6.1 shows that the majority of providers are located in metropolitan areas (58 per cent), with 39 per cent of providers in regional areas and 4 per cent of providers in both metropolitan and regional areas. A provider is classified as being regional if more than 70 per cent of their residents are in facilities in regional areas. Correspondingly most operational places are in metropolitan areas (62 per cent). However while regional providers account for 39 per cent of providers, the smaller average size of facilities in regional areas means that only 17 per cent of operational places are in regional areas (see Chart 6.5)

[25] The 63 per cent pertains to the GPFR sample

Chart 6.5: Provider and places by provider location



Care type

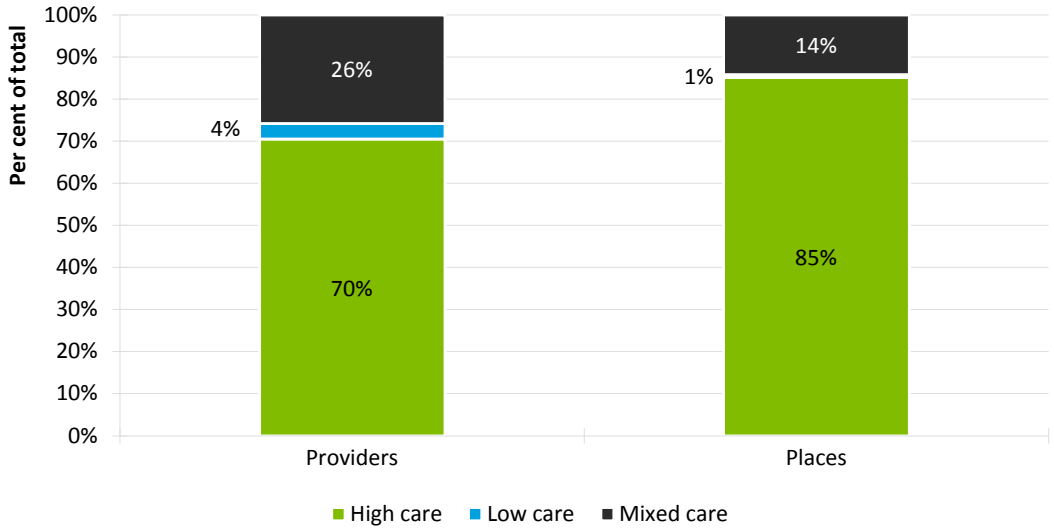
Residential aged care providers have been defined as high care, low care or mixed care based on the proportion of high care and low care days in each service:[26]

- a high care provider if over 80 per cent of high care days;
- a low care provider if over 80 per cent of low care days; and
- a mixed care provider where less than 70 per cent high care days and more than 30 per cent low care days.

Most providers operate high care services (70 per cent), with 26 per cent of providers operating mixed low and high care services and only 4 per cent operating low care only facilities. Most operational places are also occupied by high care residents (85 per cent) (see Chart 6.6). It should be noted that as of 1 July 2014 the distinction between high care and low care has been removed.

[26] Sample of GPFR

Chart 6.6: Provider and places by provider care type



6.2.2 New places

Under the current arrangements, the Commonwealth releases places through an annual Aged Care Approval Round (ACAR). After a place is allocated to an approved provider there is usually a period of time during which the place is considered 'provisional' while the provider constructs the facility; although in some instances the facility already exists. Once the place is available to be occupied by a resident the place becomes 'operational'. The median length of time between when a place is allocated and becoming operational is 4 years.

The 2014 ACAR allocated 11,196 new residential aged care places and provided $103 million in capital grants to renew or build new or improve existing residential services. At 30 June 2014 there were 21,047 provisional residential care places reflecting the carryover of allocated places from both the 2014 ACAR and from previous years which are yet to be commissioned. On average, around 10 per cent of allocated places are provisional at any time.

6.3 Demand for residential aged care

As noted previously in this Report, demand includes that which is both met by a service and that which is not met by a service. As with home care, data that would allow an estimation of unmet demand for residential aged care, is not systematically collected. Therefore, only data pertaining to resident numbers and occupancy rates (met demand) is reported in this chapter. Occupancy is measured as the cumulative number of resident days[27] divided by the cumulative number of available place days.[28]

6.3.1 Residents

The number of residents who received residential care during 2013-14 was 231,515, an increase of 2.4 per cent from 226,042 in 2012-13. The number of residents in permanent residential care as at 30 June 2014 was 173,974, an increase of 3 per cent from 168,968 at 30 June 2013. At 30 June 2014

[27] Resident days refer to the total number of days for which care was actually provided to a care recipient in an aged care place.

[28] Place days refer to the total number of days for which a place was available to be occupied by a care recipient.

there were 2,842 residents receiving respite residential aged care, a decrease of 31 per cent from 4,126 at 30 June 2013.

Chart 6.7 shows the continuing the trend towards an increasing proportion of high care residents. This trend towards high care residents becoming an increasing proportion of the residential aged care population is a result of a number of factors including:

- ageing in place;
- the increasing availability of home care services allowing people to remain in their own homes for longer;
- the higher turnover of high care residents; and
- the business strategies of providers.

Chart 6.7: Proportion of high care permanent residents, 2008-09 to 2013-14

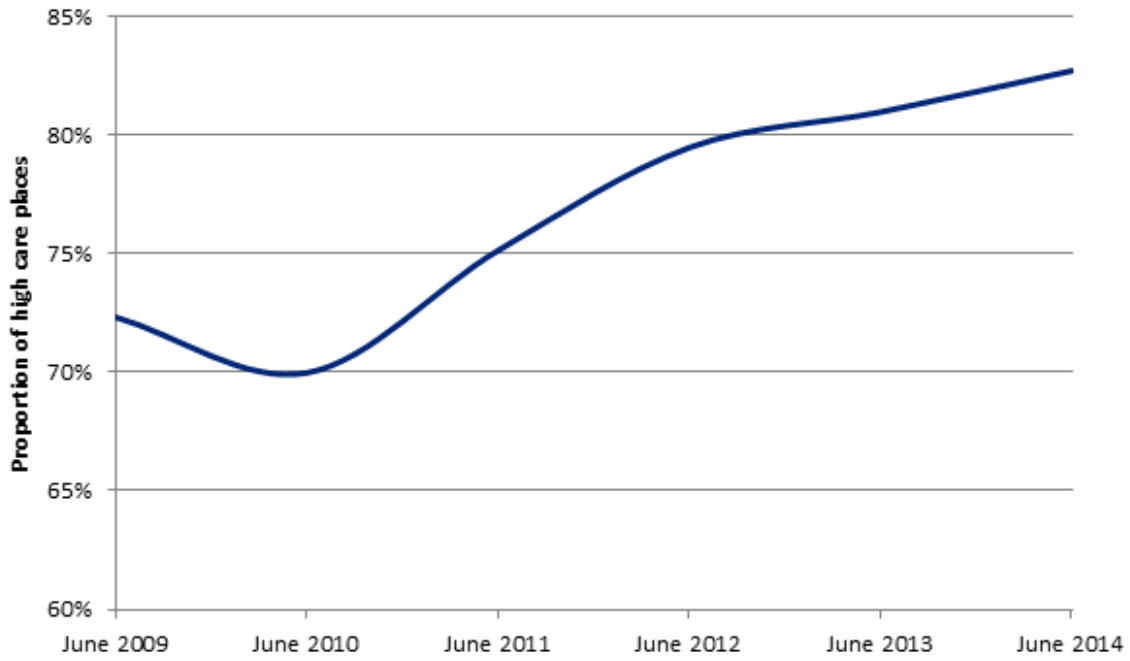
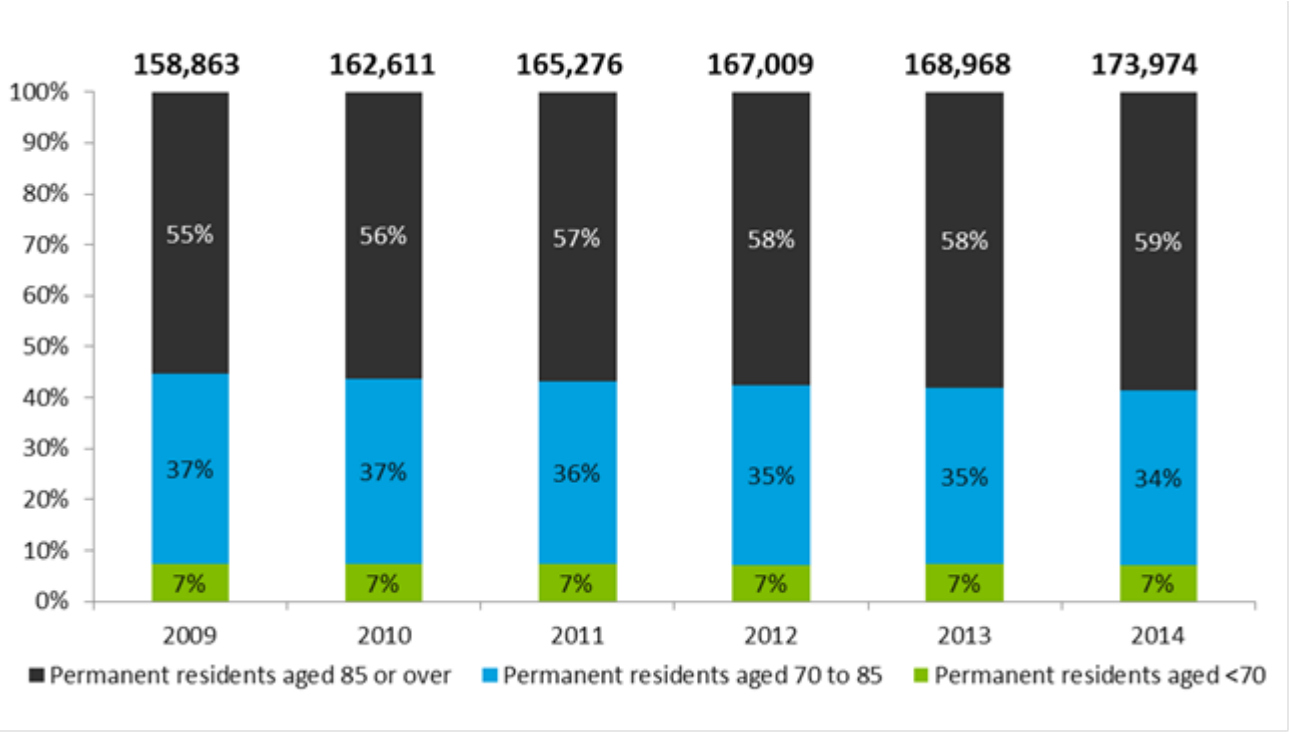


Chart 6.8 also illustrates that the residential aged care population is getting older over time as people live longer and tend to stay in their own homes longer before entering residential aged care. The proportion of residents aged over 85 years is increasing while the proportion of those aged between 70 and 85 has decreased.

Chart 6.8: Proportion of Residential Aged Care Residents by age (under 70, 70–85, 85 or over)



CALD residents

There were 29,848 older Australians from CALD backgrounds in residential aged care as at 30 June 2014, which represents over 17 per cent of the total people in permanent or respite residential care at that time, an increase from 15 per cent in 2007.

Aboriginial and Torres Strait Islander residents

The Productivity Commission defines the target population for Aged Care as all individuals over the age of 65 and Aboriginal and Torres Strait Islanders over the age of 50. Using this definition, the Productivity Commission reported that, as at 30 June 2014, 51.1 per cent of the target population for aged care in Australia were accessing residential care. By comparison, Aboriginal and Torres Strait Islander populations had lower rates of residential care utilisation – with only 18.5 per cent of the target population accessing this type of care.

Supported Residents

The accommodation supplement is paid to approved providers on behalf of residents who have been assessed as not being able to meet all or part of their own accommodation costs, including residents who have 'protected persons' living in their former residence. From 1 July 2014 the level of a new resident's accommodation supplement depends on:

- the outcome of the resident's means tested assessment;
- whether the aged care service is newly built or significantly refurbished;
- whether the aged care service in which they are a resident meets the 1999 fire safety and 2008 privacy and space requirements; and
- whether the aged care service provides more than 40 per cent of its eligible care days to supported residents.

Providers with 40 per cent or fewer supported residents in a facility have the accommodation supplement they receive for supported residents reduced by 25 per cent.

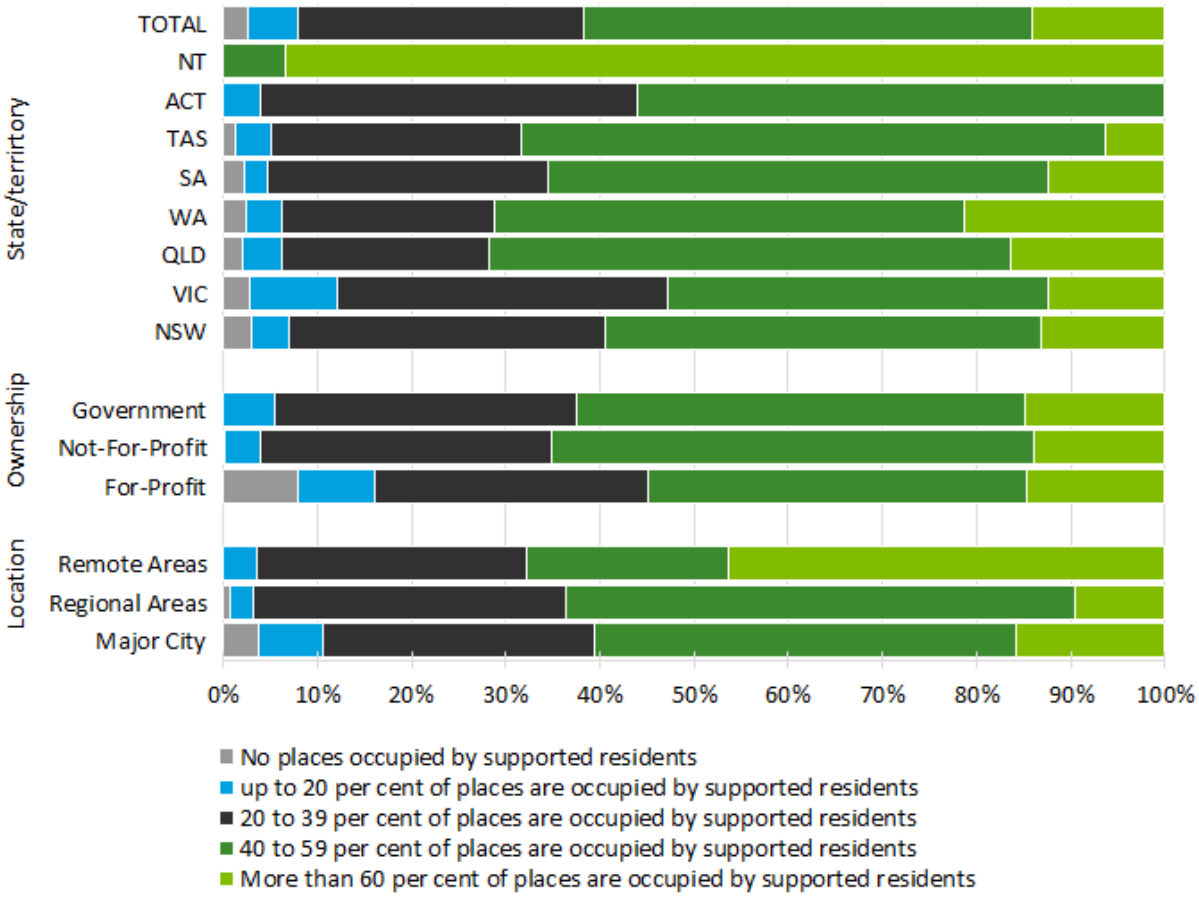
As at 30 June 2014, the nationwide proportion of supported residents (excluding extra service) was 42.7 per cent, compared with 43.5 per cent in 2012-13 and 38.2 per cent in 2011-12.

At 30 June 2014, there were 68,400 supported residents[29] in residential care accounting for 43 per cent of the non-extra services resident population. The proportion of non-extra service first admissions that were supported residents has remained relatively consistent at approximately 42 per cent over the period 2008-09 to 2013-14.

Supported residents at admission tend to be younger than non-supported residents. At first permanent admission in 2013-14, the average age of a supported resident was 81.1 years compared with 84.6 years for non-supported residents.

Chart 6.9 shows the proportion of services by location, ownership and state/territory distributed across bands of supported resident ratios in 2013-14. The majority of providers are in the bands of having more than 40 per cent of places supported.

Chart 6.9: Supported Resident Ratios



[29] For the purposes of this report, supported residents are considered as those residents who were eligible for Government support toward the cost of their accommodation. This group of residents includes the current group of supported residents whose eligibility in 2013-14 is determined through an aged care asset test, and the grand parented categories of concessional and assisted residents.

Across the segments shown in Chart 6.9, for-profit providers are more likely to be in bands with fewer than 40 per cent of places supported, with the providers that fall into this category having the accommodation supplements paid for supported residents reduced by 25 per cent.

Metropolitan areas are more likely to have facilities with no supported residents. However there is a relatively equal split across providers in bands where fewer than 40 per cent of residents are supported in metropolitan, regional and remote areas.

Around one third of aged care homes (mostly not-for-profits) always have a supported resident ratio exceeding 40 per cent, while around another third (mostly for-profits) never achieve the 40 per cent ratio needed to obtain the higher accommodation supplement. The other third of homes fluctuate, sometimes being well below the ratio, and at other times being above it. Over the longer term, the proportion of supported residents has tended to sit just below 40 per cent. Chart 6.9 summarises the mix of supported places by ownership and location.

New South Wales, Victoria and the ACT have the highest proportion of providers with fewer than 40 per cent of places supported. Queensland and Western Australia have the lowest proportion of providers below the target of 40 per cent supported places.

The Australian Government has asked ACFA to study and report to Government on cost neutral mechanisms to ensure adequate access to care for supported residents, including reviewing the supported resident ratio.

Occupancy rates

Occupancy rates reflect both demand and the number of places available. Occupancy rates have declined over time. The occupancy of operational residential care places was 93.0 per cent in 2013-14, up from 92.7 per cent in 2012-13 (see Table 6.1). Rates peaked in 2002 at 96.8 per cent.

The not-for-profit providers continue to have the highest occupancy rate at an average of 94.6 per cent, up from 94.2 per cent in 2012-13 (see Table 6.1). For-profit providers recorded an average occupancy of 91.0 per cent for 2013-14. This was up from 90.5 per cent in 2012-13 and was more than three percentage points less than not-for-profit providers.

There is minimal variation in occupancy by state or territory. However there is variation in occupancy by type of region. A clear trend is that more populous areas generally have higher occupancy rates than the less populous areas. At a high level, occupancy rates are:

- 93.2 per cent in major cities
- 92.9 per cent in inner regional Australia
- 92.4 per cent in outer regional Australia
- 88.6 per cent in remote Australia
- 84.4 per cent in very remote Australia

Over the period January to March 2014, the region with the lowest occupancy rate was ‘North-West’ Queensland at 79.0 per cent, and the region with the lowest vacancy rate ‘Whyalla, Flinders & Far North’ South Australia at 1 per cent.

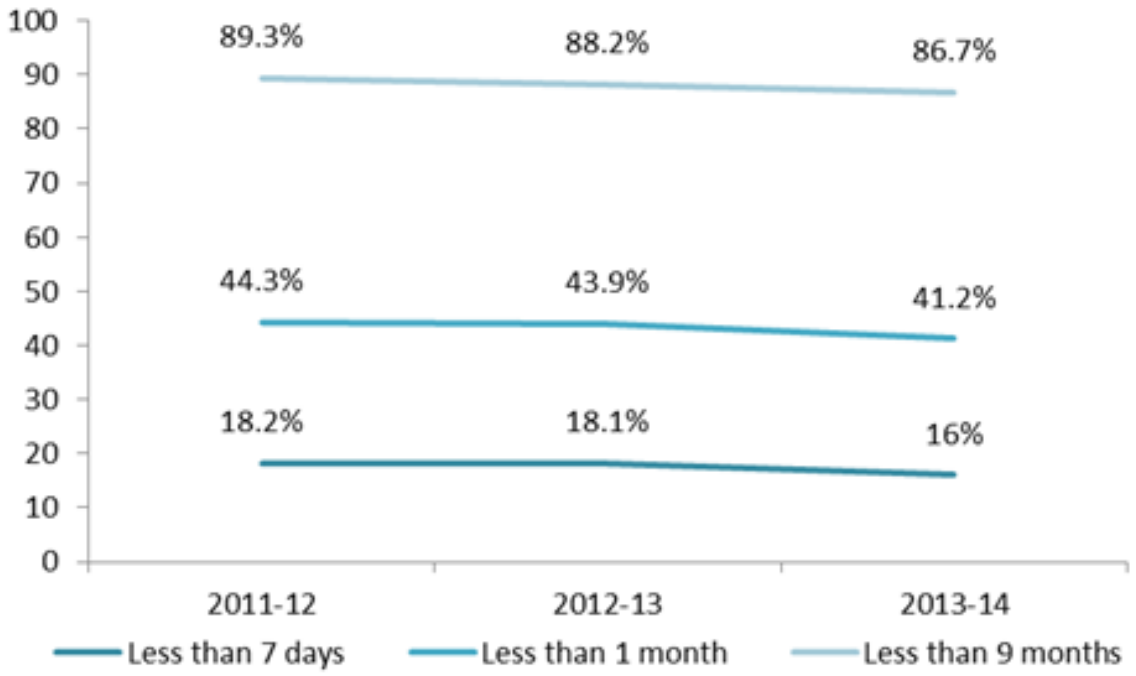
The elapsed time between when a resident is assessed as eligible for residential care and entering care is also used as a proxy for the demand for residential aged care. Although it should be noted that an eligible assessment does not necessarily mean that a person wishes to immediately access residential care as they may wish to explore other options or a range of providers/facilities. Additionally, those who enter residential care may need to organise the sale of assets in order to pay an accommodation bond.

