Australian Government

Aged Care Financing Authority

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

July 2017

Contents

Glossary

Term	Definition
Accommodation supplement	The accommodation supplement is payable on behalf of residents receiving permanent residential aged care who do not have the capacity to contribute to all or part of the cost of their accommodation.
Aged and Community Services Australia (ACSA)	A national peak body for not-for-profit providers of aged and community care in Australia.
Aged Care Act 1997 (the Act)	The primary legislation governing the provision of aged care services.
Aged Care Approvals Round (ACAR)	A competitive application process that enables prospective and existing approved providers of aged care to apply for a range of new Australian Government funded aged care places and financial assistance in the form of a capital grant.
Aged Care Assessment Team (ACAT)	ACATs are teams of medical and allied health professionals who assess the physical, psychological, medical, restorative, cultural and social needs of frail older people and help them and their carers to access appropriate levels of support.
Aged Care 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)	The classification instrument used to pay subsidies to residential aged care services.
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.
Approved provider	An approved provider of aged care is an organisation that has been approved by the Secretary of the Department of Health to provide residential care, home care or flexible care under the *Aged Care Act 1997*.
Assistance with Care and Housing for the Aged (ACHA)	ACHA is a program which provides a range of supports for eligible clients, who are at risk of becoming homeless or are homeless, to remain in the community through accessing appropriate, sustainable and affordable housing and linking them to community care. From 1 July 2015 the ACHA program was incorporated into the new Commonwealth Home Support Programme.

Term	Definition
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)	This program provides entry-level support services designed to help frail older people stay in their homes. It was introduced on 1 July 2015 and consolidates four former programs: Commonwealth Home and Community Care (HACC); the National Respite for Carers Program (NRCP); Day Therapy Centres (DTC); and Assistance with Care and Housing for the Aged (ACHA).
Community Aged Care Package (CACP)	Care consisting of a package of services provided to a person who lives in their own home. This type of care was replaced on 1 August 2013 when the new home care package levels 1-4 were introduced. A CACP package is generally consistent with the level of care provided in a level 2 home care package.
Conditional Adjustment Payment (CAP)	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 of Health and taking part in a periodic workforce census. The CAP was rolled into the basic care subsidy rates as of 1 July 2014.
Consumer Directed Care (CDC)	Consumer Directed Care gives consumers greater choice over their own lives by allowing them to decide what types of care and services they access and how those services are delivered.
Consumer Price Index (CPI)	CPI measures the changes in the price of a fixed basket of goods and services, acquired by household consumers who are resident in the eight state and territory capital cities.
Council on the Ageing (COTA)	COTA Australia is the peak national organisation representing the rights, needs and interests of older Australians.

Term	Definition
Culturally and Linguistically Diverse (CALD)	Consumers who have particular cultural or linguistic affiliations due to their: • place of birth or ethnic origin • main language other than English spoken at home • proficiency in spoken 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)	A rental-type payment which applies to people who entered care after 1 July 2014 and who asked to contribute towards their accommodation costs.
Day Therapy Centres Program (DTC)	The DTC program provides a wide range of therapy and services to eligible frail, aged people living in the community and to residents in Commonwealth funded residential aged care facilities. It assists them to regain or maintain physical and cognitive abilities which support them to either maintain or recover a level of independence. As of 1 July 2015 the DTC program became part of the new Commonwealth Home Support Programme.
Department of Health (The Department)	The department that administers the Act and regulates the aged care industry on behalf of the Commonwealth.
Earnings Before Interest, Taxes, Depreciation and Amortisation (EBITDA)	Net profit after tax with interest, taxes, depreciation, and amortisation added back to it, and can be used to analyse and compare profitability between companies and industries because it eliminates the effects of financing and accounting decisions.
EBITDA margin	EBITDA margin shows the average net profit after tax (with interested, taxes, depreciation and amortisation added back into it) generated for each $1 of revenue earned. It's calculated as EBITDA/total revenue.
Extended Aged Care at Home (EACH)	A package of home care services 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)	A package of home care services 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 were non-audited financial statements submitted by approved providers of home care services up until 2014-15 when they were replaced by the new Home Care Packages financial reports.

Term	Definition
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 in permanent residential care was removed from 1 July 2014.
Higher accommodation supplement	A higher maximum accommodation supplement was introduced on 1 July 2014 for aged care homes that have been built or significantly refurbished since 20 April 2012.
Home and Community Care (HACC)	A program that provides basic support and maintenance to people living at home to help avoid premature or inappropriate admission to long-term residential care (Victoria and WA only). Note: the former Commonwealth HACC program was consolidated into the new CHSP from 1 July 2015.
Home care	Home based care provided through a home care package to help older Australians to remain in their own homes. Home care is provided through the Home Care Packages Programme.
Home care package	A package of services tailored to meet the care needs of a person living at home. The package is coordinated by an approved home care provider, with funding provided by the Australian Government (with some contributions from the consumer). Home care packages range from level 1 to 4 depending on the care needs of the consumer. This program commenced on 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.
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.

Term	Definition
Increasing choice in home care	From 27 February 2017, funding for a home care package followed the consumer, replacing the former system where home care places were allocated to individual approved providers to deliver services in a particular location or region.
Interest Coverage	Shows the number of times that EBITDA will cover interest expense. Indicates an organisation's ability to service the interest on its debt. It is calculated as EBITDA/Interest Expense.
Leading Age Services Australia (LASA)	LASA is a peak body for aged service providers.
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.
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 Health website and is updated every three months.
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 in permanent residential care from 1 July 2014.
My Aged Care	The main entry point to the aged care system in Australia. My Aged Care aims to make it easier for older people, their families, and carers to access information on ageing and aged care, have their needs assessed and be supported to find and access services.
National Disability Insurance Scheme (NDIS)	The NDIS offers support for Australians who are under 65 years of age with a significant and permanent disability, their families and their carers.
National Respite for Carers Program (NRCP)	The NRCP aims to support caring relationships between carers and their dependent family members or friends by facilitating access to information, respite care and other support appropriate to their individual needs and circumstances and those of the people for whom they care. The NRCP was integrated into the CHSP from 1 July 2015.
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.

Term	Definition
Pay as you go (PAYG)	Pay as you go (PAYG) instalments is a system for making regular payments towards your expected annual income tax liability.
Per consumer per annum (pcpa)	An annual average financial figure relating to home care consumers.
Per consumer per day (pcpd)	A daily average financial figure relating to home care consumers.
Per resident per annum (prpa)	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.
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)	A lump sum payment applicable to people who entered care after 1 July 2014 and who are asked to contribute towards their accommodation costs.
Regional	Geographic reference to areas classified by the Australian Bureau of Statistics as inner regional, outer regional, remote and very remote.
Regional Assessment Services	RAS provides in home, face to face assessments of new and existing clients/carers to assess their eligibility to access CHSP services.
Remoteness location	Indicates where a provider, service or consumer is located based on whether they are metropolitan or regional areas. A provider is classified as metropolitan if more than 70 per cent of its services are located in metropolitan areas and similarly classified as regional if 70 per cent of its services are located in regional areas.
Report on the Operations of the *Aged Care Act 1997* (ROACA)	A legal requirement under the Act, the ROACA is tabled in Parliament in November each year and presents an annual snapshot of facts and figures on Commonwealth funded aged care services in Australia.
Resident Classification Scale (RCS)	The basic tool for residential aged care funding prior to 20 March 2008, when it was replaced by the ACFI. 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 care options and accommodation 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 which commenced in February 2017, is a flexible care program to provide restorative care to older people to improve their capacity to stay independent and living in their own homes.

Term	Definition
Retained earnings	Refers to the percentage of net earnings not paid out as dividends, but retained by the company to be reinvested in its core business, or to pay debt. This is recorded under shareholders' equity on the balance sheet.
Retention amounts	An amount that an approved provider is allowed to deduct per month from an accommodation bond for up to five years. The maximum retention amount is set by the Australian Government. Retentions are not permitted for new residents entering residential aged care on or after 1 July 2014.
Return on Assets	Indicates the productivity of assets employed in the organisation. It is calculated as EBITDA/total assets.
Return on Equity/ Return on Net Worth	Indicates the productivity of equity/net worth employed in the organisation. It is calculated as EBITDA/net worth.
Scale (providers)	Refers to the number of services operated by a provider.
Size (providers)	Refers to the number of beds operated by a specific residential aged care service or the number of home care packages operated by a home care 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 Commonwealth 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 program was integrated into the STRC 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) 2017 Report on the Funding and Financing of the Aged Care sector. This is ACFA's fifth annual report. ACFA commenced in July 2012, following the announcement of the Australian Government's significant reforms of aged care. ACFA's annual report on the aged care sector examines the developments, issues and challenges affecting the industry, and provides a range of statistics and analysis of the provision of aged care in Australia. This report includes analysis of financial data collected from the 2015-16 year. In addition, we have accessed the comprehensive benchmarking and analysis conducted by StewartBrown. The report also examines issues and trends emerging since 1 July 2016 and looks forward to challenges into the future.

Aged care is one of the fastest growing sectors in Australia. This is due primarily to the ageing population and longer life expectancies of Australians.

Financial sustainability is one of the key aims of the ongoing reform of the aged care sector. Through these annual reports, as well as other projects, ACFA is able to inform and advise the Government, the sector and other key stakeholders on funding and financing developments and issues in the Aged Care sector. Most significantly in 2017, ACFA undertook a comprehensive review of the impact of the reforms to date and provided its *Report to Inform the 2016-17 Review of Amendments to the Aged Care Act 1997*, which is being conducted by David Tune. ACFA's report is available at https://agedcare.health.gov.au/aged-care-reform/aged-care-financing-authority

I should like to acknowledge the contribution of the many providers, peak bodies, bankers and other institutions who ACFA has consulted during the year. In addition, I would like to recognise and thank StewartBrown for their considerable contribution during the year.

During 2015-16, ACFA held meetings and forums with representatives from the investment and financing sectors, providers and consumers. These wide spread consultations are 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.

With the possibility of future reforms emanating from the legislative review, ACFA looks forward to its continuing role advising Government and working with and informing other stakeholders on the funding and financing of the Aged Care sector to ensure its long-term sustainability and viability.

Lynda O'Grady
Chairman
Aged Care Financing Authority

Executive Summary

Aged care in Australia

The aged care sector in Australia provides services to 1.3 million Australians and generates annual revenues totalling around $21.5 billion. The sector makes a significant contribution to the Australian economy, representing almost 1 per cent of Gross Domestic Product (GDP).

Total Australian Government expenditure on aged care in 2015-16 was $16.2 billion, up from $15.2 billion in 2014-15. Funding for aged care included:

- $2.2 billion for home support
- $1.5 billion for home care
- $11.4 billion for residential care

Australian Government expenditure is expected to be $17.5 billion in 2016-17, and increase to $20.8 billion by 2019-20.

Consumer expenditure on aged care was $4.7 billion in 2015-16 (excluding accommodation deposits).

Aged care workforce

The 2016 National Aged Care Workforce Census and Survey reported that:

- there are over 366,000 paid workers in aged care with a further 68,000 volunteers;
- more than half of all workers are in residential care;
- the personal care workforce in both residential care and in home support and home care is more qualified when compared with the 2012 census;
- the aged care workforce is relatively stable with 25 per cent of workers having been in the sector for over 14 years;
- aged care workers have high levels of job satisfaction, but have concerns regarding remuneration, time available to provide care and a perception that aged care is not valued highly by the general community; and
- reported times to fill vacancies are not indicative of a tight labour market, though some providers, particularly in remote areas, have difficulties in recruiting appropriately qualified staff.

Aged care reforms

ACFA concludes that the funding and financial reforms have strengthened the viability and sustainability of the sector, while noting that some of the consumer focussed reforms are still in a critical phase with challenges remaining for consumers and providers. ACFA's observations include:

- the pool of lump sum accommodation deposits held by providers continues to grow ($21.9 billion at 30 June 2016 up from $15.6 billion when the reforms began on 1 July 2014);
- refundable accommodation deposits continue to be the preferred method of accommodation payment;
- new means testing arrangements in residential care and income testing in home care have not affected overall access to care; and
- the new means testing arrangements are making only a marginal contribution to the long-term sustainability of aged care services for taxpayers and Government.

Significant reforms continued in home care with the implementation on 27 February 2017 of packages following consumers. Packages are now allocated directly to consumers who are able to select the provider of their choice. ACFA will provide commentary on the effect of this change on consumers and providers in future annual reports.

ACFA notes that with the changes of February 2017 of home care packages being assigned directly to consumers, there has been strong interest from new providers seeking to deliver home care. The number of applications for approved provider status approved by the Department of Health grew from 75 in 2015-16 to over 200 in 2017.

In May 2017, ACFA provided its *Report to Inform the 2016-17 Review of Amendments*[1] to the *Aged Care Act 1997*. The Review, along with the Aged Care Roadmap, is expected to inform the next stages of aged care reforms.

1 ACFA's Report to Inform the 2016-17 Review of Amendments to the Aged Care Act 1997 is available at https://agedcare.health.gov.au/aged-care-reform/aged-care-financing-authority.

Access to aged care

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

- The provision ratios achieved at 30 June 2016 are 79.9 and 31.9 for residential care and home care respectively.
- To achieve the target ratios by 2021-22, an additional 62,000 home care packages and 49,000 residential places will need to be made operational.

Usage of aged care increases significantly with age. Thirty-nine per cent of people aged 70 and over access some form of subsidised aged care and this rises to 81 per cent for people aged 85 and over.

In 2015-16:

- 234,931 older Australians received services through permanent residential care and 56,852 received residential respite care;
- 88,875 older Australians received services through a home care package; and
- over 640,000 consumers received services through the Commonwealth Home Support Programme (CHSP) and 285,432 received services through Victorian and Western Australian Home and Community Care (HACC).

Admissions to both home care and residential care have been stable since the reforms of 1 July 2014. ACFA's observations regarding admissions and occupancy in 2015-16 are:

- the proportion of admissions to residential respite care continued to increase compared with permanent care;
- average occupancy (92.4 per cent) has continued to be relatively stable in residential care in recent years;
- average occupancy (83.2 per cent) in home care was lower compared with 2014-15 due to reduced demand for level 2 packages; and
- on-going demographic changes will see a continuing increase in demand, as the proportion of people aged 85 and over grows to nearly 5 per cent of the population by 2055, compared with 2 per cent today.

The 2016 Aged Care Approvals Round (ACAR) was the first in which home care places were not allocated to providers as packages are now assigned directly to consumers. The 2016 ACAR allocated 9,911 new residential care places.

During 2015-16, across all residential aged care homes, the average proportion of supported residents (excluding residents receiving extra services) was 46.8 per cent compared with 47.0 per cent in 2014-15 and 44.4 per cent in 2013-14.

Home support

In 2015-16, the Australian Government provided total home support funding of $2.2 billion. There were 1,160 CHSP providers and 526 HACC providers in Victoria and Western Australia.

The Victorian HACC program was transitioned into the CHSP on 1 July 2016 and the Western Australian HACC program will join the CHSP on 1 July 2018.

Home care – operational performance

Home care providers received an estimated $1.8 billion in revenue in 2015-16, paid around $1.6 billion in expenses and generated $183 million in profit. Total Commonwealth funding was $1.5 billion.

Consumers of home care contributed around $160 million toward the cost of their care through basic daily fees and incomes tested fees.

The financial performance of home care providers continued to be strong in 2015-16 despite a slight decrease in reported profits compared with 2014-15.

- 75 per cent of home care providers generated a net profit, compared with 72 per cent in 2014-15.
- The average EBITDA per package per annum was $2,086, compared with $2,235 in 2014-15, a decrease of 6.7 per cent.

Residential aged care – characteristics of the sector

In 2015-16, there were 949 residential care providers who operated 195,825 places. The residential aged care sector is continuing to consolidate with the number of residential care places increasing while the number of providers continues to decrease.

Residential aged care – operational performance

Residential care providers generated revenue of $17.4 billion in 2015-16, equating to $263.92 per resident per day. Total expenses were $16.3 billion equating to $247.58 per resident per day.

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

ACFA considers that the financial performance of residential care providers was generally strong, building on the strong performance in 2014-15:

- 69 per cent of residential providers achieved a net profit compared with 68 per cent in 2014-15;
- Average EBITDA per resident per annum increased from $10,222 to $11,134, an increase of 8.9 per cent; and
- Total net profit for the sector was $1.1 billion, including $1.3 billion of 'other' income which suggests operating profit is dependent on 'other' income, as in previous years.

ACFA notes however that the changes to the Aged Care Funding Instrument (ACFI) to date are being reflected in marginally reduced financial results as at March 2017, and that results may decline further as the full effect of the ACFI changes and indexation pauses take effect. However, the impact of these changes will not be apparent until the 2018 annual report and beyond.

ACFA also notes that without the government providers (which represent 10 per cent of all residential care providers) included in the analysis, the average EBITDA of the remaining sector would be $524 or 5 per cent higher than the $11,134 reported.

Residential aged care – capital investment

At 30 June 2016, compared with 30 June 2015, the industry as a whole had:

- total assets of $40.7 billion, up from $36.6 billion;
- total liabilities of $29.8 billion, up from $25.7 billion;
- net assets of $10.9 billion, an increase of $42 million; and
- Refundable Accommodation Deposits (including bonds) of $21.9 billion, up from $18.2 billion.

In 2015-16:

- average return on equity was 17.7 per cent, up from 16 per cent in 2014-15; and
- average return on assets was 4.9 per cent, same as 2014-15.

Accommodation deposits increased by $3.7 billion during 2015-16, which combined with a $406 million increase in other liabilities, financed increases of:

- $441 million in cash and other current assets;
- $781 million in fixed assets; and
- $2.9 billion in other assets, including an increase of $304 million in related party loans receivable and $255 million in intangible assets. ACFA notes that this means that 79 per cent of the increase in accommodation deposits during the year has been invested in this asset class.

Overall there was an increase in the sector's net worth of $42 million.

As noted in last year's annual report, investment in residential care has been improving since the 1 July 2014 reforms. The total spend on building activity in 2015-16 was $4.5 billion, an increase of 18 per cent on 2014-15.

It is estimated that the residential care sector will need to build an additional 83,500 places 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 33,667 new places that came online over the previous decade. The estimated investment requirement of the sector over the next decade is in the order of $35 billion.

The Aged Care Financing Authority and the 2017 Annual Sector Report

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This 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 $21.5 billion. The sector makes a significant contribution to the Australian economy, representing almost 1 per cent of Gross Domestic Product (GDP).

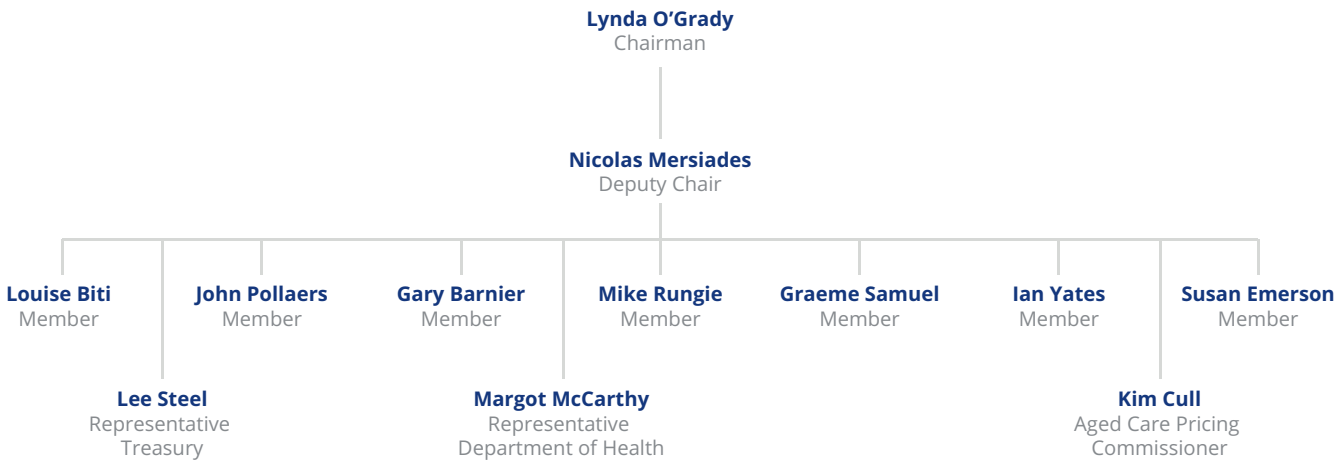
The sector remains heavily reliant on taxpayer funding, receiving $16.2 billion in Commonwealth funding in 2015-16, an increase of 6.6 per cent from the previous year. More than two-thirds of total funding ($11.4 billion) was for residential aged care. Given the level of taxpayer funding, objective and 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 funding and financing issues in the aged care sector. ACFA considers issues in the context of maintaining a viable and sustainable aged care industry and accessible services that balance the needs of consumers, providers, the workforce, taxpayers, investors and financiers.

ACFA is led by an independent Chairman (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 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

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

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

Over time, each annual report builds upon the last, producing a substantial body of in-time as well as trend data on the funding and financing of the aged care sector. This is the fifth annual report published.[2]

1.3.1 Methodology

The 2017 annual report mainly presents and analyses 2015-16 data, although this is supplemented by more recent data sources in some cases when available.

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

- From Commonwealth Home Support Programme and Home and Community Care (Vic and WA) providers:
  - CHSP Data Exchange; and
  - Home and Community Care Minimum Data Set (Vic and WA).
- From home care providers:
  - Home Care Packages Programme Financial Reports.
- 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).
- Other general data:
  - The 2015-16 Report on the Operation of the *Aged Care Act 1997* (ROACA);
  - The 2016 National Aged Care Workforce Census and Survey; and
  - Relevant supplementary information from key industry analysts, including StewartBrown.

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

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

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

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

It should be noted that the financial analysis and commentary in this report does not include providers operating Multi-Purpose services.

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 profit.

Considerations and limitations

As reforms in aged care continue, some forms of service delivery, and therefore data collection, are changing. For this reason, analysis in the 2017 annual report is not always directly comparable with analysis contained in previous reports.

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

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

1.3.2 Navigating the 2017 annual report

The 2017 annual report is structured as follows:

- **Chapter 2 Aged care in Australia.** This chapter provides an overview of the aged care sector in Australia.
- **Chapter 3 Aged care workforce.** This chapter provides an overview of the 2016 National Aged Care Workforce Census and Survey.
- **Chapter 4 Aged care reforms.** This chapter discusses and analyses the impact of previous and on-going reforms in aged care.
- **Chapter 5 Access to aged care.** This chapter discusses the supply of and access to aged care in Australia.
- **Chapter 6 Home support.** This chapter provides an overview of home support through the Commonwealth Home Support Programme and the Home and Community Care programs in Victoria and Western Australia.
- **Chapter 7 Home care: operational performance.** This chapter discusses the provision of home care through the Home Care Packages Programme and a summary of financial performance of providers in 2015-16.
- **Chapter 8 Residential aged care: characteristics of the sector.** This chapter discusses residential aged care, focusing on the scale, ownership and locational characteristics of residential aged care providers and their services.
- **Chapter 9 Residential aged care: operational performance.** This chapter provides information on the financial performance of residential aged care providers in 2015-16.
- **Chapter 10 Residential aged care: capital investment.** This chapter provides discussion pertaining to provider balance sheets and capital investments.

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 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, or the number of packages operated by a service in home care.

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

2

Aged care in Australia

2. Aged care in Australia

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

This chapter discusses:

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

This chapter reports that:

- Australian Government total expenditure on aged care was $16.2 billion in 2015-16, up from $15.2 billion in 2014-15;
- expenditure is expected to be $17.5 billion in 2016-17, and increase to $20.8 billion by 2019-20;
- consumer expenditure on aged care was $4.7 billion in 2015-16 (excluding accommodation lump sum deposits);
- services were provided to 1.3 million people in 2015-16;
- provided by:
  - over 1,160 Commonwealth Home Support Programme providers (plus 526 Home and Community Care providers in Vic and WA)
  - 496 home care providers
  - 949 residential care providers; and
- during 2015-16, 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 7 per cent accessed residential aged care.

2.1 Overview

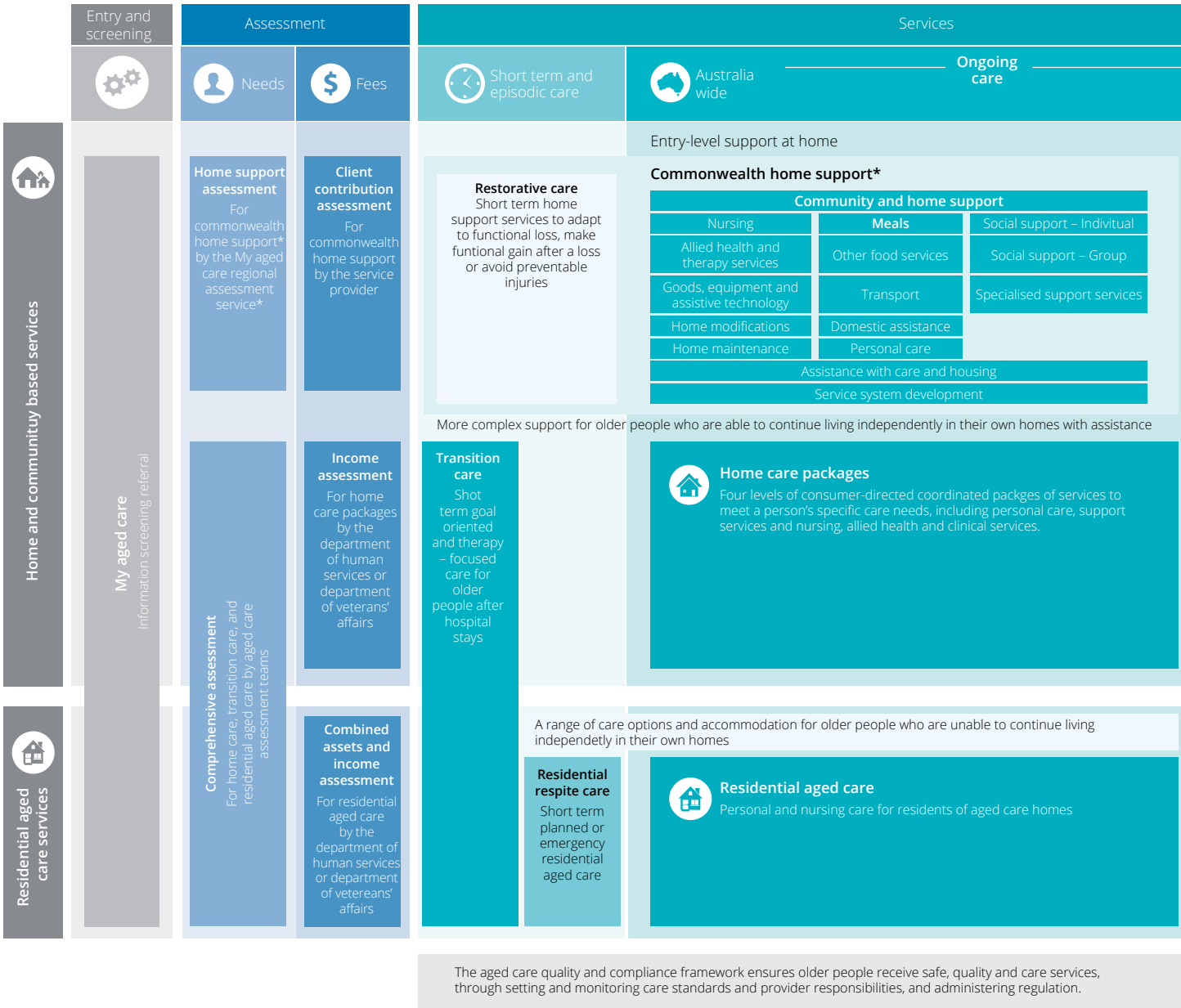
The aged care system is undergoing reform so that it more efficiently supports older people to live in their homes and communities for as long as possible, and enables people to make informed decisions about their care, while remaining sustainable for taxpayers and service providers. Older Australians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

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

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

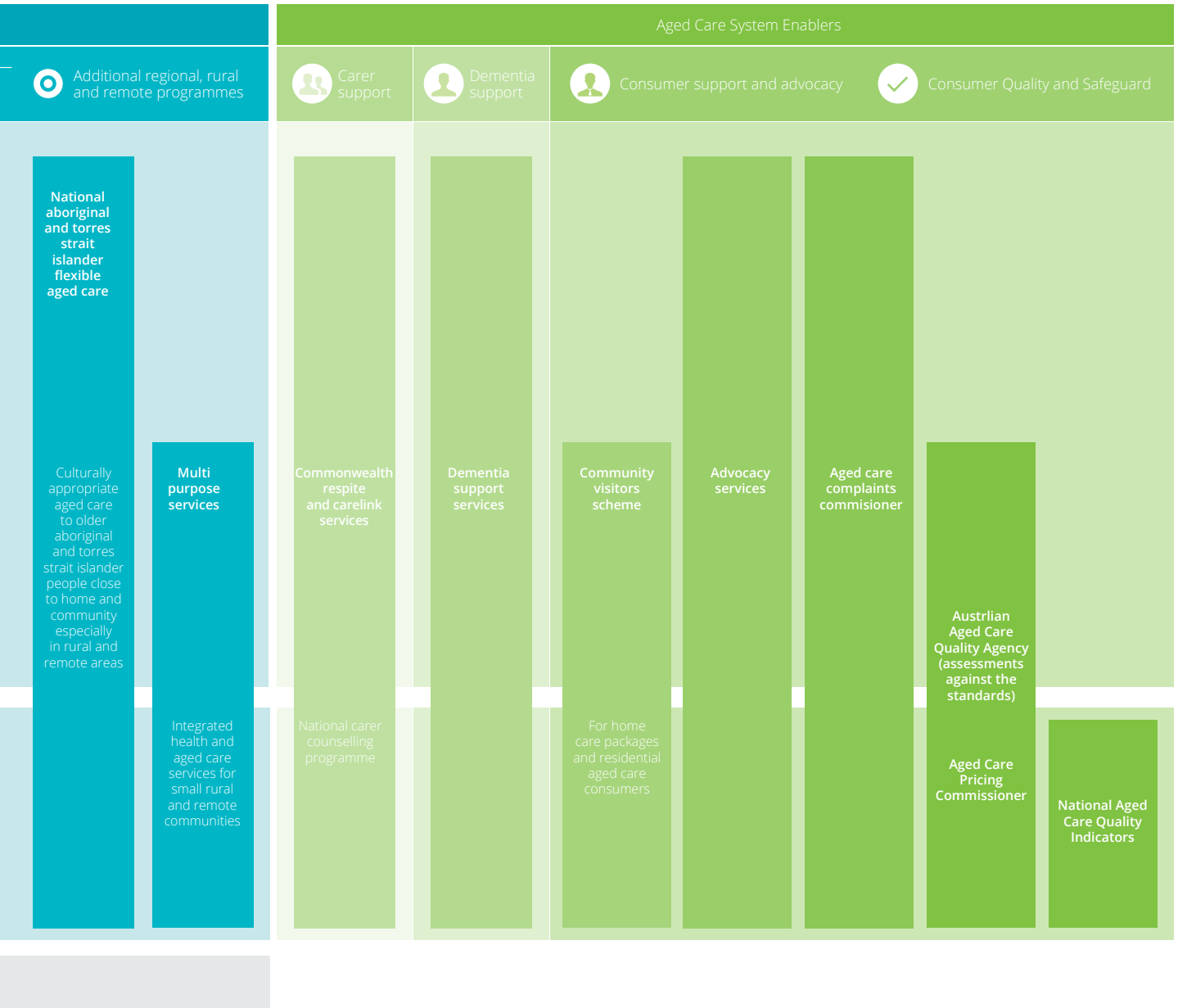
Means testing conducted by the Department of Human Services determines whether an individual is required to make a contribution towards the cost of their care and support, and the amount of the contribution.

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

The Department of Veterans' Affairs also provides Australian Government subsidised aged care services.


Aged Care System Enablers
Additional regional, rural and remote programmes
Carer support
Dementia support
Consumer support and advocacy
Consumer Quality and Safeguard
National aboriginal and torres strait islander flexible aged care
Culturally appropriate aged care to older aboriginal and torres strait islander people close to home and community especially in rural and remote areas
Multi purpose services
Integrated health and aged care services for small rural and remote communities
Commonwealth respite and carelink services
National carer counselling programme
Dementia support services
Community visitors scheme
For home care packages and residential aged care consumers
Advocacy services
Aged care complaints commisioner
Austrlian Aged Care Quality Agency (assessments against the standards)
Aged Care Pricing Commissioner
National Aged Care Quality Indicators

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. This is discussed in more detail in Chapter 5.

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

2.3 Current aged care

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

- **Commonwealth Home Support Programme (CHSP) (Home and Community Care (HACC) in Victoria and Western Australia):** For those who require basic services to assist in remaining in their own homes. As of 1 July 2015, the CHSP was implemented, combining the previous Commonwealth HACC program[3], the National Respite for Carers Program, Day Therapy Centres and Assistance with Care and Housing for the Aged. On 1 July 2016, the HACC Program in Victoria transitioned to the CHSP. HACC services in Western Australia will continue to be administered by the Western Australian government until 1 July 2018, when they will be incorporated into the CHSP.
- **Home Care Packages Programme:** 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 accommodation and 24 hour care for those who have greater care needs and choose or need to be cared for in an aged care home. Care can be provided on either a temporary (respite) or permanent basis.

Table 2.1 shows the number of providers, services, places, consumers and Commonwealth and consumer funding for each of the three care types for the five years to 2015-16.

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 in rural and remote locations 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 commenced in February 2017 and incorporates the existing Transition Care Program, aims to reverse and/or slow 'functional decline' in older people and improve their wellbeing through the delivery of a time-limited, goal-oriented, multi-disciplinary and co-ordinated range of services.

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

Table 2.1: Aged care in Australia 2011-12 to 2015-16

	2011-12			2012-13			2013-14			2014-15			2015-16		
	Home support	Home care	Residential care	Home support	Home care	Residential care	Home support	Home care	Residential care	Home support	Home care	Residential care	Home support	Home care	Residential care
Number of providers	1,043	498	1,054	1,636	504	1,034	1,676	504	1,016	1,628	504	972	1,686	496	949
Numbers of services	N/A	2,095	2,716	N/A	2,131	2,720	N/A	2,212	2,688	N/A	2,292	2,681	N/A	2,099	2,669
Number of places	N/A	59,201	182,663	N/A	60,308	186,278	N/A	66,149	189,283	N/A	72,702	192,370	N/A	78,956	195,825
Number of consumers	750,133	79,212	222,316	756,148	82,895	226,042	775,959	83,144	231,515	812,384	83,838	231,255	>925,432	88,875	234,931
Commonwealth funding ($ billion)	$1.5b	$1.1b	$8.7b	$1.6b	$1.2b	$9.2b	$1.7b	$1.3b	$9.8b	$1.9b	$1.3b	$10.6 b	$2.2b	$1.5b	$11.4b
Consumer contribution	N/A	$80m	$3.5b	N/A	$84m	$3.8b	N/A	$87m	$4.0b	N/A	$147m	$4.2b	N/A	$160m	$4.5b

Notes:

1. The home support provider number for 2011-12 is Commonwealth HACC only as Vic and WA HACC data was not reliable.
2. Home support for the years 2011-12 to 2014-15 comprises Commonwealth HACC as well as Vic and WA HACC and in 2015-16 comprises CHSP as well as VIC and WA HACC.
3. The 2015-16 home support Commonwealth funding includes $147.5 million for My Aged Care and Regional Assessment Service (RAS) to support the CHSP.
4. The number of consumers of home support in 2015-16 (925,432) includes 285,432 for Vic and WA HACC and an estimate of over 640,000 in the CHSP as accurate data is not available.
5. Consumer contributions for home support are not reported here as reliable data is not available.

2.4 Australian Government expenditure on aged care

The sector received $16.2 billion in Commonwealth funding in 2015-16, up from $15.2 billion in 2014-15 (a 6.6 per cent increase). In 2016-17, total Commonwealth funding is expected to be $17.5 billion and for 2017-18, the Australian Government has budgeted $18.6 billion in aged care expenditure. Chart 2.1 shows total Commonwealth funding in aged care since 2011-12 and budgeted expenditure to 2019-20.

Funding for residential care is by far the largest proportion of Commonwealth expenditure at 67.6 per cent. The proportions of Commonwealth funding across the sector are illustrated in Chart 2.2.

Australian Government expenditure on aged care is projected to nearly double as a share of the economy from almost 1 per cent currently to around 1.7 per cent of GDP by 2055. 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.

In previous annual reports, ACFA has noted that the shift in the balance of care in favour of home care over residential care is expected to improve affordability for taxpayers over the long term.

This is because the costs of accommodation associated with residential care are not incurred with home care, and because, on average, higher care subsidies apply in residential care. Table 2.2 shows the total Australian Government expenditure on home support, home care and residential care in terms of cost per consumer.

