Aged Care Financing Authority

Inaugural Report on the funding and financing of the Aged Care Sector

30 June 2013

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Glossary

Term	Definition
Aged Care Funding Instrument (ACFI)	Used for determining the level of care payments for residents in aged care homes. It was introduced on 20 March 2008 as the means of allocating Federal Government subsidy to residential aged care providers.
Allocated Places/Packages	The amount of 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 (subsidies) only for the specified number and type of aged care places allocated through the Australian Government's allocation processes.
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.
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.
Conditional Adjustment Payment (CAP)	CAP is payable to eligible providers who meet certain criteria including encouraging staff training, submitting a GPFR and participating in the workforce census.
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 liability. 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.
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 an equivalent to high level residential care.
Extended Aged Care at Home Dementia (EACHD)	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 an equivalent to high level residential care.

Home and Community Care (HACC)	A program 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. Access to HACC services is on the basis of relative care need.
General Purpose Financial Report (GPFR)	A financial report intended to meet the information needs common to users who are unable to command the preparation of reports tailored so as to satisfy, specifically, all of their information needs.
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.
Operational Places/Packages	Operational Place refers to a place that was allocated during an Aged Care Approvals Round and has since become available for a person to receive care.
Net Profit Before Tax	The NPBT is determined by revenue minus expenses except for taxes.
Net Profit (Before Tax) Margin	Shows the average profitability generated on each $1 of total revenue. It is calculated as Net Profit Before Tax / Total Revenue.
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.
Retention Amounts	The amount that an approved provider is allowed to deduct per month from a bond for up to five years. The maximum retention amount is set by the Federal Government.
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.
Weighted Average Cost of Capital (WACC)	Represents the cost of capital sourced from equity and debt investments by the ratio of debt to equity in the capital structure.
Working Capital	Defined as current assets less current liabilities.

Executive Summary

The Aged Care Financing Authority's (ACFA) role is to provide independent advice to Government on financing and funding issues in the aged care sector, examining issues of concern and advising Government as appropriate. ACFA's recommendations are considered in the context of maintaining a sustainable aged care sector balancing the needs of care recipients, funders, providers, workforce and financiers.

This is ACFA's inaugural report. It represents a significant cornerstone in describing the current state of the funding, financing and pricing arrangements in the aged care sector. This will allow for future analysis and assessment of the *Living Longer Living Better* (LLLB) reforms and subsequent reforms and developments in the aged care sector. The report identifies priorities for further research and analysis as well as key issues to monitor over the next 12-24 months.

The report primarily focuses on residential aged care, reflecting ACFA's focus to date and data availability. Future reports will expand the analysis on home care.

Consistent with the remit of ACFA's operating framework the report looks at the impact of aged care financing arrangements on sector viability, access to quality care, the aged care workforce and sustainability.

In this and future reports, ACFA intends to ensure that the perspectives of all key stakeholders – aged care recipients, aged care providers, financiers and investors, the aged care workforce and Government – are taken into account. To assist with this, ACFA has commenced a dialogue with a small but representative part of the aged care financing sector. ACFA intends to continue this bilateral engagement on a regular basis into the future.

Residential Aged Care

Sector overview

There are 1,054 residential aged care providers operating a total of 2,716 aged care services (homes) providing a total of 182,663 aged care places (beds):

- of the 2,716 homes 74 per cent are high care, 24 per cent mixed care and 2 per cent low care;
- of the 182,663 places 77 per cent are high care, 22 per cent mixed care and 1 per cent low care;
- 60 per cent of services are run by not-for-profit organisations, 30 per cent by for-profit and 10 per cent by state government;
- 58 per cent of providers are city based, 38 per cent are regional based and 4 per cent are in both city and regional areas; and
- 63 per cent of providers operate single homes, 29 per cent between 2 and 6 homes, 8 per cent operate 7 or more homes.

Funding and Financing

The Federal Government provides about 71 per cent of total funding to residential aged care providers. This is made up predominantly of funding through the Aged Care Funding Instrument (ACFI) (almost 80 per cent) and additional funding through various supplements. The next most significant funding source is resident care fees making up 25 per cent of total funding, followed by revenue from accommodation payments (regular accommodation payments and retention amounts drawn down from accommodation bonds) at about 4 per cent of total funding.

Lump sum accommodation bonds are not recorded as revenue funding, but play a significant role in the financial arrangements of the sector. Providers can earn interest from these bonds (offsetting interest on borrowings) or use them as a source of capital financing.

Capital financing for the sector comes from equity investment and borrowing including accommodation bonds and retained profits. The Federal Government also contributes with capital grants and zero real interest loans available to some providers.

Expenses are predominantly staff related, with staff expenses making up approximately 64 per cent of total expenses.

Financial Performance

Analysis of the 2011-12 financial results of the sector show that many providers in the sector run a profitable operation – 70 per cent of providers recorded a net profit before tax and 84 per cent have a positive Earnings Before Interest Tax, Depreciation and Amortisation (EBITDA). The average EBITDA margin for the sector is 12 per cent and the Net Profit Before Tax (NPBT) margin is 5.6 per cent. However, the results are variable across the sector and further analysis is required to determine what key factors are common to the well performing providers, what key factors are common to those providers with less profitable or loss making operations and what can be done to improve performance.

Some observations from the analysis to date include:

- Average EBITDA per resident per annum is $9,274. The top quartile has EBITDA of $21,081, the second quartile $10,394, the third quartile $5,654 and the bottom quartile negative $3,646.
- For-profit providers have higher EBITDA per resident per annum on average ($13,121) than not-for-profit providers ($8,176) and Government providers (-$1,508). For-profit providers also have a higher NPBT margin of 10.5 per cent compared to not-for-profit at 4.5 per cent.
- High care providers have higher EBITDA per resident per annum on average ($10,364) than low care providers ($2,454).
- City providers have higher EBITDA per resident per annum on average ($10,369) than regional providers ($6,663).
- Single service providers have higher EBITDA per resident per annum on average ($9,809) than providers with 2-6 homes ($8,759) and providers with 7 or more homes ($9,309).

However, these comparisons need to be considered with caution. For example, high care providers in the bottom quartile are also the worst performing on average and those regional providers in the top quartile are on average performing equally as well as city providers. This indicates that while

distinctions between provider type, care type and geographical location may have some impact on performance, there are likely to be other factors, such as management quality and provider efficiency, which are important and which vary throughout the sector and within different segments.

Balance Sheet Analysis

The sector as a whole has assets of $28 billion, current liabilities of $12.5 billion, non-current liabilities of $5.9 billion with resulting net worth/equity of $9.6 billion. Included in the liabilities are accommodation bonds held by the sector of $12.966 billion.

Key observations from the analysis include:

- Average return on assets for the sector is 5.5 per cent and average return on equity is 15.9 per cent. In both cases the for-profit sector has higher returns than the not-for-profit sector.
- Average net worth/equity per resident is higher in the not-for-profit sector ($70,371) compared to the for-profit sector ($24,660).
- Average financing from equity is 35 per cent and debt 65 per cent. The not- for-profit sector has an average of 43 per cent of financing from equity compared to 15 per cent for the for-profit sector and accordingly has a lower reliance on debt, higher interest coverage ratio and higher average returns on equity.
- Accommodation bonds are a significant source of funds and represent 48 per cent of assets for the sector (46 per cent of assets for the not-for-profit sector and 58 per cent of assets for the for-profit sector).

Investment in the sector

Analysis by the Department of Health and Ageing suggests that the residential aged care sector will need to build approximately 74,000 additional places over the next decade in order to achieve the LLLB reform provision target for residential services. This involves an estimated investment requirement for new stock and rebuilding of existing stock in the order of $25 billion over the next decade. The LLLB reforms have created some uncertainty amongst investors but more recent data from the Australian Bureau of Statistics (ABS) shows positive signs of increasing investment.

Living Longer Living Better reforms

The impact of the *Living Longer Living Better* reforms will be a key factor in influencing sector viability and investment in the sector into the future. While the transition to the new system may raise some challenges for providers, many aspects of the reforms can be expected to have a positive impact on the sector.

The LLLB reforms can be expected to impact on sector viability in a number of ways. Particular reforms of relevance include:

- Reforms to the accommodation payments system incorporating:
    - Changes to the pricing system – with the harmonisation of high care and low care through the removal of the capping of daily payments in high care and allowing lump sums to be paid in high care; and
    - Changes to the mode of payment – with full choice of payment type (lump sum versus periodic) resting with the resident and applying across high care and low care.
- The more than 50 per cent increase in the accommodation supplement being paid for residents with low means in new or significantly refurbished homes.

KPMG modelling and analysis commissioned by ACFA indicates a positive impact on the sector at the aggregate level. Positive impacts are likely to arise from the removal of regulatory restrictions on charging for accommodation in high care places (lump sum accommodation payments will be allowed and caps on periodic payments removed) and the increase in the accommodation supplement for new or significantly refurbished homes.

However, the impacts will need to be closely monitored as they will vary between providers dependent on their business models, operating and capital structures and other factors. For example, low care providers and those more dependent on lump sum bonds may find the transition to the new system more challenging than others. ACFA will monitor these impacts closely and provide further advice to Government on an ongoing basis on this issue and on other aspects of the implementation of the LLLB reforms. Refer to Appendix A for details on how ACFA will report to Government on the implementation of the reforms.

Home Care[1]

Sector overview

Home care is provided through packaged care (community or home care packages) or through the Home and Community Care (HACC) program. Not-for-profit providers are the major providers of home care providing 84 per cent of packages with 9 per cent from government providers and 7 per cent from for-profit providers.

Funding

Funding for home care package providers is sourced primarily from Federal Government payments ($1.1 billion) with some care fees ($80 million) also paid by care recipients. There are 59,201 packages in total. Community Aged Care Packages account for 55 per cent of the funding and 79 per cent of the packages. Extended Aged Care at Home packages account for 15 per cent of

[1] As part of the LLLB reforms from 1 August 2013 existing community care services will be replaced with home care services.

funding and 14 per cent of packages and Extended Aged Care at Home Dementia packages account for 30 per cent of funding and 7 per cent of packages.

The Federal Government provides funding of $1 billion to the Commonwealth HACC program and contributes $462 million to the jointly funded programs in Victoria and Western Australia (with total funding in those States of $769 million). The Commonwealth HACC program provides services to approximately 480,000 older clients and the joint programs in Victoria and Western Australia provide services to approximately 350,000 clients of all ages. In most cases, HACC fees paid by clients are generally minimal relative to total funding and vary across State and Territories.

Access to Care and Quality Care

ACFA's focus in this area is in assessing the impacts of the funding, financing and pricing arrangements, and any changes to those arrangements, on access to care and quality care. While the report sets out the current framework around access and quality issues, it is not ACFA's role to comment specifically on the broader (non-financial) approach to these issues.

The key impacts of the funding, financing and pricing arrangements on access and quality care are reflected in:

- Government funding through the ACFI to support the provision of quality care;
- regulation of the amount of fees paid by care recipients;
- specific assistance provided to address potential access issues for certain groups e.g. those with low means, those with special needs, those in remote areas;
- investment in research and innovation to improve resident wellbeing and clinical outcomes and productivity; and
- at a more macro level, the viability of the sector and attractiveness of investment in the sector which will supports the provision of places and quality care.

ACFA intends to undertake further work in assessing the impact of current and future funding and financing arrangements on access to care and quality care. A particular focus of this work will be issues relating to access for special needs groups, such as those from Culturally and Linguistically Diverse (CALD) backgrounds, the homeless, those with complex care needs and issues relating to access for those in rural and remote areas.

ACFA will also closely examine the impact of the LLLB financial reforms on access to quality care, including the impact of changes to the accommodation payment arrangements and changes to means testing arrangements.

Workforce

A resourced, capable and skilled workforce that meets the needs of aged care recipients, is essential to a strong and effective aged care system. It will provide the appropriate number of workers with the right skill mix to deliver quality care.

ACFA is required to report in time to inform the five year review of the LLLB reforms on longer term options to support a stable and skilled workforce that can meet the growing demand for aged care services.

In this report ACFA focuses on assessing the current state of the workforce, noting information on factors such as number and types of workers, skills shortages, trends in the workforce and remuneration.

ACFA intends to undertake further work on the impact of funding and financing arrangements on workforce issues, including analysis of issues such as workforce turnover, comparative wages, and expenditure on skilling and training and productivity.

Key workforce challenges going forward will include:

- ensuring the workforce has the appropriate number of appropriately qualified and skilled staff;
- dealing with increasing rates of complex chronic conditions;
- consumer expectations for improved standards of quality and access; and
- addressing the increasing competition for staff from complementary areas such as hospital and disability care.

Sustainability

Population growth and an ageing population mean that the demand for residential aged care services and care will continue to grow.

A key influence on the future of residential aged care will be the source of equity to fund growth, replace obsolete stock and move towards more efficient operating models. Improvements in quality and financial performance could be expected to attract more institutional investors, both as direct investors and as investors in listed companies.

To be sustainable the sector will also need to be viable at the provider level, provide access to care for a diverse population, meet the quality care needs of care recipients, be an attractive employer for the workforce, and be adaptable and efficient.

Sustainability for funders (Government and residents) requires the right mix between funders consistent with community expectations and Government policy.

Key issues for focus for next 12-24 months

ACFA will expand on its research and analysis in this report across all areas of the impact of financing, funding and pricing arrangements on sector viability, access to quality care, workforce and

sustainability. ACFA will also closely monitor the impacts of the *Living Longer Living Better* reforms. Particular focus will be on:

- the impact of the reforms on viability of providers across the sector (at a disaggregated level looking at impacts based on different provider operational and care levels, and geographical areas);
- the impact of the reforms on access to quality care, particularly the impact of changes to accommodation payment and care fee arrangements, with a specific focus on the impact on those with lower means and special needs groups;
- the impact of the reforms on the workforce;
- improving the availability and quality of data to better inform ACFA's ability to provide comprehensive analysis of the impact of aged care funding and financing arrangements; and
- timely reporting to Government on the impact of the reforms as outlined in Appendix A.

1. Introduction

On 20 April 2012, the Federal Government released *the Living Longer Living Better* (LLLB) aged care reform package.

As part of the reforms, the Aged Care Financing Authority (ACFA) was established to provide independent advice to Government on financing and funding issues in the aged care sector. ACFA is headed by an independent chair. Details of the ACFA's membership can be found at Appendix B.

ACFA was recently given statutory recognition as an independent committee under the *Aged Care Act 1997*.

As part of its remit, ACFA is charged with providing a report to the Government on financing and funding issues in the sector each year. This is ACFA's first report.

ACFA's work in this area is important. The LLLB reforms mean the sector is currently in a state of transition as the reforms are implemented and new funding and financing arrangements take place from 1 July 2014.

The report has been informed by work commissioned by ACFA from KPMG. ACFA worked closely with KPMG in the development of the KPMG reports, which are available at*: www.living longerlivingbetter.gov.au*

To shape this report, ACFA also consulted a small but representative segment of the aged care financing sector. ACFA expects this engagement to continue and expand as it consults on other areas of work within its operating framework and develops future reports.

This report represents a significant step forward in discussing the financing of the aged care sector. This is the first time the entire aged care sector – aged care providers, aged care recipients, financiers and investors, and the aged care workforce - will have ready access to analysis on the entire sector's financial performance and balance sheet as generated from the General Purpose Financial Reports (GPFRs). However, limitations in data and data quality have restricted the ability of ACFA to undertake meaningful analysis upon which to provide comprehensive advice in some areas.

1.1. Outline of this report

ACFA is required under its operating framework to provide advice on the impact of aged care financing arrangements on sector viability, access to quality care, the aged care workforce and sustainability.

1.1.1. Key Objectives of this Report

As this is the first report, and given proposed financing, funding and pricing reforms do not come into effect until 1 July 2014, the key objectives of this initial report are to:

- describe and scale the current state of funding and financing within the sector and establish a baseline and framework to guide analysis in future reports;

- identify potential areas where further data or analysis is required; and

- identify key issues in the current funding and financing of the sector, the impact of the LLLB reforms, and key issues to monitor over the next 12-24 months.

This report primarily focuses on residential aged care providers, reflecting ACFA's work to date and the availability of data. Future reports will include expanded analysis on home care.

1.1.2. Objectives of the aged care financing arrangements

In framing its advice, ACFA is to consider all relevant factors and take into account the Federal Government's broad objectives for aged care financing arrangements which are set out in ACFA's operating framework. These objectives are to:

- support access, quality care, flexibility and choice for care recipients including those with special needs and those living in rural and remote areas;
- recognise that accommodation is essentially a personal responsibility, so that care recipients with sufficient means should pay a reasonable price corresponding to the value of the accommodation services they receive, with appropriate safeguards for people who are marginalised, disadvantaged or have modest means;
- enable efficient aged care providers to:
    - provide quality care for their care recipients, while being appropriately rewarded for the operational risks inherent in operating an aged care business; and
    - make a return on investment that is sufficient to ensure that investment will continue to be made in the aged care sector at the rate needed to meet the demand for services;
- ensure that the cost of aged care remains sustainable for the Australian taxpayer;
- support a stable and skilled workforce that can meet the growing demand for aged care services;
- minimise the regulatory burden placed upon aged care providers;
- maximise competition, while ensuring appropriate consumer protection; and
- ensure that the availability, affordability and quality of aged care services meets the broader community's expectations.

1.1.3. Perspectives

There are a number of key stakeholders in the aged care sector and it is ACFA's intent that the perspectives of all of the following are considered in presenting this report:

- care recipients and their families;
- aged care providers;
- financiers and valuers (upon whose valuations lenders depend);
- current and prospective investors;
- the aged care workforce; and
- Government.

1.2. ACFA's work to date and forward work plan

ACFA's operating framework requires it to provide advice to Government on a range of matters. The following table summarises the key advice provided to date and ACFA's forward work program.

Table 1.1: ACFA's work program

Task	Key Date
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 Refundable Accommodation Deposit (RAD) and a Daily Accommodation Payment (DAP) using a Maximum Permissible Interest Rate (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 advice and KPMG modelling provided to Minister on 22 May 2013. Government released advice and modelling on 23 May 2013.
ACFA Report on the financing of the aged care sector.	30 June 2013
Options for improving the collection of appropriate financial data from aged care providers.	31 July 2013
The financial impacts of any changes that are proposed from the review of the schedule of specified care and services.	31 December 2013
Advice on cost neutral mechanisms to ensure access to care for supported residents, including reviewing the supported resident ratio.	31 December 2013
Advice on the impacts of LLLB reforms on the sector, including the impact of accommodation payment arrangements, choice of payments, means testing, transitional advisory services, and in particular the impact on rural, regional and remote providers.	From 1 July 2014: • monthly reports till 31 December 2014; • quarterly reports from 1 January 2015 until 31 December 2015; and • ongoing advice in its annual report.
Impact of recalibration of basic subsidy levels for home care.	31 December 2014

Five year review including longer term options that support a stable and skilled workforce that can meet the growing demands for aged care services.	30 June 2017

2. Current funding, financing and pricing arrangements for the Aged Care Sector

2.1 Summary

Table 2.1 below shows that the Federal Government is the major contributor of funding to the aged care sector, providing 76 per cent of total funding in 2011-12.

