Australian Government

Aged Care Financing Authority

Fourth report on the

Funding and Financing of the Aged Care Sector

July 2016

Contents

Glossary

Term	Definition
Accommodation supplement	The accommodation supplement is payable on behalf of residents receiving permanent residential aged care who do not have the capacity to contribute to all or part of the cost of their accommodation.
Aged and Community Services Australia (ACSA)	A national peak body for not-for-profit providers of aged and community care in Australia.
Aged Care Act 1997 (the Act)	The Act is the legislation upon which the Australian Government funded aged care system is based.
Aged Care Approvals Round (ACAR)	The ACAR is an annual competitive assessment process for releasing and allocating aged care places to approved aged care providers. The number of places released is governed by the Commonwealth's population-based aged care service provision target ratio.
Aged Care Assessment Team (ACAT)	ACATs help older people and their carers work out what kind of care will best meet their needs when they are no longer able to manage at home without assistance. ACATs provide information on suitable care options and can help arrange access or referral to appropriate residential or home care services (including HACC, Short Term Restorative Care and Transition Care). An ACAT assessment and approval is required before people can access residential aged care or a home care package.
Aged Care Financing Authority (ACFA)	ACFA is statutory committee who provides independent advice to the Australian Government on funding and financing issues, informed by consultation with consumers, and the aged care and finance sectors.
Aged Care Funding Instrument (ACFI)	Used for determining the level of care subsidies for residents in aged care homes based on the assessed care needs of each individual.
Aged Care Pricing Commissioner	The Aged Care Pricing Commissioner is an independent, statutory office holder appointed under the *Aged Care Act 1997* and reports to the Minister for Aged Care.
Aged Care Sector Committee (ACSC)	The ACSC provides advice to Government on aged care policy development and implementation and helps to guide future reform of the aged care system.
Agreed accommodation price	Accommodation prices agreed between providers and prospective residents prior to entry, as reported by providers through the Aged Care Entry Record.
Allocated places/packages	The amount of subsidised aged care that an approved provider can deliver depends on the number of aged care places allocated to it under Part 2.2 of the Act. Under these arrangements, an approved provider can receive payment for care on behalf of approved care recipients only up to the specified number and type of aged care places allocated through the Australian Government's ACAR process or acquired from a provider who was previously allocated places through the ACAR process.

Term	Definition
Assistance with Care and Housing for the Aged (ACHA)	ACHA is a programme which provides a range of supports for eligible clients, who are at risk of becoming homeless or are homeless, to remain in the community through accessing appropriate, sustainable and affordable housing and linking them where appropriate, to community care.
Australian Bureau of Statistics (ABS)	The Government agency responsible for the production and dissemination of statistics in a range of key areas.
Australian Nursing and Midwifery Federation (ANMF)	The ANMF is the union for registered nurses, enrolled nurses, midwives, and assistants in nursing doing nursing work in every state and territory throughout Australia.
Bed days	The number of days for which a place was available to be occupied by care recipients.
Bond Asset Cover	Provides an indication of the extent to which the accommodation bond liability is covered by assets. It is calculated as Total Assets/Total Accommodation Bonds.
Brownfield site	Site where an extension to an existing aged care operation is possible.
Care days	The number of days for which care was actually provided to a care recipient in an aged care place.
Catholic Health Australia (CHA)	Catholic Health Australia is a large non-government provider grouping of health, community and aged care services in Australia, nationally representing Catholic health care sponsors, systems, facilities and related organisations and services.
Commonwealth Home Support Programme (CHSP)	From 1 July 2015, the Commonwealth Home Support Programme commenced. The CHSP brings together the Commonwealth HACC Programme, the National Respite for Carers Program, the Day Therapy Centres Program and the Assistance with Care and Housing for the Aged Program. The CHSP is one consolidated program that provides entry-level home support for older people who need assistance to keep living independently at home and in their community.
Community Aged Care Package (CACP)	Care consisting of a package of services provided to a person who lives in their own home and is not in residential care. This type of care was replaced on 1 August 2013 when the new Home Care Package Levels 1-4 were introduced. A CACP package is generally consistent with the level of care provided in a Level 2 Home Care package.
Conditional Adjustment Payment (CAP)	Introduced as part of the Australian Government's initial response to the Report of Professor Warren Hogan's Review of Pricing Arrangements in Residential Aged Care. The CAP was intended to provide medium term financial assistance to providers while encouraging them to become more efficient through improved management practices. Consequently, residential aged care providers were only eligible to receive the CAP if they achieved certain business outcomes such as providing staff training, making audited accounts available each year to the department and taking part in a periodic workforce census. The CAP was rolled into the basic care subsidy rates as of 1 July 2014.

Term	Definition
Consumer Directed Care (CDC)	Consumer Directed Care gives older people and their carers greater choice and control over the types of care services they receive and the delivery of those services.
Consumer Price Index (CPI)	CPI measures the changes in the price of a fixed basket of goods and services, acquired by household consumers who are resident in the eight state and territory capital cities.
Council on the Ageing (COTA)	COTA Australia is the peak national organisation representing the rights, needs and interests of older Australians.
Culturally and Linguistically Diverse (CALD)	CALD refers to people whose first language was not English.
Current Ratio	Represents the ability to meet short term debt through current assets. A current ratio of more than one indicates that an organisation's current assets exceed its current liabilities. It is calculated as Current Assets/Current Liabilities. In the aged care context, current ratio needs to be interpreted with caution given all accommodation deposits (bonds pre 1 July 2014) held by providers are treated as current liabilities.
Daily Accommodation Payment (DAP)	An amount paid by a care recipient towards their accommodation costs in a residential aged care facility calculated on a daily basis and paid periodically.
Day Therapy Centres Programme (DTC)	The DTC Programme provides a wide range of therapy and services to frail, aged people living in the community and to residents in Commonwealth funded residential aged care facilities within an eligible resident classification range. It assists them to regain or maintain physical and cognitive abilities which support them to either maintain or recover a level of independence, allowing them to remain either in the community or in residential aged care. As of 1 July 2015 the DTC Programme became part of the new Commonwealth Home Support Programme.
Department of Health (The Department)	The Australian Government department that administers the Act and regulates the aged care industry on behalf of the Australian Government.
Earnings Before Interest, Taxes, Depreciation and Amortisation (EBITDA)	Net profit after tax with interest, taxes, depreciation, and amortisation added back to it, and can be used to analyse and compare profitability between companies and industries because it eliminates the effects of financing and accounting decisions.
EBITDA margin	EBITDA margin shows the average net profit after tax (with interested, taxes, depreciation and amortisation added back into it) generated for each $1 of revenue earned. It's calculated as EBITDA/total revenue.

Term	Definition
Extended Aged Care at Home (EACH)	Flexible care consisting of a package of care services, including nursing and other personal assistance provided to a person who lives in their own home and not in residential care, who requires a high level of care. This type of care was replaced on 1 August 2013 when the new home care package Levels 1-4 were introduced. An EACH package is generally consistent with the level of care provided in a Level 4 home care package.
Extended Aged Care at Home Dementia (EACH-D)	Flexible care consisting of a package of care services, including nursing and other personal assistance provided to a person who lives in their own home with dementia and not in residential care, who requires a high level of care. This type of care was replaced on 1 August 2013 when the new Home Care Package Levels 1-4 were introduced. An EACH-D package is generally consistent with the level of care provided in a Level 4 Home Care package, with the additional Dementia and Cognition supplement also being paid.
Facility	A residential aged care facility, approved under *the Aged Care Act 1997* to provide government subsidised accommodation and care.
Financial Accountability Reports (FARs)	FARs are non-audited financial statements that are submitted by the Approved Providers of home care services delivering care to clients in all four levels of care. Under the *Accountability Principles 2014* and Home Care Packages Programme Guidelines, the submission of FARs is a mandatory requirement in a form approved by the Secretary of the Department.
Financial Planners Association (FPA)	The FPA represents the interests of the public and Australia's professional community of financial planners.
Flexible care	For those in either a residential or home care setting, that may require a different care approach than that provided through mainstream residential and home care.
General Purpose Financial Report (GPFR)	A financial report intended to meet the information needs common to users who cannot command the preparation of specific reports for their own purposes.
Government provider	In the context of this Report, the term references a provider that is owned by a local, state or territory government.
Greenfield site	Site where an aged care operation is built for the first time.
Gross Domestic Product (GDP)	GDP is the market value of all officially recognised final goods and services produced within a country in a year, or over a given period of time.
High care facility	A facility where over 80 per cent of residents are classified as 'high care'. The distinction between high care and low care was removed from 1 July 2014.
Higher accommodation supplement	A higher maximum accommodation supplement was introduced on 1 July 2014 for aged care homes that have been built or significantly refurbished since 20 April 2012.

Term	Definition
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. As of 1 July 2015 the Commonwealth HACC programme became part of the new CHSP. The HACC Programme in Victorian and Western Australia continues to be funded as a joint Commonwealth-state funded program administered by the Victorian and Western Australian governments.
Home care	Home based care provided through a home care package to help older Australians to remain in their own homes. Home care is provided through the Home Care Packages Programme (see below).
Home care package	A coordinated package of services tailored to meet the care needs of a person living at home. The package is coordinated by an approved home care provider, with funding provided by the Australian Government. Home Care Levels 1 and 2 help people with basic or low level care needs, whilst Levels 3 and 4 help people with intermediate to high care needs. This programme commenced 1 August 2013 and replaced the Community Aged Care Programme.
Home Care Packages Programme	An Australian Government funded programme which has as its objectives to assist people to remain living at home and enable consumers to have choice and flexibility in the way that care and support is provided at home. The Home Care Packages Programme commenced on 1 August 2013, replacing the former packaged care Programmes – Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH) packages and Extended Aged Care at Home Dementia (EACH-D) packages.
Homeless supplement	The Homeless supplement commenced from October 2013, to better support aged care homes that specialise in caring for people with a history of, or at risk of, homelessness. This funding is in addition to the funding provided under the Viability supplement. Aged care homes registered for the homeless component of the Viability supplement with greater than 50 per cent of their residents meeting the homeless criterion automatically receive the Homeless supplement.
Interest Coverage	Shows the number of times that EBITDA will cover interest expense. Indicates an organisation's ability to service the interest on its debt. It is calculated as EBITDA/Interest Expense.
Leading Age Services Australia (LASA)	LASA is a peak body for aged service providers.
Low care facility	A facility where over 80 per cent of residents are classified as 'low care'. The distinction between high care and low care was removed from 1 July 2014.

Term	Definition
Maximum accommodation price	Maximum accommodation prices set by providers for a room (or bed in a shared room) set by residential providers and published on My Aged Care. These are maximum prices (providers and residents may agree lower amounts), that apply to residents who are not eligible for support with their accommodation costs.
Maximum Permissible Interest Rate (MPIR)	The MPIR is the rate used to calculate the equivalent daily payment of a refundable deposit. The refundable deposit is multiplied by the MPIR and divided by 365 days. The MPIR is determined in accordance with Section 6 of the *Fees and Payments Principles 2014* (No. 2). The MPIR is available on the Department of Social Services website and is updated every three months. As at 1 April 2016 it was 6.28 per cent.
Mixed care facility	A facility where less than 80 per cent of residents are high care residents and more than 20 per cent are low care residents. The distinction between high care and low care was removed from 1 July 2014.
My Aged Care	A service provided by the Department to assist older people, their families and carers to access aged care information and services via the My Aged Care website and national phone line.
National Disability Insurance Scheme (NDIS)	The NDIS offers support for Australians who are under 65 years of age with a significant and permanent disability, their families and their carers.
National Respite for Carers Program (NRCP)	The NRCP aims to support caring relationships between carers and their dependent family members or friends by facilitating access to information, respite care and other support appropriate to their individual needs and circumstances and those of the people for whom they care. The NRCP was integrated into the Commonwealth Home Support Programme from 1 July 2015.
Net Profit Before Tax (NPBT)	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.
Operational places/packages	Operational place refers to a place that was allocated and has since become available for a person to receive care.
Per consumer per annum (pcpa)	An annual average financial figure relating to home care consumers.
Per consumer per day (pcpd)	A daily average financial figure relating to home care consumers.
Per resident per annum (prpa)	A measure relating to residential aged care residents that converts service financial data to daily amount per resident.
Per resident per day (prpd)	A daily average financial figure relating to Residential aged care residents.

Term	Definition
Provision target ratio	The Australian Government regulates the supply of subsidised residential aged care and home care packages by specifying a national provision target of subsidised operational aged care places. These targets are based on the number of persons for every 1,000 people aged 70 years or over, known as the aged care provision target ratio. The population-based provision formula ensures that the supply of services increases in line with the ageing of the population, while capping the number of places limits the fiscal risk associated with aged care.
Refundable Accommodation Deposit (RAD)	An amount paid as a lump sum by a care recipient for their accommodation costs in a residential aged care facility.
Regional	Geographic reference to areas classified by the Australian Bureau of Statistics as inner regional, outer regional, remote and very remote.
Regional Assessment Services	Services that are responsible for conducting face-to-face assessments of older people needing entry-level support through the CHSP. The term 'entry-level' refers to home support services provided at a low intensity on a short term or ongoing basis, or higher intensity services delivered on a short-term or episodic basis. The services are delivered within 52 pre-specified regions across Australia excluding Victoria and Western Australia.
Report on the Operations of the *Aged Care Act 1997* (ROACA)	A legal requirement under the Act, the ROACA is tabled in Parliament in November each year and presents an annual snapshot of facts and figures on Commonwealth funded aged care services in Australia.
Resident Classification Scale (RCS)	The basic tool for residential aged care funding prior to 20 March 2008, when it was replaced by the Aged Care Funding Instrument (ACFI). The RCS is based on a resident's classification assessed on a scale from 1-8. A very small number of residents, who entered care before 20 March 2008 are still classified using the RCS through grand-parenting arrangements.
Residential aged care	A programme that provides a range of supported accommodation services for older people who are unable to continue living independently in their own homes.
Restorative care	Is care focusing on enhancing the physical and cognitive function of people who have lost or are at risk of losing condition and independence. The Short-Term Restorative Care (STRC) Programme aims to reverse and/or slow 'functional decline' in older people and improve their wellbeing. Funds were allocated in the 2015-16 Budget for the allocation of Commonwealth subsidised short term restorative care places.
Retained earnings	Refers to the percentage of net earnings not paid out as dividends, but retained by the company to be reinvested in its core business, or to pay debt. This is recorded under shareholders' equity on the balance sheet.

Term	Definition
Retention amounts	An amount that an approved provider is allowed to deduct per month from an accommodation bond for up to five years. The maximum retention amount is set by the Australian Government. Retentions are not permitted for new residents entering residential aged care after 1 July 2014.
Return on Assets	Indicates the productivity of assets employed in the organisation. It is calculated as EBITDA/Total Assets.
Return on Equity/ Return on Net Worth	Indicates the productivity of equity/net worth employed in the organisation. It is calculated as EBITDA/Net Worth.
Scale (providers)	Refers to the number of services operated by a provider.
Size (providers)	Refers to the number of beds operated by a specific service.
Survey of Aged Care Homes (SACH)	Each year SACH seeks information on accommodation payments and planned and actual building activity during the previous financial year for each operating residential aged care service.
Transitional Business Advisory Service (TBAS)	TBAS was a free financial advice service for providers on the 1 July 2014 accommodation payment reforms. It was provided by KPMG and funded by the Australian Government to assist with transition during the implementation of the aged care reforms. It ceased operation on 30 June 2015.
Transition care	For those requiring time-limited, goal-oriented and therapy-focused packages of services after a hospital stay. This programme is to be integrated into the Short Term Restorative Care Programme in 2016-17. Transition care is provided in an acute setting.
Viability supplement	The viability supplement for residential and home care is a payment made under the Act to assist aged care services in rural and remote areas with the extra cost of delivering services in those areas.
Weighted Average Cost of Capital (WACC)	The average cost of financing the assets of the entity weighted by the use of its debt and equity.
Working Capital	Defined as current assets less current liabilities.

Foreword

I am pleased to present the Aged Care Financing Authority's (ACFA) Annual Report on the Funding and Financing of the Aged Care Sector for the fourth time.

ACFA was established in July 2012 by the Australian Government to monitor the impact of significant reforms of aged care on the funding and financing changes in the industry and on the equitable access by consumers to the sector.

This report examines the structure and operation of the Australian aged care sector and its key characteristics; early observations on the impact of recent reforms; funding and financial performance of the sector based on 2014-15 data; and the emerging opportunities and challenges for the sector as significant reforms continue.

It has used Departmental data, sector surveys and stakeholder feedback to understand how the sector is responding to reform.

One of the objectives of aged care reform is to improve the financial sustainability of the aged care system in the face of the steadily increasing demand resulting from our ageing population. Already, a number of measures have been implemented or are in the process of being implemented which serve to achieve this objective.

There have been measurable improvements in overall financial performance of the sector's providers. There have also been significant increases in investment as well as merger and acquisition activity in the residential care sector.

Overall, ACFA considers that the reforms implemented have continued to strengthen the viability and sustainability of the sector.

Another significant focus of the aged care reform is to redress the previous lack of consumer information, discretion and market power. Whilst not widely heralded or acknowledged, the reforms have significantly upgraded the consumers' access to full information including pricing of services and providers' offerings. They have also conferred them with greater decision making power to ensure that they are involved in accessing care that meets their needs. Foreshadowed reforms are expected to further enhance consumer power.

I should like to once again acknowledge the contribution of the many providers, peak bodies, bankers and other institutions, and consumer representative groups that ACFA has consulted during the year. ACFA held meetings and forums with representatives from the investment and financing sectors, providers and consumers. These meetings and forums have been critical to ACFA's understanding of the key issues, developments and challenges facing the industry.

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

Lynda O'Grady

Chairman

Aged Care Financing Authority

Executive summary

Key messages

- In 2014-15, over 2,000 service providers supplied aged care services to 1.3 million older Australians.
- The Australian Government expended $15.2 billion on aged care and consumers contributed around $4.5 billion (excluding refundable accommodation deposits).
- Driven by the ageing of Australia's population and changing attitudes and preferences for the format of aged care, the sector is currently engaged in a phase of substantial transformation and growth.
- ACFA found that the financial and funding impacts of reforms implemented to date continue to be positive:
  - The lump sum accommodation pool continues to grow.
  - The overall financial performance of providers continues to improve.
  - There is increased investment and merger and acquisition activity in the residential sector.
- It is however acknowledged that the impact of the reforms have varied across the sector. The varied impacts of reforms on consumers and providers will continue to be monitored by ACFA.
- The financial performance of home and residential care providers continued to improve in 2014-15, strengthening further on the improvement reported in 2013-14.
  - 72 per cent of home care providers achieved a net profit compared with 66 per cent in 2013-14. The average EBITDA per package, per annum was $2,235 compared with $1,973 in 2013-14.
  - 68 per cent of residential providers achieved a net profit compared with 66 per cent in 2013-14. The average EBITDA per resident, per annum was $10,222 compared with $9,224 in 2013-14.
  - For the residential care sector as a whole, EBIDTA and NPBT increased in 2014-15 by 12.3 and 27.4 per cent respectively compared with 2013-14.
  - As at 30 June 2015, the industry held assets of $36.6 billion, a $2.9 billion increase from 2013-14.
  - A total of $1.7 billion of new building work was completed in 2014-15, an increase of 12 per cent on 2013-14.
- There was strong interest from providers in new residential and home care places with the 2015 Aged Care Approvals Round (ACAR) being significantly over-subscribed in both sectors.
- ACFA will continue to monitor the sustainability and viability of the sector. In future annual reports, ACFA will also assess the impacts of funding reforms announced in the 2016-17 Budget.

1. The Aged Care Financing Authority and the 2016 Annual Sector Report

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

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

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

What this report tells you:

- The structure and operation of the Australian aged care sector and its key characteristics;
- Observations on the impact of recent reforms;
- Funding and financial performance of the sector based on 2014-15 data;
- The emerging opportunities and challenges for the sector as significant reforms continue.

2. Aged care in Australia

The aged care system aims to support older people to live in their homes and communities for as long as they wish to, provide support to individuals who no longer can or no longer wish to do so and, to enable people to make decisions about their care. Older Australians can access a spectrum of aged care, ranging from home support services through to 24 hour care provided in residential settings. There are three main forms of aged care service supported by the Commonwealth, addressed in this report:

- Home and Community Care (HACC) programmes provide basic support services which are distinct from the more structured Home Care Packages Programme. As of 1 July 2015, the Commonwealth HACC Programme became part of the Commonwealth Home Support Programme (CHSP).
- Home Care Package Programme, for those who have greater care needs in order to remain living at home. These packages are offered at four levels, depending on the amount and complexity of care required. Home care packages offer many older people an alternative to residential care.
- Residential aged care provides care and support for people with greater care needs who choose to have their care provided within a residential aged care setting. It is generally provided on a permanent basis but can also be on a temporary basis (respite care).

Table i provides an overview of the aged care sector in 2014-15.

Table i: Aged care in Australia, 2014-15

	HACC	Home care	Residential care
Number of providers	1,628	504	972
Number of services	n/a	2,292	2,681
Number of places	n/a	72,702	192,370[1]
Total revenue	$2.1 b	$1.4 b	$15.8 b
Commonwealth contribution to total revenue	*$1.9 b*	*$1.28 b*	*$10.6 b*
Consumer contribution to total revenue	*$190 m*	*$147 m*	*$4.2 b*
Other contribution to total revenue[2]	*n/a*	*$14 m*	*$1.2 b*
Total expenditure	n/a[3]	$1.2 b	$14.9 b
Total net profit before tax	n/a[4]	$150 m	$907 m

Aged care providers

In 2014–15 there were over 2,000 providers supplying aged care in Australia. There is a large number of providers in each service sector, but relatively few operate across all three settings of HACC, home care and residential care. There were around 1600 HACC providers, 500 home care providers and nearly a thousand residential care providers. Home care providers are the most likely to also operate in other service types. However, across aged care, four out of five providers operate only one type of care, and only 2 per cent of providers operate all three service types. ACFA notes this may change as aged care moves toward a more market-based system with some providers likely to expand their operations to other service types.

Supply of aged care

The Australian Government regulates the supply of residential aged care places and home care packages by specifying national and regional targets for the provision of subsidised aged care places. These targets – termed the 'aged care provision ratio' – are based on the number of people aged 70 and over for every 1,000 people in the Australian population. By 2021-22, the aged care provision ratio is set to grow from 113 to 125 operational places for every 1000 people aged 70 and over.

In addition to setting an overall target ratio for care places, the Commonwealth has maintained ratio-based targets for residential care places and home care packages. Over the coming years, the mix of home care and residential care will be substantially altered. The target for home care packages will increase from 27 to 45, while the residential target is to reduce from 88 to 78 with an additional 2 places in the overall ratio reserved for the new Short-Term Restorative Care Programme places.

[1]Number of places does not include Multi-Purpose Services or Aboriginal and Torres Strait Islander places

[2]'Other' revenue includes interest income, asset revaluations and trust distributions

[3]Analysis of expenditure for HACC providers is not possible as they are funded on a grants and acquittal basis

[4]Analysis of profit for HACC providers is not possible as they are funded on a grants and acquittal basis

Chart i shows the changes in the target provision ratio since 2004 and Chart ii shows the achieved ratio over the last 10 years.

Chart i: Increase in provision ratio, 2004-2022 (per 1,000 people aged 70 and over)

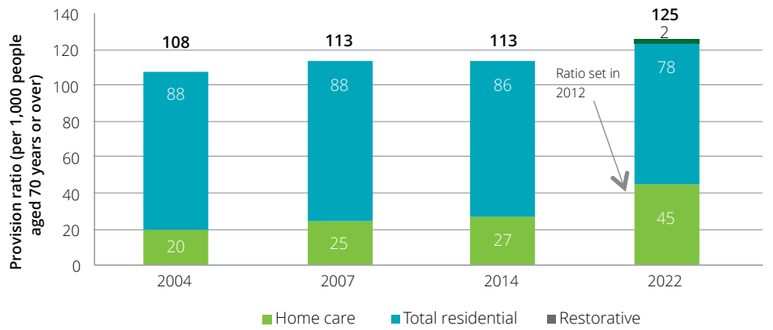
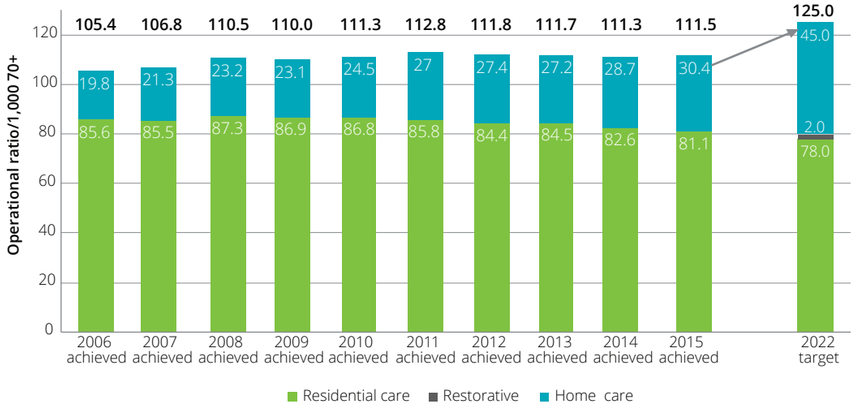


Chart ii: Aged care operational ratios achieved since 2006, compared with the target ratio to be achieved by 2022



Traditionally each year, new aged care places for residential and home care have been made available for allocation through the Aged Care Approvals Rounds (ACAR).

Changes announced in the 2015-16 Budget mean that, from February 2017, home care packages will no longer be allocated to providers. Instead, older Australians will be assigned a home care package that they will be able to direct to their preferred provider. As a result, the 2015 ACAR was the last in which providers were able to apply for home care places. This will not however change the overall restriction of the supply of places through the provision ratios.

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

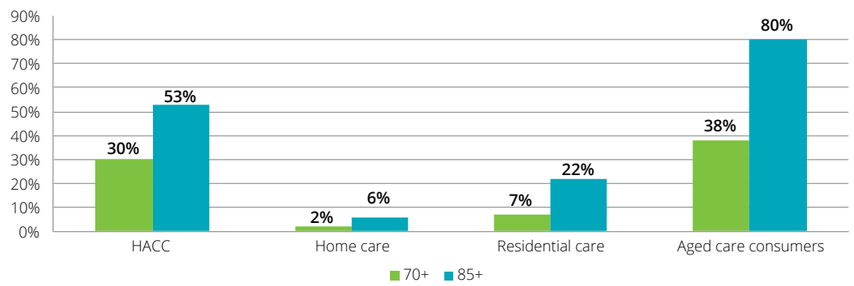
Consumers of aged care

The aged care target population definition adopted by the Australian Government in allocating residential and home care places is the population aged 70 years and over. Because of their lower life expectancy and specific care needs, Aboriginal and Torres Strait Islander Australians aged 50-69 years are also included in the target population.

As at 30 June 2015, there were 2.4 million people aged 70 and over living in Australia. This includes 473,000 people aged 85 and over.

The patterns of use of aged care services change with age. As Chart iii illustrates, at 30 June 2015, 32 per cent of people aged 70 years and over were receiving Australian Government subsidised aged care services while living at home (HACC or home care) and 7 per cent were utilising residential aged care. These proportions increase when focused on the 85 and over cohort, particularly for people accessing residential care, where the usage more than triples.

Chart iii: Proportion of people 70+ and 85+ accessing aged care at 30 June 2015



It is well recognised that Australia's population is ageing, with Australians living longer but many with chronic health conditions. This will bring about significant challenges and opportunities for the aged care system in the years ahead.

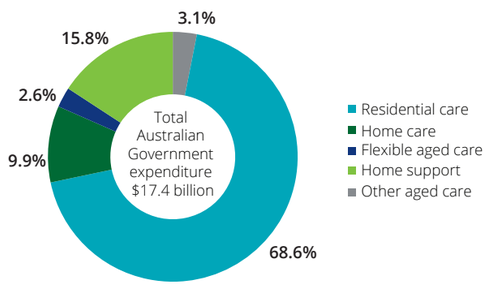
As at 30 June 2015, 15 per cent of Australia's population were aged 65 years and over (3.6 million people) and 2 per cent were aged 85 years and over (473,000 people)[5]. By 2054-55, it is estimated that 22.6 per cent of the population will be aged 65 years and over (8.9 million people) of which 4.9 per cent (1.9 million) will be 85 and over[6].

The composition of this population is also changing as the number of people from culturally and linguistically diverse (CALD) backgrounds within this cohort rises. This change has significant implications for the service delivery models adopted by providers to suit the cultural needs of consumers.

Funding and financing in 2014-15

The Australian Government is the principal funder of the aged care sector. In 2014-15, it contributed $15.2 billion to aged care, up from $14.2 billion in 2013-14. In 2016-17 it is expected to spend $17.4 billion. The proportions of funding across the sector are illustrated in Chart iv.

Chart iv: Australian Government total budgeted aged care expenditure, 2016-17



As discussed in last year's annual report, Australian Government expenditure on aged care is projected to nearly double as a share of the economy from 0.9 per cent currently to around 1.7 per cent of GDP by 2055, largely driven by the increasing number of people aged 85 and over. In addition, the costs of care are expected to rise on account of growth in input costs (e.g. wages) and the increasing complexity of chronic health conditions in ageing populations, tempered by improved efficiencies due to advancements in technology and service delivery.

One of the objectives of aged care reform is to improve the future sustainability of the aged care system in the face of the steadily increasing demand resulting from our ageing population. Already, a number of measures have been implemented or are in the process of being implemented which serve to achieve this objective.

Such measures include the shift in balance of care in favour of home care over residential care and the increasing level of contribution that aged care consumers make towards the cost of their care and accommodation. In 2014-15, aged care residents contributed some $4.2 billion to these costs (excluding refundable accommodation deposits). It is estimated consumers of home care packages contributed around $147 million to their care costs, and consumers of HACC contributed around $190 million.

[5]2014-15 Report on the Operation of the *Aged Care Act 1997*

[6]2015 Intergenerational Report

3. Evaluating aged care reform

The aged care sector has undergone substantial change in the last three years. This change comprised a suite of reforms, including:

- **2012-14 changes**, which saw the commencement of a phased increase in the aged care provision ratio and an increased proportion of home care places compared with residential care places; the introduction of new home care package levels; commencement of Consumer Directed Care for new home care packages; and accommodation price publishing. The My Aged Care website and Contact Centre, the Australian Aged Care Quality Agency and the Aged Care Pricing Commissioner were also introduced, along with the Aged Care Financing Authority.
- **2014-15 financing changes**, which saw reforms to accommodation payment arrangements, new income testing arrangements in home care and means testing in residential care and a higher maximum accommodation supplement for new and significantly refurbished homes.
- **2015-16 consumer choice changes**, which saw standardised assessments; central records that underpin assessment, referral and service provision; extension of Consumer Directed Care to all existing home care package recipients; and the formation of the Commonwealth Home Support Programme.

From July 2014 to December 2015, ACFA was tasked by the Minister to monitor the impact of the funding and financing changes on the sector. It used Departmental data, sector surveys and stakeholder feedback to understand how the sector is responding to reform. ACFA found that refundable accommodation deposits remain the most used method of accommodation payment in residential care, and that the lump sum accommodation pool continues to grow.

There have been significant improvements in overall financial performance of the sector's providers. There have also been significant increases in investment as well as merger and acquisition activity in the residential care sector.

Access to care has generally been maintained through the reform process. Data indicates that admission rates for both residential and home care have been largely stable, although occupancy in home care is lower in 2014-15 compared with 2013-14. There are also some indications that take-up of Level 1 and Level 2 home care packages may have declined slightly, potentially due to consumers preferring instead to access HACC services due to lower fees. In residential care, the level of respite care admissions has risen compared with levels of permanent admission, with some consumers and providers preferring that consumers enter respite care while financial arrangements are settled before moving into permanent care.

ACFA acknowledges that reform impacts have varied across the sector and between providers. Maximum published accommodation prices for residential care are higher in metropolitan than regional areas, and in facilities that are not government-run. The actual prices agreed with consumers for residential care follow the same pattern.

Overall, ACFA considers that the reforms implemented have continued to strengthen the viability and sustainability of the sector.

4. Home support

Home support comprises services for those who require entry-level assistance in home living. In 2014-15 home support comprised the Commonwealth Home and Community Care Programme (HACC) and the Victorian and Western Australian HACC Programmes.

On 1 July 2015 the Commonwealth Home Support Programme (CHSP) was created, which combined Commonwealth HACC, the National Respite for Carers Programme, Day Therapy Centres and the Assistance with Care and Housing for the Aged Programme. The Victorian Home and Community Care Programme (Victorian HACC) was integrated into the CHSP on 1 July 2016.

As this report considers 2014-15, some outcomes for both Western Australian HACC and Victorian HACC are reported separately to those of the Commonwealth HACC Programme.

Providers
In 2014-15, there were 1,084 Commonwealth HACC providers, slightly down from the 1,110 providers in 2013-14. There were also 544 Western Australian and Victorian HACC providers, again, down from the 566 in 2013-14 in these two states.

Providers of home support services are predominantly not-for-profit. In 2014-15, 74 per cent of Commonwealth HACC providers were not-for profit, with 18 per cent government owned.

Consumers
In 2014-15, 530,210 individual clients aged 65 and over (50 and over for Aboriginal and Torres Strait Islander people) received assistance through Commonwealth HACC. This is a 6 per cent increase compared with the number of consumers accessing the program in 2013-14 (500,615). In Victoria and Western Australia, 282,174 people within this same age bracket received services through HACC programs. This totals 812,384 older consumers across Australia.

Funding and financing
In 2014-15, The Australian Government provided funding of:

- $1.3 billion for Commonwealth HACC ($1.2 billion in 2013-14); and
- $579.7 million to Victorian and Western Australian HACC ($539.8 million in 2013-14).

Fees paid by consumers for Commonwealth HACC currently vary across states and territories though they have been estimated by the Department at about 10 per cent of total funding.

Developments and challenges
In July 2016, the Victorian HACC programme services for older people commenced transition into the CHSP. In Western Australia, the HACC programme continues to deliver basic home care services to both older and younger people.

The Australian Government has announced its intention to integrate the CHSP with the Home Care Packages Programme from 1 July 2018 to create a single care at home programme.

5. Home care

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

Home care packages are categorised into four levels:

Level 1 To support people with basic care needs that are greater than those of HACC consumers;

Level 2 To support people with low care needs (previously CACPs);

Level 3 To support people with intermediate care needs; and

Level 4 To support people with high care needs (previously EACH and EACH-D).

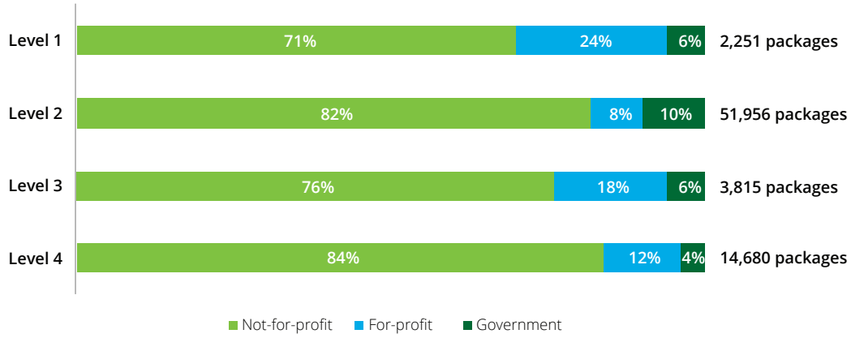
Additional specific funding in the form of a Dementia and Cognition supplement can be paid for consumers with cognitive impairment for all levels of packages. The supplement is paid at a rate of 10 per cent of the basic subsidy amount payable for each of the applicable levels. Other supplements are also payable where the consumer's circumstances require it.

Providers

In 2014-15, there were 504 home care providers that operated 2,292 services and 72,702 packages. While the number of home care providers has stayed constant from 2013-14, the number of services and packages has risen (from 2,212 and 66,149 respectively).

Not-for-profit providers continued to provide the greatest number of packages across all levels. The share of packages provided by for-profit providers did, however, increase slightly from 9.6 per cent to 10.1 per cent between 2013-14 and 2014-15. Chart v shows the proportion of each package level operated by provider ownership type.

Chart v: Proportion of home care packages by provider type, 2014-15



Consumers

In 2014-15, 83,838 individuals accessed home care packages in Australia.

Occupancy across all home care levels during 2014-15 was 85.8 per cent compared with 88.4 per cent in 2013-14:

- Though occupancy rates were lowest for the newer Level 1 and 3 packages, occupancy of these packages – which were only introduced from 1 August 2013 – increased by 13.4 per cent and 6.8 per cent respectively.
- Victoria and Tasmania had the highest rates of occupancy across all states and territories, with the lowest overall occupancy in Western Australia.

Funding and financing

Commonwealth funding is the primary source of revenue for home care providers. In 2014-15, the Commonwealth made payments of $1.28 billion to all providers on behalf of consumers as a contribution towards their support costs, an increase of 0.8 per cent from 2013-14.

Consumers contributed around 10 per cent of revenue, up from 7 per cent in 2013-14 – largely as a result of income tested fees being introduced from 1 July 2014 for new consumers.

Key observations on home care providers financial performance in 2014-15, compared with 2013-14

- Total revenue of $1.4 billion[7] up from $1.3 billion;
- Total sector profit of $150 million[8] up from $120 million;
- 72 per cent of providers achieved a net profit compared with 66 per cent;
- Staff remuneration remained the most significant expense across the sector comprising 60 per cent of total expenses compared with 61 per cent;
- On a per package basis, the average Earnings Before Interest Tax Depreciation and Amortisation (EBITDA) per package per annum was $2,235 compared with $1,973, an increase of 13.3 per cent;
- In 2013-14, for-profit providers had achieved significantly higher EBITDA per package than the not-for-profit sector. However, in 2014-15, performance of the sectors had converged;
- During 2014-15, regional providers had lower EBITDA of $1,806 per package per annum compared with $2,060 for metropolitan providers, while providers who operated in both regional and metropolitan areas had a much higher EBITDA of $2,819.

[7] Estimate based on the 89 per cent of provider's 2014-15 home care financial reports that were submitted in a useable form.

[8] Estimate based on the 89 per cent of providers' 2014-15 home care financial reports that were submitted in a useable form.

Developments and challenges
The home care sector is undergoing significant change to its operations with the full implementation of Consumer Directed Care (CDC). CDC gives consumers greater control over their own lives by enabling them to make choices about the types of care and services they purchase and how those services are delivered. From 1 July 2015 all home care packages were required to be provided on a CDC basis.

Additionally, from February 2017, funds will follow the consumer which means the consumer will be allocated a package rather than the provider. Consumers will then choose a home care provider. This will drive further change in the sector as consumers assume greater control of their care. The nature of home care will evolve further in 2018 with the Australian Government announcing its intention to integrate the CHSP and Home Care Packages Programme.

Changes in the service provision target ratios will result in an increase in the number of packages funded by the Australian Government. These changes will increase the total number of home care packages from around 72,000 currently to around 140,000 by 2021-22. The increase in the supply of home care packages will give more consumers the option to remain in their own homes, thereby increasing competition between home care and residential services.

6. Residential aged care: access to care

Residential aged care provides personal and nursing care for those who choose to have their care provided within a residential aged care setting. It is provided on a permanent or respite basis.

Providers
In 2014-15, there were 972 providers down from 1,016 in 2013-14, reflecting consolidation in the industry. There were 2,681 services operated in 2014-15 with 192,370 places. While the number of services remained relatively stable, the number of places increased from 189,283 in 2013-14 (1.6 per cent). The 2015 ACAR allocated 10,940 new residential aged care places.

The majority of residential aged care places are operated by not-for-profit providers (54 per cent of providers and 57 per cent of places). For-profit providers account for 36 per cent of providers and 38 per cent of places, with state and territory and local government owned providers accounting for 11 per cent of providers and 5 per cent of places.

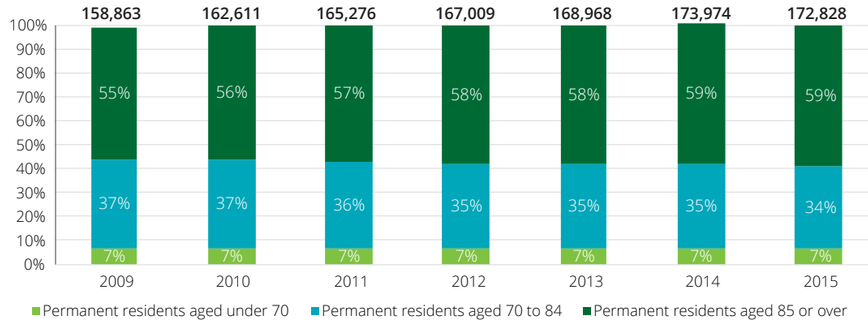
There continues to be a significant number of single home providers (64 per cent of all residential providers) though they only account for 23 per cent of places. Conversely, providers with more than 20 homes account for only 2 per cent of all providers, however, they account for 25 per cent of operational places.

The majority of providers continue to be located in metropolitan regions only, however, the number who exclusively serve metropolitan regions has dropped (52 per cent compared with 58 per cent in 2013-14). The number of providers serving both metropolitan and regional areas has risen from 4 per cent in 2013-14 to 9 per cent in 2014-15.

Residents
The number of residents who received permanent residential care during 2014-15 was 231,255 (compared with 231,515 in 2013-14). However, the number of people who accessed residential respite care increased by almost 10 per cent over the same period, to 53,021.

The residential aged care population is getting older over time as people live longer and have more opportunity to stay in their own homes longer with the help of home care packages. The proportion of residents aged 85 years and over has increased from 55 per cent in 2009 to 59 per cent in 2015, while the proportion of those aged between 70 and 84 has decreased from 37 per cent to 34 per cent. The average age of permanent residents in 2015 was 84.6 years. This has been steadily increasing since 2009 when it was 84.0 years. Chart vi illustrates the proportion of the total population accessing residential care, by age group.

Chart vi: Proportion of residential aged care residents by age (under 70, 70-84, and 85+) as at 30 June each year



7. Residential aged care: operational performance

Funding for residential aged care comprises operational funding and capital financing. Operational funding supports day-to-day services such as nursing and personal care while capital financing supports the construction and refurbishment of residential aged care services.

Key observations on operational funding of residential aged care in 2014-15 compared with 2013-14

- Revenue:
  - Total revenue was $15.8 billion, an increase of 6.6 per cent;
  - Equating to $249 per resident per day, an increase of 5.3 per cent.
- Expenditure:
  - Total expenses were $14.9 billion, an increase of 5.6 per cent.
- Profit:
  - Total EBITDA was $1.8 billion, up from $1.6 billion in 2013-14, an increase of 12.3 per cent;
  - Net Profit Before Tax (NPBT) was $907 million, up from $712 million, an increase of 27.4 per cent;
  - EBITDA per resident per annum was $10,222 up from $9,224, an increase of 10.8 per cent;
  - NPBT per resident per annum was $5,221, up from $4,150, an increase of 25.8 per cent.

Operational funding is provided by both the Commonwealth and residents. Total revenue in 2014-15 was $15.8 billion compared with $14.8 billion in 2013-14. This increase was largely attributable to growth in Commonwealth care subsidies.

The Commonwealth contributed 66 per cent of total funding ($10.6 billion up from $9.8 billion in 2013-14). Residents contributed 27 per cent of total funding ($4.2 billion)[9] and the remaining income was generated from other sources.

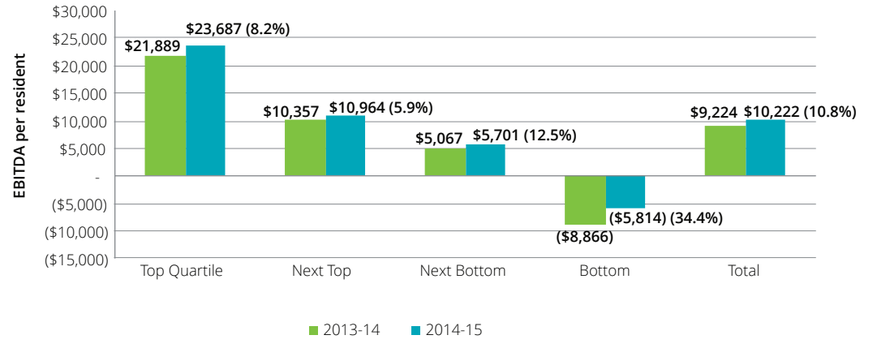
Staff costs represented 67 per cent of total expenses, up slightly from 66 per cent in 2013-14. 'Other costs' including repairs and maintenance, rent and utilities accounted for 27 per cent of operational costs.

The residential aged care sector showed an overall profit. The total sector EBITDA and Net Profit Before Tax (NPBT) both increased in 2014-15 by 12.3 and 27.4 per cent respectively compared to 2013-14. This builds on the increase in both measures reported in 2013-14 of 19.9 per cent and 7.3 per cent respectively.

The profitability of providers continues to vary greatly across the sector as shown in Chart vii. Those with performance results in the top quartile of providers achieved an average EBITDA of $23,687 per resident. Providers in the bottom quartile averaged an EBITDA of – $5,814 per resident. It is noteworthy that the greatest improvement in EBIDTA between 2013-14 and 2014-15 was in the bottom quartile which increased 34 per cent from -$8,866.

[9] Excluding refundable accommodation deposits

Chart vii: Comparative EBITDA per resident per annum in 2014-15 and 2013-14



On average, financial performance continued to vary based on ownership type (for-profit generally outperformed not-for-profit) and remoteness location (metropolitan generally outperformed regional).

Summary: Report on Issues Affecting the Financial Performance of Rural and Remote Providers

ACFA's report 'Financial Issues Affecting Rural and Remote Aged Care Providers' was delivered to the Minister in January 2016.

The analysis – which considered 2014-15 service level financial data – showed that services in rural and remote areas were more likely to experience high cost pressures that lowered their financial results. Lower financial performance became more pronounced with remoteness and lower bed numbers. Results were also generally lower for state and territory government providers who have higher costs, particularly wages, though many also receive additional state and territory government funding.

Notably, the Report did confirm that location alone was not the sole determinant of financial performance. There were a number of providers in rural and remote settings reporting strong financial results. Factors driving these pockets of strong performance were found to include:

- The quality, skills and range of organisation leadership;
- The adoption of innovative approaches (including Information Technology) to service delivery; and
- Overall organisational structure and approaches to facility/service management, covering care, administration and financial management.

2016-17 Budget
In the 2016-17 Budget and in the 2015 Mid-Year Economical Fiscal Outlook (MYEFO), the Commonwealth announced changes to the Aged Care Funding Instrument (ACFI) to address concerns of higher expenditure growth in complex health care than estimated in the 2015-16 Budget. The changes are estimated to reduce Commonwealth expenditure under ACFI by $2 billion over four years to 2019-20. Without these changes, Commonwealth expenditure under ACFI was estimated to exceed 2015-16 Budget estimates by $3.8 billion. ACFA notes sector concerns that the reduction in growth may exceed the Budget estimates, and in future Annual Reports will analyse and report on the impact of these (and other) changes.

There will also be changes to the Viability supplement that will increase the average annual viability supplement payment to residential and home care services currently receiving it, and provide a number of services with Viability supplement payments funding for the first time.

8. Residential aged care: capital investment

Capital for residential aged care comprises interest free loans from residents in the form of lump sum refundable accommodation deposits (bonds pre 1 July 2014), financing from equity investments, loans from financial institutions, Commonwealth grants and payments, and retained earnings.

Investment challenges and trends
The residential aged care target ratio of 78 places per 1,000 people aged 70 years and over by 2021-22 means the Australian Government is aiming to achieve one operational residential care place for every 13 people aged 70 years and over. If the sector is to meet this target, there will need to be significant growth in the supply of places as the baby boomer cohort reaches 70 years old.

Because the baby boomers are such a large group compared with the pre-war generation, the proportion of the 70 and over population that are aged 85 and over will reduce over the next decade then subsequently increase (Chart viii). This implies that the challenge of ensuring there is sufficient residential aged care supply to meet demand arising from the baby boomer generation is likely to be more significant in 10-15 years time than over the next decade.

Key observations on capital investment in residential aged care in 2014-15 compared with 2013-14

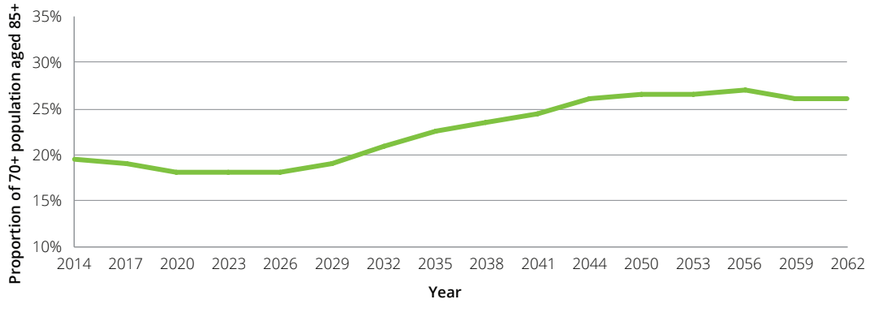
- Total assets of $36.6 billion, an increase of $2.9 billion;
- Total liabilities of $25.7 billion, up from $22.5 billion. This includes $18.2 billion of accommodation deposits held by industry;
- Accommodation deposits of $18.2 billion, up from $15.6 billion; and
- Net assets of $10.9 billion down from $11.2 billion.

Based on current policies, the Department advised ACFA that it estimates that the residential care sector will need to build approximately 76,000 additional places over the next decade, compared with the 34,788 new places that came online over the previous decade (Chart ix). Increased investment activity now and in future years is necessary to meet this challenge given the lead time in building and commissioning homes.

At the same time, the sector will need to knockdown and rebuild a substantial proportion of its current stock. Assuming that a quarter of the current stock of buildings is rebuilt at an even rate over the next decade, the Department estimates that the total investment required in the sector over the next decade to be in the order of $33 billion.

The calculation of future annual investment requirements is predicated on achieving the current residential service provision targets in each year. These planning targets are likely to over-estimate the places required to ensure sufficient provision levels during the short term. This is because the cohort that predominantly access residential care – the population aged 85 and over – is declining over the next decade as a proportion of the 70 and over population, on which the provision targets are based (See Chart viii).

Chart viii: Proportion of 70+ age group who are aged 85+



This period also coincides with a significant increase in the supply of home care packages.

There is a relatively large stock of places that have been allocated but are yet to be made operational, and demand for new places through recent ACARs has been strong as the financial performance of providers has improved. Planning undertaken by the Department indicates that future planning targets for residential care (based on the current ratio) are likely to be met.

As noted in last year's annual report, investment trends are improving. The 2015 Survey of Aged Care Homes estimated that a total of $1.7 billion in new building, refurbishment and upgrading work was completed during 2014-15, involving about 20 per cent of all homes. The amount of new building work in progress at the end of June 2015 was estimated at $2.1 billion involving 17 per cent of all homes.

Compared with 2013-14, in 2014-15, there was an increase of $184 million (or 12 per cent) in new building, refurbishment and upgrading work. There was also an increase of $494 million (or 31 per cent) in work in progress during the same period. The value of building approvals has increased in the 12 months to February 2016 – $168 million per month compared with $129 million in the previous 12 months.