As Chart 6.10 indicates, there is an increasing wait time between when a resident is assessed as eligible for residential care and entering care in 2013-14 compared with previous years:

- 16.0 per cent of people entering care did so within a week of being assessed by ACAT;
- 41.2 per cent did so within a month; and
- 86.7 per cent within nine months.

In previous years, a higher proportion of individuals entered into care within less than a week, month or nine months.

Chart 6.10: Elapsed times between assessment and entering care, 2011-12 to 2013-14 (%)



There have been improvements in the wait time for residents entering aged care from hospital. The proportion of all hospital patient days (for overnight separations only) used by patients who are waiting for residential aged care was 10.4 per 1000 patient days nationally in 2012-13, down from 14.6 in 2007-08.

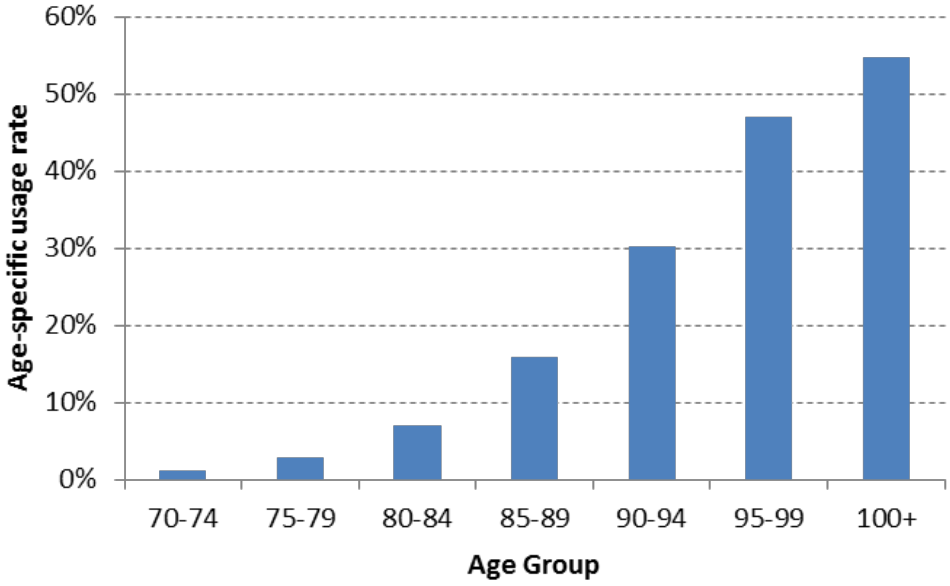
Table 6.2: Median Entry Period (Days) for First Permanent Admission to residential aged care, by ACAT Level, Face to Face Contact Setting and Supported Resident Status, 2013-2014

ACAT Level	Face to Face Contact Setting	Non supported	Supported	Overall
High	Acute Hospital	14	15	14
High	Private Residence / Other Community	63	70	65
Low	Acute Hospital	34	32	33
Low	Private Residence / Other Community	76	69	74

Future demand growth

The demand for residential aged care will expand with the ageing of the population. As can be seen in Chart 6.11 below, it is the oldest aged groups that will drive the demand for aged care. Around 3 per cent of people aged 70-74 years are in residential care compared with nearly 50 per cent of people aged 95 years and older.

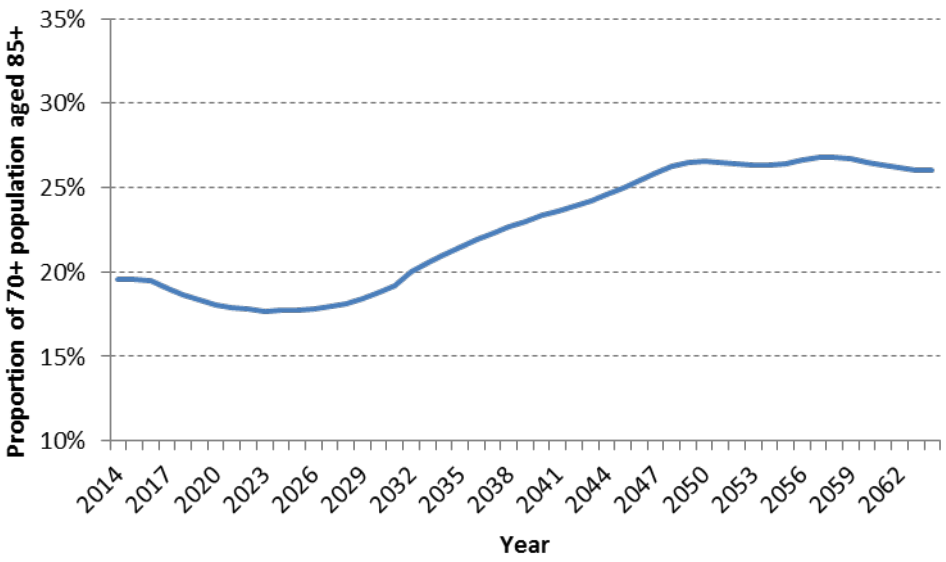
Chart 6.11: Proportion of each age group who are in residential aged care, at 30 June 2014



The residential aged care target ratio of 80 places per 1,000 people aged 70 years and over means the Australian Government is aiming to achieve one operational residential care place created for every 12.5 people 70 years or older. If the sector is to meet this target, this will result in a large supply of places required as the baby boomer cohort reaches 70 years old. This is shown in charts 6.11 and 6.12.

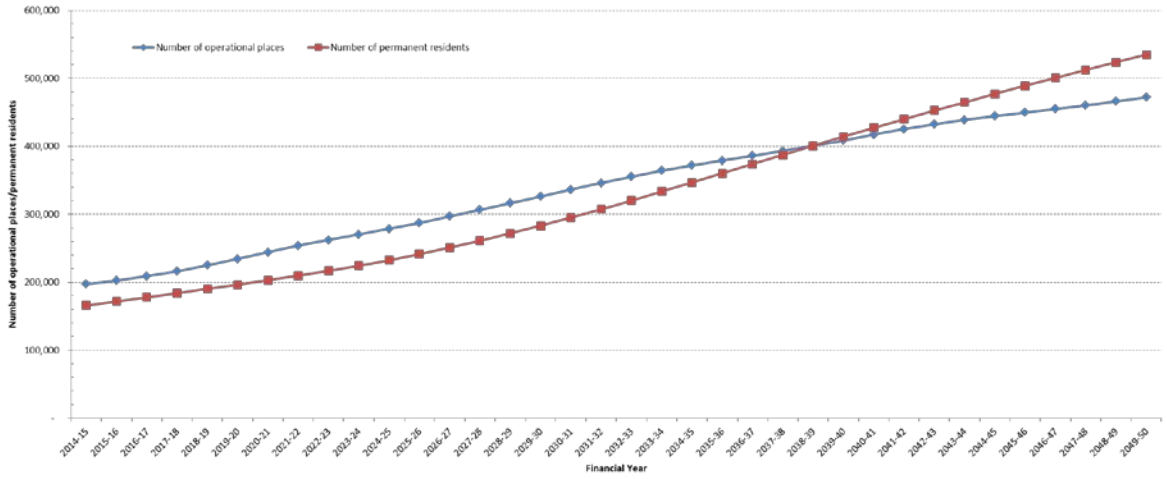
Because the baby boomers are such a large group compared with the pre-war generation, the structure of the population is such that the proportion of the 70+ population that are aged 85+ will reduce over the next decade then subsequently increase as shown in Chart 6.12. This implies that the challenge of ensuring there is sufficient residential aged care supply to meet demand arising from the baby boomer generation is more likely to accentuate in 10-15 years' time than over the next decade. Increased investment activity now and in future years is necessary to meet this challenge given the lead time in developing and building homes.

Chart 6.12: Proportion 70+ age group who are aged 85+, 2014 to 2062



The impact of the increase in the 85 years and older cohort can be seen in Chart 6.13 which shows the number of residents is projected to exceed the number of places under current ratios by around 2040.

Chart 6.13: Projected number of operational places under the current residential care ratio and the expected number of permanent residents, 2014 to 2050



Note: The above does not include residential respite residents

7 Residential aged care: operational performance

This chapter provides an overview of the operational performance of residential care providers.

This chapter discusses:

- funding arrangements for residential care
- the operational performance of residential providers for 2013-14, including revenue expenditure and profit
- operational performance by provider type, location and size
- key reforms and their impacts on operational performance
- opportunities and challenges going forward
- key findings from the ACFA Report, 'Factors influencing the financial performance of Residential care providers'

Key findings on financial performance in 2013-14:

- Total revenue in 2013-14 of $14.8 billion, equating to $237 per resident per day, an increase of 6.2% in total revenue and 5.3 per cent in revenue per resident per day from 2012-13
- total expenses in 2013-14 were $14.1 billion, an increase of 5.6 per cent from 2012-13
- 66 per cent of providers achieved a net profit
- Earnings before Interest, Taxes, Depreciation, and Amortization (EBITDA) increased from $1,473 million to $1,581 million in 2013-14 or 7.3 per cent
- Net Profit Before Tax (NPBT) increased from $594 million to $711 million in 2013-14 or 19.7 per cent
- EBITDA per resident per annum also increased from $8,660 to $9,224 or 6.5 per cent between 2012-13 and 2013-14
- NPBT per resident per annum also increased from $3,492 to $4,150 or 18.8 per cent between 2012-13 and 2013-14

There have been significant changes since 1 July 2014:

- reforms to accommodation payment arrangements
- 2.4 per cent increase in Government care subsidies from 1 July 2014 and a 20 per cent increase in the viability supplement
- some providers will be affected by the removal of the Payroll Tax Supplement from 1 January 2015 and cessation of the Dementia and Severe Behaviours Supplement from 1 August 2014
- new means testing arrangements will impact on overall sector sustainability by increasing consumer care contributions but will not affect actual care revenue for providers as increased consumer contributions will be matched by an offsetting reduction in Government care payments
- ACFA considers the net impacts of these reforms and changes will be beneficial overall for the sector though notes the impacts will vary from provider to provider

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 the residential aged care services. Capital financing is discussed in chapter 8.

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

- **By whole-of-sector.** All residential aged care providers who reported by the GPFR, which accounts for 98.5 per cent of providers. Throughout this chapter, whole of sector is defined as the 98.5 per cent of providers who reported using the GPFR.
- **By ownership type.** That is, not-for-profit, for-profit and government providers.
- **By location.** Providers with services located in metropolitan areas, regional areas or both metropolitan and regional areas[30].
- **By care type.** Providers that provide high, low or a mix of high and low care.
- **By size.** Size is categorised into providers operating one, two to six, seven to 19 and 20 or more services.

7.1 Operational funding

A combination of government and resident sources provides the operational funding for residential aged care.

Significant changes to funding arrangements took effect from 1 July 2014. These are described in section 7.3 of this chapter. As the financial analysis in this chapter is based on 2013-14 GPFRs, the descriptions in the remainder of this chapter relate to the 2013-14 funding arrangements.

7.1.1 Government operational funding

Government payments to residential aged care in 2013-14 can be classified as;

- Basic Subsidies
- Conditional Adjustment Payment (CAP)
- Accommodation payments (supplements)
- Viability Supplement
- Other supplements
    - Primary Care Supplements
    - Hardship Supplements
    - Payroll Tax Supplement
    - Dementia and Severe Behaviours Supplement

A full list of subsidies and supplements is in Appendix G. Commonwealth subsidies and supplements are indexed either biannually (accommodation related) or annually (care related). Accommodation related supplements are indexed using the Consumer Price Index and the basic care subsidies are indexed by Wage Cost Index (weighted 25% on the movements in the non-labour costs of providers reflected by the Consumer Price Index and 75% for wage costs reflecting the decisions of the Fair Work Commission in regard to Safety Net Adjustments as a measure of non-productivity based movements of the wage costs of providers).

[30] In aged care, 'regional' is any area that it outside of a major city. That is inner and outer regional, remote and very remote combined

7.1.2 Basic Subsidies

- **The basic care subsidy** is calculated based on the assessed need of each permanent resident as determined by the provider by applying the **Aged Care Funding Instrument.** The Commonwealth determines the level of payments on behalf of residents by setting the prices and rules for claiming ACFI care subsidies. **Respite residents** are assessed by an aged care assessment team as requiring either high or low level care, with payment amounts for each set by the Government.
- **The Conditional Adjustment Payment (CAP)** was paid in 2013-14 to eligible providers who met certain criteria including encouraging staff training, submitting a GPFR and participating in the workforce census. As of 1 July 2014 the CAP has been rolled up into basic subsidies and therefore paid to all providers. The CAP was paid at a rate of 8.75 per cent of the basic subsidy.

The Aged Care Funding Instrument (ACFI)

The ACFI is a funding allocation instrument. The ACFI differentiates the cost of providing care based on the needs of residents. The ACFI assesses core care needs as a basis for allocating funding.

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

7.1.3 Accommodation payments

Accommodation payments by the government are also referred to as accommodation supplements and include both the current accommodation supplement and the grand-parented supplements paid toward the accommodation costs of supported residents. The Commonwealth determines the amount of accommodation supplement payable on behalf of residents who cannot meet all of their accommodation costs by setting the maximum rate of accommodation supplement and determining the share paid by eligible residents based on an income and asset test (post 1 July 2014) or asset test (pre 1 July 2014).

7.1.4 Viability supplement

The viability supplement aims to improve the capacity of small, rural aged care services to offer quality care to care recipients which, because of location and the small number of allocated places, are constrained in their ability to realise economies of scale. The supplement is available to residential care services, home care services, Multi-Purpose Services and Aboriginal and Torres Strait Islander Flexible services. In 2012, measures were introduced to expand existing funding under the viability supplement to provide additional support to:

- aged care homes in very remote to moderately accessible locations;
- eligible aged care homes that provide specialist aged care services to Indigenous Australians; and
- eligible aged care homes that provide specialist aged care services to people with a history of, or who may be at severe risk of, homelessness.

Furthermore, as part of the 2014 Budget measure Reprioritising the Aged Care Workforce Supplement, the viability supplement was increased by 20 per cent from 1 July 2014.

The ACFA report on Factors Influencing the Financial Performance of Residential Aged Care Providers[31] conducted in 2014-15 found that for residential facilities, the viability supplement is broadly well targeted, predominantly being paid in regional areas and to providers who are generally

[31] In May 2015, ACFA reported to Government on a study into the quantitative and qualitative factors that influence and are associated with the financial performance of residential aged care providers. For the full report please see at https://www.dss.gov.au/ACFA.

in the lower groups for financial performance. A number of providers who would have otherwise been categorised in the lowest financial performance group in that report have instead been categorised in a higher group as a result of receiving the viability supplement.

7.1.5 Homeless Supplement

The homeless supplement is paid to a provider for each resident of their eligible aged care homes. Eligibility for the supplement is based on a provider 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.

7.1.6 Other supplements

The Commonwealth determines the rates of primary and other supplements payable by the Commonwealth in residential aged care such as the Veterans' Supplement, oxygen supplement and enteral feeding supplement. Of note, in 2014 there have been changes to three of these supplements:

- The Veterans' Supplement was introduced to improve access to services that cater for the needs of veterans with complex behaviours.
- The Dementia and Severe Behaviours Supplement (DSBS), which was introduced 1 August 2013, was discontinued on 31 July 2014 because budgeted expenditure was being significantly exceeded. The DSBS was payable for 11 months of 2013-14.
- The Payroll Tax Supplement (PTS) was discontinued from 1 January 2015 in order to cease the indirect transfer of revenue from the Australian Government to the states and territories. The PTS was however payable for the full 2013-14 financial year.

7.1.7 Resident operational funding

Resident contributions in 2013-14 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. It is set by Government at a maximum of 85 per cent of the single basic age pension.
- **An income tested care fee,** which is a contribution some residents make towards their care costs (personal and nursing) based on their assessable income.
- **Accommodation payments (charges),** which are payments for accommodation at an aged care home. They include accommodation charges paid by partially supported and non-supported high care residents, periodic payments made by low care residents and bond retentions and bond interest. Actual lump sum bonds are not considered revenue but are discussed in chapter 8.
- **Extra services fees,** which are additional fees that may apply for choice of a higher standard of accommodation or additional services. These vary from home to home, and only apply in homes with approved extra service status.

The Commonwealth determines:

- the rates of primary and other supplements payable by the Commonwealth;
- the maximum rate of accommodation supplement it pays;
- the maximum rate of the basic daily fee for living expenses; and
- the maximum income tested care fee that may be charged by providers.

7.2 Analysis of 2013-14 Financial Performance of Residential Aged Care

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

Table 7.1: Summary of financial performance of Residential Aged Care providers, 2012-13 and 2013-14

			Ownership type			Location			Provider size				Care type		
	Total sector 2012-13	Total sector 2013-14	NF	For-profit	Government	Metropolitan	Regional	Metro & regional	Single Home	2 to 6 Homes	7 to 19 Homes	20 & More Homes	High care	Low care	Mixed care
Revenue ($m)	$13,961	$14,826	$8,267	5,659	$901	$9,284	$2,501	$3,041	$3,505.5	$4,124.2	$3,901.6	$3,294.9	$12,952	$71	$1,803
Expenses ($m)	$13,367	$14,115	$7,998	$5,107	$1,009	$8,643	$2,553	$2,918	$3,249.8	$4,049.8	$3,712.2	$3,102.6	$12,259	$72	$1,784
Profit ($m)	$594	$711	$269	$552	-$108	$641	-$52	$123	$255.6	$74.4	$189.3	$192.3	$693	-$1	$19
EBITDA margin	11%	11%	10%	14%	-2%	13%	4%	10%	12.2%	8.5%	10.6%	11.9%	11%	5%	7%
NPBT margin	4%	5%	3%	10%	-15%	7%	-2%	4%	7.3%	1.8%	5.1%	5.8%	5%	-1%	1%
Average profit per customer Average profit (EBITDA) per resident ($) per annum.	$8,660	$9,224	$7,680	13,504	-$2,068	$11,092	$3,434	$8,542	$10,319	$7,358	$9,403	$10,145	$9,907	$2,832	$5,455

Note. Data is based on the General Purpose Financial Reports (98.5% of providers). Totals may not add due to rounding.

7.2.1 Revenue

Table 7.2 provides a break-down of the main sources of revenue reported by residential aged care providers in 2013-14. Total revenue of residential aged care in 2013-14 was $14,826 million, an increase of 6.2 per cent ($865.2 million) from 2012-13. More than half of this increase was in ACFI subsidy payments which saw a $434 million increase from 2012-13.

Analysing the change in ACFI care subsidies in terms of volume (increased number of residents) and price (higher average subsidy paid) shows that the majority of the growth has occurred through claiming higher prices due to increased resident frailty rather than through volume changes. A breakdown of this volume/price analysis explains the $434 million change as:

- $61 million in volume changes;
- $370 million in price changes; and
- $3 million due to the volume/price interaction effect (i.e. additional days of care at the higher price).

Table 7.2: Revenue sources for residential aged care providers, 2013-14

Revenue sources	2012-13 ($ million) ($million)	2013-14 ($ million)	Change ($ million)	Change (%)
Government Care Subsidies				
ACFI	$7,483.1	$7,917.2	$434.1	5.8%
Respite & Other	$805.0	$981.7	$176.7	22.0%
Income Tested Care fees	$326.0	$314.2	-$11.8	-3.6%
Accommodation payments [1]				
Accommodation supplements	$769.6	$762.4	-$7.2	-0.9%
Resident accommodation charges	$514.4	$643.5	$129.1	25.1%
Basic Daily Fee	$2,692.5	$2,855.8	$163.3	6.1%
Extra Services fees	$179.3	$194.8.	$15.5	8.6%
Total Residential Service Income	**$12,769.9**	**$13,669.6**	**899.7**	**7.0%**
Other income [2]	$1,191.0	$1,156.5	-$34.5	-2.9%
Total Revenue	**$13,960.9**	**$14,826.1**	**$865.2**	**6.2%**

Notes: 1) Accommodation payments are split between accommodation supplements paid by the Government and resident accommodation charges. 2) other income source mainly comprises of interest income (including interest from accommodation bonds), asset revaluations, trust distributions and other income

There is also a proportionately substantial increase in 'Respite and other' ($176.7 million or 22 per cent). This is due mainly to the introduction of the Dementia and Severe Behaviours Supplement (DSBS), which accounted for $117.6 million of the increase, and a $54 million aggregate increase in the conditional adjustment payment and the payroll tax supplement. The DSBS ceased on 31 July 2014.