Table 2.1: Commonwealth and resident funding in the aged care sector during 2011-12

	Ref Table	Commonwealth Funding $m	Resident Funding $m	TOTAL $m
Total Residential Care	2.2	8,738.4	3,526.1	**12,264.5**
Packaged Community Care	2.3	1,058.2	80.1	**1,138.3**
Commonwealth HACC	2.4	1,040.0	-	**1,040.0**
Commonwealth contribution to HACC in Victoria and Western Australia	2.4	462.0	-	**462.0**
TOTAL		**11,298.6**	**3,606.2**	**14,904.8**

2.2. Residential Aged Care

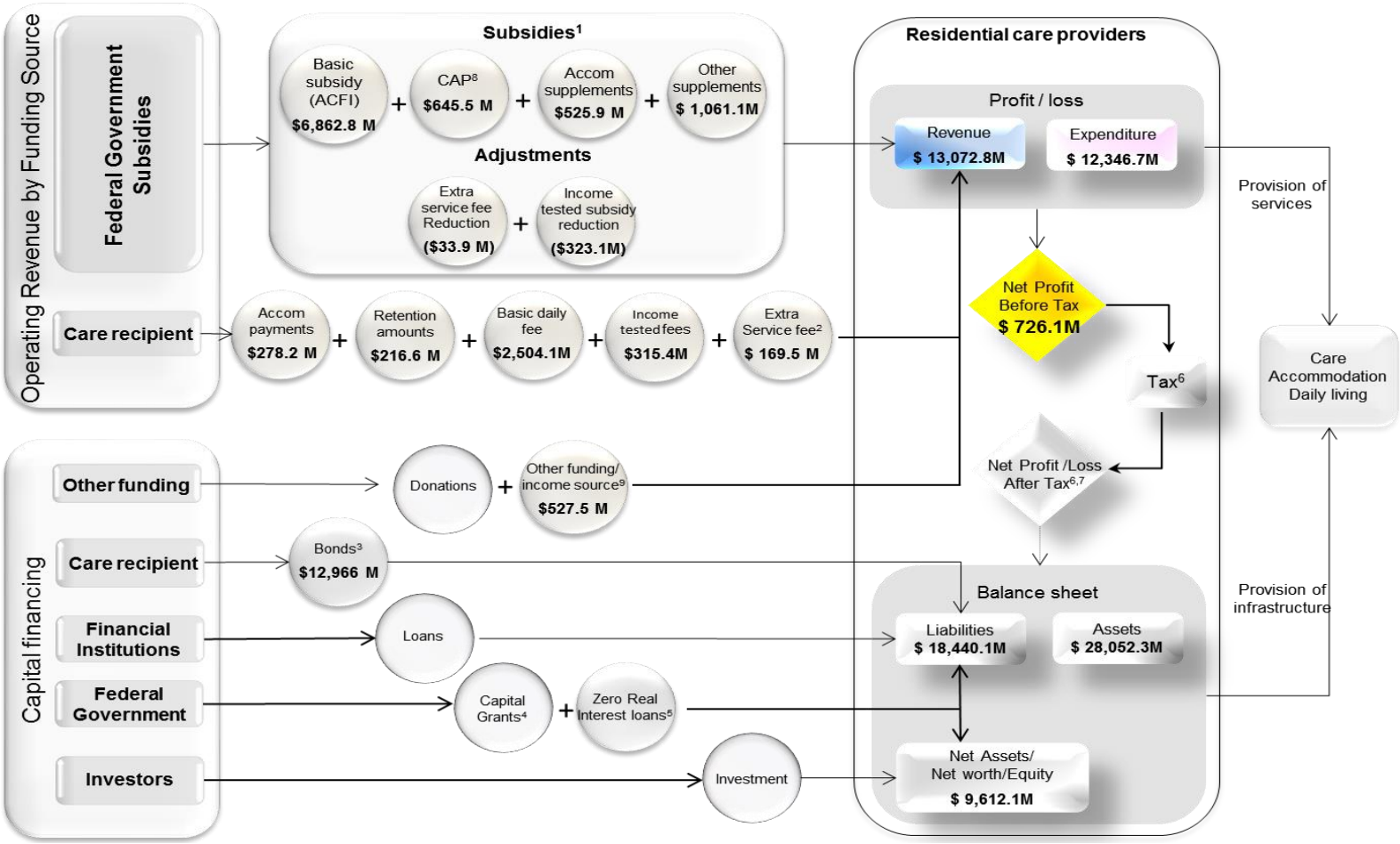
Funding to residential aged care providers is sourced primarily through subsidy payments made by the Federal Government and payments for accommodation and care fees from residents and their families.

Capital financing for residential aged care providers is sourced from equity investments, loans from financial institutions and interest free loans from residents in the form of accommodation bonds. The Federal Government also provides loans and grants to providers in special circumstances.

The sources of funding and financing as at 30 June 2012 in Residential Aged Care are shown in Diagram 1 on page 19[2].

[2] The flow chart is from General Purpose Financial Reports (GPFRs) 2011-12, the 2011-12 Report on the Operations of the Aged Care Act 1997 (ROACA), the Survey of Aged Care Homes (SACH) and the Department's payment system data for 2011-12. The information obtained from GPFRs is prepared by providers of residential aged care under the *Aged Care Act 1997* as part of the eligibility requirements for the Conditional Adjustment Payment (CAP). Notes relating to this diagram and GPFR data are provided at Appendix C.

Diagram 1: Sources of funding and financing as at 30 June 2012 in Residential Aged Care



Notes: (1) Federal Government subsidies represent the entire sector whereas care recipient section represents those providers who have given their GPFRs (95.6% of the sector). **(2)** The extra service fee is an estimated amount which includes the reduction amount adjustment. **(3)** The amount of bonds held as at 30 June 2012 (i.e. not annual flow) by those providers who have given their GPFRs. The Survey of Aged Care Homes found that $4,710.5m were taken in new accommodation bonds in 2011-12. **(4)** In the 2011 Aged Care Approvals Round, up to $58.5 million in capital grants was made available nationally to providers to undertake necessary capital works to establish, upgrade or expand residential aged care services. However, capital grants once executed do not become a liability. **(5)** The Zero Real Interest Loans is the total amount outstanding as at 28 June 2013 and is composed of the amounts executed in Rounds one, two and three applications. **(6)** The amount of tax and Net Profit/Loss After Tax is not given in the GPFRs at the residential aged care segment level by all providers. **(7)** The amount of un-appropriated profit flowing to the Balance sheet is not given by all providers at the residential aged care segment level. **(8)** CAP is the Conditional Adjustment Payment which is paid to eligible providers who meet certain criteria including encouraging staff training, submitting a GPFR and participating in the workforce census. **(9)** The other funding source mainly comprise of interest income (including interest from accommodation bonds), Asset Revaluations, trust distributions and other income ("other income" is not fully detailed in the GPFRs by all providers.

2.2.1. Revenue by Funding Source

2.2.1.1. Federal Government funding

The Federal Government provides around 71 per cent of the total funding in residential aged care. In 2011-12, the Federal Government paid $8.7 billion to approved providers in the form of subsidies on behalf of care recipients which represented nominal growth in expenditure of 9.9 per cent and annual average growth in expenditure of 9.8 per cent since 2007-08. Subsidies paid under ACFI plus primary supplements accounted for approximately 78.5 per cent of this funding, the accommodation supplement for those with low assets accounted for approximately 6 per cent and other supplements the remaining 15.5 per cent.

On 20 April 2012, the Government announced that it would make changes to the ACFI from 2011-12 to bring future growth back to the long term-trend rate of between 2 and 3 per cent above indexation and to redirect funding to other parts of the announced aged care reforms. The impact of the changes has been monitored by an independent group, established to monitor ACFI, with growth for 2012-13 currently estimated to be within the projected range.

The number of residents receiving care has been growing at approximately 1.7 per cent per year over the last five years.

2.2.1.2. Resident funding

It is estimated that residents provided approximately $3.5 billion of funding in revenue in 2011-12 in the form of accommodation payments (periodic payments and retention amounts from lump sum payments), living allowances (basic daily fees and extra services fees) and income tested care fees.

Revenue sources from Federal Government and care recipients are provided in Table 2.2.

Table 2.2: Federal Government and Resident Funding Sources 2011-12

	Commonwealth Funding $m	Resident Funding[1,3] $m	Total $m
ACFI subsidies	6,862.8		6,862.8
- Ratio to total	*78.5%*	-	*56%*
Supplements[2]	1,349.7		1,349.7
- Ratio to total	*15.5%*	-	*11%*
Accommodation payments	525.9	279.2	805.1
- Ratio to total	*6.0%*	*7.9%*	*6.6%*
Retention amounts	-	218.7	218.7
- Ratio to total	-	*6.2%*	*1.7%*
Resident care fees		3,028.2	3,028.2
- Ratio to total	-	*85.9%*	*24.7%*
TOTAL	**8,738.4**	**3,526.1**	**12,264.5**
Funding by source	*71.2%*	*28.8%*	*100%*

Source: *2011-12 Report on the Operations of the Aged Care Act 1997*, *Survey of Aged Care Homes (2012).*
Notes: (1) Includes all residential aged care providers. (2) Amount netted off after adjustments and reductions. Includes Residential Classification Scale (RCS) and other subsidies of $425.7m and supplements (CAP, primary supplements, hardship, viability and supplements related to grandparenting). A further breakdown can be found at Appendix D.
(3) Does not include accommodation bond or associated revenue benefits earned from accommodation bonds (e.g. interest on bonds).

2.2.2. Financing

Financing capital is sourced from equity investments, borrowings and retained profits. The sector overall has net equity of $9.6 billion.

Accommodation bonds paid by residents play a significant role in the sector. At 30 June 2012, $12.966 billion of bonds were held by providers, representing 70 per cent of total sector liabilities. Bonds act as an interest free loan to providers. Accommodation bonds are currently only payable by residents entering low care or an extra service place and are required to be returned, less allowable deductions, when the resident leaves care.

The Federal Government has also made available targeted capital assistance to help providers who are unable to meet the cost of necessary capital works. In the 2011 Aged Care Approvals Round, 19 grants were allocated totalling $58.5 million. The capital grants are made available to providers to undertake necessary capital works to establish, upgrade or expand residential aged care services.

In addition, the Federal Government introduced Zero Real Interest Loans in the 2008-09 Budget which provide interest free loans to residential care providers to build or expand residential and respite care facilities in areas of high need. The total amount executed under the Zero Real Interest Rate Loans to date is $282 million[3]. Since it was introduced, 55 approved providers have executed Zero Real Interest Rate Loan agreements with the Department. The average value of executed Zero Real Interest Loans is $5.1 million.

[3] This amount has been executed from applications for rounds one, two, and three of the Zero Interest Rate Loans. Source : Department of Health and Ageing, *(http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-zero-interest-results.htm)*

2.2.3. Pricing

The Federal Government determines the amount of care subsidies primarily by setting care prices and needs classification criteria within the ACFI; setting the rate of Government accommodation supplement payable on behalf of residents who cannot meet all of their accommodation costs; setting the rates of primary and other supplements payable by the Government. The Government also sets the maximum accommodation charge that residents entering high care can be asked to pay on a daily basis.

Approved providers apply the ACFI to determine the level of basic care subsidy for each resident in care.

The Federal Government sets the maximum rate of the basic daily fee[4] and the maximum daily income tested care fee[5] that can be charged by providers.

Federal Government subsidies and supplements are indexed either biannually (accommodation related) or annually (care related). The indexation factor is applied differently according to the underlying cost drivers of each payment type (e.g. the proportion of wage and non-wage costs within the total cost). To this end, the indexation arrangements use the CPI as a measure of movements in non-labour costs, including for accommodation related supplements, and Fair Work Australia minimum wage adjustments as a measure of non-productivity based movements in wage costs.

Approved providers may charge any price for an accommodation payment provided that after paying the bond the resident is left with a minimum level of assets, currently $43,000.

2.3. Home Care

Funding for home care providers is sourced primarily through payments from the Federal Government and some payments for care fees from consumers and their families.

2.3.1. Home Care Packages

The Federal Government paid approximately $1,058 million in subsidies on behalf of care recipients to home care providers for provision of Home Care Packages (CACP, EACH, EACHD – refer to the Glossary) during 2011-12.

Payments from consumers in the form of care fees are estimated to be $80.1 million. Although the fee levels are regulated, they are charged at the discretion of the provider[6]. A summary of funding in the Home Care Packages sector is provided in Table 2.3.

[4] All residents can be asked to pay the basic daily fee which is a contribution towards living expenses. The maximum is 85% of the single basic age pension.
[5] The income tested care fee is determined based on the resident's assessable income.
[6] The estimate is indexed to current prices for 2011-12 and is based on the 2008 Community Care Census.

Table 2.3: Funding sources from Federal Government and home care recipients during 2011-12

	Commonwealth Payments $m			Recipient's Contribution $m	Total Funding $m	No. of Packages	Per cent
	Basic Subsidy	*Supplements*[7]	*Total Payments*				%
CACP	556.7	5.1	561.8	59.0	620.8	46,518	79
EACH	334.9	1.6	336.5	14.7	351.2	8,503	14
EACH-D	159.6	0.3	159.9	6.4	166.3	4,180	7
Total	**1,051.2**	**7.0**	**1,058.2**	**80.1**	**1,138.3**	**59,201**	**100**

Source for Commonwealth payments: *2011-12 Report on the Operations of the Aged Care Act 1997.*

2.3.2. Home and Community Care

Federal Government funding for the Commonwealth HACC Program in 2011-12 totalled $1.04 billion and the Federal Government's contribution to the jointly funded HACC Programs in Victoria and Western Australia was $462 million, with the total cost of the joint Commonwealth-State program in these States being $769 million. The Commonwealth HACC Program provided services to 481,033 older clients, and the joint Commonwealth-State HACC program in Victoria and Western Australia provided services to 351,878 clients of all ages. The Fees paid by care recipients for HACC services currently vary across States and Territories and in most cases are minimal relative to total funding.

The Victorian and Federal Governments have agreed to split the management of HACC from July 2015 along the same age cohorts as the Commonwealth HACC Program.

Table 2.4 provides total Commonwealth and State contribution and the number of clients supported by HACC.

Table 2.4: Commonwealth and State contribution to HACC

Commonwealth and State contribution to HACC			
	Commonwealth $m	*State $m*	*No. of clients*
Commonwealth HACC	1,040	-	481,033
Contribution Victoria & Western Australia	462	307	351,878
TOTAL	**1,809**		**832,911**

[7] Supplements include viability, oxygen and enteral feeding.

3. Sector Viability – Residential Aged Care[8]

3.1. Context

The ongoing viability of residential aged care providers is essential to meeting the objectives of a sustainable sector and to support the delivery of quality care by an appropriately skilled workforce.

Good financial performance and a sound balance sheet are a central influence on the availability of financing from equity and debt providers.

3.2. Basis of Analysis

The analysis in this chapter has been based on the segment note in the General Purpose Financial Reports (GPFR) submitted by providers as part of the eligibility requirements for the Conditional Adjustment Payment (CAP).

The analysis provided in this chapter should be interpreted using the notes in Appendix E.

This chapter addresses viability in terms of operating performance using commonly accepted indicators of Net Profit Before Tax (NPBT), Earnings Before Interest, Tax, Depreciation and Amortisation (EBITDA), and trends in revenue and expenses. Analysis is provided at the aggregate sector level and at the segment level including consideration of performance by ownership type (for-profit, not-for-profit and government), type of care (high care and low care), location (city and regional) and size of provider (number of homes).

This chapter also addresses balance sheet issues, analyses the sources of financing (equity, traditional borrowing and accommodation bonds) and examines indicators of investment activity and investor sentiment. Where information is available these issues are also examined at different sector segment levels. An overview of the distribution of places at segment level is provided at Table 3.1 on page 25.

[8] Future reports will also examine viability issues affecting Home Care providers.

Table 3.1: Distribution of Places 2011-12 – Residential Aged Care[9]

	TOTAL	Care Type			Ownership Type			Location		
		High care	*Low care*	*Mixed care*	*Not-for-profit*	*For-profit*	*Government*	*City*	*Regional*	*City & Regional*
Providers who reported their GPFRs										
Provider Count	1,054	673	61	320	552	392	110	606	406	42
- Ratio to Total Providers		*63.8%*	*5.8%*	*30.4%*	*52.4%*	*37.2%*	*10.4%*	*57.5%*	*38.5%*	*4.0%*
Services Count	2,716	2,006	69	641	1,623	811	282	1,481	677	558
- Ratio to Total Services		*73.9%*	*2.5%*	*23.6%*	*59.7%*	*29.9%*	*10.4%*	*54.5%*	*24.9%*	*20.6%*
Places	182,663	141,259	2,387	39,017	106,933	64,972	10,758	111,615	33,487	37,561
- Ratio to Total places		*77.3%*	*1.3%*	*21.4%*	*58.5%*	*35.6%*	*5.9%*	*61.1%*	*18.3%*	*20.6%*
Total Sector										
Provider Count	1,103	704	64	335	563	420	120	634	425	44
- Ratio to Total Providers		*63.8%*	*5.8%*	*30.4%*	*51.0%*	*38.1%*	*10.9%*	*57.5%*	*38.5%*	*4.0%*
Services Count	2,777	2,058	71	648	1,650	836	291	1,498	694	585
- Ratio to Total Services		*74.1%*	*2.6%*	*23.3%*	*59.4%*	*30.1%*	*10.5%*	*53.9%*	*25.0%*	*21.1%*

[9] The distribution of providers into care type and location is based on the proportion of 70 per cent or more days of care provided to high care/city area residents.

	TOTAL	Care Type			Ownership Type			Location		
Places	184,570	142,823	2,428	39,319	107,380	66,234	10,956	112,433	33,807	38,330
- Ratio to Total places		*77.4%*	*1.3%*	*21.3%*	*58.2%*	*35.9%*	*5.9%*	*60.9%*	*18.3%*	*20.8%*

3.3. Operating performance-aggregate analysis

This section provides aggregate analysis at the sector level. However, results vary across the sector as outlined later in this chapter. ACFA intends to undertake further work to explore the drivers of different performance results.