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

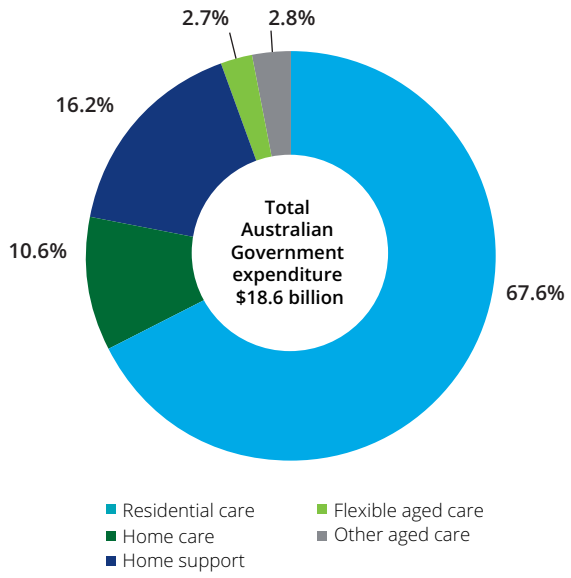


Chart 2.1: Australian Government total aged care expenditure, 2011-12 to 2015-16 and total budgeted aged care expenditure, 2016-17 to 2019-20

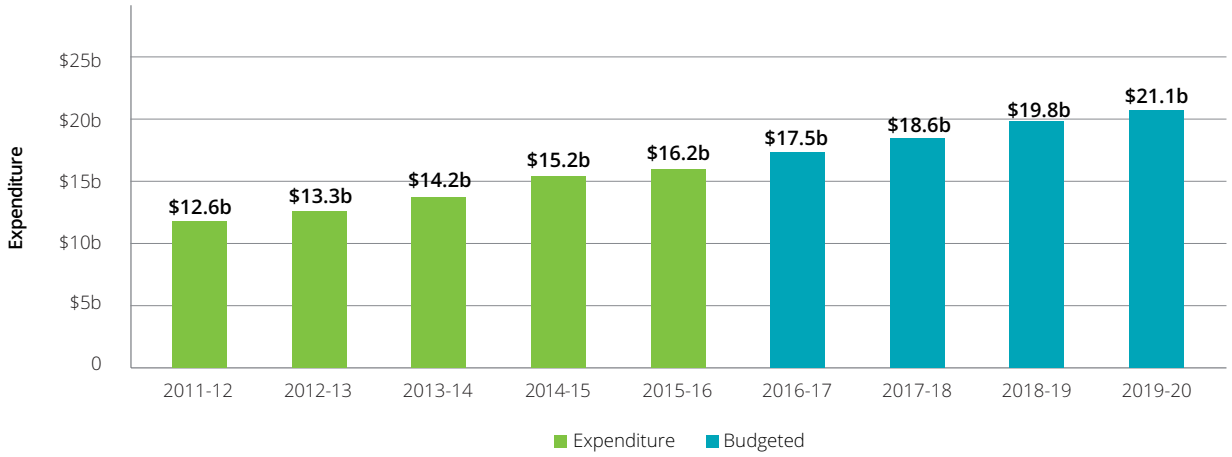


Table 2.2: Australian Government expenditure, per consumer for home support, home care and residential care in 2015-16

	Commonwealth expenditure	Consumers	Average expenditure per consumer
Home support	$2,207m	>925,432	$2,386
Home care	$1,486m	88,875	$16,760
Residential care	$11,371m	234,931	$48,403
Total	**$15,064m**	**>1,249,238**	**$12,059**

Notes:

1. Residential care consumers includes all permanent residents only
2. Does not include Commonwealth expenditure for flexible aged care and 'other' aged care
3. The number of consumers of home support in 2015-16 (925,432) includes 285,432 for Vic and WA HACC and an estimate of over 640,000 in the CHSP as accurate data is not available

2.5 Consumer contributions

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

In residential care, consumers contribute 85 per cent of the single age pension towards their living expenses and, subject to means testing, may be required to contribute towards their accommodation and care costs. In 2015-16, residents contributed $3.1 billion towards their living expenses, $444 million towards accommodation costs (excluding lump sum deposits) and $456 million towards care costs.

Consumers of home care packages in 2015-16 contributed around $160 million to their care costs. Accurate data regarding consumer contributions in the CHSP is not available, due to data limitations associated with the transition to the CHSP for providers.

2.6 Aged care providers

While the majority of providers operate only one type of aged care service, some operate two or all three types of care. Figure 2.3 and Table 2.3 show the number of providers providing only one type, two types and all three types of services.[4]

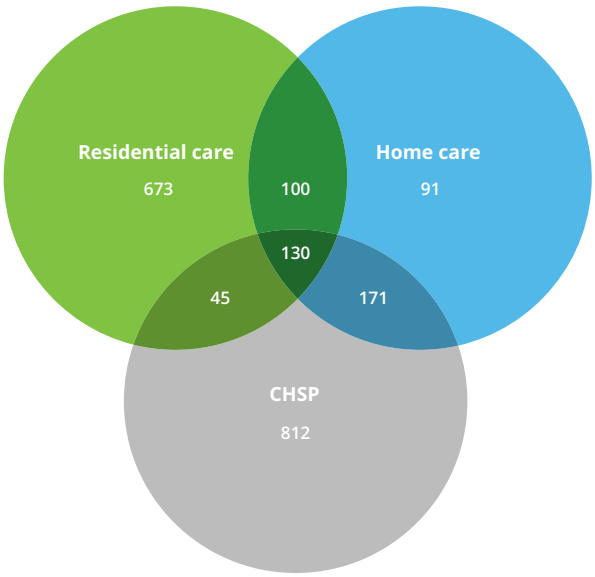
Of the total providers:

- 6 per cent provide all three types of services.
- 16 per cent provide two service types.
- 78 per cent of providers provide one type of service only.

As these figures show, there appears to be a high degree of specialisation in terms of service types offered by providers. ACFA suspects there may be more occurrences of providers providing more than one service than reported here, however separate provider registration in the three different sub-sectors means this is not always apparent, as providers often have different ABN's and different trading names.

It should be noted that this analysis excludes Victorian and Western Australia HACC providers as information on whether these providers also provide residential or home care is not available for 2015-16.

Figure 2.3: Number of providers by service type, 2015-16



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

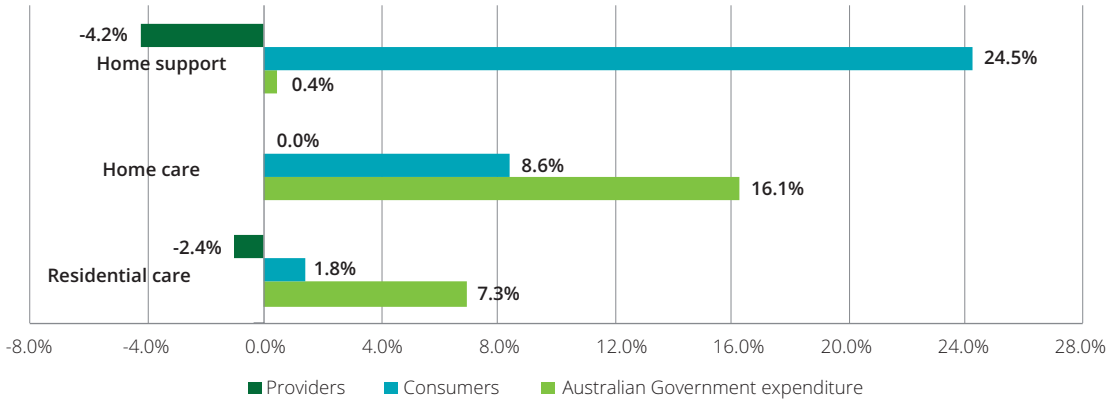
Table 2.3 : Number of providers by service type, 2015-16

Type of provider	CHSP	Home care	Residential	Number of providers
All three	•	•	•	130
Residential and home care		•	•	100
Home care and CHSP	•	•		171
Residential care and CHSP	•		•	45
Residential care only			•	673
Home care only		•		91
CHSP only	•			812
Total				**2022**

Note: does not include VIC and WA HACC providers

Chart 2.3 shows the change in funding and the number of providers and consumers for all three sub-sectors from 2014-15 to 2015-16. It shows that while funding and the number of consumers increased, the number of providers overall decreased slightly.

Chart 2.3: Growth in providers, places and Australian Government expenditure, 2014-15 to 2015-16



Home Support includes the CHSP as well as the Commonwealth contribution to the Victorian and Western Australian HACC programs.

2.7 Regulation of supply

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

The Australian Government regulates the supply of residential aged care places and home care packages it funds by specifying targets for the provision of operational aged care places. These targets, known as the aged care provision ratios, are based on the number of people aged 70 and over for every 1,000 people. The aged care provision ratio is discussed in Chapter 5.

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

Changes implemented in February 2017, mean that home care packages are no longer allocated to home care providers through the ACAR process. Instead, eligible older Australians are assigned a home care package that they can direct to their preferred provider. As a result, the 2015 ACAR was the last in which providers were able to apply for home care packages. This will not however change the overall control of the supply of home care packages through the provision ratio.

The Australian Government announced the results of the 2016 ACAR on 26 May 2017 (Table 2.4). Through this ACAR, 9,911 new residential places were allocated. These places have an estimated annual recurrent funding value of $649 million.

In addition, $64 million in capital grants was allocated to help eligible aged care providers servicing special needs groups (such as rural and remote communities, the homeless and culturally and linguistically diverse communities) to establish new services or upgrade existing facilities.

The Government had also previously, in February 2017, announced the successful applicants for the 475 new STRC places. Full details of the 2016 ACAR can be found at https://agedcare.health.gov.au/2016-17acar/results.

Table 2.4: 2016 ACAR results summary

State/ territory	Residential places	Estimated annual recurrent funding ($m)	Capital grants ($m)
NSW	2,470	$161.8	$21.1
VIC	2,645	$173.2	$7.9
QLD	2,680*	$175.5	$14.5
WA	1,623	$106.3	$9.6
SA	215	$14.1	$8.5
TAS	103	$6.8	$2.4
ACT	175	$11.5	0
NT	0	0	0
Total	**9,911**	**$649**	**$64**

Includes deferred allocations for 60 residential aged care places in Queensland, in respect of applicants who are awaiting the required approved provider status.

2.7.1 Demand for residential places

The demand from providers for places in the 2016 ACAR was strong, as it has been for the previous two ACARs. The Department of Health received applications for 45,053 residential places for the 10,000 places that were advertised for allocation.

ACFA notes that this level of demand continues to indicate that the accommodation reforms introduced on 1 July 2014 are having the intended effect of increasing investment in residential aged care. ACFA does however note that no applications were received for places in the Northern Territory, which largely accounts for the total allocation (9,911 places) falling short of the 10,000 target. This highlights the challenges facing the sector and the Government in assuring the provision of services in rural and remote areas.

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

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

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

2.9 Changing population

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

In 2015-16, 10 per cent of Australians were aged 70 years and over (2.5 million people) and 2 per cent aged 85 years and over (488,000 people). Around 57 per cent of these people accessed some form of Government-subsidised care. By 2026, an estimated 13 per cent of the population will be aged 70 years and over (3.6 million people) and 2.3 per cent will be 85 years and over (644,000 people).

2.9.1 Independence

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

During 2015-16, 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 7 per cent accessed residential aged care.

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

The Productivity Commission[5] 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 pressures on aged care in the future.

5 Productivity Commission, Caring for Older Australians 2011

3

Aged care workforce

3. Aged care workforce

This chapter provides an overview of the aged care workforce, as presented in the 2016 National Aged Care Workforce Census and Survey.

This chapter reports that:

- there are over 366,000 paid workers in aged care with a further 68,000 volunteers;
- more than half of all workers are in residential care;
- overall the personal care workforce in both residential care and in home support and home care is more qualified when compared with the previous census;
- the aged care workforce is relatively stable with 25 per cent of workers having been in the sector for over 14 years;
- the average age of workers in residential care is 46 compared with 48 in 2012, whereas in home support and home care the average age is 52 compared with 50 in 2012;
- overseas born workers continue to make up a significant proportion of aged care with 32 per cent in residential care and 23 per cent in home support and home care;
- aged care workers reported overall high levels of job satisfaction, with the biggest reported concerns being remuneration, inadequate staffing levels and a perception that aged care was not valued highly by the general community; and
- reported times to fill vacancies are not indicative of a tight labour market, though some aged care providers, particularly in more remote areas, still report difficulties in recruiting appropriately qualified staff.

3.1 Workforce

As discussed in previous reports, the sustainability and quality of the sector relies heavily on access to sufficient numbers of appropriately skilled staff which includes nurses, personal care or community care workers, support staff (such as kitchen and administrative staff) and allied health professionals. The Productivity Commission estimates that the workforce required for aged care will need to increase four-fold by 2050.

The 2016 National Aged Care Workforce Census and Survey[6] reports the number of paid workers in the aged care industry is around 366,000, with an additional 68,000 volunteers. When the census was conducted in 2012 the number of paid workers was 240,000.

It is important to note that the census counted PAYG employees and therefore did not include non-PAYG staff such as temporary and agency staff.

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

ACFA notes that the census was completed by only 76 per cent of residential care providers, compared with 96 per cent in 2012. ACFA also notes that in 2012, receipt of the Conditional Adjustment Payment by residential care providers was dependent on a number of factors, including completion of the workforce census.

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

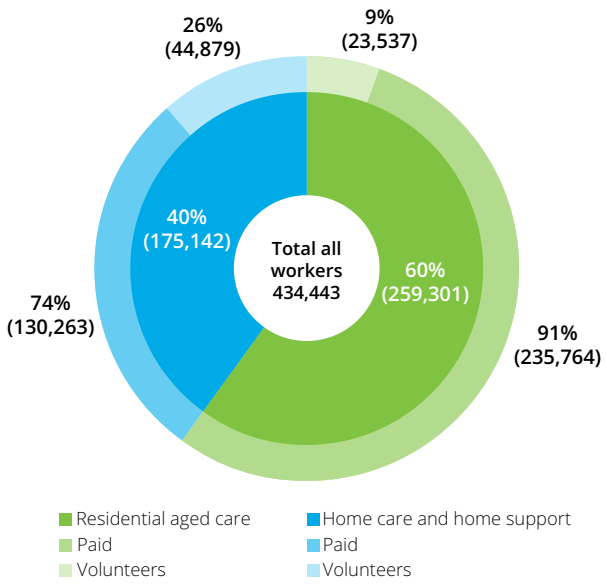
6 https://agedcare.health.gov.au/news-and-resources/publications/2016-national-aged-care-workforce-census-and-survey-the-aged-care-workforce-2016

3.1.1 Aged care workforce composition

Of the 434,443 people working in aged care, more than half (60 per cent) are in residential care, with 235,764 paid workers and a further 23,537 volunteers. The remainder of the workforce (40 per cent) are in home support and home care with 130,263 paid workers and 44,879 volunteers.

Chart 3.1 shows the composition of the aged care workforce.

Chart 3.1: Aged care workforce composition, 2016



The residential aged care workforce

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

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

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

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

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

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

Eighty-three per cent of residential care facilities reported using volunteers (on average 10 volunteers per facility).

In terms of stability, the residential care workforce showed some positive results. 42 per cent of direct care employees had worked in the sector more than nine years, and approximately 25 per cent had worked in the sector more than 14 years. Ten per cent of workers were actively seeking new employment.

The home support and home care workforce

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

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

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

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

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

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

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

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

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

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

Job satisfaction

Workers in aged care reported relatively high levels of satisfaction with their jobs. The main concerns reported remain total remuneration and the limited time available to them to care for residents.

In addition, this census found that aged care workers felt their work was not highly regarded by the community and other health care sector workers. A recommendation from respondents was that negative perceptions and working conditions should be addressed in order to make the aged care sector more appealing to prospective workers.

Workforce profile

The average age of the residential care workforce decreased from 48 to 46 between 2012 and 2016 (Table 3.4), driven mainly by a drop in the average age of RNs from 51 to 47. This indicates a change in the previous trend towards an ageing residential care workforce. However the trend towards an ageing profile in home support and home care is quite different with the average age of direct care employees increasing from 50 in 2012 to 52 in 2016 (Table 3.5).

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

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

Table 3.4: Average age of the residential direct care workforce (number of years), by occupation, all direct care employees and recent hires: 2012 and 2016

	All direct care employees	Recent hires	Difference in years in median age for all recent hires relative to all direct care employees
2016			
Registered nurse	47	42	-5
Enrolled nurse	50	37	-13
Personal care attendant	46	35	-11
Allied health	50	33	-17
All occupations	**46**	**36**	**-10**
2012			
Registered nurse	51	47	-4
Enrolled nurse	49	44	-5
Personal care attendant	47	38	-9
Allied health	50	41	-9
All occupations	**48**	**40**	**-8**

Table 3.5: Average age of the home support and home care direct care workforce, by occupation, all direct care employees and recent hires: 2012 and 2016 (number of years)

	All direct care employees	Recent hires	Difference in years in median age for all recent hires relative to all direct care employees
2016			
Registered nurse	48	51	3
Enrolled nurse	51	43	-8
Community care worker	52	46	-6
Allied health	47	41	-6
All occupations	**52**	**46**	**-6**
2012			
Registered nurse	50	47	-3
Enrolled nurse	49	45	-4
Community care worker	50	45	-5
Allied health	48	36	-12
All occupations	**50**	**44**	**-6**

Skills shortages

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

Time to fill vacancies

Time taken to fill vacancies can be a good indicator of the tightness of the labour market. In general, the reported times to fill vacancies in aged care are not considered indicative of a tight labour market. However ACFA does note that similar to skills shortages, there are instances of employers experiencing difficulties in recruiting suitable employees in more remote areas and for jobs with higher qualifications.

In residential care, 26 per cent of vacancies took less than one week to fill, and 76 per cent were filled within four weeks. In home support and home care, 71 per cent of vacancies were filled within four weeks.

Challenges for workers

Interviews with direct care workers also highlighted challenges for the aged care workforce going forward. These challenges included overall funding levels for the sector, staffing levels in residential care facilities and negative perceptions associated with aged care work.

In home care there were some concerns about future funding, the sustainability of their organisations and the potential effects on their own employment. A lack of consumer awareness and understanding of recent changes within the aged care system was also reported.

Inadequate staffing levels within residential care facilities was identified as a challenge. This was raised in the context of insufficient overall staffing numbers and the reported replacement of RNs with lesser qualified staff, leading to concerns about the possible compromise of care across some organisations. Whilst ACFA acknowledges that operational performance may be considered as having an impact on the quality of care outcomes for aged care consumers, the link between the financial performance and care outcomes is something that the industry-led taskforce, tasked with developing an aged care workforce strategy, may wish to consider.

The final emerging theme was negative perceptions of aged care work. Direct care workers suggested that aged care work was held in low esteem by the general community and those working in other healthcare sectors. Respondents suggested these perceptions (and working conditions) need to be addressed in order to attract the appropriate number of workers to the sector.

3.1.2 2017-18 Budget

As part of the 2017-18 Budget, the Australian Government announced it would create an aged care industry-led taskforce to develop an Aged Care Workforce Strategy. The strategy will explore short, medium and longer term options to boost supply, address demand and improve productivity for the aged care workforce.

3.1.3 Conclusion

Overall the report of the 2016 census and survey concluded that the current aged care workforce is stable, committed and well qualified. Employees report relatively high job satisfaction levels and a large majority wish to stay working in the sector. The retention and attraction statistics suggest that the sector overall has been competing reasonably well in the labour market. However, the report does suggest some issues remain. There are continuing skill shortages in remote and very remote areas. There are concerns about the standard of certificate level qualifications and gaps in training regarding dementia care, palliative care and mental health.

ACFA notes that on 20 June 2017, the Community Affairs References Committee of the Australian Senate tabled its report into the future of Australian's aged care sector workforce. The Senate Committee's report made 19 recommendations covering a range of issues including the make-up and representation on the industry-led taskforce developing the Aged Care Workforce Strategy and Government's role on the taskforce. The report noted that the sector has experienced significant changes in recent years putting pressure on an already stretched workforce. These changes include the increasing use of technology in service delivery, increased complexity of health needs of new entrants into the aged care system, and changing policy approaches (including CDC and funding structures) within the sector.

A copy of the full report can be accessed at: http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AgedCareWorkforce45/Report

4

Aged care reforms

4. Aged care reforms

This chapter outlines reforms in aged care since 1 July 2014 and looks ahead to future reforms.

ACFA concluded in its 2015 and 2016 annual reports, that funding and financial reforms had strengthened the viability and sustainability of the sector, while noting that some of the consumer focussed reforms were entering a critical phase.

Consumers and providers continue to face challenges in the short to medium term.

- Whilst consumers are increasingly responsible for their care choices, particularly in home care, many consumers are having difficulty navigating and comprehending the aged care system;
- The availability of comparative information to inform consumers choice is still a work in progress; and
- In response to consumer centric reform, providers must continue to innovate in an environment where competition is increasing and the continuing substantial Australian Government funding will continue to be closely scrutinised.

February 2017 saw significant reform continue in home care with the implementation of packages following consumers. Home care packages are now allocated directly to consumers who are able to select the provider of their choice. While it is too early for ACFA to provide analysis of the impact of this change in this report, the 2018 annual report and beyond will report on the effect of this change on consumers and providers.

In May 2017, ACFA provided its *Report to Inform the 2016-17 Review of Amendments*[7] to the *Aged Care Act 1997*. The Review, along with the Aged Care Roadmap, is expected to inform the next stages of aged care reforms.

4.1 Description of reforms

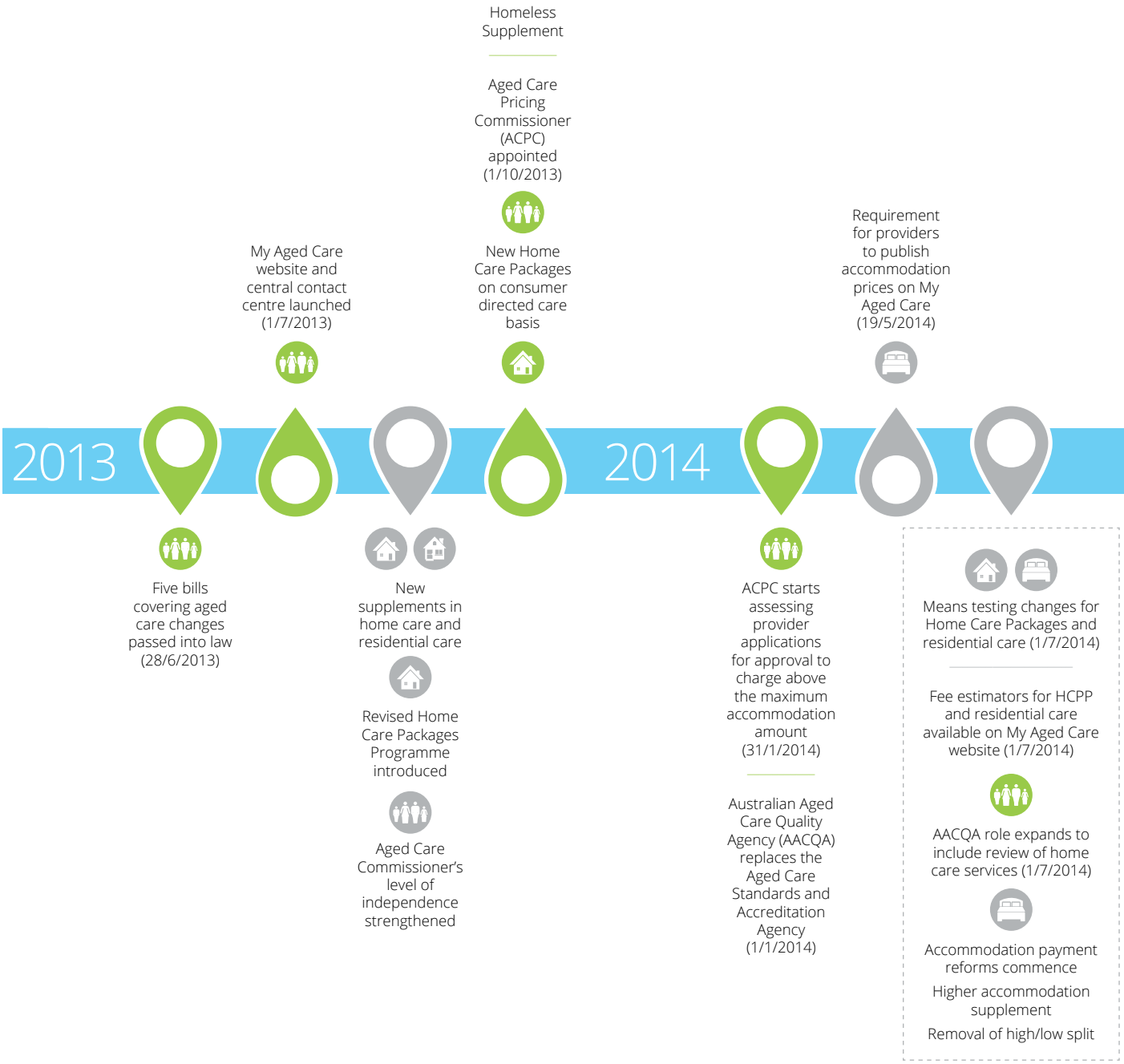
The aged care sector has undergone substantial change in recent years with a view to improving the sustainability of aged care services and increasing consumer choice and control. This change includes a suite of reforms that have had a phased implementation since first being announced in April 2012,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

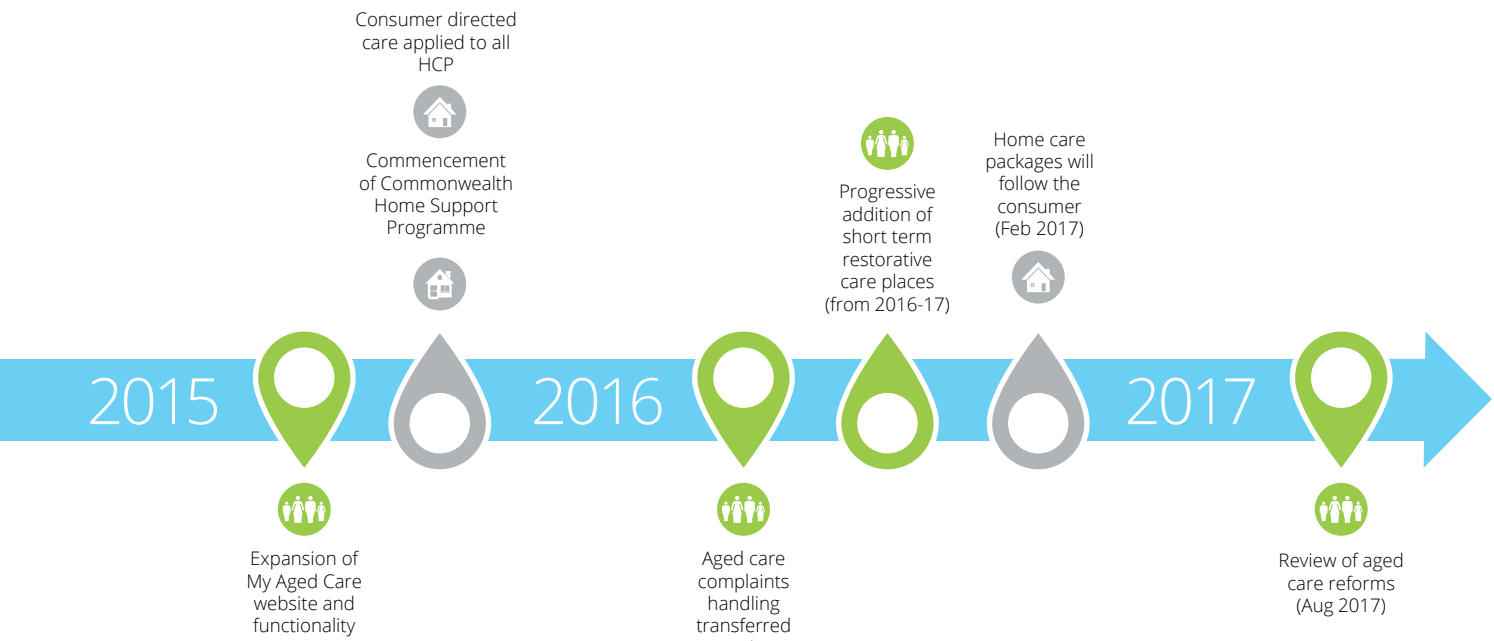
- **(2012-13 – 2013-14). Initial aged care reform.** Announcement of the Living Longer Living Better reforms, including: a phased increase in the aged care provision ratio and an increased proportion of home care places compared with residential care places; the introduction of the new home care package levels; and commencement of accommodation price publishing. The My Aged Care website and Contact Centre as well as the Australian Aged Care Quality Agency and the Aged Care Pricing Commissioner were also introduced, along with ACFA.
- **(2014-15 – 2015-16). Financing reforms.** Removal of the distinction between high and low care in residential care and the introduction of market-based accommodation prices for non-supported residents; commencement of Consumer Directed Care (CDC), including individualised budgets for new home care packages; new income testing arrangements in home care and means testing in residential care; and a higher maximum accommodation supplement for new and significantly refurbished residential care facilities. In January 2016, the disparity around the treatment of the rental income from the former family home for residential care was removed.
- **(2015-16 – 2016-17). 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 CDC to all existing home care package consumers; and the formation of the Commonwealth Home Support Programme. From 27 February 2017, home care packages were assigned to eligible consumers rather than being allocated to providers.

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

Figure 4.1 presents a timeline of reforms in aged care since 2012.

Figure 4.1: Timeline of aged care reforms




Consumer directed care applied to all HCP
Commencement of Commonwealth Home Support Programme
Progressive addition of short term restorative care places (from 2016-17)
Home care packages will follow the consumer (Feb 2017)
2015
2016
2017
Expansion of My Aged Care website and functionality
Aged care complaints handling transferred to Aged Care Commissioner (Jan 2016)
Review of aged care reforms (Aug 2017)

4.2 Aim of the reforms

Broadly put, the funding and financing reforms in aged care aim to:

- increase transparency and consumer choice;
- improve the viability and sustainability of aged care services, by increasing flexibility, funding and investment; and
- improve the long-term sustainability and equity of the aged care system by increasing consumer contributions from those who can afford to contribute to their aged care costs, and improving equity in how different forms of wealth are counted in means testing arrangements.

Table 4.1 lists the major reforms that have been implemented, categorised by program.

Table 4.1: Major reforms by program

Commonwealth Home Support Programme (CHSP)
From 1 July 2015, the CHSP commenced. The CHSP combined the: • Commonwealth Home and Community Care (HCCC) program; • National Respite for Carers program; • Day Therapy Centres program; • Assistance with Care and Housing for the Aged program. Through My Aged Care, there are new assessment and referral arrangements and a central client record. Victoria transitioned their HACC services to the CHSP on 1 July 2016. Western Australia will still provide services through their HACC program until 1 July 2018 when they will also transition to the CHSP.
Home Care Packages Programme
• new home care packages (levels 1-4) commenced 1 August 2013; • formalised income testing with subsidy reduction, including annual and lifetime caps, commenced on 1 July 2014; • all home care packages required to be delivered on a CDC basis, including individualised budgets, from 1 July 2015; and • home care packages allocated to the consumer rather than to the provider from 27 February 2017.
Residential aged care
• new means testing (combining income and assets test), including annual and lifetime caps, 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 a combination of both; • requirements for providers to publish the maximum price they charge for accommodation and extra services; • appointment of an Aged Care Pricing Commissioner; and • higher accommodation supplement payable for supported residents in new or significantly refurbished homes.

4.3 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. As noted in last year's annual report, while ACFA's formal monitoring role has ceased, ACFA continues to provide commentary regarding the impacts of reforms through its annual reports.

The monitoring reports that have been provided to the Minister can be found on the ACFA web page.[8]

In May 2017, ACFA also provided its *Report to Inform the 2016-17 Review of Amendments to the Aged Care Act 1997*, including funding, financing and pricing issues affecting the matters specified in the Review's terms of reference. In particular, ACFA was asked to focus on means testing, fees, accommodation prices, access and workforce.

4.3.1 Accommodation payment changes

The reforms of 1 July 2014 saw a number of significant changes to the way that accommodation is priced and paid for in permanent residential care.[9]

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

Residents were also given complete choice in their method of payment, 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.

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

When the reforms were introduced, there was some concern in the sector that there would be a move away from lump sum accommodation payments by consumers. However a review undertaken by ACFA concluded that the lump sum accommodation pool was continuing to grow.

As at 30 June 2016, lump sum accommodation deposits held by providers totalled around $21.9 billion.[10] This compares with $15.6 billion when the reforms began on 1 July 2014 (Chart 4.1).

In its *Report to Inform the 2016-17 Review of Amendments to the Aged Care Act 1997*, ACFA concluded this increase in the lump sum pool held by providers is likely to have been driven by three factors:

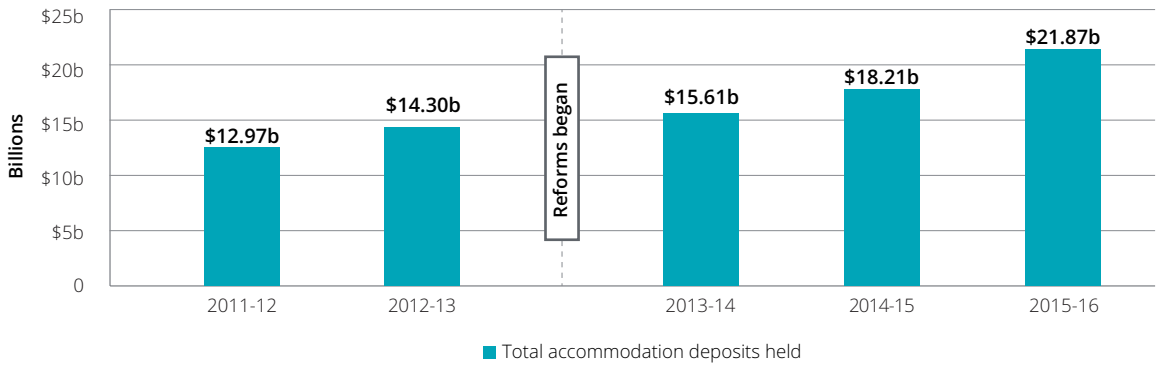
- the larger and increasing pool of residents making lump sum deposits – an intended outcome of the accommodation payment reforms and removal of the distinction between high and low care;
- a preference of many non-supported residents to pay for their accommodation by lump sum refundable deposit over daily payments; and
- an increase in the average value of accommodation prices compared with the value of average new accommodation bonds prior to the reforms, largely in response to the removal of retentions.

8 <https://agedcare.health.gov.au/aged-care-reform/aged-care-financing-authority>

9 Accommodation payments apply in permanent residential care, when they are subject to a means test. They do not apply in residential respite care.

10 The figure of $21.9 billion for total accommodations deposits held by the sector as at 30 June 2016 differs from $21.7 billion in ACFA's report on the effectiveness of the Bond Guarantee Scheme published in May 2017 due to additional financial information collected from providers who report their financial position at 31 December each year.

Chart 4.1: Total pool of accommodation deposits held, 2011-12 to 2015-16[11]



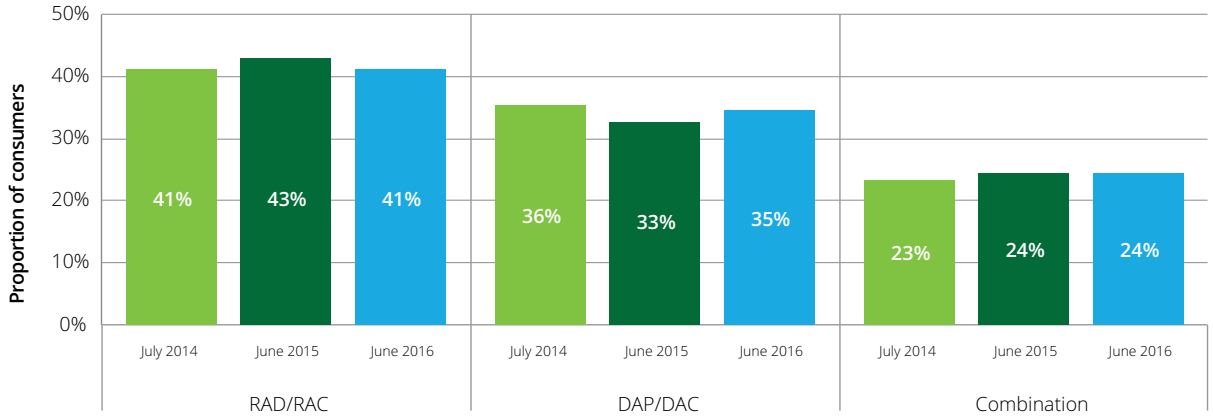
Residents who are eligible for Commonwealth assistance with their accommodation costs may still be asked to contribute to the cost of their accommodation, depending on their means and whether they are fully supported or partially supported.

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

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

As shown in Chart 4.2, RADs/RACs were once again the most used method of making accommodation payments in 2015-16, with 41 per cent of residents who pay the full or partial cost of their accommodation opting for this method of payment. This compares with 35 per cent choosing a DAP/DAC and 24 per cent paying a combination of lump sum and daily payment. This trend has been stable for the three years since the reforms were introduced on 1 July 2014.

Chart 4.2: Consumer method of accommodation payment, July 2014 to June 2016



11 The figure of $18.21 billion presented for 2014-15 in Chart 4.2 differs from the June 2015 figure of $19.84 billion in Chart 3.1 of ACFA's 2016 annual report because the latter figure from the monitoring surveys includes lump sums held and receivable, whereas figures in Chart 4.2 are sourced from the Annual Prudential Compliance Statement returns of those providers who submitted their General Purpose Financial Reports (GPFR), and do not include lump sums receivable.

While the overall trend is stable, some different trends emerge when consumer method of payment is analysed by provider ownership type and remoteness location (Chart 4.3).

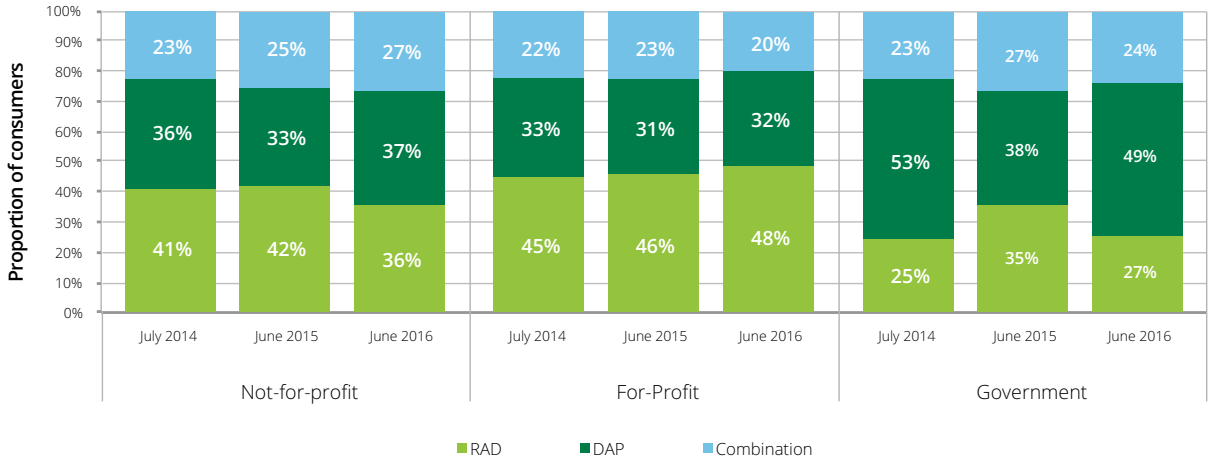
Not-for-profit providers recorded a decrease in the proportion of residents choosing a RAD from 42 per cent in 2014-15 to 36 per cent in 2015-16 and a commensurate increase in those choosing a DAP or combination. For-profit providers recorded a slight increase in the proportion of residents choosing a RAD from 46 per cent in 2014-15 to 48 per cent in 2015-16. On the other hand, there is no consistent trend in preferred payment type for government-owned services.