Basic daily fee payments to providers for living expenses in 2013-14 totalled $2.9 billion, an increase of $163 million on 2012-13. Of this it is estimated that:

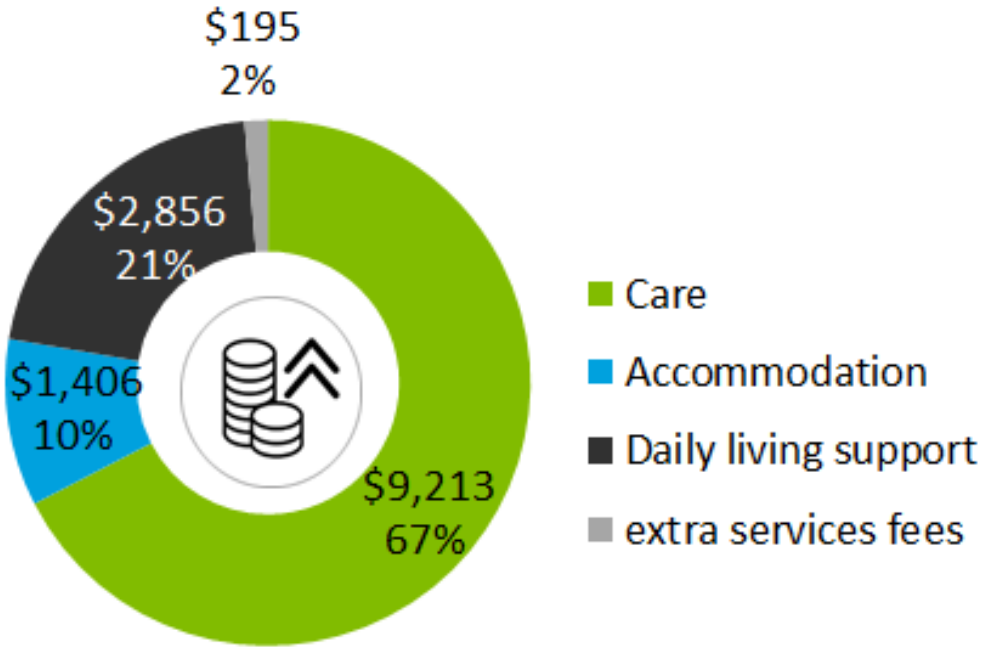
- $22 million (13 per cent) of the increase was associated with volume changes;
- $140 million (86 per cent) of the increase was associated with price variation (i.e. the flow on from the increase in the rate of the single pension to which the basic daily fee is indexed); and
- the interaction effect of the price/volume changes accounted for the remaining $1 million.

As shown in Chart 6.8, the number of residents has increased by 2.4 per cent between 2012-13 and 2013-14. The $22 million attributable to volume changes is as a result of an additional 504,377 resident claim days in 2013-14, bringing the total residential care claim days to 62,586,552.

Payments for accommodation and care are jointly funded by the Commonwealth (on behalf of residents) and residents. Funding of care constitutes the largest proportion of residential aged care funding at 67 per cent (see Chart 7.1). The majority of care funding is from the Commonwealth (96.6 per cent). Residents paid the remaining 3.4 per cent via the income tested care fee (not shown in charts). Accommodation payment (charges) account for 10 per cent, 46 per cent of which is paid by residents and 54 per cent paid by Government (not shown in charts).

Payments for living expenses and extra services are funded by residents. Basic daily fees for living expenses account for 21 per cent of the costs of residential aged care funding. Extra service fees account for 2 per cent of total operational funding.

Chart 7.1: Total funding by type of service, 2013-14



In 2013-14 the Government contributed 65 per cent of total funding ($9,661 million), residents 27 per cent ($4,008 million) and the remaining income was generated by other sources (8 per cent, $1,157 million), with these proportions unchanged from the previous year. In 2013-14, total payments by residents increased by 8.0 per cent ($296 million) and total payments by Government by 6.7 per cent ($604 million) compared with 2012-13.

Total revenue per resident per day in 2013-14 was $236.88 across all care types, an increase of 5.3 per cent from 2012-13 (see Table 7.3). Government funding via the care subsidies constitutes the largest proportion of funding of residential aged care at 60 per cent. The basic daily fee paid by all residents, is the next largest category, followed by accommodation payments made by the Government and then accommodation payments made by residents.

The distribution of revenue varies by the care type, with Government funding via care subsidies accounting for 61 per cent in high care but only 37 per cent in low care.

The amount of Government accommodation payments was slightly lower in 2013-14 compared with 2012-13 due to residents who were on grandparented arrangements (resulting in the Government

contribution being higher) leaving care and new residents being subject to comparatively higher accommodation fees.

Table 7.3: Revenue – Per Resident Per Day[1]

	2012-13	2013-14	Change ($prpd)	Change (%)
Government Care Subsidies	$133.50	$142.18	$8.68	6.5%
Government accommodation payments (Supplements)	$12.38	$12.18	-$0.20	-1.6%
Basic Daily Fee	$43.37	$45.6	$2.23	5.1%
Resident accommodation payments (charges)	$8.31	$10.28	$1.97	23.7%
Income Tested Care fees	$5.25	$5.02	-$0.23	-4.4%
Extra Services fees	$2.89	$3.11	$0.22	7.6%
Total Residential Service Income	**$205.69**	**$218.40**	**$12.71**	**6.2%**
Other Income	$19.19	$18.48	-$0.71	-3.7%
Total	**$224.88**	**$236.88**	**$12.02**	**5.3%**

Notes: GPFR only, totals do not add due to rounding

7.2.2 Expenditure

Total expenses in 2013-14 were $14.1 billion, up $0.7 billion from $13.4 billion in 2012-13. This is shown in Chart 7.2 and Table 7.4. Staff costs represent 66.0 per cent of total revenue, with 'other' costs, which include building repairs and maintenance expenses, rent, utilities and costs associated with employment support activities, accounting for 27.2 per cent. Depreciation and interest costs account for the remaining 5.3 and 1.5 per cent respectively.

Chart 7.2: Summary of Expenses 2008-09 to 2013-14

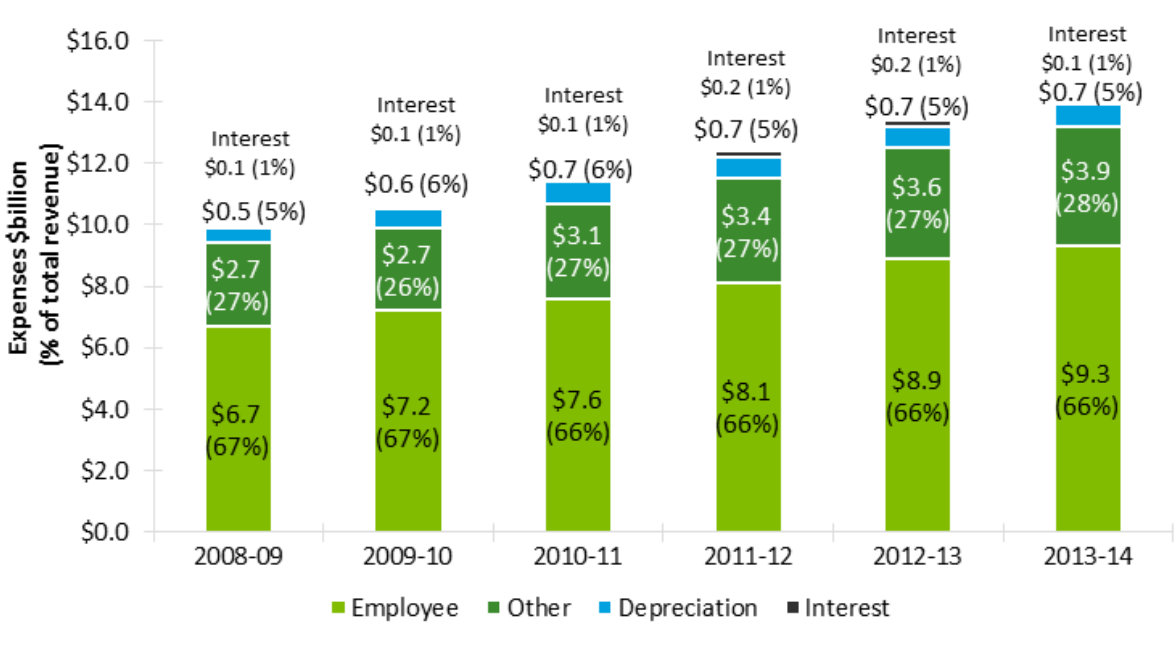


Table 7.4: Summary of Expenses 2012-13 to 2013-14

Expenses	2012-13 $million	2013-14 $million	Change ($ million)	Change (%)
Employee [1]	$8,872.7	$9,313.4	$440.7	5.0%
Depreciation	$719.3	$723.3	$4.0	0.6%
Interest paid	$159.7	$146.6	-$13.1	-8.2%
Other [2, 3]	$3,615.5	$3,931.2	$315.7	8.7%
Total	**$13,367.2**	**$14,114.5**	**$747.30**	**5.6%**

[1] employee expenses include salaries, superannuation and PAYG tax amounts and management fees.

[2] Other expenses includes other staff costs, building repairs and maintenance expenses, rent and utilities. A detailed breakdown is not available as residential aged care expenses are submitted on a voluntary basis as it is not required to be provided under the accounting standards. Many providers therefore only report aggregate in 'other expenses'.

[3] Other staff costs is the amount associated with employment support activities and includes professional development and training, job support, recruitment expenses, staff amenities, costs incurred for volunteering and other activities connected to the support and development services for the staff of the entity. It does not include salaries, superannuation, workers compensation and income or payroll tax amounts.

In 2013-14, $9.3 billion was expended in wages and management fees, an increase of $0.44 billion from 2012-13. Of this:

- $72 million (around 16 per cent) is attributable to an increase in the number of days of care provided (volume changes);[32]
- $366 million (83 per cent) is attributable to a 4.1 per cent increase ($5.89 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 $3 million (1 per cent) is due to the interaction of price/volume changes.

Operating position - Profit

The residential aged care sector showed an overall profit. Total sector Earnings Before Interest, Taxes, Depreciation, and Amortization (EBITDA) and Net Profit Before Tax (NPBT) both increased in 2013-14 by 7.3 and 19.9 per cent respectively compared to 2012-13.

Table 7.5: Overview of operating position

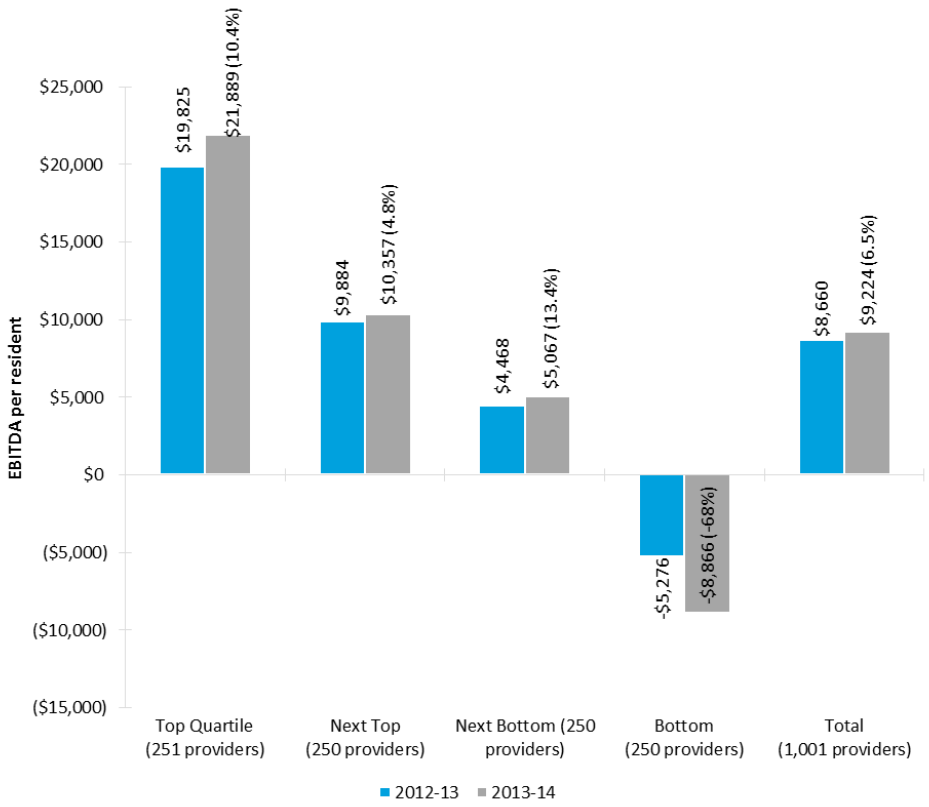
Expenses	2012-13 $million	2013-14 $million	Change ($ million)	Change (%)
Revenue	$13,961	$14,826	$865	6.2%
Expenditure	$13,367	$14,114	$747	5.6%
Earnings before interest, taxes, depreciation, and amortization (EBITDA)	**$1,473**	**$1,581**	**$108**	**7.3%**
EBITDA per resident per annum	*$8,660*	*$9,224*	*$564*	*6.5%*
Net Profit Before Tax (NPBT)	**$594**	**$711**	**$117**	**19.9%**
NPBT per resident per annum	*$3,492*	*$4,150*	*$658*	*18.8%*

The EBITDA and NPBT per resident per annum also increased by 6.5 and 18.8 per cent respectively between 2012-13 and 2013-14.

[32] This broadly reflects increases in resident numbers.

Chart 7.3 presents the EBITDA per resident per annum in 2012-13 and 2013-14 by performance quartiles. The top quartile had an EBITDA of $21,889 (a 10.4 per cent growth). The largest growth was seen in the next bottom quartile, with an increase of 13.4 per cent. The financial performance of the lowest quartile deteriorated, with a negative earnings before interest, taxes, depreciation, and amortization of $8,866 compared with $5,276 in 2012-13.

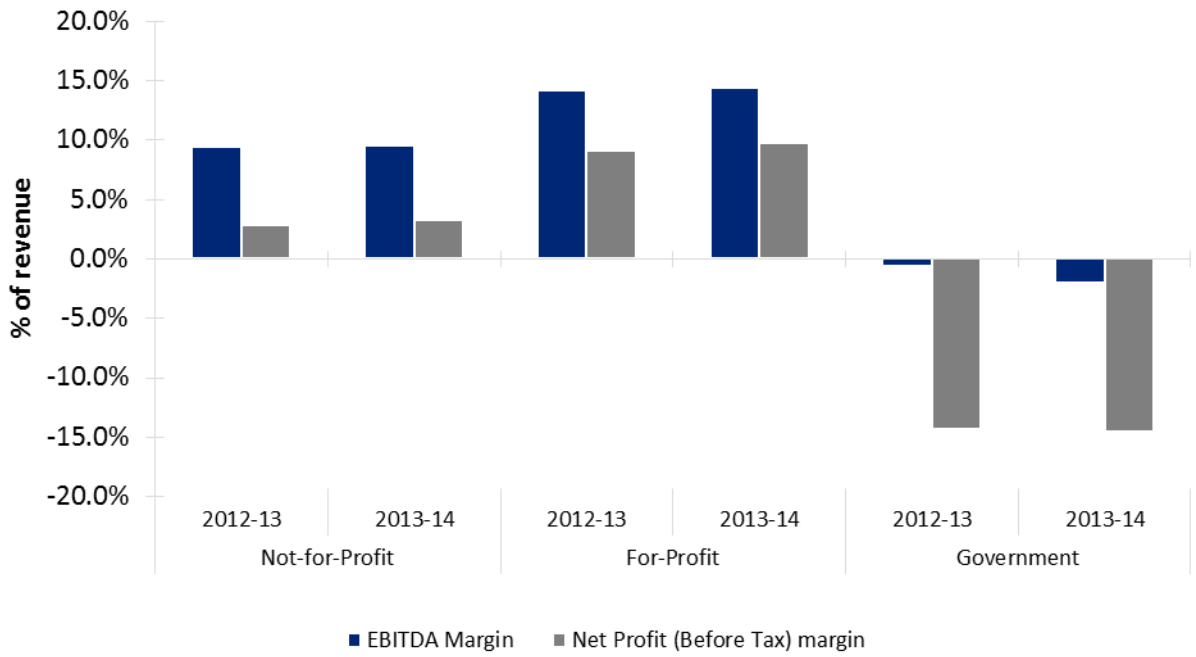
Chart 7.3: Comparative EBITDA per Resident per annum in 2012-13 and 2013-14



Operating performance in 2013-14 continued to vary across provider ownership type, type of care offered, location of services and size. Ownership can be linked to financial performance though this variable needs to be considered carefully. This is because providers in the not-for-profit and government sectors often have different business motives and funding sources and operate in areas affected by the impacts of location and facility scale. Not-for-profit providers performed the best in terms of interest coverage ratio, for-profit providers performed best in terms of NPBT margin and EBITDA margin. Government providers performed the worst in terms of the NPBT and EBITDA margin. Nevertheless for-profit, not-for-profit and government providers were represented in all quartiles.

The average NPBT and EBITDA margin has improved for for-profit providers between 2012-13 and 2013-14 and remained relatively stable for not-for-profit providers (see Chart 7.4). EBITDA margin has worsened for Government providers between 2012-13 and 2013-14 while NPBT has remained stable.

Chart 7.4: Operating performance ratios, change 2012-13 to 2013-14



A higher proportion of total for-profit providers were present in the top quartile of ranking by profit per resident. However out of the provider types in the top quartile, government providers performed the best. Conversely a higher proportion of not-for-profit providers are present in the bottom ranked quartile for EBITDA per resident. Government providers are primarily in the bottom quartile and have the largest negative EBITDA. Nevertheless providers of all ownership types are present in each quartile.

A higher proportion of total 'city' providers are present in the top quartile of ranking by profit per resident compared with 'regional' providers, including providers in rural or remote locations. A higher proportion of regional providers were represented in the bottom or next bottom quartile. Nevertheless providers from all geographical locations are present in each quartile.

In part, the finding of better performance in city areas is probably also an indication of the impact of scale of the facility as many of the facilities operated by providers in 'regional' areas also have fewer beds. Location alone, however, did not preclude higher financial performance, with 'regional' providers comprising 17 per cent of the best performing in the top quartile. 'Regional' for the purposes of this study includes large regional cities, which does not allow the financial performance of providers operating in rural, remote or very remote locations to be separately determined based on available data. ACFA is undertaking a separate study of the financial performance of rural and remote providers, which is scheduled to be provided to the Government by the end of 2015.

While there are only 16 providers who own more than 20 homes, 12 of these are in the top two quartiles of ranking by profit per resident. Single home providers are spread evenly amongst the quartiles. Providers with two to six homes had the highest proportion in the bottom quartile.

A higher proportion of total high care providers were present in the top quartile of ranking by EBITDA per resident per annum. Conversely a higher proportion of low care providers are present in the bottom ranked quartile for EBITDA per resident. Further, in the bottom quartile, low care providers had the largest negative earnings before interest, taxes, depreciation and amortisation per resident.

7.3 Looking forward: Developments, opportunities and challenges

7.3.1 Recent reforms and impacts to date

Recent Reforms post 2013-14

There have been significant and far reaching changes to the residential aged care funding and financing arrangements since the end of the 2013-14 financial year. These changes will shape the direction of the sector for years to come. Taken as a whole these changes are expected to bring significant benefit to the sector and the positive impact can already be seen in positive investment trends and interest in the sector (see following Chapter), though the impacts will vary from provider to provider. These changes are discussed below.

- **A significant deregulation of accommodation payments arrangements** for non-supported residents took effect from 1 July 2014 for new residents resulting in a more market based accommodation pricing regime.
    - Daily accommodation charges are no longer capped in high care at approximately $33 per day but rather are set by the provider and market, with the average published daily price of $64.12 in 2014-15. Providers stand to gain increased access to development capital from this reform.
    - Lump sum accommodation payments may now be paid in high care (previously they could only be paid in low care or extra service places). Providers stand to gain increased access to lump sums for capital financing from this reform.
- **Greater consumer choice** also took effect from 1 July 2014 with consumers now having full choice over whether to pay for their accommodation in lump sum form (a refundable accommodation deposit 'RAD') or periodically (a daily accommodation payment 'DAP').
    - As noted in Chapter 3 – Ongoing aged care reforms, consumer preference is currently for RADs over DAPs and the total lump sum pool has grown by over $3 billion since 1 July 2014.
    - While the accommodation payments reforms are expected to be beneficial overall for the sector, the introduction of full choice does mean every provider's flows of revenue and capital financing from accommodation payments will be dependent on consumer choice. Providers therefore need to have business models that can adjust with consumer choice.
- **A higher maximum Government accommodation supplement for supported residents** has been payable since 1 July 2014 for newly built or significantly refurbished facilities with the supplement increasing by 53 per cent to approximately $53 per day. The supplement has both increased revenue flows for eligible providers and encouraged investment activity *in the sector,* which is discussed further in the Chapter 8.
- **New means testing arrangements were introduced** from 1 July 2014 combining the previously separate income and assets tests, which determined care fees and Government accommodation support respectively, into a combined test. These new arrangements are expected to increase the level of consumer contributions towards care and accommodation. They will not change the overall level of revenue received by the provider as the increase in consumer contributions will be offset by an equivalent reduction in the level of Government care payments. ACFA is and will continue to monitor any flow on impacts of the new arrangements for consumers and providers. The new arrangements are outlined in Appendix E.