3.3.1. Profitability

Pre-tax profitability is variable across the sector. Across all residential aged care providers, approximately 70 per cent made a net profit before tax (NPBT) in 2011-12, an increase from 57 per cent in 2008-09.

3.3.2. EBITDA[10]

EBITDA varies significantly across the sector although 84 per cent of providers made a positive EBITDA in 2011-12. There has been strong growth in EBITDA per resident per annum of around 29 per cent across all providers over 2008-09 to 2011-12 and a reduction in the number of providers with negative EBITDA from 25 per cent to 16 per cent over the same period.

The average EBITDA margin (EBITDA/Total Revenue) for the sector was 12 per cent.

Table 3.2: EBITDA per resident in 2011-12

EBITDA Per Resident Claim Year 2011-12					
	Top Quartile	*Next Top*	*Next Bottom*	*Bottom*	**TOTAL**
EBITDA PRPA[11]	$21,081	$10,394	$5,654	($3,646)	**$9,274**
Provider Count	264	264	263	263	**1,054**

Due to the capital intensive nature of the residential aged care sector, subtracting maintenance capital expenditure from EBITDA can provide a better measure of operating margin. In 2011-12, an average of 7.3 per cent of total expenses was expensed by the sector towards depreciation, amortisation and interest expenses.

Chart 3.1 illustrates a six year trend for expenditure and revenue. More recently the spread has widened between total revenue and total expenses. Total revenue is growing annually at an average rate above 7 per cent whereas total expenses are growing on average at 6 per cent.

[10] Refer to Appendix F for numbers and interpretations.
[11] Per resident per annum.

Chart 3.1: Trend in revenue and expenses

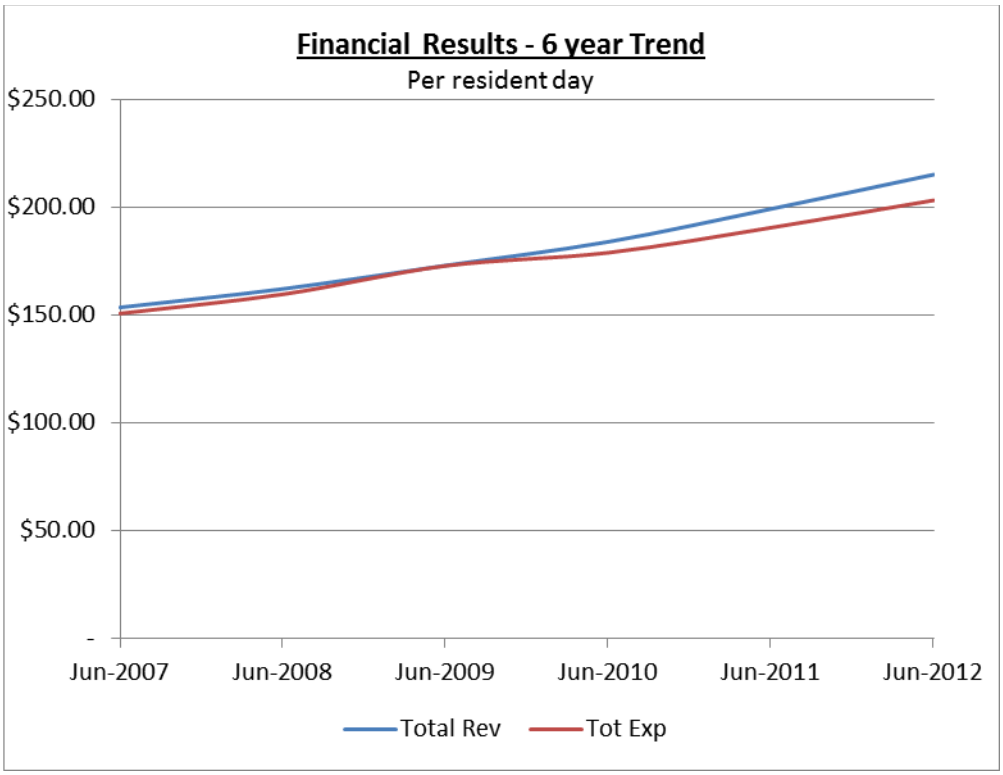


Table 3.3: Average Profitability Margins 2011-12

Profitability Margins 2011-12 (%)	
EBITDA Margin	11.8
Net Profit (Before Tax) Margin	5.6

3.3.3. Revenue

As noted in Chapter 2, Table 2.2, the Federal Government provided around 71 per cent of total funding in residential aged care and paid approximately $8.7 billion in the form of subsidies to residential care providers on behalf of residents in 2011-12.

Federal Government funding is continuing to increase and is projected to be around $11.9 billion by 2016-17 compared with $9.1 billion in 2012-13[12]. Growth in funding per resident is driven by real increases in subsidies and supplements (for example, increased frailty and the introduction of new supplements) and indexation. Funding levels are also driven by an increase in the number of allocated aged care places, which in turn reflects the growth in the population aged 70 years and over.

Residents are the second largest source of funding and were estimated to contribute about $3.5 billion in 2011-12 into the residential aged care sector by way of income tested care fees, periodic accommodation payments and retention amounts withdrawn from bonds. Revenue from residents can be expected to increase under the LLLB reforms with changes to accommodation payments and means tested care fees.

[12] As estimated by the Department of Health and Ageing.

3.3.4. Expenses

The GPFR results indicate that the major expense item for the residential aged care sector is staffing costs which represent an average of 64 per cent of total expenses. Total expenses in 2011-12 were $12.3 billion.

Table 3.4: Proportion of Expenses 2011-12

Proportions of Expenses 2011-12				
	Not-for-profit %	*For-profit* %	*Government* %	**TOTAL %**
Staff Expenses	64.4	63.3	67.9	**64.3**
Depreciation	6.4	3.1	9.2	**5.5**
Interest paid	0.9	2.9	0.5	**1.8**
Other expenses[13]	28.3	30.7	22.4	**28.4**

Expenses as a percentage of total revenue for the past six years is provided at Table 3.5. It shows revenue surpluses (total revenue less total expenses) increasing from 2009-10 to 2011-12.

Table 3.5: Expenses as a percentage of total revenue

Measure	Expenses as % of Total Revenue					
	2006-07 %	*2007-08* %	*2008-09* %	*2009-10* %	*2010-11* %	*2011-12* %
Employee Expenses	64.5	65.9	66.6	65.4	61.9	60.7
Depreciation	4.3	4.8	5.3	5.6	5.5	5.1
Interest Expenses	1.1	1.2	1.5	1.2	1.2	1.1
Other Expenses	28.2	26.6	26.5	25.0	27.0	27.5
NPBT[14]	1.9	1.5	0.1	2.8	4.4	5.6

3.4. Operating performance – segment analysis

Operating performance varies widely across provider ownership type, type of care offered, location of services and size as represented in the following sections. Appendices F to I provide more details on the breakdown.

The analysis and comparisons in the following sections need to be considered with caution. While distinctions between provider type, care type and geographical location may have some impact on performance, there are likely to be other factors, such as management quality and provider efficiency, which are important and which vary throughout the sector and within different segments.

[13] Includes staff on 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 and many providers only report aggregate 'other expenses'.
[14] Net Profit Before Tax.

3.4.1. By Ownership Type

Not-for-profit providers comprise 52 per cent of all providers and run almost 60 per cent of the residential aged care facilities. This group has the highest occupancy rate at an average of 94.7 per cent.

For-profit providers comprise 37 per cent of all providers. They report the highest overall returns and are over represented in the top quartile (62 per cent) for EBITDA.

For-profit providers recorded the largest NPBT margin of 10.5 per cent whereas for not-for-profit providers, the NPBT margin was 4.5 per cent.

State and Territory Government owned providers have a disproportionate share of providers in the lowest quartile and on average have negative EBITDA per resident per annum.

Table 3.6: EBITDA per resident claim year 2011-12 – by ownership

EBITDA Per Resident Claim Year 2011-12 – By Ownership					
	Top Quartile	*Next Top*	*Next Bottom*	*Bottom*	**TOTAL**
Not-for-profit					
- EBITDA PRPA	$19,695	$10,291	$5,726	($2,193)	**$8,176**
- Provider Count	92	155	169	136	**552**
For-profit					
- EBITDA PRPA	$21,786	$10,599	$5,321	($2,260)	**$13,121**
- Provider Count	164	94	75	59	**392**
Government					
- EBITDA PRPA	$24,419	$10,680	$5,940	($8,607)	**($1,508)**
- Provider Count	8	15	19	68	**110**
TOTAL					
- EBITDA PRPA	$21,081	$10,394	$5,654	($3,646)	**$9,274**
- Provider Count	264	264	263	263	**1,054**

Average EBITDA per resident per annum is $9,274. The top quartile has on average EBITDA per resident of $21,081, the second quartile $10,394, the third quartile $5,654 and the bottom quartile negative $3,646.

For-profit providers have on average higher EBITDA per resident per annum ($13,121) than not-for-profit providers ($8,176) and government providers (-$1,508).

Not-for-profit providers comprise 32 per cent of the bottom two quartiles compared with 14 per cent for for-profit providers.

Table 3.7: Profitability Margins

Profitability Margins 2011-12 – By Ownership type			
	Not-for-profit %	*For-profit %*	*Government %*
EBITDA Margin	11.1	15.5	-1.6

Net Profit (Before Tax) Margin	4.5	10.5	-14.1

3.4.2. Type of care – high care and low care

High care providers have higher representation in the top quartile accounting for 83 per cent of all top quartile providers. 80 per cent of all low care providers are in the bottom two quartiles. Mixed care providers performed on average better than low care providers and have higher average EBITDA than low care providers. As noted earlier, comparisons need to be treated with caution. For example, while high care providers have the highest average EBITDA they are amongst the worst performing of the providers in the bottom quartile.

Table 3.8: EBITDA per resident claim year 2011-12 – by care type

EBITDA Per Resident Claim Year 2011-12 – By Care Type					
	Top Quartile	*Next Top*	*Next Bottom*	*Bottom*	**TOTAL**
High Care					
- EBITDA PRPA	$21,390	$10,563	$5,643	($3,759)	**$10,364**
- Provider Count	219	171	150	133	**673**
Low care					
- EBITDA PRPA	$24,476	$9,488	$5,526	($3,480)	**$2,454**
- Provider Count	4	8	16	33	**61**
Mixed care					
- EBITDA PRPA	$17,866	$9,715	$5,689	($3,463)	**$5,812**
- Provider Count	41	85	97	97	**320**
TOTAL					
- EBITDA PRPA	$21,081	$10,394	$5,654	($3,646)	**$9,274**
- *Provider Count*	264	264	263	263	**1,054**

3.4.3. Location - City and Regional; Regional (only); and City (only) providers[15]

City providers have a higher EBITDA than regional providers and higher representation in the top quartile. The providers in city and regional areas report the lowest results in the top quartile but have shown relatively better results overall than regional providers. Although the number of the city and regional providers is small (4 per cent), they account for 20 per cent of all homes. Again, high level comparisons need to be treated with caution. For example, high performing regional providers are performing as well as high performing city providers in the top quartile.

[15] City refers to the ABS Major Cities Classification and Regional to all other locations. In determining the City (only) or Regional (only) providers, at least 70 per cent of subsidy days have to be provided in that geographic classification, otherwise the provider is classified as City and Regional.

Table 3.9: EBITDA per resident claim year 2011-12 – by location

EBITDA Per Resident Claim Year 2011-12 – By Location					
	Top Quartile	*Next Top*	*Next Bottom*	*Bottom*	**TOTAL**
City					
- EBITDA PRPA	$22,012	$10,517	$5,657	($3,557)	**$10,369**
- Provider Count	185	169	133	119	**606**
Regional					
- EBITDA PRPA	$21,979	$10,051	$5,346	($4,310)	**$6,663**
- Provider Count	67	84	122	133	**406**
City & Regional					
- EBITDA PRPA	$17,269	$10,160	$6,012	($2,870)	**$8,354**
- Provider Count	12	11	8	11	**42**
TOTAL					
- EBITDA PRPA	$21,081	$10,394	$5,654	($3,646)	**$9,274**
- Provider Count	264	264	263	263	**1,054**

3.4.4. Provider size

While the variations in EBITDA by provider size are not overly significant, single service providers have the highest average EBITDA followed by those with seven or more homes and those with between two and six homes. Single service providers account for 63 per cent of all providers, but only 25 per cent of total services. Larger providers account for 8 per cent of all providers but 44 per cent of all services.

Table 3.10: EBITDA per resident claim year 2011-12 – by provider size

EBITDA Per Resident Claim Year 2011-12 – By Size					
	Top Quartile	*Next Top*	*Next Bottom*	*Bottom*	**TOTAL**
Single Home					
- EBITDA PRPA	$22,065	$10,282	$5,209	($3,207)	**$9,809**
- Provider Count	186	149	163	169	**667**
2 to 6 Homes					
- EBITDA PRPA	$23,328	$10,473	$5,386	($4,646)	**$8,759**
- Provider Count	65	83	78	81	**307**
7 or More Homes					
- EBITDA PRPA	$18,143	$10,391	$6,036	($2,634)	**$9,309**
- Provider Count	13	32	22	13	**80**
TOTAL					
- EBITDA PRPA	$21,081	$10,394	$5,654	($3,646)	**$9,274**
- Provider Count	264	264	263	263	**1,054**

3.5. Financing structures and balance sheet ratios

The capital structure represents the sources of finance used to generate operating profits. Capital structure and sources of financing in the residential aged care sector, together with a summary of balance sheet analysis and other financial ratios are in the tables below.

Due to a higher proportion of not-for-profit providers in the sector (52 per cent versus 37 per cent in the for-profit), their financial position in aggregate is larger relative to other providers.

Table 3.11: Financial position of Residential Aged Care providers as at 30 June 2012

Financial Position of Residential Aged Care as at 30 June 2012				
	Not-for-profit $m	*For-profit $m*	*Government $m*	**TOTAL $m**
Total Assets	16,191	9,951	1,911	**28,053**
Current Liabilities	6,566	5,775	190	**12,531**
Non-Current Liabilities	2,844	2,792	273	**5,909**
Net Worth/Equity	6,781	1,384	1,448	**9,613**
Accommodation Bonds	7,273	5,377	316	**12,966**

Table 3.12: Proportions of Total Assets – 2011-12

Proportions of Total Assets - 2011-12[16]				
	Not-for-profit %	*For-profit %*	*Government %*	**Total %**
Current Liabilities	42.9	62.9	31.2	50.1
Non-Current Liabilities	14.0	22.4	11.8	17.1
Net Worth/Equity	43.1	14.7	57.0	32.8
Accommodation Bonds	45.6	58.2	19.9	48.4

Table 3.13: Average per Resident Claim Year 2011-12

Average Per Resident Claim Year 2011-12				
	Not-for-profit $	*For-profit $*	*Government $*	**TOTAL $**
Total Assets	161,686	176,590	193,277	**168,611**
Working Capital[17]	(37,020)	(63,912)	4,010	**(45,168)**
Net Worth/Equity	70,371	24,660	149,461	**59,198**
Accommodation Bonds	185,581	233,032	144,575	**201,182**

[16] These proportions have been calculated from providers who have provided complete data against all relevant labels. This is a subset of the data sources used to compile Table 3.11. Accordingly the ratios in Table 3.12 do not correspond directly with the aggregate amounts shown in Table 3.11.

[17] Working Capital is defined as current assets less current liabilities. With the inclusion of the total value of bonds as a current liability, the growth in bonds affects the measurement of working capital.

Table 3.14: Operating performance ratios 2011-12

Operating performance ratios 2011-12				
	Not-for-profit	*For-profit*	*Government*	**TOTAL**
Interest Coverage[18]	14.0	6.2	-9.7	**8.0**
Net Profit Before Tax margin	4.5%	10.5%	(14.1%)	**5.6%**
Occupancy	94.7%	90.4%	91.8%	**93.0%**

Table 3.15: Balance Sheet ratios 2011-12

Balance sheet ratios 2011-12				
	Not-for-profit	*For-profit*	*Government*	**TOTAL**
Current Ratio[19]	0.51	0.46	1.08	**0.50**
Return on Assets[20]	5.1%	7.4%	(0.8%)	**5.5%**
Return on Equity/Net Worth[21]	11.7%	53.2%	(0.7%)	**15.9%**
Bond Asset Cover[22]	2.19	1.72	5.04	**2.06**

3.5.1. Sources of financing

Not-for-profit providers have an average of 43 per cent of financing from equity, while for-profit providers have an average 15 per cent of financing from equity with a higher reliance on debt. Bonds are essentially a source of interest free debt (refer Tables 3.11 to 3.13 for the separation of bond amounts). As not-for-profit providers are less reliant on commercial debt they have a higher capacity to service interest payments from EBITDA with an interest coverage ratio of 14 times their EBITDA compared to six times the EBITDA of for-profit providers.

Bonds have provided residential care providers with an additional source of funds to build, upgrade and maintain facilities.

Another source of capital financing or funding are the donations and bequests which residential aged care homes receive from diverse areas of the community which eventually add to the net worth/net assets of the entity as unappropriated profits. Data provided from the Stewart Brown *Aged Care Financial Performance Survey for 2011-12* indicates that for those aged care providers reporting the receipt of donations, bequests and fundraising, the amount received has increased

[18] Interest coverage shows the number of times that EBITDA will cover interest expense. It indicates an organisation's ability to service the interest on its debt and is calculated by EBITDA/Interest Expense.

[19] Current ratio 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 treatment of bonds will impact on the current ratio.

[20] Return on Assets indicates the productivity of assets employed in the organisation and is calculated by EBITDA/Total Assets.

[21] Return on Equity/Net Worth indicates the productivity of equity/net worth employed in the organisation and is calculated by EBITDA/Net Worth.

[22] Bond Asset Cover provides an indication of the extent to which the accommodation bond liability is covered by assets and is calculated by Total Assets/Total Accommodation Bonds.

from $182.50 per resident per annum in 2010-11 to $317.55 per resident per annum[23]. Given the sample size it is not possible to calculate an aggregate amount.

3.5.2. Role of accommodation bonds

Accommodation bonds as a source of financing have increased in 2011-12 and account for a substantial percentage of providers' total financing. With the inclusion of the total value of bonds as a current liability, the growth in bonds affects the measurement of working capital.

The distribution of bonds by provider type and EBITDA quartile are shown in Table 3.16. The proportion of bonds to residents is fairly evenly spread across provider type and performance quartile.