There was also a noticeable drop in the proportion of residents paying a RAD in regional locations, from 44 per cent to 35 per cent in 2015-16, the same proportion as in 2013-14.

ACFA also reported through its *Report to Inform the 2016-17 Review of Amendments* to the *Aged Care Act 1997*, that there was a very significant difference in choice of payment between non-supported residents and partially supported residents.

Chart 4.3: Resident choice of payment method, July 2014 to June 2016

Provider ownership type



Provider remoteness location

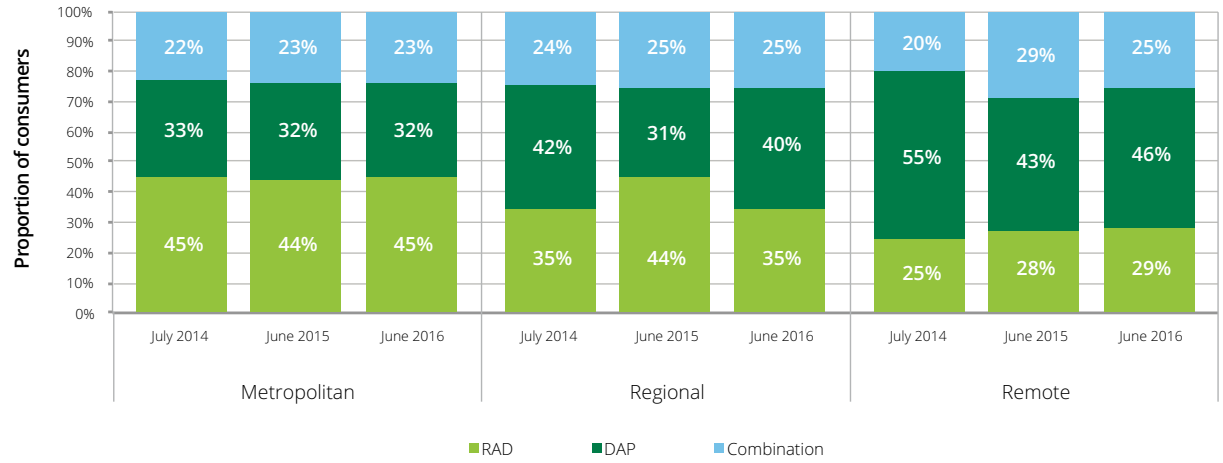
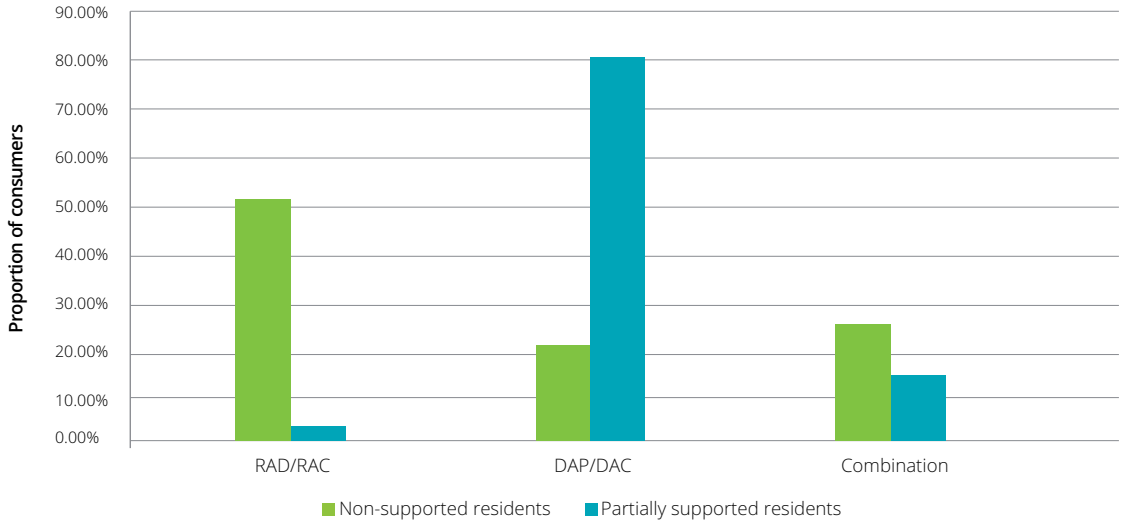


Chart 4.4: Resident choice of payment method, 2015-16



As shown in Chart 4.4, refundable deposits were the dominant method of payment for non-supported residents in 2015-16. Nearly 52 per cent of non-supported residents paid by lump sum, 22 per cent paid by daily payments and just over 26 per cent paid a combination of a partial refundable deposit and daily payment.

A significant majority (80 per cent) of partially supported residents pay daily contributions only, with nearly 16 per cent paying by a combination of refundable contribution and daily contributions. It should be noted that the proportion of residents paying by lump sum may include residents who had commenced to pay full or partial daily payments, and then paid a lump sum during the year. Similarly, residents paying a daily payment may subsequently pay a lump sum (e.g. once their house is sold).

Prices

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

Published maximum prices

At 6 April 2017, the average maximum RAD/DAP published on My Aged Care was $391,000/$61.91, compared with $377,000/$64.86 at 31 May 2016 and $355,000/$65.06 at 29 July 2014.

Table 4.2 provides a summary of published prices by ownership type and remoteness location, and shown by average and percentile. 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.

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

The threshold above which prices must be approved by the Aged Care Pricing Commissioner remained unchanged during 2015-16 at a RAD of $550,000 or equivalent daily payment of $87.09. At 6 April 2017, 6 per cent of published prices were higher than the threshold.

Table 4.2: Average maximum published RAD prices as at 6 April 2017, by ownership type and remoteness location

	Average	5th Percentile	Quartile 1	Median	Quartile 3	95th Percentile
Overall	$391,000	$220,000	$295,000	$350,000	$450,000	$650,000
Ownership type						
Not-for-profit	$389,000	$222,000	$295,000	$357,000	$456,000	$595,000
For-profit	$421,000	$220,000	$300,000	$360,000	$480,000	$824,000
Government	$329,000	$250,000	$280,000	$320,000	$350,000	$500,000
Remoteness location						
Major cities	$423,000	$225,000	$300,000	$379,000	$500,000	$750,000
Regional areas	$341,000	$200,000	$280,000	$326,000	$395,000	$550,000
Remote areas	$292,000	$198,000	$250,000	$280,000	$320,000	$420,000

Agreed prices

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

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

Table 4.3 provides a summary of agreed prices in 2016-17 up to 6 April 2017 by ownership type and remoteness location, shown by average and percentile.

The results for average agreed prices are similar to those for average published prices, albeit around $10,000-$20,000 lower. For-profit providers recorded the highest agreed prices followed by not-for-profit and government providers. Major cities had significantly higher agreed prices than regional and remote areas.

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

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

Table 4.3: Average agreed prices, 1 July 2016 to 6 April 2017, by ownership type and remoteness location

	Average	5th Percentile	Quartile 1	Median	Quartile 3	95th Percentile
Overall	$380,000	$154,000	$280,000	$351,000	$450,000	$650,000
Ownership type						
Not-for-profit	$373,000	$150,000	$282,000	$352,000	$450,000	$550,000
For-profit	$400,000	$175,000	$295,000	$370,000	$850,000	$750,000
Government	$302,000	$99,000	$250,000	$300,000	$350,000	$500,000
Remoteness location						
Major cities	$410,000	$170,000	$300,000	$395,000	$500,000	$710,000
Regional areas	$316,000	$125,000	$250,000	$320,000	$380,000	$500,000
Remote areas	$256,000	$65,000	$200,000	$280,000	$304,000	$354,000

4.3.2 Means testing and sustainability

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

In home care, a Government administered income test with subsidy reduction was introduced, and in residential care a new means test that combined formerly separate income and assets tests came into effect. These changes saw an increase in the amount that consumers contributed towards the cost of their care compared with prior to 1 July 2014.

Annual and lifetime caps were also introduced for both home care and residential care to limit the amount consumers can be asked to contribute each year and over the lifetime towards their care costs.

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

Home care

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

Under the new Government administered income testing arrangements, the amount of Government subsidy is reduced by the amount of the income tested fee and providers are required to provide services to the full value of the package should consumers wish. It was expected, as happens in residential care, that providers would charge consumers the full income tested fee. However through data collection for *its Report to Inform the 2016-17 Review of Amendments* to the *Aged Care Act 1997*, ACFA found that 17 per cent of home care providers reported not charging the income tested fee.

ACFA also found that 22 per cent of providers reported not charging the basic daily fee, and of those that did, more than half reduced the amount they charged.

ACFA notes that since providers are supposed to be providing services to the full value of the home care package, including the basic daily fee if charged, these results mean that either this is not happening in some cases, or providers are diluting their financial results.

One of the aspects ACFA was asked to monitor is whether access to aged care has been affected by the reforms.

Overall ACFA reports that access to home care has remained stable. In its *Report to Inform the 2016-17 Review of Amendments* to the *Aged Care Act 1997*, ACFA also observed that the number of part pensioners and self-funded retirees accessing lower level home care packages is lower when compared with higher levels.

- Of post-reform home care consumers receiving a level 1 package in 2015-16, only 15 per cent were part-pensioners or self-funded retirees.
- Of post-reform consumers receiving a level 4 package in 2015-16, 27 per cent were part-pensioners or self-funded retirees.

ACFA notes this is likely because the level of consumer contributions, both through the basic daily fee and income tested fees, is not affected by the level of a home care package. Put another way, the proportion of the package value that the consumer is expected to pay is higher in lower level packages compared with higher level packages, as shown in Table 4.4. The income thresholds as they are applied to income testing in home care are shown at Appendix E.

The amount of income-tested care fees collected, and the amount forecast to be collected, in home care is small in comparison to the amount of Government subsidies paid. Given the vast majority of home care consumers are pensioners (82 per cent at 30 June 2016), who are not required to contribute any care fee, or part pensioners (15 per cent at 30 June 2016), who can be charged a limited care fee, the income-tested care fees are not providing a significant improvement to fiscal sustainability from a Government perspective.

Table 4.4: Split of maximum consumer contribution (including basic daily fee) and Government subsidy, by home care package level (March 2017 rates)

		Level 1		Level 2		Level 3		Level 4	
Source		$	%	$	%	$	%	$	%
P	Consumer	$3,686.50	31%	$3,686.50	20%	$3,686.50	10%	$3,686.50	7%
	Government	$8,044.60	69%	$14,632.85	80%	$32,171.10	90%	$48,906.35	93%
PP	Consumer	$8,962.58	76%	$8,962.58	49%	$8,962.58	25%	$8,962.58	17%
	Government	$2,768.52	24%	$9,356.77	51%	$26,895.02	75%	$43,630.27	83%
SFR	Consumer	$11,731.10	100%	$14,238.68	78%	$14,238.68	40%	$14,238.68	27%
	Government	$0	0%	$4,080.67	22%	$21,618.92	60%	$38,354.17	73%
	Total package value	**$11,731.10**		**$18,319.35**		**$35,857.60**		**$52,592.85**	

P= Pensioner PP= Part pensioner SFR= Self-funded retiree

Residential care

The changes of 1 July 2014 in residential care saw the previously separate income and asset tests applied to care and accommodation contributions respectively, combined into one means test. This was to ensure consistency of assessment of wealth irrespective of whether it is in the form of assets or income. All residents can also be asked to pay a basic daily fee for their living expenses, which is set at a maximum of 85 per cent of the basic single aged pension. As at 1 July 2017, 85 per cent of the basic single aged pension was $17,910.55 per year.

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

ACFA considers that the changes to means tested fees in residential care have generally improved the equity in the treatment of different forms of wealth among residents of aged care. However, in its *Report to Inform the 2016-17 Review of Amendments* to the *Aged Care Act 1997*, ACFA did acknowledge there still remains some inequity, particularly in relation to the treatment of the principal residence, which is included in the assets assessment up to a capped value of $162,087.20.

The means-testing reforms have improved sustainability by shifting a proportion of the overall average cost per resident per year (including care, accommodation and basic daily living costs) to the consumer. The Government incurred 65.6 per cent of the cost of the average post 1 July 2014 resident in care during 2015-16. Without the reforms the Government would have borne 68.3 per cent of the cost of those residents. Most of the shift in cost to consumers is in relation to care fees.

4.3.3 The higher accommodation supplement

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

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

The higher accommodation supplement is available to services that have been built or significantly refurbished since 20 April 2012. As at 1 July 2017, the higher accommodation supplement was $55.09 per day compared with $35.90 for the standard accommodation supplement.

Uptake and impact

As at 31 December 2016, 686 services (representing 25.5 per cent of all services) were receiving the higher accommodation supplement. Of these, 559 were for significantly refurbished services and 127 for newly built services.

Expenditure

The estimated completed refurbishment spend per service averages $3.8 million, with a median of $1.7 million and total expenditure of $2.7 billion across the sector.

4.3.4 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. To be eligible for extra service status, providers must first seek approval from the Department.

Extra service subsidy reduction does not apply to residents entering care on or after 1 July 2014, although it does still apply to residents in an extra service place who were in care prior to 1 July 2014, and who are covered under the pre-reform fee arrangements.

Since the reforms began in July 2014, there has been a significant decrease in the total number of places with extra service status (see Chart 4.5). This is likely because changes made to accommodation pricing on 1 July 2014 reduced the need and motivation for providers to have extra service status, partly because:

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

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 for a fee.

During 2015-16 the number of extra service places decreased to 11,689 compared with 15,280 as at 30 June 2015. ACFA notes however that some providers are choosing to suspend their extra service places rather than hand them back, while they trial fees for additional services.

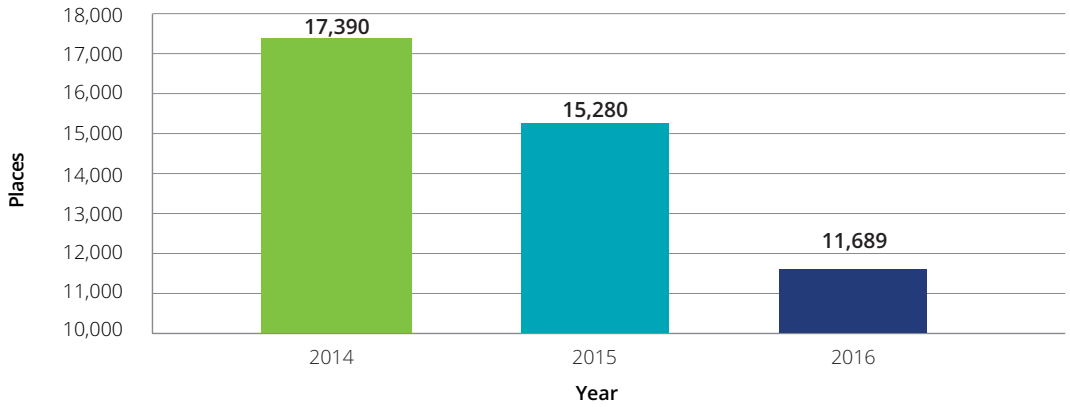
4.3.5 More choice in home care

Key reforms in home care have been CDC, including individualised budgets, and the assigning of home care packages to consumers which allows consumers to direct their package to their preferred provider. These reforms are designed to provide individuals and their carers more control over the design and delivery of services received (though there are no enforcement provisions). CDC became compulsory in all home care packages from 1 July 2015, while the assigning of packages to consumers was introduced from 27 February 2017.

ACFA noted in last year's annual report that the capacity for consumers to save their package funds means that many providers were holding a significant amount of unspent funds on behalf of their consumers. Prior to the 27 February 2017 changes, if a consumer ceased receiving a home care package from a provider, the provider retained the unspent funds.

However, since 27 February 2017, when consumers change providers, any unspent package funds (less any agreed exit amount) must be transferred to the new home care provider. If a consumer leaves home care (including moving into residential care), any unspent funds (less any agreed exit amount) must be returned to the Commonwealth and the consumer (or their estate) according to their respective contributions. Many providers are reviewing and adjusting their business models,

Chart 4.5: Number of active extra service places, 30 June 2014 to 30 June 2016



accounting processes, pricing structures and service menus, to adapt to the more competitive market-driven environment and to better manage the level of unspent funds.

ACFA notes it is too early to report on the impacts of the 27 February 2017 changes on consumers and providers. However, the Department has advised that it will be providing quarterly reports from early 2017-18. The Department has further advised that formal evaluation of the Increasing Choice changes will be undertaken after six and 12 months of operation. ACFA therefore anticipates being able to provide analysis of the impact of the more competitive service environment in future reports.

ACFA is aware that there has been strong interest from new providers seeking to deliver home care in 2016-17, with the number of applications for approved provider status approved by the Department growing from 75 in 2015-16 to over 200 in 2017. ACFA also notes that over half of the approvals are for organisations who are already approved providers for home support or residential care.

In its quarterly reports, StewartBrown noted that "the advent of new providers concurrent with the release of additional funding packages by the Department, has created increased competition to retain existing package numbers as well as gaining new packages for the established providers. The preliminary responses indicate that this has created an increased focus on marketing and branding by all providers."

ACFA also notes that the changed treatment of unspent funds has caused some differences in the way providers report income, which is discussed further in Chapter 7.

4.3.6 Changes to the Aged Care Funding Instrument (ACFI)

As noted in ACFA's 2016 annual report, the Government announced in the 2016–17 Budget that it would examine alternative care funding options to ensure sustainability and to reduce subjectivity, including using independent external assessment.

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

Following the release of the University of Wollongong report, the Department has commissioned a residential care Resource Utilisation and Classification Study to inform consideration of reform options. The study will examine the characteristics of residents that drive residential care costs and how those costs are distributed within the scope of services currently funded by the Commonwealth.

The Department also engaged external expertise to examine how the Aged Care Funding Instrument can be strengthened to reduce subjectivity, including an examination of the feasibility of external assessment under the current funding arrangement. ACFA notes that no decisions have been made on the reform options and any future changes will involve consultations with the sector.

5

Access to aged care

5. Access to aged care

This chapter outlines access to aged care in Australia for consumers.

This chapter discusses:

- Access to subsidised aged care for consumers.
- the supply of subsidised aged care.
- usage of aged care and impacts of a changing population.
- demand for aged care services.

This chapter reports that in 2015-16:

- admissions to both home care and residential care continued to be stable;
- the proportion of admissions to residential respite care continued to increase compared with permanent care;
- occupancy has continued to be relatively stable in residential care;
- occupancy in home care was lower compared with 2014-15 due to reduced demand for level 2 packages; and
- on-going demographic changes will see a continuing increase in demand, as the proportion of people aged 85 and over is growing to nearly 5 per cent of the population by 2055, compared with 2 per cent today.

5.1 Access to aged care

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

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

5.1.1 Supply of aged care

An overall aged care provision target ratio was first set in 1985 at 100 operational places per 1,000 people aged 70 and over. It was increased to 108 in 2004, further increased to 113 in 2007, and in 2012, was adjusted to increase progressively to 125 by 2022. Aboriginal and Torres Strait Islander Australians aged 50 years and older are also included in the target population due to their relatively lower life expectancy and specific care needs.

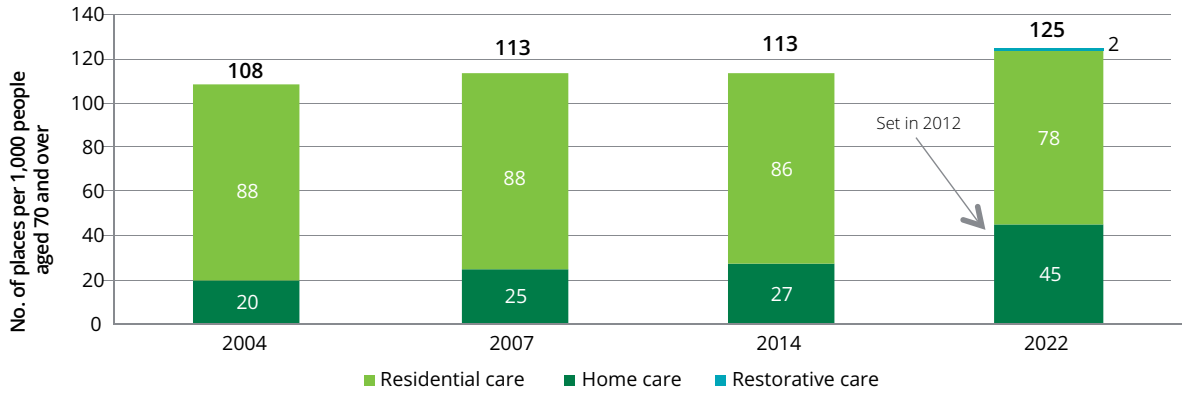
This population-based provision formula is designed to ensure that the supply of services increases in line with the ageing of the population, while also defining the total number of places thereby, helping control the Commonwealth's expenditure on aged care.

In addition to setting an overall target ratio for care places, the Commonwealth has maintained ratio-based targets for residential care and home care packages. Within the current target provision ratio of 125, the mix of home care and residential care is being significantly altered. Over the period 2012 to 2022 the target for home care places will increase from 27 to 45, while the residential care target is to reduce from 86 to 78. The remaining two places have been set aside since 2016-17 for the new Short Term Restorative Care Programme (STRC).

Appendix D details the total operational aged care places and ratios achieved in each aged care planning region as at 30 June 2016.

When the target was first set in 1985, it was exclusively for residential care. Over time, increasing provision has been made in the target for home care. Chart 5.1 shows the changes in the target ratios since 2004 and the planned increase through to 2022.

Chart 5.1: Increase in target provision ratios, 2004-2022



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 care places which reflects the Government's response to the increasing number of consumers wishing to remain in their own homes.

An additional 62,000 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 5.2 shows the achieved ratio of aged care places for the 10 years to 2015-16 and the target ratio of 125 places to be achieved by 2021-22. Chart 5.3 shows the increasing number of operational home care and residential care places since 2004.

Chart 5.2: Aged care operational ratios achieved since 2007, compared with target ratio to be achieved by 2022

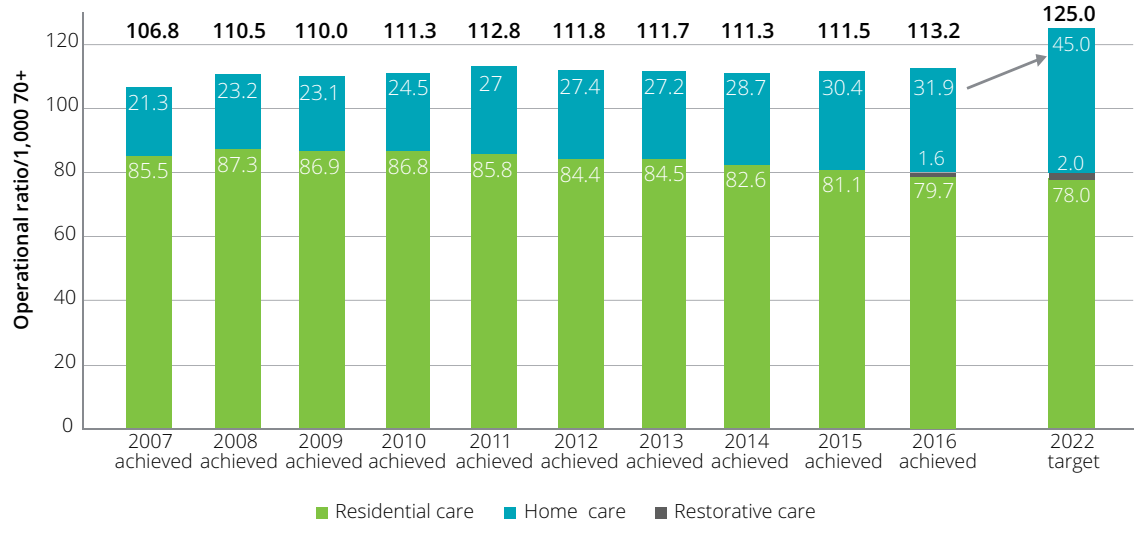


Chart 5.3: Operational places, residential care and home care, since 2004.

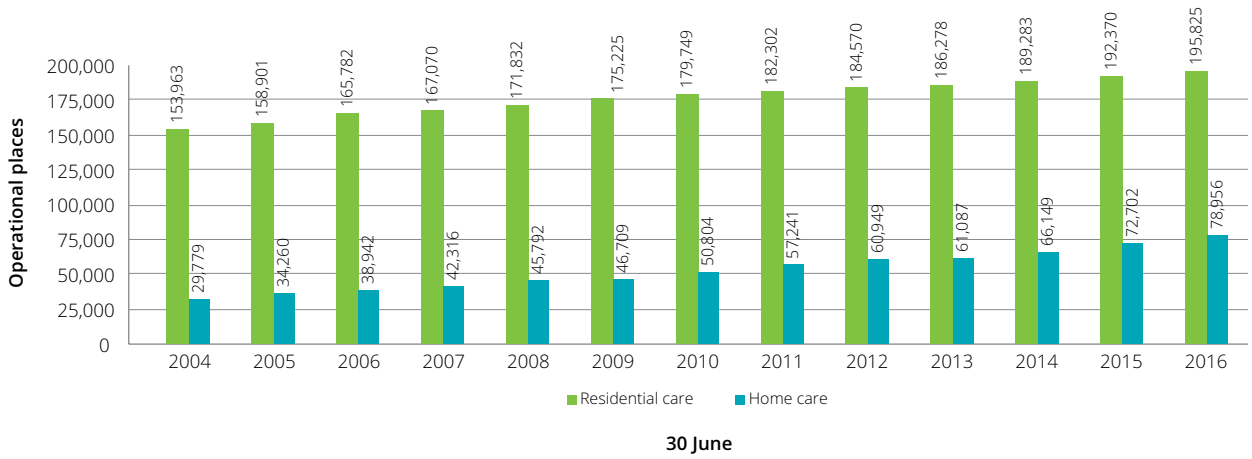


Table 5.1 shows the current proportions of places in home care and residential care by remoteness location compared with the distribution of Australians aged 70 and over. This demonstrates the balance in provision of services that the ACAR process seeks to achieve.

Table 5.1: Operational aged care places and Australia 70+ population by remoteness location, as at 30 June 2016

Remoteness location	Home care	Residential care	Australia 70+ population
Major cities	68.8%	68.1%	65.9%
Inner regional	20.8%	21.8%	22.6%
Outer regional	8.2%	8.8%	10.1%
Remote	1.1%	0.9%	1.0%
Very remote	1.2%	0.4%	0.5%

The target ratio applied to home care and residential care places does not apply to the supply of care through the Commonwealth Home Support Programme (CHSP). Instead there is a capped annual funding amount which is awarded to home support providers through grant funding. Consumers who are assessed as eligible through their ACAT can then access services through a provider funded under the CHSP. This is discussed in Chapter 6.

5.1.2 Affordability for consumers

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

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

For the consumer, cost alone is unlikely to be a 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 certain segments of the public, or consumers in some locations.

5.2 Age profile across care types

Across the continuum of care, the age profile of consumers change as their needs change over time. Chart 5.4 shows the proportion of older Australians in home support, home care and residential care in 2015-16. It shows that the proportion of usage increases as people get older. The usage of residential care increases by over three-fold in the 85 and over bracket compared with those aged 70 and over.

In home care the average age of consumers was 82.1 years compared with 84.6 years in residential care, while the proportion of people aged 85 and over in residential care was 59 per cent compared with 43 per cent in home care.

The patterns of use of aged care services change with age. As Chart 5.4 illustrates, at 30 June 2016, 39 per cent of all people aged 70 years and over were receiving some form of aged care, but this increases to 81 per cent when focused on the 85 and over cohort.

Chart 5.5 shows the age profile for consumers of home care over the five years to 30 June 2016. There is a trend that the proportion of consumers aged 65-74 has continually increased while the 75-84 age bracket is generally decreasing. Up until 2015-16 the proportion of those aged 85 and over had been increasing but in 2015-16 the proportion of those aged 85-94 decreased from 39.3 per cent to 38.6 per cent.

Chart 5.6 shows the age profile of consumers of residential care for the five years to 30 June 2016. The proportion of people aged 65-74 in residential care has slowly increased over the five years while the proportion of those aged 75-84 has noticeably dropped from 29.8 per cent at 30 June 2012 to 27.5 per cent at 30 June 2016. Those aged 95 and over has increased every year over the five years but those aged 85-94, while increasing for the three years to 30 June 2014 has slightly dropped in the last two years.

Chart 5.4: Proportion of people 70+ and 85+ accessing aged care, at 30 June 2016

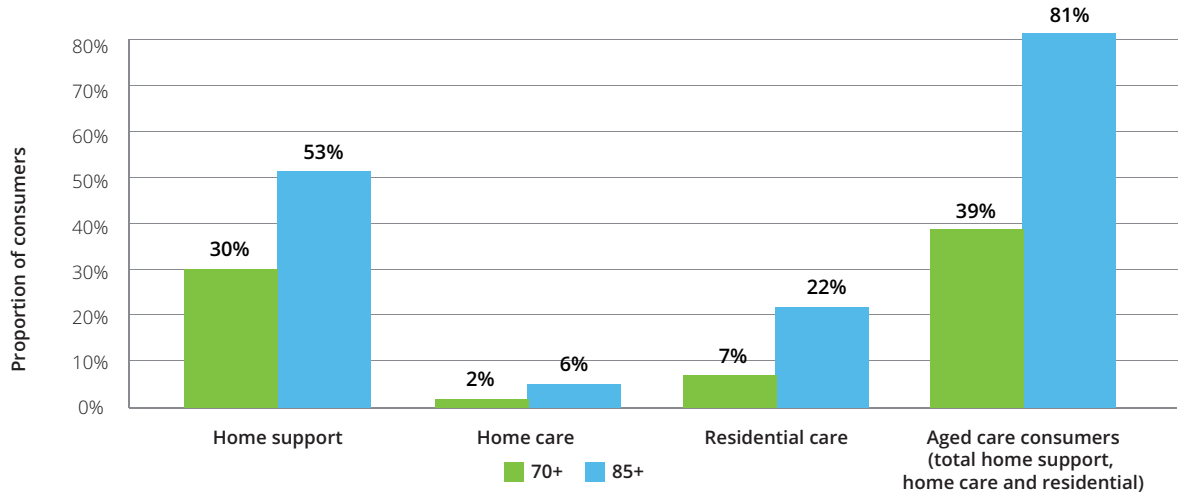


Chart 5.5: Age profile of people in home care, 30 June 2012 to 30 June 2016

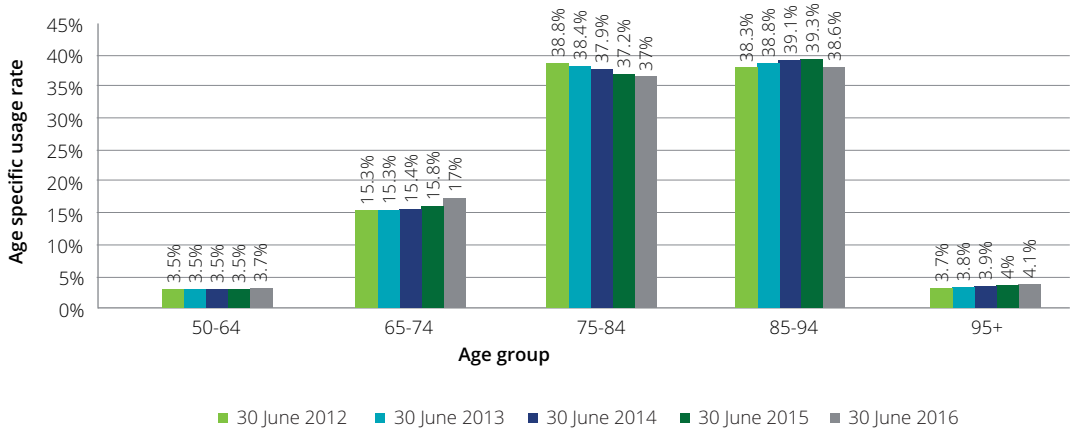
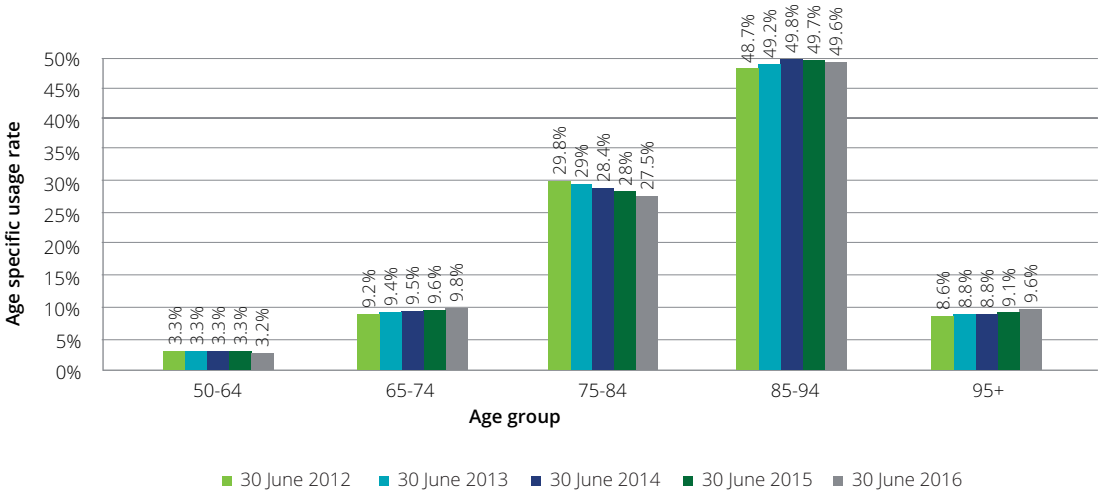


Chart 5.6: Age profile of people in residential care, 30 June 2012 to 30 June 2016



5.3 Access by Culturally and Linguistically Diverse and Indigenous Australians

5.3.1 Culturally and Linguistically Diverse Australians

There is significant cultural diversity among Australians and many people from culturally and linguistically diverse (CALD)[12] backgrounds are seeking culturally appropriate aged care. While many of these people have come from European countries, recent years have seen larger numbers of people from a number of Asian countries 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.

To assist this, the Australian Government provides aged care website information for people who do not speak English, or for whom English is a second language. The My Aged Care website provides translated material in 18 languages. In 2015-16, there were 14,928 visits to the translation pages.

Throughout 2015-16, older people from CALD backgrounds could also access home support services funded through the CHSP and the Victorian and Western Australia HACC programs. The number of CALD consumers in home support is not available for 2015-16.

There were 15,940 older Australians from CALD backgrounds in a home care package as at 30 June 2016, representing almost 25 per cent of total home care consumers. This is consistent with 2014-15 when there were 15,204 (26 per cent). Table 5.2 shows the number of CALD Australians accessing home care over the last five years.

Table 5.2: CALD consumers in home care, by state and territory, 30 June 2012 to 30 June 2016

State/territory	30 June 2012	30 June 2013	30 June 2014	30 June 2015	30 June 2016
NSW	4,209	4,436	4,804	5,118	5,416
Vic	4,298	4,439	4,967	5,460	5,905
Qld	1,350	1,443	1,534	1,574	1,557
WA	1,387	1,486	1,515	1,485	1,497
SA	871	947	951	994	1,042
Tas	157	161	162	194	211
ACT	194	220	240	248	229
NT	66	90	88	131	85
Total	**12,532**	**13,222**	**14,261**	**15,204**	**15,940**

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

There were 33,822 older Australians from CALD backgrounds in residential aged care (permanent and respite) as at 30 June 2016. This represents around 19 per cent of all residents, steady from 2014-15. The proportion of CALD people in residential care has generally increased over the last 10 years from 15 per cent in 2007. This compares with the overall population of Australians aged 65 and over, of whom currently around 20 per cent are from a CALD background. The proportion of CALD people accessing residential care is significantly less than home care (19 per cent compared with 25 per cent).

Table 5.3 shows the number of CALD consumers in residential aged care since 2012.

5.3.2 Indigenous Australians

As at 30 June 2016, 1,705 Indigenous Australians[13] were accessing home care, which represents 1.9 per cent of total home care consumers. This is down from 1,796 at 30 June 2015 and 1,963 in June 2014. Table 5.4 shows the number of Indigenous Australians accessing home care over the last five years.

As at 30 June 2016, there were 1,602 Indigenous Australians in residential care (permanent and respite) compared with 1,535 at 30 June 2015. Table 5.5 shows the number of Indigenous Australians in residential care since 2012.

Table 5.3: CALD consumers in residential aged care, by state and territory, 30 June 2012 to 30 June 2016

State/territory	30 June 2012	30 June 2013	30 June 2014	30 June 2015	30 June 2016
NSW	10,466	10,942	11,592	11,971	12,466
Vic	9,775	10,142	10,650	11,049	11,634
Qld	2,851	2,969	3,108	3,162	3,326
WA	2,533	2,566	2,676	2,696	2,683
SA	2,625	2,713	2,836	2,833	2,886
Tas	277	290	281	309	291
ACT	383	390	380	406	475
NT	69	61	59	57	61
Total	**28,959**	**30,073**	**31,582**	**32,483**	**33,822**

Table 5.4: Indigenous Australians in home care, by state and territory, 30 June 2012 to 30 June 2016

State/territory	30 June 2012	30 June 2013	30 June 2014	30 June 2015	30 June 2016
NSW	474	497	506	443	431
Vic	344	390	393	385	372
Qld	310	344	332	320	303
WA	197	224	206	171	170
SA	82	81	77	72	65
Tas	25	26	22	23	21
ACT	43	48	43	29	27
NT	420	425	384	353	316
Total	**1,895**	**2,035**	**1,963**	**1,796**	**1,705**

Note: 2012 and 2013 is CACP+EACH+EACHD

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

Table 5.5: Indigenous Australians in residential care, by state and territory, 30 June 2012 to 30 June 2016

State/territory	30 June 2012	30 June 2013	30 June 2014	30 June 2015	30 June 2016
NSW	307	324	376	420	445
Vic	88	106	109	102	110
Qld	340	384	423	456	482
WA	267	277	282	289	271
SA	62	66	71	74	76
Tas	24	26	23	26	25
ACT	6	3	4	7	11
NT	182	161	164	161	182
Total	1,276	**1,347**	**1,452**	**1,535**	**1,602**

5.4 Access to home care

5.4.1 Allocation of home care places

Following the changes to home care from 27 February 2017, home care packages are assigned directly to consumers by the Department of Health on a regular basis through the national prioritisation system within My Aged Care. Home care packages are assigned to those consumers who have reached the top of the national queue.