- **More flexible arrangements for the provision of 'additional services'** also took effect from 1 July 2014. These new arrangements allow providers to charge market prices for services over and above what they are required to provide under legislation. In conjunction with the more flexible accommodation pricing arrangements, this change can also potentially provide additional revenue flows for providers without the additional regulatory costs that attach to the more structured and regulated 'extra service' arrangements. There has been a noticeable increase in providers moving out of extra service arrangements since 1 July 2014, as noted in Chapter 3.
- **The basic care subsidy was increased by 2.4 per cent from 1 July 2014,** on top of indexation, as a result of the repurposing of the workforce supplement. This is estimated to increase sector funding significantly by around $1.0 billion over four years. Standard indexation (as described in section 7.1) was applied to the subsidy on 1 July 2015. Additionally the amount of the viability supplement was increased by 20 per cent from 1 July 2014.
- **Retention amounts are no longer able to be deducted from lump sum accommodation payments for new residents from 1 July 2014**. While this may reduce revenue flows, the net impact will depend on whether this has been counter-balanced by increased accommodation prices in the more deregulated environment and the impact of consumer choice of payment type.
- **The Payroll Tax Supplement ceased on 1 January 2015** with the Government announcing that it considered this supplement to be an indirect transfer of revenue to the states (who are responsible for imposition of the payroll tax that the supplement was designed to offset). This will result in a loss of revenue for mainly for-profit providers of $590 million over four years, and a commensurate reduction in Government aged care outlays.
- **The Dementia and Severe Behaviours Supplement ceased on 31 July 2014** because expenditure was significantly exceeding estimates. This resulted in a loss of revenue for affected providers Funding formerly allocated for the Supplement was redirected to create Severe Behaviour Response Teams to assist providers care for residents with extreme behaviour

Initial Impacts of Reforms

As noted in Chapter 3 – Ongoing aged care reforms - the initial impacts on the overall lump sum pool of the accommodation payments reforms has been very positive in the 2014-15 year.

ACFA is of the view that the overall net impact of all the reforms identified on the previous page will be positive for the sector.

Analysis by Stewart Brown on the revenue impacts of the reforms in 2014-15 is also positive and supports this view. The Stewart Brown survey includes mainly not-for-profit providers and is not necessarily reflective of the whole sector. Nevertheless it does provide more up to date information on financial performance post the 1 July 2014 reforms. Key findings from their March 2015 report support the view that the total impact of the reforms and changes mentioned on the previous page are a positive impact on revenue:

- Average Care Result was **$10.56** per bed day (June 2014: $8.46 per bed day and March 2014: $9.56 per bed day)
- Average Facility EBITDA was **$8,902** per bed per annum (June 2014: $7,784 per bed per annum)
- Care income averaged **$203.86** per bed day (June 2014: $189.46 per bed day)
- The Care Result represents a return on care income of **5.2 per cent** (June 2014: 4.5 per cent)

- Accommodation revenue (excluding lump sum accommodation payments and any income earned on such payments) was $0.14 per day on average compared with a loss of $0.18 per day for the previous year, with the improvement attributed to daily accommodation payments more than compensating for decreasing retention amounts
- **70.4 per cent** of all facilities in the survey achieved a positive care result (June 2014: 67.8 per cent)
- **75.5 per cent** of facilities in the survey (June 2014: 72.5 per cent) made an overall surplus taking into account all sources of income and expenditure.

ACFA will continue to monitor impacts of the reforms. The full impact will take some time to assess as impacts flow through the system. For example, it will take some time until all residents are under the new arrangements and some changes, such as removal of the Payroll Tax Supplement, had later commencement dates than other measures.

Future Challenges

Continuing rationalisation of the sector is likely. Providers with a strategic outlook that recognises the continuing move towards a more market based and consumer focused aged care system will be best placed to adapt to the changing landscape.

7.3.2 ACFA Report on Factors Influencing the Financial Performance of Residential Aged Care Providers

ACFA was asked by Government to prepare a report on factors influencing the financial performance of aged care providers and ACFA provided its initial report focusing on residential aged care to Government in May 2015.[33]

This report was prompted by the findings in previous ACFA annual reports that while factors such as provider ownership type (for-profit, not-for-profit and government), size or location may have some influence on reported financial performance, those influences are not consistent across the industry.

The analysis, based on 2012-13 data found that the following characteristics are more associated with higher financial performance:

- Strong disciplined management, including:
    - a strategic focus on residential care; and
    - clear financial objectives and strategies supported by strong focus on:
        - budget management of key revenue sources;
        - expense management;
        - liquidity; and
        - capital and asset management.
- **Scale of facility (number of beds per facility)** with providers with higher numbers of beds per facility generally performing better. Nevertheless, it should be noted that a number of smaller facilities were also represented in the better performing groups.

[33] DSS 0215: Factors Influencing the Financial Performance of Residential Aged Care Providers https://www.dss.gov.au/ACFA.

- **Location of facility,** with better performing providers more likely to be based in 'city' locations than 'regional', including rural or remote locations.
- **Ownership can be linked to financial performance with for-profit providers generally performing better than not-for-profit and government providers, though this variable needs to be considered carefully**, noting the different financial objectives that may apply in different ownership structures and that for-profit, not-for-profit and government providers were represented in both the better and lower performing groups.
- **Providers classified as 'high' care were associated with higher financial performance than providers classified as 'low' care.**
- **Higher performing providers have higher levels of revenue**, both from ACFI care revenues across all care profiles and accommodation payments by residents. The latter is linked to house values and correlates with 'city' providers being over-represented in the better performing groups.
- **Higher performing providers maintain lower liquidity, use more debt and manage it better.**
- **Regularly refurbished facilities were associated with better performers** with the best performing providers on average refurbishing their facilities every 9 years compared with 12 years for the lowest performing group. Fresh and appealing facilities corresponded with a strong market focus and relatively high revenue flows.
- **Greater use of outsourcing** of functions was more evident in the better performing groups.

Overall ACFA's analysis found that:

- in most cases, providers with any mix of ownership, location, size and resident care profile can achieve a sound level of financial performance;
- no constraints have been identified that would prevent lower performing providers from adopting strategies that could improve their financial performance, though further work was warranted to examine issues influencing rural and remote providers. Government has accepted ACFA's recommendation that further work be done to examine rural and remote issues with ACFA to report back to Government in December 2015 on this issue; and
- attributes associated with location can come together in some regional areas, and more likely in more sparsely populated and remote areas, in a way that can act as a constraint on financial performance and may account for regional providers being over-represented amongst the lower financial performers. In particular, regional providers are more likely to operate smaller facilities, receive less resident accommodation revenue due to lower house values, have a higher proportion of low care residents, are significantly more dependent for their viability on non-operating revenues (such as donations) and are more likely to be not-for-profit or government providers who operate services where they might not otherwise exist, reflecting mission objectives and community service obligations.

The report identified the following strategies that the lower performing providers could consider, noting that not all strategies would fit all providers:

- Stronger governance – including consideration of skill sets of boards and more regular review of risk, financial and strategic plans;
- Improved financial management – including clear financial goals and regular review of budgets and management and understanding of revenue and expenses;

- Stronger asset management – including investment in and refurbishment of facilities, consideration of appropriate size of facility and consideration of best approaches to debt and liquidity management; and
- Administration efficiencies – including use of outsourcing and shared or pooled services.

8 Residential aged care: capital investment

Residential aged care: capital investment

This Chapter discusses:

- the sources of capital financing for the residential care sector including the role of accommodation bonds
- key balance sheet metrics for 2013-14
- investment trends and requirements

On 30 June 2014, the industry as a whole had:

- $1.5 billion of new construction work was completed in 2013-14 – a 69 per cent increase
- assets of $33.7 billion up from $30.9 billion in 2012-13, a 9 per cent increase
- liabilities of $22.5 billion, $20.7 billion in 2012-13, a 9 per cent increase (including accommodation bonds)
- Net assets of $11.2 billion up from $10.2 billion in 2012-13, a 10 per cent increase
- accommodation bonds of $15.6 billion up from $14.3 billion in 2012-13, a 9 per cent increase

8.1 Capital financing

Capital for residential aged care providers comprises financing from equity investments, loans from financial institutions, interest free loans from residents in the form of lump sum accommodation payments (bonds pre 1 July 2014 and Refundable Accommodation Deposit (RADs) from 1 July 2014) and retained earnings. There are four key groups contributing residential aged care capital: government, residents, investors and financial institutions. Each of these are discussed below.

8.1.1 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. In 2013-14, $103 million of grants were offered through the ACAR. In addition up to $300 million in 'Zero Real Interest Loans' were made available in the period 2008 to 2011 to assist providers to build or extend residential aged care services in areas of high need. Loans offered under the programme attract an interest rate equivalent to the Consumer Price Index only. These loans were last offered in the 2012-13 ACAR and no further offers will be made. As at 30 June 2014, $300 million in loans remained outstanding and therefore would have appeared on the balance sheets of providers.

8.1.2 Residents

Lump sum accommodation payments by consumers contribute to capital investment in residential aged care. Refundable Accommodation Deposits (RADs) – formerly known as accommodation bonds – act as an interest free loan to providers paid by residents, and play a significant role in financing the industry. At 30 June 2014, a total of $15.6 billion of bonds were held by providers, a 10.3 per cent increase from 2012-13. This represents 71 per cent of total industry liabilities, having financed 48 per cent of total assets.

As mentioned in Chapter 3, a number of changes occurred from 1 July 2014 in relation to resident contributions, including removing restrictions preventing providers from accepting accommodation bonds from high care residents. The lump sum accommodation pool is expected to have increased by about $3 billion in 2015-16.

8.1.3 Other sources of capital finance

Residential aged care receives other sources of capital finance, including from investors, financial institution loans and donations.

8.2 Accommodation bonds

At 30 June 2014, accommodation bonds represented 71.0 per cent of liabilities for the aged care industry, the same as at 30 June 2013. There were differences in bonds based on ownership type and location:

- Ownership type
    - 77.9 per cent of liabilities for the not-for-profit industry (77.3 per cent in 2013);
    - 65.0 per cent of liabilities for the for-profit industry, (65.2 per cent in 2013); and
    - 68.4 per cent of liabilities for government providers (71.9 per cent in 2013).
- Location
    - 72.9 per cent of liabilities for metropolitan providers (72.8 per cent in 2012-13); and
    - 65.6 per cent of liabilities for regional providers (66.3 per cent in 2012-13).

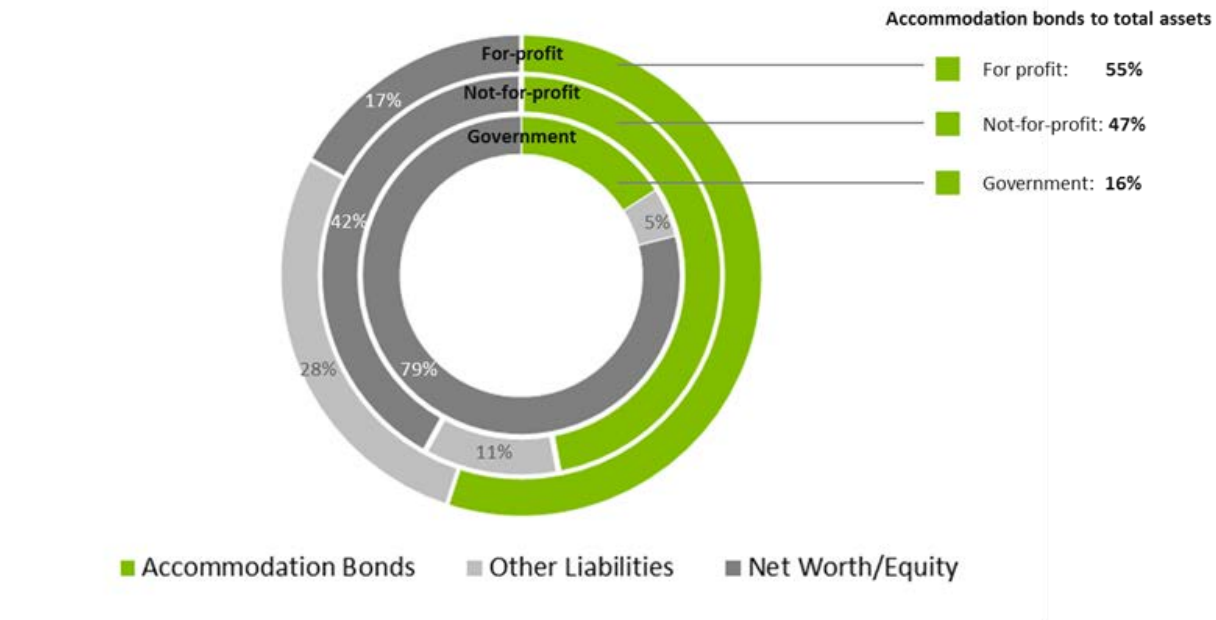
Table 8.1 and Chart 8.1 represent Accommodation bonds, other liabilities and net worth/equity as a proportion of assets. As Chart 8.1 highlights, there are differences in the proportion of accommodation bonds to total assets based on ownership type.

Table 8.1 Financial position of residential aged care providers as at 30 June 2014

	Not-for-Profit	For-Profit	Government	Total	Total
	$m	$m	$m	$m	%
Total Assets funded by:	17,892	13,633	2,137	33,662	100%
	100.0%	100.0%	100.0%	100.0%	
Accommodation Bonds	8,280	7,046	285	15,611	48%
- Proportion to Total Assets	47%	55%	16%		

	Not-for-Profit	For-Profit	Government	Total	Total
Other Liabilities	2,411	4,310	161	6,883	18%
- Proportion to Total Assets	11%	28%	5%		
Net Worth/Equity	7,201	2,277	1,691	11,169	34%
- Proportion to Total Assets	42%	17%	79%		

Chart 8.1 Financial position of residential aged care as at 30 June 2014, proportion to total assets, by ownership type



8.2.1 Bond prices

The average amount of accommodation bonds has increased in a relatively linear trend over time for not-for-profit and government owned facilities. For-profit providers have always had higher average accommodation bonds compared with not-for-profit and government providers.

The average price of new accommodation bonds by provider location has continued in an upward linear trend across all three location types; major city, regional and remote. In 2013-14, accommodation bonds were highest in major cities ($327,000), followed by regional areas ($211,000) and remote areas ($166,000).

Accommodation prices also differ by jurisdiction. In 2013-14, bonds were highest in the ACT, followed by WA, NSW, Victoria, Queensland, Northern Territory, South Australia and Tasmania. The first three jurisdictions were above the average price of $296,000. In all instances there was an increase in the average price from the previous year, except for the NT in which there was a sharp decline from $422,000 to $272,000 (noting that the small number of bonds agreed in the NT can make the average more volatile).

Table 8.2: Average price of new accommodation bonds: 2007-08 to 2013-14 (thousands), by provider state/territory

State	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
NSW	198	223	235	251	265	282	305
Vic	192	213	236	263	274	279	301
Qld	187	204	230	224	231	244	272
WA	152	188	228	252	249	281	319
SA	172	208	209	235	230	239	255
TAS	148	171	207	201	209	196	200
ACT	303	287	316	366	340	363	397
NT	128	238	252	242	172	422	272
All residents	**189**	**213**	**233**	**250**	**260**	**273**	**296**
per cent increase from 2012-13	12.7%	12.8%	9.3%	7.5%	3.8%	5.2%	8.4%

8.2.2 Operating position - Balance sheet

At 30 June 2014, the industry as a whole had assets of $33.7 billion (an increase of $2.8 billion from 2012-13), up from $30.9 billion the previous year. Of note, there was a reduction in cash assets of $384 million from 2012-13, representing a 9.7 per cent decrease. By contrast, fixed assets increased by 9.2 per cent and other assets by 13.3 per cent.

Total liabilities were $22.5 billion (compared with $20.7 billion in 2012-13), which includes accommodation bonds held by industry of $15.6 billion (compared with $14.3 billion in 2012-13).

As shown in Table 8.3 the industry overall had net equity of $11.2 billion in 2013-14, up from $10.2 billion in 2012-13 (a 9.6 per cent increase).

Table 8.3: Balance Sheet 2012-13 and 2013-14

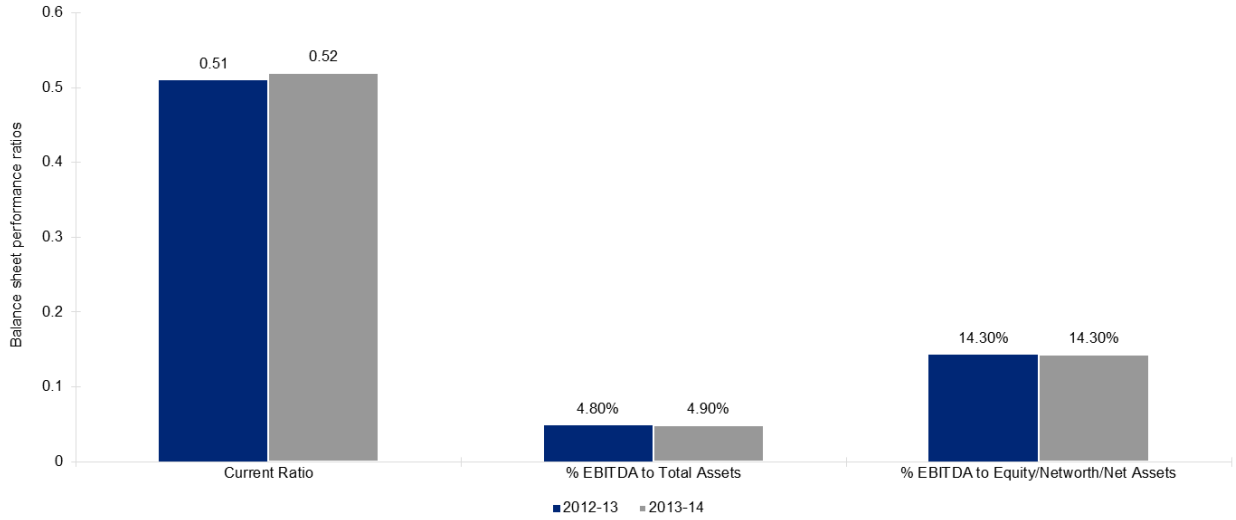
Assets/ Liabilities	2012-13 $million	2013-14 $million	Change ($ million)	Change (%)
Cash Assets [1]	$3,942	$3,558	-$384	-9.70%
Fixed Assets [2]	$9,372	$10,238	$866	9.20%
Other Assets	$17,539	$19,866	$2,327	13.30%
Total Assets	**$30,853**	**$33,662**	**$2,809**	**9.10%**
Accommodation Bonds	$14,295	$15,611	$1,316	9.2%
Other Liabilities	$6,369	$6,883	$514	8.1%
Total Liabilities	**$20,664**	**$22,494**	**$1,830**	**8.90%**
Net Worth/Equity	**$10,189**	**$11,168**	**$979**	**9.6%**

[1] Cash Assets Include: cash amounts, liquid Assets (Short term) and financial assets/Investments (Long term)

2 Fixed Assets include: Property, Plant and Equipment

As illustrated in Chart 8.3, balance sheet performance ratios remained relatively similar between 2012-13 and 2013-14. There was a small increase in both the current ratio and EBITDA to total assets while the EBITDA to equity/net worth/net assets remained the same.

Chart 8.2: Balance Sheet performance ratios 2012-13 and 2013-14



Balance sheet analysis by ownership type

The analysis of assets and liabilities can be conducted at a more granular level, including by ownership type, to identify any differences between not-for-profit, for-profit and government providers. At 30 June 2014, the not-for-profit providers (who hold 57 per cent of places in the sector) had total assets at a value of $17,892 million (see Table 8.4). The for-profit sector (37 per cent of places), had $13,634 million of assets. The for-profit sector's liabilities were the highest among all ownership types ($11,357 million). Not-for-profit providers had the highest net worth/equity, with $7,201 million, followed by for-profit providers ($2,277 million). The higher liabilities and lower equity in for-profit providers reflects both a higher proportion of accommodation bonds and greater use of debt to fund investment. These different financing characteristics affect the ratios discussed in the rest of this section. Government providers had the lowest net worth/equity, with $1,691 million.