[23] Of the facilities in the survey, 50.3% reported income from donations, bequests and fundraising in 2011 and in 2012 the proportion was 57.3%.

Table 3.16: Distribution of average accommodation bonds 2011-12, by ownership and EBITDA quartile

Distribution of Accommodation Bonds 2011-12 - By Ownership and EBITDA quartile					
	Top Quartile	*Next Top*	*Next Bottom*	*Bottom*	**Total**
Not-for-profit					
Provider count	92	155	169	136	**552**
Number of providers that held bonds	81	150	156	126	**513**
Proportion of permanent residents that paid a bond in facilities where bonds were held	40.90%	42.70%	37.80%	40.30%	**40.60%**
Average bond per resident	$172,449	$189,756	$173,310	$207,692	**$185,581**
For-profit					
Provider count	164	94	75	59	**392**
Number of providers that held bonds	125	72	59	46	**302**
Proportion of permanent residents that paid a bond in facilities where bonds were held	44.00%	42.40%	49.40%	57.30%	**45.40%**
Average bond per resident	$225,794	$227,175	$251,085	$247,896	**$233,032**
Government					
Provider count	8	15	19	68	**110**
Number of providers that held bonds	7	14	15	50	**86**
Proportion of permanent residents that paid a bond in facilities where bonds were held	38.10%	31.80%	32.20%	27.10%	**28.90%**
Average bond per resident	$157,750	$171,722	$162,501	$133,331	**$144,575**
Total					
Provider count	**264**	**264**	**263**	**263**	**1,054**
Number of providers that held bonds	**213**	**236**	**230**	**222**	**901**
Proportion of permanent residents that paid a bond in facilities where bonds were held	**42.80%**	**42.40%**	**40.00%**	**40.60%**	**41.60%**
Average bond per resident	**$205,983**	**$201,311**	**$192,818**	**$207,430**	**$201,182**

Tables 3.17 to 3.20 provide the distribution of new bonds in 2011-12 by ownership, location, state and size, respectively.

Table 3.17: Distribution of new bonds 2011-12, by ownership

Distribution of new bonds 2011-12 – by ownership						
	Under $250,000 %	*$250,000 - $499,999 %*	*$500,000 - $749,999 %*	*$750,000 - $999,999 %*	*$1,000,000 and above %*	**TOTAL %**
Not-for-profit	55.0	38.8	5.6	0.5	0.2	100
For-profit	36.3	52.6	9.6	1.1	0.4	100
Government	72.0	26.1	1.8	0.2	0.0	100
TOTAL	**47.9**	**44.0**	**7.1**	**0.7**	**0.3**	100

Table 3.18: Distribution of new bonds 2011-12, by location

Distribution of new bonds 2011-12 – by location						
	Under $250,000 %	*$250,000 - $499,999 %*	*$500,000 - $749,999 %*	*$750,000 - $999,999 %*	*$1,000,000 and above %*	**TOTAL %**
Major City	39.3	50.3	9.2	0.9	0.4	100
Regional Areas	69.4	28.5	1.9	0.3	0.0	100
Remote Areas	87.4	10.9	1.7	0.0	0.0	100
TOTAL	**47.9**	**44.0**	**7.1**	**0.7**	**0.3**	100

Table 3.19: Distribution of new bonds 2011-12, by state

Distribution of new bonds 2011-12 – by state						
	Under $250,000 %	*$250,000 - $499,999 %*	*$500,000 - $749,999 %*	*$750,000 - $999,999 %*	*$1,000,000 and above %*	**TOTAL %**
NSW	47.9	42.5	8.3	0.9	0.4	100
VIC	44.3	45.8	8.8	0.8	0.3	100
QLD	53.4	42.5	3.4	0.6	0.04	100
WA	44.8	52.2	2.7	0.2	-	100
SA	58.3	35.2	5.9	0.6	-	100
TAS	60.8	38.4	0.8	-	-	100
ACT	28.7	58.2	12.1	1.1	-	100
NT	86.4	13.6	-	-	-	100
TOTAL	**47.9**	**44.0**	**7.1**	**0.7**	**0.3**	100

Table 3.20: Distribution of new bonds 2011-12, by value of bond and size of facility

Distribution of new bonds 2011-12 – by value of bond and size of facility						
Size of facility by no. of places	*Under $250,000 %*	*$250,000 - $499,999 %*	*$500,000 - $749,999 %*	*$750,000 - $999,999 %*	*$1,000,000 and above %*	**TOTAL %**
1 to 19	82.9	15.7	1.4	0.0	0.0	100
20 to 49	64.8	31.4	3.5	0.3	0.0	100
50 to 99	49.8	43.0	6.5	0.7	0.1	100
100 and above	38.5	50.7	9.3	1.0	0.5	100
TOTAL	**47.9**	**44.0**	**7.1**	**0.7**	**0.3**	100

The average new accommodation bonds for years 2005-06 to 2011-12 is shown in Table 3.21 below.

Table 3.21: Average new accommodation bonds: 2005-06 to 2011-12

Average new accommodation bonds: 2005-06 to 2011-12							
	2005-06 $	*2006-07 $*	*2007-08 $*	*2008-09 $*	*2009-10 $*	*2010-11 $*	*2011-12 $*
Ownership							
Not-for-Profit	135,581	161,001	177,545	201,163	221,226	235,484	236,462
For-profit	167,044	193,099	215,516	237,325	256,068	277,243	298,097
Government	113,943	117,788	135,122	165,184	165,070	185,062	181,581
Location							
Major City	157,520	186,929	207,806	232,311	254,653	276,213	287,902
Regional Areas	114,053	128,157	147,045	165,964	169,355	186,642	189,796
Remote Areas	80,079	89,160	101,483	98,155	120,057	142,972	147,873
State/territory							
NSW	149,453	179,840	198,160	223,481	235,182	250,793	265,356
VIC	154,678	172,166	192,382	213,216	236,421	262,867	274,484
QLD	127,408	156,987	187,287	203,783	229,561	224,408	230,643
WA	112,913	129,935	151,646	188,043	228,193	252,354	248,548
SA	112,866	150,053	172,071	207,802	209,465	234,770	230,402
TAS	117,664	122,870	147,742	171,057	207,033	201,070	208,855
ACT	24,386	227,519	127,851	238,153	315,804	365,937	339,785
NT	211,120	254,786	303,320	286,813	252,240	242,325	172,311
All residents	141,659	167,454	188,798	212,950	232,795	250,256	259,829

3.6. Investment in residential aged care

The viability and long term sustainability of the sector is dependent on ongoing investment in new facilities and upgrading of older facilities. Investment activity reflects expected returns and investor sentiment.

3.6.1. Current Investment Activity[24]

An estimated total of $922 million of new building, refurbishment and upgrading work was completed during 2011-12, involving about 15.3 per cent of all homes. An estimated further $979 million of work was in progress at 30 June 2012, involving about 6.6 per cent of all homes. The value of both completed work and work in progress has been declining in recent years, partly reflecting the global financial crisis (GFC). However, the proportion of aged care facilities planning building work has remained relatively consistent. At 30 June 2012, the proportion of aged care facilities planning upgrading work, which includes both refurbishments and extensions was the highest it had been since 2007-08.

3.6.2. Building and construction statistics

Building statistics data from the ABS[25] show positive signs of investment:

- The total value of building approvals have been trending upward since the LLLB announcements. February 2013 had the highest total approvals ($201 million) for a single month since September 2006.
- In the 12 months to April 2013, the average monthly total building approvals for aged care facilities was $98 million, up from $69 million the previous year and $62 million the year before that.
- In the 12 months to April 2013 there were 10 building jobs approved with values between $20 million and $50 million up from nine building jobs the previous year and five building jobs the year before that.
- This trend also holds for smaller building work ($5 million-$20 million). In the 12 months to April 2013 there were 62 building jobs approved, up from 36 the previous year and 48 the year before that.

While there was a significant decline in the value of building underway from December 2010 to December 2011, as at December 2012, the value of construction work underway in the residential aged care sector was $1.17 billion. This was relatively consistent with the preceding three quarters, where the value of construction underway ranged from $1.18 billion to $1.2 billion[26] and was an increase on December 2011 amounts.

[24] 2011-12 Report on the Operations of the *Aged Care Act 1997* (ROACA).
[25] Building Approvals Cat. No. 8731.0, viewed on 19 June 2013.
[26] Building Activity Cat. No. 8752.0, viewed on 27 June 2013.

3.6.3. Investor sentiment

ACFA engaged with a number of current and prospective investors and investment stakeholders such as advisors and valuers to obtain views on current investor sentiment. While long term investor sentiment remains generally positive there is currently uncertainty over some details of the LLLB reforms and their potential impacts.

These areas will be of key focus for monitoring and ACFA is considering commissioning regular surveys on investor sentiment.

3.6.4. Returns on investment

The Weighted Average Cost of Capital (WACC) represents the cost of capital sourced from equity and debt investments weighted by the ratio of debt to equity in the capital structure. A low risk investment is characterised by a lower rate of return on equity, which by association will also have a lower WACC.

A number of reports have provided estimated ranges for WACC and highlighted that WACC is not fixed across the sector. This is because the equity component of WACC incorporates a company specific premium, and companies and their investments face different costs of debt finance which will be influenced by the operating structure and type of care offered.

PricewaterhouseCoopers (PwC) (2012) provided an indicative analysis of required rates of return in 2012 market conditions. The post-tax rates of return ranged from 8.25 per cent to 10.5 per cent for an established provider. By comparison, in 2011 Deloitte Access Economics (2011) estimated the nominal post-tax WACC at 7.7 per cent (low care) to 8.6 per cent (high care) for for-profit providers and 9.1 per cent (low care) to 10.5 per cent (high care) for not-for-profit providers. Grant Thornton (2012) estimated nominal 2012 post-tax WACC for for-profit and not-for-profit providers at 11.49 per cent to 12.98 per cent for high care, and 10.94 per cent to 12.20 per cent for mixed high-low care.

Table 3.22: Summary of WACC reviews

Summary of WACC reviews			
	PWC	*Deloitte*	*Grant Thornton*
Debt/Equity Ratio	66.67/33.33	60/40	60/40
Cost of debt (%)	6.5 - 8.0	5.65 - 7.95	7.0 - 8.3
Cost of equity (%)	10.6 - 13.6	13.2 - 14.3	20.0
Resultant WACC – low care (%)	8.25 - 10.5	7.7 for-profit 9.1 not-for-profit	10.94 for-profit[27] 12.20 not-for-profit[28]
Resultant WACC – high care (%)	8.2 - 10.5	8.6 for-profit 10.5 not-for-profit	11.49 for-profit 12.98 not-for-profit

[27] For mixed care, as Grant Thornton (2012) analysed only mixed care and high care.
[28] For mixed care, as Grant Thornton (2012) analysed only mixed care and high care.

3.7. Living Longer Living Better reforms

The LLLB reforms can be expected to impact on sector viability in a number of ways. Particular reforms of relevance include:

- Reforms to the accommodation payments system incorporating:
  - Changes to the pricing system – with the harmonisation of high care and low care through the removal of the capping of daily payments in high care and allowing lump sums to be paid in high care.
  - Changes to the mode of payment – with full choice of payment type (lump sum versus periodic) resting with the resident and applying across high care and low care.
- The more than 50 per cent increase in the accommodation supplement being paid for residents with low means in new or significantly refurbished homes.

3.8. KPMG Modelling

ACFA commissioned KPMG to conduct analysis and modelling on the potential impacts of some of the key elements of the LLLB reforms. The overall findings of the analysis are that the reforms can be expected to have an overall positive impact on the level of RAD (bonds) and revenue for the sector.

The analysis looked at impacts on both the profitability and balance sheets of residential aged care providers from a range of the LLLB reforms. In particular, the analysis examined:

- the likely choice an individual will make to pay either a DAP or RAD based on the impact of the choice on the individual's wealth and their individual budget constraints – and the subsequent impact of that choice on providers;
- the impact of the removal of retention amounts on providers;
- the impact of the removal of the current restrictions on accommodation prices in high care; and,
- the impact of extending the ability to pay lump sums (RADs) into high care.

The modelling results[29] estimated that the combined impact of these changes at the aggregate sector level in year one is:

- an estimated $3.4 billion increase in new RADS in high cares;
- an estimated $402.8 million decrease in RADs in low care and extra services high care;

[29] Modelling results available from: (http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-aged-care-acfa-final-recommendation-feedback.)

- an estimated $93.5 million increase in provider income in high care (reflecting the removal of the capping arrangements in high care); and,
- an estimated $68.4 million decrease in provider income in low care (reflecting the removal of retention amounts, but not accounting for a potential offsetting increase in revenue that may arise if residents choose to make combination payments under the new arrangements).

In choosing between a RAD or DAP, the model assumed the care recipient made his or her decision purely on financial considerations. That is, that a person entering residential aged care would make a decision that would maximise their net financial wealth, subject to their own budget constraints. This included consideration of the impacts of the new means testing arrangements, in particular how the former principal residence is treated relative to a RAD. The analysis also noted that in practice there would be a range of non-financial considerations that would influence the choice of an individual and their family.

3.9. Business Advisory Services

The Federal Government has announced that $6.9 million will be available over three years to provide subsidised business advisory services for residential aged care providers to assist them to prepare for and manage the transition to the new accommodation payments system introduced under the LLLB reforms.

3.10. Key Findings

3.10.1. General Observations

While the diversity of the sector makes it challenging to make general conclusions, the following observations can be made from the analysis in this chapter of 2011-12 data:

- Many providers in the sector run a profitable operation – 70 per cent of providers recorded a profit and 84 per cent have a positive EBITDA.
- For-profit providers have on average higher EBITDA per resident per annum ($13,121) than not-for-profit providers ($8,176) and Government providers (-$1,508). For-profit providers also have a higher NPBT margin 10.5 per cent compared to not-for-profit at 4.5 per cent.
- High care providers have on average higher EBITDA per resident per annum ($10,364) than low care providers ($2,454).
- A large proportion of low care providers (80 per cent) are represented in the bottom two quartiles.
- City providers have on average higher EBITDA per resident per annum ($10,369) than regional providers ($6,663).
- EBITDA does not vary significantly by provider size.
- Average return on assets for the sector is 5.5 per cent and average return on equity is 15.9 per cent. In both cases the for-profit sector has higher returns than the not-for-profit sector.
- Average net worth/equity per resident is higher in the not-for-profit sector ($70,371) compared to the for-profit sector ($24,660).

- Average financing from equity is 35 per cent and debt 65 per cent. The not-for-profit sector has an average of 43 per cent of financing from equity compared to 15 per cent for the for-profit sector and accordingly has a lower reliance on debt (including accommodation bonds) and higher interest coverage ratio.
- Accommodation bonds are a significant source of funds and represent 48 per cent of assets for the sector (46 per cent of assets for the not-for-profit sector and 58 per cent of assets for the for-profit sector).

However, these comparisons need to be considered with caution. For example, high care providers in the bottom quartile are also amongst the worst performing on average and those regional providers in the top quartile are on average performing equally as well as city providers. This indicates that while distinctions between provider type and care type and geographical location may have some impact on performance, there are likely to be other factors, such as management quality and provider efficiency, which are important and which vary throughout the sector and within different segments.

The LLLB reforms have created some uncertainty amongst investors but more recent data from the ABS shows positive signs of increasing investment.

The impact of the LLLB reforms will be a key factor in influencing sector viability and investment in the sector into the future. Many aspects of the reforms can be expected to have a positive impact on the sector. KPMG modelling and analysis commissioned by ACFA indicates a positive impact on the sector at the aggregate level. Positive impacts are likely to arise from the removal of regulatory restrictions in charging for accommodation in high care places and the increase in the accommodation supplement for new or significantly refurbished homes.

3.10.2. Data Limitations

Limitations in data and data quality impede the ability to undertake meaningful analysis upon which to provide comprehensive advice in some areas. For example, the GPFR data does not provide information at a facility level limiting the ability to properly analyse information at regional levels.

Also, aged care segment information is not always prepared on a uniform and consistent basis.

An additional indicator of relevance may be EBITDA less maintenance capital expenditure[30] (given the high maintenance costs in the residential care sector). However sufficient information is not currently provided through GPFRs to accurately determine this amount.

ACFA will be reporting separately to the Government on possible areas for improvement in financial data collection. Quality and timely data will be critical in enabling ACFA to meet its obligations in monitoring the impact of the LLLB reforms and providing timely advice to the Government.

3.11. Key issues to monitor and future work

[30] Maintenance that is categorised as of a capital nature based on Australian Taxation Office guidelines and accordingly applied to the Balance Sheet for subsequent amortisation and/or depreciation.

3.11.1. LLLB Reforms

There is a level of uncertainty in sector around some details of the reforms and their potential impact. This uncertainty can be expected to reduce as the new system is implemented and bedded down with the reforms expected to have positive benefits on investment in the longer term.

Of particular concern to some parts of the sector are possible impacts if there is a significant move away from lump sum payments to periodic payments. This issue is of most concern for those providers whose business model is reliant on significant amounts of funding through bonds or who may not receive new bonds from high care (for example low care only providers). It is also relevant to financiers.

The impacts can be expected to vary from provider to provider based on different capital and operational structures.

ACFA will monitor the transition to a choice of payment system for residents and the new accommodation payments system, and in particular the impacts of these changes on providers, financiers and investors. ACFA will be reporting to the Government on a monthly basis on these impacts from 1 July 2014 (refer Appendix A).

3.11.2. Performance Variability

ACFA will work to better understand what is driving the large variability in financial performance of providers including the divergence in profitability and EBITDA, and the nature of services that populate each quartile. This will include research to determine the characteristics of better performers and more efficient providers and any barriers to improve performance.

ACFA will consider what further research is required to understand factors that may affect or limit performance, noting the importance of factors such as management capabilities.

3.11.3. ACFI Changes

ACFA will also monitor the impact of changes to funding from the changes to ACFI that took effect from 1 July 2012, on revenue, profitability and EBIDTA.

4. Access to Care and Quality Care

4.1. Context

Access to aged care will be affected by a range of factors, including the regulated supply of places and demand for places, the particular care needs of the individual and broader demographic considerations, and location. The flexibility of the system and providers to respond to consumer preferences is also an important access consideration.

The quality of the care provided is integral to ensuring the health and wellbeing of the care recipient.

Funding, financing and pricing arrangements can affect access in a number of ways. For example, through assistance aimed at ensuring access by low wealth individuals and supporting facilities in remote and regional locations.

There are a number of indicators which can be used to measure access to care, including availability of beds compared to demand assessment and waiting times; and representation of special needs groups.