Chart ix: Number of operational residential aged care places required in the next decade 2015-2026

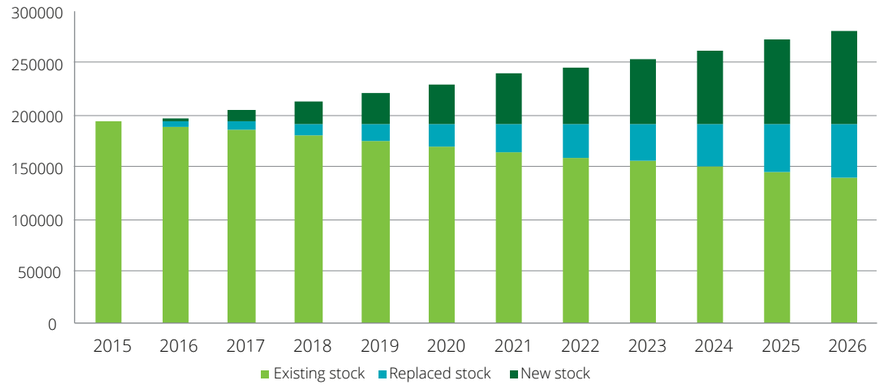
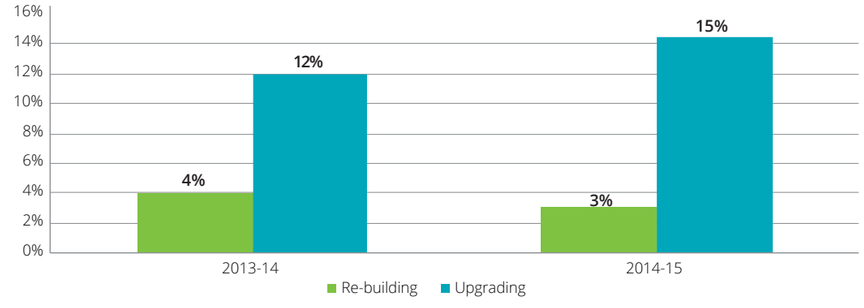


Chart x shows the proportion of homes planning to either upgrade or rebuild in 2014-15 compared with 2013-14.

Chart x: Proportion of homes planning to upgrade or rebuild, 2013-14 and 2014-15



ACFA concludes that investors are responding positively to the 1 July 2014 reforms and are showing interest in investments that leverage the ageing demographic.

9. Looking forward: reform environment ahead

The current aged care system is at a transitional point on a longer pathway to ensure there is a sustainable, high quality aged care system that meets the needs of all older Australians. This pathway includes reforms to home care announced in 2015, which will take effect in 2017 and 2018; and a longer term reform program that is being developed by the Commonwealth and the sector.

The reforms announced in 2015 include funds following the consumer in home care from February 2017, which will give consumers choice of service provider. Also announced was the intention to combine the Home Care Programme and CHSP into a single care at home programme in 2018.

ACFA has noted some uncertainty in the sector regarding these changes to home care. The market to provide home care services will develop alongside the open market for services to consumers under the National Disability Insurance Scheme. ACFA anticipates that the sector will evolve to respond to this consumer-driven market. Some rationalisation of providers could occur as the sector moves to a more competitive environment. A portion of that rationalisation is likely to involve strategic alliances and mergers between not-for-profit providers who will continue to pursue their missions in the communities that they currently serve. These reforms are also expected to result in increased involvement by the for-profit sector in home care.

Beyond these planned changes to home care, the Commonwealth and the sector are planning for further change, and ACFA recognises that the current configuration of aged care represents an intermediate stage in that longer reform process.

Likely directions for change are evident in the consensus expressed by stakeholders and reflected in that Aged Care Roadmap developed by the Minister's Aged Care Sector Committee (ACSC), and informed by the Productivity Commission's 2011 report, as well as the work of the National Aged Care Alliance.

The Roadmap represents the ACSC's views on what is required to move towards a consumer-driven, market-based and sustainable system, based on the following key elements:

- Commonwealth contributions to individuals would be based on assessed needs and means and would be agnostic as to where an eligible person chooses to live.
- The Commonwealth would no longer regulate the number, type, distribution and price of services. Instead service providers would compete on price and quality for consumers.
- Where there is insufficient market response, additional Commonwealth assistance would continue to be available.

In relation to how aged care is financed, the Roadmap suggests that increasing demand for, and cost of, aged care means that the system should change to ensure that consumers contribute consistent with their capacity to do so. The Roadmap suggests different reforms and policies for accommodation and living costs on the one hand, and care and support on the other.

The Roadmap proposes that consumers remain responsible for accommodation and everyday living costs, as they have been throughout their lives, with the Commonwealth providing a safety net, and to intervene to assist where the market does not respond to consumer needs.

On care and support, there would be less regulation of prices and choices, with consumers able to choose service types and how much they pay. The Commonwealth would however place some limits on the kinds of things on which its contribution to costs of care could be spent.

ACFA agrees with the ACSC that critical to achieving reform is a deep understanding of consumer behaviour and the economics of the sector.

ACFA considers that the success of further reforms will be dependent on the readiness of key stakeholders. ACFA considers that key areas in which stakeholders need to prepare are:

- The Commonwealth needs to provide sufficient certainty to allow informed and effective business planning, and have infrastructure and support systems in place that have the capacity to underpin intended reforms.
- Consumers need to be aware of, and ready to accept, their rights and obligations.
- Providers need to implement appropriate systems and practices to reflect the new arrangements and have the necessary culture and capacity to adapt.
- Investors need to have sufficient certainty to have the confidence to respond to the growing demand.

The Aged Care Financing Authority and the 2016 Annual Sector Report

1 This report

1.1 Aged care in Australia

The aged care sector in Australia provides services to 1.3 million Australians and generates annual revenues totalling around $20 billion. The sector makes a significant contribution to the Australian economy, representing 0.9 per cent of Gross Domestic Product (GDP).

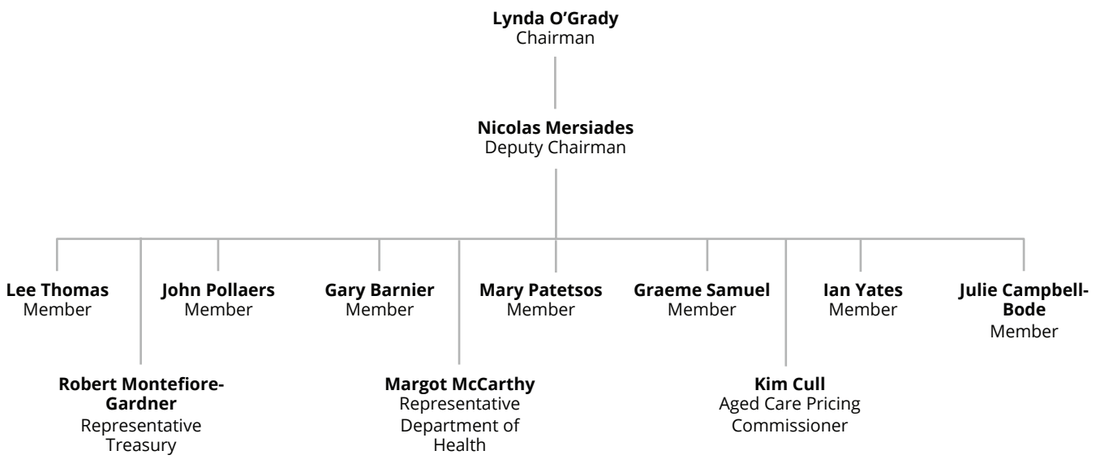
The sector is heavily dependent on taxpayer funding, receiving $15.2 billion in Commonwealth funding in 2014-15, an increase of 7.1 per cent from the previous year ($14.2 billion). Given the level of taxpayer funding, objective and thorough analysis of the funding and financing of the sector is of central importance to aged care consumers, providers and to the Australian community.

1.2 About the Aged Care Financing Authority

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

ACFA is led by an independent Chairman (Lynda O'Grady) and Deputy Chair (Nicolas Mersiades) complemented by seven Members with aged care or finance sector expertise. Further details about each member are provided in Appendix A. There are also three non-voting Australian Government representatives on ACFA, who are also detailed in Appendix A.

Figure 1.1: ACFA Membership



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

The Committee Principles 2014 require that ACFA provide the Minister responsible for aged care with a report on the funding and financing of the aged care sector (the Annual Report) each year. The objective of the Annual Report is to provide advice to the Minister regarding the impact of funding and financing arrangements on:

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

Over time, each Annual Report will build upon the last, producing a substantial body of in-time as well as trend data on the funding and financing of the aged care sector. To date, there have been three Annual Reports published.[10]

1.3.1 Method

The 2016 Annual Report analyses and presents 2014-15 financial and funding data collected from aged care service providers. Although the analysis of the financial performance and operations of providers is primarily based on 2014-15 data, this is supplemented by more recent data sources wherever possible.

The principal data source is financial and administrative data collected by the Commonwealth, including:

- From residential aged care providers:
  - General Purpose Financial Reports (GPFRs);
  - Annual Survey of Aged Care Homes (SACH); and
  - Published aged care accommodation prices (My Aged Care Website).
- From home care providers:
  - Home Care Packages Programme Financial Reports.
- From Home and Community Care providers:
  - Home and Community Care Minimum Data Set.
- Other general data:
  - ACFA's survey of aged care providers as part of its reform monitoring up to 31 December 2015;
  - The 2012 National Aged Care Workforce Census and Survey; and
  - The 2014-15 Report on the Operation of the Aged Care Act (ROACA);

In addition to the above listed data sources, ACFA has consulted widely with the sector, relevant financiers and other key stakeholders in developing this report. A list of organisations consulted in the development of the 2016 Annual Report is provided in Appendix C.

2014-15 financial data has been analysed by sub-sector (Home and Community Care[11], home care and residential aged care) to draw out key insights relating to funding and financial performance.

Financial performance of providers

When discussing the financial performance of providers in this report, Earnings Before Interest, Depreciation and Amortisation (EBITDA) is the main measure used to analyse profitability. This is because EBITDA excludes items such as interest (both income and expense) and tax expenditures, which can vary depending on the financing decisions of an organisation; and non-cash expenses, such as depreciation and amortisation which can vary greatly based on the size and age of facilities and other assets, and on ownership. EBITDA can be used to compare organisations with each other and against industry averages and is a good measure of core profit trends because it eliminates some of the extraneous factors mentioned above. This is particularly important when analysing aged care given the diversity of ownership and capital structures. EBITDA helps to smooth out these factors and for these reasons it can be viewed as a proxy for cash flow when cash flow information is unavailable.

[10] Previous ACFA Annual Reports can be accessed https://agedcare.health.gov.au/aged-care-reform/aged-care-financing-authority.

[11] From 1 July 2015, the HACC Programme became part of the Commonwealth Home Support Programme (CHSP). The CHSP also incorporates the former National Respite for Carers Programme, the Day Therapy Centres Programme and the Assistance with Care and Housing for the Aged Programme. However the 2016 ACFA Annual Report focuses mainly on the HACC programme.

This report also refers to Net Profit Before Tax (NPBT). Both measures exclude tax, which can assist in making comparison between organisations subject to different tax treatments. This is important in aged care, where the majority of providers are not-for-profit organisations that do not pay company tax. As well as excluding tax, EBITDA also excludes interest payments and depreciation, which are taken into account in NPBT.

It is important to be mindful of the sector composition and the varying objectives of providers when interpreting the data. As noted, the sector remains dominated by not for profit providers. Traditional profit-based measures are not always consistent with the mission and objectives of not-for-profit providers, many of whom seek to balance funding with expenditure rather than seeking to achieve a surplus.

Considerations and limitations

As reforms to aged care continue to be implemented, some forms of service delivery, and therefore data collection, are changing. For this reason, analysis in the 2016 Annual Report is not always directly comparable with analysis contained in previous ACFA Annual reports. Where this is the case, it is signalled.

While this report broadly discusses the characteristics of the residential aged workforce in Chapter 6, ACFA is limited in its ability to provide significant new analysis of the aged care workforce as a whole. Previous ACFA reports have provided information relating to the most recent Aged Care Workforce Census and Survey, which was conducted in 2012. Given that the survey is conducted every 4 to 5 years, ACFA is likely to be constrained in its analysis of the aged care workforce in between the surveys being conducted. The next survey is expected to be finalised early in 2017 which should allow ACFA to provide new workforce analysis in its next Annual Report.

The financial data available to ACFA is at the approved provider level. Because many providers have services in multiple locations, ACFA is constrained in its ability to analyse performance at service level or the impact of locational factors on funding, financing and financial performance of services. In its recent study of the financial performance of rural and remote providers, ACFA did obtain service level data, and where applicable, ACFA has presented the study's findings in this Annual Report. However, it does not have this level of detail for the majority of the sector.

1.3.2 Navigating the 2016 Annual Report

The 2016 Annual Report is structured as follows:

- Chapter 2 **Aged care in Australia.** This chapter provides an overview of the aged care sector in Australia, including supply, usage, sustainability and workforce.
- Chapter 3 **Evaluating aged care reforms.** This chapter discusses and analyses the impact of previous reforms in aged care.
- Chapter 4 **Home support.** This chapter discusses the Commonwealth, Victorian and Western Australian Home and Community Care Programmes and provides an overview of the Commonwealth Home Support Programme which commenced on 1 July 2015.
- Chapter 5 **Home care.** This chapter provides an overview of the provision of home care through the Home Care Packages Programme and a summary of revenue, expenditure and profit for providers in this sub-sector in 2014-15.
- Chapter 6 **Residential aged care: access to care.** This chapter provides an overview of residential aged care, focusing on the supply and demand for residential aged care.
- Chapter 7 **Residential aged care: operational performance.** This chapter provides information on the revenue, expenditure and profit of residential care providers in 2014-15.
- Chapter 8 **Residential aged care: capital investment.** This chapter provides discussion pertaining to provider balance sheets and capital investments.
- Chapter 9 **Looking forward: reform environment ahead.** This chapter provides an outline of the reforms currently being implemented, planned or contemplated for the future.

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

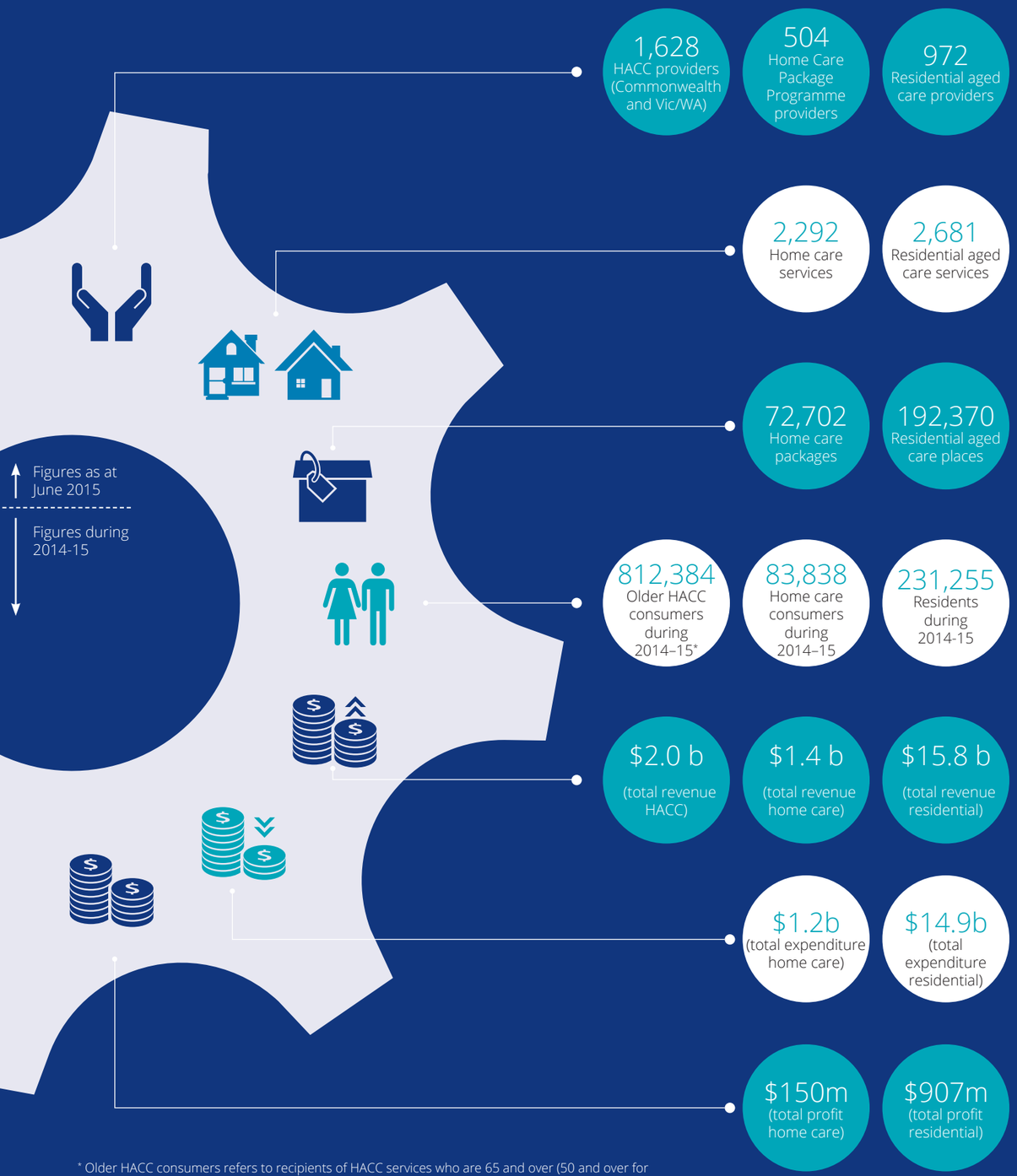
Analysis of providers in this report is generally presented in four ways:

- Whole of sector (refers to all providers operating a particular type of care);
- Ownership type (not-for-profit, for-profit or government owned);
- Remoteness location (metropolitan, regional, mix of metropolitan and regional); and
- Scale (number of services/facilities/homes operated by a provider).

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

When referring to 'government owned', the report is referring to services owned and operated by state, territory and local governments.

Chapter 2
Aged care in Australia



* Older HACC consumers refers to recipients of HACC services who are 65 and over (50 and over for Indigenous Australians)

2 Aged care in Australia

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

This chapter discusses:

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

This chapter reports that:

- aged care is one of Australia's largest service industries:
  - Services provided to 1.3 million people
  - Provided by
    - 1084 Commonwealth HACC providers
    - 544 HACC providers in VIC and WA
    - 504 Home care providers
    - 972 Residential care providers
- comprises 0.9 per cent of GDP

2.1 Overview

The aged care system aims to support older people to live in their homes and communities for as long as possible, and to enable people to make decisions about their care. Older Australians can access a spectrum of aged care, ranging from home support based services through to care provided in residential settings.

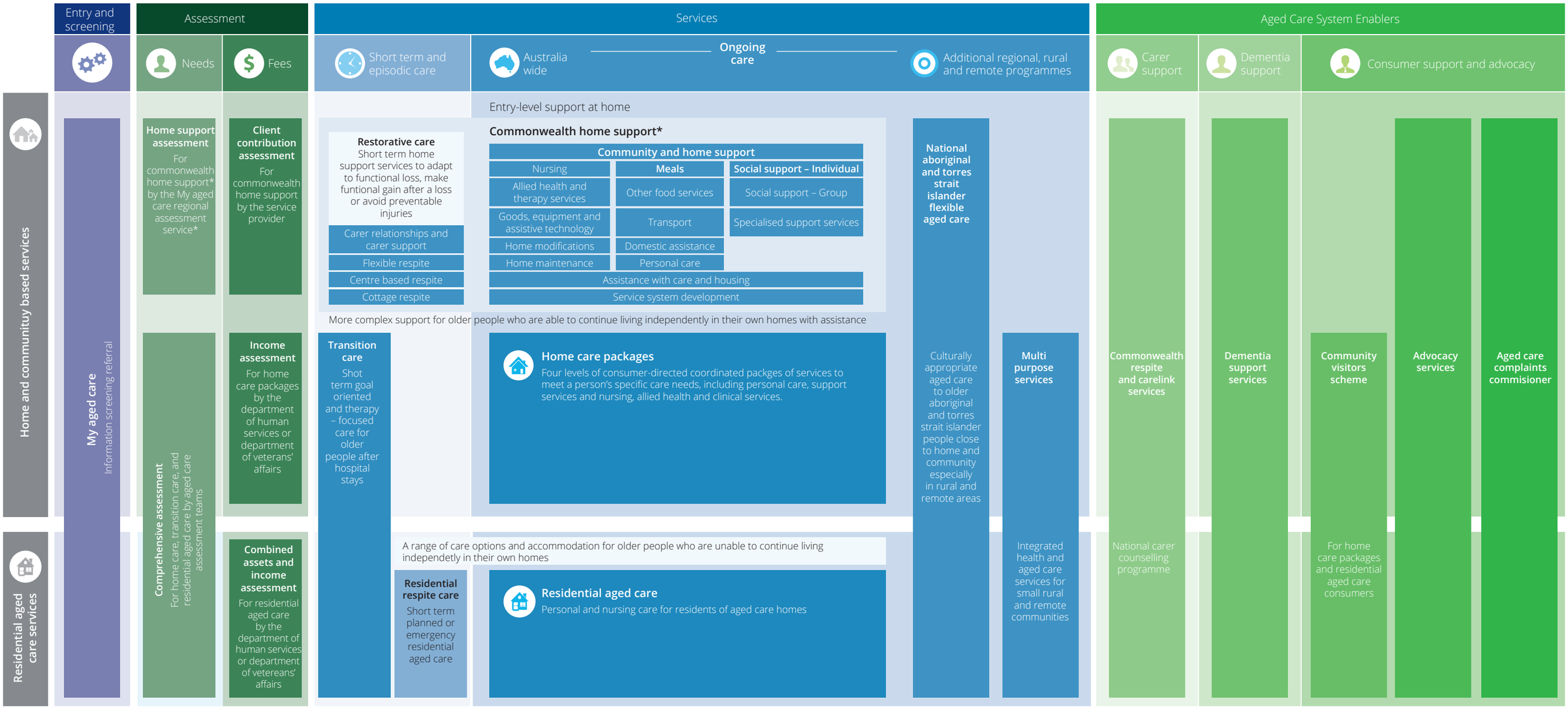
Many aged care services are subsidised and regulated by the Australian Government. Figure 2.1 illustrates the Commonwealth subsidised Australian aged care system.

From 1 July 2015, My Aged Care became responsible for arranging an assessment of a person's eligibility for Commonwealth-funded aged care services. This assessment is usually face-to-face and serves to determine each individual's care needs and goals, and to identify their preferences for support.

The assessment determines the services types (Commonwealth Home Support, Home Care Packages or Residential aged care) for which the individual may be eligible.

Each person's care and support needs are thereafter monitored and periodically re-assessed and their services changed as necessary, depending on the availability of an appropriate place.

Figure 2.1: Australian aged care system – guide to Australian Government subsidised aged care services

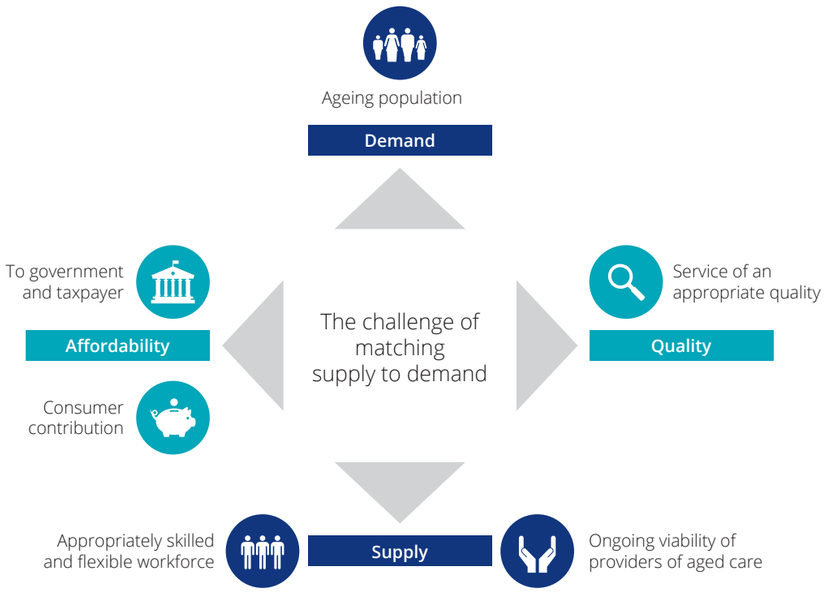


*Home support assessment and some home support services may be different in Victoria and Western Australia. My aged care assists older people in these states to access state specific home support assessment and services.

2.2 A sustainable system

A sustainable aged care system requires the supply of aged care to be effectively and efficiently matched to the demand for services. A sustainable aged care system also needs to consider affordability to taxpayers and consumers of delivering aged care, as well as the quality of care provided.

Figure 2.2: Balancing demand of an ageing population, supply, affordability and quality in the aged care sector



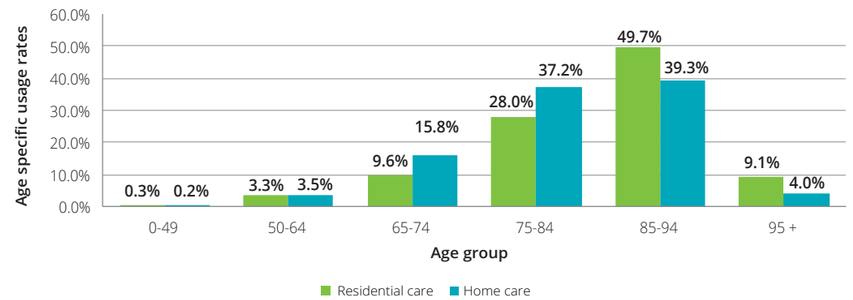
Aged composition and occupancy across care types

Across the continuum of care, the age composition of consumers changes as their needs change over time. Chart 2.1 shows the proportion of older Australians in home care and residential aged care in 2014-15 by age brackets. It shows that the proportion of residential care usage when compared with home care increases as people get older.

In home care the average age of consumers was 82.3 years compared with 84.6 years in residential care, while the proportion of people aged 85 and over in residential care was 60 per cent compared with 43 per cent in home care.

Occupancy across all home care packages dropped noticeably during 2014-15 to 85.8 per cent (88.4 per cent in 2013-14). Occupancy in residential care remained steady at 92.5 per cent in 2014-15 (93 per cent in 2012-13 and 2013-14).

Chart 2.1: Age profile of people in residential and home care, at 30 June 2015



2.3 Current aged care supply

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

- **Home and Community Care (HACC).** For those who require basic services to assist in home living, HACC provides help with daily tasks and less complex care. As of 1 July 2015 the Commonwealth HACC Programme was included in the new Commonwealth Home Support Programme (CHSP). The HACC Programme in Victoria and Western Australia continued to be administered by the Victorian and Western Australian governments during 2015-16. Victorian HACC services for older people transition to the CHSP on 1 July 2016.

- **Home care.** For those who have greater care needs in order to remain living at home. Care and support is provided through a package of home care services.

- **Residential care.** Provides 24 hour care for those who need greater care needs but choose to be cared for in an aged care home. Care can be provided on either a temporary (respite) or permanent basis.

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

- **Flexible care.** Services in either a residential or home care setting, that due to difficulties in delivering services in some communities, are delivered using different care approaches than that provided through mainstream residential and home care. Examples of flexible care. include Multi-Purpose Services and Aboriginal and Torres Strait Islander flexible care.

- **Restorative Care.** Is care that focuses on enhancing the physical and cognitive function of people who have lost or are at risk of losing condition and independence. A new Short-Term Restorative Care (STRC) Programme, which commences in 2016-17 and incorporates the existing Transition Care Programme will aim to reverse and/or slow 'functional decline' in older people and improve their wellbeing through the delivery of a time-limited, goal-oriented, multi-disciplinary and co-ordinated range of services. Unlike transition care, the STRC programme will be available to people without the need for a hospital admission.

Table 2.1 shows the number of providers, services, residential places and home care packages, consumers and funding for each of these three programmes in 2014-15.

Table 2.1: Aged care in Australia, 2014-15

	Home and Community Care	Home care	Residential care
Number of providers	1,628	504	972
Number of services	N/A	2,292	2,681
Number of places	N/A	72,702	192,370
Number of consumers/ occupancy	812,384	85.8%	92.5%
Commonwealth funding ($ billion)	$1.9 b	$1.3 b	$10.6 b

Note: Home and Community Care providers includes VIC and WA HACC program providers. This table does not include flexible residential care places in the Multi-purpose Service (MPS) Programme, Aged Care Innovative Pool Programme and the national Aboriginal and Torres Strait Islander Flexible Care Programme. Additionally, this table does not include the 121,908 recipients of Commonwealth HACC services who are aged less than 65 years.

Figure 2.3 and Table 2.2 show the number of providers providing only one type, two types and all three types of services.

Of the total providers:

- 2 per cent provide all three types of services.
- 14 per cent provide two service types.
- Over 80 per cent of providers provide one type of service only.

As these figures show, there is currently a high degree of specialisation in terms of service types offered by providers. ACFA notes this may change as aged care moves toward a more market-based system with some providers likely to expand their operations to other service types.

It should be noted that this analysis excludes Victorian and Western Australia providers as information on whether these providers also provide residential or home care is not available.

Figure 2.3: Number of providers by service type, 2014-15

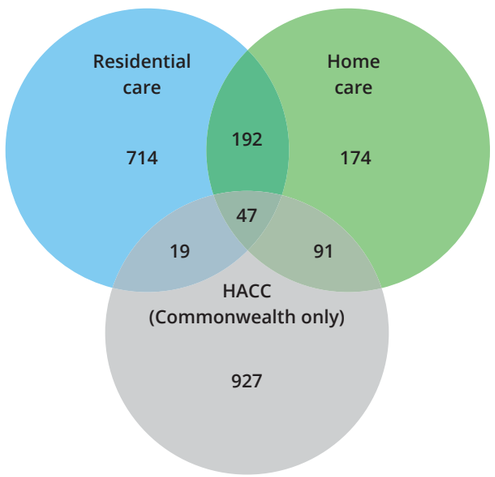


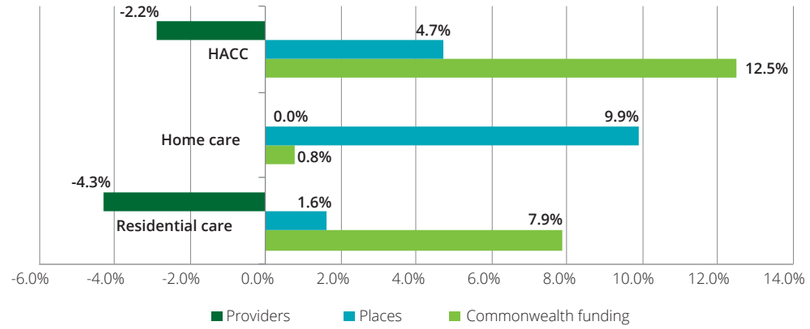
Table 2.2: Number of providers by service type, 2014-15

Type of provider	HACC	Home care	Residential care	Number of providers
All three	•	•	•	47
Residential and home care		•	•	192
Home care and Commonwealth HACC	•	•		91
Residential and Commonwealth HACC	•		•	19
Residential care only			•	714
Home care only		•		174
Commonwealth HACC only	•			927
Total				**2,164**

Note: does not include VIC and WA HACC providers

Chart 2.2 shows the change in funding and the number of providers and places for all three sub-sectors. It shows that while funding and place numbers (consumers) continue to grow, the number of providers overall has decreased

Chart 2.2: Growth in providers, places and Commonwealth funding, 2013-14 to 2014-15



2.3.1 Regulation of supply

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

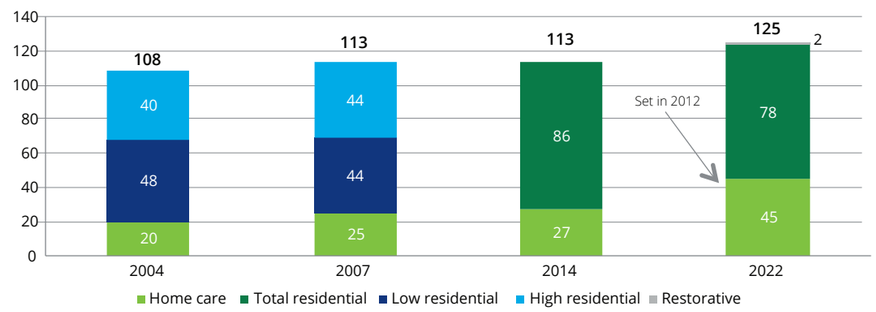
The Australian Government also regulates the supply of residential aged care places and home care packages it funds by specifying national and regional targets for the provision of operational aged care places. These targets are known as the aged care provision ratios, and are based on the number of people aged 70 and over for every 1,000 people. This population-based provision formula ensures that the supply of services increases in line with the ageing of the population, while also defining the total number of places, helping control the Commonwealth's expenditure on aged care.

The overall aged care provision target ratio was first set in 1985 at 100, increased to 108 places in 2004-05, further increased to 113 in 2007, and in 2012, was adjusted to progressively increase to 125 operational places by 2021-22. In addition to setting an overall target ratio for care places as a whole, the Commonwealth has maintained ratio-based targets for residential care and home care packages. Until 2014, the residential care ratio was further broken down into high care and low care, and in 2007, the high care proportion was increased. However, from 1 July 2014 the low care/high care distinction for residential places was removed.

Within the current target provision ratio of 125, the mix of home care and residential care is being significantly altered. The target for home care packages will increase from 27 to 45, while the residential target is to reduce from 88 to 78. Additionally, from 2016-17, new short-term restorative care places will be introduced to build on the current 4,000 transition care places. By 2022, there will be 6,000 restorative care places, including the 4,000 that are in the current transition care programme. These new restorative care places were included in the provision ratio from 1 July 2015 and will comprise 2 places in the overall target provision ratio.

Chart 2.3 shows the changes in the provisional ratio since 2004 and the planned increase through to 2022. Appendix D details the aged care provision ratio by care type and region.

Chart 2.3: Increase in target provision ratios, 2004-2022 (per 1000 people aged 70 and over)

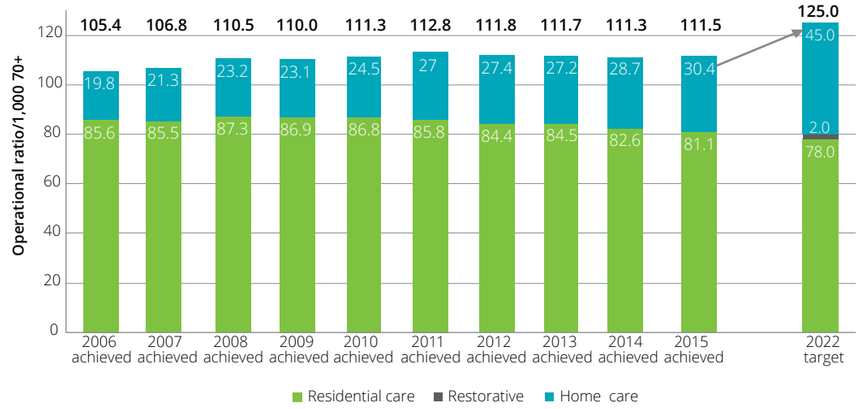


Note: The distinction between low and high residential care was removed as of 1 July 2014.

Implementation of the current target provision ratio will achieve an overall increase in the supply of home and residential care places. However, the changes see the proportion of home care places increasing at a faster rate than that of residential places which reflects the increasing number of consumers wishing to remain in their own homes. An additional 68,000 home care packages will need to be allocated between 2015-16 and 2021-22 in order to meet the target of 140,000 operational home care places by 2021-22. Over the same period around 49,000 additional residential care places will need to be made operational in order to meet the target residential provision ratio.

Chart 2.4 shows the achieved ratio of aged care places for the 10 years to 2014-15 and the target ratio of 125 places to be achieved by 2021-22.

Chart 2.4: Aged care operational ratio, 2006 to 2022



Traditionally each year, new aged care places for residential and home care have been made available for allocation through the Aged Care Approvals Round (ACAR), having regard to the service provision target ratios, population projections provided by the Australian Bureau of Statistics, the current level of service provision, estimated lead times to commission new services and the quality of applications from providers. The Australian Government seeks to use the ACAR allocation of new places to achieve a balance in the provision of services between metropolitan, rural and remote areas, as well as between people needing different levels and types of care. The 2016 ACAR will allow for the allocation of short-term restorative care places.

Changes announced in the 2015-16 Budget mean that from February 2017, home care places will no longer be allocated to providers. Instead, older Australians will be assigned a home care package which they will be able to direct to their preferred provider. As a result, the 2015 ACAR was the last in which providers were able to apply for home care places. This will not however change the overall restriction of the supply of places.

The Australian Government announced the results of the 2015 ACAR on 18 March 2016 (Table 2.3). Through this ACAR, 10,940 residential places and 6,445 home care places were allocated. In addition, $67 million in capital grants were allocated to help eligible aged care providers to establish new services or upgrade existing facilities.

Table 2.3: 2015 ACAR results summary

State/territory	Residential places	Home care places	Estimated annual recurrent funding ($m)	Capital grants ($m)
NSW	2,875	2,424	$268.9	$1.7
VIC	3,080	1,789	$257.4	$27.7
QLD	3,120	914	$222.8	$20.5
WA	1,260	438	$91.2	$3.1
SA	250	640	$40.2	$4.7
TAS	80	164	$10.9	$5.5
ACT	210	61	$14.8	-
NT	65	15	$4.5	$3.8
Total	**10,940**	**6,445**	**$910.7**	**$67**

Overall, competition for new aged care places in the 2015 ACAR was the strongest seen in recent years. This high level of competition meant that otherwise suitable applications were not successful in obtaining new places, because other applicants in the region were assessed by the Department to be more competitive.

The demand for home care places was extremely high with the department receiving applications for over 126,000 places with only 6,445 places available. Demand was also high in residential care with applications for over 38,000 places received and 10,940 places available.

Of the total of 10,940 new residential aged care places allocated in 2015:

- 62 per cent were allocated for the development of new residential aged care services.
- 38 per cent were allocated to expand existing residential aged care services, rebuild/upgrade older services and expand services yet to be developed.

Of the total of 6,445 new home care places allocated in 2015:

- 37 per cent were allocated for new home care services.
- 63 per cent were allocated to expand existing home care services.

The total number of home care places allocated through the 2015 ACAR (6,445) was a slight reduction on the total number of places that were allocated in the 2014 round (6,653). This was the result of a significant increase in the proportion of Level 3 and 4 packages being released which provide higher care levels (and hence are higher cost). This reflects the stronger consumer demand for higher level home care.

The 2015 ACAR included 5,995 Level 3 and 4 packages, which represented 93 per cent of all allocated home care packages (6,445). This is an increase of 2,129 places (55 per cent) compared with the number of Level 3 and 4 places allocated through the 2014 ACAR.

ACFA is aware that residential aged care places are occasionally transferred or traded between providers. A transfer of an operational place usually occurs as the result of a business transaction between two approved providers where a decision has been made by the transferor to sell or close their residential aged care service. For transfers of operational places, the default position of the Department is that transfers are allowed as long as the Secretary is satisfied under section 16-3 of the *Aged Care Act 1997*. However in the case of providers seeking to trade provisionally allocated places the Department will only allow a trade where exceptional circumstances justify the transfer. If provisionally allocated places do transfer between approved providers, the location in respect of which the places are allocated does not change as a result of the transfer.

2.4 Sector viability and sustainability

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

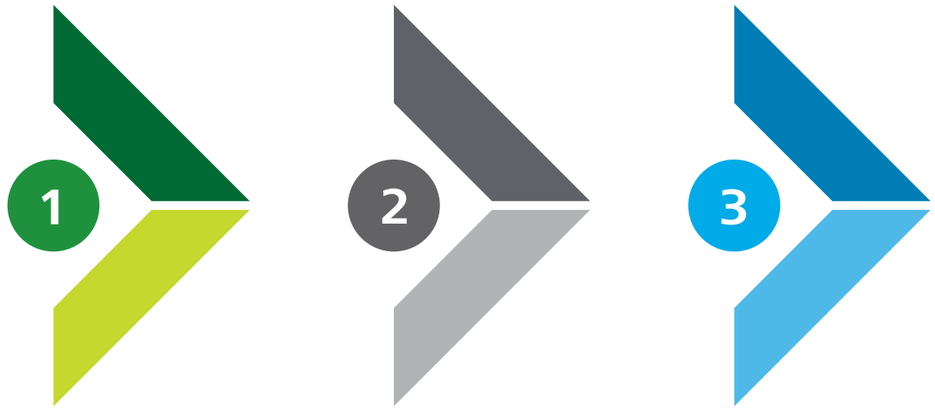
Viable and well run providers are best placed to attract the financial capital, experienced management and quality staff required to deliver long term industry sustainability and growth. To be viable, a provider, whether for-profit or not-for-profit, must have access to sufficient funds to repair and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

Investment activity requires equity investor and debt provider confidence in the viability of specific providers to deliver sustainable returns on capitals and of the sector overall. The amount of (and change in) invested capital is one key metric of sustainability. Another key sustainability metric is the growth in the capital value of aged care providers.

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

A sustainable aged care industry will meet three key principles relating to providers as illustrated in Figure 2.4.

Figure 2.4: Principles for a sustainable aged care industry



These three general principles apply across residential aged care, home care and home support. The viability of each of these sub-sectors is discussed in more detail in the sub-sector specific chapters of this report.

2.5 Workforce

ACFA recognises that the aged care workforce is a shared responsibility between the Australian Government and the aged care sector, with many of the levers to influence the workforce resting with employers/providers. The Australian Government supports the sector in its role as system steward through setting policy with appropriate funding that fosters flexibility, responsiveness and innovation, and supports competitiveness in the labour markets.

Following advice from the Minister's the Aged Care Sector Committee (ACSC), the Department recently undertook a stocktake and analysis of Commonwealth-funded aged care workforce programmes. A key objective of the stocktake was to highlight areas of duplication or gaps in the Commonwealth's approach and to identify synergies between the aged care, disability and health workforces.

Released in August 2015, the stocktake's report noted that the aged care workforce will be required to nearly triple from 352,145 people, to 827,100 people by 2050. The report further indicated that the majority of current funding and activity was directed toward workforce training, education and up-skilling. Leadership development, succession planning and regional, rural and remote service provision were identified as future priorities. ACFA notes that future workforce strategies need to focus on building a multi skilled, dynamic and flexible workforce to meet this surge in demand.

In the 2015-16 Mid-Year Economic and Fiscal Outlook (MYEFO), the Australian Government announced that the Aged Care Workforce Development Fund, the Rural Health Outreach Fund and the Health Workforce Fund would be combined into a single Health Workforce Programme. ACFA notes that there was an overall reduction in funding for these programmes across the forward estimates.

2.6 Changing population

Increasing demand for aged care is primarily driven by demographic factors. It is recognised that Australia's population is ageing, with Australians living longer but many with chronic health conditions. This will bring about significant challenges and opportunities for the aged care system in the years ahead.

As at 30 June 2015, 15 per cent of Australia's population were aged 65 years and over (3.6 million people) and 2 per cent were aged 85 years and over (473,000 people)[12]. By 2054-55, it is estimated that 22.6 per cent of the population will be aged 65 years and over (8.9 million people) of which 4.9 per cent (1.9 million) will be 85 and over[13].

2.6.1 Independence

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

During 2014-15, 68 per cent of Australians aged 65 years and over lived at home without accessing government subsidised aged care services, 25 per cent accessed some form of support or care at home, while only 7 per cent accessed residential aged care.

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

The Productivity Commission[14] has predicted that there are likely to be fewer informal carers relative to the growing older population and that the ability and willingness to provide informal care may also be declining. These trends may add to supply pressures on the paid aged care workforce.

[12]2014-15 Report on the Operation of the *Aged Care Act 1997*

[13]2015 Intergenerational Report

[14]Productivity Commission 2011, Caring for older Australians.

The recognition of informal carers and support for them in their role remains a major part of aged care delivery, particularly in the community.

2.6.2 Workforce participation

Population ageing is changing the ratio of working age to retirement age across the population. The 2015 Intergenerational Report recognises that the proportion of the population participating in the labour force is expected to decline as our community ages. In June 2014, 34 per cent of men and 20 per cent of women aged between 65 and 69 were active in the labour force.

For each older person (aged 65 years or more) in 2015, there were 4.4 'traditional' working-age people (15 to 64 years) and by 2025, this ratio is expected to decrease to 3.7 'traditional' working-age people for every older person.

The 2015 Intergenerational Report indicates that by 2054–55, the participation rate for Australians aged over 15 years is projected to fall to 62.4 per cent, compared with 64.6 per cent in 2014-15.

2.6.3 Culturally and Linguistically Diverse Australians

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

My Aged Care has features designed to facilitate access to care for the CALD population. In 2014-15, 2,581 callers to the My Aged Care contact centre identified as being from a CALD background (noting this information is collected on a voluntary basis). One of the challenges this highlights is ensuring that CALD communities are able to access care. To help address this, the Australian Government provides website information for people who do not speak English, or for whom English is a second language.

Since 1 July 2014, the My Aged Care website has been expanded to include translated material in 18 languages, an increase of 11 available languages since 2013-14. In 2014-15, there were 15,464 visits to the translation pages.

Table 2.4 shows the number of CALD consumers in home care and residential care in 2014-15. CALD consumers represent 26 per cent of home care consumers compared with 18 per cent in residential care. This suggests a preference by CALD consumers for home care.

Table 2.4: Number of consumers from CALD backgrounds in residential care and home care, at 30 June 2015, by state and territory

State/ territory	Home care	Residential care
NSW	4,863	11,272
VIC	5,098	10,455
QLD	1,437	2,977
WA	1,402	2,555
SA	959	2,742
TAS	195	297
ACT	231	383
NT	100	52
Australia	**15,204**	**32,483**

Throughout 2014-15, older people from CALD backgrounds could also access services funded through the Commonwealth and the Victorian and Western Australia HACC Programmes. In 2014-15, the number of CALD clients (aged 65 years and over) who received Commonwealth HACC services, where CALD is defined as country of birth, was 167,569 which represents 17.8 per cent.

2.7 Access to aged care

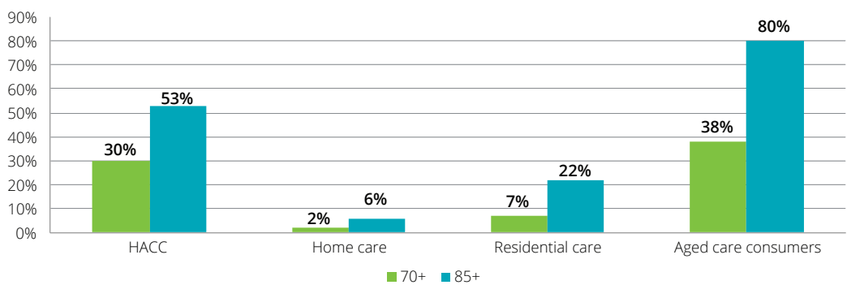
Ensuring access to appropriate quality care remains a fundamental policy objective in the funding and financing of aged care.

The aged care target population definition adopted by the Australian Government in allocating residential and home care packages is the population aged 70 years and over, Aboriginal and Torres Strait Islander Australians aged 50 years and older are also included in the target population because of lower life expectancy and specific care needs.

As at 30 June 2015, there were 2.4 million people aged 70 and over living in Australia. This includes 473,000 people aged 85 and over.

The patterns of use of aged care services change with age. As Chart 2.5 illustrates, at 30 June 2015, 32 per cent of people aged 70 years and over were receiving Australian Government subsidised aged care services while living at home (HACC and home care) and 7 per cent were utilising residential aged care. These proportions increase when focused on the 85 and over cohort, particularly for people accessing residential care, where the usage more than triples.

Chart 2.5: Proportion of people 70+ and 85+ accessing aged care at 30 June 2015



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

It is important to ensure that aged care services are distributed fairly across the country in order to achieve as equitable access as possible. Some aged care services target special needs groups including CALD, Aboriginal and Torres Strait Islander people, people living with dementia and the homeless.

For the consumer, cost alone is unlikely to be a significant barrier to access because the Australian Government subsidises services for those who cannot afford to pay the full price. The Commonwealth takes capacity to pay into account when formulating fee policies and applies annual and lifetime caps on care contributions in residential care and home care packages. However, there can be service gaps if the funding does not meet enough of the cost of care to attract investment in services to meet the needs of some populations, or in some locations.

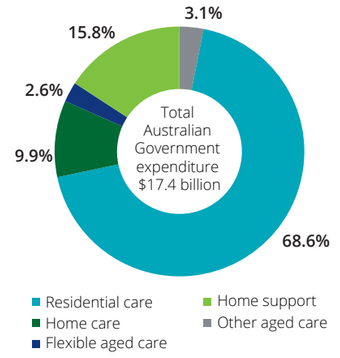
Access to care – including unmet demand – is discussed further in the following chapters:

- Chapter 3 Evaluating aged care reforms
- Chapter 5 Home care
- Chapter 6 Residential aged care: access to care.

2.8 Affordability of aged care

The sector received $15.2 billion in Commonwealth funding in 2014-15, up from $14.2 billion in 2013-14. For 2016-17, the Australian Government has budgeted $17.4 billion in aged care expenditure. The proportions of funding across the sector are illustrated in Chart 2.6.

Chart 2.6: Australian Government total budgeted aged care expenditure 2016-17



As discussed in last year's Annual Report, Australian Government expenditure on aged care is projected to nearly double as a share of the economy from 0.9 per cent currently to around 1.7 per cent of GDP by 2055, largely due to the increase in the number of people aged 85 and over. Additionally, costs of care will continue to rise on account of growth in input costs (e.g. wages) and the increasing complexity of chronic health conditions in ageing populations.

The shift in the balance of care in favour of home care over residential care is expected to improve affordability for taxpayers over the long term given the costs of accommodation associated with residential care which are not associated with home care, and on average higher care subsidies in residential care.

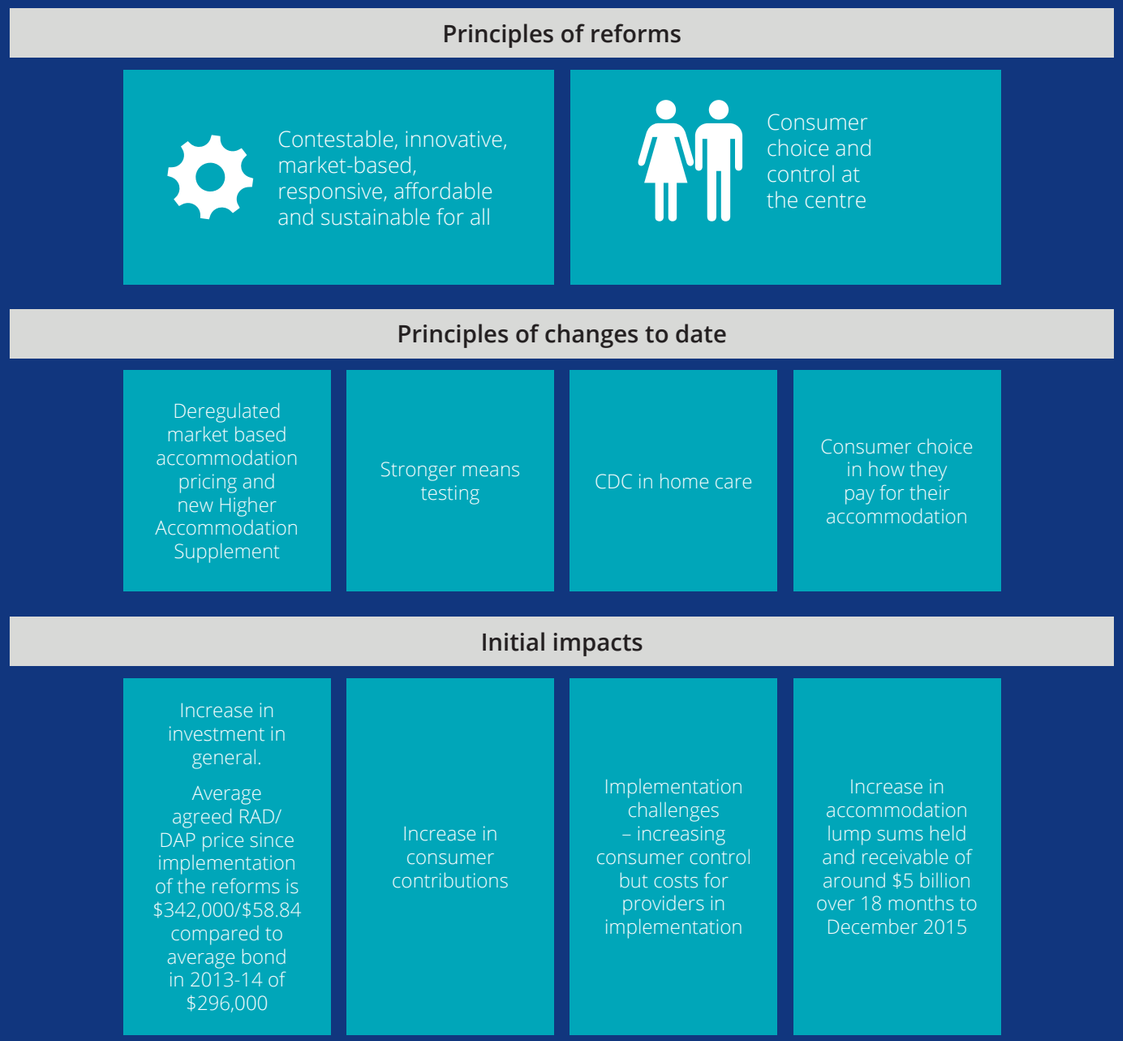
Aged care consumers also make a significant contribution to the cost of their living expenses, care and accommodation. In 2014-15, aged care residents contributed some $4.2 billion to these costs and it is estimated consumers of home care packages contributed almost $150 million to their care costs, and consumers of HACC contributed around $190 million.