Table 8.4: Financial Position of Residential Aged Care Providers as at 30 June 2014

Expenses	Not-for-Profit $million	For-Profit $million	Government	Total ($ million)	Total (%)
Total Assets	**17,892**	**13,633**	**2,137**	**33,662**	**100%**
Accommodation Bonds	8,280	7,046	285	15,611	*48%*
Other Liabilities	2,411	4,310	161	6,883	*18%*
Total Liabilities	**10,691**	**11,356**	**446**	**22,494**	**66%**
Net Worth/Equity	**7,201**	**2,277**	**1,691**	**11,169**	***34%***

Accommodation Bonds and Other Liabilities sum to the 66 per cent of total liabilities.

Chart 8.3 shows liabilities and net worth/equity as a proportion of total assets. Government providers have lower liabilities as a proportion of total assets with a high proportion of net worth and equity. For-profit and not-for-profit have higher liability ratios.

Chart 8.3: Liabilities and net worth/equity as a proportion of total assets, by provider ownership type

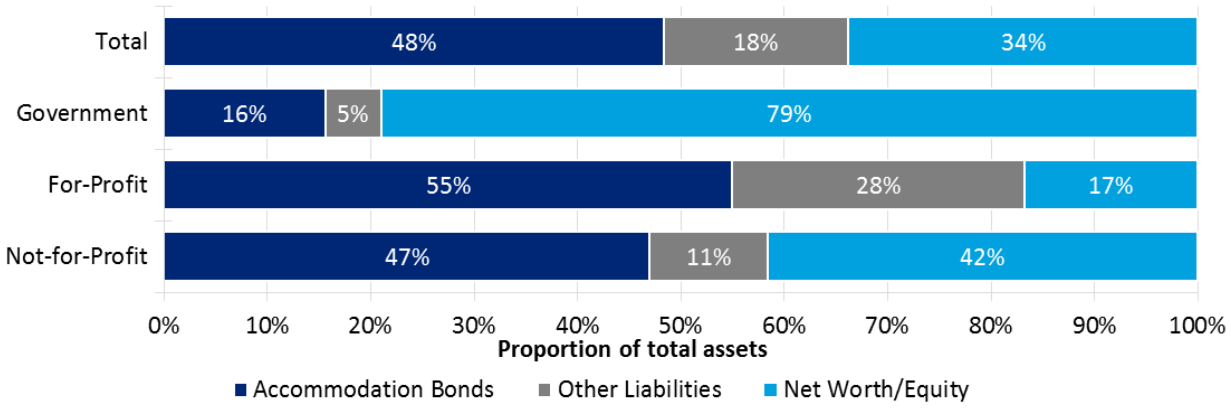
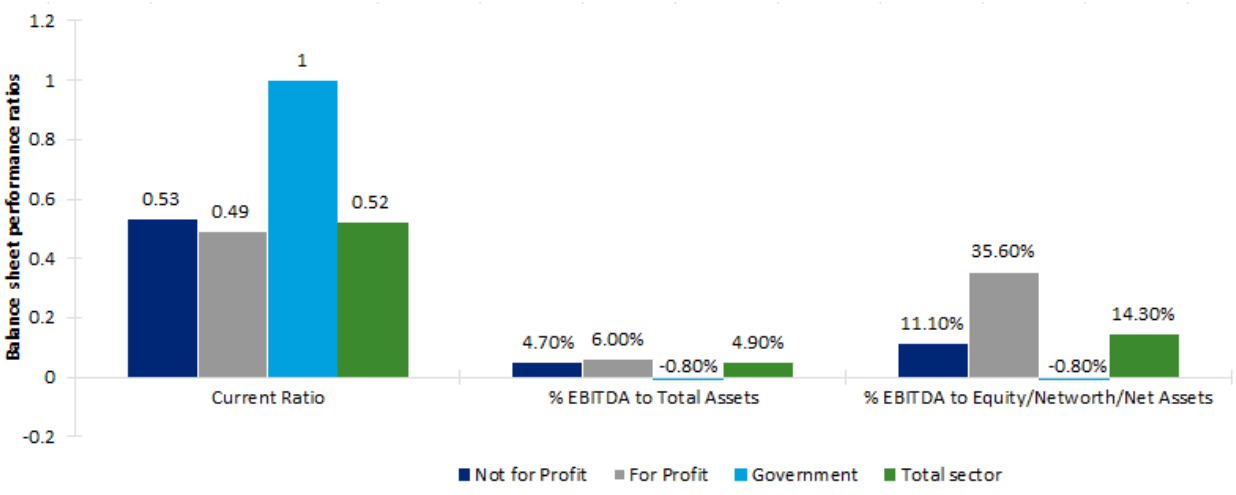


Chart 8.4 illustrates the balance sheet performance ratios by provider type. The government providers had the highest current ratio (1.00) compared to not-for-profit providers (0.53) and for-profit providers (0.49). Of note, there is a significant difference in the proportion of EBITDA to total assets for the for-profit (6.0 per cent) and not-for-profit providers (4.7 per cent) compared to the Government providers (-0.8 per cent). The for-profit providers also have a considerably higher proportion of EBITDA to equity/net worth/net assets (35.6 per cent) compared to the not-for-profit providers (11.1 per cent) and Government providers (-0.8 per cent). This reflects the lower net equity of for-profit providers.

Current ratio[34] usually indicates the organisation's ability to meet short term debt through current assets. A ratio of more than one indicates that an organisation's current assets exceed its current liability and is calculated by current assets/current liabilities. The classification of bonds as current liabilities in most instances means the current ratio needs to be treated with considerable caution in the residential aged care sector.

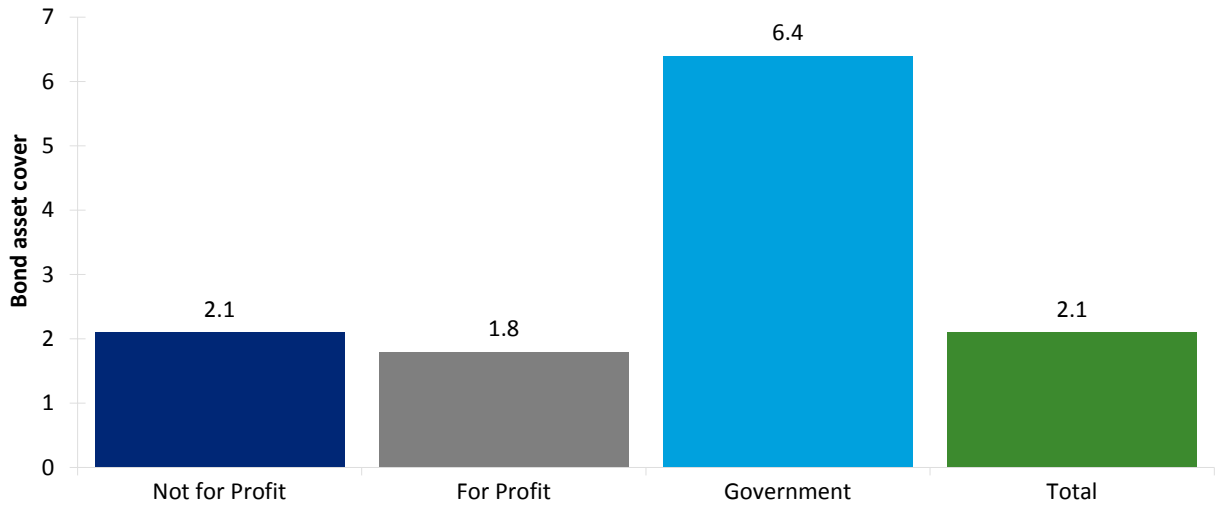
Chart 8.4: Balance Sheet performance ratios at 30 June 2013-14, by provider type



The total asset cover of bonds of 2.1 is equal to the bond asset cover for not-profit providers, as shown in Chart 8.5. Government providers have a significantly higher bond asset cover compared to the other provider types (6.4).

[34] The current ratio measures whether or not a provider has enough resources to pay its debts over the next 12 months. It compares a provider's current assets to its current liabilities.

Chart 8.5: Bonds asset cover ratio 2012-13 and 2013-14, by provider type



Average working capital[35] per resident decreased by 3.6 per cent between 2012-13 and 2013-14. This is driven by decreases among not-for-profit and for-profit providers. In addition, average liability per resident increased by 3.6 per cent between 2012-13 and 2013-14, which reflected increases in liabilities (including bonds) among all three provider types. The largest increase was among government providers (26.1 per cent).

These decreases in working capital and increases in liabilities occurred with simultaneous increases in both average assets and accommodation bonds per resident. Government providers experienced the greatest increase in average assets per resident between 2012-13 and 2013-14, of 21 per cent. This was followed by for-profit providers (11.8 per cent increase) and not-for-profit providers (5 per cent). Average accommodation bonds per resident increased 6.8 per cent between 2012-13 and 2013-14. There was a 6.9 per cent growth among for-profit providers, 6 per cent growth among not-for-profit providers and 4.7 per cent increase among government providers.

As is the case with analysis of current ratio, caution needs to be taken when examining working capital in aged care due to the bonds (lump sum payments post 1 July 2014) being classified as current liabilities in most instances.

8.3 Investment requirements

The Department has updated its estimates of the sector's annual investment requirement for residential care each year in the next decade, in terms of the amount of required investment and the number of places that will need to be built. These estimates are based on several key assumptions namely that:

- the current service provision targets continue;
- the cost of construction continues to grow at about 2.3 per cent each year;[36] and

[35] Working capital represents operating liquidity available to a provider

[36] The Department has derived estimates of the full cost of constructing an aged care home based on the results of the Department's 2013-14 Survey of Aged Care Homes. The median cost of construction of these projects was $217,010 per place. Trends in aged care construction costs are derived from Rawlinsons (2012) *Australian Construction Handbook*, various editions. Perth: Rawlinsons.

- 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.

Based on current policies, the Department estimates that the residential care sector will need to build approximately 82,000 additional places over the next decade, compared with the 36,778[37] new places that came online over the previous decade (Chart 8.6). At the same time, the sector will need to knockdown and rebuild a substantial proportion of its current stock. Assuming that the cost of construction continues to grow at about the current rate, and that a quarter of the current stock of buildings is rebuilt at an even rate over the next decade, the Department estimates that the investment requirement of the sector over the next decade to be in the order of $33 billion.

Chart 8.6: Number of Operational Residential Aged Care Places Required in the Next Decade – 2014 - 2025

As noted in last year's ACFA report, this increase in demand presents a number of challenges, including:

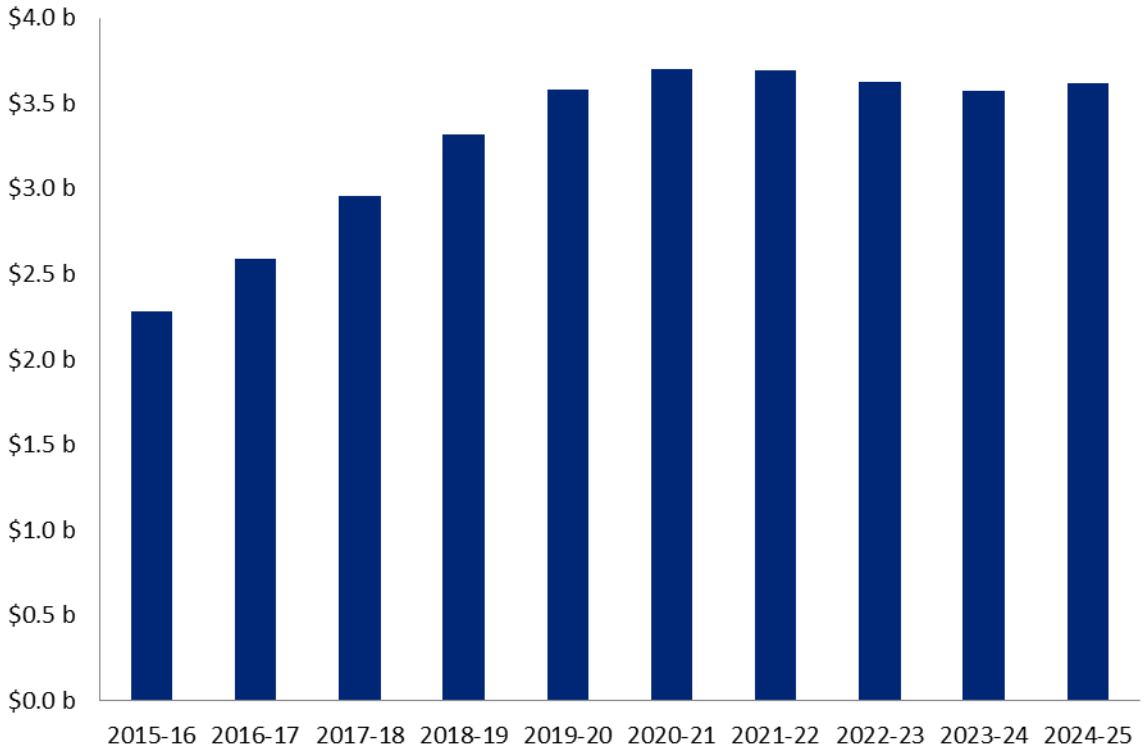
- Subsidy funding from the Australian Government;
- capital financing from residents, providers, investors and financiers;
- an appropriately skilled workforce to meet demand;

[37] 30 June 2004 to 30 June 2014.

- 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 8.7 shows the investment needed over the next decade to construct the new aged care places required to cater for the baby boom generation. Over the next seven years there is a steep ramp up from $2.3 billion needed in 2015-16 to around $3.7 billion that will be needed in 2020-21. This compares with $1.6 billion and $1.1 billion of investment in 2013-14 and 2012-13 respectively.

Chart 8.7: Future Annual Investment Requirement, 2013-14 prices

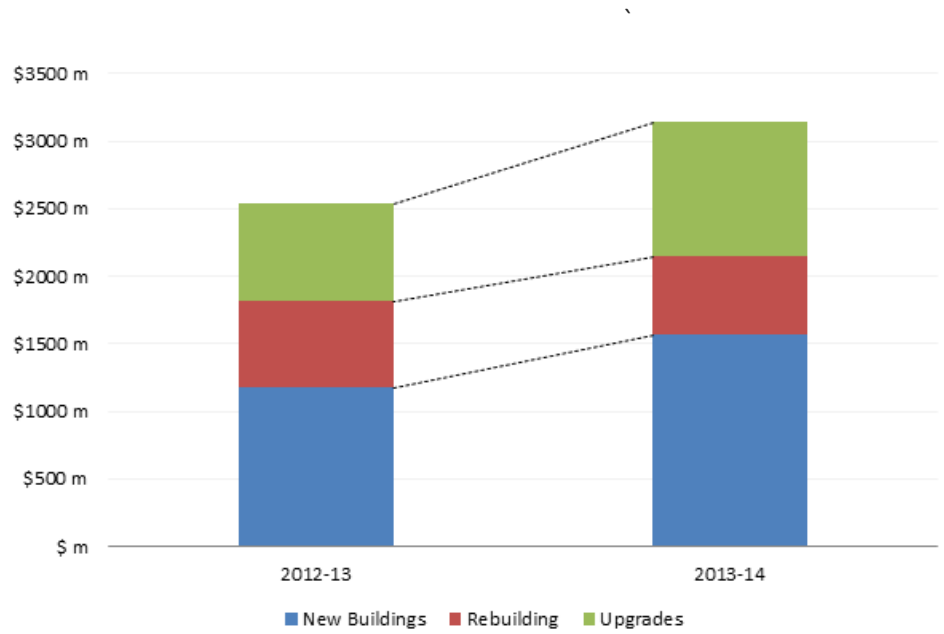


8.3.1 Recent Trends in Investment in the Residential Care Sector

Recent investment trends are improving. The 2014 Survey of Aged Care Homes estimated that a total of $1.56 billion of new building, refurbishment and upgrading work was completed during 2013-14, involving about 12 per cent of all homes. The amount of new building work in progress at the end of 2014 June was estimated at $1.59 billion involving about 17 per cent of all homes. Compared to 2012-13, in 2013-14, there was an increase of $634m (or 69 per cent) in new building, refurbishment and upgrading work. However, there was a decrease of $24m (or 1.5 per cent) in work in progress during the same period.

Taken together with other positive signs of investment activity from ABS data and a number of significant investments in the sector in 2014-15, it would appear that investors are responding positively to the 1 July 2014 reforms and interest in investments that leverage the ageing demographic.

Chart 8.8: Residential aged care building activity, 2012-13 and 2013-14

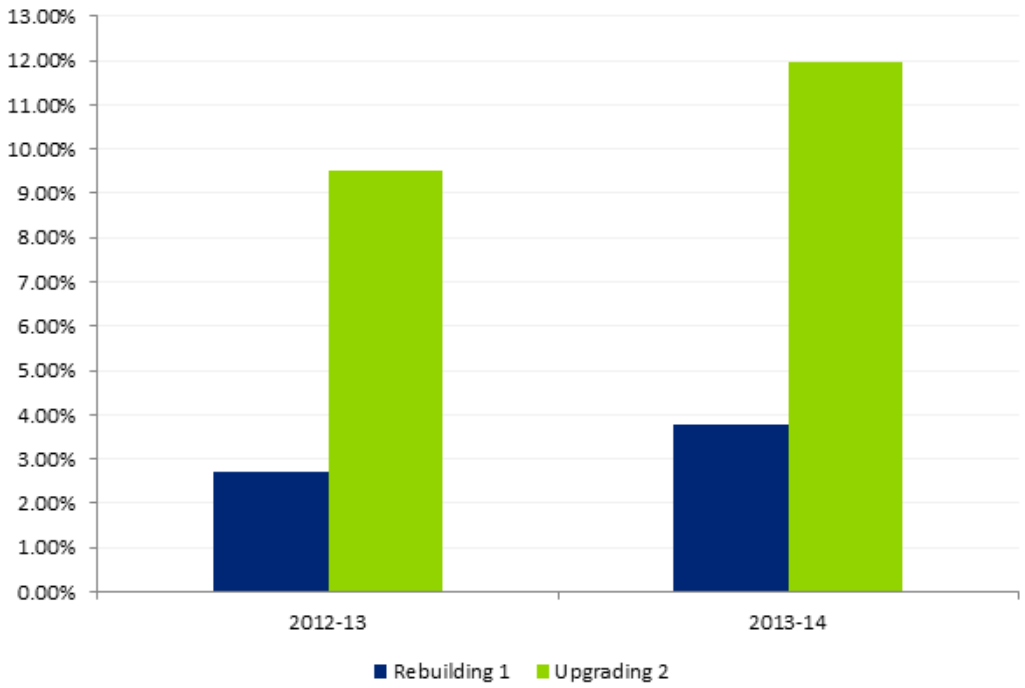


Source: Based on SACH data.

8.3.2 Building and Construction Statistics

Chart 8.9 shows the proportion of homes planning to either rebuild or upgrade over 2012-13 and 2013-14.

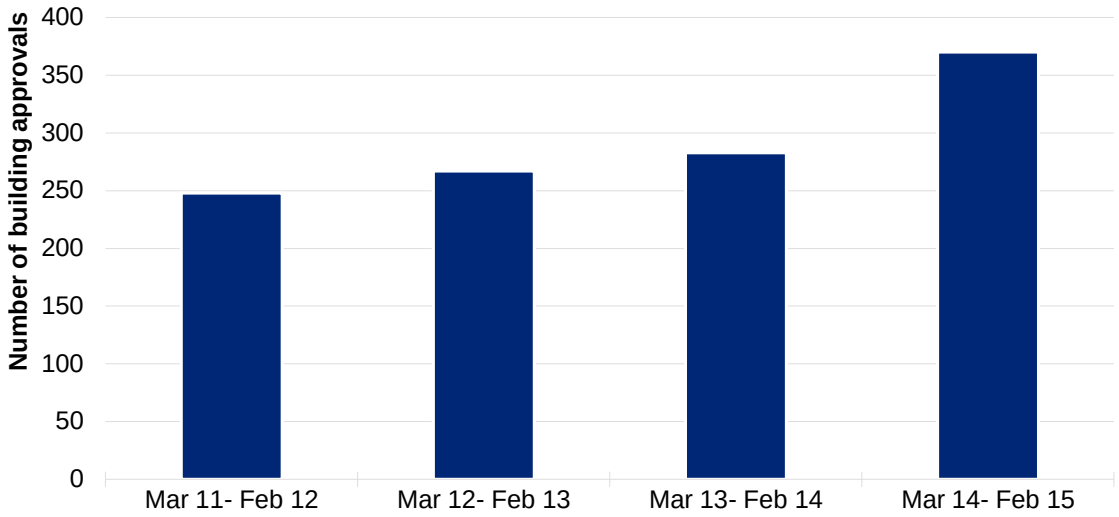
Chart 8.9: Proportion of Homes Planning to either Rebuild or Upgrade over 2012-13 and 2013-14



Source: Based on Survey of Aged Care Homes data.[1] Rebuilding is the demolition of an entire service and its reconstruction on the same site.[2] Upgrading is the renovation or refurbishment of an existing facility, including extensions to an existing building or reconstruction of part of a building. It does not include routine repairs and the maintenance of premises such as painting, plumbing, electrical work or gardening.