There are also a number of existing programs which consider issues of quality of care. Reforms are proposed under LLLB to develop additional quality indicators.

4.2. Access to Care

4.2.1. Supply of places - overview

The current planning framework for services provided under the *Aged Care Act 1997* aims to keep the growth in the number of Federal Government subsidised aged care places in line with growth in the aged population, and to ensure a balance of services across Australia, including services for people with lower levels of need and in rural and remote areas. The current national provision ratio is 113 operational aged care places per 1000 of the population aged 70 years and over. Within this overall target provision ratio of 113 places, 42 places should be residential high care, 44 places should be residential low care, and 27 places should be community care, with six of these places being for high level community care.

The total number of individuals receiving aged care services is shown in Table 4.1 as at 30 June each listed year. A break-down by provider type as at 30 June 2012 is provided in Table 4.2. Table 4.3 provides forecasting of home care places and residential aged care places up to 2021-22.

Table 4.1: Number of Home Care Packages and residential care operational places

Type of care		2008	2009	2010	2011	2012
CACP	Packages	39,552	40,195	42,634	45,096	46,518
EACH	Packages	4,244	4,478	5,587	8,150	8,503
EACHD	Packages	1,996	2,036	2,583	3,995	4,180
Total for Home Care Packages		**45,792**	**46,709**	**50,804**	**57,241**	**59,201**
Residential	Operational places	171,832	175,225	179,749	182,302	184,570

Source: 2007-08 to 2011-12 Reports on the Operations of the *Aged Care Act 1997*

Table 4.2: Number of packages and places by ownership status as at 30 June 2012

Package type	Religious	Charitable	Community based	For-profit	State govt.	Local govt.	TOTAL
CACP	16,474	14,299	7,868	2,855	2,450	2,572	**46,518**
EACH	3,366	3,154	862	753	240	128	**8,503**
EACHD	1,704	1,559	397	402	82	36	**4,180**
Total for Home Care Packages	**21,544**	**19,012**	**9,127**	**4,010**	**2,772**	**2,736**	**59,201**
Allocated residential care places	54,544	36,316	26,898	81,442	9,308	1,991	**210,499**
Operational residential care places	50,259	32,384	24,767	66,335	8,934	1,891	**184,570**

Source: 2011-12 Report on the Operations of the *Aged Care Act 1997*

Table 4.3: Projected home care places and residential aged care places to 2012-22[31].

Aged care reform projected places by home care and residential care										
	2012-13	*2013-14*	*2014-15*	*2015-16*	*2016-17*	*2017-18*	*2018-19*	*2019-20*	*2020-21*	*2021-22*
Total Home Care Packages	61,971	66,958	70,808	76,269	96,255	103,865	114,880	126,903	137,222	144,404
Total Residential Packages	192,284	197,052	202,995	210,396	218,930	227,912	236,685	244,861	252,374	259,468

[31] The variation from population ratios is due to projected places coming on-line as per Departmental modelling.

4.2.2. Supply of Home Care packages and HACC places

Not-for-profit providers are the major providers of home care, accounting for 49,683 packages, compared to 4,010 (7 per cent of the total) delivered by for-profit providers and 5,508 packages being delivered by state and local government owner providers.

EACH and EACHD packages have shown the strongest growth in recent years although lower level CACP packages still have the largest number of recipients.

Table 4.4: Growth in community care recipients and places

Number of Community Care Recipients and Places				
	2009	*2010*	*2011*	*2012*
Community Aged Care Packages				
Total operational places	40,195	42,634	45,096	46,518
- Growth		*6.1%*	*5.8%*	*3.2%*
Total recipients	38,039	40,123	40,966	42,835
- Growth		*5.5%*	*2.1%*	*4.6%*
Recipients where age is 70 or more years	34,227	36,248	37,276	39,118
- Growth		*5.9%*	*2.8%*	*4.9%*
Extended Aged Care Home				
Total operational places	4,478	5,587	8,150	8,503
- Growth		*24.8%*	*45.9%*	*4.3%*
Total recipients	4,153	5,248	6,898	7,757
- Growth		*26.4%*	*31.4%*	*12.5%*
Recipients where age is 70 or more years	3,529	4,492	5,935	6,773
- Growth		*27.3%*	*32.1%*	*14.1%*
Extended Aged Care Home - Dementia				
Total operational places	2,036	2,583	3,995	4,180
- Growth		*26.9%*	*54.7%*	*4.6%*
Total recipients	1,871	2,291	2,966	3,383
- Growth		*22.4%*	*29.5%*	*14.1%*
Recipients where age is 70 or more years	1,695	2,081	2,688	3,092
- Growth		*22.8%*	*29.2%*	*15.0%*

Source: Reports on the Operations of the *Aged Care Act 1997; DoHA payment system.*

The number of community care recipients by geographic area at 30 June 2012 is provided in Table 4.5. The distribution of package types is broadly similar across geographic areas, although there are proportionally less EACHD packages in remote and very remote areas, where they represent only 2 per cent of all packages in these areas. In other areas, EACHD packages range between 6 per cent and 7 per cent of the packages offered in that area.

Table 4.5: Community care recipients by remoteness at 30 June 2012

Remoteness Area	CACPs	EACH	EACHD	TOTAL
Major Cities	29,112	5,267	2,342	**36,721**
Inner Regional	9,457	1,749	746	**11,952**
Outer Regional	3,303	649	278	**4,230**
Remote	546	73	16	**635**
Very Remote	417	19	1	**437**
TOTAL	**42,835**	**7,757**	**3,383**	**53,975**

A summary of HACC numbers for 2011-12 by State and Territory is provided in Table 4.6.

Table 4.6: HACC client numbers for 2011-12, broken down by State and Territory, by client cohort

No. of HACC Recipients	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	TOTAL
Older persons	217,252	209,634	147,919	56,192	80,911	22,624	9,729	2,598	**746,859**
Younger persons with a disability	50,605	71,468	37,366	13,994	22,711	6,179	3,775	1,217	**207,315**
Unknown age	939	454	180	136	1,296	30	35	204	**3,274**
TOTAL	**268,796**	**281,556**	**185,465**	**70,322**	**104,918**	**28,833**	**13,539**	**4,019**	**957,448**

4.2.3. Supply of residential care places

At 30 June 2012, there were 184,570 operational residential care places (beds) in Australia. On 30 June 2012, 132,760 residents were receiving permanent residential high care while 34,249 were receiving permanent residential low care (DoHA 2012a). The growth in residential aged care residents and places is provided in Table 4.7.

Table 4.7: Growth in Residential aged care residents and places

Number of Residential Aged Care Residents				
	2009	*2010*	*2011*	*2012*
Total operational places	175,225	179,749	182,302	184,570
- Growth		*2.6%*	*1.4%*	*1.2%*
Total residents	158,863	162,611	165,276	167,009
- Growth		*2.4%*	*1.6%*	*1.0%*
Residents where age is 70 or more years	147,153	150,820	153,176	155,057
- Growth		*2.5%*	*1.6%*	*1.2%*
Residents where age is 85 or more years	88,003	91,444	93,835	96,036
- Growth		*3.9%*	*2.6%*	*2.3%*

Source: DoHA (2012a) and DoHA calculations; 2008-09 to 2011-12 Reports on the Operations of the *Aged Care Act 1997*

4.2.3.1. Number of providers

In 2011-12 there were 1,054 residential age care providers. There has been a reduction in the number of providers over recent years. In 2006-07 there were 1,282 providers. This reduction has been driven by consolidation and multiple provider groups rearranging their organisational structure to operate under a single provider structure.

Religious, charitable and community-based providers provide 58.2 per cent of operational residential care places (107,410 out of 184,570). For-profit providers provide 35.9 per cent of operational residential care places while the remainder were operated by state and local government owned providers.

4.2.3.2. High care/low care

Around 64 per cent of providers operate predominantly high care facilities, while 30 per cent operate low and high care (mixed care), and 6 per cent operate predominantly low care facilities.

There has been a recent shift away from low care and mixed care towards delivering high care only, as shown by the increase in the proportion of high care only providers between 2006-07 and 2011-12 from 45 per cent to 64 per cent (refer to Table 4.8).

Table 4.8: Operators by type of care

Operators by Care Type – Residential care						
	2006-07 %	*2007-08 %*	*2008-09 %*	*2009-10 %*	*2010-11 %*	*2011-12 %*
High care	45	48	55	56	56	64
Low care	16	13	7	7	7	6
Mixed care	39	39	38	37	37	30
TOTAL	100	100	100	100	100	100

Source: DoHA (2012b)
Note: The distribution of providers by care type is based on the proportion of 70 per cent or more days of care provided to high care residents.

This shift most likely reflects the sector adapting to the increasing number of high care residents, driven by the ageing in place provisions, whereby residents entering as low care residents can continue in the same facility as their care needs increase and the increasing longevity of Australia's aged population. In 2011–12, 54.6 per cent of operational residential care places that were allocated as low care were utilised for high care.

In 2011-12, 59 per cent of admissions were into high care. The operational places are evenly split between high (91,439) and low care (93,131). The over representation of high care admissions is due to the higher turnover of high care residents. Table 4.9 provides the number of first admissions into permanent residential aged care, by care type and extra service status in 2011-12.

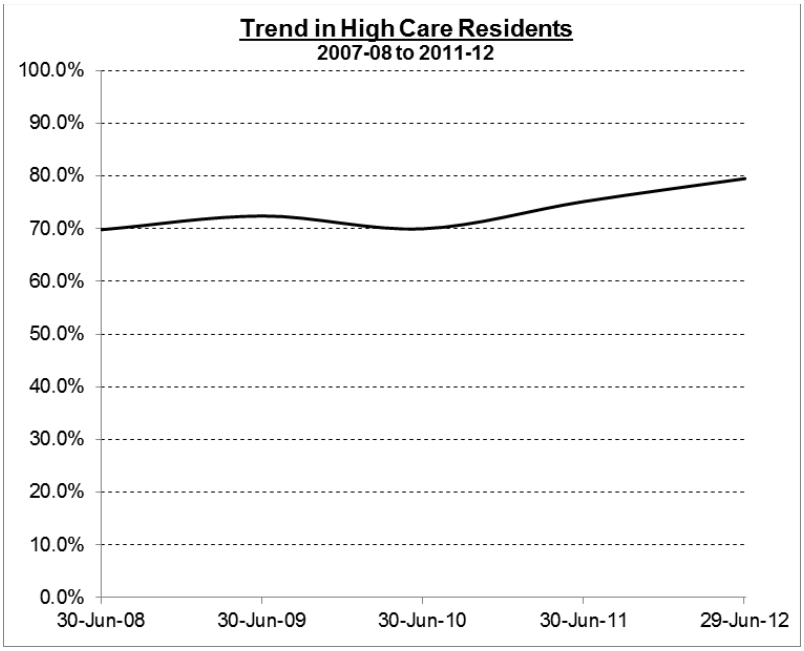
Table 4.9: Number of first admissions into permanent residential aged care, by care type and extra service status and as a proportion of total admissions in 2011-12.

No. of first admissions into permanent residential care			
	High care	*Low care*	**TOTAL**
Extra services	3,264 *6%*	1,306 *2%*	**4,654** ***8%***
Non-extra services	29,723	21,678	**51,604**

No. of first admissions into permanent residential care			
	53%	*39%*	***92%***
All admissions	33,063 *59%*	22,984 *41%*	**56,258** ***100%***

Chart 4.1 shows the number of high care residents has been increasing as a proportion of all residents.

Chart 4.1: Trend in high care residents



Note: On 1 January 2010, the definition for High Care under the ACFI was changed. This resulted in a structural shift in the proportion of high care residents reducing by 6.6 percentage points. (See http://www.health.gov.au/internet/main/publishing.nsf/Content/F4DC4192EE235386CA25740C000555E6/$File/acfi_fact_sheet11.pdf)

4.3. Demand

A person's aged care pathway is unique, determined by a range of factors including their preferences, informal care support, access to formal care services and their care needs. Many people prefer to be cared for at home for as long as possible, although this may not be possible for everyone.

The Productivity Commission's report on *Caring for Older Australians* concluded that there are future challenges in the aged care sector with the increasing numbers and expectations of older people, a relative fall in the number of informal carers and the need for more workers.

4.3.1. Unmet needs

Results from the ABS Survey of Disability Ageing and Carers (SDAC) suggest that unmet needs have increased for those aged 85 years and older (ABS 2009). Of those people aged 85 years or over in 2009, who were living in households and who self-identified as having a need for assistance with at least one everyday activity, 30.2 per cent reported that their need for assistance was not fully met.

This is in contrast to the rest of the population under 85 years, where unmet demand has been falling.

4.3.2. Different care needs

The need for complex care such as dementia care, diabetes and other morbidities associated with longevity, as well as palliative and end-of-life care, will continue to increase the demand for high care in residential aged care facilities. Residents over the age of 80 years in residential care increased from 64 per cent in 1998-99 to 74 per cent in 2010-11 (SCRGSP 2012).

In 2012, 73 per cent of operational places were utilised for high care, compared to 65 per cent in 2007 (DoHA 2012a; DoHA 2007). The utilisation of residential aged care places from 2008 to 2012 is provided in Table 4.10.

Table 4.10: Utilisation of Residential Aged Care places

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 (%)
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: Reports on the Operations of the *Aged Care Act 1997* (2006-07 to 2011-12)

4.3.3. Usage by Indigenous Australians and those from culturally and linguistically diverse backgrounds

At 30 June 2012, on average, Indigenous Australians and people born in non-English speaking countries had lower rates of use of aged care services compared with the population as a whole.

Nationally, the number of Indigenous CACP recipients per 1000 Indigenous Australians aged 50 years or over was 24.5. This has been relatively unchanged since 2006. Indigenous Australians represent 4.6 per cent of all CACP care recipients, but only about 1 per cent of all residential care recipients.

The number of people from a non-English speaking country in high care per 1000 care recipients from a non-English speaking country aged 70 and over has been increasing since 2007 from 35.6 to 53.2. However, this represents only a marginal increase as a proportion of all high care residents has from 15.9 per cent in 2007 to 17.9 per cent in 2012.

Nationally, the number of Indigenous HACC recipients per 1000 Indigenous Australians aged 50 years or over was 219.1 and the numbers of HACC recipients from non-English speaking countries per 1000 people aged 65 years or over was 220.8. These numbers compare to a total of 225.3 per 1000 of the aged care target population (people aged 65 years or over and Indigenous Australians aged 50–64 years). The monthly hours of service for Indigenous and non-Indigenous HACC clients aged 50 years and over are 5.8 and 3.7 respectively.[32]

[32] Table A8: Home and Community Care Program, Minimum Data Set 2010-11 Annual Bulletin, Department of Health and Ageing.

Several factors need to be considered in interpreting the results for this set of measures. Cultural differences can influence the extent to which people born in non-English speaking countries use different types of services. Similarly, cultural differences and geographic location can influence the extent to which Indigenous Australians use different types of services.

4.3.4. Usage by supported residents in residential care

The proportion of permanent residents classified as supported during 2011-12 was 38.2 per cent nationally but varied across regions. This was only marginally greater than the proportion in 2010-11 which was 37.9 per cent. The Federal Government assists with the accommodation costs for these residents, paying $525.9 million in accommodation supplements for this group in 2011-12. The supplement is reduced if a provider does not achieve a 40 per cent occupancy by supported residents. Government planning guidelines also require that services allocate a minimum proportion of residential places for supported residents. These targets range from 16 per cent to 40 per cent of places, depending on the service's region. The targets are intended to ensure that supported residents have equal access to care.[33]

4.3.5. Indicators on assessment and waiting times

A person must receive an Aged Care Assessment Team (ACAT) assessment before they can enter Australian Government funded residential aged care services. Total aged care assessments have declined from 78.3 in 2009-10, 74 in 2010-11 and 73.2 in 2011-12 per 1,000 people aged 70 and over and Indigenous Australians aged 50-69 years.

This coincides with legislative amendments intended to reduce the number of reassessments. For example, as a result of the changes, ACAT approvals for some types of care would no longer automatically lapse after 12 months. Between 2008-09 and 2011-12 the number of completed assessments decreased by 9.6 per cent. Over the same period the waiting time between referrals and first intervention also decreased.

The median days of waiting between an ACAT assessment and entry into residential care remains relatively unchanged in high care and has been decreasing in low care. During 2011-12, the median wait time for entry into high care was 28 days. For low care the median wait time has decreased from 66 days in 2006-07 to 56 days in 2011-12.

There have also been solid improvements in the wait time for residents entering aged care from hospital. In 2007-08, a person (non-indigenous Australian) requiring residential aged care would wait 14.6 days per 1,000 patient days in hospital which had reduced to 11.7 days by 2010-11.

Overall, 69.5 per cent of all people commencing a CACP during 2011-12 began their package within three months of being approved by an ACAT. This proportion varied across jurisdictions. On average, 39.1 per cent started receiving a CACP within one month of their ACAT approval.

[33] Under its operating framework, ACFA is due to provide advice to the Minister by 31 December 2013 on cost neutral mechanisms to ensure access to care for supported residents, including reviewing the efficiency, effectiveness, and appropriate level of the supported resident ratio for each aged care planning region, and the '40 per cent' rule for the Accommodation Supplement.

The figures on wait time must be considered with caution. There are a number of factors which may influence time before entry/commencement which are not a result of availability. These factors include hospital discharge policies and practices; client choice not to enter residential care immediately, but to take up the option at a later time; and variations in building quality, perceived quality of care and care fee regimes, which can influence client choice of preferred service and delay take up of care.

4.4. Quality of Care

There are a number of existing mechanisms in place that address quality of care issues. The aged care accreditation standards provide expected standards of quality of care and services to be provided to residents. The standards set expected outcomes across four areas: (1) Management systems, staffing and organisational development; (2) Resident health and personal care; (3) Resident lifestyle; and, (4) Physical environment and safety systems. The standards are legislated under the Quality of Care Principles 1997 and assessed and monitored by the Aged Care Standards and Accreditation Agency. In addition, the Aged Care Complaints Scheme provides a free service for people to raise concerns about the quality of care or services being delivered to people receiving aged care services.

Chapter 13 of the Steering Committee for the Review of Government Service Provision report (SCRGSP 2013) identifies other possible indicators to measure quality of care, including 'maintenance of individual physical function', 'client appraisal of service standards', 'social participation in the community', and 'hospital leave days for preventable causes'.

Quality indicators have also been developed by the Victorian Government for use in their residential aged care services.

There are also other measures, some less objective, which can assess the quality of care. These include the ability of a provider to meet the client's expectations, ensuring a skilled and sufficient workforce exists and adapting work practices as new research emerges. Clinical indicators such as nutrition, medication and pressure injuries, falls, weight change, and adverse drug events can also be used to assess the quality of care.