One of the objectives of aged care reforms is to improve the future sustainability of the aged care system in the face of the steadily increasing demand resulting from our ageing population. The key reforms in this area have included:

1. Introducing market-based pricing for accommodation in residential care;
2. Means tested consumer contributions; and
3. A focus on home care instead of residential care.

The aged care reforms are discussed in further detail in Chapter 3.

Chapter 3 Evaluating aged care reforms



3 Evaluating aged care reforms

This chapter evaluates reforms to date in the aged care sector.

In the 2015 ACFA Annual Report, ACFA reported that the reforms introduced on 1 July 2014 appeared to be strengthening the viability of the sector.

During 2014-15, ACFA has continued to monitor the effect of the funding and financing reforms on the sector and this chapter provides further analysis and commentary.

This chapter discusses:

- impacts of changes to accommodation payment arrangements, including the effect of choice of payment on the lump sum pool
- published and agreed accommodation prices
- trends in admissions to care
- the higher accommodation supplement
- impacts of Consumer Directed Care in home care

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

ACFA's monitoring of reform impacts since 1 July 2014 indicates that the lump sum accommodation pool continues to grow. There have been improvements in overall financial performance and significant increases in investment and mergers and acquisition activity in the residential care sector.

ACFA acknowledges that reform impacts have varied across the sector and between providers.

3.1 Description of reforms

The aged care sector has undergone substantial change in the last three years. This change includes a suite of reforms that have undergone phased implementation since first being announced in April 2012, and further reform announcements in later Budgets. In last year's Annual Report, ACFA considered these reforms in the following phases (Figure 3.1):

- **(2012-13 – 2013-14). Initial aged care reform.** Announcement of the Living Longer Living Better reforms, including: a phased increase in the aged care provision ratio and an increased proportion of home care places compared with residential care places; the introduction of the new home care package levels; commencement of Consumer Directed Care for new home care packages; and commencement of accommodation price publishing. The My Aged Care website and Contact Centre and the Australian Aged Care Quality Agency and the Aged Care Pricing Commissioner were also introduced, along with the Aged Care Financing Authority.
- **(2014-15). Financing reforms.** Reforms to accommodation payment arrangements, new income testing arrangements in home care and means testing in residential care, and a higher maximum accommodation supplement for new and significantly refurbished homes.
- **(2015-16). Consumer choice.** Further enhancement to the My Aged Care functionality, including standardised assessments; and central records that underpin assessment, referral and service provision. Extension of Consumer Directed Care to all existing home care package recipients; and the formation of the Commonwealth Home Support Programme.

Following the reforms to date, there are further changes occurring over the next two years, including the introduction of consumer choice of aged care provider in home care packages, to take effect in February 2017, and an announced intention to integrate home care packages with the Commonwealth Home Support Programme in 2018. These are discussed in Chapter 9.

Figure 3.1: Timeline of aged care reforms

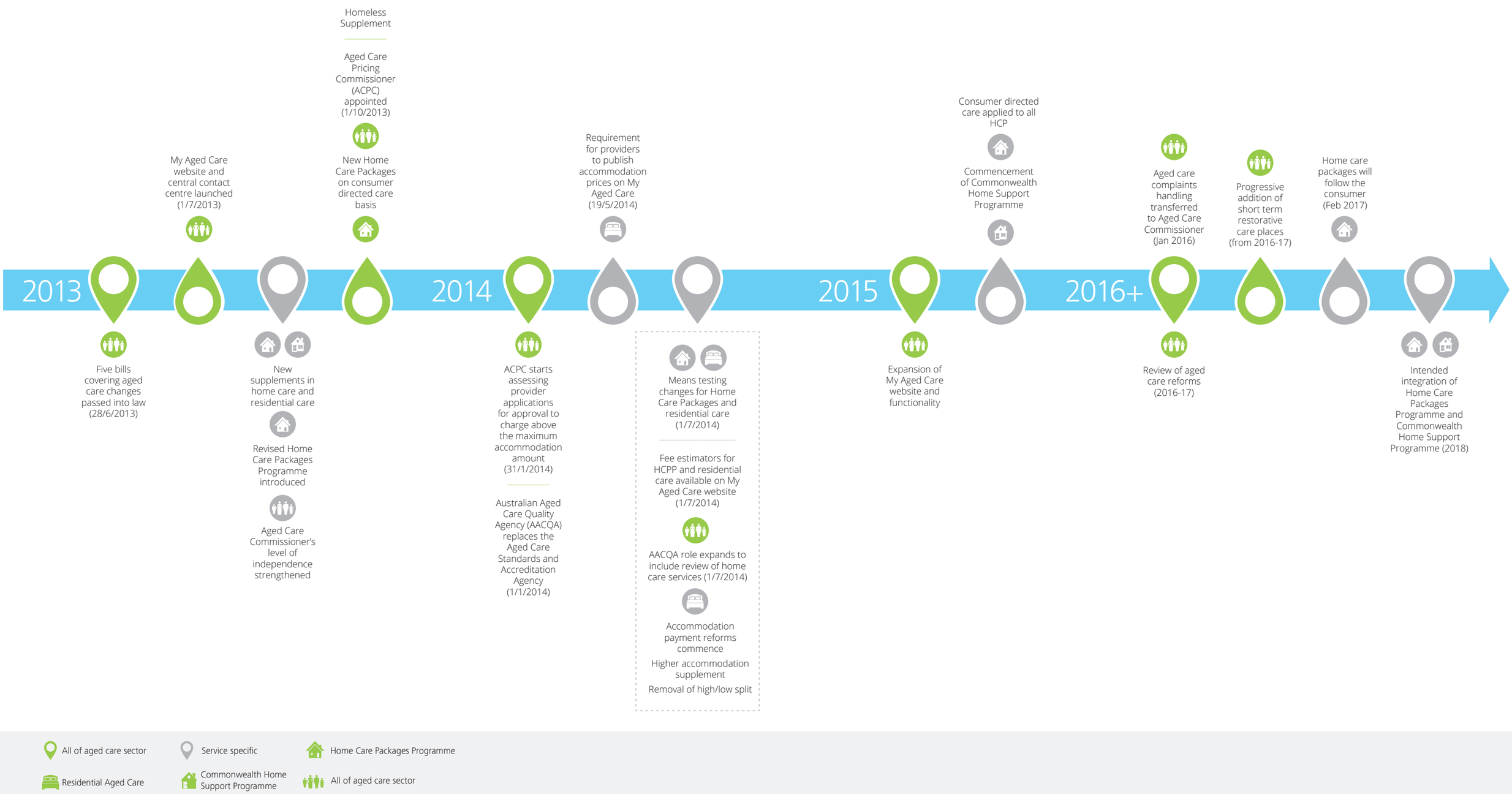


Table 3.1: Reforms to date by Programme

Commonwealth Home Support Programme
From 1 July 2015, the CHSP commenced. The CHSP combined the: • Commonwealth HACC programme; • National Respite for Carers programme; • Day Therapy Centres program; and • Assistance with Care and Housing for the Aged programme. Through My Aged Care there are new assessment and referral arrangements and a central client record.
Home Care Packages Programme
From 1 August 2013, a new four level Home Care Packages Programme was implemented to replace the former packaged care programmes: • Community Aged Care Packages (CACPs); • Extended Aged Care at Home (EACH) packages; and • Extended Aged Care at Home Dementia (EACH-D) packages. Stronger income testing arrangements were implemented from 1 July 2014, along with protections such as annual and lifetime fee caps and hardship arrangements. Packages have transitioned to Consumer Directed Care, which commenced applying to new packages from 1 August 2013 and all packages from 1 July 2015.
Residential aged care
A number of changes occurred in relation to residential aged care, primarily in relation to funding and financing. Reforms include: • A new combined income and assets test, which commenced on 1 July 2014; • New accommodation payment arrangements from 1 July 2014 which allow market-based accommodation prices for all non-supported residents, accompanied by consumer choice to pay by lump sum, daily payment or combination of both; • Requirements for providers to publish the maximum they charge for accommodation and extra services; • Establishment of the Aged Care Pricing Commissioner; • Higher accommodation supplement payable for supported residents in new or significantly refurbished homes; and • Removal of high and low care distinctions.

3.1.2 Consumer Directed Care

One of the key tenets of the reforms in home care is Consumer Directed Care (CDC), which gives individuals and their carers more control over the design and delivery of services received. In practical terms, CDC means that:

- individuals are more involved in determining their care needs and goals, and in choosing what services they receive and how they are delivered; and
- individuals have greater discretion in and oversight of how their package is expended, however the provider continues to hold the package and choose the consumer.

The CDC model was applied to all new home care packages from 1 August 2013 and became compulsory for all existing packages from 1 July 2015 (although providers could voluntarily transition existing packages to CDC prior to this date). In last year's annual report ACFA noted that some providers had experienced a slight reduction in profitability as they adapted to the CDC model, however the financial performance of home care providers discussed in Chapter 5 indicates that home care providers seem to be adapting to CDC.

More information on CDC is provided in Chapter 5.

3.2 Reform monitoring

ACFA was tasked by the Minister to monitor the impact of the 1 July 2014 funding and financing changes on the aged care sector, including the impact of the new accommodation payment arrangements, consumer choice of payment method, and the new means testing arrangements. ACFA provided monthly reports to the Minister to the end of 2014 then quarterly in 2015. ACFA's formal monitoring role has now ceased but ACFA will continue to provide commentary through its annual reports.

In undertaking its role of monitoring the reforms, ACFA consulted with sector peak organisations and jointly developed a survey to monitor the choice of payments and the amount of lump sum accommodation payments held and receivable.

The survey collected information on:

- the number of bonds/Refundable Accommodation Deposits (RADs) held and their value at the end of each survey period; and
- the number of RADs, number of Daily Accommodation Payments (DAPs) and number of combination payment options chosen by residents during the previous period.

These surveys typically secured responses from around 40 per cent of aged care providers, and have allowed ACFA to form timely estimates of capital trends in residential care. In addition to the survey, ACFA's monitoring reports also include data on the admissions to care and occupancy levels and the use of residential respite care. The ACFA Chairman and members also held regular discussions with the peak organisations and other key stakeholders to gather anecdotal insights into the impact of the reforms.

The monitoring reports that have been provided to the Minister can be found on the ACFA web page.[15]

3.2.1 Overview of impact

ACFA considers the reforms have had and will continue to have a positive impact on the sector by improving long term sector viability and sustainability.

Key reform observations:

- As was the case in last year's Annual Report, consumer choice of accommodation payment in residential care continues to favour lump sum Refundable Accommodation Deposits (RADs) at 42 per cent over rental style Daily Accommodation Payments (DAPs) at 34.5 per cent and combination payments at 23.5 per cent.
- The total lump sum accommodation pool of funds has continued to increase significantly.
- Average agreed prices for RAD/DAP of $342,000/$58.84 at 31 May 2016, with prices higher in city areas and for for-profit providers.
- Continued strong investment activity in the residential care sector, encouraged by accommodation payment reforms and the higher accommodation supplement.

[15] https://agedcare.health.gov.au/aged-care-reform/aged-care-financing-authority.

- Continued improved financial results in the residential care sector since the reforms.
- Access to care trends generally returned to normal following some transitional impacts including an increase in admissions to residential care pre 1 July 2014, and a short term decline post 1 July 2014.
- Greater use of respite care in residential care following implementation of the reforms has continued, largely due to consumers accessing respite care prior to becoming permanent residents.
- Continuation of the trend of providers relinquishing extra service places.
- Admissions to home care stable.

3.2.2 Impact of accommodation payment changes

Lump sum payments

The reforms to residential care introduced on 1 July 2014 saw a number of changes to the way that accommodation is priced and paid for.

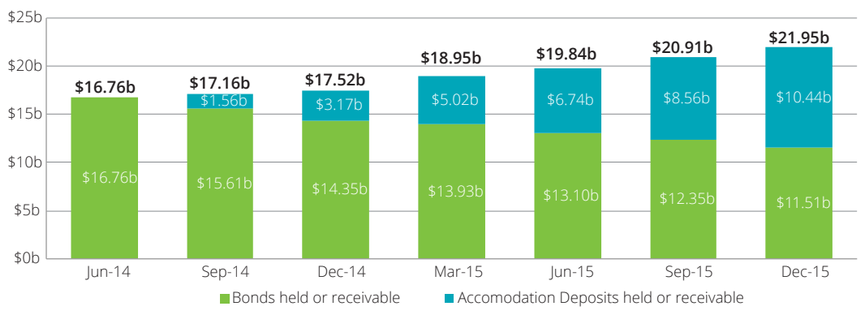
In conjunction with the removal of the distinction between 'high' and 'low' care places, controls over daily accommodation prices for non-supported residents receiving a high level of care were substantially removed, as were regulations preventing lump sum accommodation payments from being paid by residents receiving high levels of care. Lump sum payments were also made fully refundable, by removing providers' capacity to deduct retention amounts.

Residents were also given complete choice in their method of payment, informed by the transparency in prices introduced through the publication of accommodation prices. A maximum accommodation payment determined by the Minister, above which providers need to apply for approval from the Aged Care Pricing Commissioner, was set as a consumer protection mechanism.

As a consequence of these changes, there is now one set of accommodation payment arrangements across all residential care.

The analysis of ACFA's voluntary surveys of aged care providers shows that from July 2014 to December 2015, the estimated lump sum pool increased from $16.8 billion to $22 billion, an increase of $5.2 billion (Chart 3.1).

Chart 3.1: Overall pool of lump sum accommodation deposits held or receivable, June 2014 to December 2015



Note: The overall pool of lump sum accommodation amounts presented in Chart 3.1 have been derived from a regular survey of service providers. Less than half of all service providers participated in the December 2015 survey. To adjust for non-response, survey data have been weighted to estimate total lump sum payments for the entire sector. The June 2015 figure of $19.84 billion differs from lump sum payment pool amount of $18.2 billion presented elsewhere in the report. This latter figure is sourced from the Approved Provider Compliance Statement returns of those providers who submitted their GPFRs and does not include accommodation payments receivable.

Residents who are eligible for Commonwealth assistance with their accommodation costs may be asked to contribute to the cost of their accommodation, depending on their means and whether they are fully supported or partially supported. Partially supported residents can choose to pay their accommodation contribution by a lump sum refundable accommodation contribution (RAC), a daily accommodation contribution (DAC) or a combination of the two. Residents who are not eligible for Commonwealth assistance with their accommodation costs agree an accommodation price with their provider and then can choose to pay by a lump sum refundable accommodation deposit (RAD), a daily accommodation payment (DAP) or a combination of the two.

For the period from July 2014 to December 2015, RADs remained the most used method of making accommodation payments, with over 40 per cent of residents who pay the full or partial cost of their accommodation opting for this method of payment (Chart 3.2).

Chart 3.2: Consumer method of accommodation payment, July 2014 to December 2015

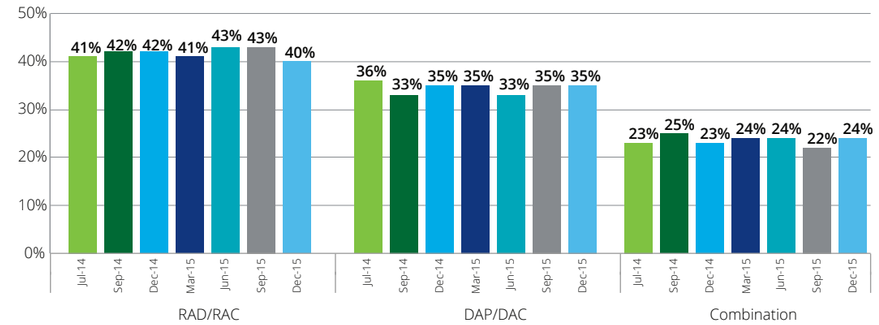


Table 3.2 shows the main findings relating to method of accommodation payment by category (ownership type, facility size and provider remoteness location).

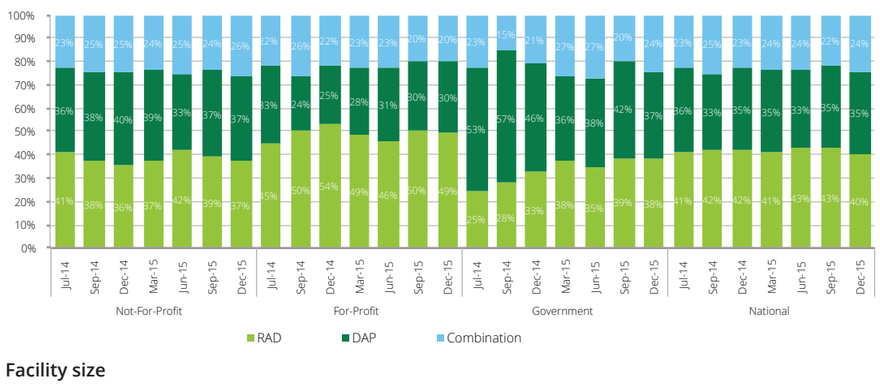
Table 3.2 Method of payment by category

Category	Finding
Ownership type	• RADs continue to be used most in the for–profit sector, with around half of all post 1 July 2014 residents using this method. • The proportion of residents in government facilities paying by RAD has increased to 38 per cent in December 2015 compared with 25 per cent in July 2014
Facility size	• The proportion of residents paying by RADs has generally increased in small size services while reducing over time in larger services.
Remoteness Location	• Residents in major cities are more likely to use RADs, compared with regional areas. • The mix of RADs and DAPs varies significantly from region to region. • In outer regional, remote and very remote areas, use of RADs has been steadily increasing from December 2014 (23 per cent) to December 2015 (30 per cent). However combination payments are still the most used form of payment in these areas, representing 45 per cent of accommodation payments in December 2015.

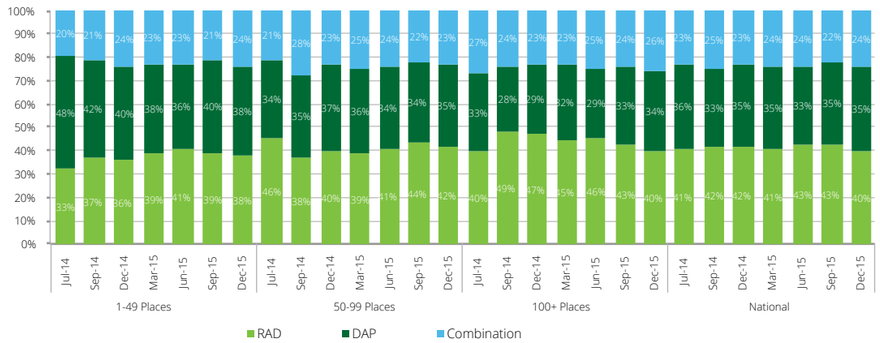
Chart 3.3 shows the method of accommodation payment by category (ownership type, facility size, provider remoteness location and provider scale) for the period July 2014 to December 2015.

Chart 3.3: Payment method, 2014-15

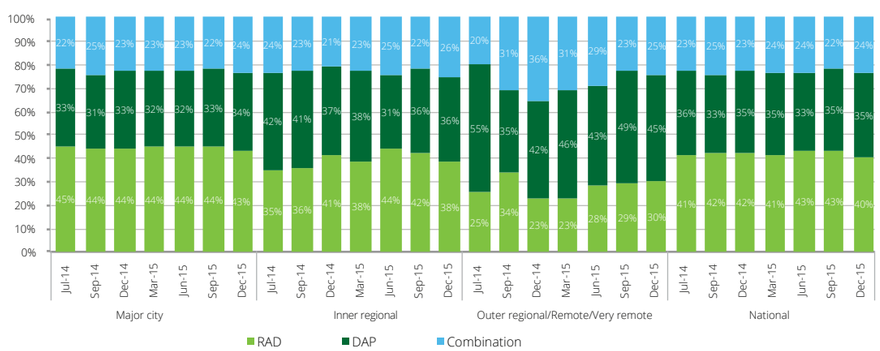
Ownership type



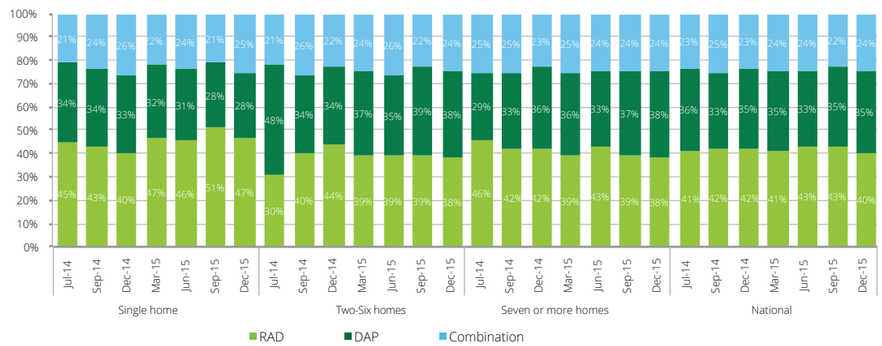
Facility size



Provider remoteness location



Provider scale



Prices

From 19 May 2014, approved providers were required to publish the maximum accommodation prices and descriptive information for rooms in their aged care facilities. Maximum prices are required to be published as RADs, equivalent DAPs and an example combination price of both RADs and DAPs. A resident cannot be charged more than the published maximum price, but they may negotiate a lower amount, referred to as the agreed price.

Published maximum prices

The average maximum RAD/DAP published on My Aged Care was $377,000/$64.86 at 31 May 2016 compared with $355,000/$65.06 at 29 July 2014. (Note that while the average published RAD on 31 May 2016 is higher, the equivalent published DAP is lower due to a decrease in the Maximum Permissible Interest Rate (MPIR) which is used to convert a RAD into a DAP).

Table 3.4 provides a summary of published prices by different categories. Available data does not allow a precise average to be calculated as data is not available on the number of rooms in a facility at a particular price point. As a result, it is assumed that the number of price points are distributed evenly within the facility.

The threshold above which prices must be approved by the Pricing Commissioner remained unchanged during 2015-16 at a RAD of $550,000 or equivalent daily payment of $94.63. At 31 May 2016, 86 per cent of published prices were less than this amount, 8 per cent were exactly this amount and the remaining 6 per cent were higher than this threshold. (See Chart 3.4)

Chart 3.4: Published prices at 31 May 2016 relative to the 2015-16 threshold

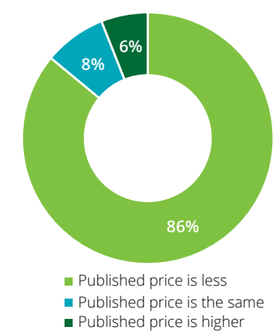


Table 3.3 and 3.4 analyse the average maximum published price by remoteness location, ownership type, facility size and state and territory.

Table 3.3: Average maximum published price by category

Category	Finding
Remoteness location	Average maximum prices published for homes in major cities ($396,000/$68.13) are higher than those in regional areas ($335,000/$57.63) and remote areas ($297,000/$51.10). The same pattern was evident in bond prices before 1 July 2014.
Ownership type	Government homes have a lower average published maximum RAD/DAP price ($335,000/$57.63, than for-profit homes and not-for-profit homes ($386,000/$66.41 and $376,000/$64.69 respectively)
Facility size	Homes with 100 or more places have a higher average published maximum RAD/DAP price ($414,000/$71.23) than homes with between 50 and 99 places ($371,000/$63.83), and homes with fewer than 50 places ($339,000/$58.32).

Unlike the 2015 ACFA report, the data on published prices excludes multi-purpose services (MPS), due to changes to reporting.

Table 3.4: Average maximum published RAD prices as at 31 May 2016, by ownership, remoteness location and state and territory

	Average	5th Percentile	Quartile 1	Median	Quartile 3	95th Percentile
Overall	$377,000	$204,000	$275,000	$350,000	$450,000	$608,000
Ownership type						
Not-for-profit	$376,000	$207,000	$284,000	$350,000	$450,000	$550,000
For-profit	$386,000	$200,000	$250,000	$348,000	$450,000	$750,000
Government	$335,000	$250,000	$280,000	$344,000	$350,000	$515,000
Remoteness location						
Major cities	$396,000	$210,000	$280,000	$350,000	$475,000	$690,000
Regional areas	$335,000	$200,000	$270,000	$320,000	$395,000	$550,000
Remote areas	$297,000	$185,000	$228,000	$299,000	$350,000	$510,000
State and territory						
NSW	$378,000	$200,000	$250,000	$330,000	$450,000	$675,000
VIC	$410,000	$225,000	$300,000	$350,000	$500,000	$700,000
QLD	$346,000	$207,000	$250,000	$350,000	$400,000	$550,000
WA	$368,000	$206,000	$285,000	$350,000	$450,000	$550,000
SA	$342,000	$200,000	$261,000	$320,000	$400,000	$550,000
TAS	$328,000	$200,000	$250,000	$310,000	$395,000	$503,000
ACT	$504,000	$300,000	$400,000	$540,000	$550,000	$710,000
NT	$290,000	$116,000	$228,000	$288,000	$320,000	$496,000

Table 3.5 shows the proportion of services, by remoteness location, size, ownership type and state and territory that publish at least one room in a particular price range. This gives an indication of the tendency of services in these different categories to offer accommodation at particular price points. For example, as can be seen in the table below, for-profit services appear to offer accommodation across the greatest range of price-brackets. For-profit providers also have a greater proportion of rooms available in the highest price brackets compared with not-for-profit and government services.

Since the reforms commenced, there has been a decrease in the proportion of for-profit facilities publishing a RAD less than $250,000, from 44 per cent in July 2014 to 37 per cent in May 2016. There has been an increase in for-profit facilities publishing prices in each of the five bands between $300,001 and $1 million.

Table 3.5: Proportion of services publishing across price bands at 31 May 2016

RAD	≤ $250,000	$250,001-$300,000	$300,001-$400,000	$400,001-$500,000	$500,001-$550,000	$550,001-$750,000	$750,001-$1 million	> $1 million
DAP	<= $43.01	$43.01-$51.62	$51.62-$68.82	$68.82-$86.03	$86.03-$94.63	$94.63-$129.04	$129.04-$172.05	> $172.05
Ownership type								
Not-for-profit	27.9%	32.3%	53.9%	26.3%	19.4%	4.9%	1.8%	0.3%
For-profit	36.6%	42.4%	66.0%	36.9%	26.8%	10.4%	6.7%	2.6%
Government	26.0%	34.5%	49.8%	16.6%	8.9%	0.0%	0.0%	0.0%
Remoteness location								
Major cities	27.6%	32.7%	58.2%	35.3%	26.4%	9.6%	5.2%	1.7%
Regional areas	34.1%	40.7%	57.3%	18.8%	11.8%	0.9%	0.1%	0.0%
Remote areas	63.4%	39.0%	31.7%	9.8%	9.8%	0.0%	0.0%	0.0%
Service size								
1-19	28.6%	24.1%	36.6%	10.7%	14.3%	0.0%	0.0%	0.0%
20-49	30.3%	35.3%	46.4%	14.8%	12.4%	2.6%	1.7%	0.6%
50-99	30.8%	36.3%	60.5%	30.6%	21.5%	5.0%	2.3%	0.9%
100+	30.6%	37.1%	67.8%	44.4%	30.1%	13.7%	7.3%	2.1%
State/territory								
NSW	32.0%	40.0%	50.9%	24.7%	19.9%	7.3%	4.1%	1.3%
Vic	19.0%	28.6%	59.6%	29.7%	26.7%	9.2%	5.2%	1.6%
Qld	37.0%	38.4%	62.1%	28.2%	14.5%	2.6%	0.7%	0.0%
WA	27.9%	27.5%	60.3%	37.1%	22.7%	3.9%	1.3%	1.7%
SA	41.6%	42.8%	62.4%	33.6%	13.2%	2.4%	0.8%	0.0%
TAS	64.8%	54.9%	63.4%	23.9%	18.3%	1.4%	0.0%	0.0%
ACT	8.0%	12.0%	48.0%	48.0%	56.0%	24.0%	12.0%	0.0%
NT	63.6%	9.1%	54.5%	18.2%	9.1%	0.0%	0.0%	0.0%

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

Agreed prices

While aged care providers are required to publish maximum prices, they may agree to a lower actual price negotiated with each resident. This is the agreed price, and is not published.

ACFA has indicative information about agreed prices, based on those reported by providers through the Aged Care Entry Record. Agreed prices are important to understanding the way the industry is operating, particularly in pricing accommodation. Whilst the key findings on agreed prices (Table 3.6) are similar to those on maximum prices, it should be kept in mind that published accommodation prices can be for multiple rooms, whereas average agreed accommodation prices (Table 3.7) are based on amounts agreed with individual residents, and as such averages cannot be compared on a like-for-like basis.

Table 3.6: Average agreed prices findings by category

Category	Finding
Remoteness location	Highest in major cities ($364,000/$62.62) Regional areas ($295,000/$50.75) Remote areas ($246,000/$42.32)
Ownership type	Highest in for-profit homes ($347,000/$59.70) Not-for-profit homes ($341,000/$58.67) Government homes ($326,000/$56.08) This pattern reflects the difference in average published prices for for-profit homes ($386,000/$66.41) and not-for-profit homes ($376,000/$64.69).
Facility size	Highest in homes with 100 or more places ($362,000/$62.28) Homes with between 50 and 99 places ($333,000/$57.29) Homes with fewer than 50 places ($311,000/$53.50) Higher average agreed prices in larger homes could also reflect the increased likelihood that larger homes will be located in major cities, which have higher average agreed prices than regional or remote locations due to higher house values. This suggests that the size of the home is probably less significant in determining agreed prices than the remoteness location of the home.

Table 3.7: Average agreed prices as at 31 May 2016, by ownership, remoteness location and state and territory

	Average	5th Percentile	Quartile 1	Median	Quartile 3	95th Percentile
Overall	$342,000	$124,000	$250,000	$325,000	$410,000	$550,000
Ownership type						
Not-for-profit	$341,000	$113,000	$250,000	$330,000	$410,000	$550,000
For-profit	$347,000	$150,000	$240,000	$320,000	$425,000	$600,000
Government	$326,000	$100,000	$250,000	$320,000	$400,000	$550,000
Remoteness location						
Major cities	$364,000	$150,000	$250,000	$350,000	$450,000	$600,000
Regional areas	$295,000	$100,000	$225,000	$300,000	$350,000	$470,000
Remote areas	$246,000	$90,000	$188,000	$250,000	$300,000	$390,000
State and territory						
NSW	$342,000	$125,000	$244,000	$310,000	$400,000	$625,000
VIC	$361,000	$116,000	$275,000	$350,000	$450,000	$600,000
QLD	$326,000	$118,000	$250,000	$325,000	$400,000	$500,000
WA	$327,000	$100,000	$206,000	$320,000	$411,000	$550,000
SA	$337,000	$150,000	$250,000	$340,000	$410,000	$550,000
TAS	$286,000	$180,000	$230,000	$290,000	$350,000	$400,000
ACT	$426,000	$113,000	$320,000	$450,000	$550,000	$659,000
NT	$315,000	$66,000	$200,000	$300,000	$320,000	$550,000

3.2.3 Impact of reforms on access to care

The 1 July 2014 changes introduced new income testing arrangements for home care and revised means testing for residential care, and new accommodation payment arrangements in residential care. These changes had the potential to impact on access to care. This section evaluates whether and how the changes have affected access.

Permanent residential care

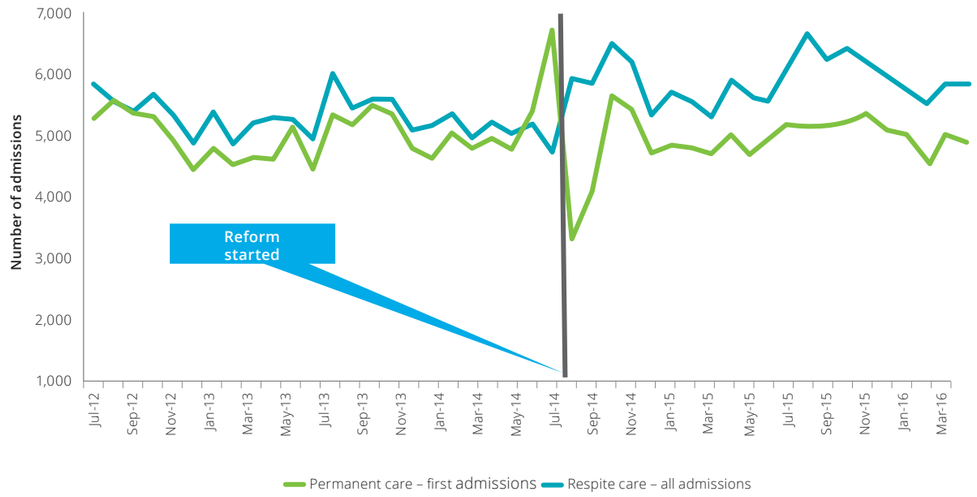
Historically, the numbers of first time admissions to permanent care have been between 4,500 and 5,500 per month (see Chart 3.5). Admissions to permanent care increased significantly in the months immediately prior to July 2014. This likely reflected a move by consumers seeking to enter care before 1 July 2014 to lock in pre 1 July 2014 arrangements for accommodation payments and means tested care fees and thus avoid potentially higher payments and fees. Most of the increase in total admissions was as a result of new residents being admitted (as opposed to transfers from other facilities).

Residential respite care

A person needing care may access residential respite for up to 63 days each financial year. This time can be extended in lots of 21 days if an ACAT assessment finds that this extra time is necessary. Accommodation payments and means tested care fees are not charged for residential respite care, though providers can charge the basic daily fee for living expenses.

Historically, the monthly respite care admission numbers have been similar to the number of new admissions to permanent care (Chart 3.5). However, the data shows that the number of admissions to respite care has increased since 30 June 2014. The number of monthly respite admissions was just over 5,000 a month up until June 2014, and since then has risen to around 6,000 a month. Since December 2014, the gap between numbers of admissions to respite care and numbers of first admissions to permanent care has widened, reflecting higher admissions to respite care. There appears to be a shift in behaviour following the July 2014 changes, with some consumers and providers preferring that consumers enter respite care while financial arrangements are settled before moving into permanent care.

Chart 3.5: Admissions for permanent and respite care, July 2012-March 2016



Occupancy in residential care

The occupancy rate is defined as the number of days of claim as a proportion of operational place days. It can be represented as the total number of days that care recipients are in a provider's facility (the numerator), divided by the total number of days that government-approved aged care places were available to be occupied (the denominator). Occupancy can thus vary both with changes to the numerator (which is affected by both admissions and departures) and with changes to the denominator (which is affected by any change in operational places, such as new services opening and services taking places offline during refurbishment. Note that occupancy is calculated to include both permanent and respite residents.

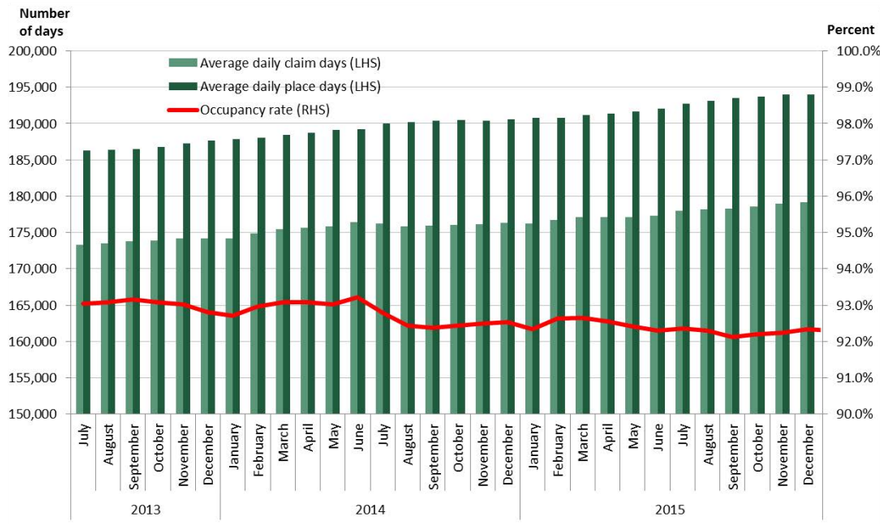
The overall yearly occupancy rates in residential care for the past five years have been in the range of 92 per cent to 93 per cent. At a national level, there has been very little change in occupancy, with less than 0.3 percentage point difference in any two successive years.

Reflecting the trend in admissions identified earlier, occupancy increased before 30 June 2014 then decreased in the months immediately following and has slowly trended downwards since then. For the 12 months to June 2014, occupancy averaged 93.0 per cent, while for the 18 months to December 2015 following 1 July 2014 it averaged 92.4 per cent.

While occupancy fell at the beginning of the 2014-15 financial year due to an initial fall in the number of residents in care, it is worth noting that the longer-term decline was driven by an increase in the number of available places rather than a fall in the number of people receiving care. From June 2014, when the occupancy peaked at 93.2 per cent, to December 2015, the available places increased by 4,805 compared to an increase of 2,752 residents.

In the period of September to December 2015, there was a slight upward movement in the monthly occupancy rate. (Chart 3.6).

Chart 3.6: Average number of claim days, place days and occupancy rate, July 2013 to December 2015



Home care

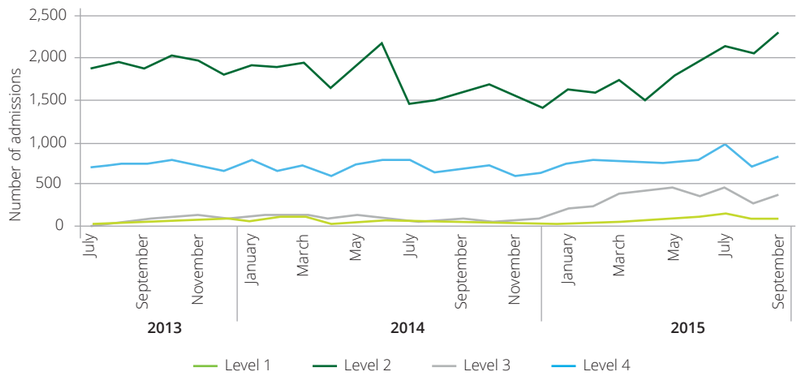
The home care admissions and occupancy data relies on claims data submitted by service providers to the Department of Human Services (DHS) and provision of this data to the Department of Health. The data for October 2015 to December 2015 quarter was affected by a delay in the provision and processing of claim and admission records to DHS by some providers. To avoid misinterpretation of the home care data, only data to September 2015 has been included in the analysis.

There were 27,800 admissions into home care packages during the first nine months in 2015.

In terms of admission trend, there has been an increase in Level 2 admissions, while admission numbers for other packages have stabilised (Chart 3.7). The slowing in admissions for Levels 3 and 4 during the last quarter may be due to the packages having filled following the ACAR release in December 2014 and fewer unoccupied care places being available.

ACFA notes that recent reports by StewartBrown relating to the first half of 2015 16 indicate that some providers have reported a slight slowing in admissions in home care packages Levels 1 and 2, potentially due to consumers preferring instead to access HACC services due to lower fees.

Chart 3.7: Admission trend, home care by level, July 2013 to September 2015



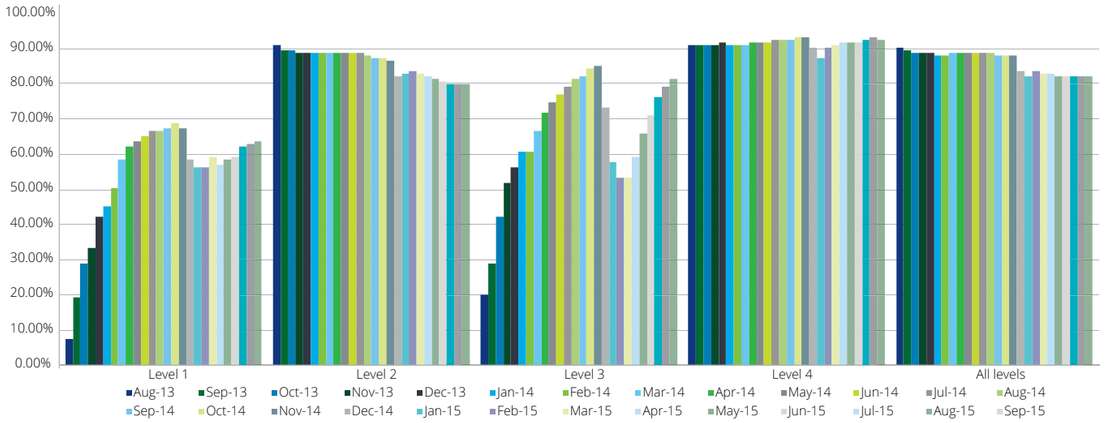
Home care packages are allocated to providers and then taken up by care recipients. Thus, although packages are not associated with 'bricks and mortar', as is the case for residential care, occupancy rates can be calculated.

Overall, Chart 3.8 shows that a noticeable drop in occupancy occurred after December 2014, stabilising at 85.8 per cent, which is a lower occupancy than for residential care (92.4 per cent).

Home care packages are allocated to providers and then taken up by care recipients. Thus, although packages are not associated with 'bricks and mortar', as is the case for residential care, occupancy rates can be calculated.

Overall, Chart 3.8 shows that a noticeable drop in occupancy occurred after December 2014, stabilising at 85.8 per cent, which is a lower occupancy than for residential care (92.4 per cent).

Chart 3.8: National home care occupancy rates August 2013-September 2015



Exposure to bad debt

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

3.2.4 Impact of higher accommodation supplement

Higher accommodation supplement and significant refurbishment

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

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

The higher accommodation supplement is available to services that have been newly built or significantly refurbished since 20 April 2012. As at 30 June 2015 the higher accommodation supplement was $52.49 per day compared with $32.20 for the standard accommodation supplement.

Uptake and impact

As at 30 June 2015, an estimated 448 services (15.3 per cent of all services) were eligible or potentially[16] eligible for the higher accommodation supplement – including 352 for significant refurbishment (12 per cent of existing services), and 96 for newly built services (3.3 per cent of existing services).

Expenditure

The estimated completed refurbishment spend per service averages $4.2 million, with a median of $2.4 million and total expenditure of $1.5 billion.

[16] 'potentially' includes applications that were not initially successful but may be approved upon review including through the Administrative Appeals Tribunal

Table 3.8 provides an overview of the expenditure based on remoteness location.

Table 3.8: Profile of eligible significantly refurbished services

Remoteness location	Number of services	Estimated additional beds/ places *	Estimated total refurbishment costs	Range of costs
Major city	191	2,113	$856 m	$292,130-$41 m
Inner regional	97	1,096	$409 m	$110,020-$17 m
Outer regional	58	247	$188 m	$139,357-$26 m
Remote and very remote	6	32	$20 m	$2 m-$5 m
Total	**352**	**3,488**	**$1.47 b**	

* Estimated Additional beds/places derived from significant refurbishment applications only

Note: refurbished services can include new beds as well as refurbished existing rooms. In some cases it can result in a net reduction in number of beds in the facility.

Extra service

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

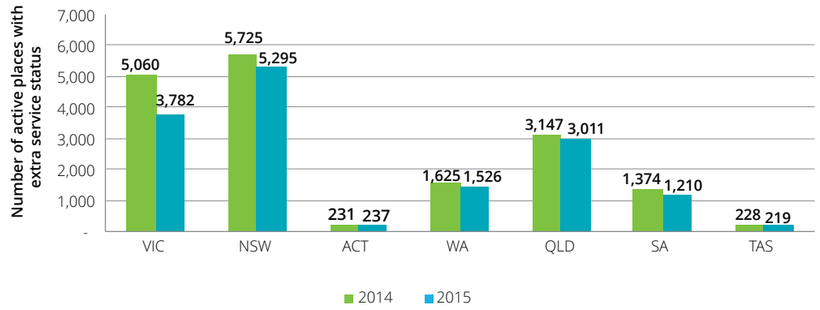
There has been a significant decrease in the total number of places with extra service status (see Chart 3.9). In the period between 1 July 2014 and 30 June 2015, providers suspended or relinquished the extra service status of 2,110 places, leaving 15,280 active extra service places. This compares with 501 places suspended or relinquished in the period 1 July 2013 to 30 June 2014.

The reason for the decrease in extra service places may be because changes made to accommodation pricing on 1 July 2014 reduced the need and motivation for providers to have extra service status, partly because:

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

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

Chart 3.9: Number of active extra service places by state and territory, 30 June 2014 and 30 June 2015



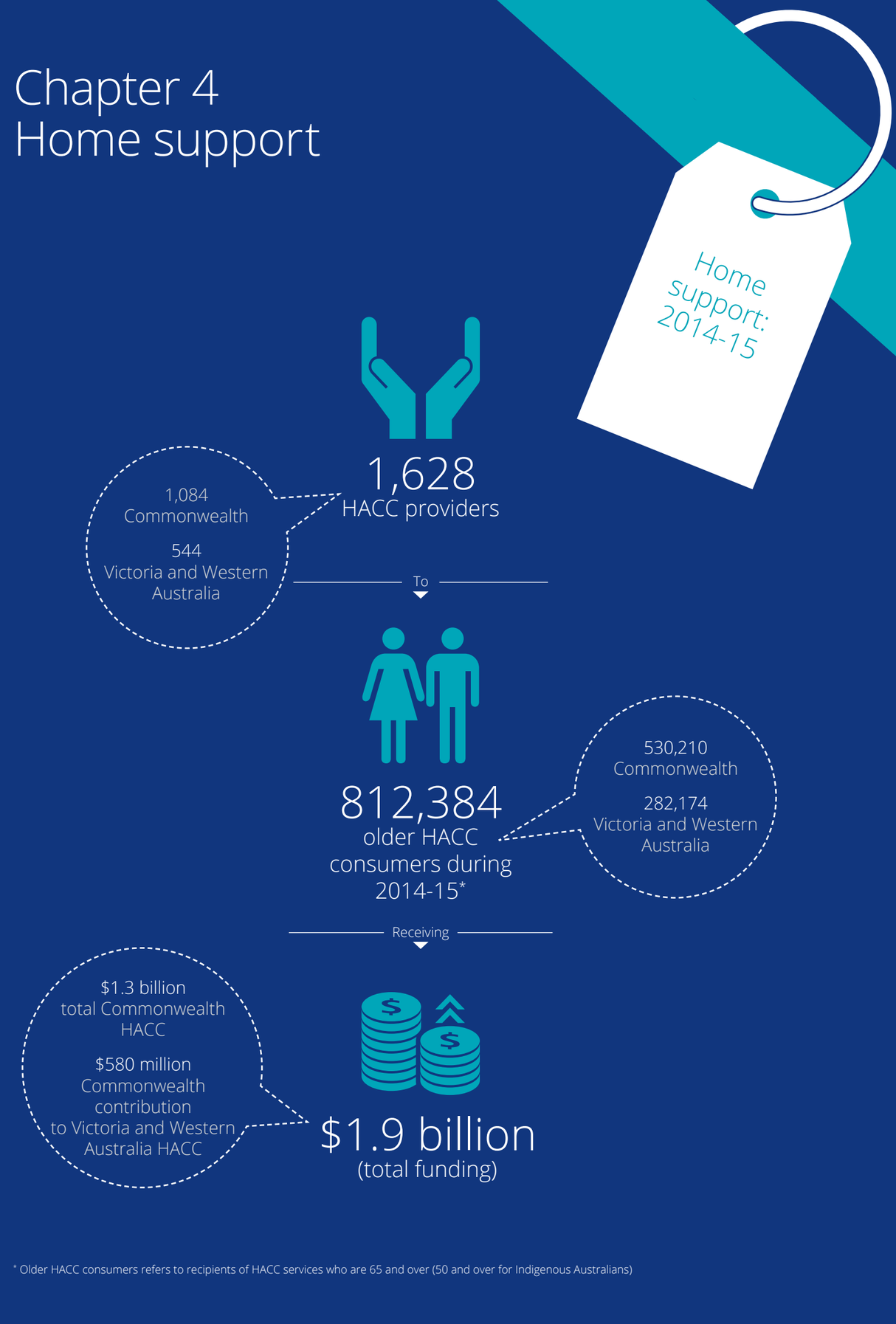
3.2.5 Administrative implementation challenges

In last year's annual report, ACFA noted that delays and errors in the DHS administration of the new means testing system had caused difficulties for some providers and consumers, particularly in the first months of the reforms. While the majority of issues have been largely resolved, there do remain some providers who are still reporting difficulties. Additionally, while the majority of providers were prepared for the changes, a number were not significantly well prepared which may have contributed at least in part to some of the difficulties experienced.

There were also some implementation issues with My Aged Care which commenced in July 2015. Some IT system issues were experienced which caused problems for some consumers and providers. Additionally call volumes into the contact centre were much higher than projected which caused some delays. By October 2015 wait times for callers were largely under control with average wait time under two minutes. Additionally the Department has addressed the majority of IT issues.

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

Chapter 4
Home support



* Older HACC consumers refers to recipients of HACC services who are 65 and over (50 and over for Indigenous Australians)

4 Home support

This chapter provides an overview of the new Commonwealth Home Support Programme and the operations of the Commonwealth, Victorian and Western Australian Home and Community Care Programmes in 2014-15.

This chapter discusses:

- the operation of home support including recent and proposed reforms;
- the supply and usage of home support;
- funding of the home support sector; and
- developments and opportunities.

This chapter reports that:

- in 2014-15, there were 1,084 Commonwealth HACC providers and 544 Victorian and Western Australian HACC providers. (1,628 total providers);
- services were provided to 812,384 older consumers; and
- $1.9 billion in total Commonwealth funding for HACC programmes, comprising
  - $1.3 billion for the Commonwealth HACC programme; and
  - $580 million in payments to the Victorian and Western Australia governments for the Victorian and Western Australian HACC programmes.

4.1 Introduction

Home support in aged care comprises services for those who require entry-level assistance with home living. Home support provides help with daily tasks and less complex care, and is separate to the Home Care Packages Programme. Home support is currently made up of the Commonwealth Home Support Programme (CHSP) and the Western Australian Home and Community Care Programme (not administered by the Commonwealth but jointly Commonwealth-state funded).

The CHSP commenced on 1 July 2015, combining the Commonwealth Home and Community Care Programme (HACC), the National Respite for Carers Programme (NRCP), Day Therapy Centres Programme (DTC) and the Assistance with Care and Housing for the Aged Programme (ACHA). In Victoria and Western Australia, HACC services continued to be delivered by each state government, separate to the CHSP. However, from 1 July 2016, Victorian HACC services for older people were integrated into the CHSP. Negotiations for transitioning Western Australian HACC services for older people into the CHSP are continuing.

This ACFA Annual Report provides analysis of the Commonwealth HACC and Victorian and Western Australian HACC programmes, referred to collectively as HACC when providing analysis and commentary that relates to both. Future reports will include analysis and commentary regarding all of the programmes that now make up the CHSP.