Building statistics data from the Australian Bureau of Statistics (ABS)[38] show strong signs of investment in the sector with building approvals across the sector increasing 30.7 per cent in the 12 months to February 2015, compared with 6.0 per cent the previous year, 7.7 per cent the year before that (See Chart 8.10). Additionally, there was a significant increase in the value of building construction commencing in 2014, with a total of $1.62 billion worth of projects commencing, compared with $1.17 billion in 2013 and $0.81 billion in 2012.[39]

Chart 8.10: Residential aged care building approvals



Source: ABS, Building Approvals Cat. No. 8731.0, viewed on 5 May 2015.

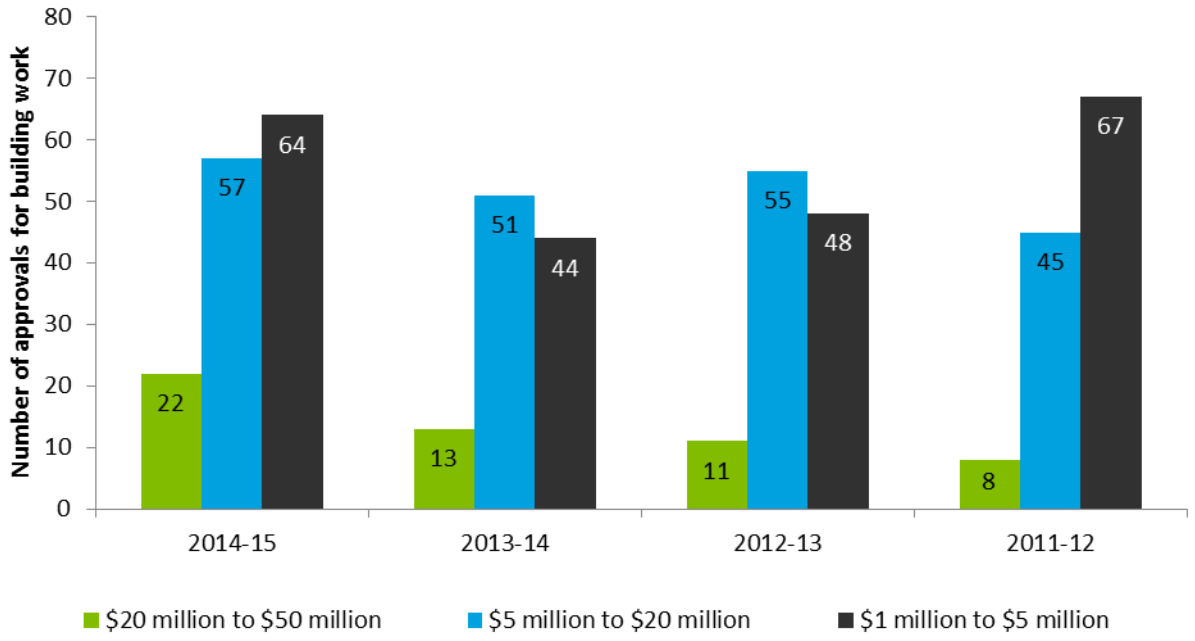
The value of building approvals has increased with average monthly total building approvals for aged care services in the 12 months to February 2015 being $122 million per month, compared with $92 million in the previous 12 months, $96 million in the year before that and $74 million in the 12 months to February 2012.

Chart 8.11 shows the number of approvals for building works over the past four years (year commencing February) by the value of build. There has been a substantial increase over the past four years in approvals for building work with values between $20 million and $50 million. As a broad rule it can be assumed that work of this size is either construction of a new home, or a knock down and rebuild of an existing home.

[38] Building Approvals Cat. No. 8731.0, viewed on 5 May 2015.

[39] Building Activity Cat. No. 8752.0, viewed on 5 May 2015.

Chart 8.11 Number of building approvals by value of building work, February 2011 to February 2015



Note. Years commence in February.

This trend is more variable for smaller building work ($1 million to $5 million, and $5 million to $20 million). Building work in the $5 million to $20 million category is likely to be a mix of new construction and refurbishment of existing stock. As a broad rule, building work in the $1 to $5 million category can be assumed that work of this size is refurbishment of existing stock.

8.3.3 Investor Sentiment

The new accommodation payment arrangements seem to be having a positive impact on investor sentiment as shown in the analysis earlier in this chapter.

In addition to general increase in investment activity a number of significant developments in terms of investments in the industry were announced during 2013-14. In the last 12 months ACFA have noted interest in the industry continuing to grow from both domestic and international investors.

Additionally, during 2013-14 and 2014-15, three companies operating aged care providers floated their companies on the Australian Stock Exchange with a combined total market capitalisation of $1.7 billion. As at 30 June 2015 the combined market value was $3.3 billion. These providers in total were operating 8,681 places as at 30 June 2014 which represents around 5 per cent of the sector.

Appendix A: ACFA Membership

Table A.1: Members

ACFA position	Name	Organisation
Chairman	Ms Lynda O'Grady	Non-Executive Director, Business Advisor
Deputy Chair	Professor Graeme Hugo AO *Up to 20 January 2015*	Director Australian Population and Migration Research Centre, University of Adelaide
Member	Mr Ian Yates	Chief Executive, COTA Australia
Member	Mr Nicolas Mersiades	Director Aged Care, Catholic Health Australia
Member	Ms Sally Evans	Head of Retirement, AMP
Member	Mr Graham Hodges	Deputy Chief Executive Officer, ANZ Banking Group
Member	Mr Gary Barnier	Managing Director, Opal Aged Care
Member	Ms Mary Patetsos	Director, Aged Care Housing Group
Member	Ms Lee Thomas	National Secretary, Australian Nursing and Midwifery Federation

Table A.2: Representatives

Representative	Ms Kim Cull	Aged Care Pricing Commissioner
Representative	Ms Carolyn Smith	Department of Social Services
Representative	Mr Robert Montefiore-Gardner	Treasury

Appendix B: Work completed by ACFA to date

Table B.1: Work completed to date

Work	Progress/date of completion
Definition of significant refurbishment to qualify for a higher accommodation supplement	Final ACFA advice to Minister on 21 November 2012. Government announced its position on 21 December 2012
The framework for setting accommodation payments in residential aged care	Final ACFA advice to Minister on 28 November 2012. Government announced its position on 21 December 2012 Further advice on method for determining a RAD and a DAP using a MPIR to Minister on 17 May 2013. Government announced its position on 23 May 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 on 22 May 2013. Government released advice and modelling on 23 May 2013
ACFA Inaugural Report on the funding and financing of the aged care sector	30 June 2013. Government released the report on 22 July 2013
Interim advice to the Minister on improving the collection of financial data from aged care providers	31 July 2013. Government released the report on 28 August 2013
Data book on supported and non-supported residents	30 April 2014. Government released the report on 28 May 2014
ACFA's second report on the funding and financing of the aged care sector	1 August 2014. Government released the report on 29 August 2014
Reports on the impact of financial reforms on the aged care sector	First report – 6 August 2014 Second report – 9 September 2014 Third report – 29 September 2014 Fourth and Fifth report – 20 January 2015 Sixth report – 13 March 2015 Seventh report – 21 April 2015
Report on improving the collection of financial data from aged care providers	Final ACFA report to Minister Released 28 October 2014
Report on factors influencing the financial performance of aged care providers	Initial report on factors influencing the financial performance of residential aged care providers delivered to Minister on 5 May 2015. Government released the report on 2 June 2015.

Appendix C: ACFA's stakeholder engagement

During 2013-14, ACFA held meetings and forums with representatives from the investment and financing industries, providers and consumers (activities outlined below). These meetings and forums have been critical to ACFA's understanding of the key issues, developments and challenges facing the industry, particularly the impact of the 1 July 2014 reforms on all stakeholders.

As part of its continuing engagement with the sector, ACFA commenced a series of regular updates in the form of a newsletter, to inform aged care providers on current activities and publications of ACFA.

Investors

In November 2014, ACFA held Equity and Debt Roundtables in Sydney and Melbourne with members of the investment and financing community to:

- share the findings of its 2014 Annual Report; and
- hear their views on key issues facing the sector, including the early indications of the impact of the 1 July 2014 reforms and longer term challenges facing the sector.

Over 60 representatives from various organisations participated in the roundtables and a diverse range of issues and views were put forward, including:

- there is strong interest in investing in the aged care industry;
- returns and scale need to be sufficient to make investment in the industry attractive;
- quality of management is a key driver for investment returns;
- some investors would be looking for opportunities to invest in the property side of the business, without taking on the risks that can arise when investing in a combined property and operational structure;
- some investors see an opportunity to build profitable businesses through scale and improving management and systems in the properties they purchase;
- availability of land for greenfield developments is challenging;
- difficulty in categorising the industry (given its mixed property and operational components) in terms of standard asset allocation processes has been one reason some investors and financiers have been reluctant to invest; and
- some investors were wary of sovereign risk issues.

Providers

In 2014-15, ACFA has been liaising closely with the provider peaks:

- Leading Age Services Australia (LASA);
- Aged and Community Services Australia (ACSA);
- Catholic Health Australia (CHA);

- The Aged Care Guild; and
- Uniting Care

The provider peaks have assisted ACFA in developing mechanisms for providers to supply ACFA with information on post 1 July 2014 reforms. This has proven to be invaluable to ACFA in helping monitor the impacts of the reforms. ACFA will continue to meet with the provider peaks on a regular basis.

Consumers

ACFA met with the Council on the Ageing (COTA) and members of the Seniors' Alliance WA to hear about their important work in aged care and to discuss ACFA's work program and monitoring the impacts of the reforms.

Other Stakeholders

ACFA met with representatives of the Financial Planners Australia (FPA), the Australian Bankers Association (ABA) and investment analysts, who will be a vital source of information and advice to prospective aged care residents. Additionally, ACFA met with the full membership of the National Aged Care Alliance.

Appendix D: Aged care provision ratio

Table D.1: Total operational aged care places and ratios (places per 1000 people aged 70 years and over) by Aged Care Planning Region as at 30 June 2014

		Total Operational Places							Total Operational Ratios						
State/ Territory	Aged care planning region	Residential care			Home care			Total Residential + home care	Residential care			Home care			Total residential + home care (planning ratio)
		Low care	High care	Total residential	Low care	High care	Total home care		Low care	High care	Total residential	Low care	High care	Total home care	
NSW	Central Coast	2,048	1,700	3,748	985	222	1,207	4,955	41.9	34.8	76.8	20.2	4.5	24.7	101.5
	Central West	960	802	1,762	470	109	579	2,341	45.2	37.7	82.9	22.1	5.1	27.2	110.2
	Far North Coast	1,854	1,878	3,732	953	239	1,192	4,924	43.7	44.3	88.0	22.5	5.6	28.1	116.1
	Hunter	3,244	2,758	6,002	1,611	373	1,984	7,986	45.5	38.7	84.2	22.6	5.2	27.8	112.0
	Illawarra	2,180	1,924	4,104	1,140	267	1,407	5,511	41.0	36.2	77.2	21.5	5.0	26.5	103.7
	Inner West	1,488	2,910	4,398	995	187	1,182	5,580	33.7	65.8	99.5	22.5	4.2	26.7	126.2
	Mid North Coast	2,222	1,990	4,212	1,112	281	1,393	5,605	44.2	39.6	83.7	22.1	5.6	27.7	111.4
	Nepean	846	1,310	2,156	549	151	700	2,856	31.9	49.4	81.3	20.7	5.7	26.4	107.7
	New England	1,022	870	1,892	545	129	674	2,566	45.7	38.9	84.6	24.4	5.8	30.1	114.8
	Northern Sydney	4,084	4,696	8,780	2,087	384	2,471	11,251	44.0	50.6	94.6	22.5	4.1	26.6	121.2
	Orana Far West	886	738	1,624	414	83	497	2,121	47.4	39.5	86.8	22.1	4.4	26.6	113.4
	Riverina/Murray	1,518	1,459	2,977	778	156	934	3,911	43.0	41.3	84.3	22.0	4.4	26.5	110.8
	South East Sydney	3,367	4,282	7,649	2,054	418	2,472	10,121	37.8	48.1	85.9	23.1	4.7	27.7	113.6
	South West Sydney	2,842	3,286	6,128	1,624	383	2,007	8,135	35.6	41.1	76.7	20.3	4.8	25.1	101.9
	Southern Highlands	1,309	1,046	2,355	587	134	721	3,076	47.0	37.6	84.6	21.1	4.8	25.9	110.5
	Western Sydney	2,335	2,926	5,261	1,403	310	1,713	6,974	35.0	43.8	78.8	21.0	4.6	25.6	104.4
	NSW	32,205	34,575	66,780	17,307	3,826	21,133	87,913	40.7	43.7	84.5	21.9	4.8	26.7	111.2
VIC	Barwon-South Western	2,216	2,137	4,353	1,025	282	1,307	5,660	48.3	46.5	94.8	22.3	6.1	28.5	123.3
	Eastern Metro	5,487	4,689	10,176	2,663	518	3,181	13,357	44.6	38.1	82.7	21.6	4.2	25.9	108.6
	Gippsland	1,599	1,320	2,919	782	207	989	3,908	44.0	36.3	80.3	21.5	5.7	27.2	107.5

State/ Territory	Aged care planning region	Total Operational Places							Total Operational Ratios						
		Residential care			Home care			Total Residential + home care	Residential care			Home care			Total residential + home care (planning ratio)
		Low care	High care	Total residential	Low care	High care	Total home care		Low care	High care	Total residential	Low care	High care	Total home care	
	Grampians	1,127	1,007	2,134	593	196	789	2,923	42.1	37.6	79.6	22.1	7.3	29.4	109.1
	Hume	1,535	1,415	2,950	744	208	952	3,902	44.8	41.3	86.1	21.7	6.1	27.8	113.9
	Loddon-Mallee	1,917	1,683	3,600	919	203	1,122	4,722	45.0	39.5	84.5	21.6	4.8	26.3	110.8
	Northern Metro	3,295	3,243	6,538	1,828	452	2,280	8,818	40.6	40.0	80.5	22.5	5.6	28.1	108.6
	Southern Metro	5,730	6,059	11,789	3,085	579	3,664	15,453	41.0	43.3	84.3	22.1	4.1	26.2	110.5
	Western Metro	2,731	2,731	5,462	1,423	332	1,755	7,217	42.8	42.8	85.7	22.3	5.2	27.5	113.2
	VIC	25,637	24,284	49,921	13,062	2,977	16,039	65,960	43.2	40.9	84.1	22.0	5.0	27.0	111.1
QLD	Brisbane North	2,037	2,060	4,097	910	255	1,165	5,262	48.8	49.3	98.1	21.8	6.1	27.9	126.0
	Brisbane South	2,842	2,716	5,558	1,412	384	1,796	7,354	45.3	43.3	88.6	22.5	6.1	28.6	117.2
	Cabool	1,495	1,343	2,838	853	224	1,077	3,915	38.4	34.5	73.0	21.9	5.8	27.7	100.7
	Central West	43	68	111	54	11	65	176	41.6	65.9	107.5	52.3	10.7	62.9	170.4
	Darling Downs	1,176	1,167	2,343	637	197	834	3,177	39.8	39.5	79.2	21.5	6.7	28.2	107.4
	Far North	826	753	1,579	557	147	704	2,283	32.6	29.7	62.3	22.0	5.8	27.8	90.1
	Fitzroy	826	735	1,561	400	119	519	2,080	48.3	42.9	91.2	23.4	7.0	30.3	121.5
	Logan River Valley	902	849	1,751	506	179	685	2,436	34.6	32.6	67.2	19.4	6.9	26.3	93.5
	Mackay	415	428	843	233	88	321	1,164	39.3	40.5	79.8	22.1	8.3	30.4	110.2
	North West	80	64	144	126	14	140	284	49.8	39.9	89.7	78.5	8.7	87.2	176.9
	Northern	756	829	1,585	418	156	574	2,159	37.9	41.5	79.4	20.9	7.8	28.8	108.2
	South Coast	2,347	2,176	4,523	1,206	440	1,646	6,169	44.4	41.2	85.6	22.8	8.3	31.2	116.8
	South West	134	108	242	113	18	131	373	49.1	39.6	88.6	41.4	6.6	48.0	136.6
	Sunshine Coast	1,911	1,750	3,661	1,076	466	1,542	5,203	39.8	36.4	76.2	22.4	9.7	32.1	108.3
	West Moreton	664	464	1,128	450	178	628	1,756	35.8	25.0	60.8	24.2	9.6	33.8	94.6
	Wide Bay	1,177	1,067	2,244	759	231	990	3,234	31.4	28.4	59.8	20.2	6.2	26.4	86.2
	QLD	17,631	16,577	34,208	9,710	3,107	12,817	47,025	40.6	38.2	78.8	22.4	7.2	29.5	108.3
WA	Goldfields	117	150	267	65	43	108	375	33.7	43.2	77.0	18.7	12.4	31.1	108.1
	Great Southern	302	212	514	165	103	268	782	39.9	28.0	68.0	21.8	13.6	35.4	103.4
	Indian Ocean Territories	0	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Kimberley	78	91	169	99	31	130	299	64.3	75.0	139.2	81.5	25.5	107.1	246.3
	Metropolitan East	1,409	1,178	2,587	844	436	1,280	3,867	43.7	36.5	80.2	26.2	13.5	39.7	119.9
	Metropolitan North	2,179	1,906	4,085	1,131	728	1,859	5,944	38.8	34.0	72.8	20.2	13.0	33.1	105.9

State/ Territory	Aged care planning region	Total Operational Places							Total Operational Ratios						
		Residential care			Home care			Total Residential + home care	Residential care			Home care			Total residential + home care (planning ratio)
		Low care	High care	Total residential	Low care	High care	Total home care		Low care	High care	Total residential	Low care	High care	Total home care	
	Metropolitan South East	1,426	1,561	2,987	763	480	1,243	4,230	40.3	44.2	84.5	21.6	13.6	35.2	119.7
	Metropolitan South West	1,703	1,735	3,438	1,043	652	1,695	5,133	33.6	34.2	67.7	20.6	12.8	33.4	101.1
	Mid West	204	190	394	202	100	302	696	33.3	31.0	64.3	33.0	16.3	49.3	113.6
	Pilbara	11	54	65	55	14	69	134	13.3	65.1	78.4	66.3	16.9	83.2	161.6
	South West	677	516	1,193	284	229	513	1,706	41.3	31.5	72.7	17.3	14.0	31.3	104.0
	Wheatbelt	276	263	539	212	105	317	856	33.7	32.1	65.8	25.9	12.8	38.7	104.5
	WA	8,382	7,856	16,238	4,863	2,921	7,784	24,022	38.4	36.0	74.4	22.3	13.4	35.7	110.0
SA	Eyre Peninsula	181	185	366	118	15	133	499	46.4	47.5	93.9	30.3	3.8	34.1	128.0
	Hills, Mallee & Southern	587	739	1,326	421	85	506	1,832	31.7	40.0	71.7	22.8	4.6	27.4	99.1
	Metropolitan East	1,533	1,692	3,225	648	140	788	4,013	50.3	55.6	105.9	21.3	4.6	25.9	131.8
	Metropolitan North	1,351	2,351	3,702	866	139	1,005	4,707	33.3	57.9	91.2	21.3	3.4	24.7	115.9
	Metropolitan South	1,792	2,021	3,813	933	194	1,127	4,940	43.1	48.6	91.8	22.5	4.7	27.1	118.9
	Metropolitan West	1,306	1,478	2,784	600	139	739	3,523	46.6	52.7	99.3	21.4	5.0	26.4	125.6
	Mid North	200	142	342	65	20	85	427	54.1	38.4	92.4	17.6	5.4	23.0	115.4
	Riverland	225	177	402	145	17	162	564	42.2	33.2	75.4	27.2	3.2	30.4	105.8
	South East	367	304	671	171	26	197	868	45.9	38.0	83.9	21.4	3.3	24.6	108.5
	Whyalla, Flinders & Far North	222	176	398	196	32	228	626	45.4	36.0	81.5	40.1	6.6	46.7	128.1
	Yorke, Lower North & Barossa	541	507	1,048	264	39	303	1,351	43.0	40.3	83.2	21.0	3.1	24.1	107.3
	SA	8,305	9,772	18,077	4,427	846	5,273	23,350	42.0	49.5	91.5	22.4	4.3	26.7	118.2
TAS	North Western	522	537	1,059	287	63	350	1,409	36.9	37.9	74.8	20.3	4.5	24.7	99.5
	Northern	631	796	1,427	385	97	482	1,909	34.6	43.7	78.3	21.1	5.3	26.5	104.8
	Southern	1,087	1,307	2,394	662	183	845	3,239	37.9	45.6	83.6	23.1	6.4	29.5	113.1
	TAS	2,240	2,640	4,880	1,334	343	1,677	6,557	36.7	43.3	80.0	21.9	5.6	27.5	107.5
ACT	ACT	1,198	875	2,073	691	487	1,178	3,251	40.8	29.8	70.6	23.5	16.6	40.1	110.7
	ACT	1,198	875	2,073	691	487	1,178	3,251	40.8	29.8	70.6	23.5	16.6	40.1	110.7
NT	Alice Springs	56	133	189	251	29	280	469	39.9	94.7	134.6	178.7	20.7	199.4	334.0