Other indicators are a provider's ability to adapt work practices to new research and agreed best practice. This can have an impact on the quality of care through improved productivity, efficiency gains and a reduction in injuries.

The Government has announced as part of the LLLB reforms that it will be developing indicators to assist in monitoring and measuring the quality of care. These indicators are currently being developed by the Government in consultation with sector and are expected to be in place by 1 July 2014.

ACFA's focus in this area is in assessing the impacts of funding, financing and pricing arrangements on quality of care. ACFA will give further consideration to how best to use these existing mechanisms and other existing and proposed indicators of quality in undertaking this work.

4.5. Impact of Living Longer Living Better reforms

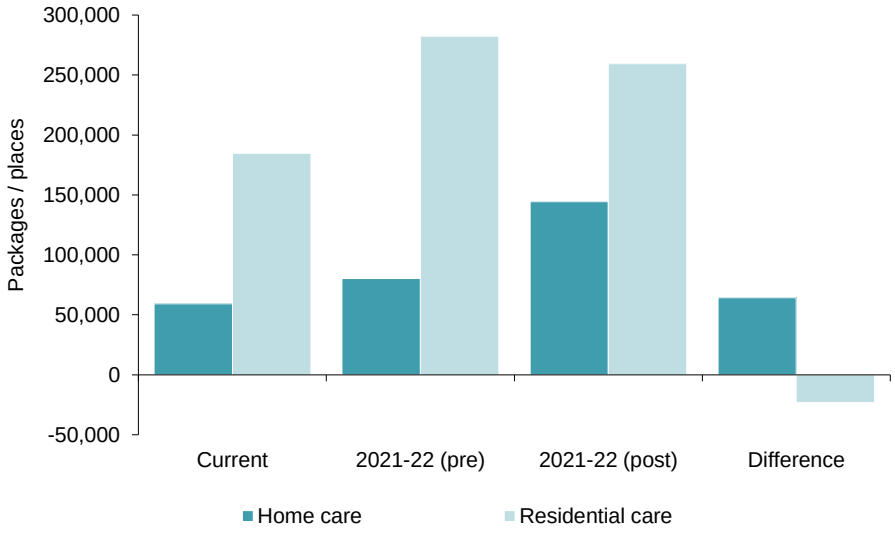
A number of the LLLB reforms are likely to impact on access to quality care.

Changes such as the Aged Care Gateway and Better Health Connections initiatives will increase access to information on aged care services and assist people accessing services.

Changes to the allocation ratios between home and residential care will also have an impact. The number of home care packages is increasing from 27 to 45 per 1000 people aged 70 years and over whereas the number of residential aged care places is reducing from 86 to 80 per 1000 places aged 70 years and over. This change will lead to approximately 85,000 additional home care packages and approximately 75,000 residential care places by 2021-22. This will translate into approximately 64,000 more home care places but approximately 23,000 less residential care places when compared to projections under current provision ratios.

The current split of packaged care into CACP, EACH and EACHD is being replaced by a new structure involving 4 levels of care - Level 1 basic care, Level 2 low level care, Level 3 intermediate care and Level 4 high care. Providers who deliver home care at any level will also be able to receive a new dementia and cognition supplement or veterans' supplement if the care recipient meets certain eligibility requirements.

Chart 4.2: Projected care packages and operational places pre and post LLLB reforms



Source: KPMG calculations.

In terms of the funding, financing and pricing arrangements, a number of aspects of the reforms could potentially impact on access:

- Changes to the accommodation payments arrangements, including enhancements to improve transparency through publication of prices, the new arrangements for providers to follow in setting accommodation prices, and changes to the high care accommodation payment arrangements.
- Changes to means testing arrangements in residential care and income testing arrangements in home care.
- The increased accommodation supplement for supported residents in new or significantly refurbished homes.
- Support for certain rural and remote facilities and those providing care to special needs groups.
- The overall impact on sector viability and investment in the sector from the reforms.

ACFA will monitor the impact of reforms to the financial arrangements on access to care and quality care, including the impact of changed provision targets and if the targets meet needs.

4.6. Findings and focus for future work

Access to aged care will be affected by a range of factors of which funding and financing arrangements are one part. Existing funding and financing arrangements continue to contribute significantly to enhancing access to care:

- Federal Government funding through the ACFI supports the provision of care and limits the level of contributions required from care recipients.
- Fees that can be charged are restricted, limiting the level of contributions required from care recipients.
- Specific assistance is provided to those with low means through the Federal Government's accommodation supplement to fully or partially meet accommodation costs.
- Federal Government support is available for facilities that provide care in particular geographic areas or for special needs groups.

Funding and financing arrangements will also affect access to care at a more macro level, through their impact on sector viability, performance and their impact on investment in the sector which will influence the number of places available.

There is limited data or research currently available that assesses the specific impact of funding and financing arrangements on the quality of care provided.

ACFA intends to undertake further analysis in this area. ACFA is already charged with reviewing the impact of supported resident ratios on access to care and examining the impact of the recalibration of home care subsidies on access to care. ACFA will similarly monitor and report on the impact of changes to funding and financing arrangements in residential and home care. This will include the impact of the changes to the accommodation payments arrangements and the means testing arrangements under the LLLB reforms on access to care.

In undertaking this work ACFA intends to, in particular, take into account issues relating to access for special needs groups, such as those from CALD backgrounds and the homeless, those with complex care needs, those on lower incomes and issues relating to access in rural and remote areas.

5. Workforce

5.1. Context

ACFA is required to report in time to inform the five year review of the LLLB reforms on longer term options to support a stable and skilled workforce that can meet the growing demand for aged care services.

A capable workforce, that meets the needs of the recipients of aged care, is essential to a strong and effective aged care system. It will provide the appropriate number of workers with the right skills mix to deliver quality care.

Achieving these objectives for the aged care workforce requires an understanding of the needs of aged care recipients, the workforce dynamics and aged care providers.

In this and future reports, ACFA will focus on assessing the current state of the workforce, identifying challenges and monitoring the impact of funding and financing arrangements on workforce issues.

5.2. Workforce Statistics

The following analysis focuses on direct care workers in the residential aged care and community aged care sectors. This includes Nurse Practitioners (NP), Registered Nurses (RN), Enrolled Nurses (EN), Personal Care Attendants (PCA) / Community Care Workers (CCW), Allied Health Professionals (AHP) and Allied Health Assistants (AHA). Non-direct care workers would include managers and administration and ancillary staff.

The following analysis and data is drawn from the Aged Care Workforce 2012 - Final Report produced by the National Institute of Labour Studies (NILS), Flinders University and commissioned by the Department of Health and Ageing.

5.2.1. Numbers employed

Tables 5.1 and 5.2 below set out the size of the direct care workforce in the residential and community aged care sectors, the proportion of workers working on a casual/contract, part-time or full-time basis and breaks down the total number of direct care workers by occupation.

Table 5.1: Direct care employees in residential aged care and community aged care, by size and form of employment as reported in 2012

	Residential aged care	Community aged care
Size of direct care workforce	147,086	93,359
Proportion of workforce in full-time equivalent	9.5%	10.6%
Proportion of workforce in part-time equivalent	71.8%	62.1%
Proportion of workforce in casual or contract	18.7%	27.3%

Table 5.2: Direct care employees in the residential aged care and community aged care workforce, by occupation as reported in 2012 (estimated headcount and per cent)

Occupation	Residential Aged Care Headcount	Community Aged Care Headcount
Personal Care Attendant (PCA)	100,312	-
- ratio to total (%)	*68.2*	
Community Care Worker (CCW)	-	76,046
- ratio to total (%)		*81.4*
Registered Nurse (RN)	21,916	7,631
- ratio to total (%)	*14.9*	*8.2*
Enrolled Nurse (EN)	16,915	3,641
- ratio to total (%)	*11.5*	*3.9*
Allied Health Professional (AHP)	2,648	3,921
- ratio to total (%)	*1.8*	*4.2*
Allied Health Assistant (AHA)	5,001	1,919
- ratio to total (%)	*3.4*	*2.1*
Nurse Practitioner	294	201
- ratio to total (%)	*0.2*	*0.2*
TOTAL	**147,086**	**93,359**
	100%	***100%***

In residential aged care, PCAs are the largest occupational group and also the group growing at the fastest rate. The mix of qualified nurses has diminished in the ten years since 2003 with the proportion of RN declining from 21.0 per cent to 14.9 per cent and a small decreases in EN from 13.1 per cent to 11.5 per cent. However, the rate of decline in qualified nurses has slowed between 2007 and 2012. Over the ten-year period there has also been a significant up-skilling of the non-nursing care staff.

In community care, CCW comprise 81.4 per cent of all employees in the direct care workforce. The proportion of RN (8.2 per cent) has decreased by 2.0 per cent in the five years to 2012, but over the same period the proportion of EN has increased from 2.7 per cent to 3.9 per cent.

The aged care workforce has been relatively stable since 2003, with approximately one-third of residential aged care workers and one-quarter of community aged care workers having been in the sector for 15 years or more. This is the case even though there has been a large growth in the aged care workforce. Further, less than 5 per cent of the aged care workforce expressed a desire to leave the sector in the short term. Workers also expressed a high level of job satisfaction.

However, there appears to be a high level of mobility within the sector. Nearly 50 per cent of the direct care workforce had worked in aged care prior to getting their current job, which is particularly the case for RN (71 per cent) and ENs (63 per cent).

However, the reasons for mobility seem unrelated to conditions of employment and relate more to the personal circumstances of the employee. The large growth in the sector would have provided opportunities for staff to pursue options that suited their personal circumstances.

5.2.2. Vacancies and skills shortages

Around three quarters of residential aged care facilities reported skills shortages in 2012 whilst 50 per cent of community care providers reported skills shortages.

RN are the most commonly reported skill shortage in residential care (reported by 62 per cent of facilities) followed by PCAs (reported by 49 per cent of facilities).

The time taken to fill vacancies can also be an indicator of worker shortages in the aged care sector.

The time taken to fill vacancies in the residential aged care sector has been decreasing since the 2007 census. More than half of vacancies for enrolled nurses and over two-thirds of vacancies for AH occupations were filled within one week.

Filling RN positions remains a challenge in the residential age care sector. On average it takes 7 weeks to fill a RN position. The median time is 2 weeks which suggests some facilities take much longer to fill RN vacancies than others. Around 30 per cent of RN vacancies took more than four weeks to fill. However, this is an improvement on 2007 when 38 per cent of facilities took longer than four weeks to fill RN vacancies.

In community aged care, CCW are the most commonly reported shortage (reported by 37.2 per cent of providers) followed by RN (15.7 per cent of providers).

In the community care sector the time taken to fill vacancies has increased since the 2007 census, most notably for RN, EN and AH occupations. For all vacancies, other than CCW, more than half were filled within two weeks. Over three-quarters of vacancies for CCW took four weeks to fill.

For both the residential and community aged care sectors, vacancies take longer to fill in rural and remote areas than in the city.

5.2.3. Gender

Only 10 per cent of the aged care direct care workforce in residential and community aged care is male. In residential aged care there has been a 7 per cent increase in the number of male staff since 2007. However, there is no reported change in the community care sector where the proportion of male workers has remained at 10 per cent since 2007. The National Aged Care Workforce Census and Survey conducted qualitative research in 2012 which indicated that men are a potential source of future aged care workers.

5.2.4. Age

The direct care residential aged care workforce has a median age of 47 years. The proportion of workers over 55 years has increased from 17 per cent in 2003 to 27 per cent in 2012. However, the proportion of recent new hires which are aged 34 years or younger has increased from 29 per cent in 2003 to 36 per cent in 2012.

The age profile in community care is older than in residential care. The median age in community care is 50 years whereas in residential care it is 48 years. Unlike residential care, there has not been

a significant change in the age distribution of new hires. In 2007, 15.9 per cent of new hires were aged 25-34. In 2012 it was 13.7 per cent. In 2007, 27.4 per cent of new hires were aged 35-44. In 2012 it was 27.6 per cent. In 2007, 32.6 per cent of new hires were aged 45-54. In 2012, it was 32 per cent.

5.2.5. Country of birth

Between 2003 and 2007 there was a significant increase in the proportion of the residential aged care workforce born outside of Australia, from 25 per cent to 33 per cent. There has not been the same growth in the period between 2007 and 2012. In 2012, the proportion of the workforce born outside of Australia was 34 per cent.

The growth in workers born outside Australia does not necessarily align with the language requirements of the current CALD care recipient profile. This poses its own difficulties in attempting to provide quality care, such that the carer has difficulties understanding the care recipient's needs and vice versa.

Since 2007 there has been a slight increase in the proportion of the workforce from Asia (including India) growing from 7 per cent in 2007 to 10 per cent in 2012. The proportion of direct care workers from an English speaking country (including Australia) has remained constant at around 75 per cent.

In community aged care the proportion of workers born overseas has remained constant since 2007 at 28 per cent.

5.2.6. Aboriginal and Torres Strait Islander People

The proportion of Aboriginal and Torres Strait Islander people in the residential aged care workforce (1-2 per cent) is marginally low relative to their proportion of the Australian population (2.5 per cent). The proportion of Aboriginal and Torres Strait Islander people in the community aged care workforce (2-3 per cent) is better aligned with their share of the wider Australian population.

As reported by providers, the majority of Aboriginal and Torres Strait Islander direct care workers are PCAs (85 per cent) in residential care or CCWs (95.6 per cent) in community care.

5.2.7. Education

The percentage of the aged care workforce with post-secondary qualifications is higher than the national average.

Of the direct care residential aged care workforce there has been an increase in the proportion with post-secondary qualification from 80 per cent in 2007 to 88 per cent in 2012. This varies by occupation, for example 16 per cent of PCAs compared to 3 per cent of RN have not undertaken further education.

Similarly, in community aged care 86 per cent of direct care workers in 2012 had post-school qualifications, an increase from 79 per cent in 2007. The proportion of CCWs reporting no post-school qualifications has decreased from 24 per cent in 2007 to 16 per cent in 2012.

5.2.8. Remuneration

The modern award pay rate for a RN (level 1 on pay point 8 and thereafter) is $948.60 per week (effective from the first full pay period commencing on or after 1 July 2013). The modern award pay

rate for an EN (Pay point 5) is $776.20 per week (effective from the first full pay period commencing on or after 1 July 2013). The modern award pay rate for a Certificate III qualified Personal Care Worker Grade 3 (Aged Care Employee Level 4) is $724.50 per week (effective from the first full pay period commencing on or after 1 July 2013).

Aged care nurses tend to be paid less than their acute care counterparts. The Australian Nursing Federation's (ANF) latest (June to August 2013) quarterly sector comparison based on 774 agreements operating in the residential aged care sector claims a difference on average of almost $208 per week or 17 per cent nationally. The Department monitors the wage rates of the aged care workforce on an ongoing basis, currently analysing 71 publicly available enterprise agreements that apply to 53 Commonwealth funded aged care providers. The Department's analysis results in a more modest difference of approximately $125 per week or nearly 10 per cent nationally.

5.2.9. Volunteers

For the first time, the 2012 survey collected data on volunteers. Volunteers provide services such as companionship, entertainment and social activities that complement care provided by the formal workforce. A typical example of a community care volunteer activity is the meals on wheels service.

Based on survey responses from residential aged care facilities using volunteers, on average there are ten volunteers per facility, with each volunteer contributing an average of 4.8 hours per fortnight, or more than 2.5 million hours of volunteer service in residential aged care in a year. This works out to 1,667 person days.

Facilities in inner regional locations are most likely to have volunteers, while those in remote and very remote areas have fewer volunteers than the average. The use of volunteers also differs by ownership type with not-for-profit facilities more likely to use volunteers (92 per cent) than for-profit or publicly owned facilities.

Based on survey responses, in community care there are on average 27 volunteers per outlet, with each volunteer averaging 4.6 hours for the fortnight. Across a year this would equate to more than 6.7 million hours, of volunteer service in community aged care, i.e. 893,333 days or 4,466 person years of 200 working days per year.

The distribution of volunteers is fairly consistent for all locations except remote areas, where 34 per cent of outlets had volunteers. The use of volunteers also differs by the ownership type. 53 per cent of not-for-profit providers used volunteers in comparison to only 11 per cent of for-profit.

5.2.10 Rates of injury

The aged care workforce is characterised by high rates of workplace injury and work-related illness. Providers in residential care report the most common injuries as sprains and strains, superficial injuries and, chronic joint and muscle conditions. Residential aged care workers report that the most common injuries are sprains and strains, chronic joint and muscle conditions as well as mental stress. This is consistent with the physically, mentally and emotionally intensive nature of the work.

Injuries and work-related illnesses represent a significant cost to aged care providers (including Workcover premiums), workers and the community. Reducing workplace injury represents an opportunity to increase productivity in the aged care sector.

5.3. Informal workforce

There is a significant informal workforce involving family and friends who support and provide care for the aged in their own home. The term informal carers does not include paid care workers or volunteer arrangements by formal services.

According to the ABS (2009) in 2009 there were 2.6 million carers in Australia or 12 per cent of the Australian population. Approximately 750,000 informal carers were primary carers and 350,000 of these primary carers provided assistance to older persons aged 65 years or over.

There is little available data on the economic value of informal carers. Access Economics (2010) estimated that informal carers provide around 1.32 billion hours of care each year and if informal care were to be replaced with services purchased from formal care providers and provided in the home, the replacement value would have been in excess of $40.9 billion per annum in 2010.

However, the provision of informal care does come at a cost to the carer, including the physical and emotional cost as well as the financial cost where the caring role limits their ability to work in the paid formal workforce.

The Productivity Commission (2011) estimates that the supply of informal carers will increase by 60 per cent between 2001 and 2031. However, based on current trends the demand for informal care is estimated to increase by 160 per cent. This will have implications for home care, which is generally complemented by live-in informal carers. This will need to be monitored as it will have implications for consumer choice of care type (See Chapter 4 – Access to Care).

5.4. Impact of Living Longer Living Better reforms

Under the LLLB aged care reform package, up to $1.1 billion is available through the Addressing Workforce Pressures initiative to better support the aged care workforce. This initiative will be delivered in two parts – through the aged care Workforce Supplement, and the Aged Care Workforce Development Plan which will be developed during 2013-14.

5.4.1. Workforce Supplement

An Aged Care Workforce Supplement will be available to providers who meet the terms and conditions of the supplement. The Aged Care Workforce Supplement will be passed on to aged care workers as wage increases. The aims of the supplement are to:

- Improve the aged care sector's capacity to attract and retain a skilled and productive workforce.
- Provide funding to assist the sector in delivering fair and competitive wages in the short-term, while longer term options for meeting the challenges of the sector are considered by the ACFA and to be included in the five year review.