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

4.2 Home and Community Care

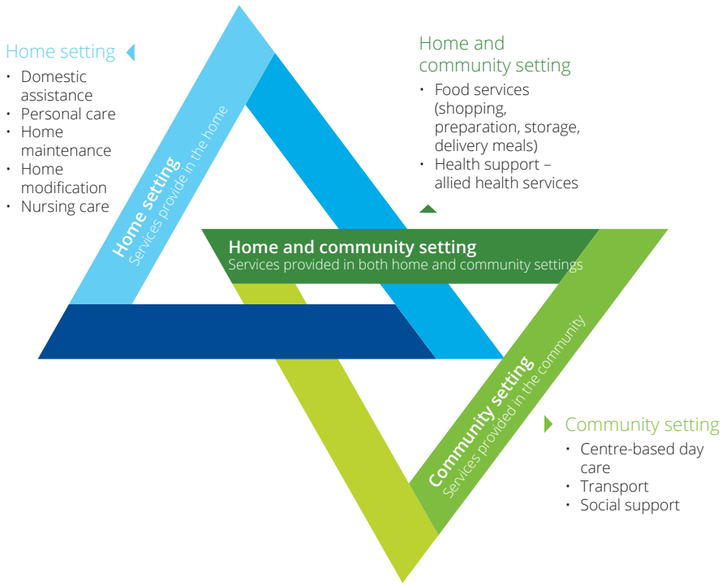
HACC targets older people who are largely independent, but who may require assistance in some areas to live independently at home. ACFA notes there were also 121,908 recipients of Commonwealth HACC services who were aged 64 or less. The Victorian and Western Australian HACC programmes also provide services for younger people with a disability. Analysis and commentary in this report focuses on the provision of services for older people.

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

The Australian Government has full financial and operational responsibility for all Commonwealth HACC. During 2014-15 and 2015-16, Victorian and Western Australian HACC services continued to be delivered through the jointly funded HACC Programmes administered under the Home and Community Care Review Agreement. From 1 July 2016 the Victorian HACC services for older people transitioned into the CHSP.

Prior to 1 July 2015, to access Commonwealth HACC services, individuals underwent a basic assessment by a HACC service provider in relation to how they were coping with their daily living. From 1 July 2015 assessments for the CHSP were coordinated through the Commonwealth My Aged Care and its Regional Assessment Services. Consumers continue to be assessed for HACC services in Western Australia through the HACC program assessment arrangements.

Figure 4.1: Examples of HACC services, by setting



4.2.1 Data collection

The Commonwealth HACC and the Victorian and Western Australian HACC services operate on a grant funding and acquittal basis. As such there are minimal details available relating to the financial performance of providers, although providers provide data relating to services provided. It is likely that HACC providers, most of whom are not-for-profit, would generally structure their operations to maximise service within a fixed budget allocation, rather than to produce a surplus, particularly given that many services rely on volunteers for much of their service provision.

The Victorian and Western Australian HACC Programmes also collect data on service provisions, though, as for Commonwealth HACC providers, there is minimal data collected on financial performance.

In future Annual Reports, ACFA anticipates being able to draw upon data collected by the Department for the CHSP through data collection, known as the Data Exchange, with more detail than is currently available.

4.3 Sector overview

4.3.1 Supply of home support

As noted earlier, this chapter focuses on the Commonwealth HACC and Victorian and Western Australian HACC Programmes.

Providers of HACC services are predominantly not-for-profit or government owned.
Chart 4.1 illustrates the ownership types for Commonwealth HACC providers, which shows that in 2014-15, 74 per cent were not-for-profit, while only 8 per cent were for-profit, with the remaining 18 per cent being government owned. This was also the case in 2013-14. Ownership data for HACC providers in Victoria and Western Australia was not available.

Not-for-profit includes religious, charitable and community based organisations. For-profit includes private incorporated bodies and publicly listed companies. Government includes state, territory and local governments.

Chart 4.1: Commonwealth HACC providers by provider ownership type, 2014-15

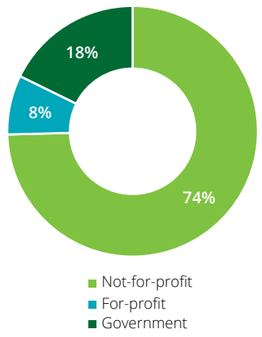


Table 4.1 provides a breakdown of Commonwealth HACC providers by ownership type and state and territory.

Table 4.1: Commonwealth HACC providers by ownership type and state and territory, at 30 June 2015

State/ territory	Religious	Charitable	Community based	Private incorporated body	Publicly listed company	State/territory government.	Local govern-ment	TOTAL
NSW	16	120	218	39	1	19	72	**485**
QLD	9	78	174	24	3	13	33	**334**
SA	8	30	62	9	0	7	28	**144**
TAS	3	13	29	6	0	2	4	**57**
ACT	2	9	14	1	0	3	0	**29**
NT	2	6	15	1	0	1	10	**35**
Australia	**40**	**256**	**512**	**80**	**4**	**45**	**147**	**1,084**

Note: This table does not include Victorian or Western Australian HACC service providers

Table 4.2 provides a breakdown of the range of services provided through both Commonwealth HACC and the Victorian and Western Australian HACC programmes.

Table 4.2: HACC by output service type, 2014-15

HACC output category	Proportion of total HACC output
Allied health	5%
Case management	3%
Centre-based day care	11%
Domestic assistance	20%
Home maintenance	4%
Home modification	2%
Meals	4%
Nursing	10%
Personal care	9%
Respite care	4%
Social support	10%
Transport	9%
Other	9%

In 2014–15, 530,210 individual clients aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander people) received assistance through the Commonwealth HACC Programme. In Victoria and Western Australia, 368,905 people received services through jointly funded Commonwealth-state HACC Programmes, of which 282,174 were aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander people). This means a total of 812,384 older Australians received HACC services in 2014-15.

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

Chart 4.2: Consumers accessing Commonwealth and Victorian and Western Australian HACC, 2011-12 to 2014-15

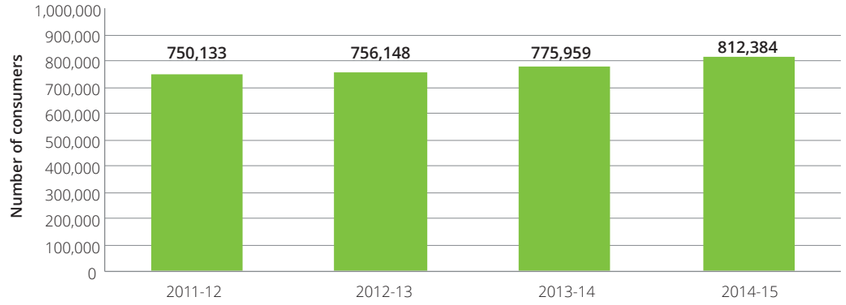


Table 4.3: Older HACC consumers, by age group and state and territory, 2014-15

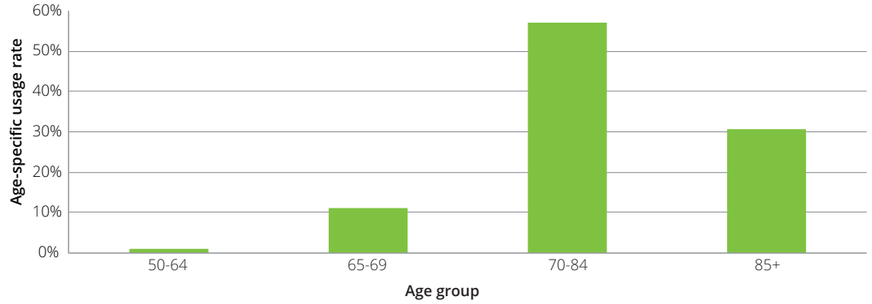
Number of HACC consumers	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
50-64	3,849	1,003	2,035	814	800	155	56	741	9,453
65-69	25,140	27,490	17,689	5,763	9,719	2,894	1,321	429	90,445
70-84	132,669	128,763	96,292	34,754	49,122	14,436	5,951	1,284	463,271
85+	77,286	64,535	50,991	19,052	27,418	6,667	2,989	277	249,215
Total	**238,944**	**221,791**	**167,007**	**60,383**	**87,059**	**24,152**	**10,317**	**2,731**	**812,384**

4.4 Access to care

Chart 4.3 provides an overview of older HACC consumers in 2014-15 by age group. The average age of HACC consumers in 2014-15 was 80, with 57 per cent aged 70-84.

Data on demand for home support services is not available, but the creation of the Regional Assessment Services will allow for better information to be collected on the level of unmet need.

Chart 4.3: Proportion HACC being used by each age group, 2014-15



4.4.1 Indigenous Australians

21,838 Indigenous Australians received some form of HACC services throughout 2014-15 compared with 20,304 in 2013-14. Table 4.4 below shows the usage by state and territory.

Table 4.4: Indigenous Australians accessing HACC, by state/territory 2013-14 and 2014-15

State/territory	2013-14	2014-15
NSW	9,193	9,365
Vic	1,856	1,972
Qld	4,452	4,824
WA	1,753	1,865
SA	1,651	1,797
Tas	371	438
ACT	103	96
NT	925	1,481
Total	**20,304**	**21,838**

4.4.2 Culturally and Linguistically Diverse Australians

Older people from a CALD background made up 20 per cent of HACC consumers in 2014-15. This is consistent with the overall population of Australians aged 65 years and over which includes 20.1 per cent of people from a CALD background.

Chart 4.4: CALD HACC consumers by state and territory, 2013-14 and 2014-15

State/territory	2013-14	2014-15
NSW	50,285	52,446
Vic	60,048	61,360
Qld	15,589	16,985
WA	11,304	11,667
SA	19,199	19,749
Tas	1,955	2,057
ACT	3,057	3,012
NT	306	329
Total	**161,743**	**167,605**

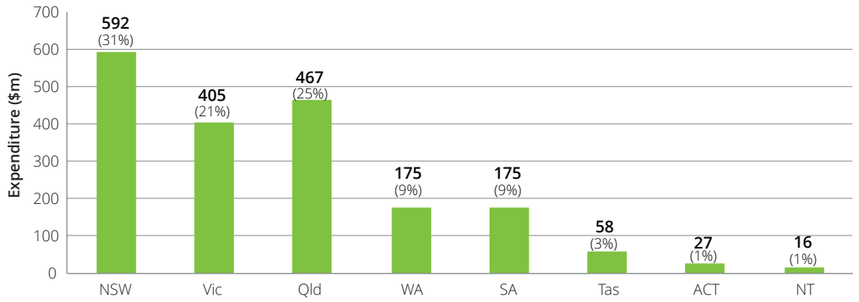
4.5 Funding of HACC

4.5.1 Commonwealth funding

In 2014-15, the Australian Government provided funding of $1.3 billion for the Commonwealth HACC programme (up from $1.16 billion in 2013-14) and contributed $579.7 million to the joint Commonwealth/state funded HACC programmes in Victoria and Western Australia (up from $539.8 million in 2013-14).

Chart 4.5 shows the total funding for the HACC programmes by state and territory.

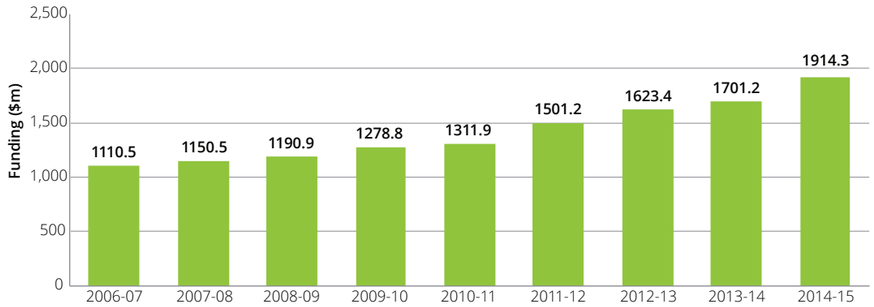
Chart 4.5: Australian Government expenditure on HACC services during 2014-15



Of the $1.3 billion in Commonwealth funding provided to the Commonwealth HACC programme in 2014-15, 61 per cent was provided to not-for-profit providers, 6 per cent to for-profit providers and 33 per cent to government providers. While ACFA does not have data pertaining to how funding in the Victorian and Western Australian HACC Programmes is split by provider ownership types, it notes that it is likely to be similar to the Commonwealth HACC programme.

Commonwealth funding for HACC across Australia has been increasing since 1990 when the programme first started. Chart 4.6 shows the growth in funding since 2006-07. As part of the 2014-15 Budget, the Australian Government announced a reduction in the annual real rate of growth of funding for the CHSP from 6 per cent to 3.5 per cent, to align funding growth with the annual growth in the population aged 65 and over. This real growth is in addition to annual indexation.

Chart 4.6: Combined funding of Commonwealth HACC and Commonwealth contribution to Victoria and Western Australia HACC Programmes



4.5.2 Consumer contributions

Fees paid by consumers for HACC services currently vary across states and territories and across service providers. However, information collected from providers in 2014-15 shows that fees collected from consumers are on average, 10 per cent of the value of the services received nationally.

In October 2015, the Department released the Client Contribution Framework and National Guide to the CHSP Client Contribution Framework. The Framework outlines a number of principles that providers can adopt in setting and implementing their own client contribution policy. The principles are designed to introduce fairness and consistency, with a view to ensuring that those who can afford to contribute do so, whilst protecting the most vulnerable.

4.5.3 Cost of service

ACFA does not have access to data about costs of individual service instances or service types. However, data on total budget and client base can be used to provide an indication of expenditure per HACC client. It should be noted that the Commonwealth HACC programme provided services to almost 122,000 younger people with a disability as well as older people. In 2014-15 expenditure was, on average, around $2,048 per HACC consumer. However, the cost per client varies considerably between states and territories, ranging from around $1,600 in South Australia to nearly $6,000 in the Northern Territory.

Differences in cost per client are likely to reflect different service delivery costs based on a number of factors including remoteness. They may also reflect differences in population care needs, because some home support services are more expensive to deliver than others. Other factors will include different numbers of services per client (related to service type), and differences in service delivery model.

4.6 Looking forward: developments, opportunities and challenges

In July 2016, Victorian HACC services for older people transitioned into the CHSP. In Western Australia, the HACC programme will continue to deliver basic home care services to both older and younger people. Discussions regarding future arrangements for the Western Australian HACC are ongoing between the Western Australian Government and the Commonwealth.

As previously stated, the Commonwealth has announced its intention to integrate the CHSP with the Home Care Packages Programme from 1 July 2018 to create a single care at home programme.

Chapter 5
Home care

Home Care Packages Programme 2014-15

Figures for whole-of-sector

504
Home care providers

47% Single service providers (small),
39% Two–six services (medium),
14% Seven or more services (large)

49% Metropolitan only 45% Regional
6% Regional and metropolitan

69% Not-for-profit, 13% For-profit
18% Government

Operated

2,292
services

Provided

72,702
packages at 30 June 2015

3% Level 1
71% Level 2
5% Level 3
20% Level 4

To

83,838
consumers occupied a package during 2014-15

$1.4 billion
(total estimated revenue)

$1.2 billion
(total estimated expenditure)

$150 million
(total estimated profit)

Larger providers more profit per consumer than small or single service providers.

For-profit providers highest average profit per consumer.

5 Home care

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

This chapter discusses:

- the operation of the Home Care Packages Programme
- the supply and usage of home care packages
- funding of the sector
- financial performance of the sector in 2014-15
- key reforms, developments, opportunities and challenges.

This chapter reports that:

- in 2014-15, there were 504 home care providers, operating 2,292 services;
- they provided services to 83,838 consumers across the year;
- 72 per cent of home care package providers achieved net profit in 2014-15.
  - the average EBIDTA was $2,235 per package
  - this compares with $1,973 in 2013-14, representing a 13 per cent increase;
- ongoing demographic challenges will see a continuing increase in demand, as the proportion of people aged 85 and over is expected to grow to represent nearly 5 per cent of the population by 2055, compared with 2 per cent of the population today; and
- Commonwealth funding was 89 per cent of revenue and consumer contribution was 10 per cent (with the remaining 1 per cent being from other sources).

5.1 The Home Care Packages Programme

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

In home care, consumers are able to gain access to a home care package which allows them to purchase a range of services and capital items which enable them to remain living in their own home.

Home care packages may be used to purchase the following:

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

Home care packages are categorised into four levels:

- **Level 1**, to support people with basic care needs;
- **Level 2**, to support people with low care needs (previously CACPs);
- **Level 3**, to support people with intermediate care needs; and
- **Level 4**, to support people with high care needs (previously EACH and EACH-D).

In addition, specific funding in the form of a Dementia and Cognition supplement can be paid at all package levels for consumers with cognitive impairment. The supplement is paid at a rate of 10 per cent of the basic subsidy amount payable for each of the applicable package levels. Other supplements are also payable where the consumer's circumstances require it.

To obtain access to a home care package, individuals are first assessed by an Aged Care Assessment Team (ACAT), which determines eligibility. Eligibility is determined for one of two bands: either a Level 1 or 2 package or a Level 3 or 4 package.

In home care,

- **Providers.** An approved home care provider is responsible for the provision of the package to the consumer. Some components of the package may be sub-contracted.
- **Services.** Some home care providers operate only one service while some operate multiple services. Services are spread across metropolitan and regional locations throughout Australia.
- **Consumers.** A consumer may only hold a single package at any time, however, can move from one package level to another if their care needs change and another package is available.

The number of consumers who accessed care through packages during 2014-15 exceeds the total number of packages. This is because, when one person stops receiving care due to changed circumstances, another person will be able to utilise that package within the same year.

5.1.1 Measuring performance of home care

This chapter provides an overview of the 2014-15 funding and financial performance of home care providers.

The discussion of financial performance in this chapter predominantly relates to Earnings Before Interest, Taxes, Depreciation and Amortisation (EBITDA). As noted in Chapter 1, this measure is the commonly used metric for analysis and comparison of the profitability of providers and the sector.

Much of the information reported in this chapter has been collected through the 2014-15 home care financial reports. The Accountability Principles 2014 made under subsection 96-1 of the *Aged Care Act 1997*, require each provider to submit a financial report. According to the Accounting Principles, home care providers are obliged to provide a financial report in a form approved by the Secretary. As such, the home care financial reports are not required to be audited and it should not be considered as a General Purpose Financial Report.

As noted earlier in this report, 89 per cent of home care providers (who operated 84 per cent of packages), submitted their 2014-15 financial reports to the Department in a usable form. Therefore the financial performance analysis throughout this chapter is based on this sample.

By using the sample and scaling up to account for all home care providers, it is estimated that the total revenue in the sector was around $1.4 billion, made up of $1.28 billion in Commonwealth funding (subsidies and supplements) and around $147 million in consumer contributions (basic daily fee and income tested care fees). It is also estimated that total expenses for all providers is around $1.2 billion and total profits around $150 million.

In 2014-15, the 89 per cent of providers who submitted usable reports generated $1,166 million in revenue, paid $1,040 million in expenses and hence, profited $127 million.

5.2 Supply of home care

In this chapter, home care is discussed in four ways:

- **By whole-of-sector.** All home care providers are considered together.
- **By ownership type.** Providers that are not-for-profit, for-profit or government.
- **By remoteness location.** Providers with services located in metropolitan areas, regional areas or both metropolitan and regional areas.
- **By provider scale.** Scale is categorised into providers operating one, two to six, and seven or more services.

Table 5.1 provides an overview of the number of providers, the number of services operated and the number of packages provided in 2014-15. The table provides a breakdown of ownership type, remoteness location and provider scale for all home care providers.

Table 5.1: Provider numbers, number of services and number of packages, as at 30 June 2015

			Ownership type			Remoteness location			Provider scale		
	30 June 2014	30 June 2015	Not-for-profit	For-profit	Government	Metropolitan	Regional	Metropolitan & regional	Single service	Two to six services	Seven or more services
No. of Providers	504	504	348 (69%)	65 (13%)	91 (18%)	247 (49%)	227 (45%)	30 (6%)	237 (47%)	197 (39%)	70 (14%)
No. of Services	2,212	2,292	1,822 (80%)	255 (11%)	215 (9%)	1,131 (49%)	528 (23%)	633 (28%)	236 (10%)	655 (29%)	1,401 (61%)
Number of Places	66,149	72,702	59,271 (82%)	7,374 (10%)	6,057 (8%)	41,103 (56%)	11,751 (16%)	19,848 (28%)	7,545 (10%)	20,253 (28%)	44,904 (62%)

Note: remoteness location information of providers is based on the physical address of their home care package services. The split of services and places by remoteness in the table is based on whether their provider has services only in 'metropolitan' areas or only in 'regional' areas or in both 'metropolitan' and 'regional' areas.

Table 5.1 shows that in 2014-15 there were 504 providers of home care (the same as in 2013-14) who offered 72,702 packages to consumers (up from 66,149 in 2013-14). Although the number of providers has remained constant in 2014-15 compared with 2013-14, the number of services has increased slightly (2,292 up from 2,212).

There were 59,506 consumers in a package as at 30 June 2015. The reason there were fewer consumers than packages is that, on any given day, some packages were not occupied. Throughout 2014-15, 83,838 older Australians were in receipt of a package at some point.

In 2014-15, Level 2 packages comprised the majority (71 per cent, down from 76 per cent in 2013-14) of all operational packages followed by Level 4 (20 per cent, down from 21 per cent). Level 1 and Level 3 packages represented only 3 and 5 per cent respectively, marginally up from 2013-14 when they were 2 and 1 per cent. This reflects that Level 1 and 3 packages were introduced in August 2013.

As illustrated in Chart 5.1 and Table 5.2, not-for-profit providers continue to provide the greatest number of packages across all levels. Government providers provide the fewest packages, except for Level 2 in which they provide 10 per cent of packages compared with the for-profit sector's 8 per cent.

Chart 5.1: Package levels by provider ownership type, as at 30 June 2015

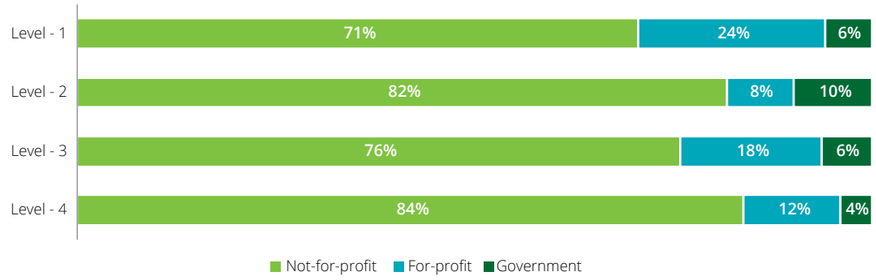


Table 5.2: Home care providers by ownership type and package level, 30 June 2015

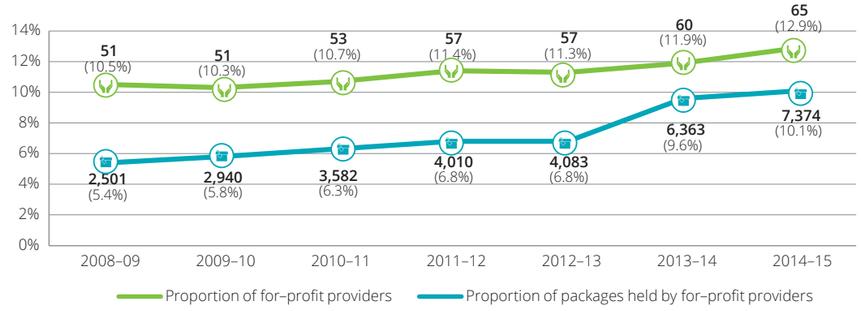
Level	Not-for-profit	For-profit	Government	Total
Level 1	1,588	529	134	2,251
Level 2	42,482	4,376	5,098	51,956
Level 3	2,891	682	242	3,815
Level 4	12,310	1,787	583	14,680
Total	**59,271**	**7,374**	**6,057**	72,702

For-profit providers have a larger share of the new Level 1 and Level 3 packages than they do of the Level 2 and Level 4 packages. ACFA notes however that the for-profit providers share of Level 1 and Level 3 packages is less in 2014-15 than in 2013-14 with Level 1 at 24 per cent, down from 27 per cent and Level 3 at 18 per cent, down from 24 per cent.

Overall, the total number of packages provided by for-profit providers increased slightly from 9.6 per cent to 10.1 per cent between 2013-14 and 2014-15 (Chart 5.2). This continues the trend, albeit gradual, of for-profit providers increasing their share of the market.

The current share of packages held by ownership type reflects previous ACAR allocations. ACFA noted in last year's report that the potential for for-profit providers to move into and increase their share of the home care market is likely to increase with the reforms for increased choice in home care to take effect from February 2017.

Chart 5.2: Number and proportion of for-profit providers and packages, 2008-09 to 2014-15



The 2012 reforms increased the aged care target ratio for operational home care packages from 27 to 45 packages per 1,000 people aged 70 and over, to be reached by 2021-22. As a result, the number of operational home care packages is set to increase from 72,702 as at 30 June 2015 to around 140,000 packages by 2021-22. A total of 6,445 new places were allocated in the 2015 ACAR.

Table 5.3 shows the number of places allocated, by package level.

Table 5.3: New aged care package allocations (2015 ACAR)

Level	Number of packages
Level 1	0
Level 2	450
Level 3	3,701
Level 4	2,294
Total	**6,445**

Table 5.4 shows the number of operational home care packages by provider type, and by state and territory.

Table 5.4: Operational home care packages, by provider type and state and territory, as at 30 June 2015

State/ territory	Religious	Charitable	Community based	For-profit	Government	Total
NSW	6,551	8,635	4,732	2,292	1,081	23,291
VIC	6,271	4,030	2,859	1,102	3,457	17,719
QLD	5,826	3,476	2,650	1,380	334	13,666
WA	2,667	3,161	362	1,694	405	8,289
SA	1,535	2,800	665	269	453	5,722
TAS	539	490	488	225	55	1,797
ACT	189	593	293	171	0	1,246
NT	172	0	287	241	272	972
Australia	23,750	23,185	12,336	7,374	6,057	72,702
% of Total	**32.7%**	**31.9%**	**17.0%**	**10.1%**	**8.3%**	**100.0%**

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

5.3 Demand for home care

At present, data is not systematically collected that would allow ACFA to estimate the extent to which supply falls short of total need. Only data pertaining to occupancy rates (met demand) is reported in this chapter.

Occupancy[17] is measured as the total number of days a package was actually being used by a consumer (occupied place) as a proportion of the number of days a package was available to be offered to a consumer by a provider (available/ operational place).

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

Occupancy across all home care levels dropped noticeably during 2014-15 to 85.8 per cent compared with 88.4 per cent in 2013-14. Table 5.5 provides occupancy rates by package level.

Table 5.5: Occupancy by home care package level, 2013-14 and 2014-15

Level	Number of operational packages at 30 June 2014	Occupancy 2013-14	Number of operational packages at 30 June 2015	Occupancy 2014-15
Level 1	1,303	48.7	2,251	62.1
Level 2	50,157	88.8	51,956	85.2
Level 3	1,010	59.9	3,815	66.7
Level 4	13,679	90.1	14,680	92.1
Total	**66,149**	**88.4**	**72,702**	**85.8**

Table 5.6 shows occupancy in 2014-15 by remoteness location.

Occupancy of home care places tends to be lower in more remote areas. This is consistent with occupancy in residential care.

Table 5.6: Occupancy by remoteness area and home care package level, 2014-15

Care level	Level 1	Level 2	Level 3	Level 4	Total
Major cities of Australia	62.8%	85.1%	66.3%	92.4%	85.7%
Inner regional Australia	61.6%	86.7%	68.9%	92.7%	86.9%
Outer regional Australia	48.6%	84.9%	61.1%	89.5%	85.3%
Remote Australia	50.0%	81.3%	85.5%	85.2%	81.7%
Very remote Australia	..	72.7%	89.5%	70.9%	72.7%
Australia	62.1%	85.2%	66.7%	92.1%	85.8%

[17] The concept of occupancy in home care is similar to that used in residential care. The numerator is the number of days that a recipient is enrolled in the home care package during a period of interest and the denominator is the number of days the package was operational during that period. So while this measure of occupancy may not directly reflect the way in which home care is delivered, it does reflect the fact that government pays home care subsidy on a per diem basis is a measure of the proportion of total subsidy revenue the provider could have received for that package over the period.

5.4 Home care admissions

In 2014-15, 58 per cent of people commenced package Levels 1 and 2 within three months of being approved by an ACAT. For package Levels 3 and 4, 62 per cent of people commenced a package less than three months after their ACAT approval.

It is important that this indicator is treated with caution as it is not an accurate indicator of waiting time for entry into care. Consumer choice not to enter care immediately can delay commencement of a package. The measure also does not include consumers who may have spent time waiting, but then decided not to take up a placement offer during the relevant period.

Chart 5.3 provides an overview of occupancy by package level type over time. Noting that the packages have recently changed, the chart combines EACH and EACH-D packages as a comparator for Level 4, while CACPs packages are treated as a comparator for Level 2 packages.

Over the last two years, occupancy levels for Level 4 packages remained relatively stable, while occupancy for Level 2 packages has decreased from 92 per cent in 2012-13 to 85 per cent in 2014-15. Occupancy for Level 1 and 3 packages increased 13.4 per cent and 6.8 per cent respectively. Increasing occupancy at Levels 1 and 3 probably reflects the process of both consumers and providers adjusting to the introduction of these new package levels.

Chart 5.3: Occupancy by package level, 2010-11 to 2014-15

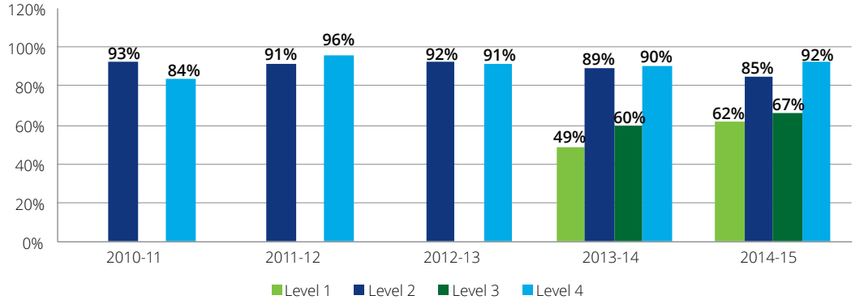


Chart 5.4 shows admission levels for the four home care package levels since they began in August 2013.

Figure 5.1 shows the occupancy levels per package level and by state and territory for 2013-14 and 2014-15. Victoria and Tasmania have the highest rates of occupancy for packages overall, with the lowest overall occupancy in Western Australia (73.8 per cent compared with the next lowest being 80.6 per cent in Queensland).

Chart 5.4: Admissions, by package level July 2013 – September 2015

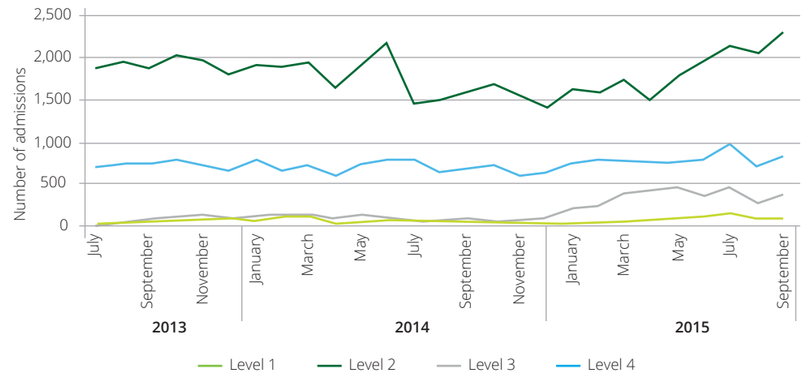
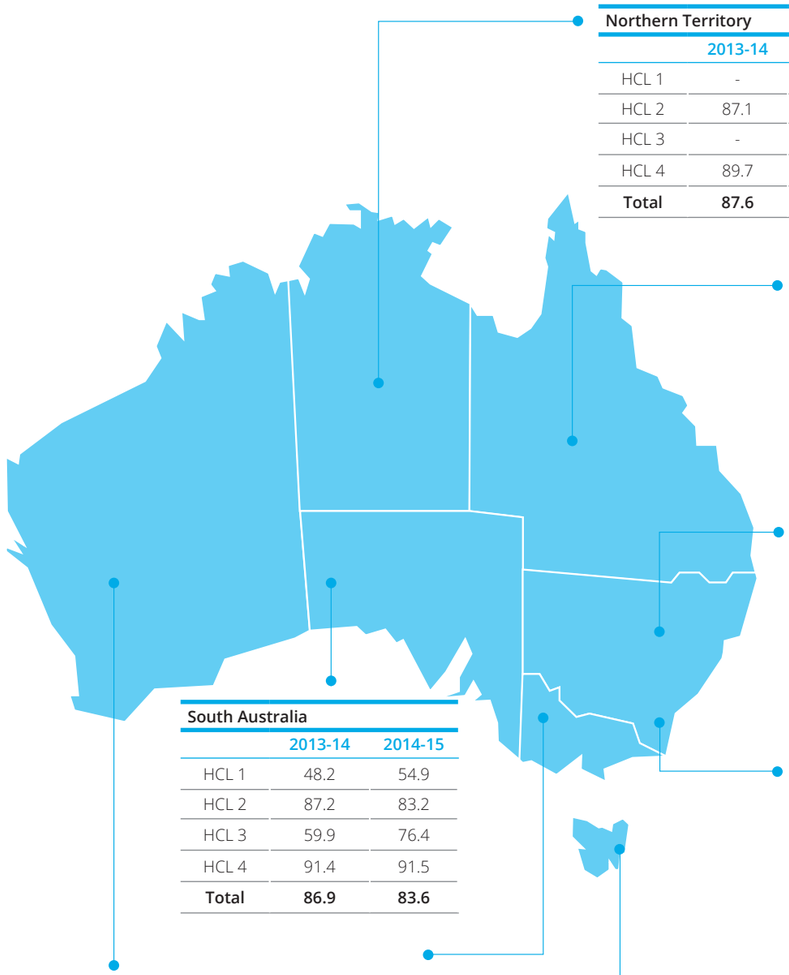


Figure 5.1: Home care occupancy rates across Australia, by package level, 2013-14 and 2014-15



Northern Territory		
	2013-14	2014-15
HCL 1	-	60.6
HCL 2	87.1	86.1
HCL 3	-	75.0
HCL 4	89.7	88.3
Total	**87.6**	**86.2**

Queensland		
	2013-14	2014-15
HCL 1	33.5	53.7
HCL 2	84	77.5
HCL 3	62.1	62.6
HCL 4	91.6	94.1
Total	**85.3**	**80.6**

New South Wales		
	2013-14	2014-15
HCL 1	48.9	60.2
HCL 2	91.8	88.4
HCL 3	58.2	66.8
HCL 4	91.7	92.6
Total	**90.8**	**87.8**

South Australia		
	2013-14	2014-15
HCL 1	48.2	54.9
HCL 2	87.2	83.2
HCL 3	59.9	76.4
HCL 4	91.4	91.5
Total	**86.9**	**83.6**

ACT		
	2013-14	2014-15
HCL 1	-	57.5
HCL 2	88.5	81.1
HCL 3	-	60.2
HCL 4	86.1	88.7
Total	**87.6**	**83.7**

Western Australia		
	2013-14	2014-15
HCL 1	43.1	35.4
HCL 2	74.5	66.8
HCL 3	37.3	48.8
HCL 4	83.3	86.6
Total	**77.8**	**73.8**

Victoria		
	2013-14	2014-15
HCL 1	53.4	71.3
HCL 2	93.8	93.6
HCL 3	61.1	69.0
HCL 4	94.1	95.7
Total	**93.2**	**92.7**

Tasmania		
	2013-14	2014-15
HCL 1	63.2	82.4
HCL 2	92.7	92.1
HCL 3	62.7	71.6
HCL 4	91.8	95.6
Total	**91.9**	**91.8**

Table 5.7 shows the number of consumers who occupied a home care package by package level as at 30 June 2015.

Table 5.7: Number of home care consumers, by package level and state and territory, as at 30 June 2015

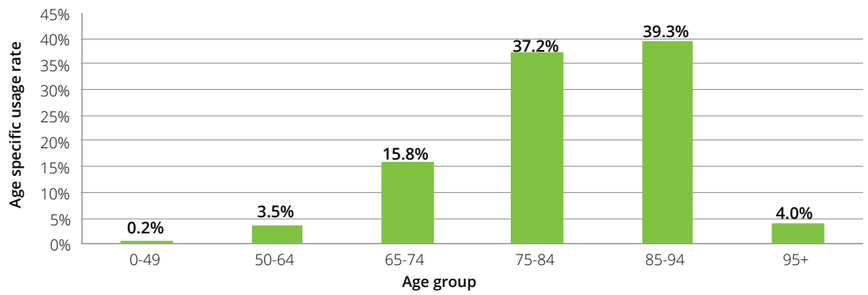
State/ territory	Level 1	Level 2	Level 3	Level 4	Total	% of Total
NSW	336	14,529	860	3,727	19,452	33%
VIC	299	12,129	734	2,927	16,089	27%
QLD	94	6,858	493	2,704	10,149	17%
WA	16	2,812	212	2,644	5,684	10%
SA	68	3,434	266	882	4,650	8%
TAS	38	1,175	83	333	1,629	3%
ACT	10	531	36	454	1,031	2%
NT	4	651	14	153	822	1%
Australia	865	42,119	2,698	13,824	59,506	
% of Total	**1.5%**	**70.8%**	**4.5%**	**23.2%**	**100.0%**	

Note: Location of home care consumers is based on the physical address of the service delivering the care.

Note: percentages do not add to 100% due to rounding.

Chart 5.5 provides a breakdown of home care usage by age bracket as at 30 June 2015. People aged between 65 and 74 represented around 16 per cent of all home care consumers but this proportion more than doubles for the 74 to 84 and 85 to 94 aged brackets.

Chart 5.5: Age profile of people in home care, at 30 June 2015



5.4.1 Indigenous Australians accessing home care

As at 30 June 2015 1,796 Indigenous Australians were accessing home care, which represents 3 per cent of total home care recipients, down from 1,963 at 30 June 2014. Table 5.8 shows the number of Indigenous Australians accessing home care, by state and territory.

Table 5.8: Indigenous Australians in home care, by state and territory, at 30 June 2014 and 30 June 2015

State/territory	30 June 2014	30 June 2015
NSW	506	443
Vic	393	385
Qld	332	320
WA	206	171
SA	77	72
Tas	22	23
ACT	43	29
NT	384	353
Total	**1,963**	**1,796**

5.4.2 Culturally and Linguistically Diverse Australians

There were 15,204 older Australians from CALD backgrounds in receipt of a home care package as at 30 June 2015, representing 26 per cent of the total home care recipients. This is up from 14,261 (22.6 per cent) in 2013-14, which continues the trend of increasing numbers of older Australians from CALD backgrounds in aged care. As at 30 June 2015 around 20 per cent of all Australians aged 65 and over were from a CALD background.

Table 5.9: CALD consumers in home care, by state and territory, at 30 June 2014 and 30 June 2015

State/territory	30 June 2014	30 June 2015
NSW	4,804	5,118
Vic	4,967	5,460
Qld	1,534	1,574
WA	1,515	1,485
SA	951	994
Tas	162	194
ACT	240	248
NT	88	131
Total	**14,261**	**15,204**

5.5 Analysis of 2014-15 financial performance of home care providers

In 2014-15, providers submitted financial performance reports to the Department using the home care financial report. The Report was introduced in 2013-14 and provides more comprehensive information that encompasses all levels of packages.

Prior to last year's Annual Report (presenting the 2013-14 financial results), ACFA used data from previous financial reports which provided financial data only in relation to CACPs.

Therefore ACFA Annual Reports did not include financial performance analysis of EACH and EACH-D packages. As a result, it is not possible to readily compare financial information prior to 2013-14 with results from 2013-14 and 2014-15. This year's report does however afford the opportunity for direct comparison between 2013-14 and 2014-15 and into future years.

Table 5.10 provides an overview of the 2014-15 financial performance of home care providers whose financial reports were submitted in a useable form (89 per cent of all providers). Further analysis is then presented on ownership type, remoteness location and provider scale.

Table 5.10: Summary of financial performance of home care providers, 2014-15

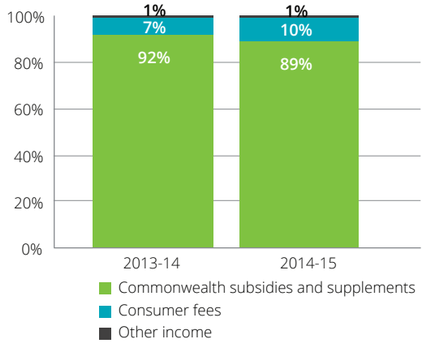
	Total sector 2013-14	Total sector 2014-15	Not-for-profit	For-profit	Government	Metropolitan	Regional	Metropolitan & regional	Single service	2 to 6 services	Seven or more services
Total revenue ($ m)	$1,139.5	$1,166.2	$988.0	$95.2	$83.0	$624.6	$184.6	$356.9	$88.3	$305.4	$772.5
Total expenses ($ m)	$1,035.3	$1,039.7	$877.6	$84.0	$78.0	$561.6	$168.4	$309.7	$85.3	$276.1	$678.3
Profit ($ m)	$104.2	$126.5	$110.3	$11.1	$5.0	$63.0	$16.3	$47.1	$2.9	$29.3	$94.2
Average EBITDA per package	$1,973	$2,235	$2,341	$2,384	$1,052	$2,060	$1,806	$2,819	$627	$1,953	$2,626

5.5.1 Revenue

Total revenue in 2014-15 across all providers who provided their financial reports in useable form was $1.17 billion. Chart 5.6 provides a break-down of the main sources of revenue reported by providers in 2014-15, compared with 2013-14.

The proportion of revenue that providers obtained through consumer fees has increased from 7 per cent in 2013-14 to 10 per cent in 2014-15. This is primarily due to the formalised income tested fees in home care which came into effect on 1 July 2014 (which is offset by a reduction in Commonwealth contributions).

Chart 5.6: Proportion of revenue sources for home care providers, 2013-14 and 2014-15



Commonwealth funding

Commonwealth funding is the primary source of revenue for home care providers. In 2014-15 the Commonwealth made payments of $1.28 billion to all home care providers on behalf of consumers as a contribution towards their support costs, up from $1.27 billion in 2013-14 (an increase of 0.8 per cent)[18].

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

[18] It is important to note that the revenue from the Commonwealth reported here exceeds what is reported as revenue for the summed value of revenue across the sector ($1.14 billion in 2013-14). The reason for this is that the revenue reported across the sector is collated from the home care financial reports which relates to 89% of the sector. Commonwealth funding reported here relates to 100% of the sector.

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

In 2014-15, the Commonwealth funding of $1.28 billion comprised $1,255 million in package funding and the remaining $25 million in supplements.

Home care subsidies are calculated on a daily basis for each day that a consumer is occupying a package. Table 5.11 shows the annualised maximum amount for each package level for 2014-15. This is the maximum payment that a provider could receive if a package was occupied every day in the full year. Supplements are paid in addition to this amount. Reductions can apply to the maximum Commonwealth subsidy and supplement amounts in respect of income tested fees where applicable, which the provider is required to offset by charging an income tested fee. The provider is required to deliver services to the value of the maximum subsidy amount even if the provider chooses not to charge part or all of the applicable income tested fee.

Table 5.11: Maximum home care subsidy payments per annum, 2014-15

Package level	2014-15 annualised subsidy
Level 1	$7,822
Level 2	$14,231
Level 3	$31,291
Level 4	$47,567

Although Level 1 and 2 packages made up almost 75 per cent of all packages, they are relatively lower in monetary value, hence they comprised only 47.6 per cent of total home care Commonwealth funding in 2014-15.

Not-for-profit providers are dominant in the sector and so receive most of the funding. Not-for-profit providers received 82.7 per cent of total Commonwealth funding. Not-for-profit providers also received the greatest level of Commonwealth funding per provider on average ($3.1 million) compared with for-profit providers ($2.1 million) and government providers ($1.0 million).

Home care supplements

Supplements in home care are paid in addition to the amount of basic subsidy applicable at each package level. Supplements are paid if a consumer is eligible due to a specific care need. The major supplements that apply to home care are set out below.

A full list of supplements payable in home care is at Appendix L

The Dementia and Cognition supplement

The Dementia and Cognition supplement in home care provides additional funding in recognition of the extra costs of caring for people with cognitive impairment associated with dementia and other conditions. This supplement is available across all levels of home care packages, for consumers with moderate to severe levels of cognitive impairment associated with dementia or other conditions. The supplement is payable at a rate of 10 per cent of the basic subsidy payable for the level of home care package. Under CDC, the Dementia and Cognition supplement is included in the individualised budget for eligible care recipients.

The Veterans' supplement

The Veterans' supplement in home care provides additional funding for veterans with a mental health condition accepted by the Department of Veterans' Affairs (DVA) as related to their service. The Veterans supplement is included in the individualised budget for eligible care recipients.

The Oxygen supplement

The oxygen supplement in home care provides additional funding for consumers who have a specified medical need for the continual administration of oxygen. The oxygen supplement is included in the individualised budget for eligible care recipients.

Total funding for packages and supplements is provided in Table 5.12.

Consumer contributions

Consumers may be asked, at the discretion of the service provider, to pay a basic daily fee up to 17.5 per cent of the single basic age pension (currently $9.93 a day/$3,625 per annum). The vast majority of revenue in the sector is from Commonwealth payments (subsidies and supplements paid on behalf of consumers). The amount contributed by consumers was about 10 per cent in 2014-15, up from 7 per cent in 2013-14. This proportion has increased due to the introduction from 1 July 2014 of income testing for home care.

It is important to note that the basic daily fee is not subject to an income or asset test. The basic daily fee, when charged by the service provider, must be included in the individualised budget for the consumer.

Providers with weaker financial performance, measured as EBITDA per consumer per day, were receiving the lowest contributions from both the Commonwealth and from consumers.

Table 5.12: Commonwealth funding for home care, 2014-15 ($m), by ownership type

	Not-for-profit	For-profit	Government	Total
Subsidy	$1,040.1	$128.3	$86.9	$1,255.2
Supplements	$20.3	$2.1	$3.1	$25.5
Total	$1,060.4	$130.4	$89.9	**$1,280.7**

Note. Totals refer to whole-of-sector

5.5.2 Expenditure

Total expenditure in 2014-15 of providers who submitted their home care financial reports in a useable form was $1.04 billion. The average expenditure per consumer per day was $59.84 (up from $58.76 in 2013-14), that is, $21,842 per consumer for the year. Chart 5.7 shows the proportion of expense types reported by providers in 2014-15.

Chart 5.7: Proportion of expense types reported by home care providers, 2014-15

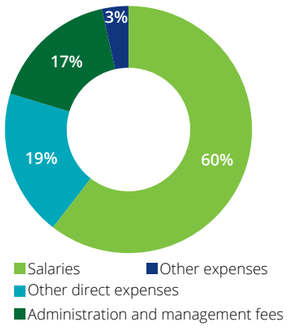


Table 5.13 provides a breakdown of expenditure according to ownership type, provider remoteness location and provider scale.

As the table shows, across all types of providers, salaries comprised the greatest proportion of expenditure, comprising 60 per cent of total expenses (compared with 61 per cent in 2013-14).

In terms of provider scale, smaller providers with only a single service incurred the lowest levels of expenditure per consumer compared with providers with two to six services, while larger providers with seven or more services incurred the highest expenses.

These results suggest it is likely that there are limited opportunities for economies of scale in administrative and management functions, with the amounts reported as expended on these functions rising with increasing scale. Alternatively, larger providers may be doing more to identify and disaggregate these costs in their operations.

In terms of provider ownership, government providers incurred the lowest level of expense per consumer day with $51.29 compared with $60.47 for the not-for-profit and $62.66 for the for-profit providers.

The table also shows some distinctive results around the remoteness location in which providers operate.

Regional providers had lower expenses per day on average than metropolitan providers. Providers who operated in both metropolitan and regional areas had the highest expenses of all driven by higher salary and administration costs. However, their other direct expenses' were significantly lower.

Table 5.13: Expenditure per consumer per day, 2014-15 by ownership type, provider remoteness location and provider scale

	Salaries($)	Admin and Mgmt fees($)	Other direct expenditure($)	Other expenses($)	Total($)
Ownership					
Not-for-profit	36.69	10.54	11.12	2.12	60.47
For-profit	42.44	10.02	8.30	1.89	62.66
Government	25.89	5.70	17.90	1.79	51.29
Remoteness location					
Metropolitan	34.19	9.05	13.86	2.21	59.31
Regional	34.57	8.33	12.15	2.67	57.72
Metropolitan & Regional	40.93	13.05	6.63	1.46	62.07
Scale					
Single service	30.84	5.73	7.45	2.21	46.22
2 to 6 services	37.51	8.13	10.65	2.68	58.96
7 and more services	36.53	11.66	12.56	1.79	62.53
Total sector	**36.19**	**10.08**	**11.50**	**2.07**	**59.84**

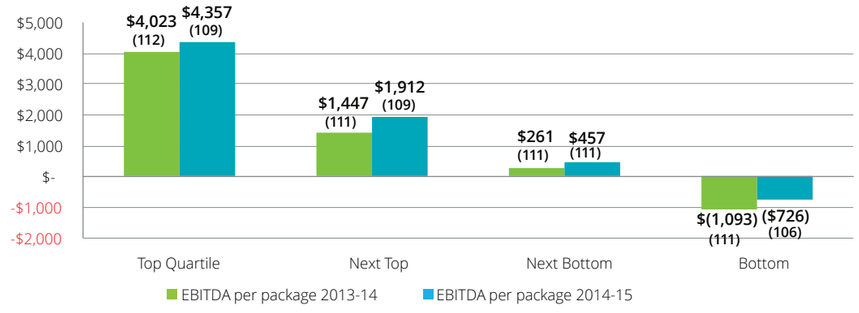
5.5.3 Profit

In 2014-15, home care providers who provided their financial reports in a useable form generated a total profit of $126.5 million, which is $2,081 per package (compared with $1,810 in 2013-14). Overall analysis of 2014-15 data shows that approximately 72 per cent of home care providers achieved a profit in 2014-15, compared with 66 per cent in 2013-14.

The average EBITDA per package was $2,235 which compares with $1,973 in 2013-14. As Chart 5.8 shows, EBITDA varies considerably across the sector with the top quartile of providers performing substantially better than the rest of the home care sector. The average EBITDA per package for the top quartile was $4,357 compared with the next top quartile returning $1,912.

Chart 5.8 also shows that providers in all four quartiles improved in 2014-15 compared with 2013-14 in terms of EBITDA, with the next bottom and bottom quartiles improving the most with increases of 75 per cent and 33.6 per cent respectively, although this is from a low base.

Chart 5.8: Provider average EBIDTA per package 2014-15, by quartile (number of providers in parentheses)



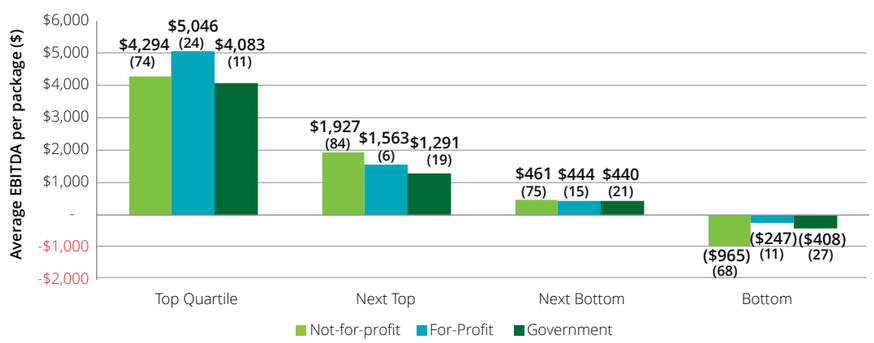
The following analysis examines profit based on ownership type, remoteness location and scale of provider. The composition of each quartile varies across all three.

In last year's Annual Report ACFA reported that for-profit providers achieved significantly higher average EBITDA per package than not-for-profit providers in 2013-14.

However, in 2014-15, performance of the sectors had converged, with for-profits achieving $2,384 ($2,563 in 2013-14), a 7 per cent reduction, while not-for-profit providers recording $2,341 per package ($2,096 in 2013-14) an 11.7 per cent increase.