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

At this stage, it is too early to report on the new home care prioritisation system. The Department has advised it will release public reports on a quarterly basis from early 2017-18.

However, as ACFA noted in its *Report to Inform the 2016-17 Review of Amendments* to the *Aged Care Act 1997*, there are indications that the changes to income testing and fee arrangements for home care packages that commenced on 1 July 2014 may be impacting how consumers take up home care packages.

The relatively high level of consumer contribution for level 1 packages, compared with higher level packages, may be influencing consumers' decisions to not take up level 1 packages. There is a clear correlation between package level and the proportion of consumers who are part-pensioners and self-funded retirees:

- Of post-reform home care consumers receiving a level 1 package in 2015-16, only 15 per cent were part-pensioners or self-funded retirees.
- Of post-reform home care consumers receiving a level 4 package in 2015-16, 27 per cent were part-pensioners or self-funded retirees.

Overall, part-pensioners and self-funded retirees make up around 18 per cent of post-1 July 2014 home care consumers at 30 June 2016.

This suggests that current fee levels may be sending a price signal resulting in part-pensioners and self-funded retirees in particular seeking services through the CHSP, in the private market, informal care arrangements, or not at all. There is strong anecdotal evidence to suggest that there are consumers receiving 'packages' of services through CHSP who will not take up a home care package because they will have to pay significantly more.

5.4.2 Occupancy in home care

Historically, data has not been available to allow an estimate to be made of the extent to which supply of home care packages was falling short of total demand. Only data pertaining to occupancy rates (met demand) is collected. As part of the changes that were implemented in February 2017, all older Australians that are assessed as eligible for a home care package are placed in a national queue to receive a home care package as one becomes available.

This will enable some assessment of unmet demand for home care packages to be included in future annual reports.

Until February 2017, occupancy was 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). Table 5.6 shows that in 2015-16 occupancy increased in package levels 1, 3 and 4 while decreasing in level 2 packages. Because level 2 packages comprise 66 per cent of home care packages, overall occupancy in home care decreased to 83.2 per cent from 85.8 per cent in 2014-15. This outcome raises questions about the appropriateness of the current allocation of packages across the four levels.

Table 5.7 shows occupancy in 2015-16 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: Home care occupancy by home care package level, 2014-15 and 2015-16

Level	Number of operational packages at 30 June 2015	Occupancy 2014-15	Number of operational packages at 30 June 2016	Occupancy 2015-16
Level 1	2,251	62.1%	2,254	68.3%
Level 2	51,956	85.2%	52,415	81.1%
Level 3	3,815	66.7%	7,369	79.5%
Level 4	14,680	92.1%	16,918	93.1%
Total	**72,702**	**85.8%**	**78,956**	**83.2%**

Table 5.7: Home care occupancy by remoteness location and home care package level, 2015-16

Location	Level 1	Level 2	Level 3	Level 4	Total
Major cities	68.4%	80.6%	79.5%	93.4%	83.0%
Inner regional	69.9%	84.3%	81.3%	93.8%	85.7%
Outer regional	59.1%	78.8%	74.1%	9.30%	80.8%
Remote	64.6%	75.3%	83.8%	84.2%	77.0%
Very remote	...	72.1%	75.5%	76.9%	75.2%
Australia	**68.3%**	**81.1%**	**79.5%**	**93.1%**	**83.2%**

Chart 5.7 provides an overview of occupancy by package level type over time. The Chart combines the previous EACH and EACH-D packages as a comparator for level 4, while the previous CACPs packages are treated as a comparator for level 2 packages. Occupancy for level 2 packages decreased for the third year in a row, while occupancy for level 4 packages remains strong despite a relatively high proportion of level 4 packages being allocated in April 2015 through the ACAR (36 per cent of all packaged allocated).

Figure 5.1 shows the occupancy levels per package level and by state and territory for 2015-16 compared with 2014-15.

All states and territories reported lower occupancy in 2015-16, driven by a significant drop in level 2 packages being occupied. Western Australia, the Northern Territory and the ACT recorded the biggest drops in occupancy with 6, 7 and 8 percentage points respectively. ACFA notes however that the 2015 ACAR allocated 6,445 places in April 2016 which would likely have a slightly negative effect on occupancy, as measured on 30 June 2016, as some of these packages would not have become occupied by consumers in that relatively short amount of time.

ACFA notes the significant variation in occupancy rates across the states and territories. ACFA will track the impact on occupancy of the post February 2017 arrangements, particularly with respect to the prioritisation arrangements, the geographic distribution of services and the composition of package waiting lists.

Chart 5.7: Home care occupancy by package level, 2010-11 to 2015-16

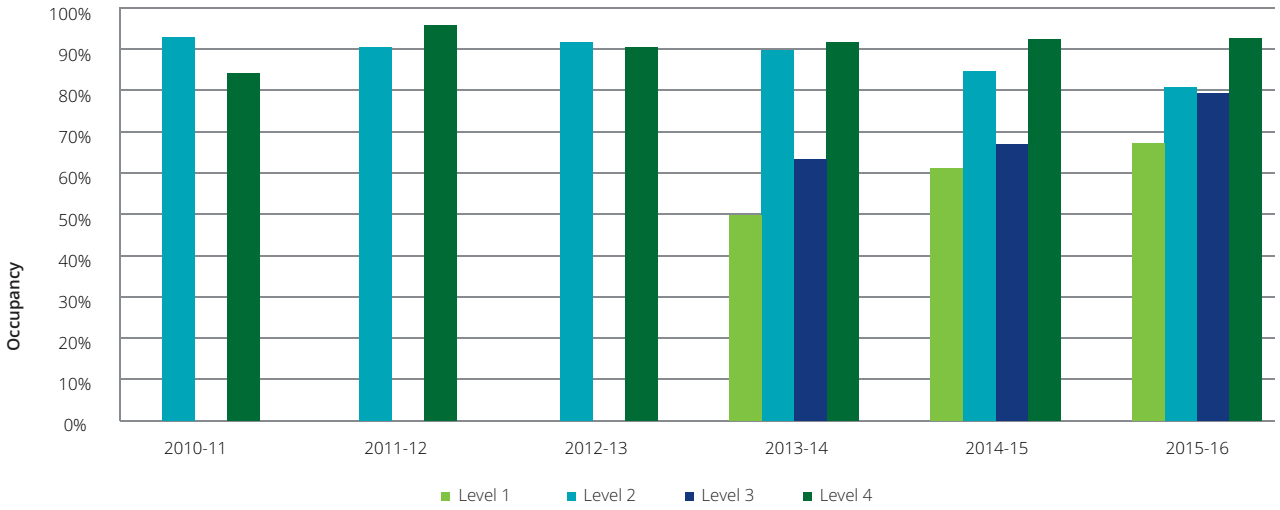
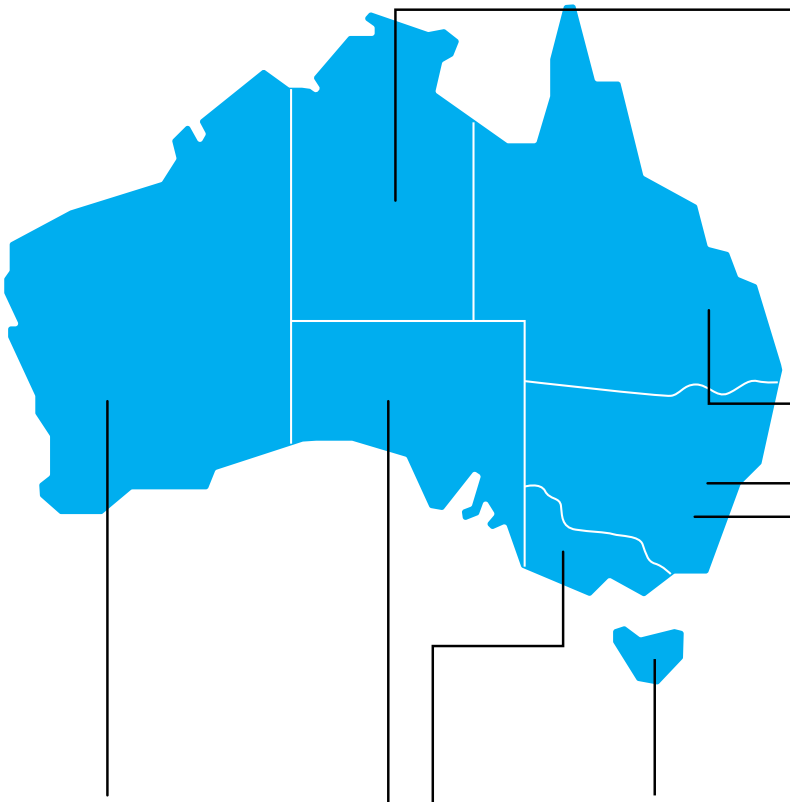


Figure 5.1: Home care occupancy rates across Australia, by package level, 2014-15 and 2015-16



Northern Territory

	2014-15	2015-16
HCL1	60.6%	62.6%
HCL2	86.1%	78.1%
HCL3	75.0%	70.5%
HCL4	88.3%	85.4%
Total	86.2%	79.2%

Queensland

	2014-15	2015-16
HCL1	53.7%	60.3%
HCL2	77.5%	72.8%
HCL3	62.6%	78.9%
HCL4	94.1%	94.6%
Total	80.6%	77.7%

Western Australia

	2014-15	2015-16
HCL1	35.4%	34.3%
HCL2	66.8%	55.3%
HCL3	48.8%	73.3%
HCL4	86.6%	90.6%
Total	73.8%	68.2%

Tasmania

	2014-15	2015-16
HCL1	82.4%	83.5%
HCL2	92.1%	90.8%
HCL3	71.6%	88.7%
HCL4	95.6%	95.5%
Total	91.8%	91.3%

New South Wales

	2014-15	2015-16
HCL1	60.2%	68.4%
HCL2	88.4%	84.8%
HCL3	66.8%	78.6%
HCL4	92.6%	93.2%
Total	87.8%	85.5%

South Australia

	2014-15	2015-16
HCL1	54.9%	63.3%
HCL2	83.2%	79.8%
HCL3	76.4%	80.3%
HCL4	91.5%	90.2%
Total	83.6%	81.2%

Victoria

	2014-15	2015-16
HCL1	71.3%	77.3%
HCL2	93.6%	92.3%
HCL3	69.0%	82.7%
HCL4	95.7%	95.5%
Total	92.7%	91.8%

Australian Capital Territory

	2014-15	2015-16
HCL1	57.5%	37.5%
HCL2	81.1%	67.1%
HCL3	60.2%	73.8%
HCL4	88.7%	89.9%
Total	83.7%	76.0%

5.4.3 Home care admissions

In 2015-16, 56.2 per cent of people commenced package levels 1 and 2 within three months of being approved by an ACAT (down slightly from 58 per cent in 2014-15). For package levels 3 and 4, 60.2 per cent of people (also down marginally from 62 per cent in 2014-15) commenced a package less than three months after their ACAT approval.

It is important that this indicator is treated with caution as it does not necessarily reflect real delay or waiting time for entry into home care. Consumers may choose not to enter care and 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 package offer.

Chart 5.8 shows admission numbers for the four home care package levels since they began in August 2013, up until September 2016. While there are peaks and troughs, the Chart shows that admissions continue to be overall steady.

Under the funding following the consumer changes introduced in February 2017, consumers will have 56 days (or 84 days if they request an extension) to decide whether to take up a package. ACFA will monitor what impact these changes might have on the elapsed time between being approved for a package and the commencement of services.

Length of stay in home care

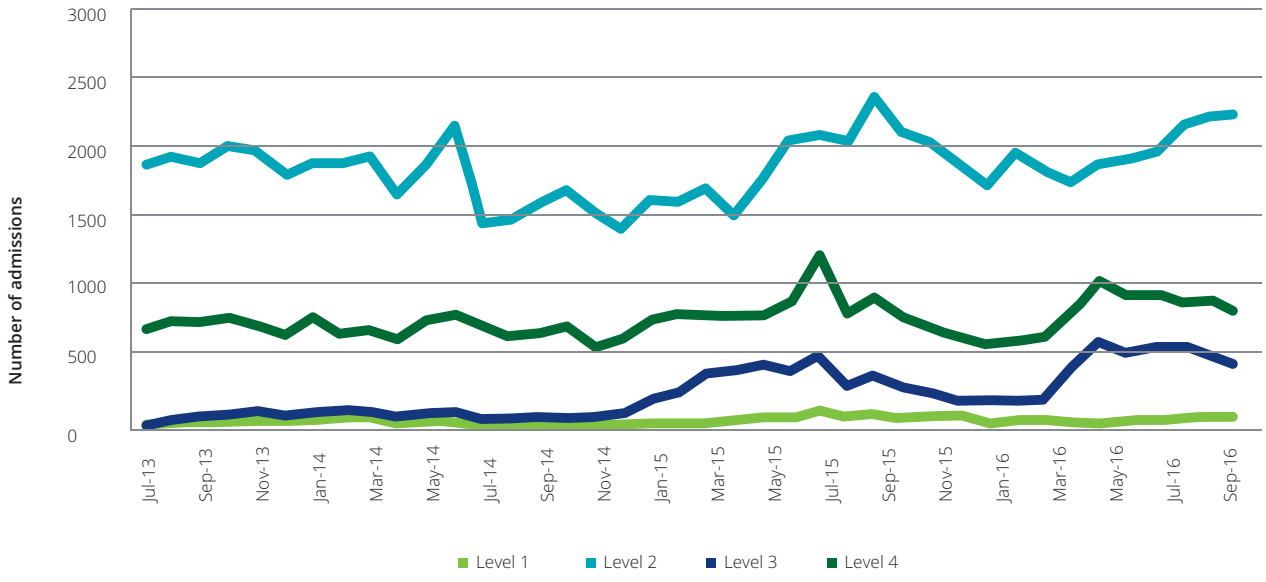
Length of stay in home care differs markedly between package levels.

For people that enter home care at a level 2 package, around half stay at least 1.5 years and around a quarter stay over three years. By contrast, for those people entering a level 4 package, around half leave care within a year and a quarter remain in care for over two years.

The new package levels 1 and 3 have not been operating for sufficient time to calculate average lengths of stay. However of those people that entered in 2014-15, around a quarter of people in both package types had left within around six months.

ACFA will expand its length of stay analysis for home care in next year's report; this will examine the impact of introducing both level 1 and level 3 packages and the changes in February 2017 with packages being assigned to consumers. Understanding these impacts and the interactions with residential care will be important as the Australian Government rapidly expands the number of home care packages available.

Chart 5.8: Home care admissions, by package level, July 2013 to September 2016



5.5 Access to residential care

5.5.1 Residents

The number of older Australians who received permanent residential care during 2015-16 was 234,931, an increase of 1.6 per cent from 231,255 in 2014-15.

The number of people accessing residential respite care is increasing faster than those accessing permanent residential care. The number of people who accessed respite care in 2015-16 was 56,852, an increase of 7.2 per cent, compared with 53,021 in 2014-15 and 48,295 in 2013-14 (an increase of 9.8 per cent). Residential respite care usage is discussed in Section 5.7.

The number of residents who were actually in permanent residential care as at 30 June 2016 was 175,989, up from 172,828 at 30 June 2015. The number of people who were receiving residential respite care as at 30 June 2016 was 5,059, up from 4,992 at 30 June 2015.

Overall the total number of residents (permanent and respite) in care as at 30 June 2016 was 181,048, an increase of 1.8 per cent increase on 177,820 at 30 June 2015.

Chart 5.9 illustrates that the age of the residential care population is gradually increasing as people live longer and more consumers have the opportunity to stay in their own homes longer, increasingly with the assistance of home care. The proportion of consumers in residential care aged 85 and over has increased from 55 per cent in 2009 to 59 per cent in 2016. In contrast, the proportion aged between 70 and 84 has decreased from 37 per cent in 2009 to 33 per cent in 2016. The average age of permanent residents in 2015-16 was 84.6. This has been increasing since 2009-10 when it was 84 years.

Chart 5.9 shows the proportion of residential aged care residents by age group, since 2008-09.

5.6 Demand for residential aged care

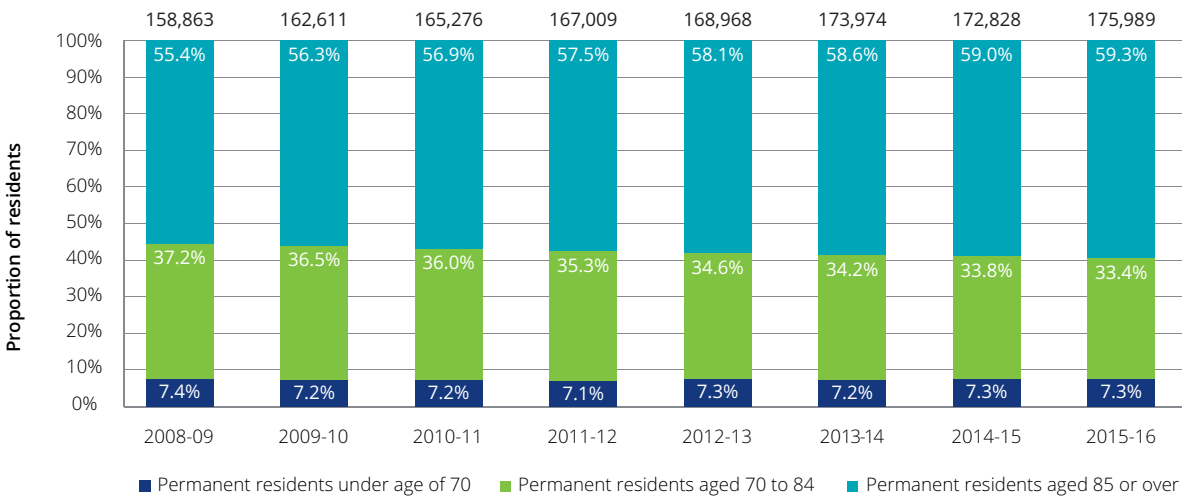
Demand includes that which is both met by a service and that which is not met. As noted in previous reports, data that would allow an estimation of unmet demand for residential care is not systematically collected. Only data pertaining to resident admissions and occupancy rates (met demand) is reported. 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.

5.6.1 Occupancy rates

Occupancy rates reflect both demand and the number of places available. In 2015-16 the occupancy across all residential care places was 92.4 per cent, steady from 92.5 per cent in 2014-15, and 93.0 per cent in 2013-14. Occupancy rates have been stable 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 93.6 per cent, down from 94.0 per cent in 2014-15. For-profit providers achieved an average occupancy of 90.8 per cent for 2015-16 compared with 90.6 per cent in 2014-15.

Chart 5.9: Proportion of permanent residential aged care residents by age, 2008-09 to 2015-16



As noted in previous annual reports, there are variations in occupancy by state or territory, with the highest occupancy in 2015-16 being the Northern Territory with 95.0 per cent and the lowest being the ACT with 88.6 per cent (Table 5.8).

Table 5.8: Occupancy in residential aged care by state/territory, 2015-16

State/territory	Occupancy (%)
New South Wales	92.3
Victoria	91.7
Queensland	92.2
Western Australia	94.5
South Australia	93.7
Tasmania	91.0
Australian Capital Territory	88.6
Northern Territory	95.0
Australia	**92.4**

The greatest variation in occupancy continues to be by remoteness location. A clear trend is that more populous areas generally have higher occupancy rates than less populous areas.

Table 5.9 shows occupancy rates in residential care by remoteness location during 2015-16.

Table 5.9: Residential aged care occupancy by remoteness area, 2015-16

Remoteness location	Occupancy (%)
Major cities	92.4
Inner regional	92.5
Outer regional	92.0
Remote	89.7
Very remote	80.0

Occupancy rates by remoteness location suggests the greatest demand pressures on average may be in metropolitan areas, with somewhat less demand in more remote areas, suggesting also that rural and remote Australia is comparatively well serviced. This pattern in occupancy rates is mirrored in home care.

As Chart 5.10 indicates, there continues to be an increase in elapsed time between when a resident is assessed as eligible for residential care and entering permanent care. This trend has been evident since 2011-12, however is more obvious since 2013-14.

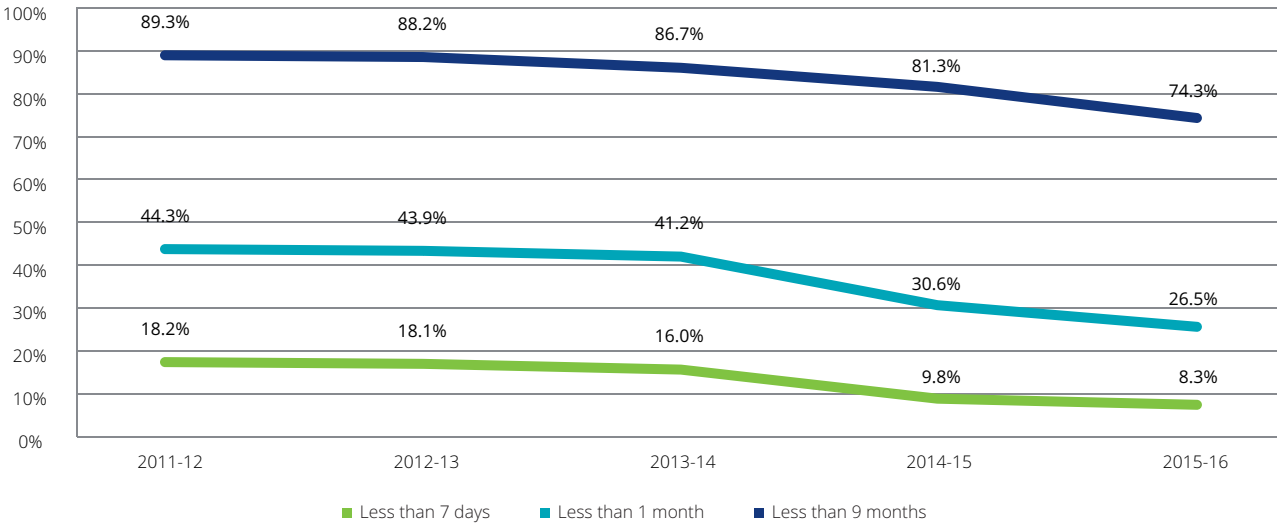
- 8.3 per cent of people entering care did so within a week of being assessed by an ACAT (18.2 per cent in 2011-12);
- 26.5 per cent did so within a month (44.3 per cent in 2011-12); and
- 74.3 per cent within nine months (89.3 per cent in 2011-12).

There was a noticeable increase in wait times in 2014-15 compared with 2013-14 which likely reflects some of the delays in means testing which occurred when the 1 July 2014 financing reforms were implemented.

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

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

Chart 5.10: Elapsed time between assessment and entering permanent residential care, 2011-12 to 2015-16 (%)



Consumers transitioning from home care to residential care

Chart 5.11 shows the proportion of consumers who enter permanent residential care after leaving home care. The proportion entering residential care was relatively stable at around 60 per cent for the years prior to the introduction of the Aged Care Funding Instrument (ACFI) in 2008, when it increased to around 63 per cent. Since 2014, the proportion has dropped to below 60 per cent.

5.6.2 Length of stay in residential aged care

The average length of time between first admission and final discharge in permanent residential care has been decreasing over the last 10 years. This decrease in length of stay (LOS) of aged care residents is shown in Chart 5.12, with the average LOS decreasing from 3.3 years in 2003 to just under 3 years in 2016.

Two drivers of this decrease in LOS have been an increasing average age of entry and an increasing proportion of male residents. Older residents and male residents have shorter average LOS, so increasing proportions of these residents result in a shorter average LOS. Chart 5.13 shows both of these indicators, with the proportion of male entrants increasing from 36 per cent in 2003 to over 40 per cent in 2016, and the average age of entry increasing from 82.7 to 84.2 over the same period.

Change since 1 July 2014

The proportion of permanent residents that leave within three or six months of first entry increased from 2003-04 to 2013-14, which is in line with a decreasing average LOS (Chart 5.14). However, since 1 July 2014, this proportion has been decreasing, which will have an upwards impact on average LOS. ACFA will continue to monitor this trend to assess whether this is a temporary change due to the 1 July 2014 changes or a more permanent change.

Chart 5.11: Proportion of consumers entering permanent residential care after leaving home care, 2002-03 to 2015-16

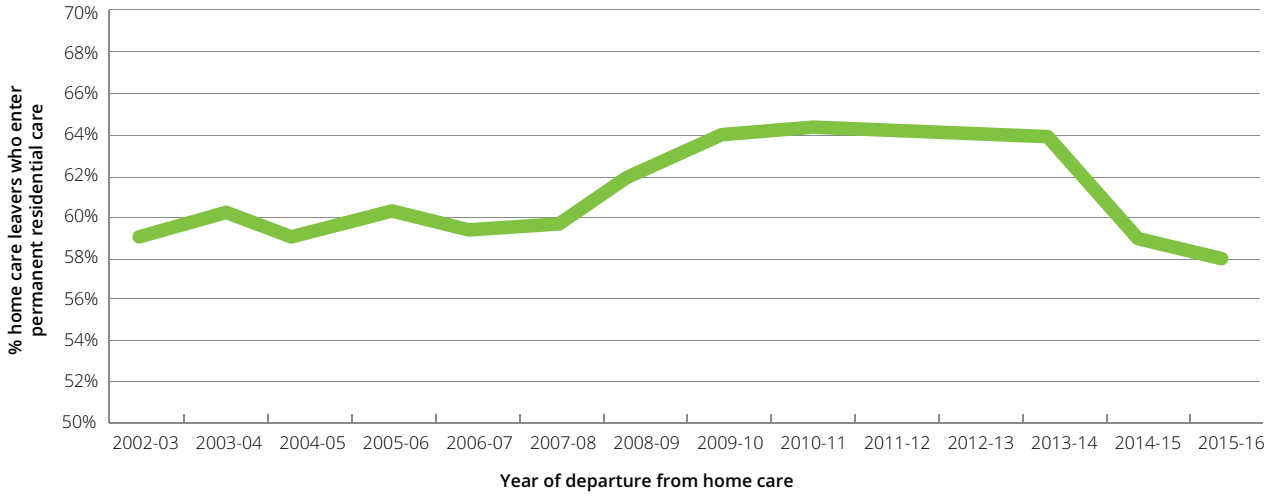


Chart 5.12: Average length of stay in residential care, by year of entry, 2003 to 2016

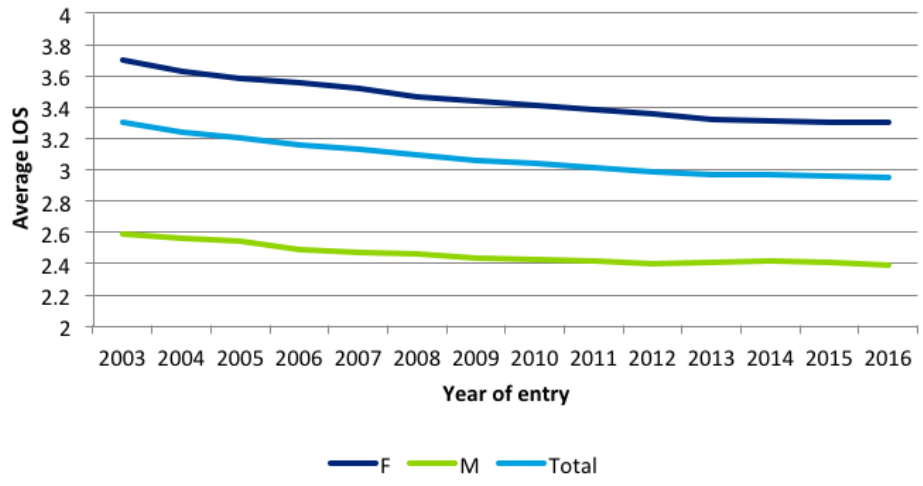


Chart 5.13: Changes in age and sex distribution, 2003 to 2016

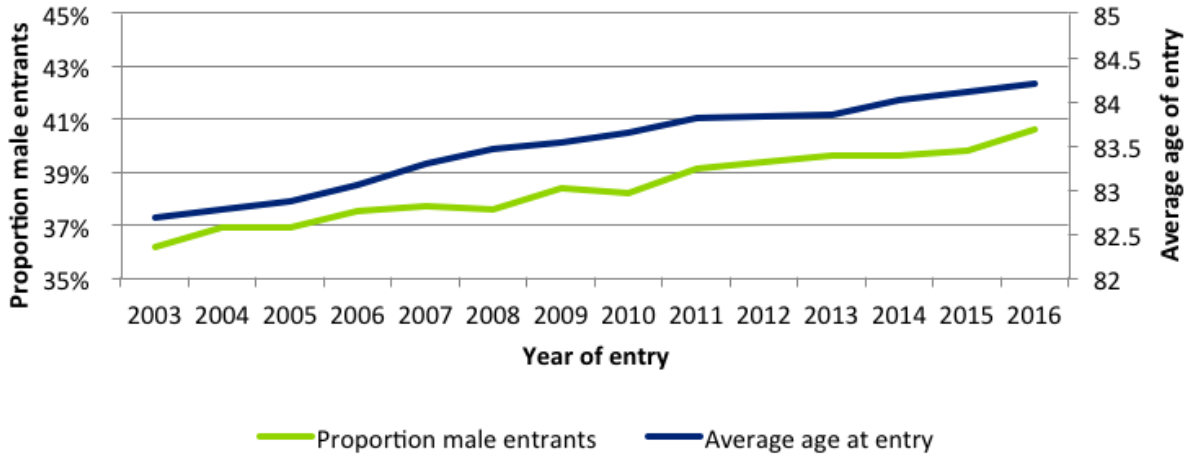
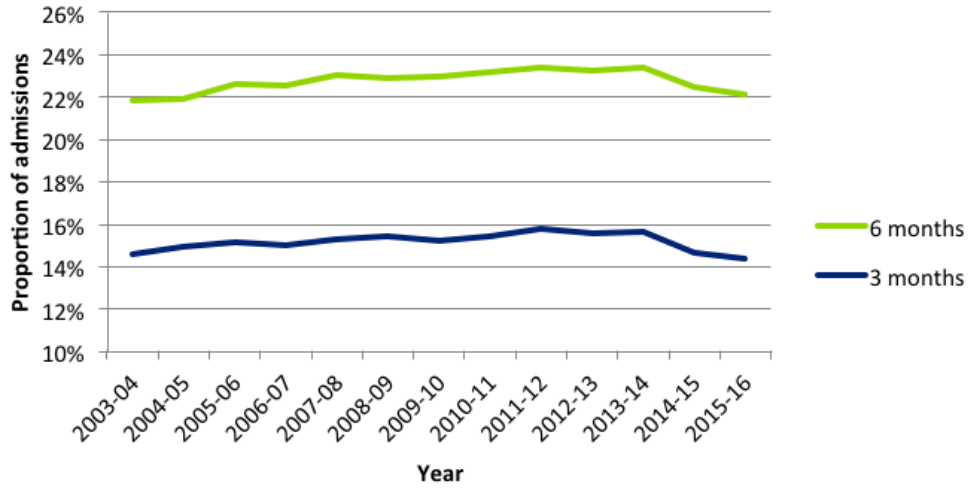


Chart 5.14: Proportion of permanent residents that leave within three or six months of first entry, 2003-04 to 2015-16



Dementia

Data that allows assessment of LOS for residents with or without dementia has not been collected for long enough to make an accurate estimate at this time. Therefore, it is not possible to compare average LOS for residents with and without a dementia diagnosis.

ACFA is however aware that available data shows that residents who enter care with dementia tend to stay in care slightly longer than those without.

5.7 Residential respite care

In recent annual reports, ACFA has noted the increasing use of residential respite care since the 1 July 2014 reforms. This section examines consumer access to residential respite care and trends behind the increase.

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

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

manner as a permanent resident. In summary, the different payment structures and rates mean that providers receive lower total income, on average, for the provision of respite care compared with permanent care.

Providers of residential respite care do not have a separate allocation of residential respite places. Rather, a portion of each permanent allocation of residential care places may be used for the provision of respite care and it is up to the provider what mix of permanent care and residential respite care that they provide. Some residential care places are subject to conditions of allocation that specify either a minimum or maximum amount of respite to be provided. Where such conditions exist, the provider's ability to determine what type of care to offer will be limited accordingly. Access to respite services will depend on a person's need/choice to access this type of care and on an approved providers willingness and ability to provide such care at that point in time.

Number of respite care consumers

The residential care reforms introduced on 1 July 2014 made no changes to residential respite care, yet the usage of respite care has increased noticeably. In 2015-16, 56,852 people received respite care, up from 53,021 in 2014-15 (a 7.2 per cent increase). This follows a 10 per cent increase from 2013-14. Prior to the reforms, the increase in consumers of respite had been around 4-5 per cent annually.

The full time equivalent number has increased by around 1,000 (around 20 per cent) over the two years since the reforms of 1 July 2014 (Chart 5.15).

Chart 5.16 shows the average respite residents (FTE) by month. As can be seen there is a strong seasonal pattern to the use of respite care, with the peak generally occurring in September. As also can be seen, the average monthly number of respite consumers (FTE) increased significantly following 1 July 2014.

Chart 5.15: Number of full time equivalent respite care consumers, 2011-12 to 2015-16

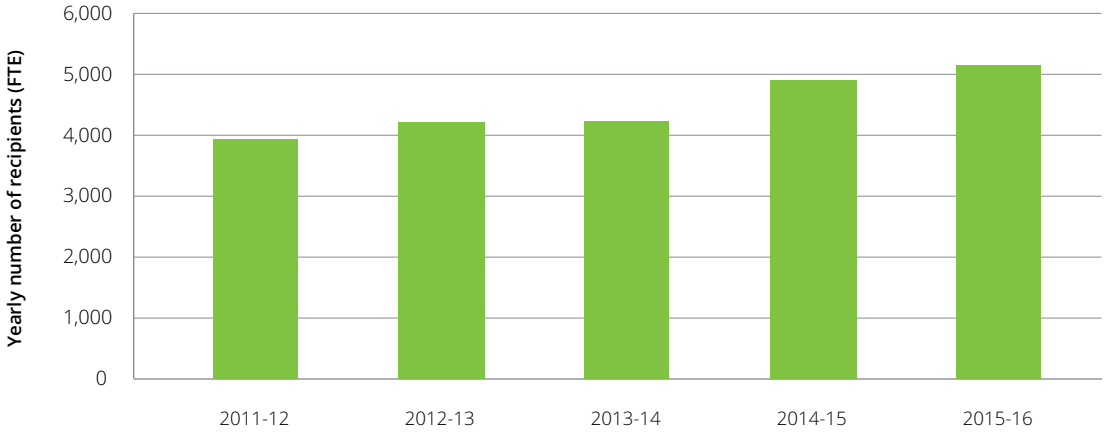
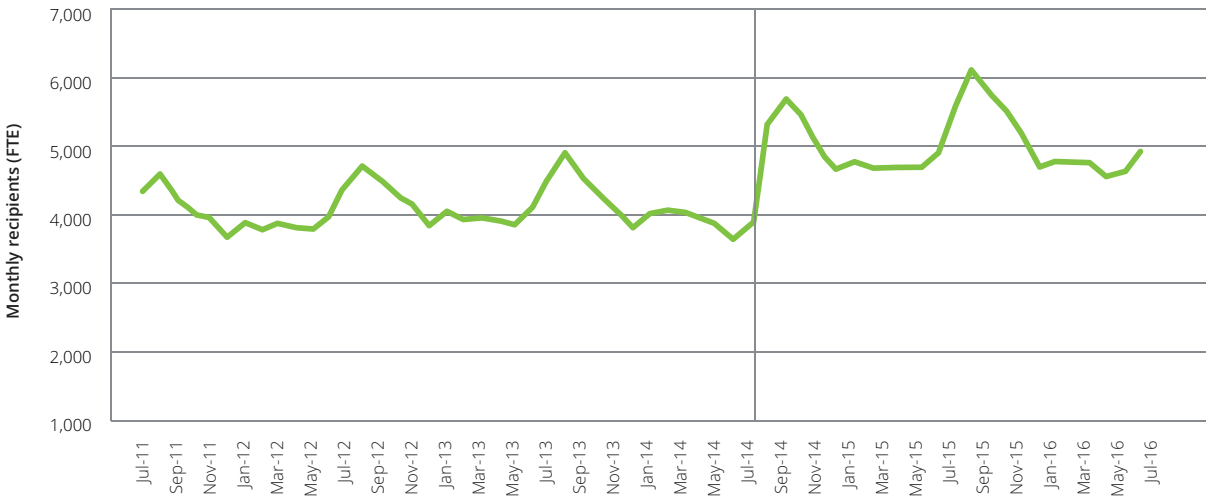


Chart 5.16: Monthly respite consumers (FTE), July 2011- June 2016



5.7.1 Length and frequency of stay in residential respite care

Throughout 2015-16, 56,852 people received respite care. Of these, on average each person had 1.4 respite care stays with each stay being an average of 26 days. The average length of stay has increased slightly from around 24 days since 1 July 2014 (Chart 5.17).

A high proportion of consumers of respite care use only one episode of respite per annum (70 per cent). This trend has remained relatively stable over the years.

A clear pattern of respite care use is that it is for whole weeks of stay at a time. A fortnight is the most common length of stay, with one or three weeks the next most common (Chart 5.18). Around 1,000 consumers (3.5 per cent) used the maximum of 63 days in one stay.

Chart 5.19 shows the cumulative average length of stay for respite residents since 2010, by care level. This indicates high care respite residents tend to stay in care longer than low care.