State/ Territory	Aged care planning region	Total Operational Places							Total Operational Ratios						
		Residential care			Home care			Total Residential + home care	Residential care			Home care			Total residential + home care (planning ratio)
		Low care	High care	Total residential	Low care	High care	Total home care		Low care	High care	Total residential	Low care	High care	Total home care	
	Barkly	3	22	25	70	5	75	100	8.5	62.4	70.9	198.5	14.2	212.6	283.5
	Darwin	111	206	317	306	122	428	745	19.0	35.2	54.1	52.3	20.8	73.1	127.3
	East Arnhem	6	9	15	115	11	126	141	25.1	37.7	62.8	481.2	46.0	527.2	590.0
	Katherine	75	36	111	129	15	144	255	100.2	48.1	148.2	172.3	20.0	192.3	340.5
	NT	251	406	657	871	182	1,053	1,710	29.2	47.2	76.4	101.3	21.2	122.5	198.9
Australia		95,849	96,985	192,834	52,265	14,689	66,954	259,788	41.1	41.6	82.6	22.4	6.3	28.7	111.3

Appendix E: Means testing arrangements

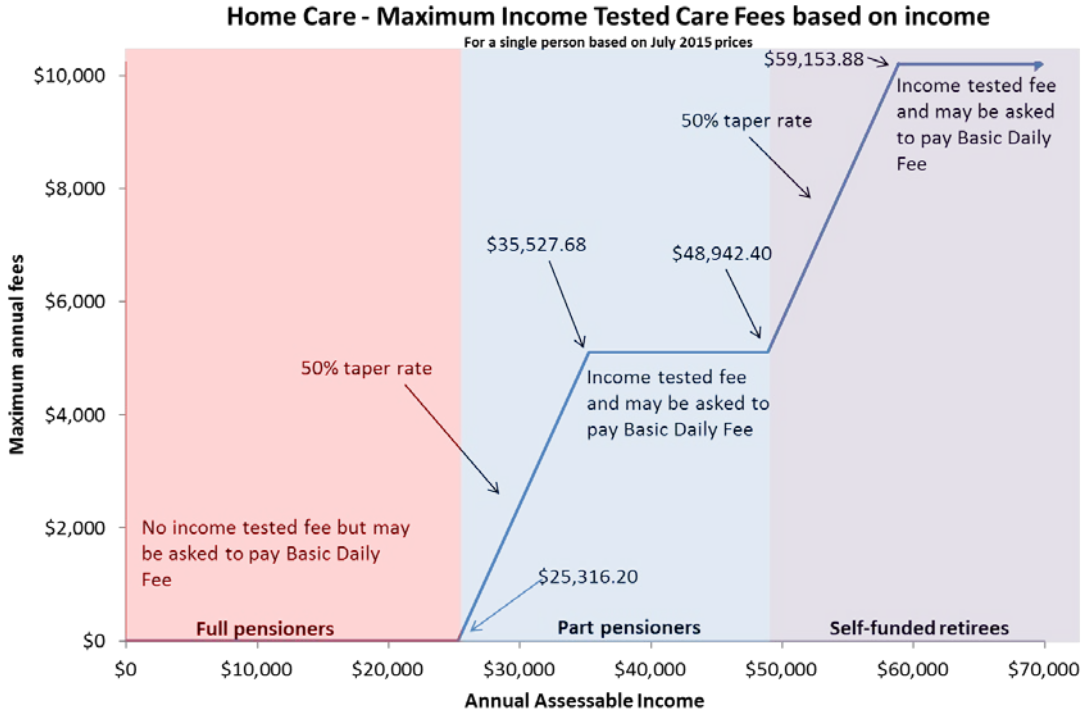
Home care

In addition to the basic daily fee, an income tested 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 fee. Accordingly, to receive an amount equivalent to the full subsidy the provider needs to charge the appropriate income tested fee.

Annual income tested fees in home care are currently capped at $5,105.74 for part-pensioners and $10,211.48 for non-pensioners (July 2015 rate). A lifetime cap of $61,268.92 per consumer currently applies for care contributions across home care and residential care (July 2015 rate). Full pensioners are not required to contribute to their care costs.

Income testing in home care is expected to result in annual consumer contributions increasing to $123 million by 2016-17, with commensurate reductions in Commonwealth outlays.

Figure E.1: Current income testing for home care (post 1 July 2014)



Note. Income tested care fees could be charged up to 50 per cent of income over $48,942.40 but this is capped for an income over $59,153.88

Residential 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 fee structure.

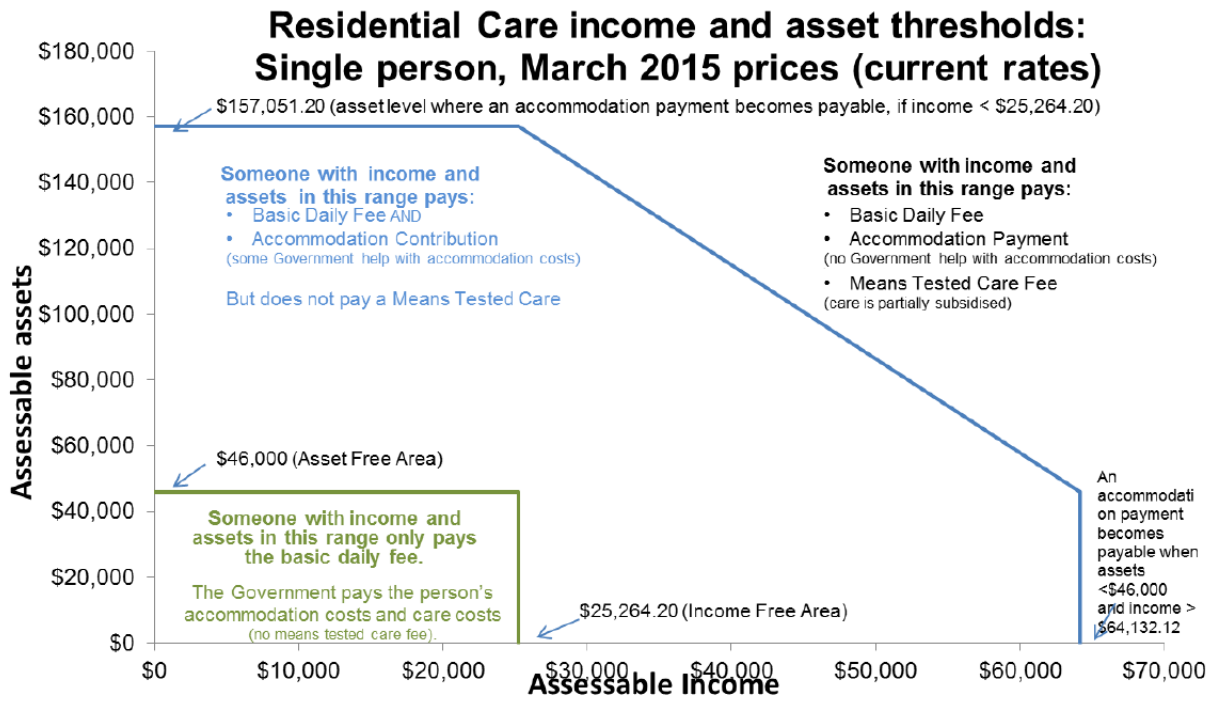
Annual and lifetime caps were also introduced, with an annual cap of $25,528.71 applying to the means tested care fee and a lifetime cap of $61,268.92 for care contributions across home care and residential care (July 2015 rate).

The figure below 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.

Changes to means testing in residential aged care are expected to deliver savings to the Commonwealth of $181.1 million in 2016-17 (as per the 2012-13 Budget).

Figure E.2: Residential aged care income and asset thresholds



Appendix F: Financial Ratios by provider ownership type

Note: For each of the tables, the calculation of financial ratios, a provider is excluded where only a part of the financial information required for each ratio is given in the segment note. As a result the number of providers may differ between each metric/ratio, providers may not be the same in every ratio and results may not fully represent the sector.

Table F.1: Financial ratios of total sector by provider type, 2013-14

	Not-for-Profit	For-Profit	Government	Total
No of Providers	531	363	107	1,001
EBITDA	**$7,680**	**$13,504**	**($2,068)**	**$9,224**
Capital Structure				
T. Assets P.R.P.A	$175,755	$226,727	$245,353	$197,268
No of Bonds	39,436	26,925	1,821	68,182
Avg Bond P.R.	$209,968	$261,676	$156,630	$228,963
Net Worth P.R.P.A.	$73,482	$38,004	$196,779	$67,032
Wrk Cap P.R.P.A.	($41,822)	($75,197)	($73)	($51,640)
Non.Curr Liab as % of T.Assets	11.0%	19.6%	2.6%	13.9%
Bonds as % of T. Assets	47.0%	54.6%	15.6%	48.3%
Net Wth as % T.Assets	41.6%	16.7%	79.0%	33.8%
Financial ratios				
Current Ratio	0.53	0.49	1.00	0.52
Interest Coverage	13.9 Times	6.8 Times	6.1 Times	8.4 Times
NPBT Margin	3.3%	9.8%	(14.5%)	4.9%
Occupancy	94.5%	91.0%	90.2%	93.0%
%EBITDA to T. Assets	4.7%	6.0%	(0.8%)	4.9%
%EBITDA to Net Worth	11.1%	35.6%	(0.8%)	14.3%
Bond Asset Cover (T.A.)	2.1 Times	1.8 Times	6.4 Times	2.1 Times

Table F.2: Financial ratios for not-for-profit providers, 2013-14

	Top	Next Top	Next Bottom	Bottom	Total
No of Providers	91	144	159	137	531
EBITDA	**$17,922**	**$10,149**	**$5,214**	**($7,004)**	**$7,680**
Capital Structure					
T. Assets P.R.P.A	$208,827	$175,565	$154,811	$186,559	$175,755
No of Bonds	7,404	14,251	13,070	4,711	39,436
Avg Bond P.R.	$218,535	$218,439	$200,344	$197,579	$209,968
Net Worth P.R.P.A.	$86,100	$77,187	$58,991	$85,140	$73,482
Wrk Cap P.R.P.A.	($49,936)	($40,920)	($44,187)	($26,116)	($41,822)
Non.Curr Liab as % of T.Assets	11.1%	12.2%	8.9%	11.9%	11.0%
Bonds as % of T. Assets	44.7%	47.7%	50.3%	41.1%	47.0%
Net Wth as % T.Assets	41.2%	43.5%	38.1%	45.6%	41.6%
Financial ratios					
Current Ratio	0.52	0.54	0.47	0.68	0.53
Interest Coverage	23.5 Times	20.9 Times	11.8 Times	-14.1 Times	13.9 Times
NPBT Margin	14.5%	5.9%	0.6%	(14.5%)	3.3%
Occupancy	94.7%	94.8%	94.8%	92.8%	94.5%
%EBITDA to T. Assets	8.6%	5.8%	3.4%	(1.8%)	4.7%
%EBITDA to Net Worth	20.8%	13.3%	8.9%	(3.9%)	11.1%
Bond Asset Cover (T.A.)	2.2 Times	2.1 Times	2.0 Times	2.4 Times	2.1 Times

Table F.3: Financial ratios of Government providers, 2013-14

	Top	Next Top	Next Bottom	Bottom	Total
No of Providers	12	13	19	63	107
EBITDA	**$31,047**	**$10,624**	**$4,453**	**($15,906)**	**($2,068)**
Capital Structure					
T. Assets P.R.P.A	$223,789	$191,760	$529,217	$178,700	$245,353
No of Bonds	308	201	270	1,042	1,821
Avg Bond P.R.	$147,216	$131,027	$152,118	$165,521	$156,630
Net Worth P.R.P.A.	$159,545	$165,356	$481,961	$122,855	$196,779
Wrk Cap P.R.P.A.	($13,812)	$24,240	$28,653	($15,122)	($73)
Non.Curr Liab as % of T.Assets	2.3%	4.4%	1.3%	3.4%	2.6%
Bonds as % of T. Assets	19.6%	22.1%	5.6%	23.4%	15.6%
Net Wth as % T.Assets	71.3%	86.2%	91.1%	67.1%	79.0%
Financial ratios					
Current Ratio	0.77	2.35	1.70	0.72	1.00
Interest Coverage	123.0 Times	10.1 Times	4.0 Times	-16.2 Times	6.1 Times
NPBT Margin	17.4%	5.7%	(19.1%)	(24.8%)	(14.5%)
Occupancy	95.6%	85.7%	93.8%	89.5%	90.2%
%EBITDA to T. Assets	13.9%	5.5%	0.8%	(9.0%)	(0.8%)
%EBITDA to Net Worth	19.5%	6.4%	0.9%	(13.0%)	(0.8%)
Bond Asset Cover (T.A.)	5.1 Times	4.5 Times	17.9 Times	4.3 Times	6.4 Times

Table F.4: Financial ratios of for-profit providers, 2013-14

	Top	Next Top	Next Bottom	Bottom	Total
No of Providers	148	93	72	50	363
EBITDA	**$24,289**	**$10,733**	**$4,579**	**($7,566)**	**$13,504**
Capital Structure					
T. Assets P.R.P.A	$217,055	$238,805	$189,493	$273,538	$226,727
No of Bonds	10,943	8,344	4,101	3,537	26,925
Avg Bond P.R.	$259,515	$254,265	$259,305	$288,592	$261,676
Net Worth P.R.P.A.	$45,140	$41,019	$14,936	$31,189	$38,004
Wrk Cap P.R.P.A.	($66,273)	($64,981)	($82,819)	($128,214)	($75,197)
Non.Curr Liab as % of T.Assets	18.5%	22.2%	16.7%	17.6%	19.6%
Bonds as % of T. Assets	55.1%	46.7%	71.1%	60.0%	54.6%
Net Wth as % T.Assets	20.8%	17.1%	7.9%	11.4%	16.7%
Financial ratios					
Current Ratio	0.51	0.55	0.46	0.36	0.49
Interest Coverage	12.7 Times	4.5 Times	3.1 Times	-2.3 Times	6.8 Times
NPBT Margin	19.8%	6.6%	1.9%	(14.0%)	9.8%
Occupancy	92.8%	91.1%	90.3%	85.2%	91.0%
%EBITDA to T. Assets	11.2%	4.5%	2.4%	(2.8%)	6.0%
%EBITDA to Net Worth	53.8%	26.2%	30.7%	(24.3%)	35.6%
Bond Asset Cover (T.A.)	1.8 Times	2.1 Times	1.4 Times	1.7 Times	1.8 Times

Appendix G: Residential care funding sources

Table G.1: Summary of funding amounts for subsidy and supplements in Residential Aged Care, 2013-14

Types of payments	$million
Basic subsidies	
Permanent residents	8,027.4
Respite residents	173.3
CAP	716.4
Sub-total	*8,917.1*
Primary care subsidies	
Oxygen	15.3
Enteral feeding	7.8
Payroll Tax	191.3
Respite incentive	15.9
Sub-total	*230.3*
Hardship	
Hardship	3.6
Sub-total	*3.6*
Accommodation supplements	
Hardship	4.1
Accommodation supplements	580.9
Transitional accommodation supplements	44.8
Concessional	76.1
Accommodation charge top-up	4.7
Pension	63.7
Sub-total	*774.3*
Viability supplement	
Viability	29.8
Sub-total	*29.8*
Supplements relating to grand parenting	
Transitional	9.2
Charge exempt	1.3
Resident contribution top-up	0.03
Other	39.9
Basic daily fee	1.1

Types of payments	$million
Sub-total	*51.5*
New supplements	
Dementia and severe behaviours	117.6
Veteran's	2.1
Homeless	4.5
Workforce	3.8
Sub-total	*128.0*
Reductions	
Income tested	-320.5
Other reductions	0.0
Sub-total	*-320.5*
Total	**9,814.1**

Appendix H: Residential Care Subsidy and Supplements rates

Table H.1: ACFI rates ($ per day), 2013-14 to 2015-16

ACFI	2013-14	2014-15	2015-16
Activities of daily living (ADL)			
Low	$31.43	$35.65	$36.11
Medium	$68.42	$77.61	$78.62
High	$94.79	$107.52	$108.92
Behaviour (BEH)			
Low	$7.18	$8.14	$8.25
Medium	$14.88	$16.88	$17.10
High	$31.03	$35.20	$35.66
Complex Health Care (CHC)			
Low	$14.14	$16.04	$16.25
Medium	$40.27	$45.68	$46.27
High	$58.15	$65.96	$66.82
Interim rate for new residents pending ACFI assessment	$48.21	$54.68	$55.39

Daily Residential Respite Subsidy Rates	2013-14	2014-15	2015-16
Low	38.98	44.21	$44.78
High	109.3	123.97	$125.58

Table H.2 Residential care supplements table, 2013-14 to 2015-16

Residential Care	2013-14	2014-15	2015-16
Oxygen Supplement	$10.60	$10.84	$10.98
Enteral Feeding Supplement – Bolus	$16.78	$17.17	$17.39
Enteral Feeding Supplement – Non-bolus	$18.86	$19.29	$19.54
Adjusted Subsidy Reduction	$11.98	$12.50	$12.66
Conditional Adjustment Payment	8.75%	-	-
Veterans' Supplement	$6.57	$6.69	$6.78
Homeless Supplement	-	$15.29	$15.49
Dementia and Severe Behaviours Supplement	$16.15	$16.46	-

Table H.3: Residential Aged Care Supplements (Accommodation and Hotel relate)

Residential Care	2013-14	2014-15	2015-16
Higher Accommodation Supplement	-	$52.49	$53.39
Accommodation Supplement	$33.29	$34.20	$34.79
Concessional	$20.35	$20.91	$21.27
Assisted residents	$8.38	$8.61	$8.76
Transitional Accommodation Supplement	$7.63	$7.84	$7.97

Residential Care	2013-14	2014-15	2015-16
Transitional Supplement	$20.35	$20.91	$21.27
Basic Daily Fee Supplement	$0.52	$0.54	$0.55
Respite Supplement – High Level greater than 70%	$83.48	$85.76	$87.24
Respite Supplement – High Level less than 70%	$49.06	$50.40	$51.27
Respite Care – Low Level	$34.99	$35.95	$36.57
Concessional or Assisted if a service is significantly refurbished or newly built More than 40% low means, supported, concessional and assisted residents	-	$52.49	$53.39
40% or fewer low means, supported, concessional and assisted residents	-	-	$40.04
Concessional If a service is not significantly refurbished or newly built - more than 40% low means, supported, concessional and assisted residents	$20.35	$20.91	$21.27
Concessional - 40% or fewer low means, supported, concessional and assisted residents	$13.31	$13.67	$13.90
Assisted residents	$8.38	$8.61	$8.76
Pensioner Supplement	$7.63	$7.84	$7.97
Accommodation Supplement (maximum)			
If a service is significantly refurbished or newly built			
More than 40% low means, supported, concessional and assisted residents	-	$52.49	$53.39
40% or fewer low means, supported, concessional and assisted residents	-		$40.04
If on the day the service meets building requirements in Schedule 1 of Aged Care (Transitional Provisions) Principles 2014 - More than 40% low means, supported, concessional and assisted residents	$33.29	$34.20	$34.79
40% or fewer low means, supported, concessional and assisted residents	-	-	$26.09
If on the day of service does not meet those requirements - More than 40% low means, supported, concessional and assisted residents	$27.98	$28.75	$29.24
40% or fewer low means, supported, concessional and assisted residents	-	-	$21.93
Transitional Accommodation Supplement			
After 19 March 2008 and before 20 September 2010	$7.63	$7.84	$7.97
After 19 September 2010 and before 20 March 2011	$5.09	$5.23	$5.31
After 19 March 2011 and before 20 September 2011	$2.54	$2.61	$2.66
Transitional Supplement	$20.35	$20.91	$21.27
Basic Daily Fee Supplement	$0.52	$0.54	$0.55
Respite Supplement – High Level is equal to or greater than 70% of the specified proportion of respite care for the approved provider.	$83.48	$85.76	$87.24
Respite Supplement – High Level is less than 70% of the specified proportion of respite care for the approved provider.	$49.06	$50.40	$51.27
Respite Supplement – Low Level	$34.99	$35.95	$36.57

Table H.4: Residential aged care viability supplement

Residential Aged Care Viability Supplement	2013-14	2014-15	2015-16
2005 Scheme Services*			
Eligibility score of 100	$40.32	$49.30	$49.94
Eligibility score of 95	$35.73	$43.69	$44.26
Eligibility score of 90	$32.07	$39.22	$39.73
Eligibility score of 85	$27.50	$33.63	$34.07
Eligibility score of 80	$22.89	$27.99	$28.35
Eligibility score of 75	$18.32	$22.40	$22.69
Eligibility score of 70	$14.70	$17.98	$18.21
Eligibility score of 65	$10.07	$12.31	$12.47
Eligibility score of 60	$8.24	$10.08	$10.21
Eligibility score of 55	$5.50	$6.73	$6.82
Eligibility score of 50	$3.67	$4.49	$4.55
Eligibility score of 45 #	$0.00	$0.00	$0.00
Safety net – former 1997 or 2001 scheme services: viability supplement is	$1.51	$1.85	$1.87

Appendix I: Residential aged care financing structures and balance sheets

Table I.1: Distribution of Average Accommodation Bonds by ownership and earnings before interest, taxes, depreciation and amortisation quartile

	Top	Next Top	Next Bottom	Bottom	Total
Not-For-Profit					
No of Providers	91	144	159	137	531
Number of Provider that held bonds	83	140	144	126	493
Proportion of permanent residents that paid bond in facilities, where bonds were held.	40.6%	38.6%	38.9%	37.4%	38.9%
Average bond per resident	$218,535	$218,439	$200,344	$197,579	$209,968
For-Profit					
No of Providers	148	93	72	50	363
Number of Provider that held bonds	113	74	60	41	288
Proportion of permanent residents that paid bond in facilities, where bonds were held.	45.3%	45.4%	51.6%	50.0%	46.9%
Average bond per resident	$259,515	$254,265	$259,305	$288,592	$261,676
Government					
No of Providers	12	13	19	63	107
Number of Provider that held bonds	11	12	15	47	85
Proportion of permanent residents that paid bond in facilities, where bonds were held.	30.0%	31.8%	21.3%	25.0%	26.3%
Average bond per resident	$147,216	$131,027	$152,118	$165,521	$156,630
TOTAL					
No of Providers	251	250	250	250	1,001
Number of Provider that held bonds	207	226	219	214	866
Proportion of permanent residents that paid bond in facilities, where bonds were held.	42.9%	40.8%	40.7%	39.5%	41.1%
Average bond per resident	$241,396	$230,782	$213,461	$228,635	$228,963

Appendix J: Access to care

Table J.1: Services by type of care

	30 June 2011	30 June 2012	30 June 2013	30 June 2014
High care	45%	51%	55%	59%
Low care	4%	3%	2%	2%
Mixed care	51%	46%	43%	38%
Total	100%	100%	100%	100%

Source. Report on Government Services (2014)

Table J.2: Number of First Admissions into Permanent Residential Aged Care, by Care Type and Extra Service Status and as a Proportion of Total First Admissions in 2013-14[40]

	2010-11	2011-12	2012-13
Extra services	4,303	1,657	5,690
	7.0%	2.7%	9.7%
Non-extra services	34,020	21,361	55,381
	55.5%	34.82%	90.3%
All admissions	38,323	23,018	61,341
	62.5%	37.5%	100%

Source. Unpublished departmental data

Table J.3: Number of recipients in permanent residential aged care at 30 June 2014, by Provider organisation Type (For-Profit, Not-For-Profit, Government)

	Total operational places	Number of permanent residents in care		
		All residents	*Residents aged 70 or more years*	*Residents aged 85 or more years*
Not-for-profit	108,747	101,820	95,207	61,115
For-profit	70,842	63,564	58,753	36,623
State and local government	9,694	8,590	7,488	4,277
Total	189,283	173,974	161,448	102,015

Source. Unpublished departmental data

[40] Departmental data.