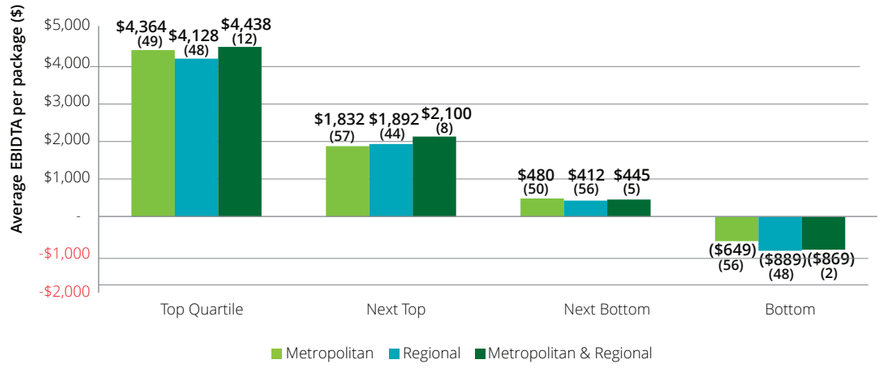
Government providers had the lowest results, with an EBITDA of $1,052 per package. As was the case in 2013-14, a higher proportion of for-profit providers were present in the top quartile of ranking by EBIDTA per package, as shown in Chart 5.9.

Chart 5.9: Provider average EBIDTA per package per annum 2014-15, by quartile and ownership type (number of providers in parentheses)



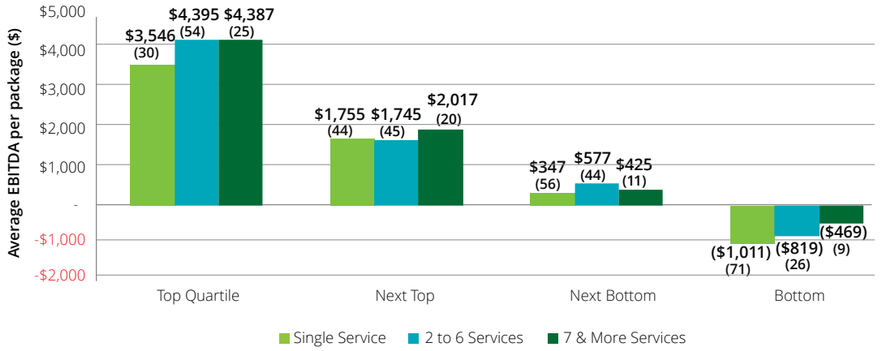
When classified on the basis of remoteness location, providers who operated all of their services in regional locations achieved the lowest level of average EBIDTA per package ($1,806 compared with $2,060 for metropolitan providers and $2,819 for providers with services in metropolitan and regional locations).

Chart 5.10: Provider average EBITDA per package per annum 2014-15, by quartile and provider remoteness location (number of providers in parentheses)



As was the case in 2013-14, providers who only operate one service are under-represented in the top quartile (27 per cent) and over-represented in the bottom quartile (67 per cent) (Chart 5.11). Single service providers overall achieved the least EBITDA, being out performed by providers with more than one service in all but one quartile.

Chart 5.11: Provider average EBIDTA per package per annum 2014-15, by quartile and provider scale (number of providers in parentheses)



5.6 ACFA Report on Financial Issues Affecting Rural and Remote Aged Care Providers

ACFA's report, 'Financial Issues Affecting Rural and Remote Aged Care Providers' was provided to the Minister in January 2016.

ACFA found the following relating to home care providers operating in rural and remote areas.

During 2014–15, rural and remote services (in comparison with non-rural services):

- had slightly lower financial results with EBITDA of $1,712 per package per annum (pppa) compared with $1,885 pppa for non-rural and remote; and
- while the differences were not major, they reflect higher Australian Government subsidies (including viability supplement), lower consumer contributions (fees), higher direct labour costs, lower contracted services and higher administration costs.

ACFA's findings from the Rural and Remote Report are also discussed in Chapter 7.

5.7 Consumer Directed Care

The home care package sector is undergoing significant change to its operations with the full implementation of Consumer Directed Care (CDC). CDC has required changes to how providers operate as noted in Chapter 3. From 1 August 2013, all new home care packages were required to be offered by providers on a CDC basis, and from 1 July 2015 this was extended to all existing packages.

CDC gives consumers greater choice and control over their care. In practical terms, CDC is intended to ensure:

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

CDC presented some challenges for both providers and consumers who were unaccustomed to operating within what is a more consumer-driven paradigm.

The Department implemented various support mechanisms for the sector and consumers to assist with the transition to CDC, including operating the CDC transition hotline, and providing additional funding to support providers to help meet the costs of reskilling and retraining their workforce. In addition, COTA Australia, in partnership with Aged Care Services Australia and Leading Age Services Australia, was funded to undertake capacity building projects for providers and consumers to support the introduction of CDC. This included the development of the 'homecare today' website and several resources for both consumers and providers.

ACFA commented in last year's report how the introduction of CDC increases transparency, and the level of involvement by consumers which changes the relationship between the provider and consumer. Consumers are empowered as they have greater control over their individual budget. The introduction of new arrangements for income tested fees in home care from 1 July 2014 has also seen consumers take a more active role in their packages as they now see part of the total cost being directly funded by them.

Issues for providers during the transition to CDC included ensuring cultural change in their organisations, upgrading financial systems to ensure that individualised budgets and monthly statements could be delivered, and eliminating the practice of providers cross-subsidising some consumers at the expense of others.

5.7.1 Evaluating the transition to CDC

COTA Australia has stated that while most providers seem to be transitioning well to CDC, some are still experiencing problems which are impacting on the consumers in some instances. They further state that the changes that will occur in 2017 will allow consumers to change providers if they are not happy.

One aspect of CDC that has received attention is the capacity for consumers to choose to save package funds up over time either as a contingency, or to purchase larger capital items or services. This means that providers have a responsibility to hold unspent funds in trust to meet future services requested by the consumer, or transfer the unspent monies if the consumer changes home care provider, or to return the unspent monies when the consumer leaves home care. Data collected by StewartBrown's quarterly financial performance surveys indicates that consumers unspent funds are, on average over 10 per cent of the value of the package. StewartBrown has also seen that some consumers are choosing to spend their built-up funds on one-off capital items or services that offer little or in some cases no margin to providers.

5.8 Looking forward: developments, opportunities and challenges

Changes in the service provision target ratios mean that the number of home care packages released by the Commonwealth will double over the next five years from 72,702 currently to around 140,000 by 2021-22. This increase is in line with the provision ratio target of 45 home care places for every 1000 people aged 70 and over by 2021-22, up from 27 places in 2012.

The increase in the supply of home care packages will give more consumers the option to remain in their own homes, thereby increasing competition between home care and residential services. The early intervention nature of short-term restorative care could be expected to impact the number of consumers accessing home care packages following the introduction of the programme in 2016-17.

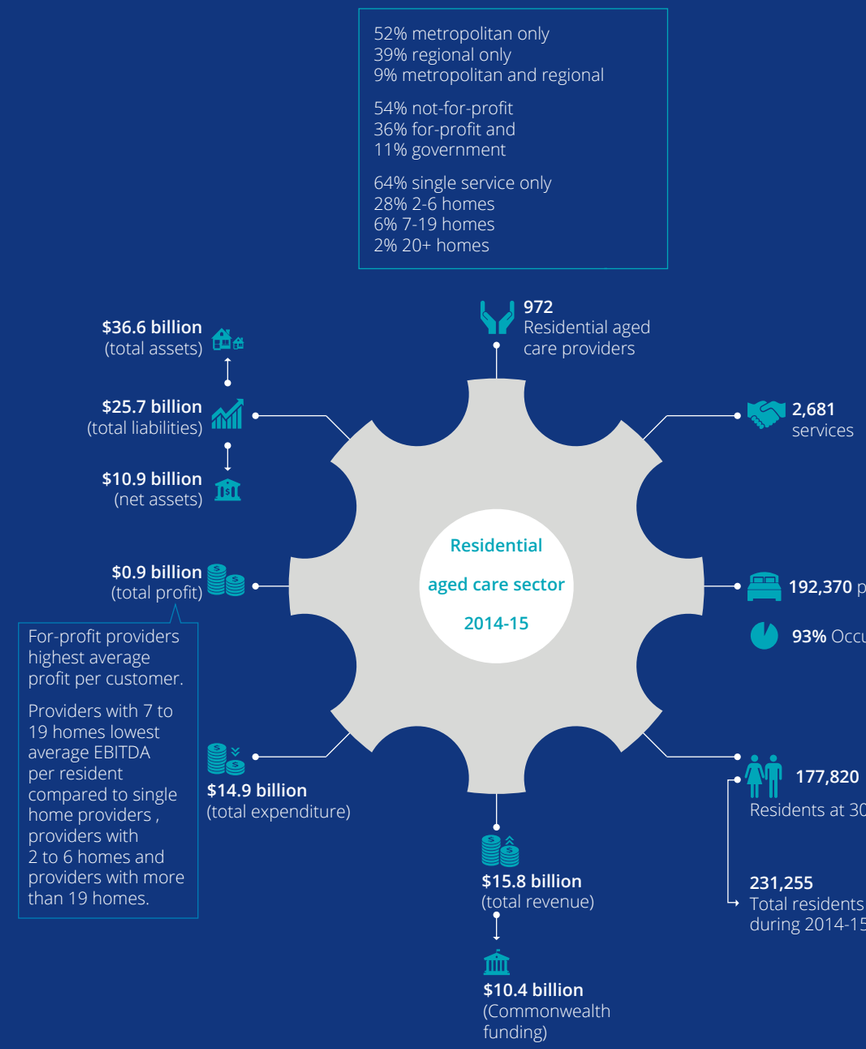
The implementation in February 2017 of funds following the consumer (outlined in Chapter 9) will drive further change in the sector, toward greater consumer control of their care. The nature of home care will evolve further in 2018 with the intended integration of the CHSP and home care packages.

All of these reforms stand to create opportunities for consumers to secure care that is more closely aligned to their needs and preferences and for providers to deliver services that are more responsive to consumer preferences.

In so doing, it will also open up opportunities for innovation among providers. This may result in change in the provider mix. The challenge for existing providers is to understand and adapt to the changes so that their care recipients are satisfied consumers.

Chapter 6
Residential aged care: access to care

Snapshot of the residential aged care sector 2014-15



Notes: Provider, services, places, occupancy and resident numbers relate to the whole of sector. Financial results relate to the 98 per cent of providers who completed the General Purpose Financial Report (GPFR). The GPFR is 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.

6 Residential aged care: access to care

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

This chapter discusses:

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

This chapter reports that:

- in 2014-15 there were 192,370 places, up from 189,283 in 2013-14;
- in 2014-15 there were 972 providers, down from 1,016 in 2013-14;
- the residential aged care sector is consolidating with the number of residential aged care places increasing while the number of providers continues to decrease;
- occupancy has continued to be relatively stable (92.5 per cent in 2014-15 compared with 93 per cent in the previous two years);
- the proportion of residents from a CALD background is continuing to increase steadily from 15 per cent in 2007 to 18 per cent in 2015;
- not-for-profit providers represent the largest proportion of ownership type in residential aged care, with 54 per cent of providers and 57 per cent of places;
- ongoing demographic challenges will see a continuing increase in demand, as the proportion of people aged 85 and over is expected to grow to represent nearly 5 per cent of the population by 2055, compared with 2 per cent of the population today; and
- ACFA has been asked to undertake a study on access to care for supported residents.

6.1 Sector overview

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

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

Up until 30 June 2014, approvals for permanent residential care were classified as high care or low care. From 1 July 2014, the distinction between high and low care levels was removed. For this reason, analysis from previous ACFA annual reports based on the low care and high care split is not comparable with this report.

Residential care is provided on a permanent or respite basis. The majority of residential aged care places are occupied by permanent residents who have security of tenure. Residential respite provides short-term care on a planned or emergency basis in aged care homes. There is an emerging trend of respite care being utilised by residents for a period of time immediately prior to locking in permanent care. This is discussed in Chapter 3.

Permanent residential aged care is generally offered to older people who can no longer be supported to live in their own home.

Respite residential aged care is short-term care in aged care services. It is generally available on a planned or emergency basis for older people who intend returning to their own home yet need residential aged care on a temporary basis. It supports older people in transitory stages of health, as well as carers, to provide them with a break from their caring duties. It is also used by some older people to transition into permanent residential care.

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

6.2 Supply of residential aged care

The Australian Government uses a planning framework based on the provision of a specified national level of subsidised operational residential aged care places. This is outlined in Chapter 2.

Table 6.1 provides an overview of the number of providers, the number of services operated, the number of places provided and number of residents in 2014-15.

Table 6.1: Number of providers, services, places and residents in residential aged care, 2014-15

			Ownership type			Remoteness location			Provider scale			
	Total sector 2013-14	Total sector 2014-15	Not-for-profit	For-profit	Government	Metropolitan	Regional	Metropolitan & regional	Single home	2 To 6 homes	7 To 19 homes	20 & More homes
Providers	1,016	972	522	346	104	506	376	90	621	276	56	19
Services	2,688	2,681	1,576	850	255	846	614	1221	621	784	601	675
Places	189,283	192,370	109,873	73,097	9,400	66,564	30,990	94,816	44,580	51,967	45,216	50,607
Occupancy	93.0%	92.5%	94%	91%	89%	92%	92%	93%	93%	92%	93%	92%
Residents	176,816	177,820	102,977	66,446	8,397	61,166	28,735	87,919	41,234	47,703	41,993	46,890
Permanent	173,974	172,828	100,549	64,110	8,169	59,368	27,801	85,659	39,866	46,347	40,913	45,702
Respite	2,842	4,992	2,428	2,336	228	1,798	934	2,260	1,368	1,356	1,080	1,188

Note: This does not include MPS and flexible care providers and places.

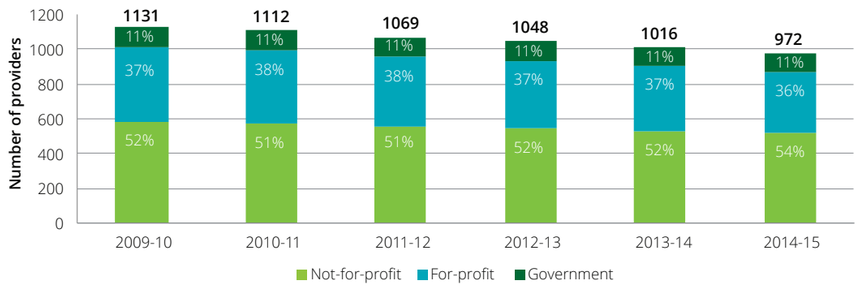
6.2.1 Number of places and providers

At 30 June 2015, there were 192,370 operational residential care places in Australia. The 1.6 per cent increase in residential operational places is consistent with the annual average growth of 1.6 per cent over the previous five years.

At 30 June 2015, the operational ratio was 81.1 residential care places for every 1,000 people aged 70 years and over. Despite the policy to reduce the aged care provision ratio for residential care from 88 to 78 places (plus 2 places for restorative care) by 2021-22, the structural ageing of the population means that the number of residential places will continue to grow each year.

As the residential aged care industry matures, an increasing number of providers are seeking to expand the scale of their businesses. As a result there has been a consolidation of industry providers. Chart 6.1 shows the decreasing provider numbers over the six years to 2014-2015.

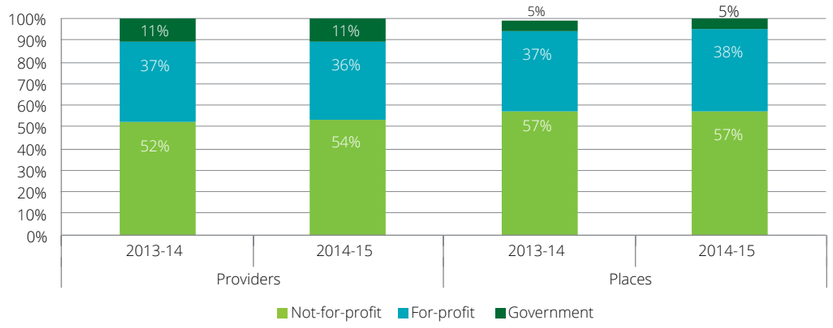
Chart 6.1: Provider numbers, 2009-10 to 2014-15



6.2.2 Ownership type

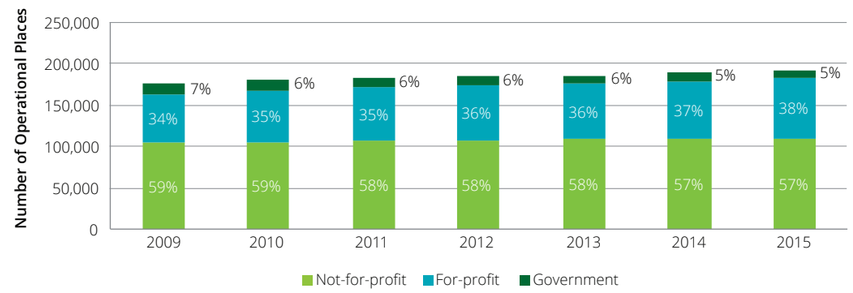
As shown in Chart 6.1 and Chart 6.2, the largest provider group is the not-for-profit providers (religious, charitable and community-based organisations). They represent 54 per cent of providers and also operate the most residential aged care places (57 per cent). For-profit providers account for 36 per cent of providers and 38 per cent of places. The remaining 11 per cent are operated by state and territory and local government owned providers, but only account for 5 per cent of places.

Chart 6.2: Proportion of providers and places by provider ownership



The proportion of providers across ownership types has remained relatively stable (Chart 6.2), while overall numbers of providers has slowly decreased. However, the proportion of operational residential aged care places held by for-profit providers has increased over the last seven years (Chart 6.3). This reflects for profit providers increasing the scale of their operations.

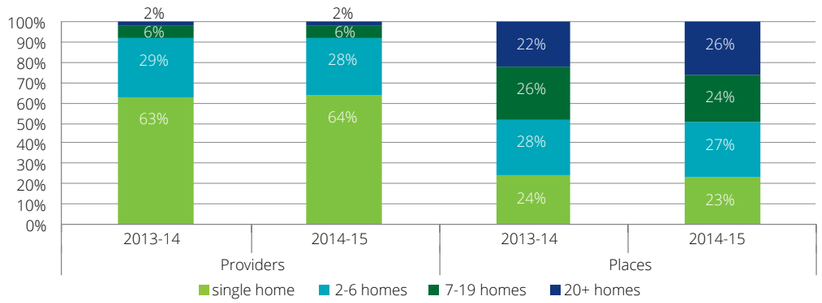
Chart 6.3: Operational places 2009 to 2015



6.2.3 Provider scale

Most providers (64 per cent) only own one residential aged care home. These single home providers account for 23 per cent of all operational aged care places (Chart 6.4). Conversely, 19 providers (only 2 per cent of all providers) have more than 20 homes, with a total of 50,000 places or 25 per cent of operational places. This is up from 22 per cent in 2013-14, which further shows the consolidation of the sector with larger providers continuing to expand their operations.

Chart 6.4: Provider and operational places by provider scale, 2013-14 and 2014-15

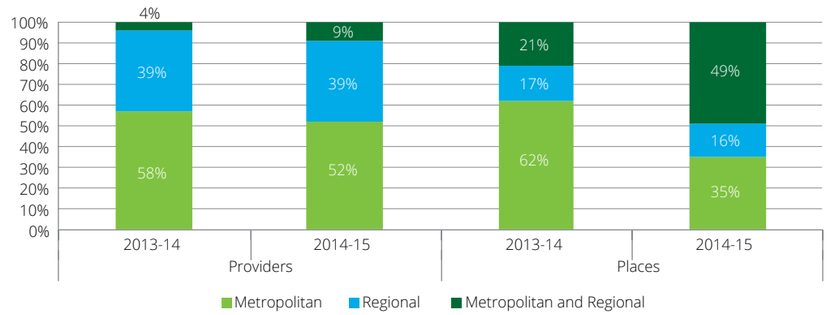


6.2.4 Remoteness location

Providers are broken down into those operating only in metropolitan areas, those operating only in regional areas, and those who have services in both metropolitan and regional areas. A provider is classified as being regional if more than 70 per cent of their residents are in facilities in regional areas.

Chart 6.5 shows that the majority of providers are located in metropolitan areas only (52 per cent compared with 58 per cent in 2013-14), with 39 per cent of providers in regional areas and the remaining 9 per cent of providers operating services in both metropolitan and regional areas (up from 4 per cent in 2013-14.). This shows that more providers who previously only provided services in metropolitan areas are expanding into regional areas.

Chart 6.5: Provider and places by provider remoteness location, 2013-14 and 2014-15



6.2.5 New places

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

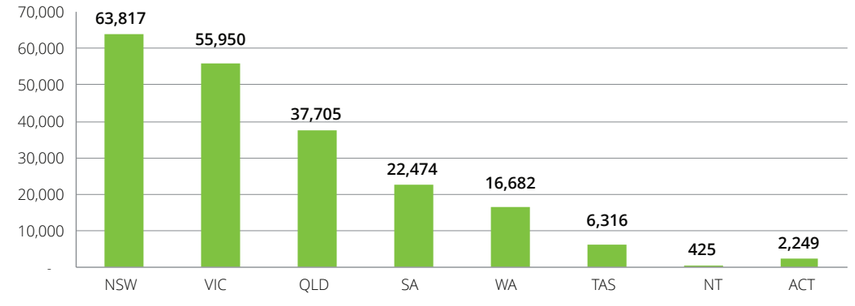
The 2015 ACAR allocated 10,940 new residential aged care places and provided $67 million in capital grants to 22 providers to build new or improve existing residential aged care services.

At 30 June 2015 there were 28,344 provisional residential care places reflecting the carryover of allocated places from both the 2015 ACAR and from previous years which are yet to be constructed. 12 per cent of all allocated places are currently provisional. Over the last seven years, on average, around 10 per cent of allocated places have been provisional at any time.

6.3 Residential aged care workforce

The current residential aged care workforce can be defined as a subset of the 'Residential Care Services' workforce, as published quarterly by the Australian Bureau of Statistics. Approximately 90 per cent of the Residential Care Services workforce is employed in the aged care setting. Based on this, it can be estimated that in 2014-15 there were approximately 230,000 people working in the residential aged care sector. Chart 6.6 illustrates the breakdown of the residential aged care workforce by state and territory.

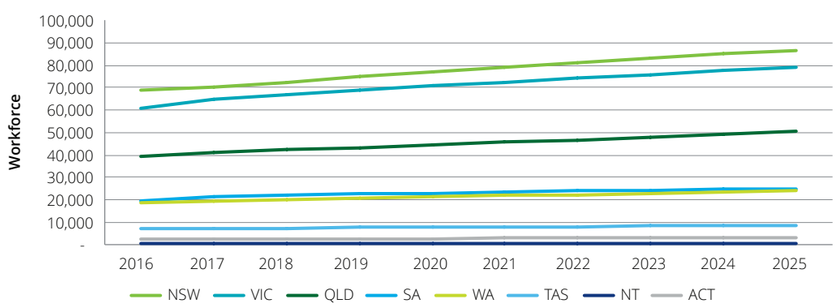
Chart 6.6: Residential aged care workforce, 2014-15 by state and territory



Source – Australian Bureau of Statistics, Residential Services' workforce data

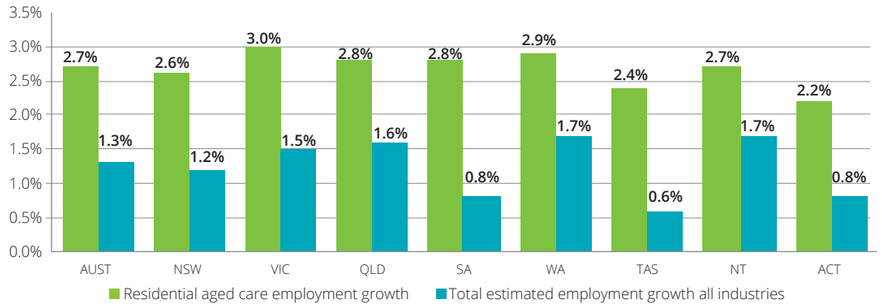
Using forecasts produced by Deloitte Access Economics, and data from the 2012 Aged Care Workforce Census and Survey as a base, the growth and expected size of the residential aged care workforce can be forecast to 2025. Chart 6.7 illustrates the forecast size of the residential aged care workforce from 2016 to 2025. Clearly the workforce is expected to grow, though the rate of growth varies by state and territory (see Chart 6.8). In addition, the rate of employment growth in the residential aged care workforce is anticipated to be faster than the total forecast employment growth rate across all industries. This demonstrates the residential aged care workforce growing to meet increasing demand from an ageing population.

Chart 6.7: Estimated residential aged care workforce, 2016-2025



Source – Deloitte Access Economics projections

Chart 6.8: Estimated compound annual employment growth rate by state and territory, 2016-2025



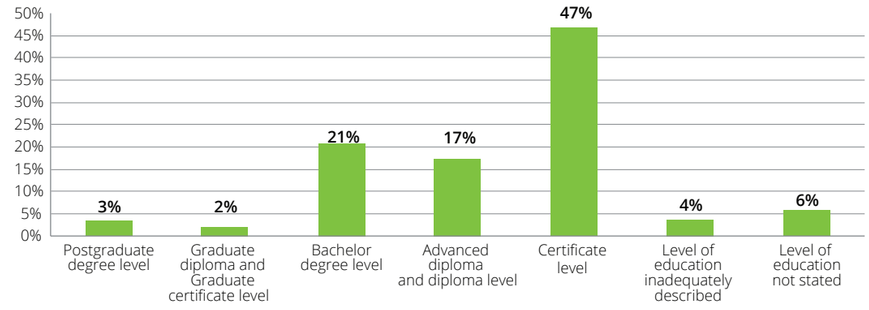
Source – Deloitte Access Economics projections

6.3.1 Characteristics of the residential aged care workforce

Deloitte Access Economics reports that the residential aged care workforce is a relatively older workforce, with 44 per cent of workers aged 50 and over. This has implications for the sustainability of the workforce, with older workers leaving the labour force in the short-medium term to retirement. To support the increasing size of the workforce required, this labour force will need to be replenished by new workers, who often enter this sector at an older age.

The sustainability of the workforce also relies on sufficient numbers of appropriately skilled staff. Based on the 2011 Census, of those who reported a qualification, 47 per cent had a certificate level qualification (Chart 6.9), which likely relates to personal care roles.

Chart 6.9: Qualifications of the residential aged care workforce



Source – Australian Bureau of Statistics, Residential Services' workforce data

6.4 Demand for residential aged care

Demand includes that which is both met by a service and that which is not met. As noted previously in this report with regard to home care, data that would allow an estimation of unmet demand for residential aged care has not been systematically collected. This will change to some extent with the implementation of My Aged Care, and in future annual reports ACFA anticipates being able to provide further analysis. Therefore, only data pertaining to resident numbers and occupancy rates (met demand) is reported in this chapter. Occupancy is measured as the total number of days a place is occupied by a resident divided by the total number of days a place was available to be occupied.

6.4.1 Residents

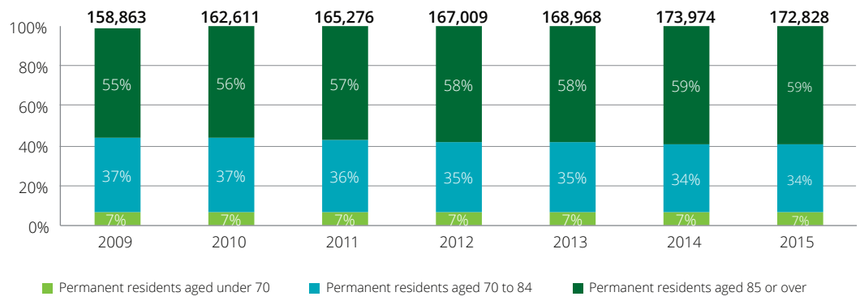
The number of residents who received permanent residential care during 2014-15 was 231,255, a decrease of 0.1 per cent from 231,515 in 2013-14. However the number of people who accessed residential respite care in 2014-15 was 53,021, an increase of 9.8 per cent from 48,295 in 2013-14.

Similarly, the number of residents who were actually in permanent residential care as at 30 June 2015 was 172,828, a decrease of 0.7 per cent from 173,974 at 30 June 2014. However the number of people who were receiving respite residential aged care as at 30 June 2015 was 4,992, an increase of 76 per cent from 2,842 at 30 June 2014. The increase in residential respite care numbers is discussed in Chapter 3. Combining both categories shows that the total number of residents as at 30 June 2015 was 177,820, a 0.6 per cent increase on 176,816 at 30 June 2014.

Chart 6.10 illustrates that the residential aged care population is getting older over time as people live longer and more consumers have the opportunity to stay in their own homes longer, often with the assistance of home care. The proportion of residents in residential aged care aged 85 and over has increased from 55 per cent in 2009 to 59 per cent in 2015 while the proportion of those aged between 70 and 84 has decreased from 37 per cent in 2009 to 34 per cent in 2015. The average age of permanent residents in 2014-15 was 84.6. This has been steadily increasing since 2009-10 when it was 84.0 years.

Chart 6.10 shows the proportion of residential aged care residents by age group.

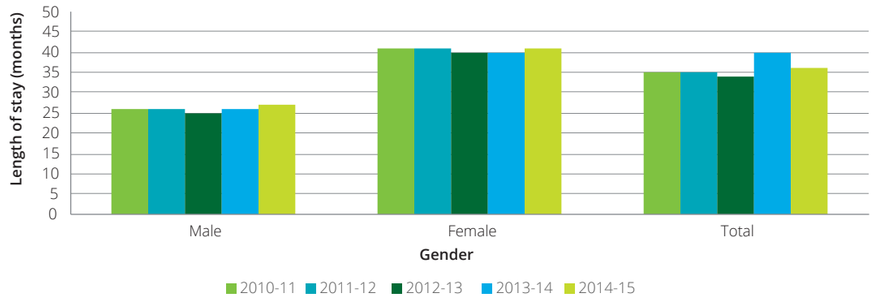
Chart 6.10: Proportion of permanent residential aged care residents by age (under 70, 70–84, 85+), 2009–2015



6.4.2 Length of stay

The average length of stay has remained relatively constant over the past five years (Chart 6.11). The total average length of stay for residents leaving residential care in 2014-15 was three years although females (three years and five months) has significantly longer stays than males (two years and three months).

Chart 6.11: Average length of stay, by gender, 2010-11 to 2014-15



Source – Australian Bureau of Statistics, Residential Services' workforce data

6.4.3 Indigenous Australians

As at 30 June 2015 there were 1,535 Indigenous Australians in residential care compared with 1,452 in June 2014. Table 6.2 below shows the number of Indigenous Australians in residential care in 2014 and 2015 by state and territory.

Table 6.2: Indigenous Australians in residential care as at 30 June 2014 and 30 June 2015

State/territory	30 June 2014	30 June 2015
NSW	376	420
Vic	109	102
Qld	423	456
WA	282	289
SA	71	74
Tas	23	26
ACT	4	7
NT	164	161
Total	**1,452**	**1,535**

6.4.4 CALD residents

There were 32,483 older Australians from CALD backgrounds in residential aged care (permanent and respite) as at 30 June 2015, or 18.3 per cent, compared with 31,582 (17.9 per cent) at 30 June 2014 (Table 6.3). The proportion of CALD people in residential care has been steadily increasing for some years and was 15 per cent in 2007. This compares with the overall population of Australians aged 65 and over, of which around 20 per cent are from a CALD background.

Table 6.3: CALD consumers in residential aged care as at 30 June 2014 and 30 June 2015.

State/territory	30 June 2014	30 June 2015
NSW	11,592	11,971
Vic	10,650	11,049
Qld	3,108	3,162
WA	2,676	2,696
SA	2,836	2,833
Tas	281	309
ACT	380	406
NT	59	57
Total	**31,582**	**32,483**

6.4.5 Supported residents

An accommodation supplement is paid to approved providers on behalf of residents who have been assessed as not being able to meet all or part of their own accommodation costs.

Since 1 July 2014 the level of a new resident's accommodation supplement depends on:

- the outcome of the resident's means tested assessment;
- whether the aged care service has been built or significantly refurbished since 20 April 2012;
- whether the aged care service meets 2008 privacy and space requirements; and
- whether the aged care service provides more than 40 per cent of its eligible care days to supported residents.

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

As at 30 June 2015, the proportion of supported residents (excluding extra service places) was 46.8 per cent compared with 44.3 per cent in 2013-14 and 44.4 per cent in 2012-13.

Table 6.4 shows that when analysed by remoteness locations the proportion of residents in care who are supported was higher in 2014-15 when compared with the previous two years. In addition these results show that the proportion of supported residents increases with remoteness.

Table 6.4: Supported residents by remoteness location of the service, 2012-13 to 2014-15

Remoteness location	2012-13	2013-14	2014-15
Metropolitan	44.0%	44.0%	46.0%
Regional	44.8%	44.7%	48.3%
Remote and very remote	60.2%	59.0%	61.8%

When analysed based on provider ownership type, government providers had the highest proportion of supported residents in 2014-15 (Table 6.5), as they did for the previous two years. The not-for-profit providers had the next highest proportion and the for-profit providers had the least, as they also did for the previous two years, however the proportion of supported residents has increased across all three provider types when compared with the previous two years. This likely reflects the changes to means testing from 1 July 2014 under which the asset threshold for being a supported resident was raised.

Table 6.5: Supported residents by provider type, 2012-13 to 2014-15

Ownership type	2012-13	2013-14	2014-15
For-profit	44.2%	43.7%	45.2%
Not-for-profit	44.4%	44.5%	47.4%
Government	46.4%	47.2%	50.9%

As was the case noted in last year's Annual Report, supported residents tend to be, on average, around three years younger than non-supported residents at first admission.

The role of supported residents, and the way in which the Australian Government supports their care, is important to how residential care is funded and used.

The Minister has asked ACFA to study and report on cost neutral mechanisms to ensure adequate access to care for supported residents, including reviewing the supported resident ratio. This report is due to be provided to the Minister in December 2016.

6.4.6 Occupancy rates

Occupancy rates reflect both demand and the number of places available. The occupancy of operational residential care places was 92.5 per cent in 2014-15, down from 93.0 per cent in 2013-4. Occupancy rates have been steady in recent years however have declined overall since they peaked at 96.7 per cent in 2002.

The not-for-profit providers continue to have the highest occupancy rate at an average of 94.0 per cent, down from 94.6 per cent in 2013-14. For-profit providers achieved an average occupancy of 90.6 per cent for 2014-15. This was also down from 91.0 per cent in 2013-14 and was more than three percentage points less than not-for-profit providers.

There is some variation in occupancy by state or territory, with the highest occupancy being the ACT with 94.5 per cent and the lowest being Tasmania with 90.6 per cent. However, the greatest variation is by remoteness location. A clear trend is that more populous areas generally have higher occupancy rates than less populous areas. Table 6.6 shows occupancy rates by remoteness location during 2014-15.

Table 6.6: Residential aged care occupancy by remoteness areas, 2014-15

Remoteness area	Occupancy (%)
Metropolitan	92.6
Inner	92.4
Regional outer	92.1
Regional remote	86.5
Regional very remote	84.8

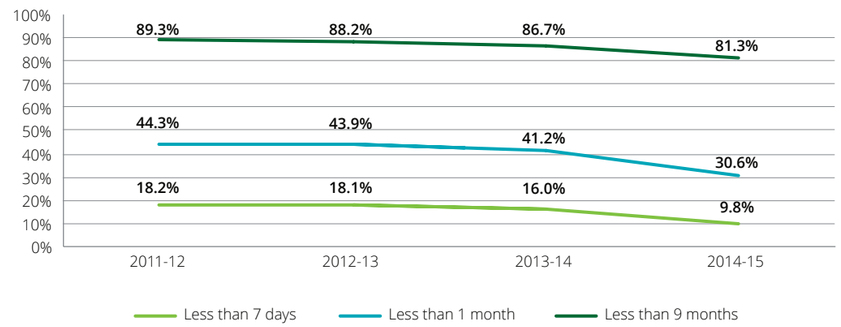
This trend in occupancy rates suggests the greatest demand pressures on average may be in metropolitan areas, with somewhat less demand in more remote areas. This pattern in occupancy rates is mirrored in home care.

As Chart 6.12 indicates, and as was noted in last year's Annual Report, there is an increase in elapsed time between when a resident is assessed as eligible for residential care and entering permanent care in 2014-15 compared with previous years:

- 9.8 per cent of people entering care did so within a week of being assessed by an ACAT (16.0 per cent in 2013-14);
- 30.6 per cent did so within a month (41.2 per cent in 2013-14); and
- 81.3 per cent within nine months (86.7 per cent in 2013-14).

The increasing availability of home care and the increased usage of respite care could be contributing to the longer time between assessment and someone entering permanent care. The 2014-15 results would also likely reflect some of the delays in means testing which occurred when the 1 July 2014 financing reforms were implemented. Elapsed time statistics need to be treated with some caution. An eligible assessment does not necessarily mean that a person wishes to immediately access residential care as they may wish to explore other options. Additionally, those who enter residential care may need to organise the sale of assets in order to pay an accommodation deposit.

Chart 6.12: Elapsed time between assessment and entering care, 2011-12 to 2014-15 (%)



6.4.7 Future demand growth

The demand for residential aged care will expand with the ageing of the population. As can be seen in Chart 6.13, it is the older age groups that will drive the demand for aged care with people aged 85 years and over representing 60 per cent of all residential aged care consumers.

The residential aged care target ratio of 78 places per 1,000 people aged 70 years and over by 2021-22 means the Australian Government is aiming to achieve one operational residential care place created for every 13 people aged 70 years and older. If the sector is to meet this target, there will need to be significant growth in the supply of places as the baby boomer cohort reaches 70 years of age. This is shown in Chart 6.14 and Chart 6.15.

Because the baby boomers are such a large group compared with the pre-war generation, the proportion of the 70 and over population that are aged 85 and over will reduce over the next decade then subsequently increase as shown in Chart 6.14. This implies that the challenge of ensuring there is sufficient residential aged care supply to meet demand arising from the baby boomer generation is more likely to be felt in 10-15 years time than over the next decade. Increased investment activity now and in future years is necessary to meet this challenge given the lead time in developing and building homes.

The impact of the increase in the 85 years and older cohort can be seen in Chart 6.15 which shows the number of residents is projected to exceed the number of places under current ratios by around 2040.

Chart 6.13: Age profile of residents at 30 June 2015

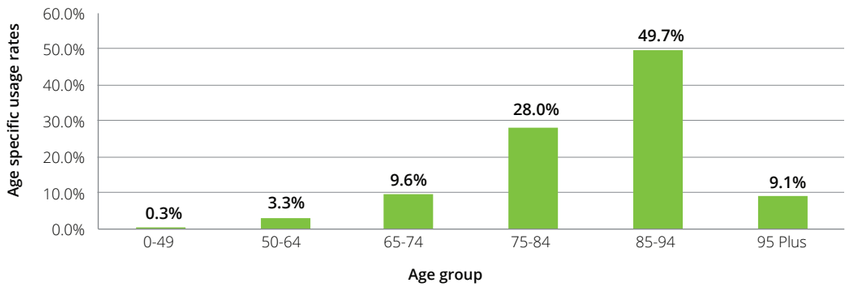


Chart 6.14: Proportion of 70+ age group who are aged 85+

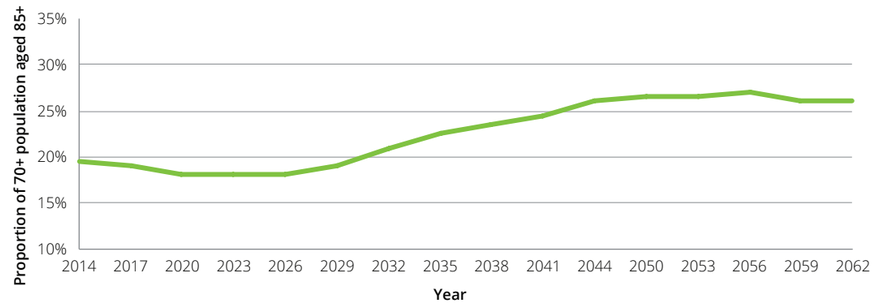
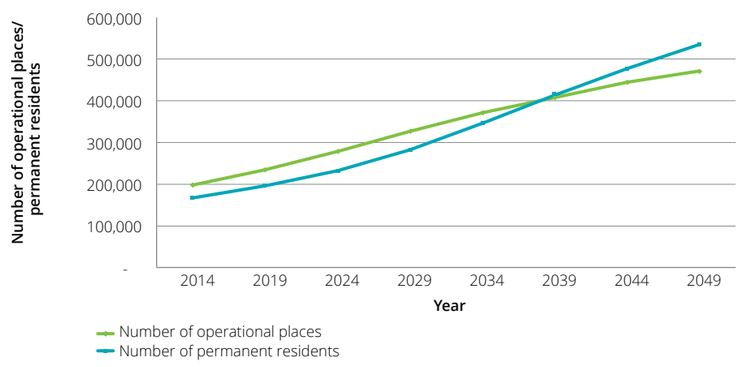


Chart 6.15: Projected number of operational places under the current residential care ratio and the expected number of permanent residents, 2014 to 2050



Note: The above does not include residential respite residents

6.4.8 Conclusion

As aged care evolves and transforms, access to residential aged care will remain important, despite a growing proportion of people seeking care in their own homes. As people are staying in their own homes longer and entering residential care later in life, consideration could be given to whether a planning ratio based on people aged 70 and over is appropriate in the future when the average age of entry to residential care is already 84.6 years and increasing each year.

Chapter 7 Residential aged care: operational performance

7 Residential aged care: operational performance

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

This chapter discusses:

- funding arrangements for residential care
- the operational performance of residential providers for 2014-15, including revenue, expenditure and profit
- operational performance by provider ownership type, remoteness location and scale
- developments, opportunities and challenges
- key findings from ACFA's report on, 'Issues Affecting the Financial Performance of Rural and Remote Aged Care Providers'

Key findings on financial performance in 2014-15 compared with 2013-14:

- total revenue of $15.8 billion (an increase of 6.6 per cent), equating to $249 per resident per day (an increase of 5.3 per cent);
- total expenses of $14.9 billion, equating to $235.05 resident per day, an increase of 5.6 per cent;
- Earnings before Interest, Taxes, Depreciation, and Amortisation (EBITDA) increased from $1,581 million to $1,775 million, an increase of 12.3 per cent;
- EBITDA per resident per annum increased from $9,224 to $10,222 or 10.8 per cent;
- Net Profit Before Tax (NPBT) increased from $712 million to $907 million, an increase of 27.4 per cent;
- NPBT per resident per annum increased from $4,150 to $5,221, an increase of 25.8 per cent; and
- 68 per cent of providers achieved a net profit, up from 66 per cent.

There were significant changes from 1 July 2014:

- reforms to accommodation payment arrangements;
- 2.4 per cent increase in care prices and a 20 per cent increase in the viability supplement;
- removal of the Payroll Tax supplement from 1 January 2015 and cessation of the Dementia and Severe Behaviours supplement from 1 August 2014; and
- new means testing arrangements that increased the amount of consumer contributions while reducing the amount of Commonwealth subsidies.

Overall ACFA considers the financial performance of residential aged care providers has continued to improve in 2014-15, building on the improvement reported in 2013-14. ACFA also considers the viability and resultant sustainability of the sector shows signs of further strengthening as a result of the 1 July 2014 reforms though notes the impacts will vary from provider to provider.

ACFA notes the sector has expressed concerns over the changes to funding for complex health care through the Aged Care Funding Instrument announced in the 2015 MYEFO and 2016-17 Budget which are scheduled to take effect from 1 July 2016 and 1 January 2017. In future annual reports ACFA will analyse and report on the impact of these (and other) changes.

7.1 Introduction

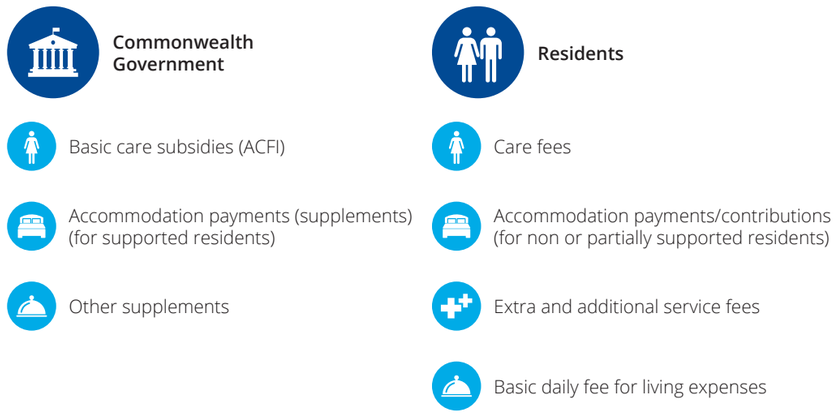
Funding for residential aged care is made up of operational funding and capital financing. Operational funding supports day-to-day services such as nursing and personal care, living expenses and accommodation expenses. Capital financing supports the construction of new and refurbishment of existing residential aged care services. Capital financing is discussed in Chapter 8.

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

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

ACFA notes that in previous reports residential providers were also discussed based on whether they operated predominately high care places, low care places or mixed care. The distinction between high and low care was removed from 1 July 2014 and therefore is not discussed in this report.

Figure 7.1: Residential aged care services



[19] In aged care, 'regional' is any area that it outside of a major city. That is inner and outer regional, remote and very remote combined. A provider is classified as metropolitan if 70 per cent or more of their residents are in facilities in metropolitan locations and classified as regional if 70 per cent or more of their residents are in facilities in regional locations.

7.2 Operational funding

A combination of Australian Government and resident sources provides the operational funding for residential aged care as described in Figure 7.1.

The Commonwealth determines its contributions to residential aged care by setting:

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

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

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

7.2.1 Commonwealth Government operational funding

Commonwealth payments to residential aged care in 2014-15 can be classified as:

- Basic care subsidies[20]
- Accommodation payments (supplements)
- Viability supplement
- Other supplements

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

7.2.2 Basic care subsidies

- **The basic care subsidy** is a payment intended to support the costs of providing personal and nursing services to residents. It is calculated based on the assessed need of each permanent resident as determined by the provider by applying the **Aged Care Funding Instrument (ACFI).** The Commonwealth determines the level of payments on behalf of residents by setting the prices and rules for claiming ACFI care subsidies. Respite residents are assessed by an Aged Care Assessment Team as requiring either high or low level care, with payment amounts for each set by the Commonwealth[21].
- **The Conditional Adjustment Payment (CAP)** was paid prior to 2014-15 to eligible providers who met certain criteria including encouraging staff training, submitting a GPFR and participating in the workforce census. As of 1 July 2014 the CAP was abolished and funding included in the basic care subsidy paid to all providers. Prior to its abolition, CAP was paid at a rate of 8.75 per cent of the basic care subsidy.

The Aged Care Funding Instrument (ACFI)

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

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

As part of the 2016-17 Budget, the government announced changes to the ACFI to reduce the rate of growth in expenditure per person. These changes are outlined at the end of this chapter. Under current policy, funding growth reflects annual indexation and a factor for the increasing frailty of residents.

[20] The Conditional Adjustment Payment ceased from 1 July 2014 and was included in the amount paid for basic care subsidies.
[21] The distinction between high and low care was not removed from residential respite care on 1 July 2014 when it was removed from permanent residential care.

7.2.3 Accommodation payments
Accommodation payments by the Commonwealth, also referred to as accommodation supplements, are payments made to assist with the accommodation costs of people who do not have the means to meet all of that cost themselves (supported residents). These payments include both the current accommodation supplement and grand-parented supplements under previous policies.

The Commonwealth determines the amount of accommodation supplement payable by setting the maximum rate of accommodation supplement and determining the share paid by residents based on an income and asset test (post 1 July 2014) or asset test (pre 1 July 2014).

Two significant reforms from 1 July 2014 affected accommodation payments. New means testing arrangements were introduced for residents entering residential care after 1 July 2014, which increased resident contributions and the accommodation supplement paid by the Commonwealth to a provider on behalf of supported residents living in aged care homes built or significantly refurbished since 20 April 2012 by 53 per cent. These reforms are discussed in more detail in Chapter 3.

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

The supplement is available to residential care services, home care services, Multi-Purpose Services and Aboriginal and Torres Strait Islander Flexible services. On 1 July 2014 the amount paid by the Commonwealth for the Viability supplement was increased by 20 per cent on top of normal annual indexation.

ACFA's report on the Issues Affecting the Financial Performance of Rural and Remote Providers, which was provided to the Minister in January 2016, noted that $66 million in Viability supplement was paid to aged care providers in 2014-15, with $35 million of this being for residential providers.

Of the 311 residential aged care facilities reviewed by ACFA for that report, 295 (95 per cent) were in receipt of the Viability supplement. An average payment of $41,430 per facility was received for residential facilities in inner regional locations (45 facilities), an average of $69,353 for residential facilities in outer regional locations (199 facilities), an average of $178,994 for residential facilities in remote locations (36 facilities) and an average of $219,831 for facilities in very remote locations (15 facilities). On average, the Viability supplement provided $2,774 per resident per annum (prpa) for residential care facilities in rural and remote areas, directly improving their financial results. This compared with an average of $60 prpa for metropolitan residential care services.

ACFA concluded that the Viability supplement is generally well targeted with regional facilities receiving substantially more supplement than metropolitan facilities for both residential and home care services. However ACFA did note that the Viability supplement uses a classification scale for determining remoteness which had not been updated for some time and continued to pay some facilities based on rules in operation from an older version of the scheme.

In the 2016-17 Budget the Commonwealth announced further increases to the Viability supplement effective from 1 January 2017, including moving to a more modern classification system, the Modified Monash Model[22].

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

7.2.6 Resident operational funding
Resident contributions in 2014-15 for operational funding were made up of:

- **A basic daily fee,** which is a contribution towards living expenses such as meals, laundry services, utilities and toiletries. It is set by the Commonwealth, and is currently at a maximum of 85 per cent of the single basic age pension.
- **A means tested care fee,** which is a contribution some residents make towards their care costs (personal and nursing) based on their assessable income and assets.
- **Accommodation payments,** which are daily payments for accommodation in an aged care home. Lump sum accommodation deposits are not considered revenue and are discussed in Chapter 8.
- **Extra or optional additional services fees,** which are additional fees that may be chosen by a resident for a higher standard of accommodation or additional services. These vary from home to home.

7.3 Analysis of 2014-15 financial performance of residential aged care providers

The financial performance of residential aged care providers is affected by variations in both revenue and expenditure. It also varies with the setting in which care is delivered. Significant changes to funding arrangements took effect from 1 July 2014. These are described in Chapter 3. The effect of some of the reforms has been reflected in the financial performance of the sector in 2014-15.