Chart 5.17: Average length of stay in residential respite care, 2011-12 to 2015-16

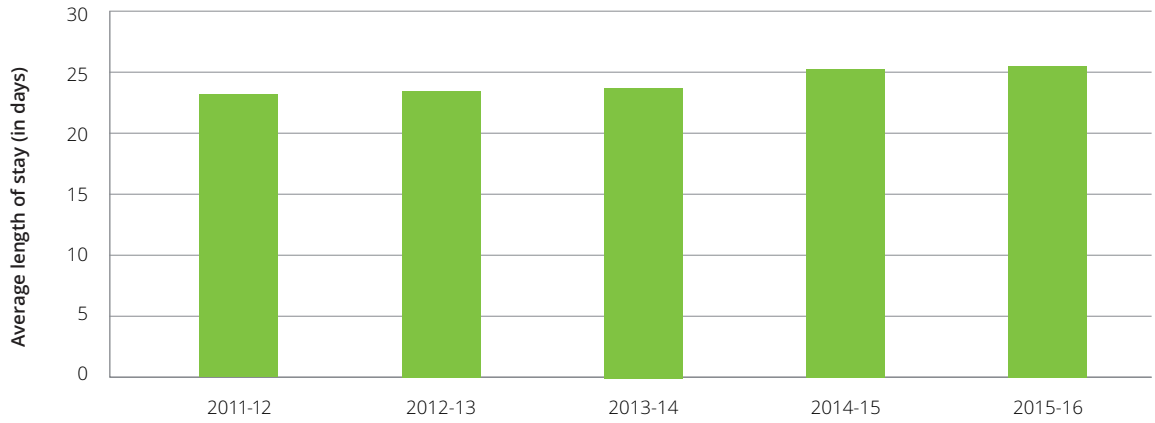


Chart 5.18: Frequency of length of respite care stay, 2015-16

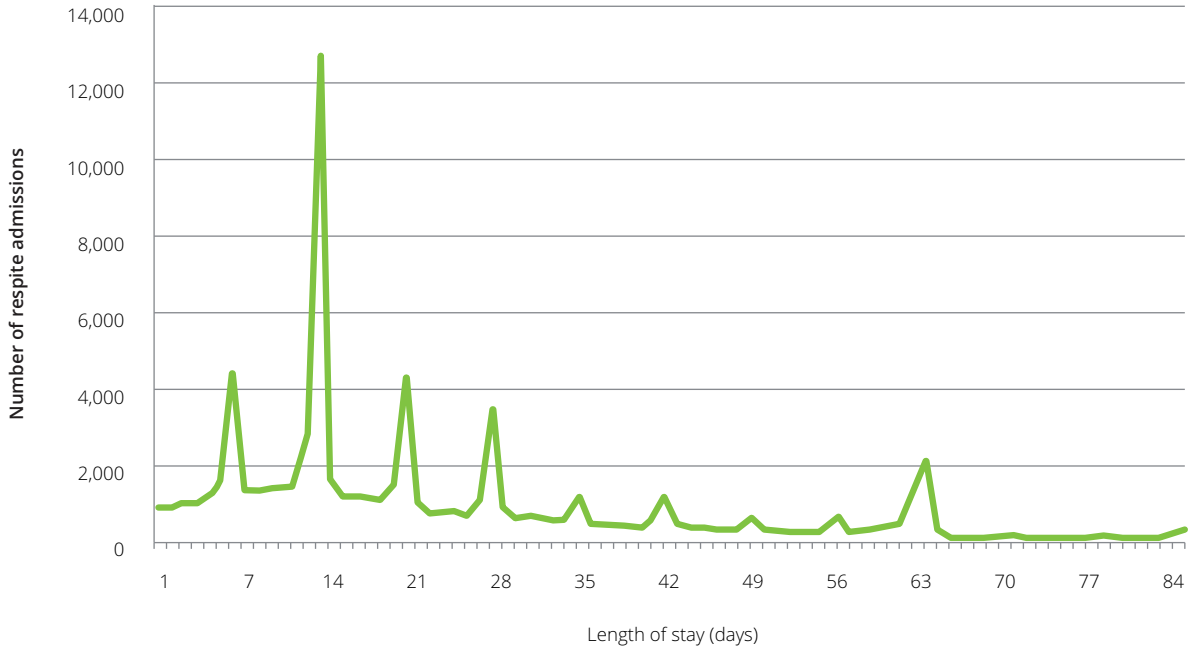
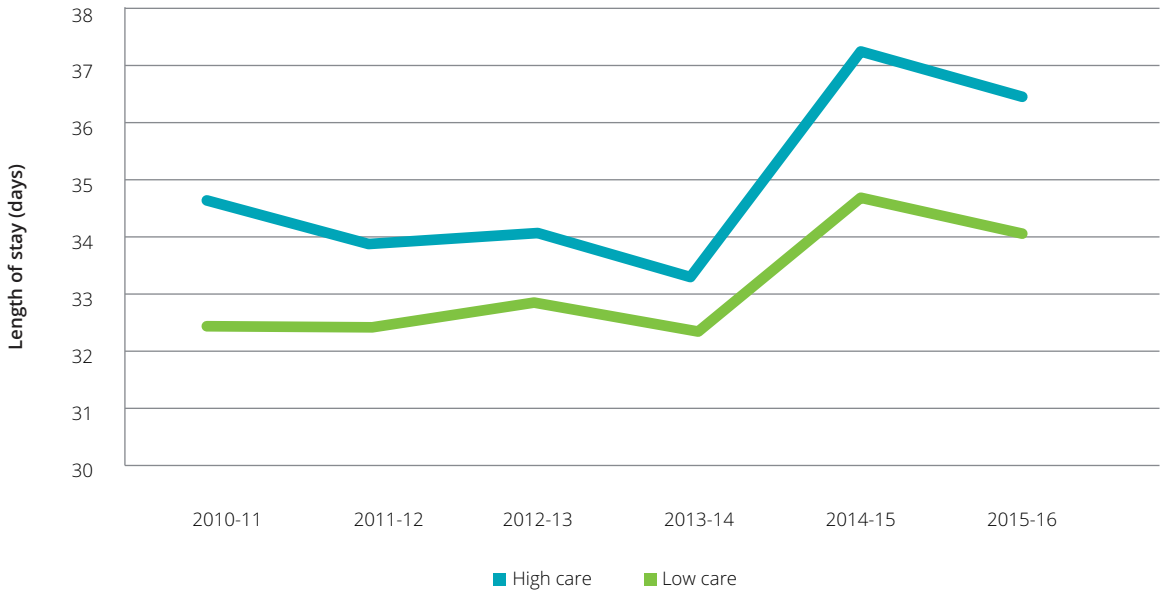


Chart 5.19: Length of respite stay by care level, 2010-11 to 2015-16

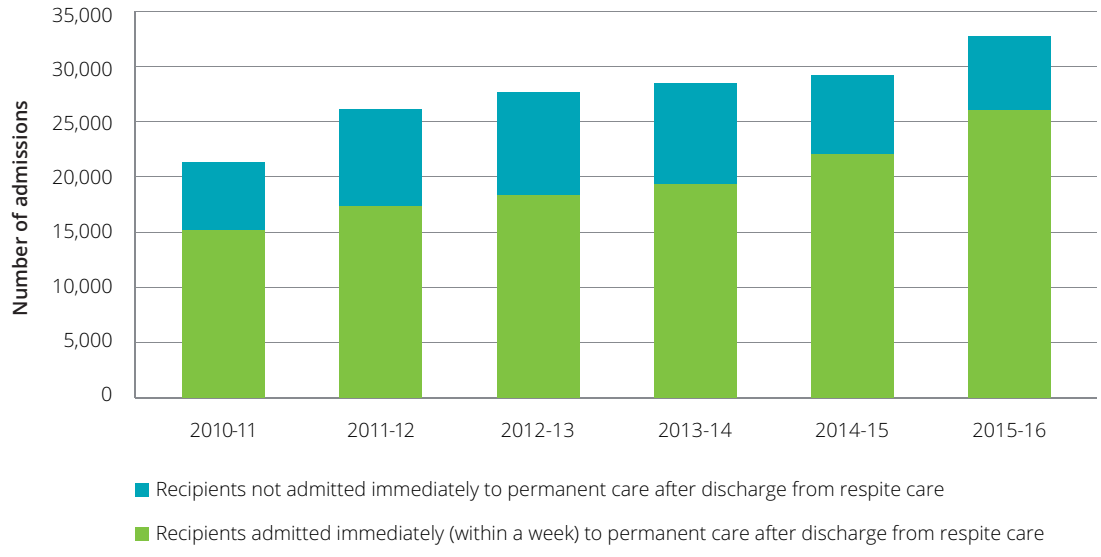


Transfers to permanent residential care

One of the factors that has been attributed to the increased usage of respite care is that people are entering respite care in higher numbers within a week prior to assuming permanent resident status. The data on admissions to permanent care supports this observation (Chart 5.20). While the number of residents entering permanent care straight after respite care has been increasing since 2010, the increase has been noticeably more significant since 1 July 2014. This increase suggests that there may be a shift in the use of respite care that appears not to be in line with the original intent. In other words, residents may be accessing respite services while they arrange their financial affairs or await means testing.

ACFA notes that data from the Department of Health indicates that around 5 per cent of home care consumers in 2015-16 also accessed some form of residential respite care. However, taking into account some data matching difficulties, the proportion could be higher.

Chart 5.20: Number of permanent care admissions, by use of respite care prior to entry into permanent care, 2011-12 to 2015-16



When admissions to permanent care after discharge from respite care were analysed by whether or not residents entered respite care as a "High" or "Low" care, a more significant change can be seen (Chart 5.21).

Prior to 1 July 2014, there was only a gradual increase in the number of permanent admissions within a week from discharge from high respite care. Since 1 July 2014, the number has increased significantly. The number of admissions to permanent care within a week of discharge from high respite care increased from 6,455 in 2013-14 to 10,807 in 2015-16 (an increase of 67 per cent). By contrast, the numbers among low respite care residents entering permanent care within a week of discharge from respite care increased by around 1,200 (9 per cent).

The data on average length of stay in respite care, which was discussed earlier in this section, has shown that consumers are staying longer in respite care; an increase of around two days from (23.6 days in 2013-14 to 25.5 days in 2015-16).

Age of respite care consumers

Chart 5.22 shows a breakdown of residential respite residents by age since 2011-12. While there is a slight increase in the proportion aged 85 and over accessing respite care, overall the age profile has remained relatively stable. Over half of all residential respite consumers are aged 85 and over, with around 40 per cent aged between 70 and 84.

ACFA will continue to monitor the usage of and changes in residential respite care.

Chart 5.21: Transfer admissions to permanent care within a week after discharge from respite care, by care type, 2010-11 to 2015-16

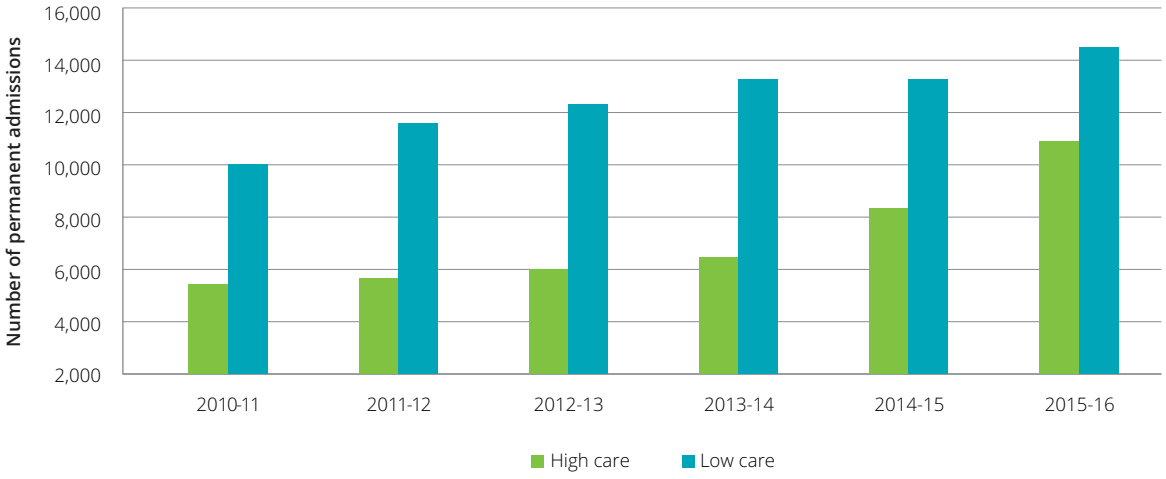
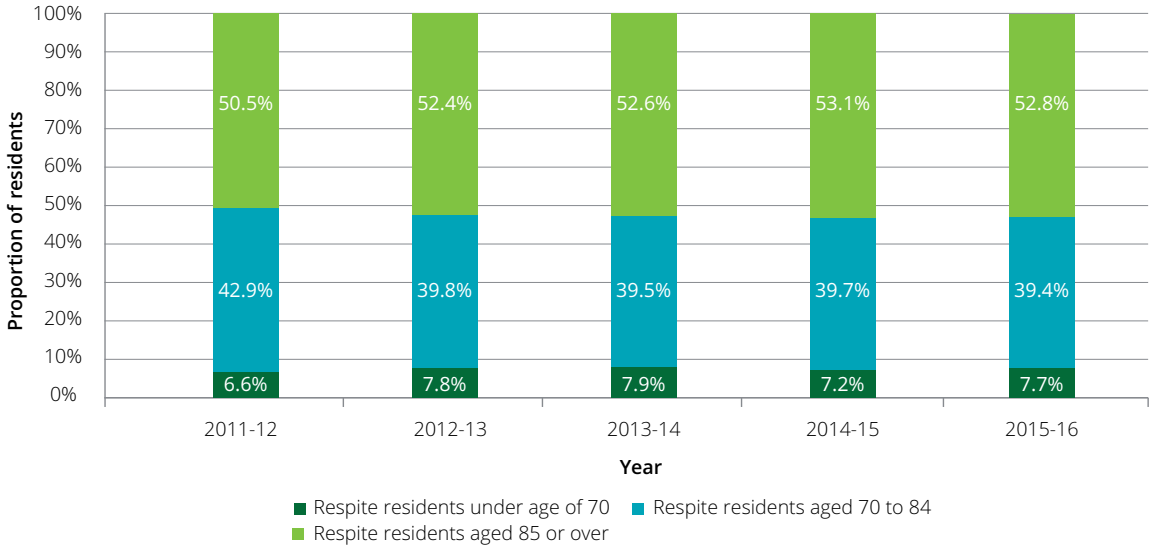


Chart 5.22: Residential respite residents by age, 2011-12 to 2015-16



5.8 Supported residents

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

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

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

Providers with 40 per cent or fewer supported residents (excluding those residents receiving extra services) in a facility have the accommodation supplement they receive for all the supported residents in that facility reduced by 25 per cent. Providers may choose to have no or low proportion of supported residents at their total discretion.

During 2015-16, across all providers, the average proportion of residents (excluding those receiving extra services) who were supported residents, was 46.8 per cent compared with 47.0 per cent in 2014-15 and 44.4 per cent in 2013-14.[14]

Table 5.10 shows that when analysed by remoteness location, the proportion of supported residents in regional and remote areas was higher in 2015-16 compared with the previous two years. In addition, the proportion of supported residents increases with increasing remoteness.

In terms of provider ownership type, not-for-profit and Government providers reported higher proportions of supported residents (48 and 52.8 per cent respectively) than the for-profit providers (44.3 per cent) (Table 5.11).

Table 5.10: Proportion of claims for supported residents, by remoteness location, 2013-14 to 2015-16

Remoteness location	2013-14	2014-15	2015-16
Metropolitan	44.0%	46.0%	45.8%
Regional	44.7%	48.3%	48.9%
Remote	59.0%	61.8%	63.5%

Table 5.11: Proportion of claims for supported residents, by provider type, 2013-14 to 2015-16

Ownership type	2013-14	2014-15	2015-16
Not-for-profit	44.5%	47.4%	48.0%
For-profit	43.7%	45.2%	44.3%
Government	47.2%	50.9%	52.8%

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

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

This is consistent with ACFA's findings in its *Report to Inform the 2016-17 Review of Amendments* to the *Aged Care Act 1997*. ACFA found that the changes to means testing and accommodation payments have not impaired access to residential care by people with low means. There has been no substantial change in the average income (in real terms) of new entrants to residential care in the years leading up to the 1 July 2014 reforms compared with people entering since then. Similarly, total admissions by pension status (i.e. full pensioner, part-pensioner and self-funded retiree) over 2014-15 and 2015-16 have not changed significantly compared with admissions for 2012-13 and 2013-14.

14 It should be noted that the average proportion of residents (excluding those receiving extra services) who were supported residents reported in the annual ACFA reports (46.8 per cent in 2015-16) is calculated using an average of claims over the whole financial year. This differs from the snapshot profile of all residents by supported/low means status (44.6 at 30 June 2016) that was reported in ACFA's *Report to Inform the Review of Amendments to the Aged Care Act 1997* provided to Government in May 2017 which is a proportion of all residents who are actually in care on 30 June 2016.

ACFA also found in its report that the higher accommodation supplement ($55.09 as at 1 July 2017) paid by the Australian Government on behalf of supported residents residing in newly built or significantly refurbished homes is broadly in line with the average accommodation prices agreed between providers and non-supported residents (DAP of $55.23). This indicates that, on average, the accommodation price the Government has set for supported residents is reasonable for generating investment in accommodation.

5.9 Future demand growth for aged care

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

The structural ageing of the Australian population over the next 20 years will see the size of the 70 years and over cohort increase by around 1 million people each decade (Chart 5.23); this is on a base of 2.6 million people. Underneath this, the older age groups will more than double over this period; for example, the 85 years and over cohort will increase from just under 500,000 people in 2017 to just over 1 million people by 2037.

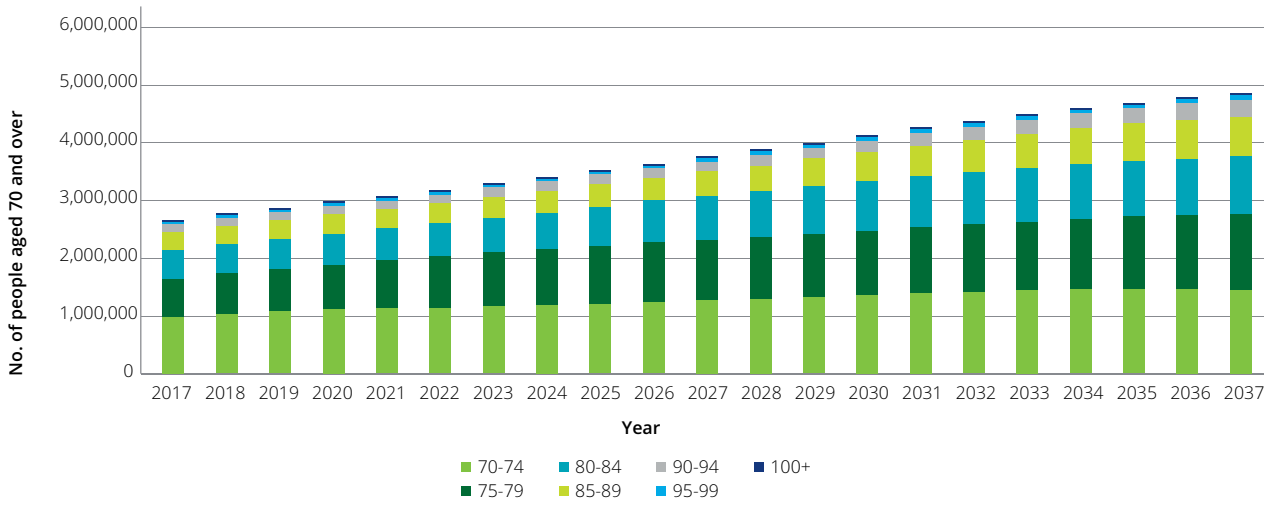
This rapid expansion in the number of older people, particularly in the oldest age groups, will result in a marked increase in demand for aged care services. As shown in Chart 5.24, the proportion of each age group who use aged care services increases dramatically with age. By age 80 years old, the proportion of people using either permanent residential care or a home care package is around 7 per cent; this doubles to 15 per cent by aged 85; and doubles again to 32 per cent by aged 90 years.

Because the baby boomers are such a large group compared with the pre-war generation, the proportion of the 70 and over population who are aged 85 and over will actually reduce over the next decade before subsequently increasing, as shown in Chart 5.25. This implies that the challenge of ensuring there is sufficient aged care supply to meet demand arising from the baby boomer generation is more likely to be felt in 10-15 years (from the late 2020s) rather than over the next decade.

When looking at the future demand for aged care, there are a number of uncertainties. The most pressing is the level of unmet demand in the population. Since residential care and home care are each supply-capped, it is difficult to ascertain directly whether demand is being met, or how close it is to being met, or whether the current spread of usage across residential care and home care would be the case if the separate supply caps did not apply.

There seems to be evidence that home care demand is not being met, at least at the level 3 and level 4 end of the spectrum. On the other hand, there appears to be some evidence for demand being met in residential care. For example, average occupancy rates are stable at about 93 per cent, but this needs to be treated with caution since there may be local undersupply in some areas that are covered by oversupply in others.

Chart 5.23: Number of people aged 70 years old and over, by 5 year age cohort, 2017 to 2037[15]



15 Source: ABS population projections, 2012

Chart 5.24: Proportion of people of each age using residential care and home care, by gender and age, 2016

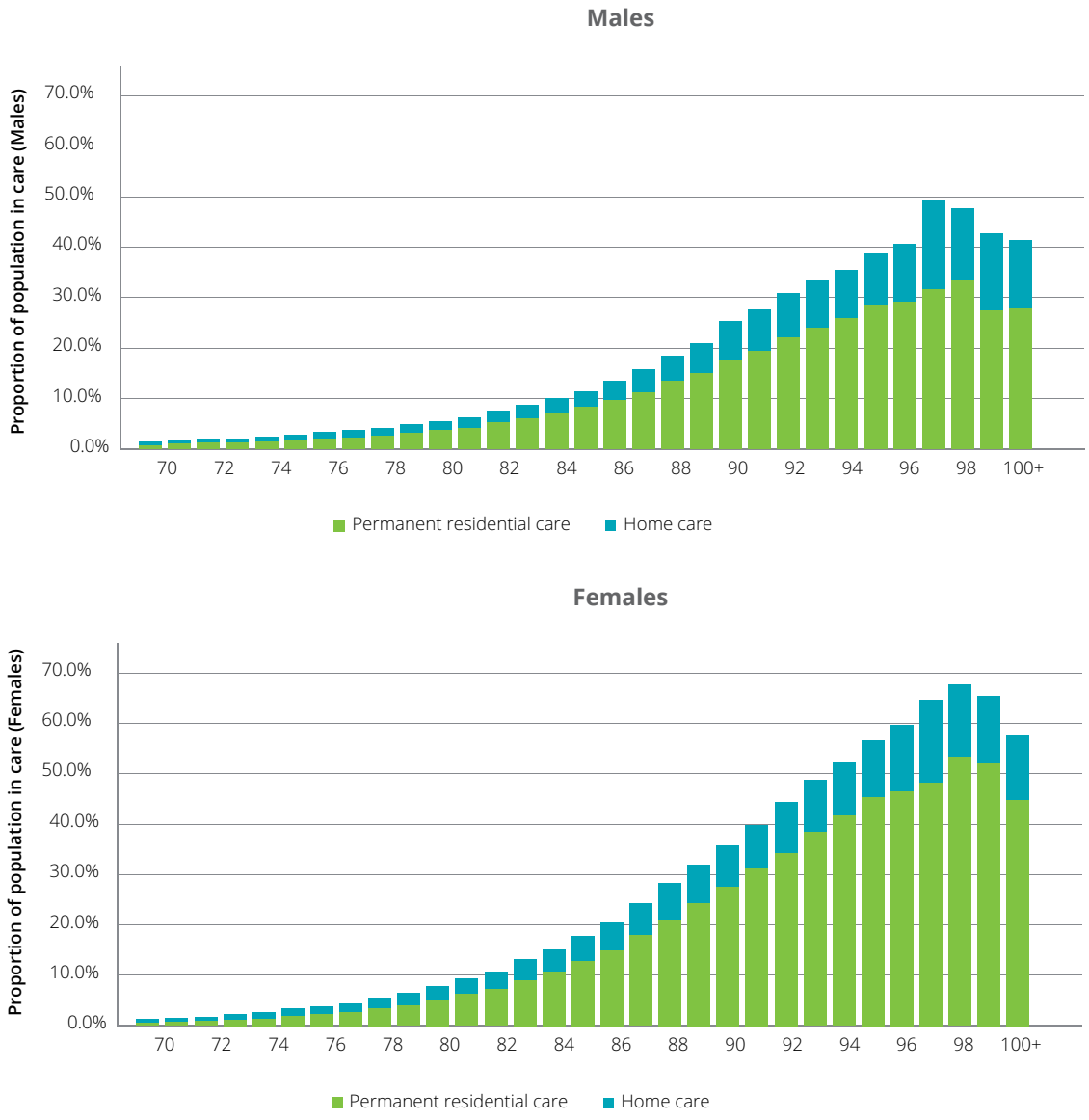
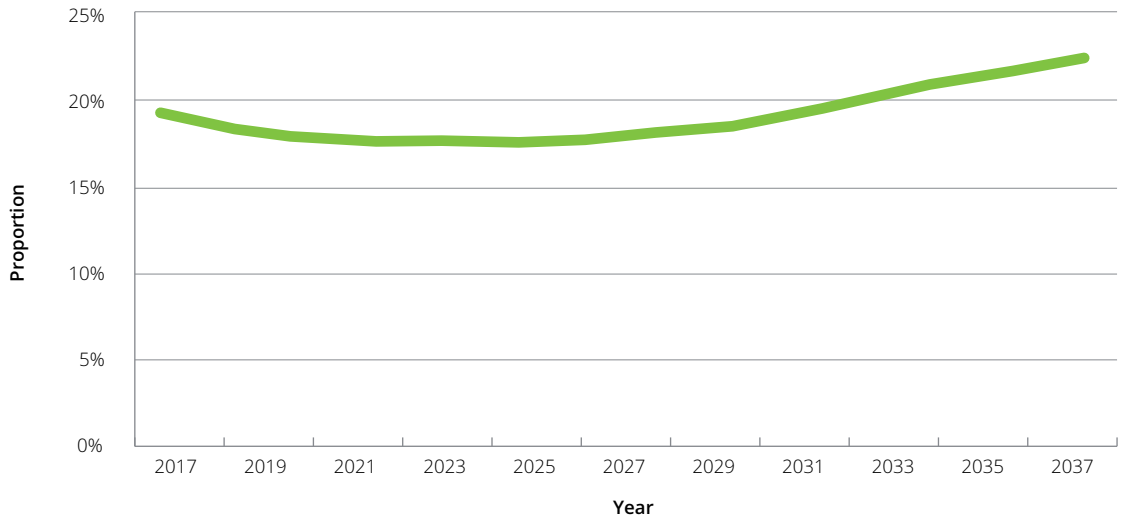


Chart 5.25: Proportion of 70+ age group who are aged 85+, 2017 to 2037



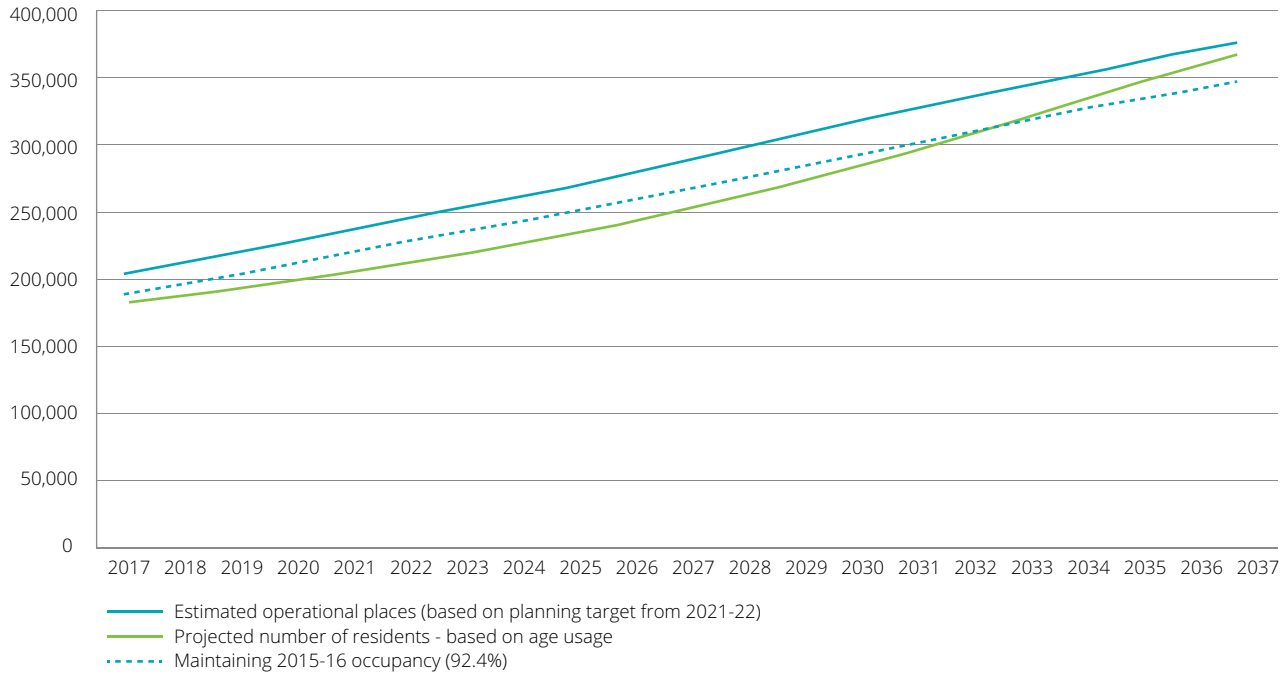
As reported in the 2015 annual report, there seems to be a relationship between expanding home care packages and a reducing proportion of each age group using residential care; this may indicate substitutability of service types. If the reduction in residential care age usage is related to the expansion of home care, then the Government's planned expansion of home care to 45 places per 1,000 people aged 70 years and over would further reduce demand for residential care; this would be observable over the next few years.

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

The solid blue line in Chart 5.26 is the expected number of operational places; this grows at the same rate as the size of the population aged 70 years and older (i.e. the provision target formula). The green line uses the current age usage of residential care, both permanent and respite care, and projects this forward with population growth in each age group; this provides an estimate of demand. As can be seen, a gap widens, which indicates that the expansion in the number of planned residential care places is in excess of the likely growth in demand. However, from about 2027, this gap starts to reduce as the baby boomers start to enter their 80s; this indicates that demand will start to grow at a faster rate than the provision target is allowing for. The dashed blue line is 92.4 per cent of the solid blue line; this would be the usage of residential care if recent occupancy levels were maintained.

ACFA notes, however, historical age-related usage rates will not necessarily apply in a more consumer-driven market-based system. Accordingly, close monitoring, analysis and reporting of occupancy rates as supply is expanded will be important for understanding future access to and demand for aged care services.

Chart 5.26: Projected demand for residential care, 2017 to 2037



5.9.1 Probability of entering permanent residential aged care

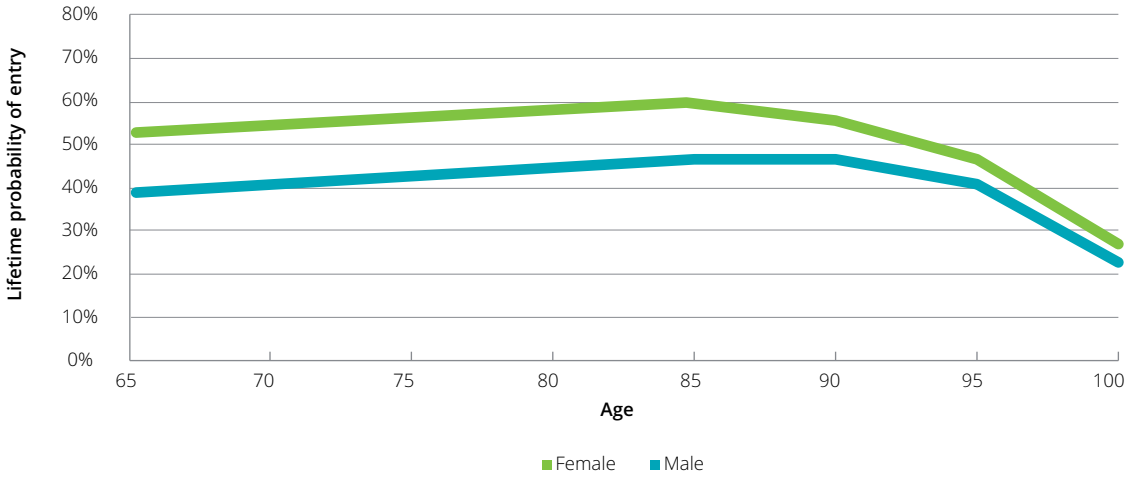
Chart 5.27 shows the probability of entering permanent residential care.

Females have a higher chance of entering care than males, though the difference between males and females reduces in older age. At age 70, the probability of an individual entering residential care in their lifetime is 55 per cent for females compared with 40 per cent for males.

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

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

Chart 5.27: Probability of entering permanent residential care, 2012 to 2014



6

Home support

6. Home Support

This chapter provides an overview of the Commonwealth Home Support Programme (CHSP) and Victorian and Western Australian Home and Community Care (HACC) programs in 2015-16.

This chapter discusses:

- the introduction and the operation of the CHSP.
- the supply and usage of CHSP and HACC.
- the funding of CHSP and HACC.

This chapter reports that in 2015-16:

- The Australian Government funded 1,686 providers to deliver CHSP and HACC services. There were 1,160 CHSP providers and 526 HACC providers in Victoria and Western Australia;
- The CHSP provided services to more than 640,000 older Australians;
- The Victorian and Western Australian HACC services provided services to 285,432 older Australians; and
- The total number of older Australians that received home support services was over 925,432.

The Australian Government contributed $2.2 billion to home support, comprising:

- $1.45 billion for CHSP;
- $147.5 million for My Aged Care and Regional Assessment Service (RAS) to support the CHSP; and
- $609 million in payments to the Victorian and Western Australian governments to support the jointly funded HACC programs.

ACFA notes that there is some data limitations regarding consumers of the CHSP in 2015-16. This is due to limited data collection for the period 1 July 2015 to 30 October 2015 when providers transitioned to the CHSP and the new reporting requirements. ACFA anticipates having more complete data and analysis regarding the CHSP in future annual reports.

6.1 Introduction – Home support

Home support provides entry-level services designed to help older Australians continue living in their own homes for as long as they can and wish to do so. The home support programs discussed in this chapter are the Commonwealth Home Support Programme (CHSP) and the Home and Community Care (HACC) programs in Victoria and Western Australia.

The CHSP provides a range of services for older people who need assistance to remain living independently at home and in their community. CHSP support is increasingly being underpinned by a wellness approach, which is about building on older people's strengths, capacity and goals to help them remain independent and to live safely at home. A list of CHSP services is provided in Table 6.1.

The HACC programs in Victoria and Western Australia provide similar services to those provided under the CHSP. In 2015-16, the HACC programs in Victoria and Western Australia were jointly funded by the Australian Government and the respective state government, with the latter also having administrative responsibility for the HACC program in their state.

6.2 Commonwealth Home Support Programme

On 1 July 2015, the Australian Government implemented the CHSP through the consolidation of the following programs:

- Commonwealth Home and Community Care program (HACC)[16];
- Planned respite services under the National Respite for Carers program (NRCP);
- Assistance with Care and Housing for the Aged program (ACHA); and
- Day Therapy Centres program (DTC).

16 Prior to 1 July 2015, the Commonwealth HACC comprised the formerly joint-funded HACC programs in all states and territories except Victoria and Western Australia.

To be eligible for CHSP, a person must be aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander people) and have difficulty performing daily activities due to functional limitations. The CHSP also supports homeless people, or people at risk of homelessness, access care and housing. To be eligible for assistance with care and housing services through the CHSP, a person must be aged 50 years and over (45 years and over for Aboriginal and Torres Strait Islander people), on a low income and be homeless or at risk of homelessness as a result of experiencing housing stress or not having secure accommodation.

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

Table 6.1 sets out the types of services that may be accessed through the CHSP.

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

Sub-Program	Community and home support	Care relationships and carer support	Assistance with care and housing	Service system development
Objective	To provide entry-level support services to assist frail, older people to live independently at home and in the community.	To support and maintain care relationships between carers and clients, through providing good quality respite care for frail, older people so that regular carers can take a break.	To support those who are homeless or at risk of homelessness, to access appropriate and sustainable housing as well as community care and other support services, specifically targeted at avoiding homelessness or reducing the impact of homelessness.	To support the development of the community aged care service system in a way that meets the aims of the CHSP and broader aged care system.
Service types funded	• Meals • Other food services • Transport • Domestic assistance • Personal care • Home maintenance • Home modifications • Social support-individual • Social support-group (formerly centre-based day care) • Nursing • Allied health and therapy services • Goods, equipment and assistive technology • Specialised support services	Flexible respite: • In-home day respite • In-home overnight respite • Community access – individual respite • Host family day respite • Host family overnight respite • Mobile respite • Other planned respite • Centre-based respite • Centre based day respite • Residential day respite • Community access-group respite • Cottage respite (overnight community)	Assistance with care and housing	Sector support and development activities

6.3 Home and Community Care — Victoria and Western Australia

In 2015-16, the Victorian and Western Australian HACC programs provided services for older Australians needing support, as well as younger people with a disability.

HACC provides support services for eligible older consumers and their carers to assist them to continue living independently at home. Support services include:

- social support and counselling;
- respite care and centre-based day care;
- transport;
- domestic assistance and home maintenance;
- home modifications;
- nursing and allied health care;
- personal care;
- meals;
- goods and equipment; and
- case management and care coordination.

During 2015-16, Victorian and Western Australian HACC services were delivered through the jointly funded HACC programs under the HACC Review Agreement 2007. Consumers continued to be assessed for HACC services through the HACC program assessment arrangements.

From 1 July 2016, Victorian HACC services for older people were integrated into the CHSP while HACC services in Western Australia will transition to the CHSP from 1 July 2018.