- The supplement will be available to eligible providers from 1 July 2013. Aged care providers must ensure annual increases in wages of a minimum of 2.74 per cent per annum, or the Fair Work Commission annual minimum wage increase, whichever is higher, and maintain minimum margins above relevant award rates for all employees.
- The workforce supplement payable in respect of a day for an eligible care recipient will be 1 per cent of the basic subsidy amount payable in respect of that care recipient.

ACFA will report on implementation and take up of the supplement in future annual reports.

5.4.2. Workforce Development Plan

The Aged Care Workforce Development Plan will consider the following:

- Improved career structure.
- Enhanced training and education opportunities.
- Improved career development and workforce planning.
- Better work practices.

ACFA will report on implementation and the impacts of the Workforce Development Plan in future reports.

5.5. Workforce challenges and future ACFA focus

Achieving the desired objectives for the aged care workforce will present a number of challenges, including:

- the impacts of population ageing resulting in increasing rates of complex chronic conditions;
- consumer expectations for improved standards of quality and access;
- meeting the needs of special needs groups such as those from CALD backgrounds; and
- the increasing competition for carers, nurses and medical staff from complementary areas such as health and hospital care, and disability care.

Improving productivity, adopting new technologies, up-skilling staff, and adjusting work practices will become the imperatives for aged care providers and workforce regulators.

Funding and financing arrangements can affect the workforce in a number of ways, directly through measures such as the workforce supplement and more indirectly through their impact on providers and their ability to attract, retain and skill an appropriate workforce.

In future annual reports, and in the lead up to its report to inform the five year review, ACFA intends to undertake further analysis on workforce issues, including analysis of issues such as workforce turnover, comparative wages, expenditure on skilling and training, and productivity and the impacts of funding and financing arrangements on these issues, including the Workforce Supplement and Development Plan.

6. Sustainability

6.1.1. Context

Population growth and an ageing population mean that the demand for aged care services will continue to grow.

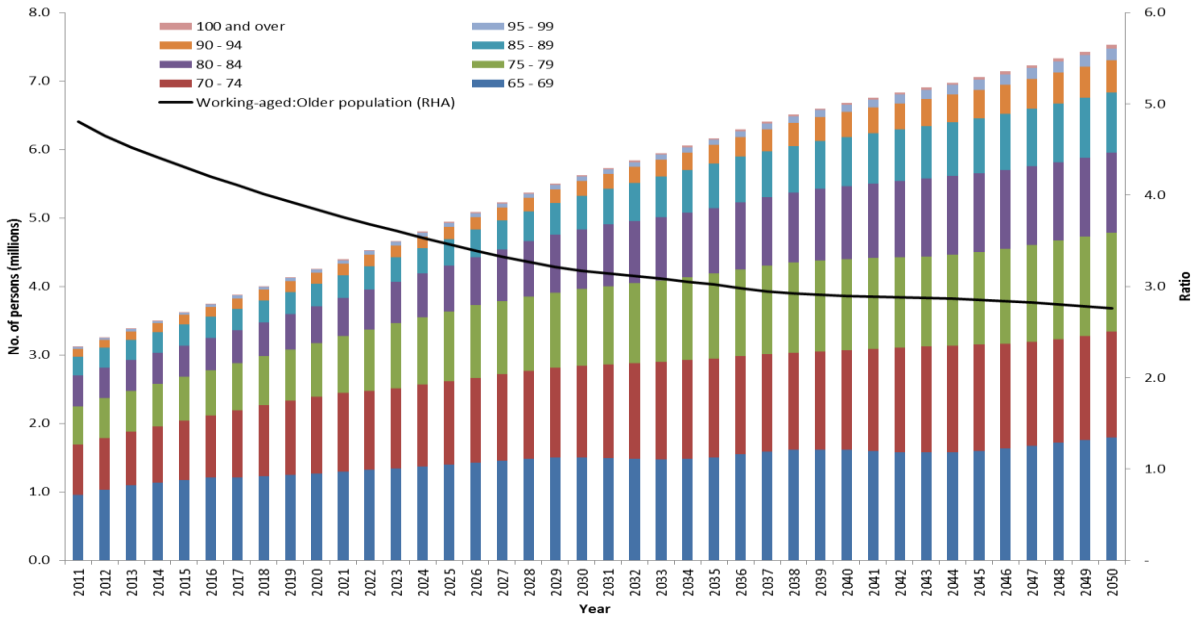
This chapter outlines the demographics and resulting challenges, and examines the implications for investment in the aged care sector followed by a discussion on sustainability from the perspective of each of the key stakeholders, being:

- Aged care providers;
- Aged care financiers – both debt and current and prospective equity investors;
- Aged care recipients and their families - as consumers and part funders of aged care services;
- Aged care workers; and
- Federal Government, both as policymakers and funders.

6.2. Demographics

Australia has an ageing population. (See Chart 6.1 – left hand axis.) The *2010 Intergenerational Report* prepared by the Commonwealth Treasury reports that there are currently five working aged people (15 to 64 years) per person aged 65 years and over. This will fall to 2.7 per cent by 2050. (See Chart 6.1 – right hand axis.) This population ageing is expected to lead to slowing economic growth, particularly driven by reduced labour force participation and increased expenditure on health and aged care services.

Chart 6.1: The ageing of the population



Source: ABS population projections (Series B, ABS Cat. 3222.0)

The ageing of the population is being driven by increasing life expectancy and relatively low levels of fertility. A male aged 65 years old today is expected to live a further 19.1 years, this is 3.7 years longer than 20 years ago (Table 6.1). This has significant implications for increasing the likelihood of a person requiring aged care.

Table 6.1: Life expectancy at age 65, by sex and year, Australia

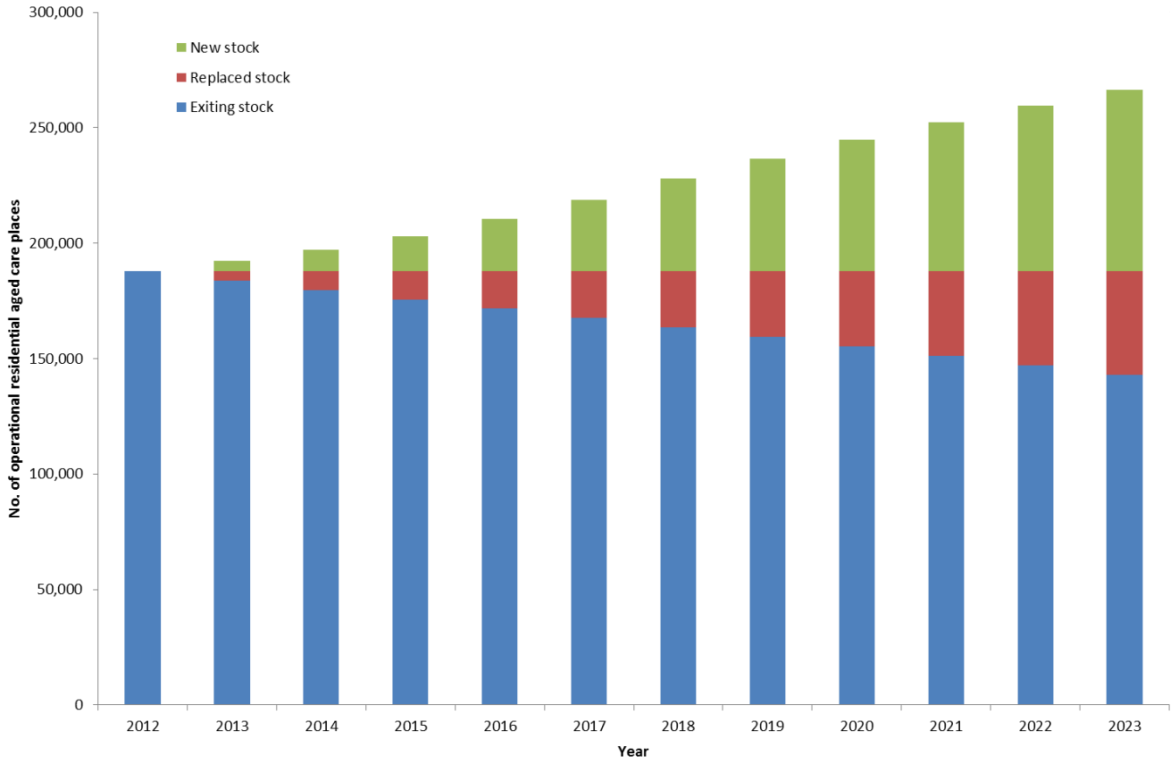
Year	Males	Females
2009-11	19.1	22.0
1990-92	15.4	19.3
1970-72	12.2	15.9

Source: *ABS 3105.0.65.001 Australian Historical Population Statistics, 2008, ABS 3302.0.55.001 Life Tables, States, Territories and Australia, 2009-2011*

The likelihood that a person will enter permanent residential aged care is increasing. A female aged 65 in 1997 had a 51 per cent likelihood of entering permanent residential aged care. A decade later, a 65 year old female was 3 per cent more likely to enter residential aged care. Similarly, a male aged 65 in 1997 had a 31 per cent likelihood of entering residential aged care. A decade later, a 65 year old male had a 37 per cent likelihood of entering residential aged care. The driving factor behind this increase is that people are living longer, which is leading to a larger proportion of people living to an age where they require aged care services.

When the reforms are fully implemented, the Federal Government will be using a target planning ratio based on 80 places in residential care per 1,000 people aged 70 years and over. The size of the 70 years and over population will increase rapidly as the post war baby boomer population start to turn 70 years old. The first baby boomers, those born in 1946, will turn 70 years old in 2016, although the largest baby boomer annual cohort year is those born in 1947. In 2017 the 70 years and over population will increase by nearly 5 per cent in that one year. Meeting the provision target as these baby boomers age will require significant investment in building new aged care places and replacing old stock over the next decade and beyond. The number of operational residential aged care places required to meet the provision target in the next decade is provided in Chart 6.2.

Chart 6.2: Number of operational residential aged care places required in the next decade



These demographic changes pose significant challenges to many areas of society and to Federal Government. In the aged care area, the impacts will be seen in continuing and increased demand for aged care services and for longer periods of care. This presents both challenges and significant opportunities for aged care providers, age care investors, the aged care workforce and Federal Government in delivering the aged care services that recipients of care need.

6.3. Investment in the residential care sector

Chart 6.3 illustrates the Department's estimates of the sector's annual investment requirement for residential care each year in the next decade, in terms of both of the amount of required investment (in real terms) and the number of places that will need to be built. These estimates are based on several key assumptions, namely that:

a) the current service provision targets continue;

b) the cost of construction continues to grow at about 2.5 per cent real each year[34]; and

c) the average lifetime of an aged care building is about 40 years[35] so that the current stock will need to be replaced over the next four decades.

[34] The Department has derived estimates of the full cost of constructing an aged care home based on the results of the Department's 2011-12 survey of aged care homes. The median cost of construction of these projects was $188,250 per place. Trends in aged care construction costs are derived from Rawlinsons (2012) *Australian Construction Handbook*, various editions. Perth: Rawlinsons.

[35] Based on 2.3% of homes undertaking new (which includes transferred places) and rebuilding works reported in the 2011-12 survey of aged care homes.

Chart 6.3: Estimated investment requirement for the residential care sector, 2010 to 2020

Based on current policies, the Department estimates that the residential care sector will need to build in the order of 74,000 additional places over the next decade. At the same time, the sector will need to rebuild some of its current stock. Assuming that the cost of construction continues to grow at about its current rate, and that about a quarter of the current stock of building is rebuilt at an even rate over the next decade, the Department estimates that the investment requirement of the sector over that period to be in the order of $25 billion (in 2011-12 prices). The Department's estimate is necessarily indicative, but provides a useful insight into the magnitude and likely timing of the sector's investment requirements over the next decade. Over the longer term, even with a significant shift towards home care, population ageing and the need to refresh the sector's capital stock will require significant new investment in the residential care sector.

It should be noted that the above analysis does not include an estimate of investment in refurbishing stock that does not involve knockdown and rebuilding.

These estimates represent both a challenge and a significant opportunity. Providers need to operate at a level that encourages investment, Federal Government policies need to be supportive of investment in the sector and investors need to recognise the opportunities that the growth and demand for services will bring.

As noted earlier, the LLLB reforms have the potential to assist funding and investment in the sector and this will be closely monitored by ACFA.

6.4. Aged care providers

Sustainability for providers reflects a number of considerations:

- Financial viability, reflected in operating results and balance sheet strength, which in turn reflect funding flows from both the Federal Government and care recipients through accommodation payments and care fees, and improvements in operational efficiency which is influenced by the business model and management expertise.
- Workforce challenges – attracting and retaining quality staff.
- Care provision – providing quality care.
- Investment attractiveness – the aged care sector needs to be viewed as an attractive investment relative to other potential investments.
- Governance practices that align the interests of residents, staff, management, funders and financiers.

The LLLB reforms will impact provider sustainability in various ways as outlined in earlier chapters. These reforms and other broader factors affecting provider sustainability will be monitored by ACFA.

Further analysis of sustainability issues should also explore those segments of the market which are operating below their cost of capital, as this raises issues for sustainability where lenders may not be willing to provide finance to renew obsolete infrastructure.

There may also be efficiency gains that can be achieved in the aged care sector in the pursuit of sustainability. Further analysis of sustainability issues should also involve consideration of the scope for providers to operate more efficiently and a focus on ensuring that funding and financing arrangements encourage efficient providers rather than support inefficient providers. This would also involve greater use of technology and adjustments in work practices. Consideration of whether the structure of the sector maximises efficiency would also inform these considerations.

6.5. Debt financiers

Debt financing to the aged care sector is predominantly provided by Australia's major banks. Prior to the GFC in 2008, a number of international banks had entered the aged care debt financing market increasing competitiveness and access to debt financing. However, these banks exited the market post 2008 and are only slowly returning, resulting in relatively less competition.

Financing arrangements in the sector currently allow for bonds paid by residents in residential aged care to form a significant part of financing. Banks currently see bonds as an important part of their lending decision making as they represent a substantial no-cost, dependable supply of financing. Bonds are also a substitute for equity in many cases and allow new investments to be leveraged with low equity.

In the shorter term, the focus of debt financiers is likely to be on the impact of the LLLB reforms on the mix of RADs and DAPs and the impact a change in the mix may have on the capital structure and

cost of capital. If bond levels were to materially fall, there would be a need to secure additional debt and equity to replace bond capital. As noted in earlier chapters, while there is some uncertainty over impacts amongst some financiers, analysis undertaken by KPMG estimates a significant positive benefit on both bond holdings and revenue from the reforms overall.

In the longer term, the expected growth in the demand for residential care will require a substantial amount of investment in new and redeveloped facilities as outlined earlier.

There will likely be a need for substantial brownfield investments to refurbish old stock and new investments to meet growing demand. The increased accommodation supplement provided on significant refurbishments and new homes and the ability of providers to establish accommodation prices in high care will assist with arranging debt financing.

Taking into account the anticipated need for extra investment in the sector, the current sector balance sheet of approximately $28 billion can be expected to increase significantly. This increase can potentially be funded from increases in the bond pool and a continued demand for additional debt and equity.

Debt financiers will be monitoring movements in their lending criteria during the transition from the previous accommodation payment arrangements to the LLLB arrangements. The most commonly adopted debt metrics are Loan to Valuation Ratio (LVR), Interest Cover ratio and Debt/EBITDA ratio. Debt financiers adopt qualitative indicators when considering new debt arrangements including management expertise and track record, age and quality of facilities, and characteristics within the local area. Trends and movements in these criteria will accordingly affect investment.

Aged care debt financiers rely on valuation reports to establish the appropriate LVR. In the short term valuers also face uncertainty about the potential change in the mix of RADs and DAPs and will not have the benchmark data to base their valuations on until the LLLB reforms come into force. In the longer term, valuation processes could be expected to adjust appropriately to the new system.

6.6. Equity financing

The residential aged care sector ownership structure is a mix of large church and charitable groups, medium sized private sector owners, large private sector institutional owners and private owners of 1-3 homes. Almost all ownership structures include ownership of the assets and the operations. A key influence on the future of residential aged care is the source of equity to fund growth, replacement of obsolete stock and consolidation of inefficient providers into efficient platforms.

The home care sector ownership structure is largely weighted towards the church and charitable groups with a number of emerging private sector groups. The anticipated growth in home care services and increasing user funding will likely require existing providers to increase working capital financing and increase operational risk. Whilst home care services require lower levels of start-up capital compared to residential aged care ownership structures the required returns on capital relative to the risk are likely to rely on providers leveraging scale to increase operational efficiency. Hence equity will need to be invested to fund acquisitions and business expansion to fund the growth.

The large institutional investors include Australian superannuation funds and insurance companies and international sovereign wealth and pension funds. These investors generally invest through a fund which co-invests in the aged care provider. The funds may be open-ended, i.e. have no term and hence the investment is classified as illiquid, or through a close ended fund which needs to sell the investment within a prescribed timeframe to return capital to the original investors.

Aged care has yet to emerge as an investment available to the public markets through the Australian stock market. As aged care providers increase in scale, the opportunity to attract capital through the public markets becomes more likely.

Investments aligned to the ageing demographic are increasingly attractive to domestic and international institutional investors as they seek to balance the impact of ageing across their investment portfolios. The main driver for institutional investor investment decisions is the financial and quality performance of the investment and the calibre and track record of the management team. As management of the Australian aged care sector continues to strengthen and evidence of increased success at optimising quality and financial performance emerges, it is reasonable to assume the aged care sector will become increasingly attractive to institutional investors.

Whilst it is likely the large church and charitable groups and medium-sized private sector groups may leverage their existing portfolios to fund further growth, this is likely to only contribute a small amount of the equity required. Therefore, it is likely that attracting reputable and sustainable sources of equity will rely on the large domestic and international institutional investors either as direct investors, through existing funds or as investors in listed aged care providers.

One option for further exploration is the viability of separately owned property and operating companies as evident in hospitality, retail and some industrial and commercial operations (e.g. hotels and shopping centres) which could provide scope for sourcing new equity allocations. Whilst there has been some success in attracting equity to aged care property companies, it has been difficult to derive adequate returns for the operating company owner that leases the property. As accommodation pricing becomes more flexible under the LLLB reforms this model may become more sustainable.