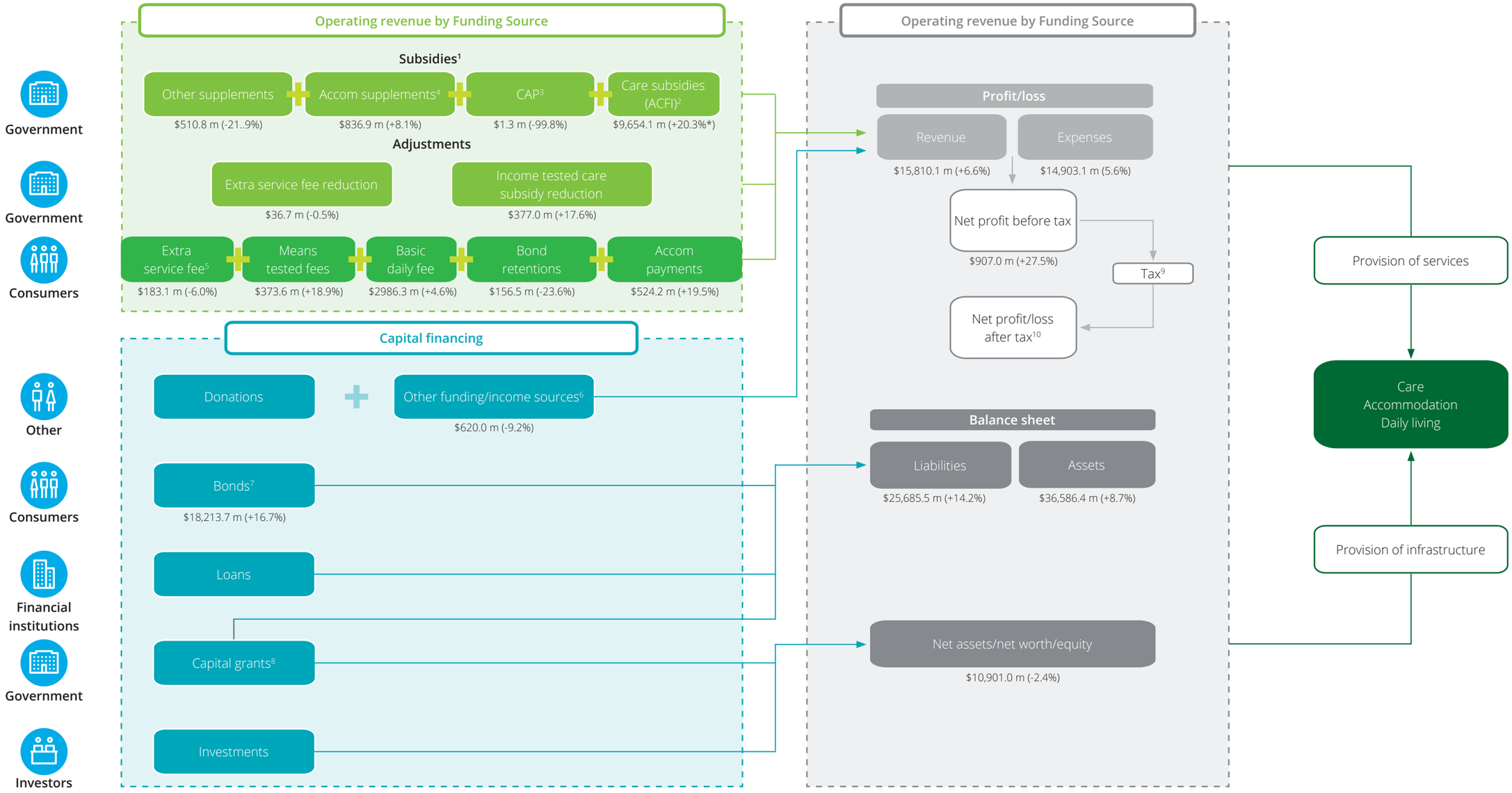
Operational funding contributes to meeting the cost of provision of services to residents. Additionally, if surpluses in any one year contribute to Retained Earnings in the balance sheet, such equity may be contributed towards capital financing for the provision of infrastructure.

The left side of Figure 7.2 maps operational funding of the residential aged care sector in 2014-15.

The capital financing portion of the figure is explained and discussed in Chapter 8 (Figure 8.1). The financial performance (profit and loss in the current financial year) is discussed in this section.

[22] The Modified Monash Model was developed by the Department of Health and is currently in use for health workforce programmes.

Figure 7.2: Residential aged care funding/financing sources, operational side



* The 20.3% increase in Care Subsidies (ACFI) includes the funding previously paid through the Conditional Adjustment Payment (CAP) which was rolled into basic subsidy payments from 1 July 2014. The CAP was previously paid at a rate of 8.75% of the value of the basic subsidy.

Table 7.1 provides an overview of the 2014-15 financial performance of residential aged care providers who submitted their GPFRs.

Table 7.1: Summary of financial performance of residential aged care providers, 2014-15

			Ownership type 2014-15			Remoteness location 2014-15			Provider scale 2014-15			
	Total sector 2013-14	Total sector 2014-15	Not-for-profit	For-profit	Government	Metropolitan	Regional	Metropolitan & regional	Single home	2 To 6 homes	7 To 19 homes	20 & more homes
Revenue ($m)	$14,826	$15,810	$8,742	$6,199	$869	$9,897	$2,621	$3,292	$3,554	$4,204	$3,893	$4,159
Expenses ($m)	$14,115	$14,903	$8,340	$5,642	$921	$9,234	$2,587	$3,083	$3,264	$4,008	$3,734	$3,898
Profit ($m)	$712	$907	$402	$557	-$52	$663	$35	$209	$290	$196	$160	$261
EBITDA margin	10.7%	11.2%	10.9%	13.3%	0.3%	11.8%	7.2%	12.6%	12.9%	10.1%	10.3%	11.8%
NPBT margin	4.9%	5.8%	4.6%	9.0%	-7.1%	6.7%	1.4%	6.4%	8.2%	4.7%	4.2%	6.3%
Average profit (EBITDA) per consumer ($) per annum	$9,224	$10,222	$9,318	$12,945	$341	$10,934	$6,442	$11,166	$11,685	$9,162	$9,619	$10,590

Note: Totals of percentages may not add to 100% due to rounding.

(1) Commonwealth subsidies represent the entire industry whereas contributions by residents represents those providers who have given their GPFRs (approx. 99 per cent of the sector).

(2) Includes grand parented accommodation supplements. The growth in accommodation supplements is measured by including grand-parented supplements in both years.

(3) 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.

(4) The amount of un-appropriated profit flowing to the balance sheet is not given by all providers at the residential aged care segment level.

7.3.1 Revenue

Table 7.2 provides a breakdown of the main sources of revenue reported by residential aged care providers. Total revenue in 2014-15 was $15,810 million, an increase of 6.6 per cent ($984 million) from 2013-14. Most of this increase was due to a net increase of $1,603 million (20 per cent) in care subsidies (ACFI), offset by a decrease in the respite and other supplements payments, which reduced by $843 million.

Analysis of the change shows that the revenue growth was mainly due to two factors. There were higher prices claimed through the ACFI, and there was also a significant increase in ACFI expenditure due to the Conditional Adjustment Payment being rolled into the basic care subsidy.

A breakdown of the $1,603 million change is as follows[23]:

- $724 million estimated due to price change (increase in care prices claimed);
- $756 million estimated to be due to CAP being rolled into the basic subsidy;
- $104 million in volume changes (increase in claim days); and
- $19 million due to the volume/price interaction effect (i.e. additional days of care at the higher price).

There was a significant reduction (65 per cent) in the amount of 'Respite and other supplements' reported by providers in 2014-15. This reduced from $1,295.9 million in 2013-14 to $453.4 million in 2014-15 due primarily to the CAP being rolled into the basic care subsidies.

Basic daily fee payments to providers for living expenses in 2014-15 totalled almost $3 billion, an increase of $131 million on 2013-14. Of this it is estimated that:

- $38 million (29 per cent) of the increase was associated with volume changes;
- $92 million (70 per cent) of the increase was associated with price variation (i.e. the flow on from the increase in the rate of the single pension to which the basic daily fee is indexed); and
- $1 million due to the interaction effect of the price/volume interaction effect;

ACFA notes that the revenue source of 'respite and other supplements' reported by providers reduced significantly.

[23] The splits regarding frailty and CAP are estimates only as the amount attributed to CAP is based on the rate of CAP (8.75%) and the proportion of providers (99%) in 2013-14.

Table 7.2: Revenue sources for residential aged care providers, 2013-14 and 2014-15

Revenue sources	2013-14 ($million)	2014-15 ($million)	Change ($million)	Change (%)
Commonwealth				
ACFI	$7,917.2	$9,520.4	$1,603.2	20.2
Respite and other supplements	$1,295.9	$453.4	-$842.5	-65.0
Reductions & adjustments	-$314.2	-$373.6	-$59.4	-18.9
Accommodation supplements	$762.4	$827.6	$65.2	8.6
Resident				
Means tested care fees	$314.2	$373.6	$59.4	18.9
Accommodation payments	$643.5	$680.7	$37.2	5.8
Basic daily fee	$2,855.8	$2,986.3	$130.5	4.6
Extra services fees	$194.8	$183.1	-$11.7	-6.0
Total residential service income	**$13,669.6**	**$14,651.5**	**$981.9**	**7.2**
Other income	$1,156.5	$1,158.6	$2.1	0.2
Total revenue	**$14,826.1**	**$15,810.1**	**$984.0**	**6.6**

Overall in 2014-15 the Commonwealth contributed 66 per cent of total provider funding ($10,428 million). Residents contributed 27 per cent ($4,224 million) while the remaining income was generated from other sources (7 per cent, $1,159 million), such as interest earned and sale of assets. This compares with 2013-14, when the Commonwealth contributed 65 per cent ($9,661 million), residents 27 per cent ($4,008) and 8 per cent ($1,157 million) was contributed from other sources. Payments for accommodation and care are jointly funded by the Commonwealth and residents.

Funding of care (from both the Commonwealth and residents) constitutes the largest proportion of residential aged care provider revenue at 63 per cent (Chart 7.1). The majority of care funding is from the Commonwealth (96.2 per cent) with residents paying the remaining 3.8 per cent via the means tested care fee.

Resident contributions to care funding increased by 0.4 per cent in 2014-15 following the introduction of changed means testing arrangements for residents entering care from 1 July 2014. Resident contributions towards care are expected to increase further as the proportion of residents who entered care after 1 July 2014 increases.

Accommodation payments account for 10 per cent of provider revenue. Payments for living expenses and extra services are funded by residents. Basic daily fees for living expenses account for 19 per cent of revenue. Extra service fees account for 1 per cent of total revenue.

Chart 7.1: Proportions of total residential care provider revenue, 2014-15

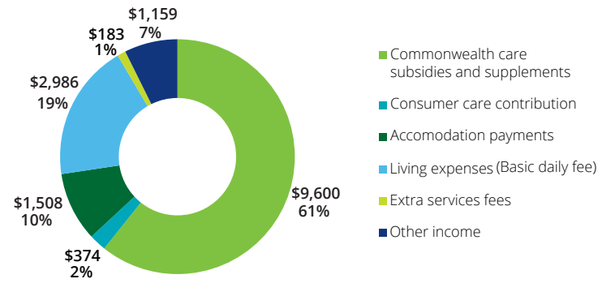
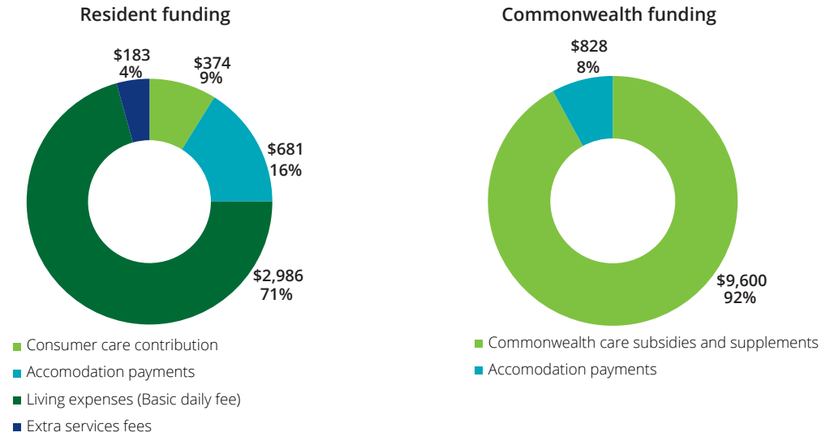


Chart 7.2: Proportions of provider revenue, resident and Commonwealth, 2014-15

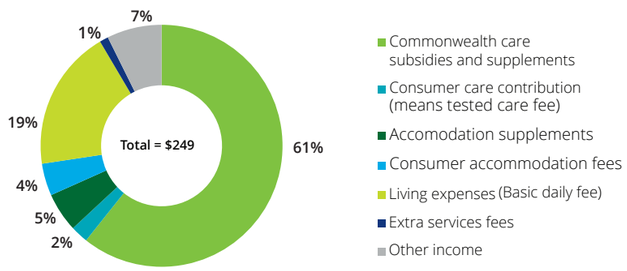


Total revenue per resident per day in 2014-15 was $249.35, an increase of 5.3 per cent over 2013-14 (Table 7.3 and Chart 7.3). Commonwealth funding via care payments constitutes the largest proportion of revenue for residential aged care providers at 61 per cent. The basic daily fee paid by all residents is the next largest category, followed by accommodation payments made by the Commonwealth and then accommodation payments made by residents.

Table 7.3: Revenue per resident per day 2013-14 and 2014-15

Revenue sources	2013-14 ($million)	2014-15 ($million)	Change ($million)	Change (%)
Commonwealth				
Care subsidies and supplements	$142.18	$151.41	$9.23	6.5
Accommodation supplements	$12.18	$13.05	$0.87	7.1
Resident				
Consumer care contribution (means tested care fee)	$5.02	$5.89	$0.87	17.3
Consumer accommodation payments	$10.28	$10.74	$0.46	4.5
Living expenses (basic daily fee)	$45.63	$47.10	$1.47	3.2
Extra services fee	$3.11	$2.89	-$0.22	-7.1
Total residential service income	**$218.40**	**$231.08**	**$12.68**	**5.8**
Other income	$18.48	$18.27	-$0.21	-1.1
Total revenue	**$236.88**	**$249.35**	**$12.47**	**5.3**

Chart 7.3: Revenue source per resident per day, 2014-15



7.3.2 Expenditure

Total expenses in 2014-15 were $14.9 billion, up from $14.1 billion in 2013-14 (an increase of 5.6 per cent). Chart 7.4 shows the growth in expenses over the seven years to 2014-15.

Staff costs represent 67 per cent of total expenses (up from 66 per cent in 2013-14), with 'other' costs, which include building repairs and maintenance expenses, rent, utilities and costs associated with employment support activities, accounting for 27 per cent. Depreciation and interest costs account for the remaining 4.9 and 0.9 per cent respectively. Table 7.4 shows the change in expenses from 2013-14 to 2014-15.

Chart 7.4: Summary of expenses 2008-09 to 2014-15

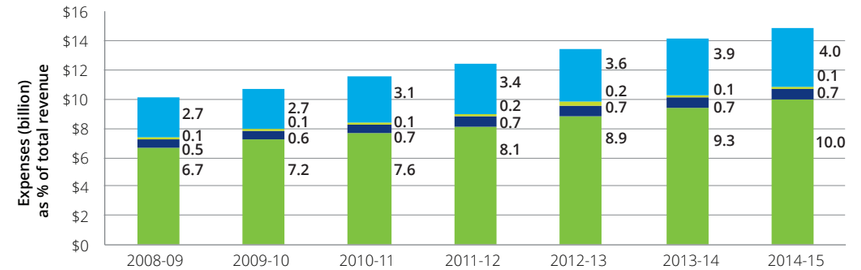


Table 7.4: Summary of expenses 2013-14 to 2014-15

Expenses	2013-14 ($million)	2014-15 ($million)	Change ($million)	Change (%)
Employee expenses	$9,313	$9,998	$684	7.3
Depreciation expenses	$723	$728	$5	0.7
Interest expenses	$147	$140	-$6	-4.3
Other expenses	$3,931	$4,037	$106	2.7
Total	**$14,115**	**$14,903**	**$789**	**5.6**

In 2014-15, $10 billion was expended in wages and management fees, an increase of $684 million from 2013-14. Of this:

- $122 million (18 per cent) is attributable to an increase in the number of days of care provided (volume changes); [24]
- $555 million (81 per cent) is attributable to a 6 per cent increase ($8.87 per claim day) in the average amount paid per claim day in wages and management fees. This would reflect a combination of factors including wage increases, increased hours worked per claim day, increased staffing levels and changes in the mix of staff to cater for increased care needs; and
- The remaining $7 million (1 per cent) is due to the interaction of price/volume changes.

7.3.3 Operating position – profit

The residential aged care sector reported an overall profit.

Total sector Earnings Before Interest, Taxes, Depreciation, and Amortisation (EBITDA) and Net Profit Before Tax (NPBT) increased in 2014-15 by 12.3 and 27.4 per cent respectively compared with 2013-14 as shown in Table 7.5. In last year's annual report ACFA reported that EBITDA and NPBT had both increased by 7.3 and 19.9 per cent respectively between 2012-13 and 2013-14.

Table 7.5: Overview of operating position

Expenses	2013-14 ($million)	2014-15 ($million)	Change ($million)	Change (%)
Revenue	$14,826	$15,810	$984	6.6%
Expenditure	$14,115	$14,903	$789	5.6%
EBITDA	**$1,581**	**$1,775**	**$194**	**12.3%**
EBITDA p.r.p.a	$9,224	$10,222	$998	10.8%
NPBT	**$712**	**$907**	**$195**	**27.4%**
NPBT p.r.p.a	$4,150	$5,221	$1,071	25.8%

Average EBITDA and NPBT per resident per annum also increased by 10.8 and 25.8 per cent respectively between 2013-14 and 2014-15.

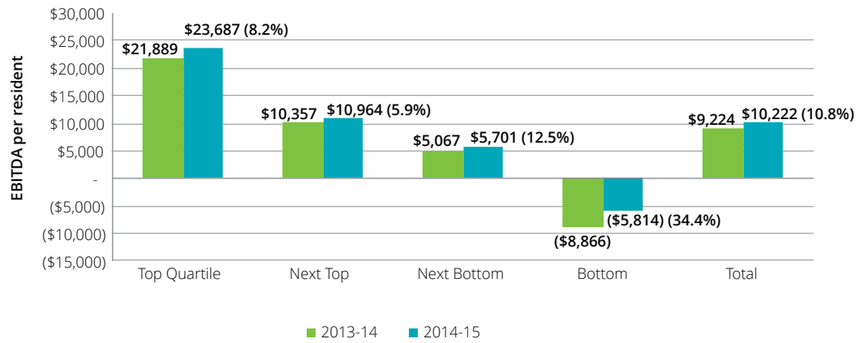
Chart 7.5 presents the EBITDA per resident per annum in 2013-14 and 2014-15 by performance quartiles. The top quartile had an EBITDA of $23,687 (an increase of $1,798 or 8.2 per cent).

The bottom quartile had a negative EBITDA of $5,814 which represented a 34.4 per cent improvement, or $3,052 reduction in loss from 2013-14.

Similarly, the next bottom quartile improved EBITDA by $634 to $5,701 or 12.5 per cent.

[24] This broadly reflects increases in resident numbers.

Chart 7.5: Comparative EBITDA per resident per annum in 2013-14 and 2014-15

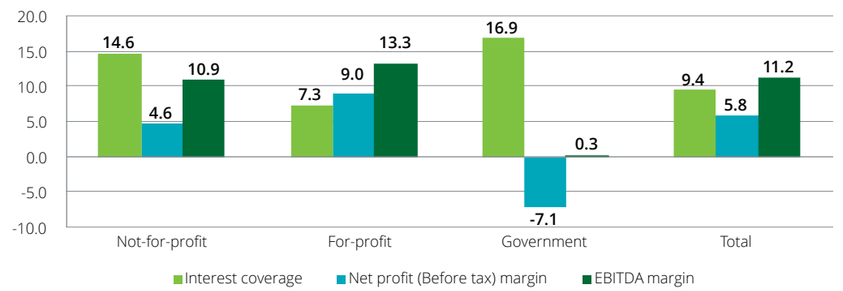


Operating performance in 2014-15 continued to vary across provider ownership type, remoteness location and provider scale. Chart 7.6 provides analysis across the segments of providers[25].

In general terms, ownership seems to be linked to financial performance with the for-profit providers continuing to outperform the not-for-profit and government providers in terms of EBITDA margin and Net Profit margin (Chart 7.6). However, this variable needs to be considered carefully because providers in the not-for-profit and government sectors often have different business motives, business models and funding sources and operate in areas affected by the impacts of location and facility size.

Government and not-for-profit providers outperformed for-profit providers in terms of interest coverage ratio, likely due to their lower use of debt to fund operations and finance assets. Government providers reported the lowest NPBT and EBITDA margin. Nevertheless for-profit, not-for-profit and government providers were represented in all quartiles.

Chart 7.6: Operating performance ratios 2014-15



[25] The analysis and comparisons in the following sections need to be considered with caution. While provider ownership, care type and remoteness location can in some cases correlate with poorer financial performance, there are likely to be other factors, such as the mission, objectives and financing framework, management quality and provider efficiency which are important and vary throughout the industry and within different segments. Additional details on provider performance can be found in Appendices F - I]

Despite still being outperformed by for-profit providers, the not-for-profit providers had an increase in both EBITDA margin and NPBT margin in 2014-15 compared with 2013-14 (Chart 7.8). Conversely, for-profit and government providers had a decrease in 2014-15 compared with 2013-14.

As was the case in 2013-14, a higher proportion of for-profit providers were present in the top quartile of ranking by profit per resident (Chart 7.8 and Chart 7.9). Also, as was the case in 2013-14, of the provider types in the top quartile, government providers performed the best[26]. Conversely, over half of all government providers are present in the bottom ranked quartile for EBITDA per resident. However providers of all ownership types are present in each quartile.

Chart 7.7: Operating performance ratios, 2013-14 and 2014-15

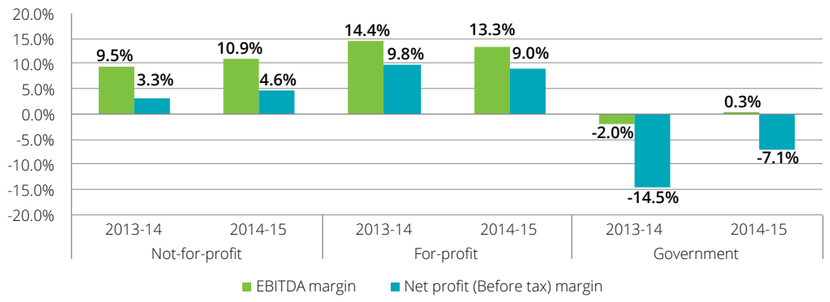
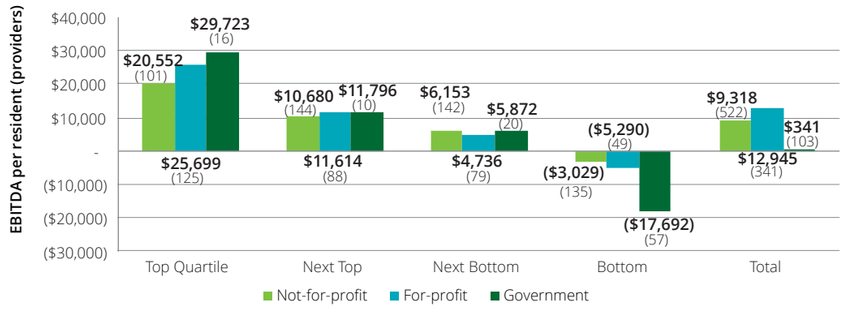
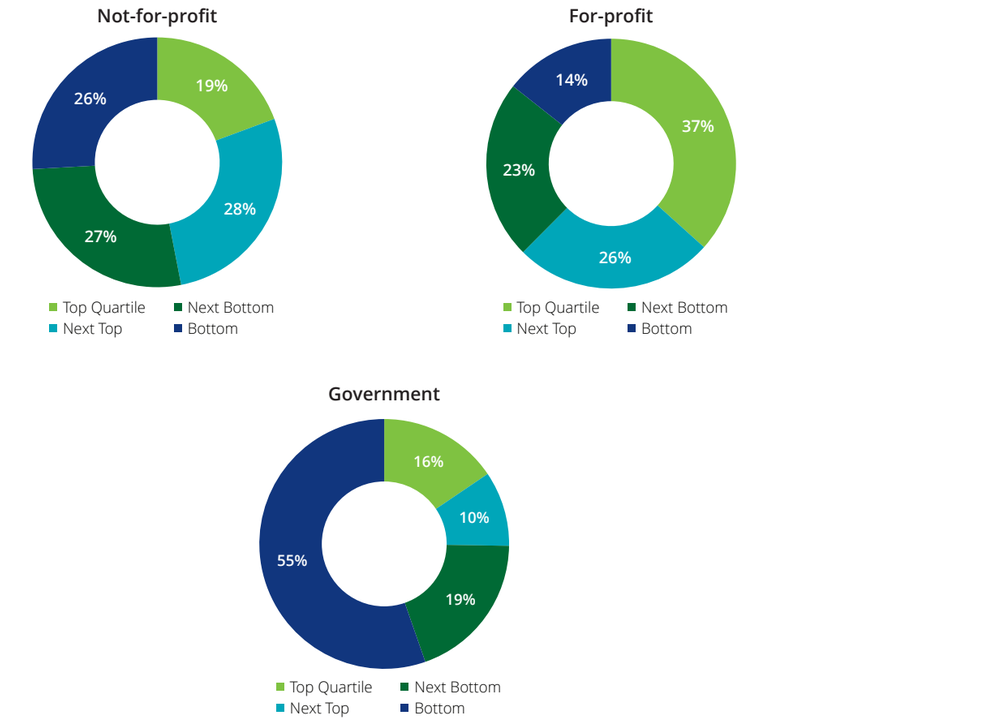


Chart 7.8: Residential aged care provider average EBITDA per resident per annum 2014-15, by quartile (number or providers in parentheses) – by provider ownership type



[26] In ACFA's Report on the Issues Affecting the Financial Performance of Rural and Remote Providers, it was noted that government owned services reported high levels of state/territory and local government subsidies. Detailed analysis on this is not able to be undertaken here.

Chart 7.9: Residential aged care provider distribution between quartile of average EBITDA per resident per annum 2014-15 – by provider ownership type



A higher proportion of total metropolitan providers are present in the top quartile of ranking by profit per resident compared with regional providers (Chart 7.10 and Chart 7.11). Conversely, a higher proportion of regional providers were represented in the bottom and next bottom quartile. As was the case with analysis based on ownership type, providers from all remoteness locations are present in each quartile.

Chart 7.10: Residential aged care provider average EBITDA per resident per annum 2014-15, by quartile (number of providers in parentheses) – by provider remoteness location

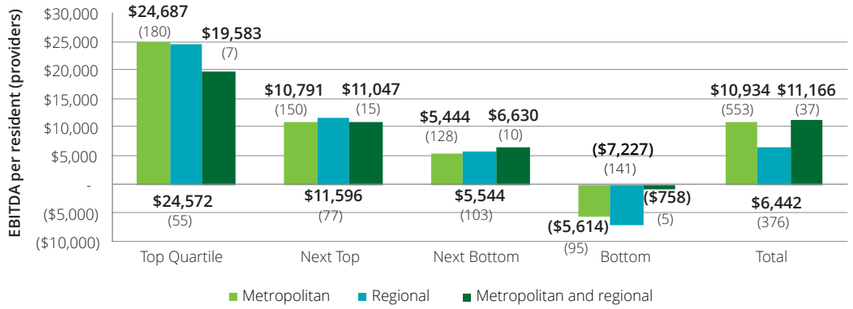
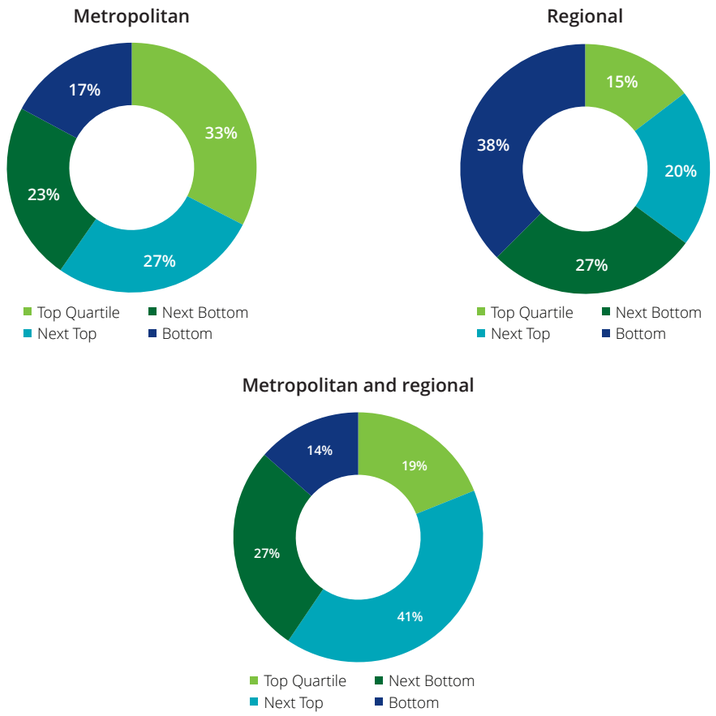


Chart 7.11: Residential aged care provider distribution between quartile of average EBITDA per resident per annum 2014-15 – by provider remoteness location



ACFA has published a separate study of the Issues Affecting the Financial Performance of Rural and Remote Providers. This is discussed in Section 7.4.

While there are only 19 providers who own more than 20 facilities, 13 of these are in the top two quartiles of ranking by profit per resident (Chart 7.12 and Chart 7.13). This was also the case in 2013-14.

Around two thirds of all providers operate only one facility. In terms of financial performance, they are spread relatively evenly across all four quartiles. This was also the case with providers who operate two to six facilities. Of the 59 providers who operate between seven and 19 facilities, 44 are represented in the middle two quartiles.

Chart 7.12: Residential aged care provider average EBITDA per resident per annum 2014-15, by quartile (number of providers in parentheses) and by provider scale

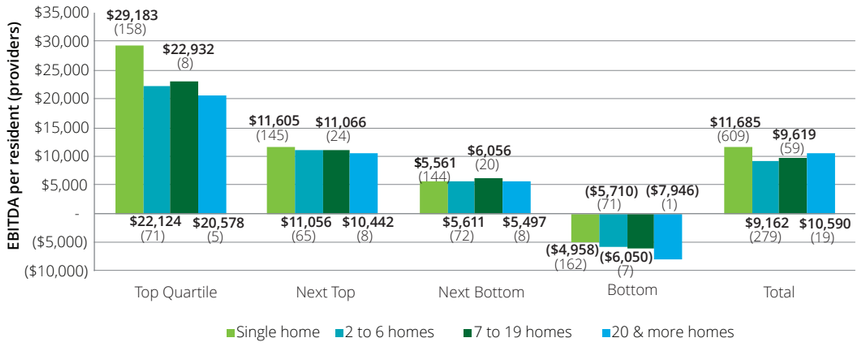
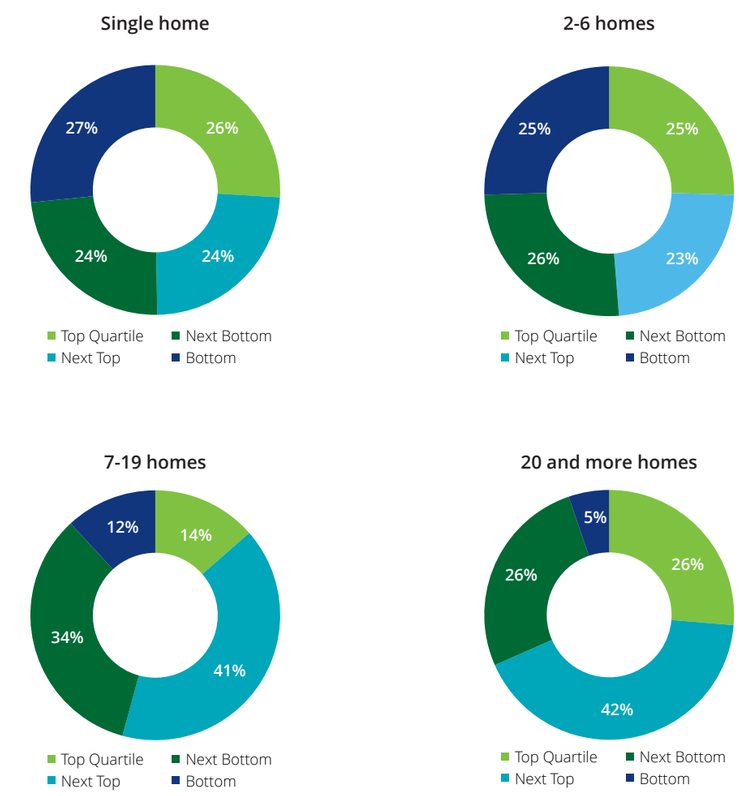


Chart 7.13: Residential aged care provider distribution between quartile of average EBITDA per resident per annum 2014-15 – by provider scale



7.4 ACFA Report on Issues Affecting the Financial Performance of Rural and Remote Providers

In January 2016, ACFA provided its report on Issues Affecting the Financial Performance of Rural and Remote providers to the Minister.

The analysis, based on 2014-15 service level financial data, rather than provider as is the case for all other ACFA reports, confirmed that providers operating in rural and remote areas face extra challenges in their financial operations. They generally have higher cost pressures and lower revenue, which result in lower financial results.

During 2014–15, rural and remote providers (in comparison with other providers):

- received less funding per resident per annum (prpa) for personal and nursing care through the ACFI (likely a combination of more residents with lower care needs and more limited access to health professionals to deliver higher level care);
- received higher funding from non-operating sources (in particular, capital grants but also other sources such as donations);
- had significantly higher expenses, particularly labour costs;
- benefited from receipt of the Viability supplement;
- were of smaller average size – average of 39 places compared with 81 places;
- received lower average Refundable Accommodation Deposits ($131,284 lower) but had access to capital grants; and
- had lower overall financial results:
  - Facility Earnings Before Interest, Tax, Depreciation and Amortisation (EBITDA), which includes non-operating income such as capital grants and donations, of $2,069 prpa ($5.67 prpd) compared with $9,267 prpa in non-rural and remote areas ($25.39 prpd); and
  - Operating EBITDA, which does not include non-operating income, at negative $2,004 prpa (negative $5.49 prpd) compared with positive $8,840 prpa ($24.22 prpd) in non-rural and remote areas.

The analysis also showed that the impacts of greater geographical isolation affect a number of areas, including:

- workforce costs to engage and retain staff;
- travel;
- freight;
- access to allied health professionals;
- limited internet coverage in some areas; and
- limited catchment areas resulting in smaller scale facilities/services.

In general, results are lower the more remote the facility becomes and the lower the bed numbers. Results are also generally lower for state and territory government providers who have higher costs, particularly wages, though also receive additional state and territory government funding.

ACFA's analysis also found that there are providers in the rural and remote sector (across a spectrum of inner regional, outer regional and remote/very remote) who are producing strong financial results. In 2014–15, the top third of rural and remote residential facilities had average facility EBITDA of $16,065 prpa, compared with the overall average facility EBITDA in the non-rural and remote sector of $9,266 prpa.

While mindful of the availability of capital grants and the viability supplements to compensate for location disadvantage, these results re-confirm that location alone is not a sole determinant of financial performance. As would be the case for all aged care services, there are other factors at play which also affect financial performance, including:

- the quality, skills and range of organisational leadership;
- the adoption of innovative approaches (including Information Technology) to service delivery; and
- overall organisational structure and approaches to facility/service management, covering care, administration and financial management.

Overall, there would appear to be scope for many providers to improve their operations and performance. Findings of earlier ACFA work about strategies to improve performance are relevant. These strategies included consideration of:

- stronger governance—including consideration of skill sets of Boards and more regular review of risk, financial and strategic plans;
- improved financial management—including clear financial goals, regular review of budgets and management of expenses and key revenue streams;
- better asset management—including investment in and refurbishment of facilities, consideration of appropriate scale of facilities and consideration of best approaches to debt and liquidity management; and
- administration efficiencies—including use of outsourcing and shared or pooled services.

These comments, made in the context of the sector more generally, apply to the rural and remote sector as well, though as noted earlier, scale is likely to reflect demand in many areas. As evidenced by the varying results within the rural and remote sector and the strong results of some providers/facilities/services, it is likely some are already focusing on these issues. For others, there is the potential to see improvement in performance from tailoring action in these areas.

7.5 Looking forward: Developments, opportunities and challenges

Aged Care Roadmap

In April 2015, the Minister tasked the Aged Care Sector Committee (ACSC)[27] with developing a Roadmap to advise on future directions for aged care.

The Roadmap represents the ACSC's views on what is required to move towards a consumer-driven, market-based and sustainable system. The Roadmap was provided to the Minister on 23 March 2016 and publicly released on 6 May 2016.

The Roadmap's vision for a consumer-driven market-based aged care system is based on the following key elements:

- Commonwealth contributions to individuals would be based on assessed needs and means and would be agnostic as to where an eligible person chooses to live.
- The Commonwealth would no longer regulate the number, type, distribution and price of services. Instead service providers would compete on price and quality for consumers.
- Where there is insufficient market response, additional Commonwealth assistance would continue to be available.

The Roadmap also observes that currently, consumer contributions to care are not consistently in proportion to individuals' capacity to pay, and consumer contributions are capped. The ACSC's view is that increasing demand for, and cost of, aged care means that the system should change to ensure that consumers contribute to their care consistent with their wealth.

The ACSC reasons that consumers should remain responsible for accommodation and everyday living costs, as they have been throughout their lives. The Commonwealth would provide a safety net for consumers, as well as regulate the security of lump sum accommodation payments, but other aspects of pricing and choice would be less regulated. Capital financing of the sector would continue to be sourced from residents' Refundable Accommodation Contributions and debt and equity markets.

The Roadmap is discussed in more detail in Chapter 9.

[27] The Aged Care Sector Committee is a committee appointed by the Minister for aged care to provide advice to the Australian Government on aged care policy development and implementation and helps to guide the future reform of the aged care system.

7.6 2016-17 Budget

ACFA notes that a number of measures announced in the 2016-17 Budget will have an effect on the funding and financing of the sector.

The Commonwealth announced changes to the Aged Care Funding Instrument which are anticipated to reduce Commonwealth care payments to providers by $1.2 billion over four years to 2019-20. This is in addition to changes announced in the November 2015 MYEFO that are designed to reduce care payments by around $800 million over the same period. These measures were announced following higher than anticipated growth in funding particularly for complex health care which without these changes would have increased Commonwealth expenditure over 2015-16 Budget forward estimates by $3.8 billion.

ACFA notes that the sector has expressed concerns that the reductions in care payments may exceed the 2016-17 Budget estimates and that the industry is undertaking modelling to assess the impacts of the changes. In future annual reports, ACFA will analyse and report on the impact of these (and other) changes.

The Commonwealth also announced it will be consulting further with the sector regarding the way care funding is determined, including options such as separating residents' needs assessments from provider services by having assessments conducted by an independent party.

In addition the Commonwealth announced further increases to the Viability supplement effective from 1 January 2017 including changing to a more modern classification system (the Modified Monash System). It is expected that this Budget measure will increase the average annual Viability supplement payment to eligible residential care services currently in receipt of the supplement from around $88,000 to $100,000, and provide approximately 70 additional services with Viability supplement funding for the first time.

Chapter 8
Residential aged care: Capital investment

8 Residential aged care: capital investment

This chapter provides an overview of capital investment in the residential aged care sector.

This chapter discusses:

- the sources of capital financing for the residential care sector, including the role of Refundable Accommodation Deposits (accommodation bonds prior to 1 July 2014)
- key balance sheet metrics for 2014-15
- investment trends and requirements

On 30 June 2015, compared with 30 June 2014, the industry as a whole had:

- assets of $36.6 billion up from $33.7 billion
- liabilities of $25.7 billion, up from $22.5 billion
- net assets of $10.9 billion, down from $11.2 billion
- Refundable Accommodation Deposits (including bonds) of $18.2 billion, up from $15.6 billion
- average return on equity in 2014-15 was 16 per cent
- average return on assets in 2014-15 was 4.9 per cent
- average debt ratio across the sector of 0.70 in 2014-15, up from 0.67.

ACFA notes:

- $2.1 billion of new construction work was completed in 2014-15, a 12 per cent increase on the previous year
- the accommodation payment arrangements that came into effect on 1 July 2014 are providing a positive impact on investor sentiment
- in 2014-15 there was an increase in consolidation activity in the industry together with an increase in investment activity, from both domestic and international investors.

8.1 Capital financing

Capital for residential aged care providers comprises financing from equity investments, loans from financial institutions, interest free loans from residents in the form of lump sum refundable accommodation deposits (bonds pre 1 July 2014), capital investment support from government, and retained earnings. As noted in last year's annual report, there are four key groups contributing to residential aged care capital: residents, the Australian Government, investors, and financial institutions.

8.1.1 Residents

Lump sum accommodation payments by residents contribute to funding of capital investment in residential aged care. Refundable Accommodation Deposits (RADs) – formerly known as accommodation bonds – act as an interest free loan to providers paid by residents, and play a significant role in financing the industry. At 30 June 2015, a total of $18.2 billion of accommodation deposits (including bonds) were held by providers. As an alternative to RADs, residents may pay Daily Accommodation Payments (DAPs). As noted in Chapter 3, around a third of residents who provide accommodation payments

are paying DAPs alone and another quarter are contributing a mix of RAD and DAP.

As discussed in Chapter 3, prior to 1 July 2014 providers were restricted from charging an accommodation bond to residents in a high care place (unless it had extra service status). With the removal of the distinction between high and low care places on 1 July 2014, this restriction was lifted and providers can now accept lump sum refundable deposits from all residents, regardless of the level of care they receive.

8.1.2 Australian Government

The Australian Government makes capital grants available for services that target communities and geographic areas where there may be insufficient access to capital from other sources. In 2014-15, $103 million (made available through the 2014 ACAR) were allocated to 25 providers. A further $67 million was made available in the 2015 ACAR to be allocated to 22 providers in 2015-16.

In addition, $600 million in Zero Real Interest Loans (ZRIL) were made available in the period 2008 to 2013 to assist providers to build or extend residential aged care services in areas of high need. Loans offered under the ZRIL programme attract an interest rate equivalent to the Consumer Price Index. The ZRIL programme terminated in 2013, however, payments to providers continued to be made in 2014-15 (and beyond) as construction works progressed. As at 30 June 2015, $310 million in loans was remaining to be repaid and therefore would have appeared on the balance sheets of providers. The terms of the loans vary up to a maximum length of 22 years.

8.1.3 Other sources of capital finance

Residential aged care providers also obtain capital finance from investors, financial institution loans and donations. ACFA does not have data across the sector on debt and equity financing, other than that reported in the aggregated balance sheets.

8.2 Accommodation deposits (including bonds)

At 30 June 2015, refundable accommodation deposits (including bonds) totalling $18.2 billion[28] financed 49.7 per cent of total assets of $36.6 billion and represented 71.0 per cent of liabilities ($25.7 billion) for the aged care industry. There were differences by ownership type and remoteness location:

- Ownership type
  - Not-for-profit providers – 79.7 per cent of liabilities (77.9 per cent at 30 June 2014);
  - For-profit providers – 62.8 per cent of liabilities (65.0 per cent at 30 June 2014); and
  - Government providers – 78.4 per cent of liabilities (68.4 per cent at 30 June 2014).
- Remoteness location
  - Metropolitan providers – 71.5 per cent of liabilities (72.9 per cent at 30 June 2014);
  - Regional providers – 71.8 per cent of liabilities (65.6 per cent at 30 June 2014).

Table 8.1 shows accommodation deposits, other liabilities and net worth/equity, with each item being shown as a proportion of assets.

Accommodation deposits as a proportion of total assets is a measure that indicates an organisation's leveraging and shows the proportion of total assets that have been financed by accommodation deposits. Other liabilities, which is split between secured and unsecured lenders and creditors and provisions represent 20 per cent of total asset financing.

In general, the higher the proportion of other liabilities, the higher the level of leveraging and possible associated level of financial risk.

Net worth/total equity as a proportion of assets is a measure of the share of an organisation which is contributed by and held beneficially by the owners/shareholders.

[28] The overall total of lump sum accommodation deposits have been sourced from the Approved Provider Compliance Statement returns of those providers who submitted their GPFRs and does not include accommodation payments receivable. This figure of $18.2 billion therefore is less than the June 2015 figure of $19.84 billion presented in Chapter 3 of this report. The figure of $19.84 billion, which includes reported accommodation payments receivable, was derived from the Reform Monitoring surveys of service providers conducted by ACFA from July 2014 through to December 2015.

As Table 8.1 highlights, there are differences in the proportion of accommodation deposits to total assets based on ownership type, with both for-profit providers and not-for-profit having more than double that of government providers.

Other liabilities as a proportion of total assets also shows differences across ownership types, with for-profit providers holding almost triple that of not-for-profit providers and five times government providers.

Table 8.1: Financial position of residential aged care providers as at 30 June 2015 ($m)

	Not-for-profit	For-profit	Government	Total $m
Total assets *Funded by:*	$19,191	$15,778	$1,617	$36,586
Accommodation deposits (% of total assets)	$9,535 (50%)	$8,329 (53%)	$349 (22%)	$18,213 (50%)
Other liabilities (% of total assets)	$2,433 (13%)	$4,943 (31%)	$96 (6%)	$7,472 (20%)
Net worth/equity (% of total assets)	$7,223 (38%)	$2,506 (16%)	$1,172 (72%)	$10,901 (30%)
Total	**100%**	**100%**	**100%**	**100%**

8.2.1 Accommodation deposit prices

In previous Annual Reports, ACFA has reported the average price of new accommodation bonds. Average new bond prices had increased in a relatively linear trend over time up until the end of 2013-14 (Chart 8.1 and Chart 8.2).

As of 1 July 2014, new accommodation pricing arrangements came into effect. These changes included the following:

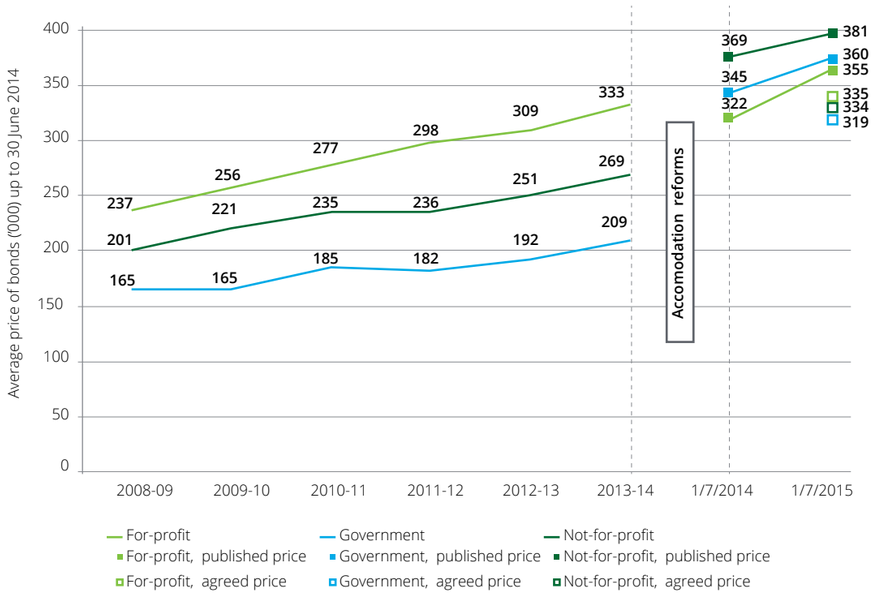
- Lump sum accommodation payments are now known as Refundable Accommodation Deposits (RADs);
- Providers can charge a RAD to any eligible resident whereas they had previously only been able to charge a bond to a low care resident, or a high care resident who had opted for extra services, but providers can no longer deduct a retention amount from the RAD;
- Residents can, at their discretion, choose to pay a RAD, a Daily Accommodation Payment (DAP) or any combination of RAD and DAP; and
- Providers are required to publish the maximum price for their rooms, or part of a room, in their aged care homes. Residents may negotiate a lower price (known as the agreed price) but cannot be asked to pay more than the published price.

These changes are detailed in Chapter 3. Due to the changes outlined above and issues with data collection since the new accommodation arrangements were introduced, average accommodation bond prices prior to 1 July 2014 are not directly comparable with the value of RADs following the 1 July 2014 changes[29]. However, the average bond price prior to the 1 July 2014 changes and the published and agreed prices since 1 July 2014 can be compared, with qualifications, as per the differences noted above. It should be noted that the agreed price can be a RAD, DAP or combination of the two, which is why there can be no direct comparison with bond prices prior to 1 July 2014.

[29] There was a problem with data collected from providers through the annual SACH and through the Aged Care Entry Records regarding the value of new RADs, resulting in the data being unable to be used. These issues are being addressed by the Department so that ACFA will be able to provide analysis on the price of new RADs in future reports.

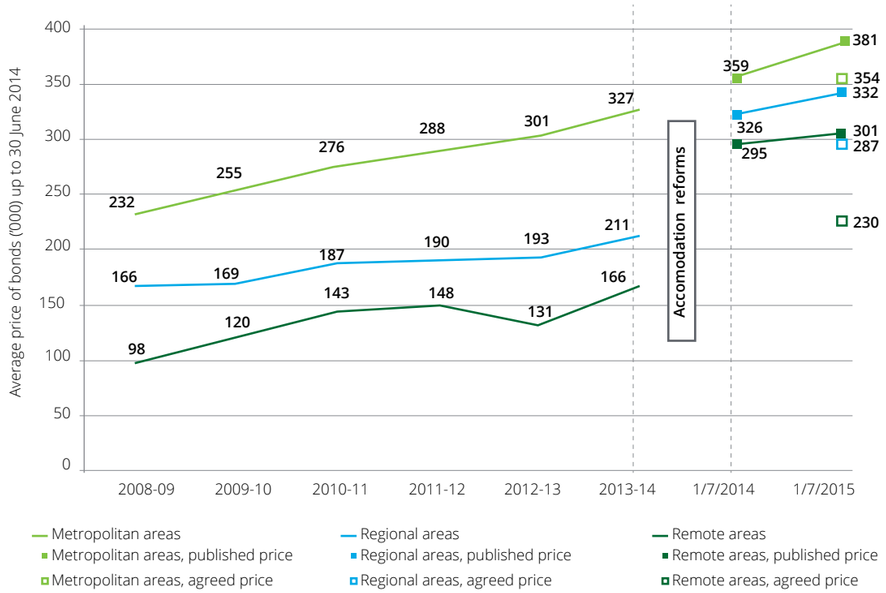
As seen in Charts 8.1 and 8.2 the published and agreed prices were consistently higher at 1 July 2014 and 1 July 2015 when analysed against average new bond prices in 2013-14. However, it should be noted that the significant increase in the maximum published prices (when compared with average new bond prices in 2013-14), immediately after 30 June 2014, is likely due to the removal of retention amounts from RADs with further increases, a result of providers adjusting to the new accommodation pricing regime and changes in house prices.

Chart 8.1: Average price of new accommodation bonds: 2008-09 to 2013-14 and average published and agreed accommodation prices (lump sum equivalent): 1 July 2014 and 1 July 2015 (thousands), by ownership type



Note: The average published and agreed prices shown are not averages for a period of time. They are the average prices on 1 July 2014 and 1 July 2015.

Chart 8.2: Average price of new accommodation bonds: 2008-09 to 2013-14 and average published and agreed accommodation prices (lump sum equivalent): 1 July 2014 and 1 July 2015 (thousands), by provider remoteness location

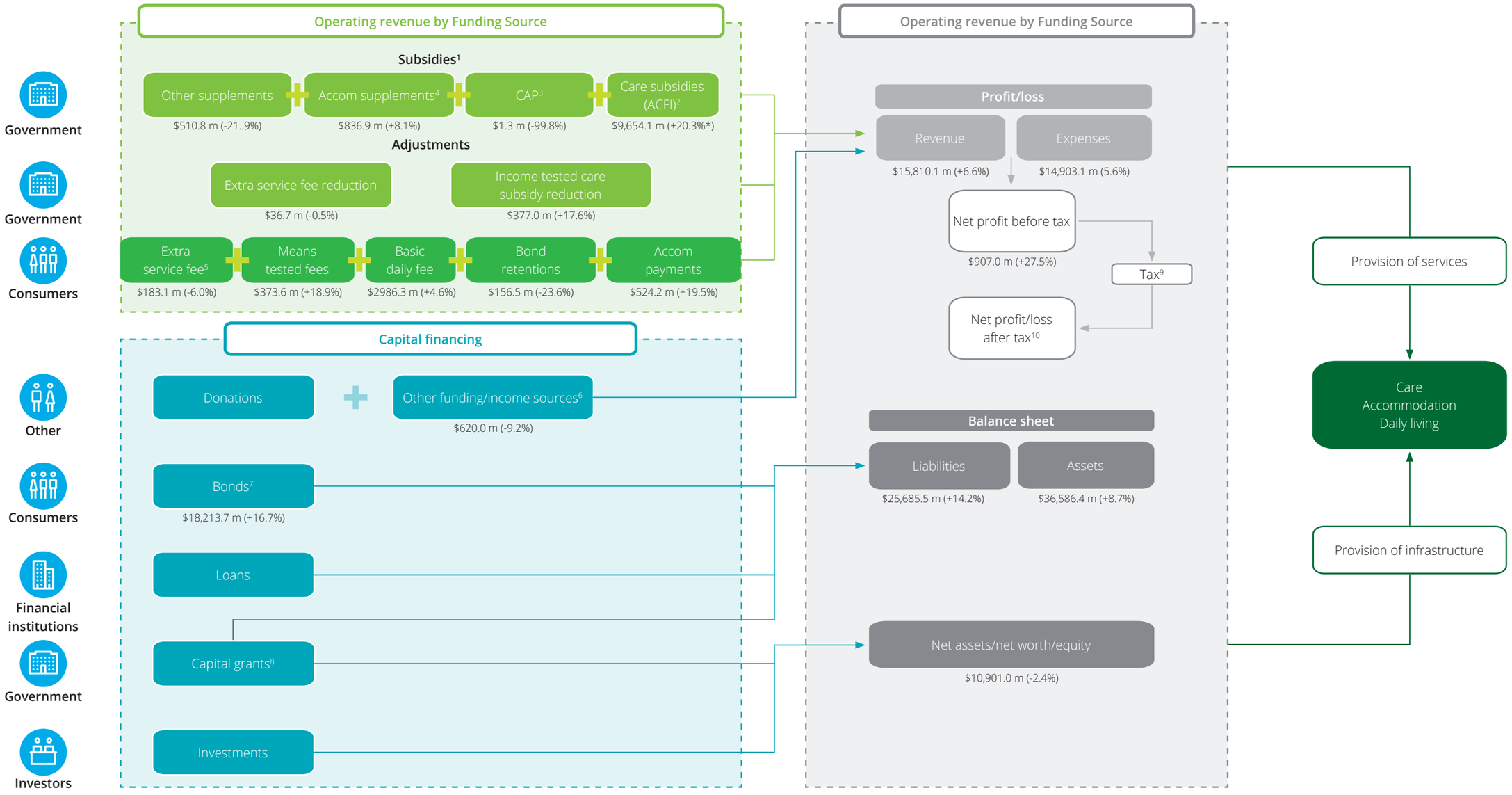


Note: The average published and agreed prices shown are not averages for a period of time. They are the average prices on 1 July 2014 and 1 July 2015.