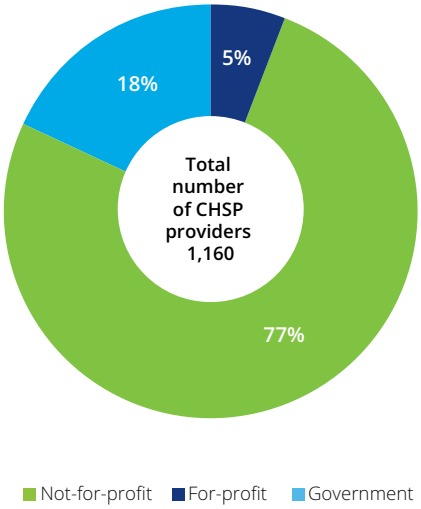
6.4 Sector overview

6.4.1 Supply of home support

In 2015-16, there were 1,160 providers of home support under the CHSP consolidating the former Commonwealth HACC, NRCP, ACHA and DTC programs. A direct comparison with providers in 2014-15 of the previous programs that formed the CHSP is not possible as data pertaining to providers of NRCP, ACHA and DTC is not available for all programs.

As was the case for the former Commonwealth HACC program, CHSP services are predominately provided by not-for-profit organisations (77 per cent), as shown in Chart 6.1.

Chart 6.1: CHSP providers by provider ownership type, 2015-16

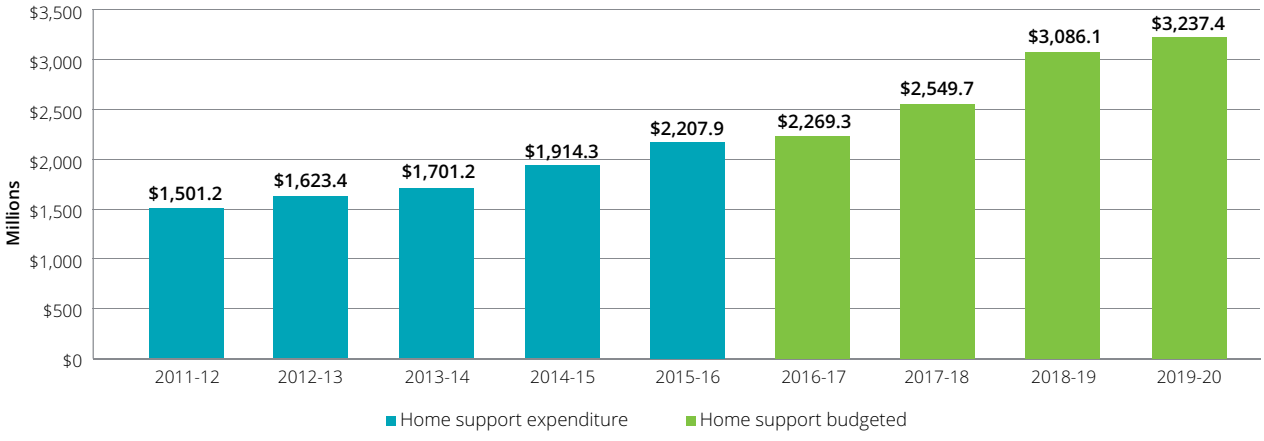


6.5 Funding for CHSP and HACC

In 2015-16, the Commonwealth provided funding of $1.45 billion for the CHSP. An additional $147.5 million was spent on My Aged Care and the Regional Assessment Service to support the implementation of the CHSP. The Commonwealth also contributed $609 million to the joint Commonwealth-state funded HACC programs in Victoria and Western Australia ($580 million in 2014-15). Total Commonwealth expenditure on home support was $2.2 billion. Chart 6.2 shows total expenditure on home support since 2011-12, and budgeted expenditure to 2019-20.

As shown in Chart 6.2, Commonwealth funding for home support across Australia has increased annually since 2011-12.

Chart 6.2: Government expenditure and budgeted expenditure of CHSP, HACC and Victorian and Western Australian HACC programs, 2011-12 to 2019-20



As part of the 2014-15 Budget, the Australian Government announced a reduction in the annual real rate of growth for the CHSP from 6 per cent to 2.8 per cent in 2015-16, 1.5 per cent in 2016-17 and 2.4 per cent in 2017-18. From 1 July 2018, the growth rate will be set at 3.5 per cent per annum to align funding growth with the annual growth in the population aged 65 and over. Real growth is in addition to annual indexation.

Chart 6.3 shows the Commonwealth expenditure for home support (including Victorian and Western Australian HACC) in 2015-16 by state and territory.

Table 6.2 shows a breakdown of the size of grants provided through the CHSP in 2015-16 by organisation type. The vast majority (87 per cent) of providers receive less than $1 million and of those, three-quarters receive less than $500,000.

Table 6.2: CHSP grants provided in 2015-16, by size of grant and organisation type

Grant size	Not-for-profit	For-profit	Government
Less than $1 million	810	21	178
$1-10 million	108	6	26
$10-50 million	7	1	4
Over $50 million	1	2	0

6.5.1 Consumer contributions

In October 2015, the Department released the *Client Contribution Framework* and *the National Guide to the CHSP Client Contribution Framework*. The Framework outlines a number of principles that CHSP providers can adopt in setting and implementing their own client contribution policy.

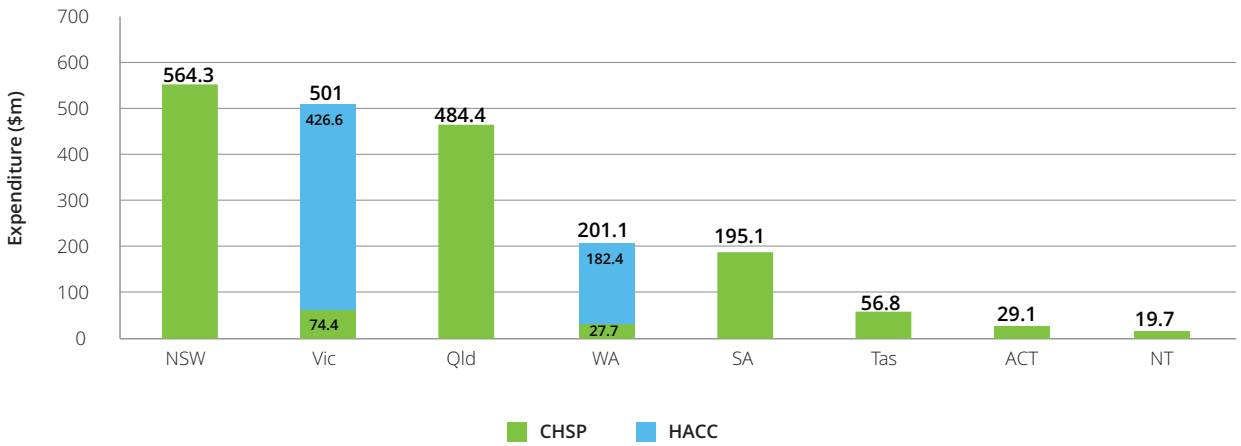
The principles are designed to introduce fairness and consistency, with a view to ensuring that those who can afford to contribute do so, whilst protecting the most vulnerable. Due to the data limitations noted at the beginning of this chapter, the amount of consumer contributions in CHSP in 2015-16 is not known. In last year's annual report, ACFA noted that consumer contributions in the HACC programs were on average around 10 per cent of the total Commonwealth funding amount.

6.6 Looking forward

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

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

Chart 6.3: Commonwealth expenditure on CHSP and HACC services during 2015-16, by state and territory



7

Home care: operational performance

7. Home care: operational performance

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

This chapter discusses:

- the operation of home care.
- funding of the sector.
- financial performance of home care providers in 2015-16.

The chapter reports that:

- home care providers received an estimated $1.8 billion in revenue in 2015-16, paid around $1.6 billion in expenses and generated $183 million in profit;
- services were provided to 88,875 consumers;
- 75 per cent of home care package providers achieved net profit in 2015-16, compared with 72 per cent in 2014-15;
- average EBITDA was $2,086 per package, compared with $2,235 in 2014-15, a 6.7 per cent decrease; and
- average NPBT was $1,949 per package, compared with $2,081 in 2014-15, a 6.3 per cent decrease.

7.1 The Home Care Packages Programme

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

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

Consumers may purchase the following:

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

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

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

To obtain access to a home care package, individuals are first assessed by an Aged Care Assessment Team (ACAT) which determines eligibility for a home care package. Prior to 27 February 2017, a consumer approved for home care would have to locate a provider with a vacant package at their assessed level (or alternatively join a wait list managed by the provider). Since the reforms, consumers may direct their package to a preferred provider. Some components of the package may be sub-contracted by the primary provider.

Some home care providers operate only one service while some operate multiple services. Services are spread across metropolitan, regional and remote locations throughout Australia.

7.1.1 Measuring performance of home care

This chapter provides an overview of the funding of home care and the financial performance of home care providers in 2015-16.

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

Financial information reported in this chapter has been collected through the 2015-16 home care financial reports. The Accountability Principles 2014, made under Section 96-1 of the *Aged Care Act 1997*, require each provider to submit a financial report in a form approved by the Secretary of the Department of Health. It should be noted however that home care financial reports are not required to be audited and should not be considered a General Purpose Financial Report.

Ninety-five per cent of home care providers submitted their 2015-16 financial reports to the Department in a usable form. Therefore, the financial performance analysis throughout this chapter is based on this sample. Wherever appropriate, the sample data has been scaled up to estimate totals for all home care providers.

7.2 Providers of home care

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

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

Table 7.1 provides an overview of the number of home care providers, services operated and allocated packages over the last five years to 2015-16 while Table 7.2 provides this overview broken down by ownership type, remoteness location and provider scale for all home care providers in 2015-16.

While the number of home care providers has declined since 2014-15, as reported in Chapter 4, the number of applications to become an approved home care provider rose significantly in the early part of 2016-17. Given this, the total number of home care providers could be expected to increase significantly in 2016-17.[17]

Table 7.1: Provider numbers, number of services and number of packages, 2011-12 to 2015-16

	30 June 2012	30 June 2013	30 June 2014	30 June 2015	30 June 2016
No. of providers	498	504	504	504	496
No. of services	2,095	2,131	2,212	2,292	2,099
No. of packages	59,201	60,308	66,149	72,702	78,956

17 Over 200 new providers have been approved in 2016-17.

Table 7.2: Provider numbers, number of services and number of packages, by ownership type, remoteness location and provider scale, as at 30 June 2016

			Ownership type		Remoteness location				Provider scale		
	30 June 2015	30 June 2016	Not-for-profit	For-profit	Government	Metropolitan	Regional	Metropolitan & regional	Single service	Two to six services	Seven or more services
No. of providers	504	496	347 70%	65 13%	84 17%	248 50%	218 44%	30 6%	223 45%	194 39%	79 16%
No. of services	2,292	2,099	1,658 79%	273 13%	168 8%	1,070 51%	483 23%	546 26%	210 10%	546 26%	1,343 64%
No. of packages	72,702	78,956	64,669 82%	8,182 10%	6,105 8%	45,005 57%	11,843 15%	22,108 28%	7,896 10%	19,739 25%	51,321 65%

In 2015-16 there were 496 providers of home care (down from 504 in 2014-15) that held 78,956 packages (up from 72,702). The number of services operated by all providers fell in 2015-16 compared with 2014-15 (2,099 down from 2,292). Throughout 2015-16, 88,875 older Australians were in receipt of a package at some point.

In 2015-16, level 2 packages comprised the majority of all operational packages (66 per cent), followed by level 4 (21 per cent). Level 3 and level 1 packages comprised 9 per cent and 3 per cent respectively.

As illustrated in Chart 7.1 and Table 7.3, not-for-profit providers continue to provide the most packages across all levels.

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, with 24 and 16 per cent compared with 9 and 12 per cent. Overall, the total share of packages provided by for-profit providers increased from 10.1 per cent to 10.4 per cent in 2015-16 (Chart7.2), continuing the trend previously noted, albeit gradual, of for-profit providers increasing their share of the home care market.

Chart 7.1: Package levels by provider ownership type, as at 30 June 2016

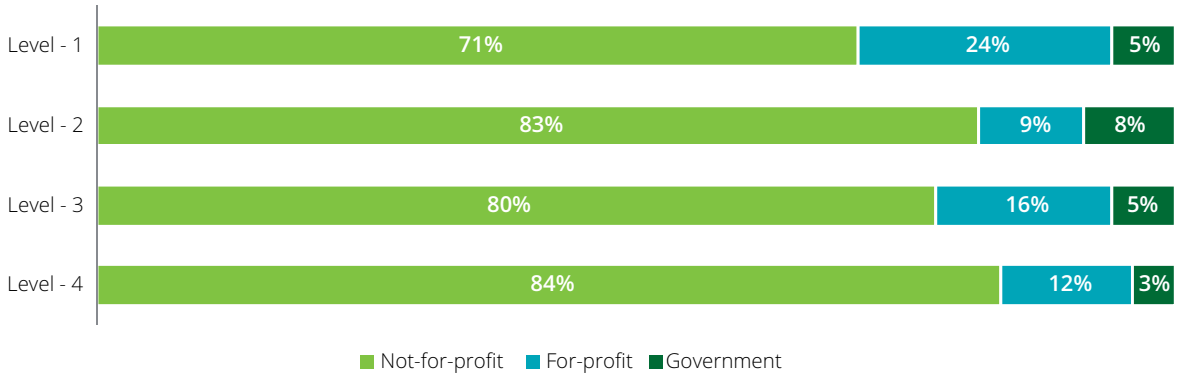
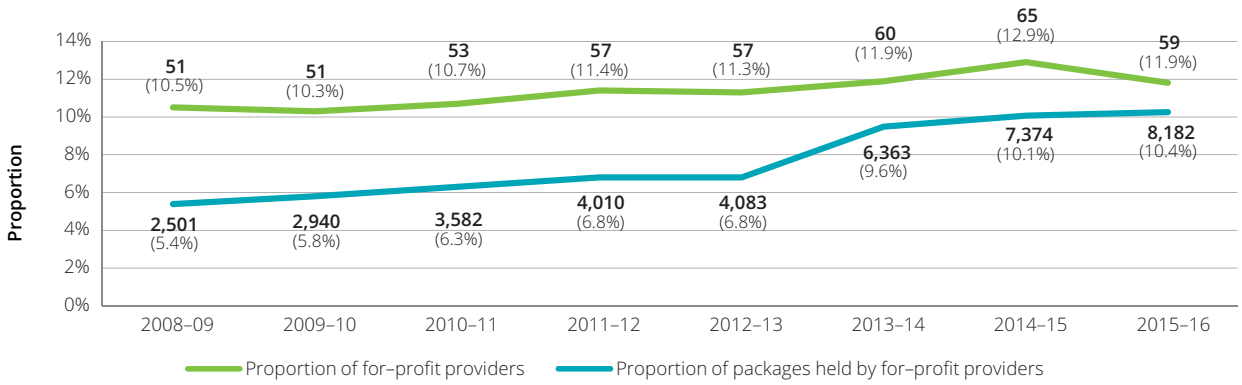


Table 7.3: Home care packages by ownership type and package level, 30 June 2016

Level	Not-for-profit	For-profit	Government	Total
Level 1	1,597	515	142	2,254
Level 2	43,037	4,486	4,892	52,415
Level 3	5,823	1,128	418	7,369
Level 4	14,212	2,053	653	16,918
Total	**64,669**	**8,182**	**6,105**	**78,956**

Chart 7.2: Number and proportion of for-profit providers and packages, 2008-09 to 2015-16



The current share of packages held by ownership type reflects past Aged Care Approvals Round (ACAR) allocations. ACFA notes that the February 2017 changes that allow consumers to direct their package to their preferred provider mean that providers' market shares will no longer be determined by the ACAR but by consumer choice. ACFA will monitor the impact of this more competitive environment on provider market shares.

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 will continue to increase significantly from 78,956 as at 30 June 2016 to around 140,000 packages by 2021-22.

Chart 7.3 shows the breakdown of operational home care places by provider organisation type. In the forthcoming analyses, not-for-profit is further broken down into religious, charitable and community based organisations.

Table 7.4 shows the number of operational home care packages by provider ownership type, and by state and territory.

Chart 7.3: Operational home care places by provider organisation type, 30 June 2016

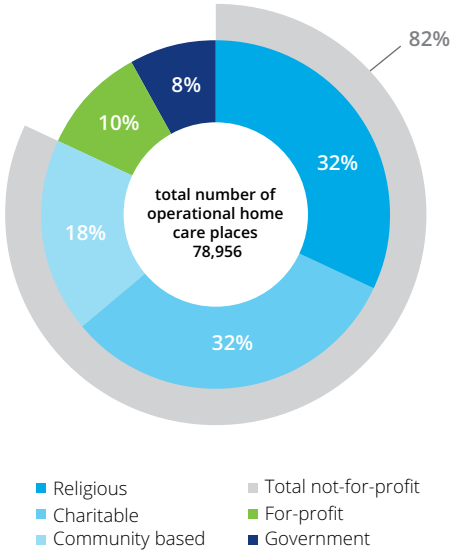


Table 7.4: Operational home care packages, by provider ownership type and state and territory, as at 30 June 2016

State/territory	Religious	Charitable	Community based	For-profit	Government	Total
NSW	7,399	9,178	5,193	2,689	1,151	25,610
VIC	6,746	4,673	3,337	1,266	3,462	19,484
QLD	5,819	3,976	3,062	1,352	315	14,524
WA	2,873	3,304	400	1,753	372	8,702
SA	1,631	3,167	687	367	252	6,377
TAS	558	498	566	329	8	1,959
ACT	201	593	316	171	0	1,281
NT	197	8	295	255	272	1,027
Australia	25,424	25,389	13,856	8,182	6,105	78,956
% of Total	**32.2%**	**32.2%**	**17.5%**	**10.4%**	**7.7%**	**100%**

Across Australia, almost 69 per cent of operational home care places are in major cities with just under 21 per cent in 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.

7.3 Analysis of 2015-16 financial performance of home care providers

Home care providers submit financial performance reports to the Department of Health using the home care financial report. The financial report was introduced in 2013-14 to provide more comprehensive information that encompasses all levels of packages.

Prior to the 2015 annual report (presenting the 2013-14 financial results), ACFA used data from financial reports which provided financial data only in relation to CACPs and did not include data in relation to EACH and EACH-D packages. Therefore it is not possible to compare some financial results prior to 2013-14 with results from 2013-14 and beyond. This year's report does however afford the opportunity for direct comparison across the three financial years from 2013-14 to 2015-16.

Table 7.5 provides an overview of the 2015-16 financial performance of home care providers whose financial reports were submitted in a useable form. Further analysis is then presented by ownership type, remoteness location and provider scale. While much of the analysis and commentary regarding the profitability and financial performance of providers relates to only those who submitted their useable financial reports, where possible and appropriate, the results have been scaled up to represent all home care providers.

7.3.1 Revenue

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

In 2015-16, total sector revenue for all home care providers is estimated at being approximately $1.8 billion, up from an estimated $1.4 billion in 2014-15, an increase of 26 per cent. Commonwealth contributions represent more than 80 per cent of the total revenue received by home care service providers, about the same as in 2014-15.

Table 7.5: Summary of financial performance of home care providers who submitted their home care financial reports, 2015-16

	Total sector 2014-15	Total sector 2015-16	Not-for-profit	For-profit	Government	Metropolitan	Regional	Metropolitan & regional	Single service	2 to 6 services	Seven or more services
Total revenue ($ m)	$1,166.2	$1,390	$1,180.2	$114.2	$95.6	$801.4	$211.5	$376.9	$119.2	$366.0	$904.7
Total expenses ($ m)	$1,039.7	$1,248.3	$1,076.7	$87.0	$84.6	$715.2	$186.1	$346.9	$111.5	$328.4	$808.3
Profit ($ m)	$126.5	$141.7	$103.4	$27.2	$11.0	$86.2	$25.4	$30.1	$7.7	$37.6	$96.3
Average EBITDA per package	$2,235	$2,086	$1,824	$4,837	$2,122	$2,184	$2,462	$1,661	$1,141	$2,112	$2,239
Average NPBT per package	$2,081	$1,949	$1,685	$4,720	$1,992	$2,053	$2,280	$1,536	$981	$1,944	$2,119
EBITDA margin	11.6%	10.9%	9.5%	24.5%	12.3%	11.4%	13.0%	8.6%	7.5%	11.2%	11.3%
NPBT margin	10.8%	10.2%	8.8%	23.9%	11.5%	10.8%	12.0%	8.0%	6.5%	10.3%	10.7%

Commonwealth funding

In 2015-16, total Commonwealth expenditure on home care subsidies and supplements was $1.49 billion, comprising $1.46 billion in subsidies and the remaining $33 million in supplements, an increase of 16 per cent on $1.28 billion in 2014-15. By 2019-20 it is projected that total Commonwealth expenditure will be around $2.65 billion (Chart 7.4).

Commonwealth subsidy and supplement revenue that was reported by home care providers who submitted their financial reports for 2015-16 was $1.15 billion, with an additional $0.24 billion reported for consumer contributions and other revenue sources, totalling $1.39 billion.

Total sector revenue has been derived by including $1.49 billion that was paid by the Commonwealth in supplement and subsidy funding during 2015-16 and an estimated $0.31 billion from consumer contributions and other revenue sources, with the latter scaled up to represent 100 per cent of the sector. Although $1.49 billion was paid by the Commonwealth in subsidy and supplement funding, the proportionally lower amount that was reported by home care providers ($1.15 billion) is partly due to unspent home care package funds for services that were yet to be delivered and therefore not booked as revenue.

As discussed in Section 7.3.4, in readiness for the changes applying to home care in February 2017, many providers have adjusted their business models and pricing structures to adapt to the more competitive market-driven environment.

Commonwealth funding is determined per consumer based on the level of package accessed. It is calculated on a daily basis and paid monthly. Each package level has a fixed maximum amount of annual funding set by the Commonwealth (Table 7.6). Supplements can also be paid in circumstances where the consumer requires additional care and/or services.

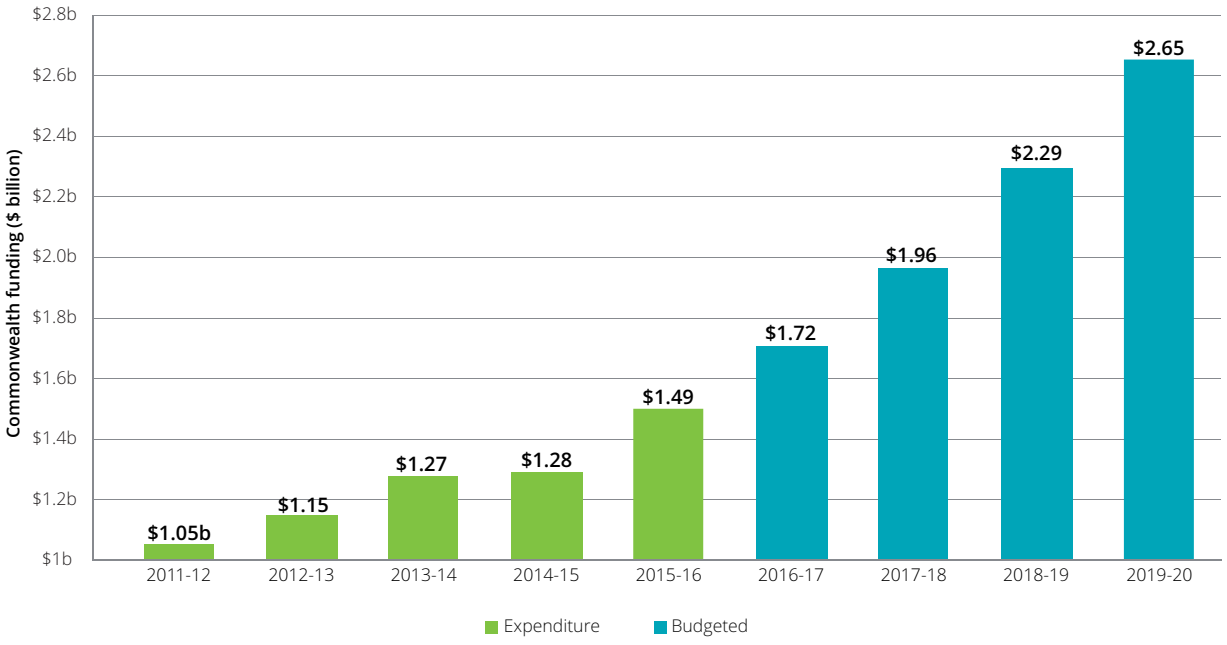
Prior to the changes that occurred in home care in February 2017, when consumers moved between home care providers or exited care (often to enter residential care), unspent package funds could be retained by the former home care provider. Under the new arrangements applying from this date, unspent package funds will follow the consumer to their new home care provider or be returned to the Commonwealth when the consumer leaves care. Unspent package funds will not generally, and should not, be recognised as income until the funds have been spent or are committed for the consumers care.

Table 7.6: Maximum home care subsidy payments per annum, 2015-16

Package level	2015-16 annualised subsidy
Level 1	$8,045
Level 2	$14,633
Level 3	$32,171
Level 4	$48,906

Reductions apply to the Commonwealth subsidy and supplement amounts in respect of consumer income tested fees, where applicable.

Chart 7.4: Total Australian Government expenditure on home care, 2011-12 to 2015-16 and budgeted expenditure to 2019-20



Home care supplements

Supplements in home care are paid in addition to the amount of basic subsidy applicable at each package level. Supplements are paid if a consumer is eligible due to a specific care need or circumstance. The supplements that apply to home care are set out below. The amount of expenditure on each supplement in 2015-16 is at Appendix L. All supplements are included in the consumer's individualised budget.

The Dementia and Cognition supplement

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

The Veterans' supplement

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

The Oxygen supplement

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

Enteral Feeding supplement

The enteral feeding supplement provides additional funding for care recipients with a specified medical need for enteral feeding.

Viability supplement

The viability supplement is paid in recognition of the higher costs of providing services in rural and remote areas.

Hardship supplement

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

Consumer contributions

Consumers may be asked, 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 $10.10 a day/$3,686 per annum). The basic daily fee is not subject to an income or asset test and all consumers can be asked to pay unless they prove financial hardship, in which case the Commonwealth pays the provider on their behalf. The basic daily fee, when charged by the service provider, must be included in the individualised budget for the consumer.

Additionally, consumers may be asked to make a contribution towards the cost of their care through an income tested fee. The amount paid by the Commonwealth on behalf of a consumer is automatically reduced by the amount of the income tested fee, even if the provider chooses not to charge all or part of the fee. The provider is still required to deliver services to the full value of the package, including the full income tested fee, plus the basic daily fee if charged.

7.3.2 Expenditure

Total expenditure in 2015-16 was around $1.6 billion. This is scaled up for all providers based on those that provided their home care financial reports. This compares with $1.4 billion in 2014-15.

The average expenditure per consumer per day was $68.88 ($25,141 per consumer for the year), up from $59.84 in 2014-15, an increase of 15 per cent. This is a considerable increase given the increase in expenses per day from 2013-14 to 2014-15 was only 2 per cent. As Table 7.7 shows, the main drivers behind the increase in expenses in 2015-16 compared with 2014-15 were care related salaries, which increased $4.56 per day (13 per cent) and other care related expenses (including consumables such as food and cleaning products, travel expenses and amounts paid to sub-contract services), which increased by $2.96 per day (26 per cent).

Table 7.7: Home care expenditure per consumer per day, 2013-14 to 2015-16

Expenses	2013-14	2014-15	2015-16
Care related salaries	$35.70	$36.19	$40.75
Admin salaries and management fees	$8.78	$10.08	$10.55
Other care related expenses and sub-contracted care services	$11.72	$11.50	$14.46
Other expenses and non-direct costs	$2.56	$2.07	$3.12
Totals	**$58.76**	**$59.84**	**$68.88**

Care related salary costs are the main expense item for providers at 59 per cent while other care related expenses and administration salaries and management fees make up 21 and 15 per cent respectively. Chart 7.5 shows the proportion of expense types reported by providers in 2015-16.

Chart 7.5: Proportion of expense types reported by home care providers, 2015-16

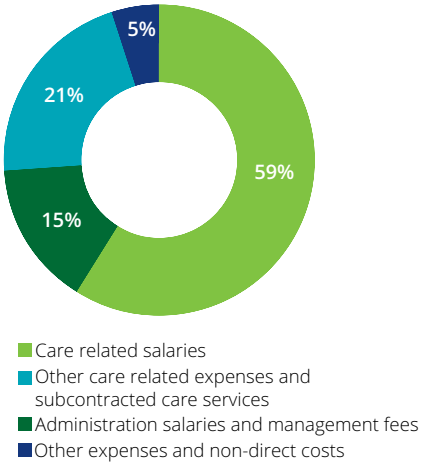


Table 7.8 provides a breakdown of expenditure according to ownership type, provider remoteness location and provider scale. Overall, there are some notable differences.

In terms of ownership type, government providers incurred the lowest level of expense per consumer per day with $55.20, compared with $63.78 for the for-profit providers and $70.71 for the not-for-profit providers. In 2014-15, the expenses for the not-for-profits and the for-profits were very similar.

There are also distinctive results depending on the remoteness location. As for last year, regional providers had the lowest expenses per day on average. Providers who operated in both metropolitan and regional areas again had the highest expenses, largely driven by significantly higher care salaries and administration costs.

Scale of a provider's operations is associated with very large differences in terms of average expenses per consumer per day. While single service providers recorded $52.33 per day, providers who operated seven or more services recorded $72.44 (38 per cent higher).

Care related salaries comprise the greatest proportion of expenditure across all ownership types, remoteness location and size of provider. However there are also differences within these sub-groups. While the not-for-profit and for-profit providers reported similar care staff costs at around $42 per consumer per day, government-owned providers (including local, state and territory government) reported an average of $27 per consumer per day. In terms of remoteness location, regional providers had care related staffing costs of around $35 per consumer per day, compared to $39 for metropolitan providers and $48 for providers who provide services in both regional and metropolitan areas.

Table 7.8: Expenditure per consumer per day, 2015-16 by ownership type, remoteness location and provider scale

	Care related salaries ($)	Admin and mgmt fees ($)	Other care related expenses ($)	Other expenses and non-direct costs ($)	Total ($)
Ownership					
Not-for-profit	$41.99	$11.31	$13.96	$3.45	$70.71
For-profit	$42.36	$7.08	$12.93	$1.42	$63.78
Government	$26.98	$6.08	$20.74	$1.40	$55.20
Remoteness location					
Metropolitan	$39.12	$9.81	$16.38	$2.24	$67.55
Regional	$35.45	$9.16	$14.15	$2.76	$61.52
Metropolitan & regional	$48.15	$13.23	$10.13	$5.44	$76.95
Scale					
Single service	$33.62	$6.41	$10.20	$2.10	$52.33
2 to 6 services	$42.79	$8.96	$12.95	$3.27	$67.97
7 and more services	$41.23	$12.03	$15.92	$3.25	$72.44
Total sector	**$40.75**	**$10.55**	**$14.46**	**$3.12**	**$68.88**

Care salary costs also vary depending on the scale of provider. Single service providers reported the lowest care salary costs, $34 per consumer per day, with providers operating more than one service reporting care salary costs above $41. This pattern is also reflected in administration salaries and administration costs, with providers operating seven or more services reporting $12 per consumer per day compared with single service providers reporting only $6. This may suggest that there are limited opportunities for economies of scale in staffing, administration and management for multiple service providers or each of the services are sub-scale to absorb centralised overheads.

7.3.3 Profit

Table 7.9: Summary of financial performance of home care providers (total sector), 2012-13 to 2015-16

	2013-14	2014-15	2015-16
Average EBITDA per package	$1,973	$2,235	$2,086
Average NPBT per package	$1,810	$2,081	$1,949

In 2015-16, after scaling up the results from the financial reports submitted, total profit for all home care providers can be estimated at $183 million, up from $150 million in 2014-15.

As shown in Table 7.9 home care providers recorded an average profit (NPBT) per package of $1,949 compared with $2,081 in 2014-15 (a decrease of 6.3 per cent). Approximately 75 per cent of home care providers achieved a profit in 2015-16 compared with 72 per cent in 2014-15 and 66 per cent in 2013-14. This continues the recent trend of a higher proportion of providers recording a profit.

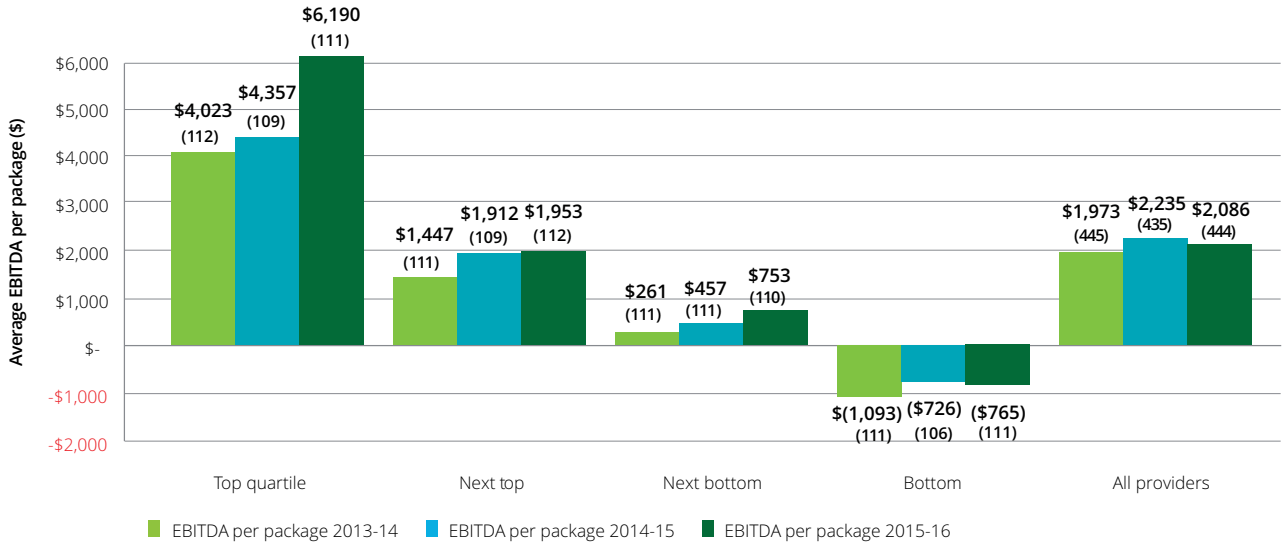
As was the case with NPBT, the average EBITDA in 2015-16 ($2,086 per package) decreased by 6.7 per cent compared with 2014-15 ($2,235).

As reported in previous annual reports and shown in Chart 7.6, 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 $6,190 compared with the next top quartile returning only $1,953. It is noteworthy that the gap between the top and second quartile has almost doubled from 2014-15 to 2015-16. In 2014-15, the average EBITDA per package for the top quartile was $4,357 compared with the next top quartile returning $1,912.

Chart 7.6 also shows that EBITDA for providers in all but the bottom quartile improved in 2015-16 compared with 2014-15.

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

Chart 7.6: Provider average EBIDTA per package 2015-16, by quartile (number of providers in parentheses)



In last year's annual report, ACFA reported that average EBITDA per package reported by not-for-profit providers of $2,341 had almost caught up to for-profit providers, $2,384. However, in 2015-16 this has changed noticeably. For-profit providers reported an average EBITDA of $4,837 per package, considerably higher than the $1,824 reported by not-for-profit providers (Chart 7.7).

The largest difference is in the top quartile where for-profit providers reported average EBITDA of $8,677 ($5,046 in 2014-15) compared with the not-for-profit providers who reported $5,725 ($4,294 in 2014-15).

It is also noteworthy that government providers actually outperformed the not-for-profit providers in 2015-16, more than doubling their EBITDA to $2,122 per package compared with $1,052 in 2014-15. This continues the improvement in the performance of government providers who also improved in 2014-15 compared with 2013-14, as shown in Chart 7.8.