Table J.4: Occupancy rate in aged care by state and territory 2013-14 (%)

State/Territory	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Australia
Residential aged care	93.1	92.5	92.8	94.5	93.9	92.1	95.5	86.0	93.0
Level1	48.9	53.4	33.5	43.1	48.2	63.2	..	n.p.	48.7
Level 2	91.8	93.8	84.0	74.5	87.2	92.7	88.5	87.1	88.8
Level 3	58.2	61.1	62.1	37.3	59.9	62.7	..	n.p.	59.9
Level 4	91.7	94.1	91.6	83.3	91.4	91.8	86.1	89.7	90.1%
Total home care	90.8	93.2	85.3	77.8	86.9	91.9	87.6	87.6	88.4%

Source. Unpublished departmental data

Table J.5: Residential Occupancy by remoteness area Financial Year (%)

Year	2006-7	2007-8	2008-9	2009-10	2010-11	2011-12	2012-13	2013-14
Major cities	94.1	93.4	92.6	92.1	92.8	92.7	92.9	93.2
Inner regional	95.5	94.4	94.1	93.7	94.1	93.6	93.3	92.9
Outer regional	95.6	93.7	92.7	91.9	92.3	91.7	92.2	92.4
Remote	91.4	87.5	88.4	89.5	90.9	90.8	90.3	88.6
Very remote	79.8	80.2	79.5	80.9	88.3	82.3	81.2	84.4

Source. The Report on Government Service (2014)

Table J.6: Number of operational Home Care Packages and operational Residential Care Places at 30 June

	2008	2009	2010	2011	2012	2013 (c)	2014
Residential	171,832	175,225	179,749	182,302	184,570	186,278	189,283
Home care level 1	. .	. .	. .	. .	. .	. .	1,303
Home care level 2 (a)	39,552	40,195	42,634	45,096	46,518	47,158	50,157
Home care level 3	. .	. .	. .	. .	. .	. .	1,010
Home care level 4 (b)	6,240	6,514	8,170	12,145	12,683	13,150	13,679
Total for Home Care Packages	45,792	46,709	50,804	57,241	59,201	60,308	66,149

a) Includes Community aged care packages, b) including EACH and EACH D, c) On 1 August 2013 the Home Care Packages Programme replaced the former community packaged care programmes – CACP, EACH packages and EACH Dementia packages.
Note: Excludes MPS, Innovative care, and National Aboriginal and Torres Strait Islander Flexible aged care program services.

Source. Department Stocktake of Aged Care

Table J.7: Utilisation of operational residential care places at 30 June

Utilisation as at 30 June	Proportion of Residential Care Places Utilised for High Care (%)	Proportion of Residential Care Places Allocated as Low Care, Utilised for High Care (%)
2014	76.8	61.2
2013	74.6	57.6
2012	73.0	54.6
2011	69.2	48.9
2010	62.5	37.6
2009	66.3	42.9
2008	68.6	45.1
2007	64.9	37.4

Source. Report on Government Services (2014) and The Report on Operation of the Aged Care (2014)

Table J.8: Average Age of People Living and Entering Permanent Residential Aged Care

Period	Average Age at First Admission to Permanent Residential Aged Care	Average Age of Permanent Residential Aged Care Residents as at 30 June
2013-14	83.5	84.5
2012-13	83.3	84.4
2011-12	83.3	84.4
2010-11	83.2	84.2
2009-10	83.1	84.1
2008-09	83.0	84.0

Source. Unpublished departmental data

Table J.9: Occupancy in Residential Aged Care Services by Provider Type (%) 2012-13

Organisation Type	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Australia
Not- for- profit	94.2	94.6	94.4	96.7	96.1	92.3	94.9	86.0	94.6%
For- profit	90.8	91.1	91.0	91.0	90.7	92.3	98.0	..	91.0%
State/ local government	93.7	91.5	80.8	94.6	89.0	84.5	..	..	90.0%
All organisation types	93.1	92.5	92.8	94.5	93.9	92.1	95.5	86.0	93.0%

Source. Unpublished departmental data

Appendix K: Home Care

Table K.1: Revenue and expenditure by ownership type, quartiles by NPBT, 2013-14

	Top Quartile	Next Top	Next Bottom	Bottom	Total
Not-for-Profit					
No of Providers	80	85	77	64	306
Govt Care Subsidies	$64.34	$58.64	$57.05	$46.27	$59.78
Client Contrib.	$5.16	$5.55	$4.91	$4.27	$5.15
Other Income	$0.37	$0.32	$0.54	$0.33	$0.38
Tot. Expenses	$58.23	$60.27	$61.98	$54.93	$59.16
Net Profit Before Tax	$11.65	$4.23	$0.51	($4.06)	$6.16
For-Profit					
No of Providers	22	8	16	7	53
Govt Care Subsidies	$77.60	$51.78	$52.18	$48.10	$64.90
Client Contrib.	$4.34	$4.30	$5.14	$4.48	$4.64
Other Income	$1.08	$0.13	$0.33	$0.32	$0.70
Tot. Expenses	$64.37	$51.56	$57.24	$62.30	$60.90
Net Profit Before Tax	$18.65	$4.65	$0.41	($9.41)	$9.34
Government					
No of Providers	10	18	18	40	86
Govt Care Subsidies	$69.31	$58.17	$47.92	$44.17	$49.19
Client Contrib.	$12.10	$2.15	$2.90	$2.42	$3.16
Other Income	$0.77	$0.43	$0.16	$0.10	$0.22
Tot. Expenses	$70.07	$57.13	$50.69	$49.77	$52.65
Net Profit Before Tax	$12.11	$3.63	$0.29	($3.09)	($0.08)
Total					
No of Providers	112	111	111	111	445
Govt Care Subsidies	$65.78	$58.49	$55.31	$45.62	$59.34
Client Contrib.	$5.17	$5.34	$4.74	$3.64	$4.94
Other Income	$0.45	$0.32	$0.46	$0.25	$0.39
Tot. Expenses	$59.02	$59.95	$60.03	$53.46	$58.76
Net Profit Before Tax	$12.37	$4.21	$0.47	($3.95)	$5.91

Table K.2: Revenue and expenditure by ownership type, per package, quartiles by NPBT, 2013-14

	Top Quartile	Next Top	Next Bottom	Bottom	Total
Not-for-Profit					
No of Providers	80	85	77	64	306
T. Rev per Pkg	$21,824	$20,037	$19,710	$15,225	$20,319

	Top Quartile	Next Top	Next Bottom	Bottom	Total
T. Exp per Pkg	$18,186	$18,722	$19,548	$16,440	$18,403
NPBT Per Pkg	$3,638	$1,314	$162	($1,215)	$1,915
For-Profit					
No of Providers	22	8	16	7	53
T. Rev per Pkg	$22,366	$14,473	$15,737	$12,560	$18,809
T. Exp per Pkg	$17,342	$13,277	$15,625	$14,793	$16,307
NPBT Per Pkg	$5,024	$1,196	$113	($2,233)	$2,502
Government					
No of Providers	10	18	18	40	86
T. Rev per Pkg	$26,202	$19,467	$14,773	$14,234	$16,008
T. Exp per Pkg	$22,341	$18,304	$14,690	$15,175	$16,033
NPBT Per Pkg	$3,861	$1,163	$83	($941)	($25)
Total					
No of Providers	112	111	111	111	445
T. Rev per Pkg	$21,945	$19,890	$18,442	$14,747	$19,813
T. Exp per Pkg	$18,142	$18,587	$18,298	$15,924	$18,002
NPBT Per Pkg	$3,803	$1,304	$145	($1,177)	$1,810

Table K.3: Home Care Occupancy by Level and by State, 2013-14

Levels	NSW	Vic.	Qld	WA	SA	Tas.	ACT	NT	Australia
HCL1	48.9	53.4	33.5	43.1	48.2	63.2	..	n.p.	48.7%
HCL2	91.8	93.8	84	74.5	87.2	92.7	88.5	87.1	88.8%
HCL3	58.2	61.1	62.1	37.3	59.9	62.7	..	n.p.	59.9%
HCL4	91.7	94.1	91.6	83.3	91.4	91.8	86.1	89.7	90.1%
Total	90.8	93.2	85.3	77.8	86.9	91.9	87.6	87.6	88.4%

Table K.4: Operational Home Care Packages by provider type and by state, at 30 June 2014

	Not-for-profit	For-profit	State and local government	Total
Level 1				
NSW	377	108	0	485
VIC	199	86	65	350

	Not-for-profit	For-profit	State and local government	Total
QLD	156	89	0	245
WA	10	20	0	30
SA	106	19	10	135
TAS	24	26	0	50
ACT	0	0	0	0
NT	6	2	0	8
Australia (number)	878	350	75	1,303
Australia (%)	**67%**	**27%**	**6%**	**100%**
Level 2				
NSW	14,348	1,293	1,032	16,673
VIC	9,226	720	2,678	12,624
QLD	8,105	904	307	9,316
WA	3,571	720	375	4,666
SA	3,656	159	395	4,210
TAS	1,008	150	62	1,220
ACT	602	89	0	691
NT	401	108	248	757
Australia (number)	**40,917**	**4,143**	**5,097**	**50,157**
Australia (%)	**82%**	**8%**	**10%**	**100%**
Level 3				
NSW	258	117	0	375
VIC	179	15	78	272
QLD	133	77	0	210
WA	7	3	0	10
SA	84	11	5	100
TAS	21	14	0	35
ACT	0	0	0	0
NT	4	4	0	8
Australia (number)	**686**	**241**	**83**	**1,010**
Australia (%)	**68%**	**24%**	**8%**	**100%**
Level 4				
NSW	2,932	480	39	3,451
VIC	2,236	98	371	2,705
QLD	2,755	123	19	2,897
WA	2,132	734	45	2,911
SA	695	27	24	746
TAS	248	47	13	308
ACT	423	64	0	487
NT	107	56	11	174

	Not-for-profit	For-profit	State and local government	Total
Australia (number)	**11,528**	**1,629**	**522**	**13,679**
Australia (%)	**84%**	**12%**	**4%**	**100%**
Total				
NSW	17,915	1,998	1,071	20,984
VIC	11,840	919	3,192	15,951
QLD	11,149	1,193	326	12,668
WA	5,720	1,477	420	7,617
SA	4,541	216	434	5,191
TAS	1,301	237	75	1,613
ACT	1,025	153	0	1,178
NT	518	170	259	947
Australia (number)	**54,009**	**6,363**	**5,777**	**66,149**
Australia (%)	**82%**	**10%**	**9%**	**100%**

Source. Unpublished departmental data

Table K.5: Operational Home Care Packages by provider type and Remoteness area at 30 June 2014

	Not-for-profit	For-profit	State and Local Government	Total
Major Cities of Australia	38,583	5,329	2,051	**45,963**
Inner Regional Australia	11,068	517	2,026	**13,611**
Outer Regional Australia	3,758	412	1,004	**5,174**
Remote Australia	389	74	264	**727**
Very Remote Australia	211	31	432	**674**
Remoteness Area	**54,009**	**6,363**	**5,777**	**66,149**

Source. Unpublished departmental data

Table K.6: Operational Home Care Packages by organisation type and remoteness area – 30 June 2014

	Community Based	Private For-Profit	Territory Gov't	Total
Major Cities of Australia	38,583	5,329	2,051	45,963
Inner Regional Australia	11,068	517	2,026	13,611
Outer Regional Australia	3,758	412	1,004	5,174
Remote Australia	389	74	264	727
Very Remote Australia	211	31	432	674
Australia Total	**54,009**	**6,363**	**5,777**	**66,149**

Source. Unpublished departmental data

Appendix L: Segment analysis

Residential care

- The information about residential aged care providers is obtained from GPFRs prepared by providers of residential aged care under the *Aged Care Act 1997* as part of the eligibility requirements for the CAP.
- The segment information contains financial information for only those services that were operational as at 30 June 2014 and therefore, averages are not fully representative of the entire residential aged care sector.
- The comprehensiveness of the financial information contained in GPFRs varies from provider to provider. The accounting standards are also subject to interpretation and it is possible that interpretations may differ between provider and between auditors. In addition, the Department's interpretation of the accounting data provided in the GPFRs has not been verified with the aged care providers. Analysis of financial data is affected by incomplete and aggregated data provided in the segment notes of the GPFRs.
- The data quality at the segment level is subject to each provider's allocation rules which are not fully disclosed in the GPFRs of the providers and therefore may not necessarily reflect the true income, expenses, assets and liabilities of the residential aged care segment.
- Care needs to be taken when interpreting the averages as detailed segment information is not mandatory and may be inconsistent in quality and level of details. As a result it may not fully represent sector averages.
- For the calculation of ratios, a provider is excluded when only a part of the financial information is given that cannot become useful to measure a financial ratio/proportion. Due to this reason, the number of providers differs in each metric/ratio. It is also possible that a provider who is included in the measurement of one ratio may not be included in the measurement of another ratio. Hence the ratios may not fully represent the entire sector.
- The averages and financial ratios presented in the analysis are based on those providers who have given residential aged care segment information in their GPFRs.
- The inconsistent treatment of certain items in balance sheet (like accommodation bonds - which can be treated as a current liability, non-current liability or both) impacts the liquidity metrics and other sustainability ratios such as current ratio.
- The Return on Assets and Return on Equity /Net worth ratios are a simple measure of proportion of EBITDA earning to Total Assets and Net worth respectively. It does not relate to the evaluation of capital financing measurements of the sector.
- Since many of the providers have given "finance ratios", which may contain other expense items in addition to interest expense, the average EBITDA estimate may be overstated.
- The total Accommodation Bond amount included in the analysis is extracted from the Department's records and not from GPFRs. The Bond amounts provided in the GPFRs has not been verified from the residential aged care providers.

Home Care

Notes to the financial data presentations

- The financial information about Home Care level packages is collected through Home Care Packages Programme 2013-14 Financial Report (HCPPFR) that is prepared by providers of Home Care services under the requirement of Accountability Principles 2014.
- The 2013-14 financial information for Home Care is collected for the first time using HCPPFR structure under new Home Care arrangements that became effective from 01 August 2013.
- About 84% of the Home Care Sector has provided data in useable strength to derive the necessary analysis and measurements whereas 4% of the sector did not provided the data. The data of the rest of the services is not in a useable form.
- The averages and financial ratios of the Home Care services include only those services that were operational as at 30 June 2014 and also provided their HCPPFRs. Therefore the averages and other financial metrics/ratios may not be fully representative of the entire Home Care Sector.
- The HCPPFR data contain aggregate data of all four Home Care levels. Hence the analysis and measurements are also based on the aggregates of all four levels of Home Care packages. Due to this reason, the HCPPFR results are not comparable with the Home Care financial results published by the commercially available independent financial performance surveys.
- In terms of the Accountability Principles 2014, the HCPPFR is not an audited report and does not contain any auditor's opinion on the HCPPFR data/information. Therefore the financial data in HCPPFR may contain some qualification towards its fairness.
- As the HCPPFR is not audited information, it is presumed that the financial information provided by the service in their HCPPFR is most likely extracted from their Management Accounts system.
- In view of the above observation, it also appears that the HCPPFR data may contain financial information that pertains to later or beyond the asked 2013-14 period, in addition to the 2013-14 period data.
- During 2013-14, there were instances where a lag existed between the claims filed by the Home Care Services and payments received against the same due to which most of the claims were paid after 2013-14 period. In terms of accrual based accounting and considering these lags, it appears that the income and expense amounts of these services reflect the partial period of 2013-14 for which the claims are received by them. Consequently, the analysis and measurements of the average results of the sector may have been under estimated.
- It also appears from the above that the income amounts disclosed in most of the HCPPFRs may include the unspent amount of subsidies, supplements and client fees that is reserved for Consumer Directed Care (CDC) clients, which may have overestimated the results.
- The HCPPFRs data is not cleanable as the source information from where the HCPPFR information is presumed to be extracted is not available with the Department.
- Significant discrepancies occur in the HCPPFR statements creating an impact on the overall average results of the sector. For example, there are instances where the item wise details of the expenses are aggregated to other expenses or total expenses. This results in inconsistency and limitations in deriving various metrics and measurements of the analysis at micro level.
- Instances occur where the income and expense totals are written in opposite signs in HCPPFRs which creates an ambiguity in making surplus profit providers into loss making providers. Such instances are not verifiable in the absence of cleaning process of the data. Due to this reason, it is possible that in real terms there may be more providers in surplus profit than the number of providers derived from available data.

- The Department's interpretation of the accounting data information provided in the HCPPFRs has not been verified by the Home Care Providers.
- Some of the HCPPFRs contain negative income items and positive expense items, reasons of which are not given in the HCPPFR. In the absence of data cleaning process, such instances are not verifiable and may have under/overestimated the averages of total income and total expenses of the sector.
- The Net Profit Before Tax (NPBT) and Earnings Before Interest Taxes and Depreciation & Amortisation (EBITDA) of the sector may not be fully representative as the Total income earned by the service and Total expenses paid by a service are not disclosed in the HCPPFR to its entirety. For example, it is anticipated that some providers may have aggregated the Goods and Services Tax with the other expense item in the HCPPFR.
- It appears that in HCPPFR, some services have moved their carry-over previous year/future year income or expense amounts to the current year period due to which the average results for current period may over/under represent the sector results.
- A limited number of financial metrics/ratios are measureable from the useable data due to incomprehensive details provided in the HCPPFRs.
- The comprehensiveness of the financial information contained in the HCPPFRs varies from provider to provider. The accounting standards are subject to interpretation and it is possible that interpretations may differ between provider and their auditors. Analysis of financial data is affected by incomplete and aggregated data provided in the HCPPFRs of these providers/services.
- The data quality is subject to each provider's allocation rules which are not fully disclosed in the HCPPFRs and therefore may not necessary reflect the true income and expense of the Home Care service facility.
- Due to inconsistent allocation rules across the sector, there are instances where discretionary apportionments of income and expenses have resulted in inconsistent analysis at micro level.
- For the calculation of ratios, a provider is excluded when only a part of the financial information is given that cannot become useful to measure a financial ratio/proportion. Due to this reason, the number of providers differs in each metric/ratio. It is also possible that a provider who is included in the measurement of one ratio may not be included in the measurement of another ratio. Hence the ratios may not fully represent the entire sector.

Appendix M: References

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