8.3 Financing status – balance sheet

This section focuses on the balance sheet of the residential aged care industry, showing the liabilities, assets and net assets. This is indicated in the dark grey area of Figure 8.1.

Figure 8.1: Residential aged care funding/financing sources, operational side



* The 20.3% increase in Care Subsidies (ACFI) includes the funding previously paid through the Conditional Adjustment Payment (CAP) which was rolled into basic subsidy payments from 1 July 2014. The CAP was previously paid at a rate of 8.75% of the value of the basic subsidy.

At 30 June 2015, the industry as a whole had assets of $36.6 billion (an increase of $2.9 billion from 2013-14).

Of note, there was a significant increase in cash assets of 45 per cent to $5.2 billion, up from $3.6 billion in 2013-14. This follows a slight reduction in cash assets between 2012-13 and 2013-14 of $384 million.

Fixed assets and other assets increased by 4.3 per cent and 4.4 per cent respectively, compared with last year which saw them increase by 9.2 per cent and 13.3 per cent respectively.

Total liabilities were $25.7 billion (compared with $22.5 billion in 2013-14), which includes the $18.2 billion of accommodation deposits held by industry.

As shown in Table 8.2, the industry overall had net equity of $10.9 billion in 2014-15, down from $11.2 billion in 2013-14 (a 2.4 per cent decrease).

Table 8.2 Balance sheet 2013-14 and 2014-15

Assets/liabilities	2013-14 ($million)	2014-15 ($million)	Change ($million)	Change (%)
Cash assets	$3,558	$5,170	$1,612	+45.3%
Fixed assets	$10,238	$10,674	$436	+4.3%
Other assets	$19,866	$20,742	$876	+4.4%
Total assets	**$33,662**	**$36,586**	**$2,924**	**+8.7%**
Accommodation bonds	$15,611	$18,213	$2,602	+16.7%
Other liabilities	$6,883	$7,472	$589	+8.6%
Total liabilities	**$22,494**	**$25,685**	**$3,191**	**+14.2%**
Net worth/equity	**$11,168**	**$10,901**	**($267)**	**-2.4%**

The three performance ratios used to undertake balance sheet ratios are current ratio, EBITDA to total assets, and EBITDA to equity/net worth/net assets[30].

[30]The financial position of an organisation as at a point in time (usually the end of each financial year to coincide with the production of the annual Profit and Loss Statement for a financial year) sets out a statement of Assets and Liabilities with sub-categories reflecting in timing – Current (likely to be receivable or payable within 12 months) and Non-Current (longer than 12 months). It shows the calculation of the residual or Net Assets – calculated as Total Assets less Total Liabilities, It also represents the net value of the enterprise which is comprised of equity contributions by the owners of the organisation plus Retained Earnings which represents the net accumulated Profits and Losses over the life of the organisation. Whilst Retained Earnings may be distributed to owners in accordance with the constitution of the organisation, equity can generally not be distributed and owners requiring liquidation of their contributions are obliged to transfer their ownership to another party on mutually agreed terms. This Net Assets sum is differentially labelled Equity in For-Profit enterprises and Net Worth in Not-for-Profit or Government organisations.

Balance sheet performance ratios

Current Ratio

Current ratio is a short term measure of an organisation's ability to meet its short term obligations (current liabilities) from its current assets. The current ratio measures an organisation's liquidity and this provides an indication of risk that the organisation may not be able to meet its short term obligation as and when they fall due. It is calculated by dividing current assets of an organisation by its current liabilities.

Generally organisations aim to have a current ratio of at least 1.0 which shows that the organisation has sufficient current assets to meet its short term obligations.

The categorisation, in the aged care sector of accommodation deposits (bonds pre 1 July 2014) as current liabilities on the balance sheet means that the current ratio needs to be treated with great caution when being used as a measure of liquidity for aged care organisations.

This is because accounting standards (AASB 101 paragraph 69 (d)) require all accommodation deposits to be treated as current liabilities as the aged care provider does not have an unconditional right to defer settlement of the liability despite the fact that they are not repaid until a resident leaves care. On average, accommodation deposits and bonds are held by providers between two and three years. If an appropriate proportion of accommodation deposit liabilities were instead viewed as 'non-current' liabilities on the basis that they would not be due for payment for at least 12 months after the reporting period this would improve the current ratio accordingly. It should also be recognised that to date since the 1 July 2014 reforms, new residents are largely demonstrating the same profile of tabling refundable deposits compared with paying daily accommodation payments. This results in a turnover or replacement of deposits.

EBITDA to assets ratio

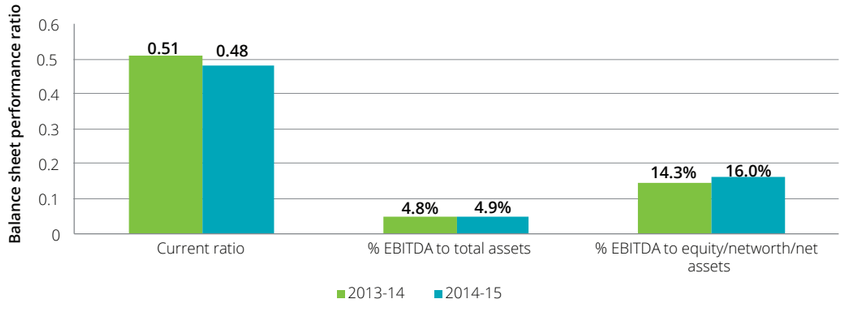
The EBITDA to total assets ratio measures the operating return generated from an organisation's total assets. The ratio is a measure of financial performance and is calculated by taking the earnings, before interest, tax, depreciation and amortisation (EBITDA) and dividing this by the organisation's total assets. The EBITDA excludes non-operating income and expenses that can be distortive for the purposes of comparative analysis, as well as non-cash expenditure items, enabling comparison between organisations with differing capital and debt arrangements. In general, the higher the EBITDA to total assets ratio, the better the level of return generated from the organisation's total assets.

EBITDA to total equity/net worth/net assets ratio

The EBITDA to total equity ratio measures the effectiveness of the return generated on an organisation's total equity. The ratio is a measure of financial performance and is calculated by taking the earnings, before interest, tax, depreciation and amortisation (EBITDA) and this is divided by the organisation's total equity or net asset position. The EBITDA excludes non-operating income and expenses, as well as non-cash expenditure items, enabling comparison between organisations with differing capital and debt arrangements. In general, the higher the EBITDA to total equity ratio, the greater the level of return on the owners' contribution and retention of earnings over time.

As illustrated in Chart 8.3, balance sheet performance ratios remained relatively similar between 2013-14 and 2014-15. There was a small decrease in the current ratio and a small increase in EBITDA to total assets and in the EBITDA to equity/net worth/net assets.

Chart 8.3: Balance sheet performance ratios 2013-14 and 2014-15



8.3.1 Balance sheet analysis by ownership type

Assets and liabilities have been analysed by ownership type, in order to identify differences between not-for-profit, for-profit and government providers.

At 30 June 2015, the not-for-profit providers (who hold 57 per cent of places in the sector) had total assets at a value of $19.2 billion (52 per cent of total industry assets) (Table 8.3), up from $17.9 billion in 2013-14. The for-profit sector (36 per cent of places), had total assets of $15.8 billion (43 per cent of total industry assets), up from $13.6 billion in 2013-14. Government providers held total assets of $1.6 billion in 2014-15.

As was the case in 2013-14, the for-profit sector had the highest proportion of liabilities among ownership types ($13.3 billion). This was made up of $8.3 billion in accommodation deposits (46 per cent of total industry accommodation deposits) and $4.9 billion in other liabilities (66 per cent of total industry other liabilities).

Not-for-profit providers had the highest net worth/equity, with $7.2 billion, followed by for-profit providers ($2.5 billion). The higher liabilities and lower equity in for-profit providers reflects both a higher proportion of accommodation deposits and greater use of debt to fund investment. These different financing characteristics affect the ratios discussed in the rest of this section. Government providers had the lowest net worth/equity ($1.2 billion).

Not-for-profit providers operate with the policy of either applying profits to funding future services provided or returning capital contributed by the parent entities. Not-for-profit services are operated by charitable, religious and community based providers. For-profit providers generally operate with the mission of generating profits, either for investment and growth or to distribute some proportion to owners/shareholders.

Table 8.3: Financial position of residential aged care providers as at 30 June 2015 ($m)

Assets/liabilities	Not-for-profit $m	For-profit $m	Government $m	Total $m	Total %
Total assets	**19,191**	**15,778**	**1,617**	**36,586**	**100%**
Refundable accommodation deposits	9,535 (50%)	8,329 (53%)	349 (22%)	18,213	50%
Other liabilities	2,433 (13%)	4,943 (31%)	96 (6%)	7,472	20%
Total liabilities	**11,968**	**13,272**	**445**	**25,685**	**70%**
Net worth/equity	**7,223 (38%)**	**2,506 (16%)**	**1,172 (72%)**	**10,901**	**30%**

Chart 8.4 shows liabilities and net worth/equity as a proportion of total assets. Government providers have lower liabilities as a proportion of total assets with a subsequent much higher proportion of residual net worth/equity.

Chart 8.4: Liabilities and net worth/equity as a proportion of total assets, by provider ownership type

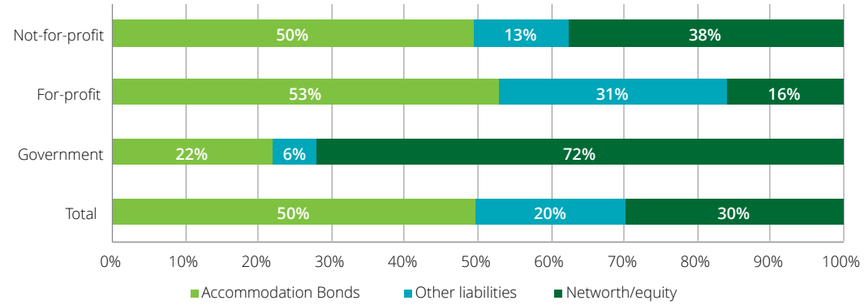
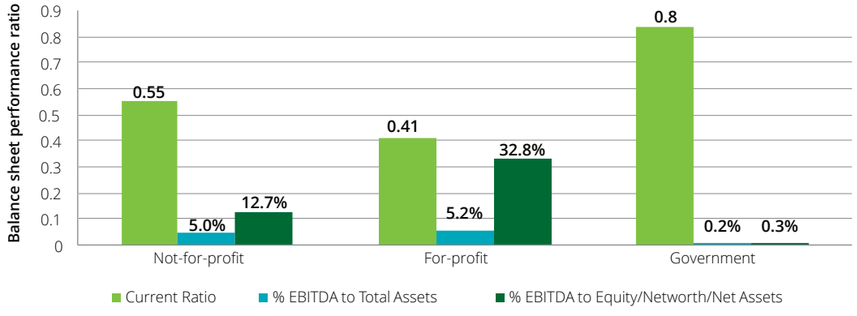


Chart 8.5 illustrates the balance sheet ratios by provider type.

Government providers had the highest current ratio (0.8) compared with not-for-profit providers (0.55) and for-profit providers (0.41). ACFA notes that for-profit providers' current ratio is down from 0.47 in 2013-14.

There is a significant difference in the proportion of EBITDA to total assets for the for-profit (5.2 per cent) and not-for-profit providers (5.0 per cent) compared with the government providers (0.2 per cent). The for-profit providers also have a considerably higher proportion of EBITDA to equity/net worth/net assets (32.8 per cent) compared with the not-for-profit providers (12.7 per cent) and government providers (0.3 per cent). This reflects the lower net equity of for-profit providers due to their propensity to use RAD flows and debt to finance growth.

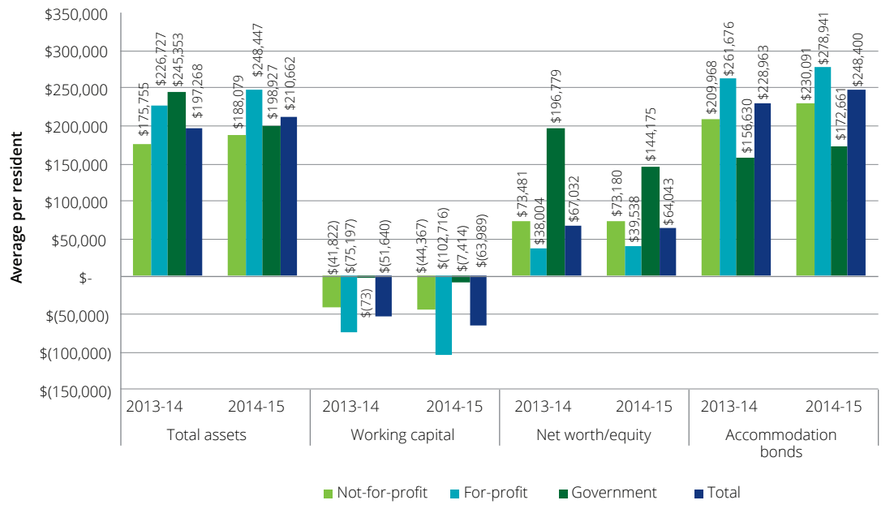
Chart 8.5: Balance sheet performance ratios at 30 June 2015, by provider type



For the whole of sector, the average for all accommodation deposits held increased to $248,400 per resident from $228,963 in 2013-14, an increase of 8.5 per cent. This metric measures the average value of all bonds (pre 1 July 2014) and accommodation deposits (post 1 July 2014) that a provider holds. This contrasts with earlier analysis and commentary that related to the average price of new accommodation deposits only (Section 8.2).

As is the case with analysis of current ratio, caution needs to be taken when examining working capital in aged care due to accommodation deposits being classified as current liabilities.

Chart 8.6: Average balance sheet metrics by resident 2013-14 and 2014-15, by provider type



8.4 Investment requirements

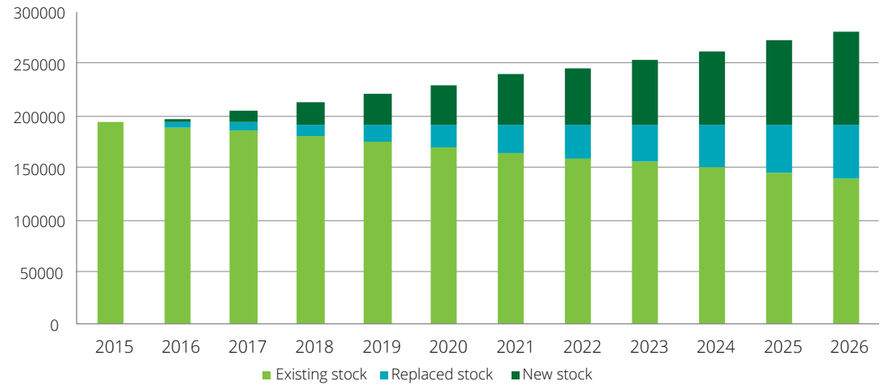
The Department has provided its updated estimates of the sector's annual investment requirement for residential care each year over the next decade, in terms of the amount of required investment and the number of places that will need to be built. These estimates are based on several key assumptions:

- the current service provision targets continue;
- the cost of construction continues to grow at about 2.8 per cent each year;[31] and
- the average lifetime of an aged care building is about 40 years, so that the current stock will need to be replaced over the next four decades.

The Department estimates that the residential care sector will need to build an additional 76,000 places that the over the next decade in order to meet the provision target of 78 operational places per 1,000 people aged 70 and over. This compares with 34,788[32] new places that came online over the previous decade (Chart 8.7).

At the same time, the sector will need to knock down and rebuild a substantial proportion of its current stock. Assuming that a quarter of the current stock of buildings is rebuilt at an even rate over the next decade, the Department estimates that the investment requirement of the sector over the next decade to be in the order of $33 billion. It should be noted that this is almost equal to the total asset value of the industry as at 30 June 2015 ($36.6 billion).

Chart 8.7: Number of operational residential aged care places required in the next decade – 2015-2026



[31] The Department derived estimates of the full cost of constructing an aged care home based on 2014-15 Report on the Operation of the Aged Care Act 1997 and Rawlinsons (2016) Construction Cost Guide. Perth: Rawlinsons. Trends in aged care construction costs are derived from Rawlinsons (2016) and Producer Price Indexes. Cat. No. 6427.0

[32] 30 June 2005 to 30 June 2015

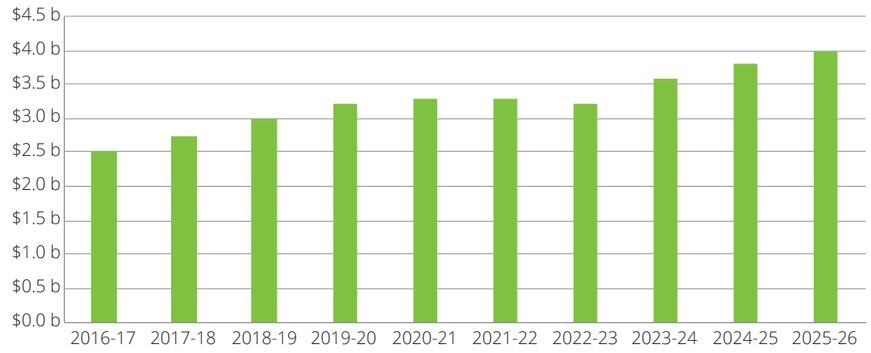
This increase in investment will require several inputs in order to be met, including:

- subsidised operational funding from the Commonwealth on behalf of supported residents;
- consumer contributions to operational funding;
- capital financing from residents, providers, investors and financiers and the Commonwealth;
- industry wide access to detailed medium term demographic forecasts to ensure correct siting of future facilities; and
- availability of greenfield sites for the construction of new aged care homes in the areas needed.

Chart 8.8 shows the investment needed over the next decade to construct the new aged care places required to cater for the impact of the baby boomer generation on the number of places generated under the provision ratio. Over the next seven years, there is a steep ramp up from $2.5 billion needed in 2016-17 to around $4 billion that will be needed in 2025-26.

The pattern in annual investment, including the slight contraction in the early 2020s, reflects the underlying growth in the 70 years and over population and most notably the large number of births in 1946. As noted earlier in this report, ACFA notes that consideration could be given to whether a planning ratio based on people aged 70 and over is appropriate in the future when the average age of entry to residential care is 84.6 years and increasing each year.

Chart 8.8: Future annual investment requirement



The calculation of future annual investment requirements are predicated on achieving the current service provision targets in each year, and includes an investment requirement for the new short term restorative care places which will comprise 2 places per 1000 people aged 70 and over within the target ratio. As noted in Section 6.4, these planning targets are likely to over-estimate the places required to ensure sufficient provision levels during the short term. This is because the cohort that predominantly access residential care – the population aged 85 and over – is declining as a proportion of the 70 and over population on which the provision targets are based.

Nevertheless, planning undertaken by the Department as part of the ACAR process indicates that future planning targets for residential care (based on the current ratio) are likely to be met.

As at 30 June 2015 there were over 28,000 provisionally allocated residential care places, meaning that they have been allocated to aged care providers but not yet made operational due to the building time required to bring a place online. In addition to the relatively large stock of places the sector is yet to bring online, demand for new places is strong, with over 38,000 places sought by providers in the last ACAR, compared with the 10,940 that were available for allocation.

8.4.1 Recent trends in investment in the residential care sector

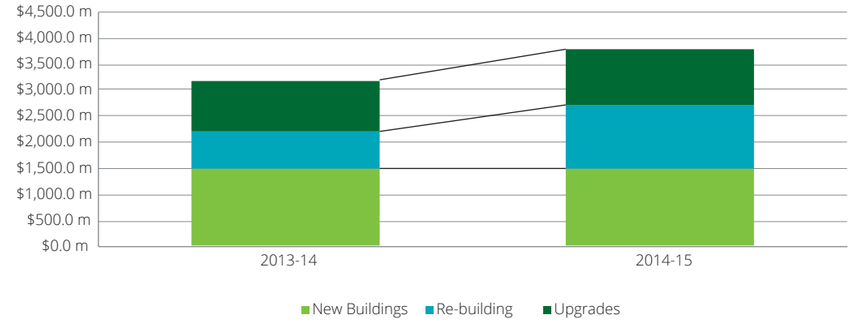
As noted in last year's Annual Report, investment trends are improving.

The 2015 Survey of Aged Care Homes estimated that a total of $1.7 billion in new building, refurbishment and upgrading work was completed during 2014-15, involving about 20 per cent of all homes. The amount of new building work in progress at the end of June 2015 was estimated at $2.1 billion involving about 17 per cent of all homes.

In 2014-15 there was an increase of $184 million (12 per cent) in new building, refurbishment and upgrading work compared with 2013-14. There was also an increase of $494 million (31 per cent) in work in progress during the same period.

ACFA concludes that investors are continuing to respond positively to the 1 July 2014 reforms and are showing interest in investments that leverage the ageing demographic.

Chart 8.9: Residential aged care building activity, 2013-14 and 2014-15

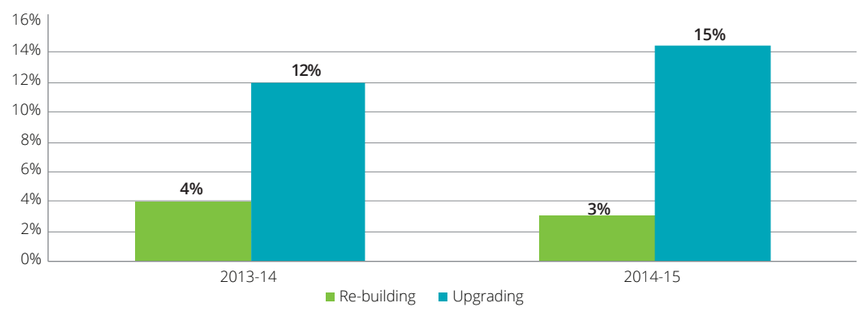


Source: Based on SACH data.

8.4.2 Building and construction statistics

Chart 8.10 shows the proportion of homes planning to either rebuild or upgrade over 2013-14 and 2014-15.

Chart 8.10: Proportion of homes planning to either upgrade or rebuild in 2013-14 and 2014-15

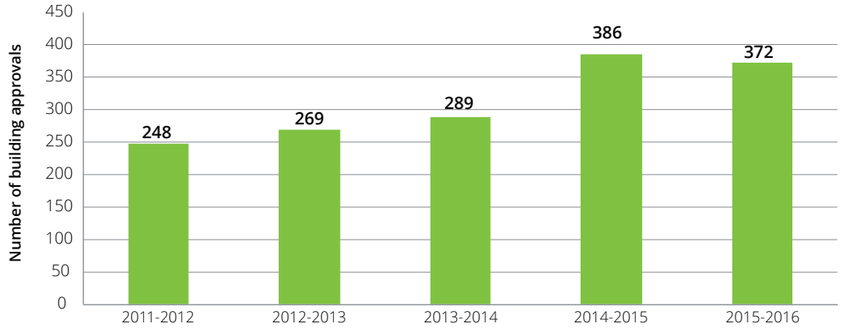


As was the case in last year's report, building statistics data from the Australian Bureau of Statistics (ABS)[33] are showing strong signs of investment in the sector. There were 372 building approvals for aged care homes in the 12 months up to the end of February 2016. This compares with the average number of approvals each year for the previous four years of 298 (Chart 8.11).

The value of building approvals has increased with average monthly total building approvals for aged care services in the 12 months to February 2016 being $168 million per month, compared with $129 million in the previous 12 months.

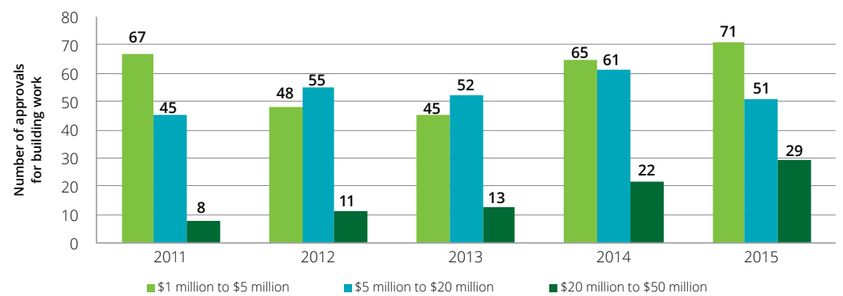
Chart 8.12 shows the number of approvals for building works over the past five years (year commencing March) by the value of build. There was a substantial increase over the last 12 months in building approvals for work between $1 million and $5 million.

Chart 8.11: Residential aged care building approvals



Note: Dates are from March to February

Chart 8.12: Number of building approvals by value of building work, 2011 to 2015



Note: Dates are from March to February

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

Chapter 9
Looking forward: Reform environment ahead

9 Looking forward: reform environment ahead

This chapter outlines and comments on the reforms ahead.

The aged care sector in Australia will continue to undergo significant transformation as it moves toward a consumer-driven, market-based system. The number of consumers is increasing and their preferences are changing. The provider and funding landscape is also undergoing significant reform. There is extensive work being undertaken by the Australian Government and stakeholders to map out the trajectory for a sustainable, high quality aged care system that meets the needs of all older Australians.

This chapter discusses:

- challenges for 2017 and 2018 reforms
- the reform pathway
- the legislated review of aged care
- the Aged Care Roadmap

9.1 Introduction

The current aged care system is at a transitional point on a longer pathway to ensure there is a sustainable, high quality aged care system that meets the needs of all older Australians. It is a sector that is growing rapidly, with Commonwealth funding contributions tracking that growth. This is most evident in home care packages, which are the focus of the next round of reform.

The first steps along the reform path include implementation of 2015-16 Budget measures including funds following the consumer in home care in February 2017, which will give consumers choice of service provider. The budget measure also announced the intention to combine home care packages and the CHSP into a single care at home programme, and the introduction of short-term restorative care places. Additionally, an independent review of the reforms already introduced is scheduled to be tabled in Parliament by August 2017, and further reform is likely to follow.

Table 9.1: Future aged care reform

Commonwealth Home Support Programme
From 1 July 2018, the Commonwealth intends to integrate the CHSP with the Home Care Packages Programme. Further consideration of a fees policy for the CHSP is likely as part of the intended reforms in 2018.
Home Care Packages Programme
Future changes for home care packages from February 2017 include: • Packages will not be allocated first to providers but instead to consumers, who will then choose their provider; and • Funding will then be paid to the provider chosen by the consumer. Although a consumer may only have one provider at a time, packages will be portable, allowing consumers to change their service provider when they choose, including when they move to another location. As a consequence, the March 2016 ACAR was the final time home care packages were allocated through the ACAR.
Introduction of Short-Term Restorative Care Programme
• STRC services may be delivered in a home setting, a residential setting, or a combination of both. • A total of 2000 STRC places will be operational by 2021-22.

9.2 Next reforms: 2017 and 2018

9.2.1 Increasing choice in home care
Legislation was passed in March 2016 giving effect to the next round of reforms in home care, to take effect on 27 February 2017. The change will see home care packages being assigned to consumers rather than allocated to providers.

For consumers, the change means that they will direct their package funding to the provider of their choice and also to have the flexibility to change provider if they wish. As well as giving consumers greater choice in deciding who provides their care, this will establish a consistent national approach to prioritising access to care.

For providers, the change means that they will no longer hold an allocation of home care packages, though the Commonwealth will still control the total number of places it will fund through the target provision ratio. Once a consumer has chosen their provider, Commonwealth payments will be paid to that provider. The changes will increase competition and are expected to lead to enhanced quality and innovation in service delivery and reduced regulation and red tape for providers.

ACFA has noted some uncertainty in the sector regarding these changes to home care. In particular there has been some concern from the sector regarding the viability of some providers as they will no longer be allocated home care places but will instead need to compete in the market to attract consumers.

The 2017 opening of the market to provide for home care services will occur at the same time as the development of an open market for services to consumers under the National Disability Insurance Scheme. ACFA anticipates that the sector will evolve to respond to a consumer-driven market. Some rationalisation of providers could occur as the sector moves to a more competitive environment. A portion of that rationalisation is likely to involve strategic alliances and mergers between not-for-profit providers who will continue to pursue their missions in the communities that they currently serve. A greater involvement by for-profit providers is also expected to emerge.

ACFA will monitor and report on how the service landscape changes, considering the financial effectiveness of the change, and how it affects services to vulnerable groups and in thin markets.

9.2.2 Integrating the Home Care Packages and the Commonwealth Home Support programmes
As previously stated, the Commonwealth has announced its intention to integrate the CHSP with the Home Care Packages Programme from 1 July 2018 to create a single care at home programme. This could have implications for the separate funding and fee arrangements that currently apply in CHSP and for home care packages.

9.3 Future reform

ACFA recognises that the current configuration of aged care represents an intermediate stage in a reform process that will continue over the coming decade. Possible future directions for change are evident in the consensus expressed by stakeholders and reflected in the work of both the Aged Care Sector Committee (ACSC) and the National Aged Care Alliance (NACA), and from change occurring within the sector.

The ACSC comprises key stakeholders in the aged care sector. Its purpose is to provide the Minister with advice on matters relevant to the future reform of the aged care sector. The ACSC developed the Aged Care Sector Statement of Principles, endorsed by all stakeholders and the Prime Minister in November 2014, to guide the future direction of aged care reform and to ensure a shared vision for aged care in Australia. The central objectives underlying the Statement of Principles are:

- consumer choice is at the centre of quality aged care
- support for informal carers will remain a major part of aged care delivery
- the provision of formal aged care is contestable, innovative and responsive
- the system is both affordable for all and sustainable.[34]

The Statement of Principles envisages:

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

9.4 Aged Care Roadmap

Having agreed the Statement of Principles, in April 2015, the ACSC was tasked by the Minister with developing a Roadmap to advise on future directions for aged care.

The Roadmap represents the ACSC's views on what is required to move towards a consumer-driven, market based and sustainable system. The Commonwealth indicated that the Roadmap is central to its plan for the future and "continues the theme of moving aged care to a market based system, giving consumers choice and allowing providers to run their own services"[35]. The Roadmap was provided to the Minister on 23 March 2016 and publicly released on 6 May 2016.[36]

The Roadmap broadly aligns with and continues the reform proposals recommended by the Productivity Commission's 2011 Inquiry Report 'Caring for Older Australians.' It takes into account progress to date and identifies areas for further action in nine key domains:

- How do consumers prepare for and engage with their aged care?
- How are eligibility and care needs assessed?
- How are consumers with different needs supported?
- How do we make dementia care core business throughout the system?
- What care is available?
- Who provides care?
- Who pays?
- How will the informal and formal workforce be supported?
- How will quality be achieved?

The Roadmap was informed by the National Aged Care Alliance's Blueprint 'Enhancing the quality of life of older people through better support and care' (June 2015) and considers the work of ACFA on the long term sustainability of the sector.

Figure 9.1 summarises key elements of the Roadmap.

While the Roadmap is a product of the ACSC rather than the Commonwealth, it provides a useful insight into the direction of future reform.

In a message to the sector on 26 May 2016, the Minister for Aged Care indicated that the Commonwealth is committed to delivering a plan to create a consumer-driven market approach to aged care, and that the Roadmap will guide the way.

[34] https://agedcare.health.gov.au/aged-care-reform/aged-care-sector-committee/aged-care-sector-statement-of-principles

[35] Ley, LASA Tri-State Conference, 21 February 2016

[36] Please see webpage at: https://agedcare.health.gov.au/aged-care-reform/aged-care-sector-committee

Figure 9.1: Elements of the Roadmap

	Domain	Destination	Description of key features
A consumer driven, market based, sustainable aged care system	**How do consumers prepare for and engage with their aged care?**	Consumers, their families and carers are proactive in preparing for their future care needs and are empowered to do so	Older Australians will be proactive, and will be encouraged and supported to have early conversations about when they may require care and support. They will understand what options are available and how to use their own resources to meet their care needs. A range of appropriate information and support services (including independent advocacy) will be made available by government to enable informed decision making regarding care options.
	How are eligibility and care needs assessed?	A single government operated assessment process that is independent and free, and includes assessment of eligibility, care needs and maximum funding level	Any older person may seek an aged care assessment, including those with the means to self-fund their care and support, to help them to make informed choices about their care. An assessment process, independent of providers, will be an essential pre-requisite for older people to receive government support and the assessment will determine the level of government funding based on a person's needs and their ability to fund their own care and support.
	How are consumers with different needs supported?	Regardless of cultural or linguistic background, sexuality, life circumstance or location, consumers can access the care and support they need	Older people should be able to choose and access aged care, regardless of their individual circumstances, however they may require additional support to do so. Assessment of need will consider individual circumstances. Government-set core standards will require providers to treat all consumers with dignity and respect, not to discriminate, and to design services around the preferences and needs of individuals. There will be continued investment in improving providers' capacity to meet the diverse needs of consumers, and monitoring of access patterns to identify and address barriers so consumers are able to access the care they need.
	How do we make dementia care core business throughout the system?	The community is dementia aware and dementia care is integrated as core business throughout the aged care system	Older people with dementia have the same rights as all other people; however they may require additional support to exercise choice and access services. Government and providers will continue to work together to ensure dementia care is evidence based and research is translated into improved dementia care and services in a timely way. Providers will have good dementia awareness and be able to identify and appropriately refer consumers requiring dementia support.
	What care is available?	A singled aged care and support system that is market based and consumer driven, with access based on assessed need	Aged care and support will be delivered based on consumer need. Consumers will be able to choose the setting (be it in a person's home, in the community or in a residential setting) and the types of care and support they receive. Care and support will be available on an episodic, short term early intervention/restorative, and ongoing basis. Government will no longer regulate the number or distribution of services. The market will respond to consumer demand, however when it doesn't or can't respond, government will act as a safety net to ensure services are available and accessible to those in need.
	Who provides care?	A single aged provider registration scheme that recognises organisations registered or accredited in similar systems, and that has a staged approach to registration depending on the scope of practice of the providers	Providers will have greater flexibility and incentive to develop innovative and responsive services that respond to consumer needs and expectations. They will be registered to provide care and support, based on their scope of practice, and similar registration or participation in other accreditation systems will be recognised for particular categories of registration. Providers who wish to receive government contributions and list on My Aged Care must be a registered or recognised provider.
	Who pays?	Sustainable aged care sector financing arrangements where the market determines price, those that can contribute to their care do, and government acts as the 'safety net' and contributes when there is insufficient market response	Consumers will be primarily responsible for their accommodation and everyday living costs, as they have been throughout their lives. Providers will determine how much they expect consumers to pay for their accommodation/everyday living, and care/support costs. Government will set and publish reasonable prices it will pay on behalf of consumers who cannot afford to fully meet their own costs. Consumers' lump sum payments will be protected.
	How will the formal and informal workforce be supported?	A well-led, well-trained workforce that is adept at adjusting care to meet the needs of older Australians	The aged care sector will be considered a desirable and rewarding place to work, with providers attracting and maintaining a well-led, flexible and responsive workforce. Unpaid carers and volunteers will continue to be supported and recognised as having an important role in caring for older people. Networks and partnerships between the aged care and other industries (education, research and employment) will boost supply, and the needs of care industries (aged care, health, disability and child care) will be considered in the development of government policies and programmes.
	How will quality be achieved?	Greater consumer choice drives quality and innovation, responsive providers and increased competition, supported by an agile and proportionate regulatory framework	Consumer protections will include core standards, compliance and an independent complaints mechanism, with providers required to meet core standards based on their registration category and scope of practice. Government will have a more proportionate regulatory framework that gives providers freedom to be innovative, whilst ensuring a safety net for consumers. Platforms will exist for providers to market their services, including by demonstrating the quality of what they deliver beyond these consumer protections. Consumers will drive quality and innovation by exercising choice as to which provider/s they use.

9.4.1 Roadmap – who pays?
Of the nine domains, the one that addresses 'who pays' is of greatest direct significance to ACFA, and that section is included in Appendix M.

The Roadmap observes that currently, consumer contributions to care are not consistently in proportion to their capacity to contribute, and that consumer contributions are capped. The ACSC's view is that increasing demand for, and cost of, aged care means that the system should change to ensure that consumers contribute consistently with their capacity to do so. This requires different reforms and policies for accommodation and living costs on the one hand, and care and support on the other.

The ACSC reasons that consumers should remain responsible for accommodation and everyday living costs, as they have been throughout their lives. The Commonwealth would provide a safety net for consumers, as well as regulate the security of lump sum accommodation payments, but other aspects of pricing and choice would be less regulated. Capital financing for the sector would come through resident contributions and debt and equity markets; the Commonwealth would only intervene to assist where the market does not respond to consumer needs.

The ACSC sets out a similar vision for reform of care and support. There would be less regulation of prices and choices, with consumers able to choose service types and how much they pay. The Commonwealth would however place some limits on the kinds of services on which the Commonwealth contribution to costs of care could be spent.

The Roadmap recognises that critical to achieving reform is a deep understanding of consumer behaviour and the economics of the sector. Many of its short term recommendations focus on undertaking analysis of costs and prices for stakeholders as the system is restructured toward the broader reform destination.

9.5 Legislated review

While the Roadmap represents a stakeholder view on future directions for reform, the next major assessment of how the aged care sector is responding to the changes to date, is the legislated review. This review, required under section 4 of the *Aged Care (Living Longer Living Better) Act 2013,* will commence soon after July 2016 and report a year later in 2017.

The Act requires that the formal review of the changes made by the reforms must consider at least the following matters:

(a) whether unmet demand for residential and home care places has been reduced;

(b) whether the number and mix of places for residential care and home care should continue to be controlled;

(c) whether further steps could be taken to change key aged care services from a supply driven model to a consumer demand driven model;

(d) the effectiveness of means testing arrangements for aged care services, including an assessment of the alignment of charges across residential care and home care services;

(e) the effectiveness of arrangements for regulating prices for aged care accommodation;

(f) the effectiveness of arrangements for protecting equity of access to aged care services for different population groups;

(g) the effectiveness of workforce strategies in aged care services, including strategies for the education, recruitment, retention and funding of aged care workers;

(h) the effectiveness of arrangements for protecting refundable deposits and accommodation bonds;

(i) the effectiveness of arrangements for facilitating access to aged care services; and

(j) any other related matter that the Minister specifies.

The legislated terms of reference require close examination of whether the current supply of aged care can be 'uncapped', and this question is similarly at the centre of the Roadmap, and the National Aged Care Alliance's Blueprint.

The legislated terms of reference also make clear that there will need to be an examination of how prices are being set and charged. ACFA has been asked by the Minister to provide advice on funding and financing issues affecting the matters to be considered by the legislated review. In particular, ACFA's advice will focus on such issues as they relate to means testing, fees, accommodation prices, access and workforce.

9.6 Ongoing challenges

As noted in ACFA's 2015 Annual Report, the continued success of the reforms is also dependent on the readiness of key stakeholders. ACFA considers that key areas in which stakeholders need to prepare are:

- The Commonwealth needs to provide sufficient certainty to allow informed and effective business planning, and have infrastructure and support systems in place that have the capacity to underpin the intended reforms.
- Consumers need to be aware of, and ready to accept, their rights and obligations.
- Providers need to implement appropriate systems and practices to reflect the new arrangements and have the necessary culture and capacity to adapt.
- Investors need to have sufficient certainty to have confidence to respond to the growing demand and changing regulatory environment.

Appendices

Appendix A: ACFA Membership

Table A.1: Members

ACFA position	Name	Organisation
Chairman	Ms Lynda O'Grady	Non-Executive Director, Business Advisor
Deputy Chair	Mr Nicolas Mersiades	Director Aged Care, Catholic Health Australia
Member	Mr Ian Yates AM	Chief Executive, COTA Australia
Member	Mr Gary Barnier	Managing Director, Opal Aged Care
Member	Ms Mary Patetsos	Director, Aged Care Housing Group
Member	Ms Lee Thomas	National Secretary, Australian Nursing and Midwifery Federation
Member	Ms Sally Evans (up until 24 October 2015)	Head of Customer Segment, AMP Capital
Member	Mr Graham Hodges (up until 24 October 2015)	Deputy Chief Executive Officer, ANZ
Member	Ms Julie Campbell-Bode (from 25 October 2015)	Former Chief Executive Officer, Heartlands Seniors Finance
Member	Professor Graeme Samuel AC (from 25 October 2015)	Vice Chancellor's Professorial Fellow, Monash Business School, Monash University
Member	Mr John Pollaers (from 25 October 2015)	Chair of the Australian Industry and Skills Committee (AISC)

Table A.2: Representatives

ACFA position	Name	Organisation
Representative	Ms Carolyn Smith – up until July 2015.	A/g Deputy Secretary, Ageing and Aged Care Stream, Department of Social Services
Representative	Ms Margot McCarthy – from September 2015	Deputy Secretary, Aged Care Policy and Reform Division, Department of Health
Representative	Ms Kim Cull	Aged Care Pricing Commissioner
Representative	Mr Robert Montefiore-Gardener	Senior Advisor, Department of the Treasury

Appendix B: Work completed by ACFA to date

Table B.1: Work completed to date

Work	Date of completion
2016 Annual Report on funding and financing of the aged care sector	Provided to Minister in July 2016.
Report on Issues Affecting the Financial Performance of Rural and Remote Providers, both residential and home care	Provided to Minister on 19 January 2016. Report published on 16 February 2016.
2015 Annual Report on funding and financing of the aged care sector	Provided to Minister on 31 July 2015. Report published on 28 August 2016.
Report on factors influencing the financial performance of residential aged care providers	Provided to Minister on 5 May 2015. Report published on 2 June 2015.
Report on improving the collection of financial data from aged care providers	Provided to Minister 30 September 2014. Report published on 28 October 2014.
Reports on the impact of financial reforms on the aged care sector	• First monthly report – 6 August 2014 • Second monthly report – 9 September 2014 • Third monthly report – 29 September 2014 • Fourth and fifth monthly reports – 20 January 2015 • Sixth monthly report – 13 March 2015 • Seventh monthly report – 21 April 2015 • First quarterly report – 18 September 2015 • Second quarterly report – 21 December 2015 • Third quarterly report – 26 February 2016 • Final quarterly report – 1 June 2016.
2014 Annual Report on the funding and financing of the aged care sector	Provided to Minister on 1 August 2014. Report published on 29 August 2014.
Supported residents data book	Provided to Minister on 30 April 2014. Published on 28 May 2014.
Interim advice to the Minister on improving the collection of financial data from aged care providers	Provided to Minister on 31 July 2013. Advice published on 28 August 2013.
ACFA first Annual Report (2013) on the funding and financing of the aged care sector	Provided to Minister on 30 June 2013. Report published on 22 July 2013.
Estimation of the possible impacts on revenue and balance sheet funding from changes to accommodation payment arrangements	ACFA's advice and KPMG modelling provided to Minister on 22 May 2013. Advice and modelling published on 23 May 2013.
The framework for setting accommodation payments in residential aged care	Final ACFA advice provided to Minister on 28 November 2012. Government announced its position on 21 December 2012. Further advice on the method for determining a RAD and a DAP using a MPIR provided to Minister on 17 May 2013. Government announced its position on 23 May 2013.

Appendix C: ACFA's stakeholder engagement

During 2014-15, ACFA held meetings and forums with representatives from the investment and financing industries, providers and consumers. These meetings and forums have been critical to ACFA's understanding of the key issues, developments and challenges facing the industry, particularly the impact of the 1 July 2014 reforms on all stakeholders.

Investors

In November and December 2015, ACFA held Equity and Debt Roundtables in Sydney and Melbourne with members of the investment and financing community to:

- share the findings of its 2015 Annual Report; and
- hear their views on key issues facing the sector, including the early indications of the impact of the 1 July 2014 reforms and longer term challenges facing the sector.

Over 50 representatives from various organisations participated in the roundtables and a diverse range of issues and views were put forward, including:

- continued strong interest in investing in the aged care industry;
- returns need to be sufficient to make investment in the industry attractive;
- quality of management is a key driver for investment returns;
- a quality workforce is critical to successful operations;
- some investors are looking to invest in the property side of aged care without taking on the risks that can arise when investing in a combined property and operational structure;
- some investors see an opportunity to build profitable businesses through scale and improving management and systems in the properties they purchase;
- availability of land for greenfield developments is challenging; and
- some investors are having difficulty in categorising the industry (given its mixed property and operational components) in terms of standard asset allocation processes.

Providers

In 2014-15, ACFA liaised closely with the provider peaks:

- Leading Age Services Australia (LASA);
- Aged and Community Services Australia (ACSA);
- Catholic Health Australia (CHA);
- The Aged Care Guild; and
- Uniting Care .

The provider peaks have assisted ACFA in developing mechanisms for providers to supply ACFA with information on post 1 July 2014 reforms. This has proven to be invaluable to ACFA in helping monitor the impacts of the reforms. ACFA will continue to engage with the provider peaks on a regular basis.

Other Stakeholders

ACFA presented at various forums during 2015. Stakeholder engagement continues to be a vital activity to inform ACFA's ongoing forward work programme and subsequent advice to Government. Some of the forums ACFA attended during 2015 include:

- The Aged and Community Services NSW/ACT Board
- The Aged and Community Services Finance Forum
- The Aged Care Leaders Symposium
- The South West Aged Care Alliance
- The Independent Agencies for Older Australians
- The Aged Care Informatics Forum 2015
- The Aged and Community Services ACT Forum
- The Leading Age Services Australia National Finance Seminar
- The Leading Age Services Australia National Congress
- The Aged and Community Services QLD and VIC Forum
- The memorial for the late Professor Graeme Hugo, previous Deputy Chair of ACFA
- The Consumer Choice and Control in Home and Community Care.