ACFA notes commentary from the not-for-profit sector that the generally lower operating financial results may be consistent with their community or religious missions. They may fulfil their charters in a range of ways that might be difficult or inappropriate in a more commercial environment where investors

Chart 7.7: Provider average EBIDTA per package per annum 2015-16, by quartile and ownership type (number of providers in parentheses)

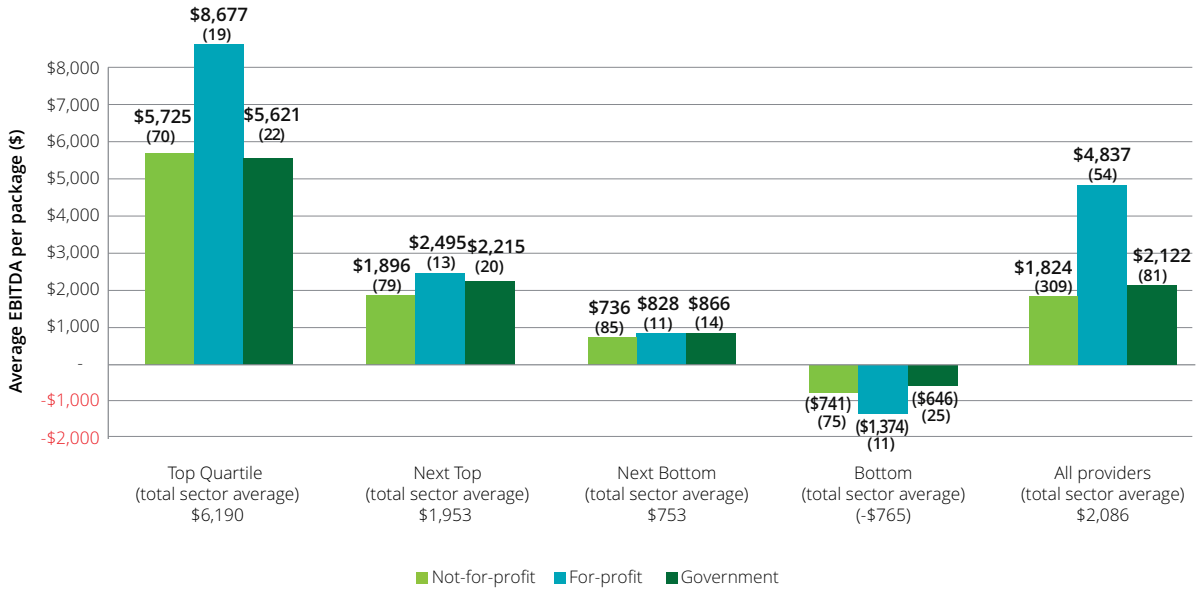
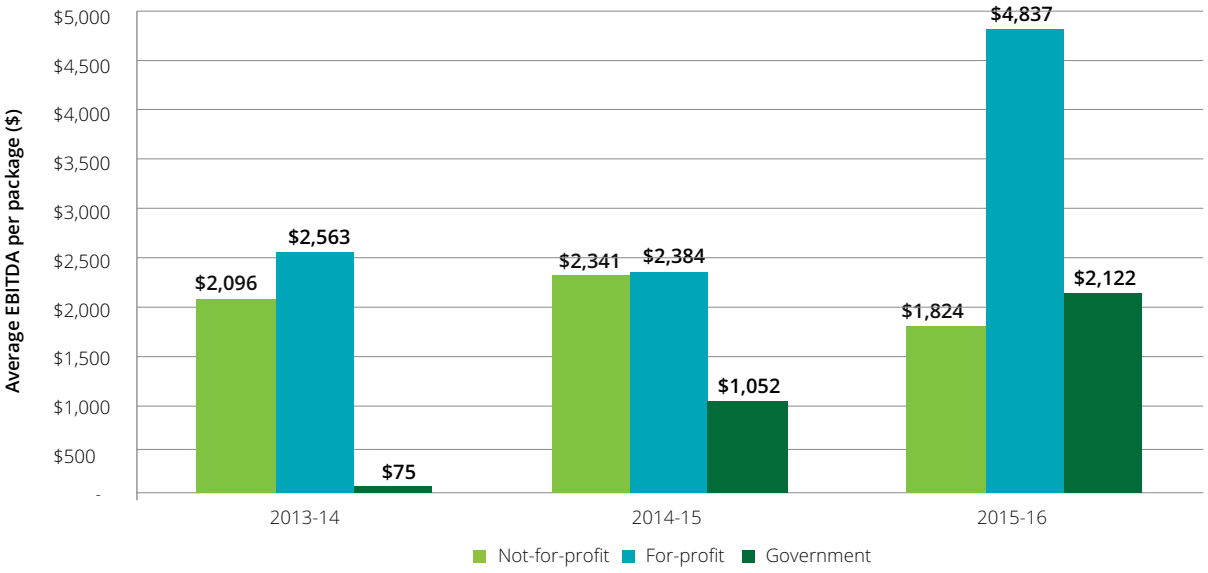


Chart 7.8: EBITDA per package, by ownership type, 2013-14 to 2015-16



are seeking returns. Specifically, not-for-profit providers may choose to invest in or expend funds on amenities and services for which they are not funded through regulated sources. Not-for-profit providers may be enabled to do this through a range of funding pathways and tax benefits, including payroll tax relief, income tax exemptions and tax deductible donations. However, where these costs are not covered by such incremental revenue, the comparatively lower EBITDA for many not-for-profit organisations may be the product of the delivery of additional "community benefits" or "social impacts" or returns which are not recognised in the annual financial accounts.

When considered by remoteness location, providers who operated all of their services in regional locations achieved the highest level of average EBITDA per package ($2,462), compared with $2,184 for metropolitan providers and $1,661 for providers in both regional and metropolitan areas (Chart 7.9). This is in contrast to 2014-15 when regional providers recorded the lowest EBITDA as shown in Chart 7.10.

It is noteworthy, as observed earlier in this chapter, that providers operating in both regional and metropolitan areas recorded significantly higher average expenses per package, and this is reflected in their profitability.

Chart 7.9: Provider average EBIDTA per package per annum 2015-16, by quartile and provider remoteness location (number of providers in parentheses)

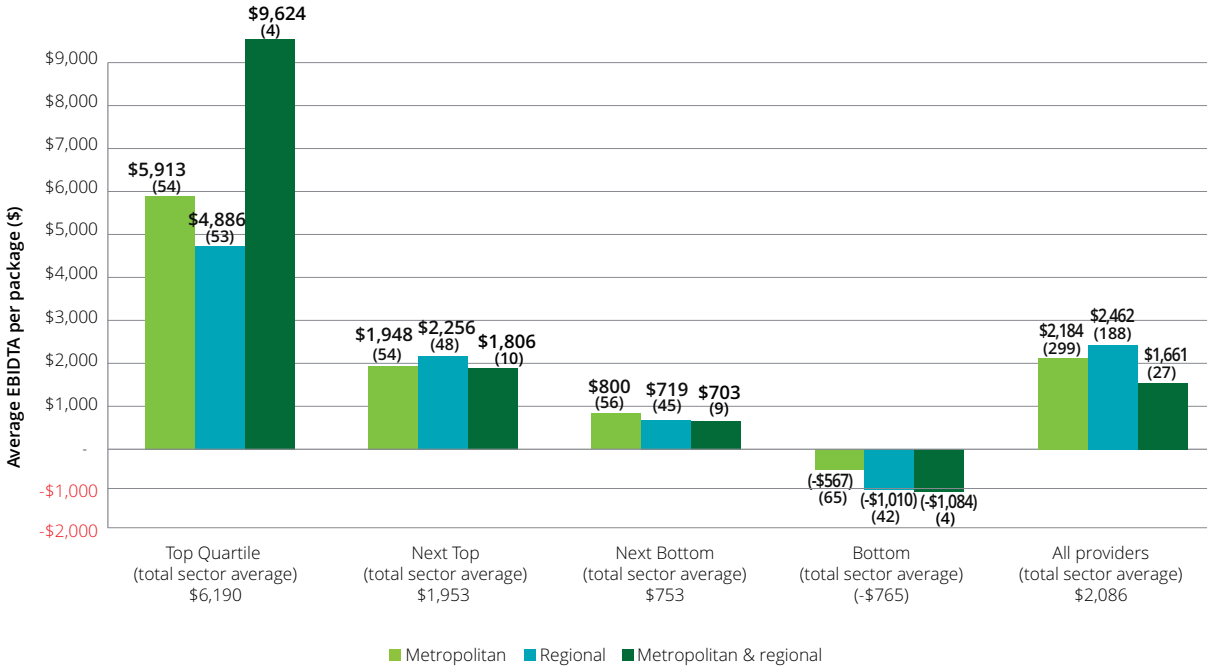
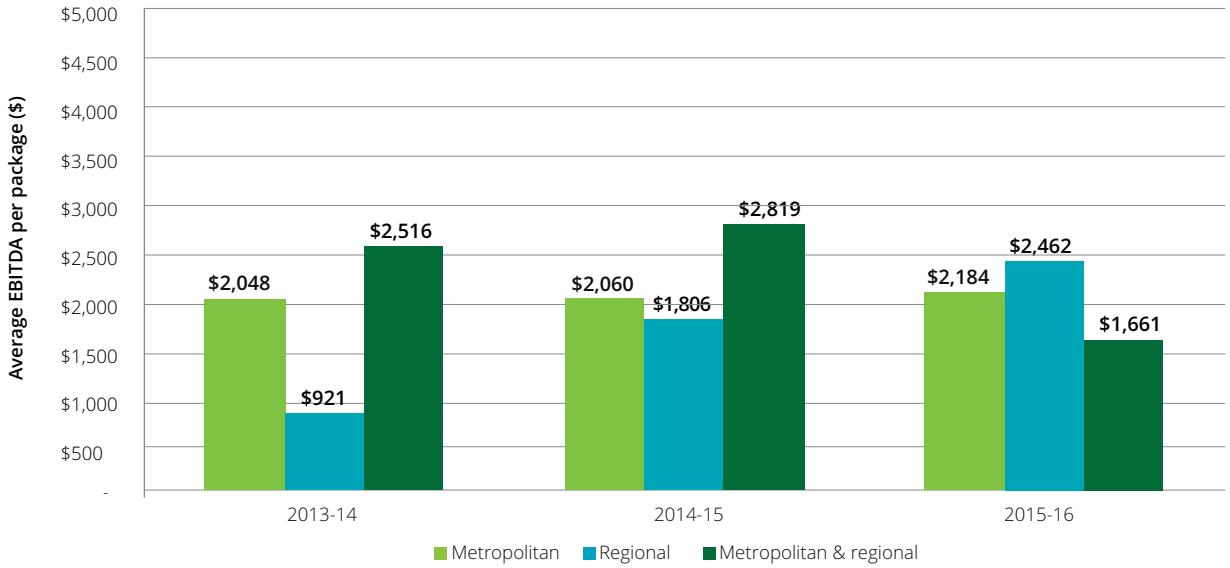


Chart 7.10: EBITDA per package, by remoteness location, 2013-14 to 2015-16 (total sector)



There are some interesting results when analysing profitability based on the scale of a provider.

Although providers with seven or more services recorded higher average expenses per package when compared with smaller operators, they actually recorded the highest average EBITDA with $2,239 compared with $2,112 for providers operating two to six services and $1,141 for single service providers. Whilst it is possible that this reflects a difference in the mix of packages, i.e more level 3 and 4 packages, this multi-variant analysis is not possible at this stage.

Larger providers were the best performing in terms of EBITDA, as they were in the previous two years. However, the gap between the larger and smaller providers has decreased significantly, as can be seen in Chart 7.12, with the providers with seven or more services showing a decrease in EBITDA while smaller scale providers improved.

Chart 7.11: Provider average EBIDTA per package per annum 2015-16, by quartile and provider scale (number of providers in parentheses)

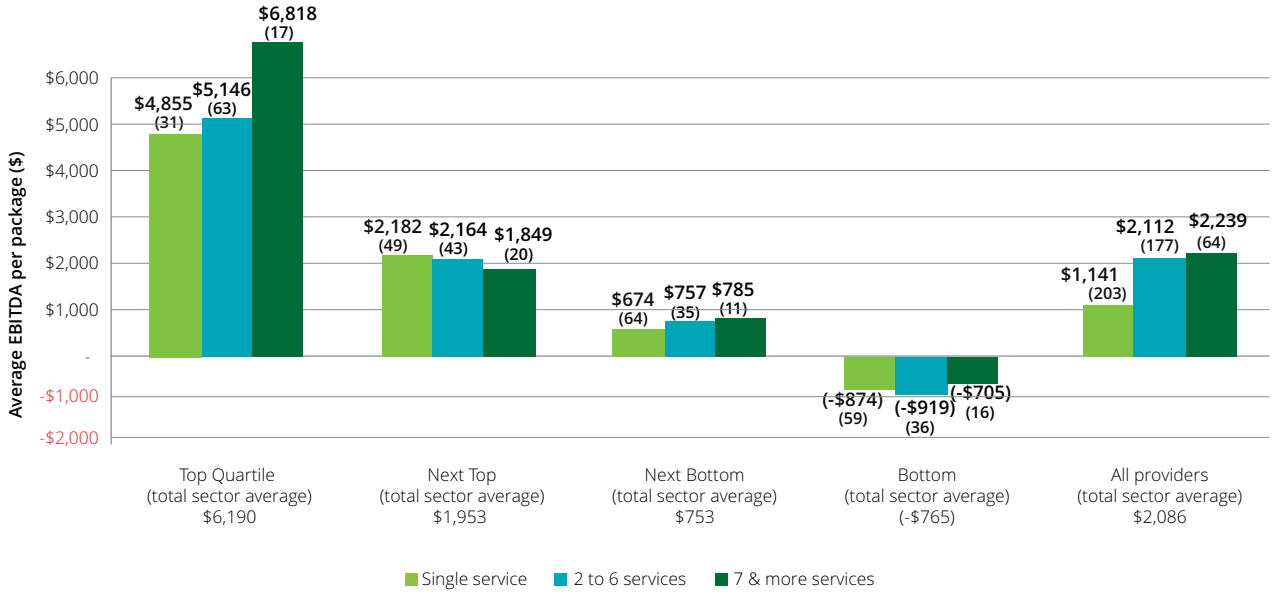
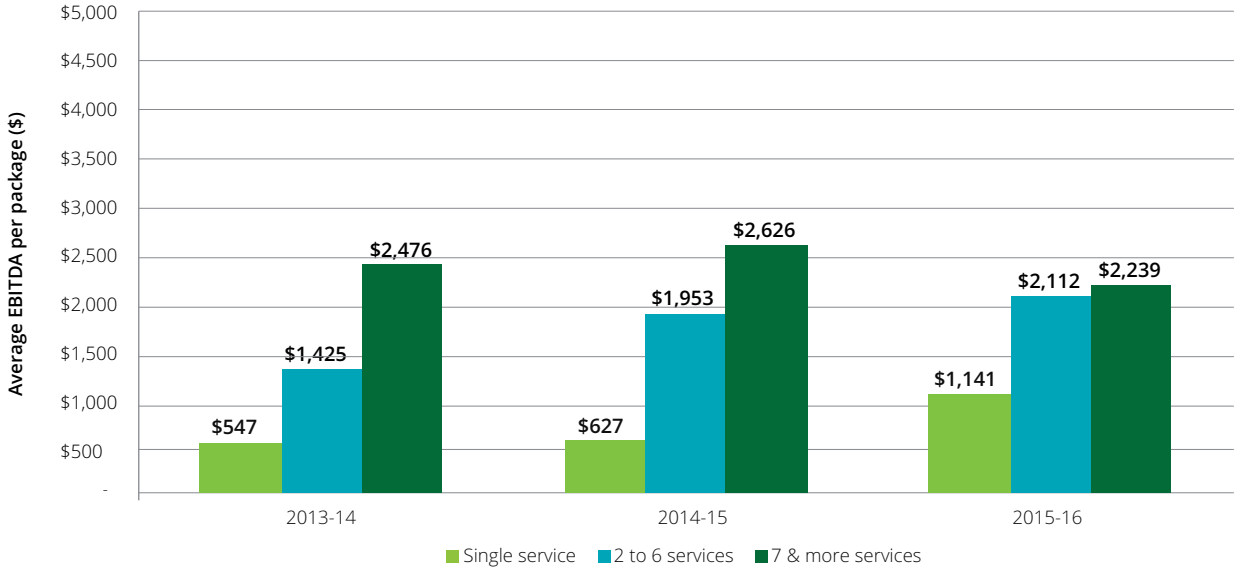


Chart 7.12: EBITDA per package, by provider scale, 2013-14 to 2015-16



7.3.4 Financial performance analysis 2016-17

As highlighted earlier, the majority of financial analysis presented in this report is based on 2015-16 results. ACFA does however have access to more recent financial performance results that have been provided by StewartBrown[18].

It is not possible to directly compare results presented for 2015-16 in this report with the nine months results up to March 2017 provided by StewartBrown as collection methods vary considerably in addition to the treatment of non-operating revenue items. However, the financial result achieved across their survey population could broadly reflect the trend experienced by the sector as a whole. StewartBrown's survey results indicate that average provider revenue continued to increase to March 2017, contributing to an increase in earnings before interest when compared to 2015-16.

Additionally, StewartBrown reported that the portability of home care packages, which started on 27 February 2017, has changed the landscape of home care provision in Australia. However, it is too early to quantify the impact on the results of the sector.

Unspent funds

ACFA noted in last year's annual report that the capacity for consumers to accumulate package funds over time meant that many providers were holding a significant amount of unspent funds on behalf of their consumers.

The changes to home care in February 2017 mean that providers can no longer retain unspent funds when a consumer leaves their care or changes provider. When consumers change providers, any unspent funds (less any agreed exit amount) within their package will follow them to the new home care provider. When consumers leave home care (including moving to residential care), any unspent funds (less any agreed exit amount) are returned to the Commonwealth and the consumer (or their estate) according to their respective contributions.

Many providers are reviewing and adjusting their business models and pricing structures to adapt to the more competitive market-driven environment. ACFA does note that StewartBrown reported that average unspent funds across home care providers included in their survey had dropped from over 14 per cent in 2014-15 to around 11 per cent in the six months to December 2016 and continued this trend to March 2017, (although an exact figure is not available).

7.4 Looking forward

The home care sector is undergoing significant change to its operations with providers and consumers still adjusting to CDC. The introduction of funding following the consumer in home care packages in February 2017 has significantly accelerated the adjustment required in the sector, both for providers and consumers. However, these changes will give consumers greater control over their own lives by enabling them to make choices about the types of care and services they purchase and from whom they are purchased.

In last year's annual report, ACFA noted that a further significant change had been flagged by Government i.e. an intention to integrate the Home Care Packages Programme and the CHSP into a single home care and support program from 1 July 2018. In the 2017-18 Budget, the Government extended the funding agreements for CHSP providers by two years, meaning that the Home Care Packages Programme and CHSP will continue to operate as separate programs until at least mid-2020.

18 StewartBrown collects detailed financial and supporting data on a voluntary basis which represents approximately 25 per cent of home care packages through its quarterly Aged Care Financial Performance Surveys.

8

Residential aged care: characteristics of the sector

8. Residential aged care: characteristics of the sector

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

This chapter discusses:

- the operation of residential aged care.
- the scale, ownership and locational characteristics of residential care services.
- the supply of residential aged care.

This chapter reports that:

- in 2015-16 there were 195,825 operational places, up from 192,370;
- in 2015-16 there were 949 providers, down from 972;
- residential aged care services were provided to 234,931 older Australians;
- the residential aged care sector is continuing to consolidate with the number of residential care places increasing while the number of providers continues to decrease;
- not-for-profit providers represent the largest proportion of ownership type in residential care, with 54 per cent of providers and 56 per cent of places; and
- as at 30 June 2016 there were 35,124 provisionally allocated places and an additional 7,894 places that were off-line for refurbishment or redevelopment.

8.1 Sector overview

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

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

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

8.2 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 care places. This is detailed in Chapter 5.

Table 8.1 shows the number of providers, services[19], places and residents since 2011-12. As can be seen, the number of providers has decreased each year while the number of places and residents continues to increase. Although the total number of residents has increased each year the number of respite residents in care as 30 June 2014 was significantly lower (33 per cent) than at 30 June 2013. This was due to a sharp increase in permanent admissions just prior to the means testing reforms commencing on 1 July 2014 and therefore a subsequent sharp decline in respite admissions in the same period.

19 In residential care, a 'service' refers to an aged care home.

Table 8.1: Number of providers, services, places and residents, 2011-12 to 2015-16

	Total sector 2011-12	Total sector 2012-13	Total sector 2013-14	Total sector 2014-15	Total sector 2015-16
Providers	1,069	1,048	1,016	972	949
Services	2,716	2,718	2,688	2,681	2,669
Operational places	184,570	186,278	189,283	192,370	195,825
Achieved residential care operational ratio	84.4	84.5	82.6	81.1	79.7
Provisionally allocated places	20,832	24,232	21,047	28,000	35,124
Occupancy	93.0%	92.7%	93.0%	92.5%	92.4%
Total residents	171, 065	173,094	176,816	177,820	181,048
– Permanent	167,009	168,968	173,974	172,828	175,989
– Respite	5,056	4,126	2,842	4,992	5,059

The achieved ratios reflect the target operational ratio for 2022, of 125 per 1000 people 70 and over. The 2022 target comprises 78 residential places, 45 homes care places and two short term restorative care places.

Table 8.2: Number of providers, services, places and residents in residential aged care, 2015-16

			Ownership type			Remoteness location			Provider scale			
	Total sector 2014-15	Total sector 2015-16	Not-for-profit	For-profit	Government	Metropolitan	Regional	Metropolitan & Regional	Single home	2 To 6 homes	7 To 19 homes	20 & More homes
Providers	972	949	514	336	99	486	375	88	616	257	57	19
Services	2,681	2,669	1,557	864	248	807	608	1,254	616	728	623	702
Operational places	192,370	195,825	110,178	76,630	9,017	65,761	31,280	98,784	45,676	48,367	48,000	53,782
Occupancy	92.5%	92.4%	94%	91%	90%	92%	93%	93%	92%	92%	93%	92%
– Total residents	177,820	181,048	103,013	69,903	8,132	60,293	28,942	91,813	42,063	44,313	44,667	50,005
– Permanent	172,828	175,989	100,583	67,486	7,920	58,531	27,972	89,486	40,655	43,112	43,558	48,664
– Respite	4,992	5,059	2,430	2,417	212	1,762	970	2,327	1,408	1,201	1,109	1,341

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

Data presented in this table is at the provider level

8.2.1 Residential care providers

At 30 June 2016, there were 949 residential care providers operating 195,825 residential care places in Australia. This compares with 972 operating 192,370 places as at 30 June 2015.

As the residential care industry matures, some providers are seeking to expand the scale of their businesses. As a result there has been a consolidation of industry providers. Chart 8.1 shows the decreasing provider numbers over the seven years to 2015-16, and shows the proportion of ownership across not-for-profit, for-profit and government providers.

8.2.2 Ownership type

As shown in Charts 8.1 and 8.2, the largest provider group remains the not-for-profit providers (religious, charitable and community-based organisations). They represent 54 per cent of providers and operate 56 per cent of all residential aged care places. For-profit providers account for 35 per cent of providers and 39 per cent of places. The remaining providers and places are state and territory and local government-owned providers.

Chart 8.1: Provider numbers, 2009-10 to 2015-16

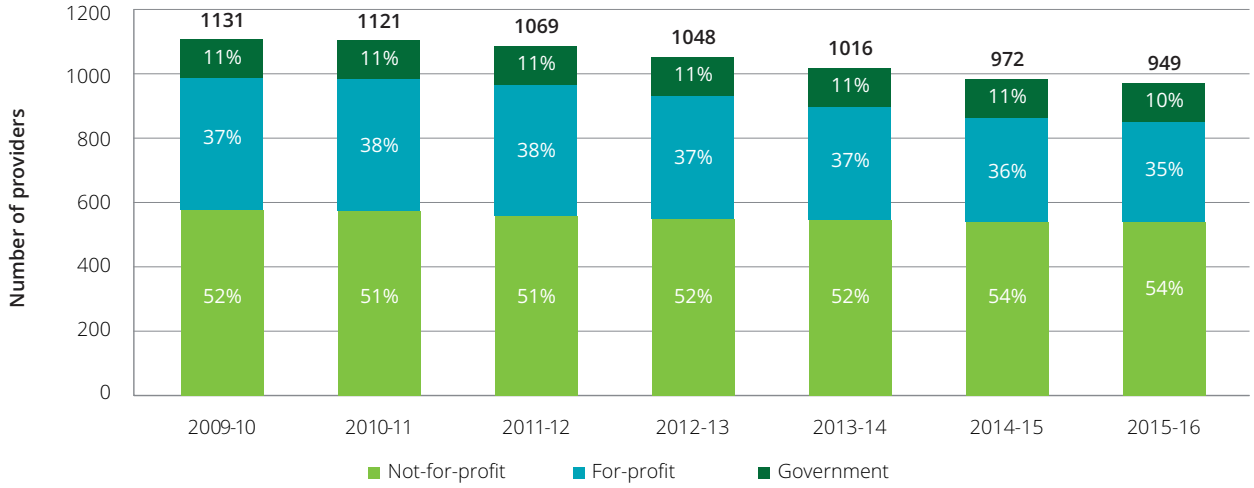
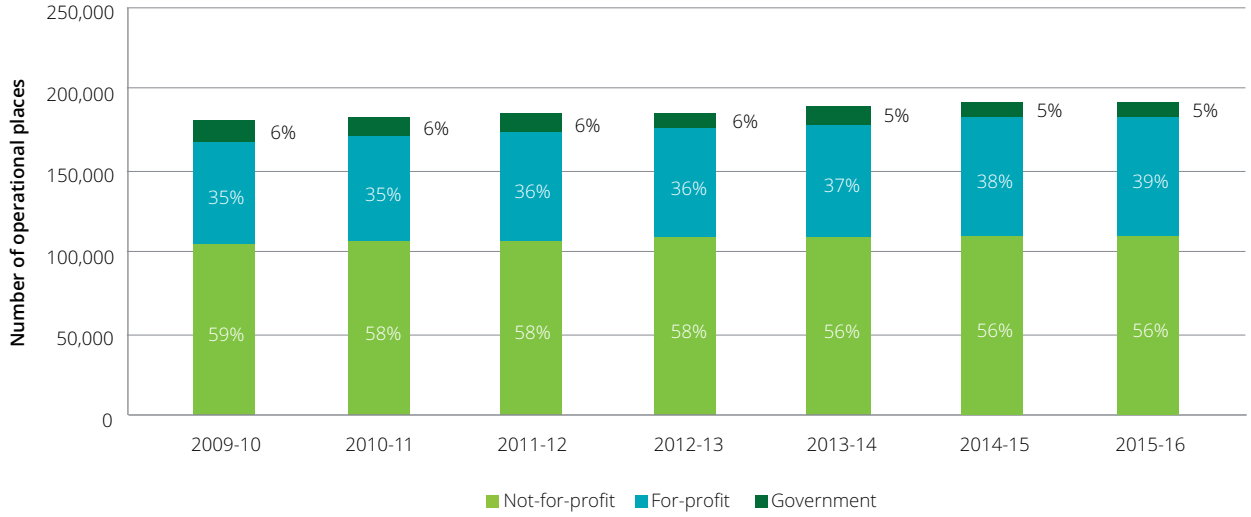


Chart 8.2: Operational places 2009-10 to 2015-16



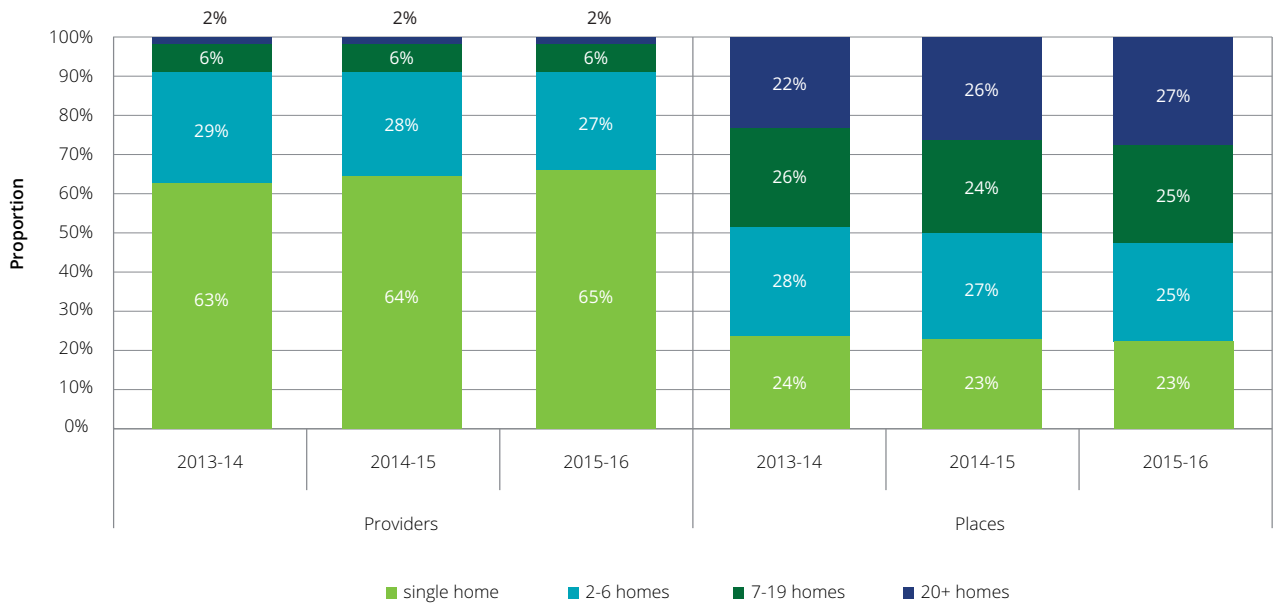
The proportion of providers across ownership types has remained relatively stable. However, the proportion of operational residential care places held by for-profit providers has increased slowly in recent years (Chart 8.2). This reflects for-profit providers gradually increasing the scale of their operations through both acquisitions and greater success at gaining new allocations through the annual Aged Care Approvals Rounds (ACAR).

ACFA also notes that while the not-for-profits operate 56 per cent of all operational residential care places, they operate 66 per cent of all regional places. Conversely, for-profit providers, who operate 39 per cent of all places, operate only 23 per cent of regional places. Government providers operate the remaining 11 per cent of regional residential care places.

8.2.3 Provider scale

The majority of residential care providers (616 or 65 per cent) operate only one residential care home (Chart 8.3). These single home providers account for 45,676 or 23 per cent of all operational residential care places. Conversely, 19 providers operate more than 20 homes, but they account for 53,782 or 27 per cent of operational places.

Chart 8.3: Provider and operational places by provider scale, 2013-14 to 2015-16

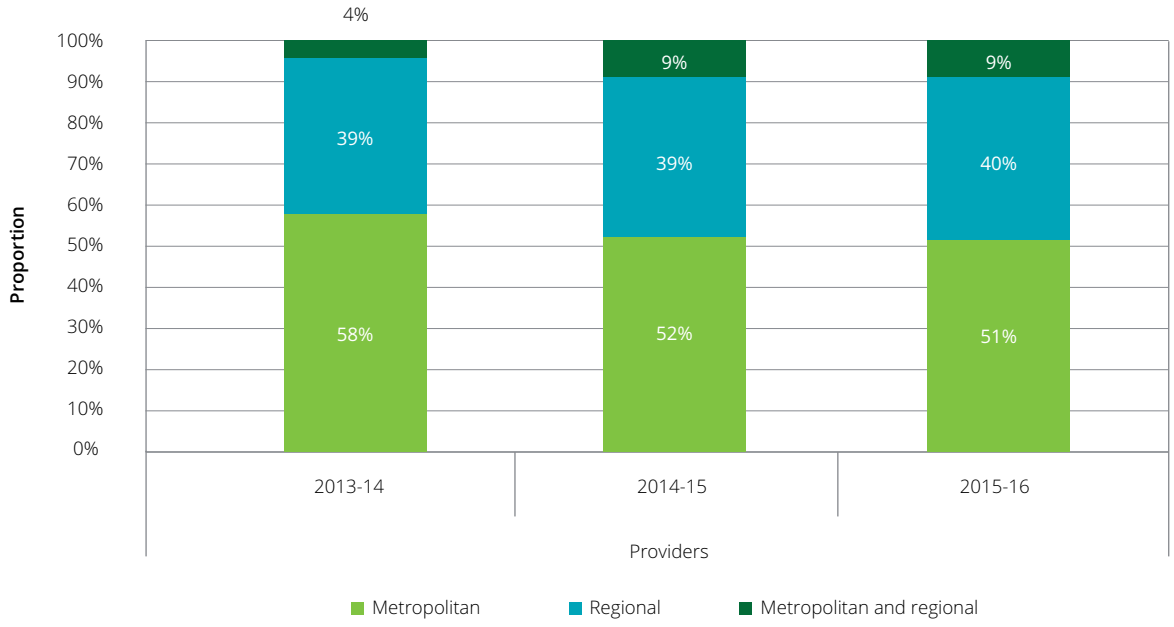


8.2.4 Remoteness location

ACFA generally categorises residential care providers as those operating only in metropolitan areas, those operating only in regional[20] areas, and those who have services in both metropolitan and regional areas. A provider is categorised as being regional if more than 70 per cent of their residents are in facilities in regional areas.

Chart 8.4 shows that 51 per cent of providers operate only in metropolitan areas. However, this number has decreased from 58 per cent in 2013-14 as more providers who previously only provided services in metropolitan areas are expanding into regional areas. Conversely, 9 per cent of providers operate services in both metropolitan and regional areas, up from 4 per cent in 2013-14. The remaining 40 per cent of providers operate in regional areas only.

Chart 8.4: Providers remoteness location, 2013-14 to 2015-16



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

8.2.5 Provisionally allocated places

The Commonwealth releases residential aged care places through an annual 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. Once the place is available to be occupied by a resident, it becomes 'operational'. The average time it takes providers to bring places online is currently 4.3 years.

The 2016 ACAR allocated 9,911 residential care places and provided $64 million in capital grants to 22 providers to build new residential care places (rooms), or to upgrade existing rooms.

At 30 June 2016, there were 35,124 provisional residential care places reflecting the carryover of allocated places from previous ACARs which are yet to be constructed. This represents around 14 per cent of all allocated places, which compares with 12 per cent at 30 June 2015. ACFA notes that during the seven years up to 2015, on average, 10 per cent of allocated places were provisional.

The provisional allocations relate to around 500 aged care homes which represents around 20 per cent of all homes.

Queensland and the ACT have the highest proportion of provisionally allocated places with both having just over 20 per cent. South Australia and Tasmania have the lowest with 3 and 5 per cent respectively (Table 8.3).

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

Table 8.3: Provisionally allocated residential care places by state/territory, at 30 June 2016.

State/ territory	Residential provisionally allocated places	All allocated residential care places	Proportion
NSW	10,911	81,739	13.4%
Vic	8,837	63,392	13.9%
Qld	9,812	47,230	20.8%
WA	3,892	21,161	18.4%
SA	636	19,438	3.3%
Tas	281	5,434	5.2%
ACT	670	3,250	20.6%
NT	85	856	9.9%
Australia	**35,124**	**242,500**	**14.5%**

In addition, there were also 7,894 formerly operational places at 30 June 2016 that were offline pending redevelopment in some way.

Thirty-one per cent of provisional places have been allocated in the last year, and nearly 67 per cent in the last two years. There are currently around 700 provisionally allocated places that were allocated 10 or more years ago.

ACFA notes that in February 2016, legislative changes were made to encourage providers to operationalise their provisional places. The changes include limiting the provisional allocation period to four years (noting that up to two extensions of 12 months can be granted by the Department and further extensions in exceptional circumstances). At the end of this time, the provisional allocations lapse and the places return to the Department for redistribution in a future ACAR.

Tables 8.4 and 8.5 show the distribution of the ages of provisionally allocated places by remoteness location and state and territory.

Table 8.4: Provisional allocated residential places by remoteness location and year distribution, as at 30 June 2016

	<1 year old	1-2 years old	2-4 years old	4-6 years old	6-8 years old	8-10 years old	10 + years	Total
Metropolitan	7,410	7,621	4,404	3,935	1,392	1,276	699	26,737
Regional	3,351	2,453	1,004	1,167	147	185	0	8,307
Remote	30	0	0	50	0	0	0	80
Total	**10,791**	**10,074**	**5,408**	**5,152**	**1,539**	**1,461**	**699**	**35,124**

Does not include flexible aged care places

Table 8.5: Provisional allocated Residential places by state and year distribution, as at 30 June 2016

	<1 year old	1-2 years old	2-4 years old	4-6 years old	6-8 years old	8-10 years old	10 + years	Total
NSW	2,855	2,708	1,841	1,949	596	676	286	10,911
VIC	3,034	2,825	1,601	1,073	170	42	92	8,837
QLD	3,071	2,838	1,278	1,514	427	426	258	9,812
WA	1,259	1,228	627	210	306	222	40	3,892
SA	233	180	20	203	0	0	0	636
TAS	80	108	0	93	0	0	0	281
ACT	194	187	41	90	40	95	23	670
NT	65	0	0	20	0	0	0	85
Total	**10,791**	**10,074**	**5,408**	**5,152**	**1,539**	**1,461**	**699**	**35,124**

Does not include flexible aged care places

Transferring residential aged care places

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

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

9

Residential aged care: operational performance

9. Residential aged care: operational performance

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

This chapter discusses:

- funding arrangements for residential care.
- the operational performance of residential care providers in 2015-16, including revenue, expenditure and profit.
- operational performance by provider ownership type, remoteness location and scale.

Key findings on financial performance in 2015-16 compared with 2014-15:

- total revenue of $17.4 billion, an increase of 8.6 per cent, equating to $263.92 per resident per day compared with $249.35, an increase of 5.8 per cent;
- care revenue of $10.8 billion, an increase of 8.4 per cent;
- other income of $1.3 billion, an increase of 11.7 per cent, contributing to all of the net profit;
- total expenses of $16.3 billion, an increase of 8.1 per cent, equating to $247.58 per resident per day, compared with $235.05, an increase of 5.3 per cent;
- total EBITDA of $1,985 million compared with $1,776 million, an increase of 11.8 per cent;
- average EBITDA per resident per annum of $10,222 compared with $11,134, an increase of 8.9 per cent;
- total profit of $1,063 million compared with $907 million, an increase of 17.2 per cent;
- NPBT per resident per annum of $5,221 compared with $5,962, an increase of 14.2 per cent; and
- 69 per cent of providers achieved a net profit compared with 68 per cent.

ACFA considers that the financial performance of residential care providers was generally strong, building on the strong performance in 2014-15. ACFA further considers that the financial reforms implemented on 1 July 2014 have improved the viability and sustainability of the sector.

ACFA notes however that the sector has expressed concerns regarding the impact of changes to the Aged Care Funding Instrument (ACFI) and indexation arrangements being progressively implemented since 1 July 2016. As this report focuses on the performance during 2015-16, the full effect of these changes will not be apparent to ACFA until the 2018 annual report and beyond. There is, however, limited analysis available to ACFA for the nine months up to March 2017, and is outlined at the end of this chapter.

9.1 Introduction

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

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

- **All providers.** All residential care providers who reported using the General Purpose Financial Report (GPFR), accounting for around 99 per cent of providers. Where appropriate ACFA have scaled to represent the whole of the sector.
- **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[21].
- **By scale.** Scale is categorised into providers operating one, two to six, seven to 19, and 20 or more services.

9.2 Operational funding

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

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

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

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

The Commonwealth also sets some maximum levels for contributions made by permanent 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.

Figure 9.1: Residential aged care services

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

9.2.1 Commonwealth operational funding

Commonwealth payments for residential aged care in 2015-16 can be classified as:

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

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

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

Accommodation related supplements are indexed using the Consumer Price Index (CPI) and basic care subsidies and respite care subsidies are normally indexed by a Wage Cost Index (WCI). The WCI for residential aged care is weighted:

- 25 per cent on the movements in the non-labour costs of providers reflected by the CPI, and
- 75 per cent for wage costs reflecting the decisions of the Fair Work Commission in regard to Safety Net Adjustments, (a measure of non-productivity based movements of the wage costs of providers).