Further analysis is required to quantify the sources of new equity funding growth through development and acquisition, the expected investment returns associated with those sources and the capacity of new sources to fund the growth forecasts. In the event analysis indicates industry sustainability is strengthened through some level of consolidation, that is, acquisition of inefficient operations by efficient operators, then further analysis is required to quantify the sources of equity available to fund this consolidation activity.

6.7. Aged care recipients and their families

For the system to be sustainable for aged care recipients and their families it needs to provide access to the quality care they need in the form and place where needed.

This requires ensuring:

- Places are available when needed.
- The care provided meets individual consumer assessed care and support need.
- The individual choice of provider and how and where care is received (home or residential care) is provided.
- Care is available in an appropriate geographic location.
- Quality care is provided by appropriately skilled workers who fulfil the needs of the individual.
- Information and assistance in finding the right type of care is readily available.
- Care is affordable.
- The number of recipients with adequate wealth to fund their accommodation and care needs does not decrease.

ACFA is due to report by 31 December 2014 on the impact of the recalibration of home care subsidy levels on service provision, and will also monitor the impacts of other changes to financial arrangements on aged care recipients, including the changes to accommodation payment arrangements and means testing.

6.8. Aged care workforce

Issues relevant to the aged care workforce have been discussed in Chapter 5.

As noted in that chapter, ACFA is required to report in time to inform the five year review of the LLLB reforms on longer term options to support a stable and skilled workforce that can meet the growing demand for aged care services. This will include consideration of the impact of the Workforce Supplement.

Challenges to sustainability include attracting and retaining workers in an increasingly competitive environment and ensuring an appropriately skilled workforce that can meet the growing demands in terms of staff availability and quality of care exists.

6.9. Federal Government

Federal Government can be expected to continue to be the primary funder of aged care, with residential aged care funding of $9.12 billion in 2012-13 expected to grow to $11.86 billion in 2016-17. The LLLB reforms relating to user contributions, such as strengthened means testing will help the sustainability of Federal Government funding.

Changes to ACFI were introduced on 1 July 2012 to bring future growth in care subsidies in line with historic growth rates of between 2-3 per cent above indexation and to provide funds to be redirected to other elements of the LLLB package. Changes to ACFI were made due to the higher than expected growth in Federal Government funding per resident since the introduction of ACFI in 2008.

A continued focus from Federal Government on managing its expenditure can be expected with the pressures of an ageing population evident from Chart 6.2.

The effectiveness of the aged care means testing arrangements and equity in user contributions between home care and residential care are matters listed for the five year review in the LLLB legislation.

6.10. Key issues to monitor and future work

Sustainability in the aged care sector will be impacted by various factors. ACFA will closely monitor:

- Investment drivers, investment activity and financiers' sentiment.
- Provider efficiency.
- Impact of accommodation payment changes and means-testing on access to quality of care and sector funding.
- Sector's ability to attract and retain appropriately skilled workers in an increasingly competitive environment.

Appendix A – Scope of ACFA reporting on the impact of the reforms

THE HON MARK BUTLER MP
MINISTER FOR MENTAL HEALTH AND AGEING
MINISTER FOR HOUSING AND HOMELESSNESS
MINISTER FOR SOCIAL INCLUSION
MINISTER ASSISTING THE PRIME MINISTER ON MENTAL HEALTH REFORM

Ms Lynda O'Grady
Chair
Aged Care Financing Authority
ACFA Secretariat
GPO Box 9848
CANBERRA ACT 2601

Dear Ms O'Grady

Consistent with section 6 of the Authority's operating framework I am writing to request the Authority provide me with advice on the following matters arising from the implementation of the *Living Longer Living Better* reforms.

The *Living Longer Living Better* aged care reforms represent a significant change to the aged care sector and can be expected to bring substantial benefits to industry over the long term. As with any significant change, it is important the transition to the new system is managed efficiently and effectively. The Government acknowledges the need for mechanisms to support the sector in transition and to monitor the impacts of the reforms, particularly those relating to the new accommodation payments and means tested fee arrangements. I see the Authority as having a key role to play in the timely and active monitoring of the impacts of the reforms as they are implemented and in providing timely independent advice to Government as appropriate on implementation issues.

In this context I request the Authority provide advice to me on the following issues.

The impact of the *Living Longer Living Better* accommodation payment reforms on aged care providers

As you are aware the reforms introduce a new framework for accommodation payments in residential aged care. Key changes include a new framework for setting and publishing accommodation prices (including pre-approval by the Aged Care Pricing Commissioner of Level 3 prices), providing residents with full choice of payment method between refundable accommodation deposits (RADs) and daily accommodation payments (DAPs) and removing the ability for providers to deduct retention amounts from RADs.

I request that the Authority provide me with advice on the impact of these reforms on aged care providers and residents as follows:

- Annually in its annual report to Government due by 31 May each year; and
- At the end of each month in the first six months of the implementation of the reforms commencing on 31 July 2014 and ending on 31 December 2014, and then at the end of each quarter during 2015.

The advice should include in particular the number and distribution of care recipients choosing RADs and DAPs and consideration of the impacts on different types of providers (eg: current low care only providers, small providers and rural providers). The advice should also include consideration of the impact of the different means tests that apply to different asset types.

Impacts of changes to means testing arrangements in home care and residential care

I also request that the Authority provide me with advice on the impacts of the changes to means testing arrangements in home care and residential care as follows:

- Annually in its annual report to Government due by 31 May each year; and
- At the end of each month in the first six months of the implementation of the reforms commencing on 31 July 2014 and ending on 31 December 2014, and then at the end of each quarter during 2015.

The advice should examine the impacts of the changes on take-up and access to care and the impacts of the design of the fee scales on care recipient welfare in both residential and home care. In particular it should examine any changes in the number of persons entering different types of care with a specific focus on different income groups, particularly part pensioners subject to the 50% home care taper rate. The advice will include considering whether there is any evidence that the fee scales are creating barriers to access for some client groups (such as self-rationing) and if so how these could be addressed.

The impact of the transitional support arrangements announced by Government

To support the sector in transition the Government will be providing subsidised business advisory services for residential aged care providers to assist providers prepare for and manage the transition to the new accommodation payments system in residential aged care. I request the Authority to provide advice on the impact of this transitional support in its annual reports due on 31 May 2014, 31 May 2015 and 31 May 2016.

The impact of reforms on rural, regional and remote aged care providers

Given the range of concerns raised by stakeholders regarding the viability of rural, regional and remote providers, I request that the Authority, consistent with its current remit, specifically consider these provider cohorts when monitoring the impact of the reforms as outlined above. Many of the concerns raised relate to the remoteness, size (in bed numbers) and current mix of low/high care places across these providers.

I note that I have asked my Department to review and report to me on the operation of the viability supplement in both home care and residential care for rural, regional and remote providers. In doing so I have asked them to seek ACFA's advice.

Recognition of ACFA in legislation

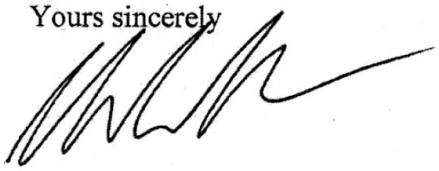
I would also like to take this opportunity to advise that the Government will ensure that ACFA is given legislative recognition of its role and responsibilities as a committee under section 96-3 of the *Aged Care Act 1997*. This reflects recommendations of the Senate Standing Committee on Community Affairs and the integral role ACFA will play in providing independent advice to Government on the implementation of the reforms.

The purpose of the ACFA will continue to be to provide independent advice to the

Government on funding and financing issues across the aged care sector.

It is intended that the arrangements commence from 1 August 2013 to allow a seamless transition of the current members to the new Committee. This will ensure retention of current members and avoid disruption to the ACFA's work plan.

Yours sincerely



MARK BUTLER

Appendix B – ACFA membership

ACFA position	Name	Organisation
Chair	Ms Lynda O'Grady	Managing Director Advanced Management Services
Deputy Chair	Professor Graeme Hugo	Director Australian Population and Migration Research Centre Department of Geographical and Environmental Studies The University of Adelaide
Member	Mr Ian Yates	Chief Executive Council on the Ageing (COTA)
Member	Mr Nicolas Mersiades	Director Aged Care Catholic Health Australia
Member	Ms Susan Lines Resigned effective on 1 May 2013	Assistant National Secretary United Voice
Member	Mr Paul Gregersen Resigned effective on 24 May 2013	CEO Bupa Care Services
Member	Ms Sally Evans	Head of Aged Care AMP Capital
Member	Mr Graham Hodges	Deputy Chief Executive Officer ANZ Banking Group
Representative – Department of Health and Ageing	Ms Carolyn Smith	First Assistant Secretary Ageing and Aged Care Division
Representative – The Treasury	Ms Joanne Evans	Manager Health Policy Unit The Treasury

Appendix C – Notes Diagram 1

- The flow chart is composed from General Purpose Financial Reports (GPFRs) 2011-12, the 2011-12 Report on the Operations of the *Aged Care Act 1997* (ROACA), Survey of Aged Care Homes (SACH) and the Department's payment system data for the year 2011-12.
- The information in the flow chart is based on those providers who have given their GPFRs (95.6 per cent) and therefore, the flow chart is not fully reflective of the entire aged care sector.
- The information about residential 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 Conditional Adjustment Payment (CAP).
- 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 providers 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.
- The payment system data is based on the life cycle of the residents which is updated periodically and therefore can contain differences due to reconciliation between the entitlement and claim date amounts.
- The care recipient information is obtained from the SACH data which is a voluntary survey and therefore not reflective of the whole aged care sector and subject to errors impacting quality.
- The other funding source/income source item is used as a balancing item to reconcile with the total revenue of the sector as per given GPFRs for 2011-12.
- Due to information from multiple sources, the number of providers differs between the calculation of care recipient funding and Federal Government funding as the amounts of care recipient funding are based on those providers who have given their GPFRs, while Federal Government funding is based on all providers.
- The accommodation bonds amount and zero interest loans amount is obtained from the Department's payment system and inclusion of the same in the total liabilities in the GPFRs has not been verified with the aged care providers.
- The donations, loans and investment amounts are not fully available to the Department as the information is given voluntarily by providers in their GPFRs.
- The financial information of other components of total liabilities in the GPFRs (i.e. other than bonds, loans and zero real interest loans) is not fully available to the Department as it is given voluntarily by the providers.

Appendix D – Summary of subsidy and supplements in residential aged care, 2011

2011-12 Reports on the Operations of the *Aged Care Act 1997*

Types of Payments	$m
Basic Subsidies	
Permanent residents	7,288.5
Respite residents	160.0
CAP	645.5
Primary Care Supplements	
Oxygen	13.4
Enteral feeding	8.6
Payroll Tax	147.0
Respite Incentive	13.7
Hardship	
Hardship	3.6
Accommodation Supplements	
Hardship	2.9
Accommodation Supplements	446.9
Transitional Accommodation Supplements	76.1
Viability	
Viability	28.4
Supplements relating to grandparenting	
Concessional	132.4
Transitional	14.2
Charge Exempt	1.6
Pension	112.1
Other	27.1
Reductions	
Income tested	-323.1
Other reductions	-60.5
TOTAL	**8,738.4**

Appendix E – Notes to Segment Analysis

- The averages and financial ratios presented in the analysis are based on those providers who have given the residential aged care segment information in their General Purpose Financial Reports (GPFRs).
- The information about residential 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 Conditional Adjustment Payment (CAP).
- The segment information contains financial information for only those services that were operational as at 30 June 2012 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 providers 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 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.
- 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 earnings to Total Assets and Net Worth respectively. It does not have any relation to the evaluation of capital financing measurement of the sector.
- Since many of the providers have given "finance costs", which may contain other expense items in addition to interest expense, the average EBITDA estimate may be overstated.

Appendix F – Viability of Total sector, 2011-12

	Not-for-profit	For-profit	Government	Total
Provider count	552	392	110	**1054**
EBITDA per resident per annum	$8,176	$13,121	-$1,508	**$9,274**
Capital structure				
Total assets per resident per annum	$161,686	$176,590	$193,277	**$168,611**
No. of bonds	39,189	23,077	2,183	**64,449**
Average bond per resident per annum	$185,581	$233,032	$144,575	**$201,182**
Net worth per resident per annum	$70,371	$24,660	$149,461	**$59,198**
Net working capital per resident per annum	-$37,020	-$63,912	$4,010	**-$45,168**
Non-current liabilities as % of total financing	20.10%	31.70%	15.20%	**23.90%**
Accommodation bonds as % of total financing	45.60%	58.20%	19.90%	**48.40%**
Equity as % of total financing	43.20%	14.00%	75.50%	**34.90%**
Viability				
Current ratio	0.51	0.46	1.08	**0.5**
Interest coverage	14	6.2	-9.7	**8**
Net Profit Before Tax margin	4.50%	10.50%	-14.10%	**5.60%**
Occupancy	94.70%	90.40%	91.80%	**93.00%**
Return on assets	5.10%	7.40%	-0.80%	**5.50%**
Return on equity	11.70%	53.20%	-0.70%	**15.90%**
Accommodation bond asset cover	2.2	1.7	5	**2.1**

Notes:

- For 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.
- Due to the differences in provider numbers, the results here do not match Tables 3.11 and 3.12.
- Please also refer to the notes outlined in Appendices C and E regarding data quality.

Appendix G – Viability of Not-For-Profit providers, 2011-12

	Top Quartile	Second Quartile	Third Quartile	Bottom Quartile	Total
Provider count	92	155	169	136	**552**
EBITDA per resident per annum	$19,695	$10,291	$5,726	-$2,193	**$8,176**
Capital structure					
Total assets per resident per annum	$189,055	$160,008	$143,430	$180,418	**$161,686**
No. of bonds	4,881	17,140	11,258	5,910	**39,189**
Average bond per resident per annum	$172,449	$189,756	$173,310	$207,692	**$185,581**
Net worth per resident per annum	$101,249	$61,907	$68,628	$69,989	**$70,371**
Net working capital per resident per annum	$9,829	-$63,139	-$24,984	-$26,356	**-$37,020**
Non-current liabilities as % of total financing	21.70%	16.40%	18.70%	29.10%	**20.10%**
Accommodation bonds as % of total financing	36.20%	49.40%	45.00%	45.40%	**45.60%**
Equity as % of total financing	53.60%	38.50%	47.10%	38.80%	**43.20%**
Viability					
Current ratio	1.17	0.3	0.59	0.67	**0.51**
Interest coverage	39.9	13.9	17.5	-2.6	**14**
Net Profit Before Tax margin	18.70%	6.70%	2.00%	-9.50%	**4.50%**
Occupancy	94.90%	94.80%	95.30%	93.00%	**94.70%**
Return on assets	10.40%	6.40%	4.00%	-1.20%	**5.10%**
Return on equity	19.50%	16.80%	8.50%	-3.10%	**11.70%**
Accommodation bond asset cover	2.8	2	2.2	2.2	**2.2**

Notes:

- For 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.
- Due to the differences in provider numbers, the results here do not match Tables 3.11 and 3.12.
- Please also refer to the notes outlined in Appendices C and E regarding data quality.

Appendix H – Viability of For-Profit providers, 2011-12

	Top Quartile	Second Quartile	Third Quartile	Bottom Quartile	TotaL
Provider count	164	94	75	59	**392**
EBITDA per resident per annum	$21,786	$10,599	$5,321	-$2,260	**$13,121**
Capital structure					
Total assets per resident per annum	$186,949	$167,624	$165,775	$182,686	**$176,590**
No. of bonds	8,625	7,964	3,959	2,529	**23,077**
Average bond per resident per annum	$225,794	$227,175	$251,085	$247,896	**$233,032**
Net worth per resident per annum	$35,828	$26,646	$8,689	-$4,880	**$24,660**
Net working capital per resident per annum	-$61,786	-$59,040	-$69,708	-$73,697	**-$63,912**
Non-current liabilities as % of total financing	23.10%	50.70%	20.90%	25.30%	**31.70%**
Accommodation bonds as % of total financing	51.40%	57.90%	70.20%	68.40%	**58.20%**
Equity as % of total financing	19.20%	15.90%	5.20%	-2.70%	**14.00%**
Viability					
Current ratio	0.43	0.47	0.46	0.54	**0.46**
Interest coverage	6.5	8.2	3.9	-1.9	**6.2**
Net Profit Before Tax margin	17.80%	8.50%	3.20%	-6.10%	**10.50%**
Occupancy	92.00%	91.30%	88.60%	83.70%	**90.40%**
Return on assets	11.70%	6.30%	3.20%	-1.20%	**7.40%**
Return on equity	60.80%	39.80%	60.90%	46.30%	**53.20%**
Accommodation bond asset cover	1.9	1.7	1.4	1.5	**1.7**

Notes:

- For 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.
- Due to the differences in provider numbers, the results here do not match Tables 3.11 and 3.12.
- Please also refer to the notes outlined in Appendices C and E regarding data quality.

Appendix I – Viability of government providers, 2011-12

	Top Quartile	Second Quartile	Third Quartile	Bottom Quartile	Total
Provider count	8	15	19	68	**110**
EBITDA per resident per annum	$24,419	$10,680	$5,940	-$8,607	**-$1,508**
Capital structure					
Total assets per resident per annum	$187,298	$184,634	$161,925	$208,788	**$193,277**
No. of bonds	149	268	364	1,402	**2,183**
Average bond per resident per annum	$157,750	$171,722	$162,501	$133,331	**$144,575**
Net worth per resident per annum	$115,413	$125,336	$128,395	$165,959	**$149,461**
Net working capital per resident per annum	$85,398	$20,126	-$22,568	$350	**$4,010**
Non-current liabilities as % of total financing	37.30%	12.60%	10.50%	15.80%	**15.20%**
Accommodation bonds as % of total financing	29.80%	27.70%	32.30%	16.10%	**19.90%**
Equity as % of total financing	61.60%	67.90%	79.30%	76.20%	**75.50%**
Viability					
Current ratio	33.53	1.36	0.76	1.01	**1.08**
Interest coverage	N/A	15.8	4.7	-21.4	**-9.7**
Net Profit Before Tax margin	21.10%	5.80%	-1.50%	-22.90%	**-14.10%**
Occupancy	92.60%	95.90%	90.80%	91.60%	**91.80%**
Return on assets	13.00%	5.80%	3.70%	-4.10%	**-0.80%**
Return on equity	21.20%	8.50%	4.60%	-5.00%	**-0.70%**
Accommodation bond asset cover	3.4	3.6	3.1	6.2	**5**

Notes:

- For 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.
- Due to the differences in provider numbers, the results here do not match Tables 3.11 and 3.12.
- Please also refer to the notes outlined in Appendices C and E regarding data quality.

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