Appendix D: Aged care provision ratio

Table D.1: Total operational aged care places and ratios (places per 1000 people aged 70 years and over) by aged care planning region as at 30 June 2015

State/ territory	Aged care planning region	Total Operational Places					Operational Ratios				
		Residential care	Home care			Total residential and home care	Residential care	Home care			Total residential + home care (planning ratio)
			Low care	High care	Total home care			Low care	High care	Total home care	
NSW	Central Coast	3,729	1,040	311	**1,351**	**5,080**	73.0	20.4	6.1	**26.5**	**99.5**
	Central West	1,888	513	139	**652**	**2,540**	87.1	23.7	6.4	**30.1**	**117.1**
	Far North Coast	3,716	996	279	**1,275**	**4,991**	85.2	22.8	6.4	**29.2**	**114.5**
	Hunter	5,924	1,684	499	**2,183**	**8,107**	81.0	23.0	6.8	**29.8**	**110.8**
	Illawarra	4,104	1,195	337	**1,532**	**5,636**	74.9	21.8	6.2	**28.0**	**102.9**
	Inner West	4,431	1,057	263	**1,320**	**5,751**	95.7	22.8	5.7	**28.5**	**124.2**
	Mid North Coast	4,239	1,182	349	**1,531**	**5,770**	81.8	22.8	6.7	**29.6**	**111.4**
	Nepean	2,160	604	203	**807**	**2,967**	75.4	21.1	7.1	**28.2**	**103.5**
	New England	1,907	592	213	**805**	**2,712**	83.5	25.9	9.3	**35.2**	**118.7**
	Northern Sydney	8,729	2,152	574	**2,726**	**11,455**	93.3	23.0	6.1	**29.1**	**122.4**
	Orana Far West	1,633	469	158	**627**	**2,260**	83.6	24.0	8.1	**32.1**	**115.7**
	Riverina/Murray	3,017	815	191	**1,006**	**4,023**	82.0	22.2	5.2	**27.3**	**109.4**
	South East Sydney	7,826	2,129	569	**2,698**	**10,524**	87.3	23.7	6.3	**30.1**	**117.4**
	South West Sydney	6,337	1,693	491	**2,184**	**8,521**	76.9	20.5	6.0	**26.5**	**103.4**
	Southern Highlands	2,344	637	179	**816**	**3,160**	81.2	22.1	6.2	**28.3**	**109.5**
	Western Sydney	5,274	1,486	439	**1,925**	**7,199**	74.3	20.9	6.2	**27.1**	**101.5**
	NSW	**67,258**	**18,244**	**5,194**	**23,438**	**90,696**	**82.5**	**22.4**	**6.4**	**28.7**	**111.2**
VIC	Barwon-South Western	4,393	1,067	335	**1,402**	**5,795**	93.8	22.8	7.2	**29.9**	**123.7**
	Eastern Metro	10,623	2,774	783	**3,557**	**14,180**	83.1	21.7	6.1	**27.8**	**110.9**
	Gippsland	3,039	830	249	**1,079**	**4,118**	80.8	22.1	6.6	**28.7**	**109.4**
	Grampians	2,214	633	206	**839**	**3,053**	80.6	23.0	7.5	**30.5**	**111.1**
	Hume	3,006	809	245	**1,054**	**4,060**	84.2	22.7	6.9	**29.5**	**113.7**
	Loddon-Mallee	3,599	958	277	**1,235**	**4,834**	80.3	21.4	6.2	**27.6**	**107.9**
	Northern Metro	6,648	2,025	589	**2,614**	**9,262**	80.0	24.4	7.1	**31.4**	**111.4**
	Southern Metro	12,075	3,161	901	**4,062**	**16,137**	83.9	22.0	6.3	**28.2**	**112.1**
	Western Metro	5,534	1,530	435	**1,965**	**7,499**	83.5	23.1	6.6	**29.7**	**113.2**

State/ territory	Aged care planning region	Total Operational Places					Operational Ratios				
		Residential care	Home care			Total residential and home care	Residential care	Home care			Total residential + home care (planning ratio)
			Low care	High care	Total home care			Low care	High care	Total home care	
	VIC	**51,131**	**13,787**	**4,020**	**17,807**	**68,938**	**83.3**	**22.5**	**6.6**	**29.0**	**112.3**
QLD											
	Brisbane North	4,033	972	345	**1,317**	**5,350**	95.4	23.0	8.2	**31.1**	**126.5**
	Brisbane South	5,577	1,465	479	**1,944**	**7,521**	86.5	22.7	7.4	**30.2**	**116.7**
	Cabool	3,029	928	329	**1,257**	**4,286**	73.0	22.4	7.9	**30.3**	**103.3**
	Central West	116	54	11	**65**	**181**	97.9	45.6	9.3	**54.9**	**152.7**
	Darling Downs	2,360	697	227	**924**	**3,284**	75.9	22.4	7.3	**29.7**	**105.7**
	Far North	1,655	557	147	**704**	**2,359**	60.3	20.3	5.4	**25.6**	**85.9**
	Fitzroy	1,562	435	154	**589**	**2,151**	90.5	25.2	8.9	**34.1**	**124.6**
	Logan River Valley	1,822	519	187	**706**	**2,528**	64.3	18.3	6.6	**24.9**	**89.2**
	Mackay	843	263	118	**381**	**1,224**	78.3	24.4	11.0	**35.4**	**113.7**
	North West	144	131	14	**145**	**289**	90.0	81.9	8.8	**90.6**	**180.6**
	Northern	1,581	498	186	**684**	**2,265**	75.3	23.7	8.9	**32.6**	**107.9**
	South Coast	4,797	1,206	452	**1,658**	**6,455**	87.9	22.1	8.3	**30.4**	**118.3**
	South West	245	113	18	**131**	**376**	84.0	38.8	6.2	**44.9**	**128.9**
	Sunshine Coast	3,776	1,102	484	**1,586**	**5,362**	76.5	22.3	9.8	**32.1**	**108.7**
	West Moreton	1,129	454	180	**634**	**1,763**	57.3	23.0	9.1	**32.2**	**89.4**
	Wide Bay	2,246	809	281	**1,090**	**3,336**	56.2	20.2	7.0	**27.3**	**83.4**
	QLD	**34,915**	**10,203**	**3,612**	**13,815**	**48,730**	**77.0**	**22.5**	**8.0**	**30.5**	**107.5**
WA											
	Goldfields	267	65	43	**108**	**375**	71.9	17.5	11.6	**29.1**	**101.0**
	Great Southern	514	171	113	**284**	**798**	64.9	21.6	14.3	**35.8**	**100.7**
	Indian Ocean Territories	0	0	0	**0**	**0**	0.0	0.0	0.0	**0.0**	**0.0**
	Kimberley	169	103	35	**138**	**307**	125.7	76.6	26.0	**102.7**	**228.4**
	Metropolitan East	2,397	874	491	**1,365**	**3,762**	72.4	26.4	14.8	**41.2**	**113.7**
	Metropolitan North	4,286	1,206	813	**2,019**	**6,305**	73.1	20.6	13.9	**34.4**	**107.5**
	Metropolitan South East	3,068	808	535	**1,343**	**4,411**	82.8	21.8	14.4	**36.3**	**119.1**
	Metropolitan South West	3,415	1,123	737	**1,860**	**5,275**	64.8	21.3	14.0	**35.3**	**100.2**
	Mid West	394	211	112	**323**	**717**	61.6	33.0	17.5	**50.5**	**112.2**
	Pilbara	76	55	14	**69**	**145**	80.5	58.3	14.8	**73.1**	**153.6**
	South West	1,203	343	264	**607**	**1,810**	70.3	20.1	15.4	**35.5**	**105.8**

State/ territory	Aged care planning region	Total Operational Places					Operational Ratios				
		Residential care	Home care			Total residential and home care	Residential care	Home care			Total residential + home care (planning ratio)
			Low care	High care	Total home care			Low care	High care	Total home care	
	Wheatbelt	561	219	121	**340**	**901**	67.0	26.2	14.5	**40.6**	**107.7**
	WA	**16,350**	**5,178**	**3,278**	**8,456**	**24,806**	**71.9**	**22.8**	**14.4**	**37.2**	**109.1**
SA											
	Eyre Peninsula	507	155	56	**211**	**718**	78.2	23.9	8.6	**32.6**	**110.8**
	Hills, Mallee & Southern	227	139	28	**167**	**394**	115.2	70.6	14.2	**84.8**	**200.0**
	Metropolitan East	1,542	455	113	**568**	**2,110**	72.2	21.3	5.3	**26.6**	**98.8**
	Metropolitan North	3,138	754	186	**940**	**4,078**	108.4	26.0	6.4	**32.5**	**140.8**
	Metropolitan South	3,515	805	181	**986**	**4,501**	88.4	20.2	4.6	**24.8**	**113.2**
	Metropolitan West	3,834	927	234	**1,161**	**4,995**	90.1	21.8	5.5	**27.3**	**117.4**
	Mid North	2,808	567	184	**751**	**3,559**	100.4	20.3	6.6	**26.8**	**127.2**
	Riverland	375	117	41	**158**	**533**	87.9	27.4	9.6	**37.0**	**124.9**
	South East	415	145	42	**187**	**602**	75.8	26.5	7.7	**34.1**	**109.9**
	Whyalla, Flinders & Far North	717	176	61	**237**	**954**	85.0	20.9	7.2	**28.1**	**113.1**
	Yorke, Lower North & Barossa	1,312	341	97	**438**	**1,750**	82.6	21.5	6.1	**27.6**	**110.1**
	SA	**18,390**	**4,581**	**1,223**	**5,804**	**24,194**	**90.5**	**22.6**	**6.0**	**28.6**	**119.1**
TAS											
	North Western	1,051	293	77	**370**	**1,421**	72.5	20.2	5.3	**25.5**	**98.0**
	Northern	1,439	417	122	**539**	**1,978**	75.5	21.9	6.4	**28.3**	**103.8**
	Southern	2,497	711	241	**952**	**3,449**	84.8	24.2	8.2	**32.3**	**117.2**
	TAS	**4,987**	**1,421**	**440**	**1,861**	**6,848**	**79.2**	**22.6**	**7.0**	**29.5**	**108.7**
ACT											
	ACT	2,247	719	527	**1,246**	**3,493**	73.1	23.4	17.1	**40.5**	**113.6**
	ACT	**2,247**	**719**	**527**	**1,246**	**3,493**	**73.1**	**23.4**	**17.1**	**40.5**	**113.6**
NT											
	Alice Springs	207	301	37	**338**	**545**	143.6	208.7	25.7	**234.4**	**377.9**
	Barkly	25	70	5	**75**	**100**	63.8	178.6	12.8	**191.3**	**255.1**
	Darwin	317	311	133	**444**	**761**	50.4	49.4	21.1	**70.6**	**120.9**
	East Arnhem	15	115	11	**126**	**141**	54.3	416.7	39.9	**456.5**	**510.9**
	Katherine	111	125	15	**140**	**251**	139.4	157.0	18.8	**175.9**	**315.3**
	NT	**675**	**922**	**201**	**1,123**	**1,798**	**73.4**	**100.2**	**21.9**	**122.1**	**195.5**
Australia		**195,953**	**55,055**	**18,495**	**73,550**	**269,503**	**81.1**	**22.8**	**7.7**	**30.4**	**111.5**

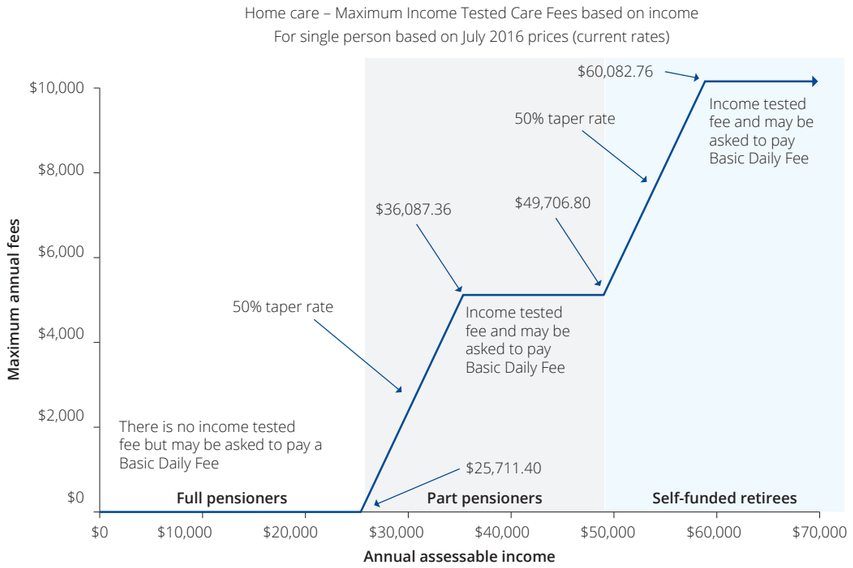
Appendix E: Means testing arrangements

Home care

In addition to the basic daily fee, an income-tested care fee was introduced in home care from 1 July 2014. Unlike the arrangements for the basic daily fee, the Commonwealth payment received by the provider is reduced by the amount of the income-tested care fee. Accordingly, to receive an amount equivalent to the full subsidy the provider needs to charge the appropriate income-tested care fee.

Annual income-tested care fees in home care are currently capped at $5,187.97 for part-pensioners and $10,375.96 for non-pensioners (July 2016 rate). A lifetime cap of $62,255.85 per consumer currently applies for care contributions across home care and residential care (July 2016 rate). Full pensioners are not required to contribute to their care costs and may only be required to pay the basic daily fee.

Figure E1: Current income testing for home care (post 1 July 2014)



Note. Income tested care fees could be charged up to 50 per cent of income over $49,706.80 but this is capped for an income over $60,082.76

Residential care

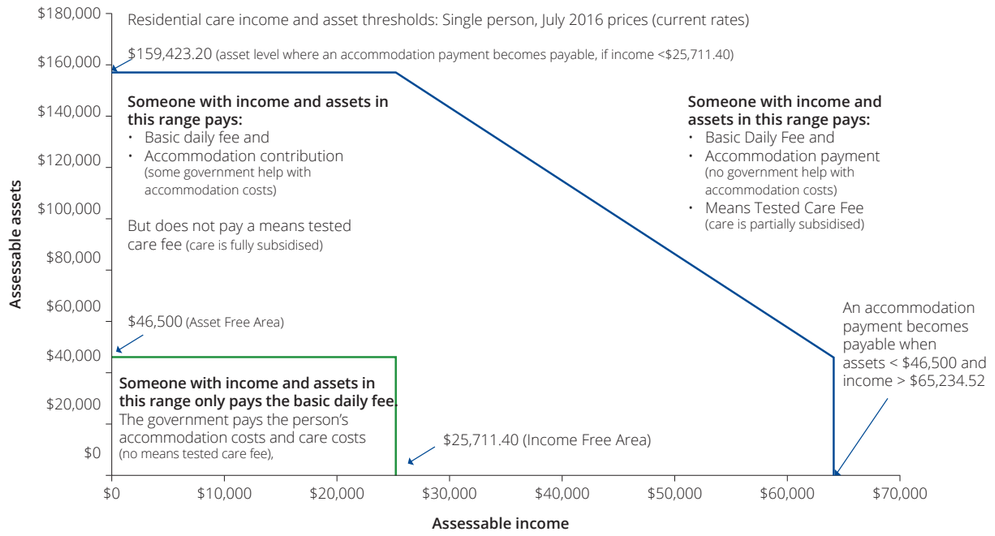
Changes to residential care from 1 July 2014 introduced more comprehensive means testing arrangements by way of a combined assets and income assessment and a new fees structure.

Annual and lifetime caps were also introduced, with an annual cap of $25,939.92 applying to the means-tested care fee and a lifetime cap of $62,255.85 for care contributions (July 2016 rate).

The figure below demonstrates how the means testing arrangements created three tiers of consumer contributions in residential aged care:

- consumers with low means, who are required to pay only the basic daily fee (85 per cent of the single basic age pension) as a contribution towards their daily living expenses, while their accommodation and care costs are funded by the Australian Government;
- consumers with moderate means, who in addition to contributing towards their daily living expenses by paying the basic daily fee, also make a capped contribution towards their accommodation costs; and
- consumers with greater means, who in addition to contributing towards their daily living expenses, also pay the basic daily fee for their accommodation costs in full and make a capped contribution towards their care costs.

Figure E2: Residential aged care income and asset thresholds



Appendix F: Financial ratios by provider ownership type

Table F.1: Financial ratios of total sector by provider type, 2014-15

	Not-for-profit	For-profit	Government	Total
Accommodation bonds	$9,535	$8,329	$349	$18,213
No of providers	522	341	103	966
EBITDA	$9,318	$12,945	$341	$10,222
Capital structure				
T. Assets P.R.P.A	$188,078	$248,446	$198,927	$210,661
No of Bonds	41,443	29,859	2,022	73,324
Avg Bond P.R.	$230,090	$278,941	$172,660	$248,400
Net Worth P.R.P.A.	$73,180	$39,538	$144,174	$64,042
Wrk Cap P.R.P.A.	($44,367)	($102,715)	($7,414)	($63,989)
Non.Curr Liab as % of T.Assets	11.5%	15.5%	4.2%	13.0%
Bonds as % of T. Assets	50.2%	53.0%	24.7%	50.4%
Net Wth as % T.Assets	38.9%	15.9%	72.5%	30.3%
Viability				
Current Ratio	0.55	0.41	0.84	0.48
Interest Coverage	14.6 Times	7.3 Times	16.9 Times	9.4 Times
NPBT Margin	4.6%	9.0%	7.1%	5.8%
Occupancy	94.0%	91.0%	89.3%	92.6%
%EBITDA to T. Assets	5.0%	5.2%	0.2%	4.9%
%EBITDA to Net Worth	12.7%	32.8%	0.3%	16.0%
Bond Asset Cover (T.A.)	2.0 Times	1.9 Times	4.1 Times	2.0 Times

Table F.2: Financial ratios for not-for-profit providers, 2014-15

	Top	Next top	Next bottom	Bottom	Total
No of providers	101	144	142	135	522
EBITDA	$20,552	$10,680	$6,152	($3,029)	$9,318
Capital structure					
T. Assets P.R.P.A	$236,047	$167,535	$182,496	$207,546	$188,078
No of Bonds	7,007	17,139	12,294	5,003	41,443
Avg Bond P.R.	$247,655	$219,516	$228,966	$244,481	$230,090
Net Worth P.R.P.A.	$94,431	$57,908	$76,105	$88,102	$73,180
Wrk Cap P.R.P.A.	($59,367)	($43,366)	($42,566)	($31,748)	($44,367)
Non.Curr Liab as % of T.Assets	8.7%	11.7%	10.4%	16.8%	11.5%
Bonds as % of T. Assets	45.3%	52.9%	50.6%	49.2%	50.2%
Net Wth as % T.Assets	40.0%	35.0%	41.4%	42.5%	38.9%
Financial ratios					
Current Ratio	0.54	0.54	0.55	0.65	0.55
Interest Coverage	21.8 Times	16.1 Times	13.9 Times	-5.0 Times	14.6 Times
NPBT Margin	16.1%	6.0%	1.6%	9.6%	4.6%
Occupancy	95.8%	94.0%	93.3%	93.3%	94.0%
%EBITDA to T. Assets	8.7%	6.4%	3.4%	1.5%	5.0%
%EBITDA to Net Worth	21.8%	18.3%	8.0%	3.5%	12.7%
Bond Asset Cover (T.A.)	2.2 Times	1.9 Times	2.0 Times	2.0 Times	2.0 Times

Table F.3: Financial ratios of government providers, 2014-15

	Top	Next top	Next bottom	Bottom	Total
No of providers	16	10	20	57	103
EBITDA	$29,723	$11,795	$5,872	($17,692)	$341
Capital structure					
T. Assets P.R.P.A	$229,878	$252,384	$199,309	$178,713	$198,927
No of Bonds	315	186	566	955	2,022
Avg Bond P.R.	$182,805	$151,521	$163,408	$178,915	$172,660
Net Worth P.R.P.A.	$181,522	$194,998	$153,115	$113,261	$144,174
Wrk Cap P.R.P.A.	($4,426)	$33,797	($6,947)	($15,730)	($7,414)
Non.Curr Liab as % of T.Assets	2.9%	7.0%	5.0%	3.5%	4.2%
Bonds as % of T. Assets	22.8%	21.5%	18.5%	32.1%	24.7%
Net Wth as % T.Assets	79.0%	77.3%	76.8%	63.4%	72.5%
Financial ratios					
Current Ratio	0.89	1.78	0.82	0.73	0.84
Interest Coverage	93.5 Times	24.2 Times	10.5 Times	-6.9 Times	16.9 Times
NPBT Margin	14.3%	6.3%	0.1%	26.1%	7.1%
Occupancy	93.2%	93.4%	87.3%	89.4%	89.3%
%EBITDA to T. Assets	12.9%	4.7%	3.0%	9.8%	0.2%
%EBITDA to Net Worth	16.4%	6.1%	3.8%	15.5%	0.3%
Bond Asset Cover (T.A.)	4.4 Times	4.7 Times	5.4 Times	3.1 Times	4.1 Times

Table F.4: Financial ratios of for-profit providers, 2014-15

	Top	Next top	Next bottom	Bottom	Total
No of providers	125	88	79	49	341
EBITDA	$25,699	$11,614	$4,735	($5,289)	$12,945
Capital structure					
T. Assets P.R.P.A	$249,554	$267,599	$204,271	$284,896	$248,446
No of Bonds	10,338	8,719	6,607	4,195	29,859
Avg Bond P.R.	$291,572	$260,218	$267,212	$305,202	$278,941
Net Worth P.R.P.A.	$53,618	$29,161	$25,265	$49,098	$39,538
Wrk Cap P.R.P.A.	($97,547)	($103,422)	($90,934)	($138,087)	($102,715)
Non.Curr Liab as % of T.Assets	14.7%	21.0%	10.3%	12.5%	15.5%
Bonds as % of T. Assets	53.3%	47.4%	58.3%	56.7%	53.0%
Net Wth as % T.Assets	21.5%	10.9%	12.4%	17.2%	15.9%
Financial ratios					
Current Ratio	0.40	0.44	0.43	0.32	0.41
Interest Coverage	13.2 Times	4.9 Times	3.7 Times	-5.6 Times	7.3 Times
NPBT Margin	20.0%	7.2%	1.4%	9.2%	9.0%
Occupancy	92.8%	91.2%	89.6%	88.0%	91.0%
%EBITDA to T. Assets	10.3%	4.3%	2.3%	1.9%	5.2%
%EBITDA to Net Worth	47.9%	39.8%	18.8%	10.8%	32.8%
Bond Asset Cover (T.A.)	1.9 Times	2.1 Times	1.7 Times	1.8 Times	1.9 Times

Appendix G: Residential care funding sources

Table G.1: Summary of funding amounts for subsidy and supplements in residential aged care, 2014-15

Type of payment	$ (million)
Basic care subsidies	
Permanent residents	9,662.4
Respite residents	239.0
CAP	0.0
Sub total	9,901.4
Primary care supplements	
Oxygen	16.4
Enteral feeding	6.7
Payroll Tax	107.4
Respite incentive	22.6
Sub total	153.1
Hardship	
Hardship	4.1
Sub total	4.1
Accommodation supplements	
Hardship	4.1
Accommodation supplements	592.5
Transitional accommodation supplements	31.7
Concessional	72.3
Accommodation charge top-up	3.1
Pension	48.0
Sub total	751.7
Viability supplement	
Viability	35.4
Sub total	35.4
Supplements relating to grand parenting	
Transitional	7.4
Charge exempt	1.0
Basic daily fee	0.8
Sub total	9.2
Other supplements	
Dementia and severe behaviours	
Veteran's	3.5
Homeless	7.4
Other	100.5
Sub total	111.4
Reductions	
Means tested fees	-377.0
Sub-total	-377.0
Total	**10,598.4**

Appendix H: Residential care subsidy and supplements rates

Table H.1: ACFI rates ($ per day), 2014-15 to 2016-17

ACFI	2014-15	2015-16	2016-17
Activities of daily living (ADL)			
Low	$35.65	$36.11	$36.65
Medium	$77.61	$78.62	$79.80
High	$107.52	$108.92	$110.55
Behaviour (BEH)			
Low	$8.14	$8.25	$8.37
Medium	$16.88	$17.10	$17.36
High	$35.20	$35.66	$36.19
Complex Health Care (CHC)			
Low	$16.04	$16.25	$16.37
Medium	$45.68	$46.27	$46.62
High	$65.96	$66.82	$67.32
Interim rate for new residents pending ACFI assessment	$54.68	$55.39	$56.22
Daily residential respite subsidy rates			
Low	44.21	$44.78	$45.45
High	123.97	$125.58	$127.46

Table H.2 Residential care supplements table, 2014-15 to 2016-17

Residential care	2014-15	2015-16	2016-17
Oxygen supplement	$10.84	$10.98	$11.12
Enteral Feeding supplement – Bolus	$17.17	$17.39	$17.62
Enteral Feeding supplement – Non-bolus	$19.29	$19.54	$19.79
Adjusted Subsidy Reduction	$12.50	$12.66	$12.85
Conditional Adjustment Payment	-	-	
Veterans' supplement	$6.69	$6.78	$6.88
Homeless supplement	$15.29	$15.49	$15.72
Dementia and Severe Behaviours supplement	$16.46	-	-

Table H.3: Residential aged care supplements (accommodation and hotel related)

Residential care	2014-15	2015-16	2016-17
Higher Accommodation supplement	$52.49	$53.39	$54.29
Accommodation supplement	$34.20	$34.79	$35.37
Concessional	$20.91	$21.27	$21.63
Assisted residents	$8.61	$8.76	$8.90
Transitional Accommodation supplement	$7.84	$7.97	$8.11
Transitional supplement	$20.91	$21.27	$21.63
Basic Daily Fee supplement	$0.54	$0.55	$0.56
Respite supplement – high level greater than 70%	$85.76	$87.24	$88.70
Respite supplement – high level less than 70%	$50.40	$51.27	$52.13
Respite Care – low level	$35.95	$36.57	$37.19
If a service is significantly refurbished or newly built Concessional or Assisted if a service is significantly refurbished or newly built. More than 40% low means, supported, concessional and assisted residents+	$52.49	$53.39	$54.29
40% or fewer low means, supported, concessional and assisted residents	-	$40.04	$40.72
If a service is not significantly refurbished or newly built Concessional If a service is not significantly refurbished or newly built – more than 40% low means, supported, concessional and assisted residents	$20.91	$21.27	$21.63
Concessional – 40% or fewer low means, supported, concessional and assisted residents	$13.67	$13.90	$14.14
Assisted residents	$8.61	$8.76	$8.90
Pensioner supplement	$7.84	$7.97	$8.11
Accommodation supplement (maximum)			
If a service is significantly refurbished or newly built			
More than 40% low means, supported, concessional and assisted residents	$52.49	$53.39	$54.29
40% or fewer low means, supported, concessional and assisted residents		$40.04	$40.72
If on the day the service meets building requirements in Schedule 1 of Aged Care (Transitional Provisions) Principles 2014 – More than 40% low means, supported, concessional and assisted residents	$34.20	$34.79	$35.37
40% or fewer low means, supported, concessional and assisted residents	-	$26.09	$26.53

Residential care	2014-15	2015-16	2016-17
If on the day of service does not meet those requirements – More than 40% low means, supported, concessional and assisted residents	$28.75	$29.24	$29.74
40% or fewer low means, supported, concessional and assisted residents	-	$21.93	$22.31
Transitional Accommodation supplement			
After 19 March 2008 and before 20 September 2010	$7.84	$7.97	$8.11
After 19 September 2010 and before 20 March 2011	$5.23	$5.31	$5.41
After 19 March 2011 and before 20 September 2011	$2.61	$2.66	$2.70
Transitional supplement	$20.91	$21.27	$21.63
Basic Daily Fee supplement	$0.54	$0.55	$0.56
Respite supplement – high level is equal to or greater than 70% of the specified proportion of respite care for the approved provider.	$85.76	$87.24	$88.70

Table H.4: Residential aged care viability supplement

Residential aged care Viability supplement	2014-15	2015-16	2016-17
2005 Scheme Services*			
Eligibility score of 100	$49.30	$49.94	$50.69
Eligibility score of 95	$43.69	$44.26	$44.92
Eligibility score of 90	$39.22	$39.73	$40.33
Eligibility score of 85	$33.63	$34.07	$34.58
Eligibility score of 80	$27.99	$28.35	$28.78
Eligibility score of 75	$22.40	$22.69	$23.03
Eligibility score of 70	$17.98	$18.21	$18.48
Eligibility score of 65	$12.31	$12.47	$12.66
Eligibility score of 60	$10.08	$10.21	$10.36
Eligibility score of 55	$6.73	$6.82	$6.92
Eligibility score of 50	$4.49	$4.55	$4.62
Eligibility score of 45 #	$0.00	$0.00	$0.00
Safety net – former 1997 or 2001 scheme services: viability supplement	$1.85	$1.87	$1.90

Appendix I: Residential aged care financing structures and balance sheets

Table I.1: Distribution of average lump sum accommodation deposits by ownership and earnings before interest, taxes, depreciation and amortisation quartile, 2014-15

	Top	Next top	Next bottom	Bottom	Total
Not-for-profit					
No. of providers	101	144	142	135	522
No. of providers that held deposits	93	142	138	129	502
Proportion of permanent residents that paid deposits in facilities, where deposits were held	42.8%	40.2%	40.3%	41.7%	40.8%
Average deposits per resident	$247,655	$219,516	$228,966	$244,481	$230,091
For-profit					
No. of providers	125	88	79	49	341
No. of providers that held deposits	120	84	78	49	331
Proportion of permanent residents that paid deposits in facilities, where deposits were held	45.0%	46.9%	43.6%	49.5%	45.8%
Average deposits per resident	$291,572	$260,218	$267,212	$305,202	$278,941
Government					
No. of providers	16	10	20	57	103
No. of providers that held deposits	14	10	18	49	91
Proportion of permanent residents that paid deposits in facilities, where deposits were held	28.4%	33.9%	24.3%	32.1%	29.0%
Average deposits per resident	$182,805	$151,521	$163,408	$178,915	$172,661
Total					
No. of providers	242	242	241	241	966
No. of providers that held deposits	227	236	234	227	924
Proportion of permanent residents that paid deposits in facilities, where deposits were held	43.7%	42.1%	40.6%	43.3%	42.2%
Average deposits per resident	$272,207	$232,656	$240,040	$263,403	$248,400

Appendix J: Access to care

Table J.1: Number of first admissions into permanent residential aged care by extra service status and as a proportion of total first admissions

	2013-14	2014-15
Extra services	5,690	4,329
	9.7%	7.7%
Non-extra services	55,381	51,983
	90.3%	92.3%
Admissions	61,341	56,312
	100%	100%
No. of supported/concessional/assisted permanent residents#		

Source: Unpublished departmental data. #Excludes low means residents data. Low means residents data are not available for 2014-15. Therefore, the 2014-15 data for all permanent residents are not comparable with earlier years.

Table J.2: Number of recipients in permanent residential aged care at 30 June 2015, by provider organisation type (for-profit, not-for-profit, government)

	Total operational places	Number of permanent residents in care		
		All residents	Residents aged 70 years and over	Residents aged 85 years and over
Not-for-profit	109,873	100,549	93,911	60,544
For-profit	73,097	64,110	59,205	37,247
Government	9,400	8,169	7,158	4,112
Total	**192,370**	**172,828**	**160,274**	**101,903**

Source. Unpublished departmental data

Table J.3: Occupancy rate in aged care by state and territory 2014-15 (%)

State/ territory	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Australia
Residential aged care	92.5%	91.6%	92.7%	94.4%	93.2%	90.6%	94.5%	92.8%	92.5%
Level1	60.2%	71.3%	53.7%	35.4%	54.9%	82.4%	57.5%	60.6%	62.1%
Level 2	88.4%	93.6%	77.5%	66.8%	83.2%	92.1%	81.1%	86.1%	85.2%
Level 3	66.8%	69.0%	62.6%	48.8%	76.4%	71.6%	60.2%	75.0%	66.7%
Level 4	92.6%	95.7%	94.1%	86.6%	91.5%	95.6%	88.7%	88.3%	92.1%
Total home care	87.8%	92.7%	80.6%	73.8%	83.6%	91.8%	83.7%	86.2%	85.8%

Source. Unpublished departmental data

Table J.4: Residential occupancy by remoteness area 2006-7 to 2014-15 (%)

	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
Major cities	94.1	93.4	92.6	92.1	92.8	92.7	92.9	93.2	92.6
Inner regional	95.5	94.4	94.1	93.7	94.1	93.6	93.3	92.9	92.4
Outer regional	95.6	93.7	92.7	91.9	92.3	91.7	92.2	92.4	92.1
Remote	91.4	87.5	88.4	89.5	90.9	90.8	90.3	88.6	86.5
Very remote	79.8	80.2	79.5	80.9	88.3	82.3	81.2	84.4	84.8

Source. The Report on Government Service (2015), Table 13A.17

Table J.5: Number of operational home care packages and operational residential care places at 30 June 2015

Care type		No. of all providers	No. of providers in regional	No. of all services	No. of services in regional	No. of all places	No. of places in regional
Residential care		972	466	2,681	1,028	192,370	58,940
Home Care	Level 1	133	72	327	112	2,251	624
	Level 2	501	292	1461	629	51,956	16,162
	Level 3	169	92	441	161	3,815	1,043
	Level 4	241	144	1,067	417	14,680	4,326
	Total (Levels 1-4)	504	294	2,292	960	72,702	22,155
Residential care & home care		1,237	618	4,944	1,988	265,072	81,095
Multi-Purpose Services (MPS)		24	24	165	165	3,545	3,545
Innovative care		8	4	9	4	84	28
Transition care		10	9	83	39	4000	1,340
National Aboriginal & Torres Strait Islander Flexible Aged Care Programme		29	25	31	27	802	637
Grand total (all care types)		1,287	661	5,232	2,223	273,503	86,645

Table J.6: Average age of people living and entering permanent residential aged care 2008-09 to 2014-15

Period	Average age at first admission to permanent residential aged care	Average age of permanent residential aged care residents as at 30 June
2014-15	83.5	84.6
2013-14	83.5	84.5
2012-13	83.3	84.4
2011-12	83.3	84.4
2010-11	83.2	84.2
2009-10	83.1	84.1
2008-09	83.0	84.0

Source. Unpublished departmental data

Table J.7: Occupancy in residential aged care services by provider type (%) 2014-15

Organisation type	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Australia
Not-for-profit	93.2%	94.1%	94.2%	96.1%	95.7%	90.9%	94.2%	93.3%	94.0%
For-profit	91.2%	90.1%	91.3%	91.6%	88.1%	90.1%	95.3%	90.6%	90.6%
Government	91.2%	90.3%	78.9%	95.7%	93.5%	76.6%	-	-	89.4%
All organisation types	92.5%	91.6%	92.7%	94.4%	93.2%	90.6%	94.5%	92.8%	92.5%

Source. Unpublished departmental data

Appendix K: Home care

Table K.1: Revenue and expenditure by ownership type, quartiles by NPBT, 2014-15

	Top Quartile	Next Top	Next Bottom	Bottom	Total
Not-for-profit					
No of providers	74	84	75	68	301
Government care subsidies	$67.95	$55.60	$54.74	$57.69	$60.63
Client contribution	$6.87	$6.96	$6.60	$6.72	$6.83
Other income	$0.78	$0.59	$0.30	$0.69	$0.62
Total expenses	$61.48	$56.94	$60.45	$69.45	$60.47
Net Profit Before Tax	$14.11	$6.21	$1.19	($4.35)	$7.60
For-profit					
No of providers	24	6	15	11	56
Government care subsidies	$65.93	$64.57	$52.47	$55.46	$60.72
Client contribution	$9.48	$6.74	$7.33	$9.48	$8.65
Other income	$2.65	$0.10	$0.71	$1.38	$1.61
Total expenses	$60.30	$65.74	$59.53	$68.18	$62.66
Net Profit Before Tax	$17.76	$5.67	$0.97	($1.86)	$8.33
Government					
No of providers	11	19	21	27	78
Government care subsidies	$49.48	$55.32	$45.49	$44.89	$48.70
Client contribution	$13.60	$3.44	$2.66	$3.67	$4.50
Other income	$8.47	$0.46	$0.55	$0.07	$1.35
Total expenses	$58.18	$53.19	$47.60	$50.30	$51.29
Net Profit Before Tax	$13.38	$6.03	$1.10	($1.67)	$3.26
Total					
No of providers	109	109	111	106	435
Government care subsidies	$67.26	$55.91	$53.36	$54.44	$59.59
Client contribution	$7.28	$6.65	$6.14	$6.45	$6.77
Other income	$1.15	$0.56	$0.36	$0.66	$0.76
Total expenses	$61.28	$56.94	$58.71	$64.91	$59.84
Net Profit Before Tax	$14.41	$6.18	$1.16	($3.35)	$7.28

Table K.2: Revenue and expenditure by ownership type, per package, quartiles by NPBT, 2014-15

	Top quartile	Next top	Next bottom	Bottom	Total
Not-for-profit					
No of providers	74	84	75	68	301
T. Rev per Pkg	$21,881	$18,387	$17,695	$16,874	$19,527
T. Exp per Pkg	$17,796	$16,578	$17,354	$18,002	$17,346
NPBT Per Pkg	$4,085	$1,808	$341	($1,128)	$2,181
For-profit					
No of providers	24	6	15	11	56
T. Rev per Pkg	$21,485	$18,533	$16,993	$16,250	$18,937
T. Exp per Pkg	$16,597	$17,062	$16,720	$16,705	$16,715
NPBT Per Pkg	$4,888	$1,471	$273	($455)	$2,221
Government					
No of providers	11	19	21	27	78
T. Rev per Pkg	$20,825	$17,929	$15,106	$13,258	$16,052
T. Exp per Pkg	$16,933	$16,103	$14,765	$13,714	$15,094
NPBT Per Pkg	$3,892	$1,826	$341	($456)	$958
Total					
No of providers	109	109	111	106	435
T. Rev per Pkg	$21,816	$18,355	$17,325	$15,990	$19,183
T. Exp per Pkg	$17,663	$16,559	$16,989	$16,862	$17,102
NPBT Per Pkg	$4,153	$1,796	$335	($872)	$2,081

Table K.3: Home care occupancy by level and by state and territory, 2014-15

Home care	NSW	Vic.	Qld	WA	SA	Tas.	ACT	NT	Australia
Level 1	60.2%	71.3%	53.7%	35.4%	54.9%	82.4%	57.5%	60.6%	62.1%
Level 2	88.4%	93.6%	77.5%	66.8%	83.2%	92.1%	81.1%	86.1%	85.2%
Level 3	66.8%	69.0%	62.6%	48.8%	76.4%	71.6%	60.2%	75.0%	66.7%
Level 4	92.6%	95.7%	94.1%	86.6%	91.5%	95.6%	88.7%	88.3%	92.1%
Total (Levels 1-4)	87.8%	92.7%	80.6%	73.8%	83.6%	91.8%	83.7%	86.2%	85.8%

Table K.4: Operational home care packages by provider type and by state and territory, at 30 June 2015

	Not-for-profit			For-profit	Government	Total
	Religious	Charitable	Community based			
NSW	6,551	8,635	4,732	2,292	1,081	23,291
VIC	6,271	4,030	2,859	1,102	3,457	17,719
QLD	5,826	3,476	2,650	1,380	334	13,666
WA	2,667	3,161	362	1,694	405	8,289
SA	1,535	2,800	665	269	453	5,722
TAS	539	490	488	225	55	1,797
ACT	189	593	293	171	0	1,246
NT	172	0	287	241	272	972
Australia (number)	**23,750**	**23,185**	**12,336**	**7,374**	**6,057**	**72,702**
% of total	**32.7%**	**31.9%**	**17.0%**	**10.1%**	**8.3%**	**100.0%**

Source. Unpublished departmental data

Table K.5: Operational home care packages by level and state and territory, 30 June 2015

State/territory	Level 1	Level 2	Level 3	Level 4	Total	% Total
NSW	755	17,342	1,268	3,926	23,291	32.0%
Vic	572	13,127	981	3,039	17,719	24.4%
Qld	423	9,631	715	2,897	13,666	18.8%
WA	214	4,797	367	2,911	8,289	11.4%
SA	190	4,309	320	903	5,722	7.9%
Tas	59	1,298	104	336	1,797	2.5%
ACT	28	691	40	487	1,246	1.7%
NT	10	761	20	181	972	1.3%
Australia	**2,251**	**51,956**	**3,815**	**14,680**	**72,702**	**100%**
% Total	**3.1%**	**71.5%**	**5.2%**	**20.2%**	**100%**	

Source. Unpublished departmental data

Table K.6: Operational home care packages by provider type and remoteness area at 30 June 2015

	Not-for-profit	For-profit	Government	Total
Major cities of Australia	42,132	6,239	2,176	50,547
Inner regional Australia	12,322	551	2,155	15,028
Outer regional Australia	4,263	469	1,023	5,755
Remote Australia	390	74	252	716
Very remote Australia	164	41	451	656
Australia total	**59,271**	**7,374**	**6,057**	**72,702**

Source. Unpublished departmental data

Appendix L: Home care subsidies and supplements

Home care package subsidies per day, 2013-14 – 2016-17

HCL	2013-14 subsidy ($)	2014-15 subsidy ($)	2015-16 subsidy ($)	2016-17 subsidy ($)
Level 1	20.55	21.43	21.71	22.04
Level 2	37.38	38.99	39.50	40.09
Level 3	82.20	85.73	86.84	88.14
Level 4	124.95	130.32	132.01	133.99
CACP	37.38	-	-	-
EACH	124.95	-	-	-
EACH-D	139.92	-	-	-

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

Home care supplement amounts per day, 2013-14 – 2016-17

Home care supplements	2013-14	2014-15	2015-16	2016-17
Dementia and Cognition and Veterans' supplement (10% of basic care subsidy)				
Level 1	$2.06	$2.14	$2.17	$2.20
Level 2	$3.74	$3.90	$3.95	$4.01
Level 3	$8.22	$8.57	$8.68	$8.81
Level 4	$12.50	$13.03	$13.20	$13.40
Other				
EACH-D Top Up supplement	$2.47	$2.58	$2.62	$2.66
Oxygen Supplement	$10.60	$10.84	$10.98	$11.12
Enteral Feeding supplement – Bolus	$16.78	$17.17	$17.39	$17.62
Enteral Feeding supplement – Non–bolus	$18.86	$19.29	$19.54	$19.79
Home Care Viability supplement				
ARIA Score 0 to 3.51 inclusive	$0.00	$0.00	$0.00	$0.00
ARIA Score 3.52 to 4.66 inclusive	$4.21	$5.15	$5.22	$5.30
ARIA Score 4.67 to 5.80 inclusive	$5.06	$6.19	$6.27	$6.36
ARIA Score 5.81 to 7.44 inclusive	$7.08	$8.66	$8.77	$8.90
ARIA Score 7.45 to 9.08 inclusive	$8.50	$10.39	$10.53	$10.69
ARIA Score 9.09 to 10.54 inclusive	$11.89	$14.54	$14.73	$14.95
ARIA Score 10.55 to 12.00 inclusive	$14.27	$17.45	$17.68	$17.95

Appendix M: Aged Care Roadmap – Domain No.7 'who pays?'

What's currently in place?

Consumers are primarily responsible for their accommodation and everyday living costs, as they have been throughout their lives. Generally, consumer contributions are capped by government. Government provides support for accommodation and living costs on behalf of low means residents. Providers are generally responsible for sourcing capital finance and rely heavily on lump sum deposits from consumers. Government guarantees the repayment of consumers' lump sums should an aged care home be unable to refund these. Contributions are not currently based on ability to contribute. Care costs are paid for by government (through subsidies/ block-funding), and consumers (based on assets, and/or income, and provider determined fees). The respective contributions of each party vary greatly depending on the care type and do not consistently take account of consumers' capacity to contribute to the costs of their care.

Why does it need to change?

A fiscally sustainable aged care system requires consumers to contribute to their care costs where they can afford to do so. The increasing population of older people who are living longer necessitates an aged care system that is sustainable into the future. The system will need to continue to rely on consumers' contributions, as an increasing source of funding. Fees and payments need to be transparent to consumers and matched to the services they receive, with a range of financing mechanisms to allow consumers to use their assets more effectively.

"Consumers will be responsible for meeting some of the costs of their care… where they have the financial means to do so… Financing and funding arrangements will enable efficient aged care services to thrive while being financially sustainable for Government and the public, private and not-for-profit providers who deliver programmes."

–Source -Aged Care Sector Statement of Principles

What needs to be done?

Short term (within 2 years)

- For both accommodation and everyday living costs (residential care only) and care and support:
  - Financial modelling of future cost to consumers, providers and government under various scenarios, including consumer fee scenarios.
  - Determine the market informed price that government is prepared to pay (through the 2016–17 Legislated Review or other process including Aged Care Funding Authority (ACFA)).
  - Identify and assess options for securing the development of affordable home equity release and other financial products to facilitate consumer contributions.
  - Monitoring of impacts of fees arrangements by ACFA.
- Change official aged care regulatory concepts and language away from 'subsidies to providers' to 'government contributions for consumers'.
- ACFA to report on funding, financing and pricing issues to inform the 2016–17 Legislated Review.

Accommodation

- Include rental income in means testing arrangements for residents who pay their accommodation costs by periodic payments to align with the arrangements that currently apply to those residents who pay via a lump sum.
- The 2016–17 Legislated Review will consider:
- The effectiveness of means testing arrangements for aged care services, including an assessment of an alignment of charges across residential care and home care services.
- The effectiveness of arrangements for regulating prices for aged care accommodation.

The Bond Guarantee Scheme

- ACFA project to examine alternative arrangements to the Bond Guarantee Scheme to inform the 2016–17 Legislated Review.
- The 2016–17 Legislated Review will consider the effectiveness of arrangements for protecting refundable deposits and accommodation bonds.

Care and support

- ACFA project to consider cost neutral mechanisms to ensure access to care for supported residents.
- The 2016–17 Legislated Review will consider the effectiveness of means testing arrangements for aged care services, including an assessment of an alignment of charges across residential care and home care services.

Medium term (3–5 years)

For both accommodation and everyday living costs (residential care only) and care and support:

- New financial products available to support consumer choice (e.g. home equity release).
- Measures are in place to enable continued access to care and accommodation by vulnerable consumers (low means, special needs, people with dementia, as under the Aged Care Act 1997).

The Bond Guarantee Scheme

- Reform or replace the Bond Guarantee Scheme in response to the findings of the 2016–17 Legislated Review.

Care and support

- Integrate fee arrangements for home care and Commonwealth home support as part of the intended 2018 consolidation of the Home Care Packages Programme and the Commonwealth Home Support Programme.

Long term (5–7 years)

- Means test all income and all assets and treat them equally.
- Re-calibrate consumer contributions in line with capacity to pay.
- Ensure measures are in place to enable continued access to care and accommodation by vulnerable consumers.

Care and support

- Align consumer subsidies for care and support in residential with those for home care for people with the same assessed care needs.

Destination

SUSTAINABLE AGED CARE SECTOR FINANCING ARRANGEMENTS WHERE THE MARKET DETERMINES PRICE, THOSE THAT CAN CONTRIBUTE TO THEIR CARE DO, AND GOVERNMENT ACTS AS THE 'SAFETY NET' AND CONTRIBUTES WHEN THERE IS INSUFFICIENT MARKET RESPONSE.

Accommodation and everyday living costs (residential care only)

Consumers are primarily responsible for their accommodation and everyday living costs, as they have been throughout their lives.

Providers will set and publish their price for accommodation and everyday living costs. These prices will take account of the costs of maintaining, renewing and expanding their capital stock.

Government will set and publish a reasonable market informed price for accommodation and everyday living costs for low means consumers accessing residential care. The price may vary, for example, based on the geographical location of the consumer.

Consumers will be able to compare and negotiate the price that they pay for accommodation and living costs with their preferred provider.

Government will not regulate provider prices or what consumers choose to pay for accommodation and everyday living.

For consumers with limited means, government will contribute to the cost of the consumer's accommodation and everyday living based on the reasonable market informed price and the consumer's ability to pay.

The market will provide an expanded range of financial products to provide flexible ways for people to pay for their aged care.

Where consumers have negotiated to pay a lump sum (bond) with a provider, there will continue to be protections in place for consumers. This will include a combination of prudential regulation and a means for refunding lump sums in the event that a provider defaults on repayment. The means for doing this will be determined through the 2016–17 Legislated Review.

The nature and degree of regulation of accommodation payments will be determined through the 2016–17 Legislated Review.

In addition to consumer contributions, providers' capital needs will continue to be funded through debt and equity markets.

Where there is a service need and insufficient market response, additional government assistance may contribute to capital costs.

Care and support

Consumers are best placed to determine how their needs will be met.

Providers will set and publish their price for care and support.

Government will set and publish reasonable market informed prices for care and support based on levels of need.

Government will contribute to the cost of a consumer's care and support based on the reasonable market informed price and the consumer's ability to pay.

Consumers will decide how much they personally contribute to their care and support costs.

Government will not regulate provider prices or what consumers choose to pay for care and support.

Consumers will be able to compare prices and negotiate the price that they pay for care and support with their preferred provider/s.

An expanded range of financial products will be available to provide flexible ways for people to pay for their aged care and use their means to meet their costs.

Consumers will be able to use their government contribution with any registered provider/s to purchase care and support of their choice, but will not be able to spend any government contribution on excluded items.

Consumers can also purchase care and services from any provider/s using their personal contributions.

Where there is insufficient market response, or to support services targeting certain 'special needs' groups, additional government assistance will continue to be provided.

For both accommodation and everyday living costs (residential care only) and care and support:

New payment arrangements that will enable consumers to direct government and personal contributions to their provider/s of choice.

Appendix N: Segment analysis

Residential care

- The financial information about residential aged care providers is obtained from segment information in the GPFRs required to be prepared by providers of residential aged care under the *Aged Care Act 1997*.
- The segment information contains financial information for only those services that were operational as at 30 June 2015 and therefore, averages are not fully representative of the entire residential aged care sector.
- The comprehensiveness of the financial information contained in GPFRs varies from provider to provider. The accounting standards are also subject to interpretation and it is possible that interpretations may differ between provider and between auditors. In addition, the Department's interpretation of the accounting data provided in the GPFRs has not been verified with the aged care providers. Analysis of financial data is affected by incomplete and aggregated data provided in the segment notes of the GPFRs.
- The data quality at the segment level is subject to each provider's allocation rules which are not fully disclosed in the GPFRs of the providers and therefore may not necessarily reflect the true income, expenses, assets and liabilities of the residential aged care segment.
- Care needs to be taken when interpreting the averages as detailed segment information is not mandatory and may be inconsistent in quality and level of details. As a result it may not fully represent sector averages.
- The inconsistent treatment of certain items in balance sheet (like lump sum accommodation deposits – 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.
- Since many of the providers have given "finance expenses" (in their income and expense statement) which may contain other expense items in addition to interest expense, the average EBITDA estimate may be overstated.
- The total amountfor lump sum accomodation deposits included in the analysis is extracted from the Department's records and not from GPFRs. The accommodation deposit amounts provided in the GPFRs have not been verified from the residential aged care providers.

Home care

Notes to the financial data presentations

- The financial information about Home Care Level packages is collected through the home care financial report that is prepared by providers of home care services under the requirement of the Accountability Principles 2014.
- About 89 per cent of the home care provided data in useable form to derive the necessary analysis and measurements. The data from the rest of the services is not in a useable form.
- The averages and financial ratios of the home care services include only those services that were operational as at 30 June 2015 and also provided their home care financial reports. Therefore the averages and other financial metrics/ratios may not be fully representative of the entire home care sector.
- The home care financial report data contain aggregate data of all four home care levels. Hence the analysis and measurements are also based on the aggregates of all four levels of home care packages.
- In terms of the Accountability Principles 2014, the home care financial report is not an audited report and do not contain any auditor's opinion on the home care financial report data/ information.

- The income amounts disclosed in most of the home care financial reports may include the unspent amount of subsidies, supplements and client fees that is reserved for Consumer Directed Care (CDC) clients, which may have overestimated the results.
- Discrepancies occur in the home care financial report statements creating an impact on the overall average results of the sector. For example, there are instances where the item wise details of the expenses are aggregated to other expenses or total expenses. This results in inconsistency and limitations in deriving various metrics and measurements of the analysis at micro level.
- The Department's interpretation of the accounting data information provided in the home care financial reports has not been verified by the home care providers.
- Some of the home care financial reports contain negative income items and positive expense items, reasons of which are not stated. In the absence of data cleaning process, such instances are not verifiable and may have under/overestimated the averages of total income and total expenses of the sector.
- The Net Profit Before Tax (NPBT) and Earnings Before Interest Taxes and Depreciation & Amortisation (EBITDA) of the sector may not be fully representative as the total income earned by the service and total expenses paid by a service are not disclosed in the home care financial report to its entirety.
- It appears that in home care financial report, some services have moved their carry-over previous year/future year income or expense amounts to the current year period due to which the average results for current period may over/under represent the sector results.
- The comprehensiveness of the financial information contained in the home care financial reports varies from provider to provider. The accounting standards are subject to interpretation and it is possible that interpretations may differ between provider and their auditors. Analysis of financial data is affected by incomplete and aggregated data provided in the home care financial reports of these providers/services.
- The data quality is subject to each provider's allocation rules which are not fully disclosed in the home care financial reports and therefore may not necessary reflect the true income and expense of the home care service facility.
- Due to inconsistent allocation rules across the sector, there are instances where discretionary apportionments of income and expenses have resulted in inconsistent analysis at micro level.

Appendix O: Notes for Figure 7.2 and Figure 8.1

- The flow chart is composed from General Purpose Financial Reports (GPFRs) 2014-15, 2014-15 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 2014-15.
- The information in the flow chart pertaining to care recipient is based on only those providers who have given their GPFRs and therefore, it may not be fully interpretive of the entire aged care industry.
- The information about residential care providers is obtained from GPFRs prepared by providers of residential aged care under the Aged Care Act 1997.
- The comprehensiveness of the financial information contained in GPFRs varies from provider to provider. In addition, the accounting standards are 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 information pertaining to Commonwealth Subsidies is extracted from payment system data that is based on the life cycle of the residents and updated periodically. Therefore it can contain differences due to reconciliation between the amounts of entitlement period and claim date period.
- The care recipient information is extracted from the SACH survey data which is a voluntary participation by the aged care providers and therefore contains qualification towards its fairness.
- The other funding source/income source item is used as a balancing item to reconcile with the total revenue of the industry as per given GPFRs for 2014-15.
- Due to information from multiple sources, the number of providers differs in calculation of care recipient funding and government funding as the amounts of care recipient funding are based on those providers who have given their GPFRs.
- The total Refundable Accommodation Deposit amount is extracted from the Department's records and not from GPFRs. The Bond amounts provided in the GPFRs has not been verified from the residential aged care providers.
- The donations, loans and investment amount received by the residential aged care providers is not fully available to the Department as these amounts are given voluntarily by the 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 residential aged care providers.

Appendix P: References

Aged Care Financing Authority (2016), 'Report on Issues Affecting the Financial Performance of Rural and Remote Providers, both Residential and Home Care Providers, available at https://agedcare.health.gov.au/aged-care-reform/aged-care-financing-authority

Australian Accounting Standards Board, Accounting Standard AASB 101 Presentation of Financial Statements, Commonwealth of Australia, Melbourne, available at: AASB

Australian Bureau of Statistics (ABS), Australian Demographic Statistics, Jun 2015 Cat No. 3101.0 Commonwealth of Australia, available at the ABS website

Australian Bureau of Statistics (ABS), Building Activity, Cat No. 8762.0 Commonwealth of Australia, Canberra, available at the weblink to the ABS website: www.abs.gov.au

Australian Bureau of Statistics (ABS), Building Approvals, Cat No. 8731.0 Commonwealth of Australia, Canberra, available at: the weblink to the ABS website: www.abs.gov.au

Australian Institute of Health and Welfare (2012) Dementia in Australia. Cat no Age 70 Canberra: AIHW

Department of Health and Ageing 2013, The National Aged Care Workforce Census and Survey – The Aged Care Workforce, 2012 Final Report, Commonwealth of Australia, Canberra

Department of Health (Australia), 2015, 2014-15 Report on the Operation of the Aged Care Act 1997 (ROACA), Commonwealth of Australia Canberra

Department of the Treasury (Australia), 2015 Intergenerational Report: Australia in 2055. Department of the Treasury (Australia)

(Department of Social Services) DSS 2014, 2013-14 Report on the Operation of the Aged Care Act 1997 (ROACA), Commonwealth of Australia, Canberra

Rawlinsons 2012, Australian Construction Handbook, various editions, Perth

Steering Committee for the Review of Government Service Provision, 2016, Report on Government Services 2016, Productivity Commission, Canberra

StewartBrown, Aged Care Financial Performance Surveys: Home Care Report – various editions

StewartBrown 2015, Aged Care Financial Performance Survey: Residential Aged Care Report – various editions

The Intergenerational Report 2015– Australia to 2050, Commonwealth of Australia, Canberra, available at: http://archive.treasury.gov.au/igr/igr2010/default.asp