9.2.2 Basic care subsidies

- **The basic care subsidy** is a payment intended to support the costs of providing personal and nursing services for permanent residents. It is calculated based on the assessed need of each permanent resident as determined by the provider by applying the **Aged Care Funding Instrument (ACFI)**. The Commonwealth determines the level of payments on behalf of residents by setting the prices and rules for claiming ACFI care subsidies.
- **The basic respite subsidy** is a payment intended to support the costs of providing personal and nursing services for respite consumers. Respite consumers are assessed by an ACAT as requiring either high or low level care, with payment amounts for each set by the Commonwealth.
- **The Conditional Adjustment Payment (CAP)** was paid prior to 2014-15 to providers who met certain criteria including 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, the 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 tool. It assesses the care needs of permanent residents as a basis for allocating care funding by focusing the funding allocation around the main areas that differentiate relative care needs among residents.

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

In 2016, the Government announced changes to the ACFI and indexation arrangements to reduce the rate of growth in expenditure per person. Under current policy, care funding growth reflects annual indexation and a factor for the increasing frailty of residents.

ACFA also notes that the Government is consulting with the sector on long-term reform options for residential aged care funding.

The ACFI does not apply for residential respite care. Instead, respite care funding is paid at either a low or high rate depending on the level of care for which the consumer is approved by the ACAT. Additionally, providers who use 70 per cent or more of their respite allocation over a 12-month period receive a higher payment[22].

9.2.3 Payments for residential respite care

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

The subsidy and supplement are paid at either a low or high rate depending on the level of respite care the consumer is approved for by the ACAT. As at 30 June 2017 the daily residential respite subsidy rates are $45.45 for low and $127.46 for high level respite care. The daily respite supplement rates are $37.74 for low and $52.90 for high level respite care. Providers that use 70 per cent or more of their respite allocation over a 12 month period receive a

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

higher daily respite supplement rate of $90.01 per eligible care high care recipient. Respite subsidies are indexed on 1 July each year. Supplements are indexed on 20 March and 20 September each year in line with pension indexation.

The daily amount of low respite care subsidy and supplement combined is higher than the lowest daily rate of care subsidy payable in permanent residential care. The higher respite care subsidy and supplement is $217.47, which is approximately equivalent to the highest daily rate of care subsidy payable in permanent residential care.

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

Chart 9.1 shows the Australian Government payments for residential respite care since 2012-13. While payments for low care have remained stable, there has been a significant increase in payments for high care since the reforms of 1 July 2014.

9.2.4 Accommodation supplements

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

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

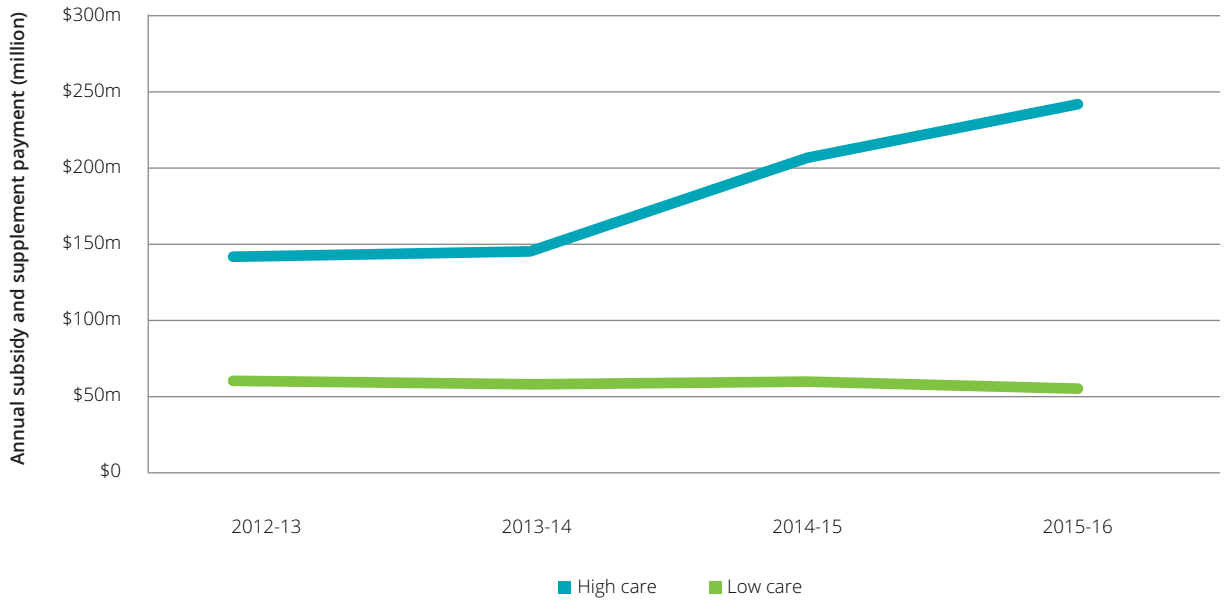
The Commonwealth determines the amount of accommodation supplement payable by setting the maximum rate of accommodation supplement and determining the share paid by residents based on an income and asset test.

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

9.2.5 Viability supplement

The viability supplement aims to improve the financial position of smaller, rural and remote aged care 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 also supports providers who specialise in aged care services for Indigenous people, or people who are homeless or who are at risk of becoming homeless, in recognition of the often higher costs associated with providing these services.

Chart 9.1: Australian Government payments for residential respite care, by care level, 2012-13 to 2015-16



The supplement is available to residential care services, home care services, Multi-Purpose Services and Aboriginal and Torres Strait Islander Flexible services. In 2015-16, on average, the viability supplement provided $8,200 per resident per annum (prpa) for residential care facilities in remote and very remote areas, directly improving their financial results.

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

9.2.6 Homeless supplement

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

As at 30 June 2016 the homeless supplement was being paid in respect of around 1,400 residents.

9.2.7 Resident operational funding

Contributions by permanent residents in 2015-16 for operational funding were made up of:

- **A basic daily fee**, which is a contribution towards living expenses such as meals, laundry services, utilities and toiletries. The price is set by the Commonwealth, and is currently set at a maximum of 85 per cent of the single basic age pension.
- **A means tested care fee**, which is a contribution some residents make towards their care costs (personal and nursing) based on their assessable income and assets. Annual and lifetime caps on care contributions apply as a consumer protection. As at 1 July 2017 the annual cap for a means tested care fee is $26,380.51, with the lifetime cap of $63,313.28 applying.
- **Accommodation payments**, are daily payments for accommodation in an aged care home. Lump sum accommodation deposits are not treated as revenue, but as capital financing which is discussed in Chapter 10.
- **Extra service fees**, which residents may be asked to pay for significantly higher standards of accommodation, food and non-care services. These vary from home to home.
- **Additional services fees**, which are for care and services over and above those that providers are required to deliver and must be agreed between the resident and provider. These vary from home to home.

9.3 Analysis of 2015-16 financial performance of residential aged care providers

As noted in previous ACFA reports, the financial performance of residential care providers is affected by variations in both revenue and expenditure. It can also vary depending on the location in which care is delivered. Significant changes to funding arrangements took effect from 1 July 2014. The effect of some of the reforms was seen in 2014-15 and the financial performance of providers in 2015-16 further reflects the impact of those reforms.

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

The left side of Figure 9.2 maps operational funding of the residential care sector in 2015-16.

The capital financing portion of the Figure is explained and discussed in Chapter 10 (Figure 10.1). The financial performance (profit and loss in the current financial year) is discussed in this section.

Table 9.1 shows the overall financial performance of residential care providers for the five years up to 2015-16. The average EBITDA per resident has improved in each of the last three years after dropping in 2012-13 compared with 2011-12. Table 9.2 shows the overall financial performance of providers by ownership type, remoteness location and scale in 2015-16.

Figure 9.2: Residential aged care funding/financing sources, operational side

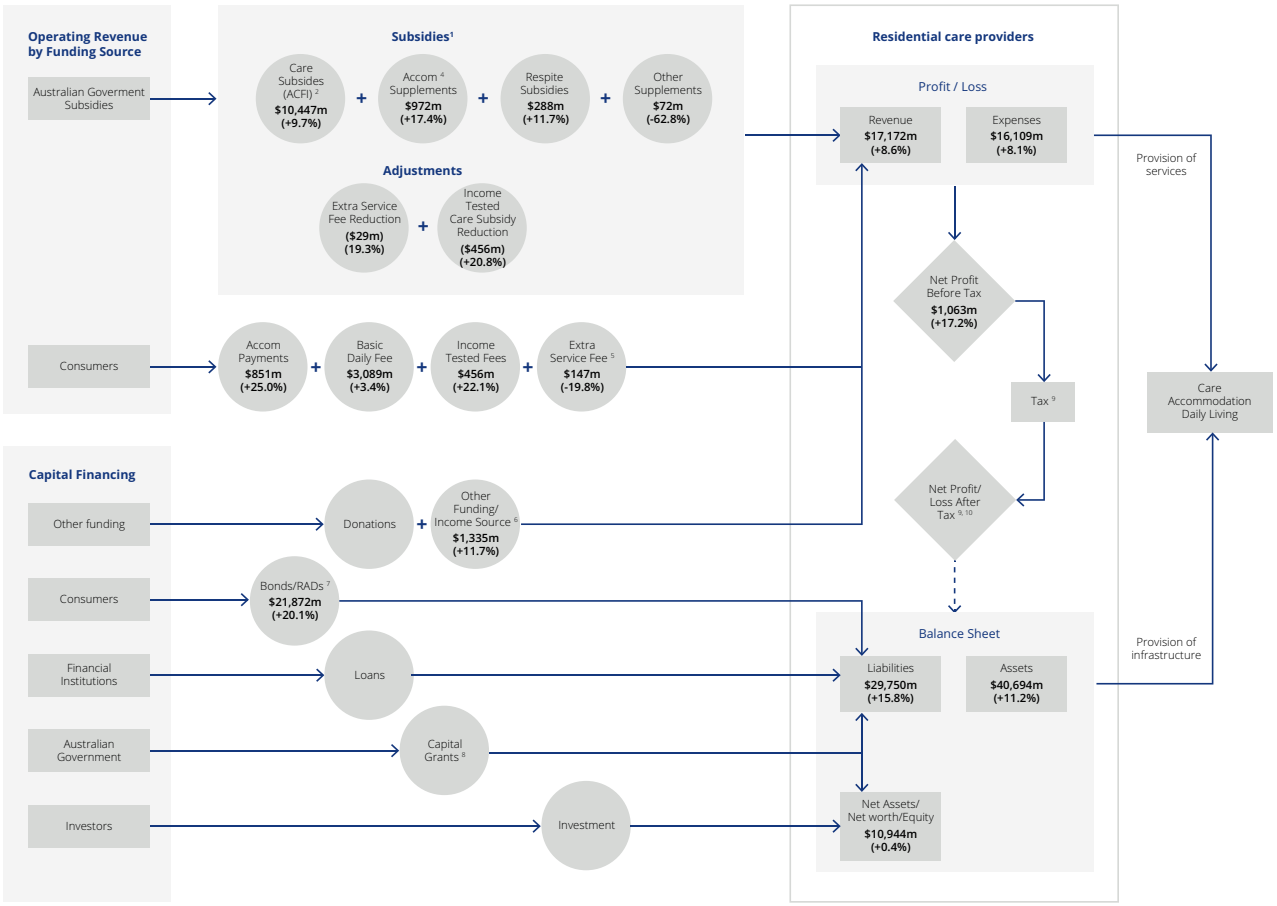


Table 9.1: Summary of financial performance of residential aged care providers who submitted their GPFRs, 2011-12 to 2015-16

	Total sector 2011-12	Total sector 2012-13	Total sector 2013-14	Total sector 2014-15	Total sector 2015-16
Revenue ($m)	$13,073	$13,961	$14,826	$15,810	$17,172
Expenses ($m)	$12,347	$13,367	$14,115	$14,903	$16,109
Profit ($m)	$726	$594	$712	$907	$1,063
Average EBITDA per resident per annum	$9,274	$8,660	$9,224	$10,222	$11,134
EBITDA margin	11.8%	10.6%	10.7%	11.2%	11.6%
NPBT margin	5.6%	4.3%	4.9%	5.8%	6.2%

Table 9.2: Summary of financial performance of residential aged care providers, 2015-16

			Ownership type 2015-16			Remoteness location 2015-16			Provider scale 2015-16			
	Total sector 2014-15	Total sector 2015-16	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)	$15,810	$17,172	$9,350	$6,893	$929	$10,922	$2,777	$3,473	$3,835	$4,300	$4,290	$4,747
Expenses ($m)	$14,903	$16,109	$8,828	$6,265	$1,015	$10,163	$2,669	$3,277	$3,525	$4,170	$4,050	$4,364
Profit ($m)	$907	$1,063	$522	$628	-$87	$759	$108	$196	$310	$130	$240	$382
EBITDA ($m)	$1,776	$1,985	$1,047	$938	-$0	$1,306	$266	$413	$496	$405	$481	$603
EBITDA per resident per annum ($)	$10,222	$11,134	$10,182	$13,908	-$12	$11,701	$9,046	$11,081	$12,220	$9,072	$10,901	$12,325
EBITDA margin	11.2%	11.6%	11.2%	13.6%	0.0%	12.0%	9.6%	11.9%	13.0%	9.4%	11.2%	12.7%
NPBT margin	5.8%	6.2%	5.6%	9.1%	-11.0%	6.9%	4.1%	5.6%	8.1%	3.0%	5.8%	8.1%

1. Amounts presented in this table represent those providers who have given their GPFRs (approx. 99 per cent of the sector).
2. 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.
3. The amount of un-appropriated profit flowing to the balance sheet is not given by all providers at the residential aged care segment level.
4. Totals may not add due to rounding.

9.3.1 Revenue

Table 9.3 provides a breakdown of the main sources of revenue reported by residential aged care providers in 2015-16, compared with 2014-15. Scaled up total revenue in 2015-16 was $17.4 billion[23], an increase of 8.6 per cent from 2014-15.

The majority (68 per cent) of this increase was due to a 10 per cent ($927 million) increase in care subsidies for permanent residents (ACFI).

A breakdown of the $927 million increase is as follows:

- $660 million (71 per cent) was due to price change (increase in care prices claimed);
- $249 million (27 per cent) was due to volume changes (increase in claim days); and
- $17 million (2 per cent) was due to the volume/price interaction effect (i.e. additional days of care at the higher price).

Basic daily fee payments to providers for living expenses in 2015-16 totalled $3.1 billion, an increase of $103 million on 2014-15. Of this increase it is estimated that:

- $72 million (70 per cent) was due to 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);
- $30 million (29 per cent) was due to volume changes; and
- $1 million was due to the interaction effect of the price/volume interaction effect.

Table 9.3 shows the total revenue for residential care providers who submitted their GPFRs (99 per cent of total providers) in 2015-16 compared with 2014-15.

As in previous years, other income was an additional source of revenue for providers, forming 7.8 per cent of the total revenue earned (7.6 per cent in 2014-15). More particularly, at $1,335 million, it totals more than the reported NPBT of $1,063 million ($907 million in 2014-15) which suggests aggregate EBIT is negative.

Table 9.3: Revenue sources for residential aged care providers, 2014-15 and 2015-16

Revenue sources	2014-15 ($million)	2015-16 ($million)	Change ($million)	Change (%)
Commonwealth				
Basic care subsidy (ACFI)	$9,520.40	$10,447.30	$926.90	9.7%
Respite subsidy	$257.50	$287.70	$30.20	11.7%
Other supplements	$195.90	$72.80	-$123.10	-62.8%
Means tested care fee reduction	-$373.60	-$456.00	-$82.40	22.1%
Extra service fee reduction	-$36.60	-$29.40	$7.20	-19.7%
Accommodation supplements	$827.60	$971.60	$144.00	17.4%
Total	**$10,391.20**	**$11,294.00**	**$902.80**	**8.7%**
Resident				
Means tested care fees	$373.60	$456.00	$82.40	22.1%
Accommodation payments	$680.70	$850.80	$170.10	25.0%
Basic daily fee	$2,986.30	$3,088.90	$102.60	3.4%
Extra services fee	$183.10	$146.90	-$36.20	-19.8%
Total	**$4,223.70**	**$4,542.60**	**$318.90**	**7.6%**
Total residential service income	**$14,651.50**	**$15,836.60**	**$1,185.10**	**8.1%**
Other income	$1,195.10	$1,335.20	$140.10	11.7%
Total revenue	**$15,810.10**	**$17,171.80**	**$1,361.80**	**8.6%**

1. Extra service subsidy reduction does not apply to new residents entering care from 1 July 2014, however it still applies to residents in ESS places who were in care prior to 1 July 2014.
2. Note Revenue from additional service fees including capital refurbishment fees, asset replacement contributions and other similar fees that are charged by some providers are likely to be included as part of the other income that is reported by providers.
3. The significant drop ($123 million) in Other supplements is due to the cessation of the Payroll Tax supplement as of 1 January 2015.

23 Total revenue of $17.4 billion is scaled up from the 99 per cent of providers who submitted their 2015-16 GPFRs.

For providers, other income sources include additional service fees, net interest earned, donations and contributions, capital grants as well as income from the sale of assets. Net interest for providers may include interest earned on lump sum deposits less any interest payments made on borrowings (providers may show these separately in their balance sheets or may combine them as 'net').

Interest income earned on the average total lump sums held during the year, at an assumed average bank deposit rate of 2.05 per cent or higher, is estimated to provide the sector with income of at least $407 million per annum (or provide a greater benefit where the lump sum deposits are used to offset borrowings providing an interest saving).

Overall in 2015-16, the Commonwealth contributed 65.8 per cent of total provider funding ($11.3 billion). Residents contributed 26.5 per cent ($4.5 billion) while income from other sources comprised the remaining 7.8 per cent (1.3 billion).

Accommodation payments, made up of accommodation supplements paid by the Government and accommodation payments paid by residents, account for 10.6 per cent of total provider revenue. Basic daily fees paid by residents for living expenses, account for 18 per cent of revenue.

Accommodation payments received by providers in both 2014-15 and 2015-16 have been reported by providers through the annual Survey of Aged Care Homes (SACH). Anomalies in the collection of this data has resulted in greater than expected increases in reported payments in 2015-16. The longer term average annual growth in accommodation payments over the period 2008 to 2015 was 11 per cent. The published amount for 2015-16 represents the reported payments by the sector. It is expected that consolidation of SACH data within the aged care financial reporting portal, which mandates 100 per cent participation, will improve the reliability of the data in future years.

As shown in Table 9.4, total revenue per resident per day in 2015-16 was $263.92, an increase of 5.8 per cent from 2014-15 ($249.35).

Chart 9.2: Proportions of total residential care provider revenue ($m), 2015-16

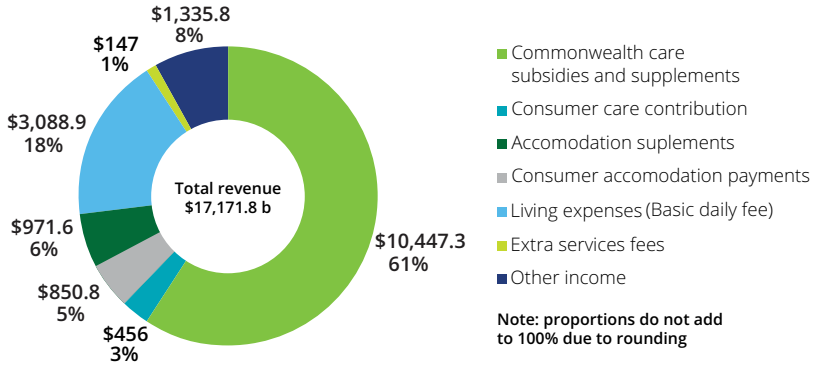


Chart 9.3: Proportions of provider revenue ($m), resident and Commonwealth, 2015-16

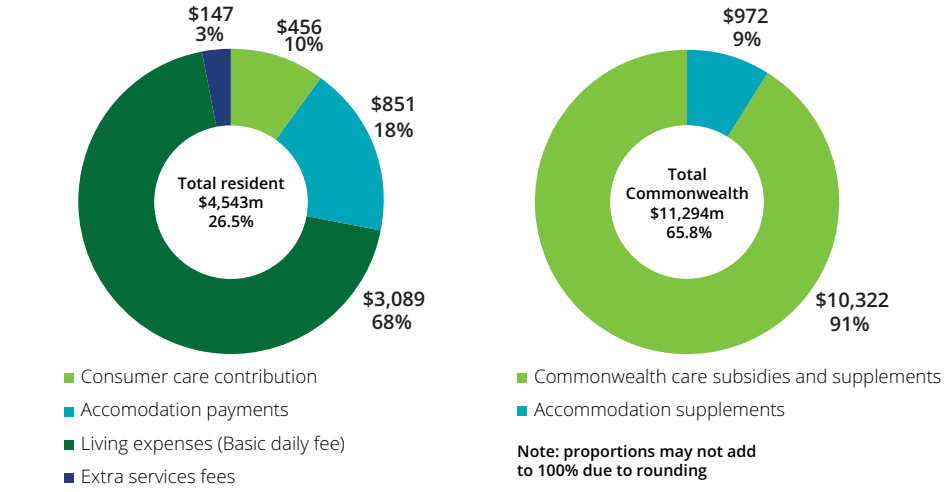


Table 9.4: Revenue sources per resident per day, 2014-15 and 2015-16

			Change	
	2014-15	2015-16	$ p.r.p.d.	%
Government Care Subsidies				
– ACFI & RCS	$150.15	$160.57	$10.42	6.9%
– Respite & respite Incentive	$4.06	$4.42	$0.36	8.9%
– Other supplements	$3.09	$1.12	-$1.97	-63.8%
– Means tested reduction	($5.89)	($7.01)	-$1.12	-19.0%
– Extra Service fee reduction	($0.58)	($0.45)	$0.13	22.4%
Accommodation Supplements	$13.05	$14.93	$1.88	14.4%
Consumer Care Contribution (Means Tested Care Fee)	$5.89	$7.01	$1.12	19.0%
Consumer Accommodation payments	$10.74	$13.08	$2.34	21.8%
Living Expenses (Basic Daily Fee)	$47.10	$47.47	$0.37	0.8%
Extra Services fees	$2.89	$2.26	-$0.63	-21.8%
Total Residential Service Income	**$230.50**	**$243.40**	**$12.90**	**5.6%**
Other Income	$18.85	$20.52	$1.67	8.9%
Total	**$249.35**	**$263.92**	**$14.57**	**5.8%**

1. Extra service subsidy reduction does not apply to new residents entering care from 1 July 2014, however it still applies to residents in ESS places who were in care prior to 1 July 2014.
2. Revenue from additional service fees including capital refurbishment fees, asset replacement contributions and other similar fees that are charged by some providers are likely to be included as part of the other income that is reported by providers.
3. The significant drop in Other supplements is due to the cessation of the Payroll Tax supplement as of 1 January 2015.

Revenue from the provision of services

The vast proportion ($15.8 billion or 92 per cent) of total revenue in 2015-16 for residential care providers was from the provision of residential care services, as opposed to other income. Residential service income can be considered in four streams: care, accommodation, basic daily living and extra services. Table 9.5 shows the total residential service income for residential care providers in 2015-16 compared with 2014-15.

Table 9.5: Total service income for residential care providers, 2014-15 and 2015-16

Income type	2014-15 ($million)	2015-16 ($million)	Change %
Care			
Government contribution	$9,600.2	$10,351.8	7.8%
Resident contribution	$373.6	$456.0	22.0%
Sub-total	**$9,973.8**	**$10,807.8**	**8.4%**
Accommodation			
Government contribution	$827.6	$971.6	17.4%
Resident contribution	$680.7	$850.8	25.0%
Sub-total	**1,508.3**	**$1,822.4**	**20.8%**
Basic daily fee	**$2,986.3**	**$3,088.9**	**3.4%**
Extra service			
Extra service fee	$183.10	$146.90	(19.8%)
Extra service fee reduction	-$36.6	-$29.4	19.7%
Sub-total	**$146.5**	**$117.5**	**(19.8%)**
Total service income	**$14,614.9**	**$15,836.6**	**8.4%**

1. Extra service subsidy reduction does not apply to new residential entering care from 1 July 2014, however it still applies to residents in ES places who were in care prior to 1 July 2014.
2. Additional service fees are not currently reported separately by providers and therefore are in other income.

Chart 9.4 shows the proportions of total residential service income streams in 2015-16. Income received for providing care is by far the greatest share of service income for residential care providers (68 per cent). The majority of care funding is from the Commonwealth (95.8 per cent) with residents paying the remaining 4.2 per cent via the means tested care fee. The share paid by residents is increasing as the proportion of post 1 July 2014 residents increase.

Table 9.6 shows the service income for residential care providers per resident per day for 2015-16 compared with 2014-15.

Chart 9.4: Service income in 2015-16, by service type

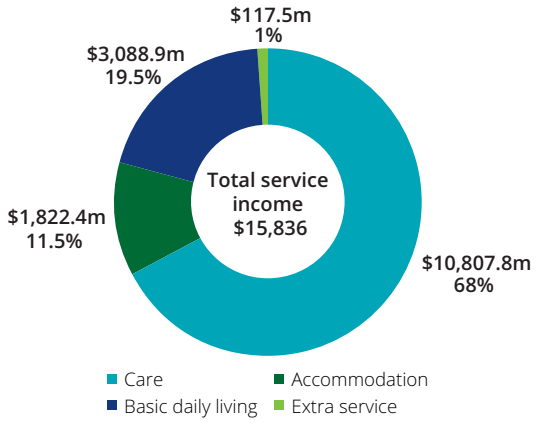


Table 9.6: Service income, per resident per day, 2014-15 and 2015-16

Income type	2014-15 ($)	2015-16 ($)	Change %
Care			
Government contribution	$151.41	$159.1	5.1%
Resident contribution	$5.89	$7.01	19.0%
Sub-total	**$157.30**	**$166.11**	**5.6%**
Accommodation			
Government contribution	$13.05	$14.93	14.4%
Resident contribution	$10.74	$13.08	21.8%
Sub-total	**$23.79**	**$28.01**	**17.7%**
Basic daily fee	**$47.10**	**$47.47**	**0.8%**
Extra service			
Extra service fee	$2.89	$2.26	-21.8%
Extra service fee reduction	-$0.58	-$0.45	22.4%
Sub-total	**$2.31**	**$1.81**	**-21.6%**
Total service income	**$230.50**	**$243.40**	**5.6%**

Notes:

1. Extra service subsidy reduction does not apply to new residential entering care from 1 July 2014, however it still applies to residents in ES places who were in care prior to 1 July 2014.
2. Additional service fees are not currently reported separately by providers and therefore are in other income.

9.3.2 Expenditure

Total expenses for the 99 per cent of providers who submitted their GPFRs in 2015-16 were $16.1 billion, up 8.1 per cent from $14.9 billion in 2014-15, compared with the increase in total revenue of 8.6 per cent. Chart 9.5 shows the growth in expenses over the seven years to 2015-16.

Chart 9.6 shows the proportion of total expenses for residential care providers in 2015-16. Staff costs represent 67 per cent of total expenses (same as in 2014-15), 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 5 and 1 per cent respectively. Table 9.7 shows the major expense types for providers in 2015-16 compared with 2014-15.

Chart 9.5: Total expenses, residential care providers, 2009-10 to 2015-16

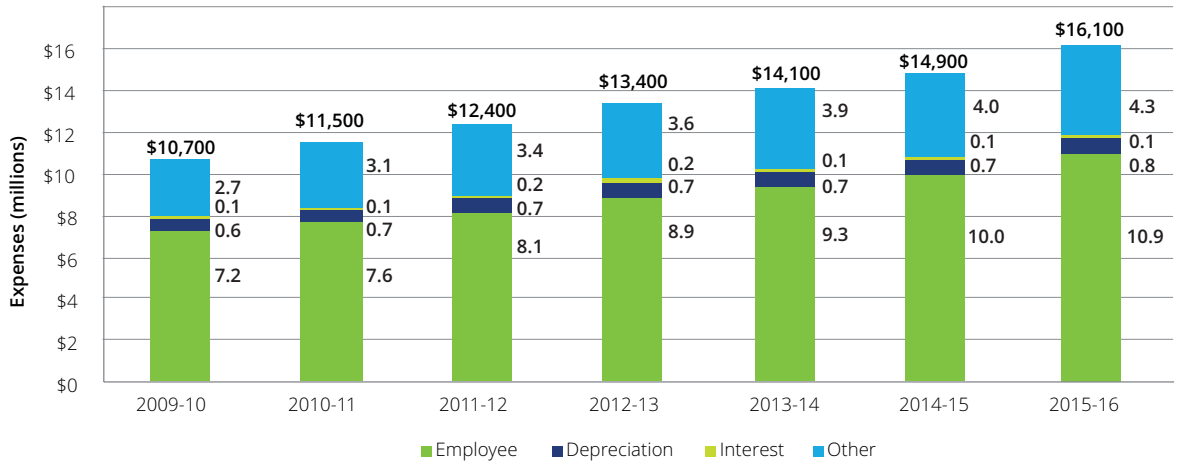


Chart 9.6: Proportion of total expenses, 2015-16

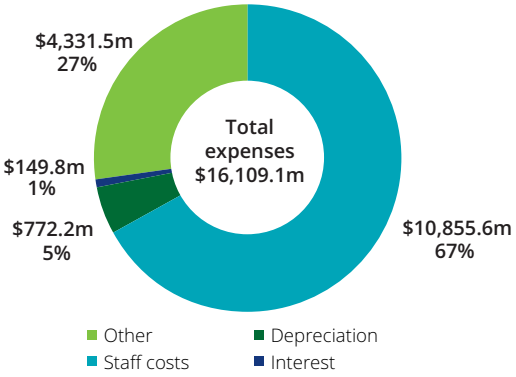


Table 9.7: Summary of expenses 2014-15 to 2015-16

Expenses	2014-15 ($million)	2015-16 ($million)	Change ($million)	Change (%)
Employee	$9,997.6	$10,855.6	$858.0	8.6%
Depreciation	$728.4	$772.2	$43.8	6.0%
Interest	$140.3	$149.8	$9.5	6.8%
Other	$4,036.8	$4,331.5	$294.7	7.3%
Total	**$14,903.1**	**$16,109.1**	**$1,206.6**	**8.1%**

In 2015-16, $10.9 billion was expended in wages and management fees (employee expenses), an increase of $858 million from 2014-15. Of this increase:

- $262 million (31 per cent) is attributable to an increase in the number of days of care provided (volume changes);[24]
- $581 million (68 per cent) is attributable to a 5.8 per cent increase ($9.16 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 $15 million (2 per cent) is due to the interaction of price/volume changes.

Expenses per resident per day (prpd) were $247.58, up from $235.05 in 2014-15. Table 9.8 shows the expenses prpd since 2011-12. Expenses prpd increased by 5.3 per cent in 2015-16 and revenue increased by 5.8 per cent.

24 This broadly reflects increases in resident numbers.

Table 9.8: Summary of expenses, per resident per day, 2011-12 to 2015-16

Expenses	2011-12	2012-13	2013-14	2014-15	2015-16
Employee	$133.90	$142.92	$148.81	$157.68	$166.84
Depreciation	$10.99	$11.59	$11.56	$11.49	$11.87
Interest	$2.47	$2.57	$2.34	$2.21	$2.30
Other	$55.78	$58.24	$62.81	$63.67	$66.57
Total Expenses	**$203.14**	**$215.31**	**$225.52**	**$235.05**	**$247.58**

9.3.3 Operating position – profit

The residential aged care sector reported an overall profit. ACFA notes that 'other' income of $1.3 billion offsets the otherwise Net Loss of $240 million and contributes to a substantial portion of the positive EBITDA.

Sixty-nine per cent of providers reported a net profit compared with 68 per cent in 2014-15.

As shown in Table 9.9, in 2015-16 the total sector EBITDA and NPBT increased by 11.8 and 17.2 per cent respectively compared with 2014-15. Average EBITDA and NPBT per resident per annum also increased by 8.9 and 14.2 per cent respectively.

Table 9.10 shows an overview of the operating position of providers since 2011-12. There was a drop in profitability in 2012-13. However both EBITDA and NPBT have improved over the three years since then.

Chart 9.7 presents the EBITDA per resident per annum in 2014-15 and 2015-16 by performance quartiles. All four quartiles saw an improvement in performance in terms of EBITDA.

The biggest improvement was in the bottom quartile where there was negative EBITDA of $3,613, which represented a $2,201 improvement, or 38 per cent reduction in loss from 2014-15. There has been sustained improvement in the performance of bottom quartile EBITDA since 2012-13, when EBITDA was negative $8,866. The top quartile had an EBITDA of $25,254, up from $23,687 (an increase of 6.6 per cent).

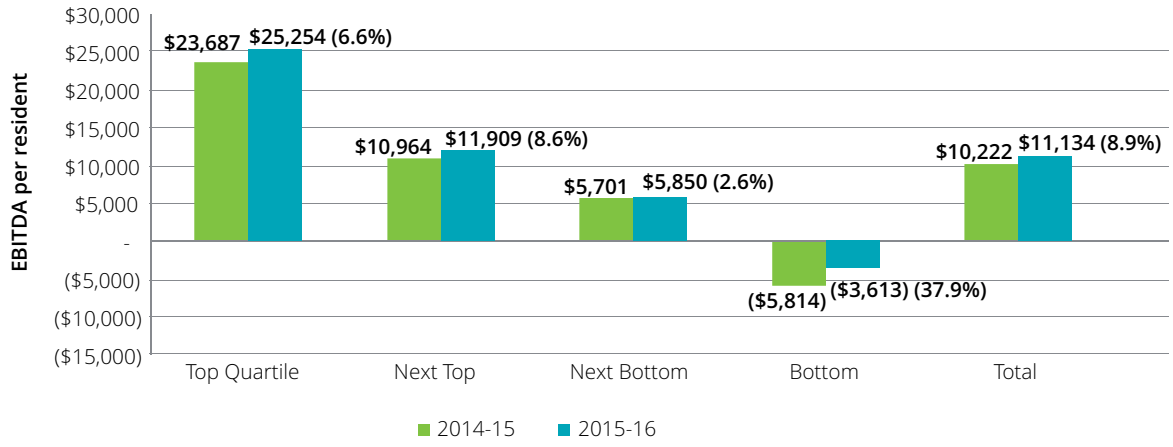
Table 9.9: Overview of operating position

	2014-15	2015-16	Change	Change (%)
Revenue	$15,810m	$17,172m	$1,362m	8.6%
Expenditure	$14,903m	$16,109m	$1,206m	8.1%
EBITDA	**$1,775m**	**$1,985m**	**$210m**	**11.8%**
EBITDA p.r.p.a.	$10,222	$11,134	$912	8.9%
NPBT	**$907m**	**$1,063m**	**$156m**	**17.2%**
NPBT p.r.p.a.	$5,221	$5,962	$741	14.2%

Table 9.10: EBITDA and NPBT 2011-12 to 2015-16

	2011-12	2012-13	2013-14	2014-15	2015-16
Total EBITDA ($m)	$1,544m	$1,473m	$1,581m	$1,775m	$1,985m
EBITDA p.r.p.a ($)	$9,274	$8,660	$9,224	$10,222	$11,134
EBITDA margin (%)	11.8	10.6	10.7	11.2	11.6
Total NPBT ($m)	$726m	$594m	$711m	$907m	$1,063m
NPBT p.r.p.a ($)	$4,360	$3,492	$4,150	$5,221	$5,962
NPBT margin (%)	5.6	4.3	4.9	5.8	6.2

Chart 9.7: Comparative EBITDA per resident per annum, 2014-15 and 2015-16



Operating performance continues to vary across provider ownership type, remoteness location and provider scale. The following commentary provides analysis across the segments of providers.

Overall, for-profit providers have continued to outperform the not-for-profit and government providers in terms of EBITDA margin and Net Profit margin (Charts 9.8 and 9.9). However, this variable needs to be considered carefully because providers in the not-for-profit and government sectors often have different business motives, business models and funding sources and often operate in areas affected by the impacts of location and facility size.

ACFA notes commentary from the not-for-profit sector that the generally lower operating financial results may be consistent with their community or religious missions. They may fulfil their charters in a range of ways that might be difficult or inappropriate in a more commercial environment where investors are seeking returns.

Specifically, not-for-profit providers may choose to invest in or expend funds on amenities and services for which they are not funded through regulated sources. Not-for-profit providers may be enabled to do this through a range of funding pathways and tax benefits, including payroll tax relief, income tax exemptions and tax deductible donations. However, where these costs are not covered by such incremental revenue, the comparatively lower EBITDA for many not-for-profit providers may be the product of the delivery of additional "community benefits" or "social impacts" or returns which are not recognised in the annual financial accounts.

Government and not-for-profit providers reported higher interest coverage ratios than for-profit providers, likely due to their lower use of debt to fund operations and finance assets.

Chart 9.8: Operating performance ratios, by ownership type, 2014-15 and 2015-16

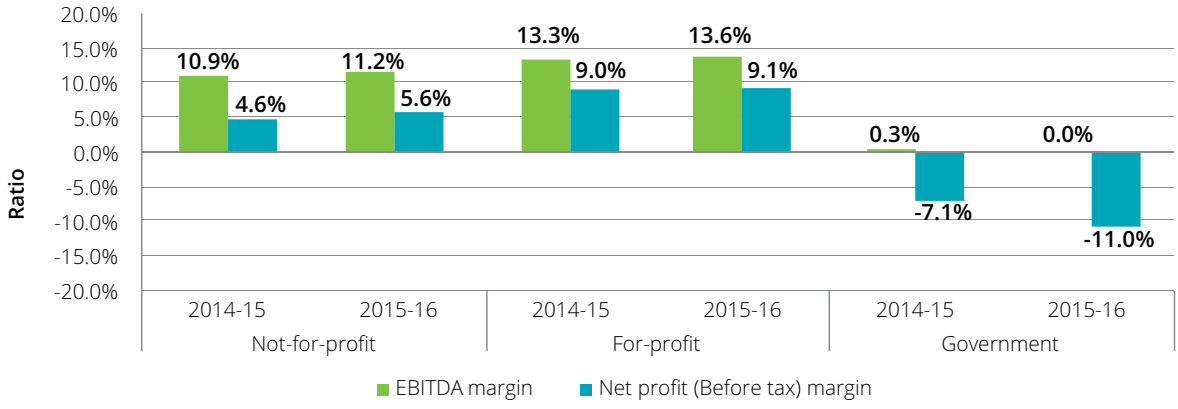
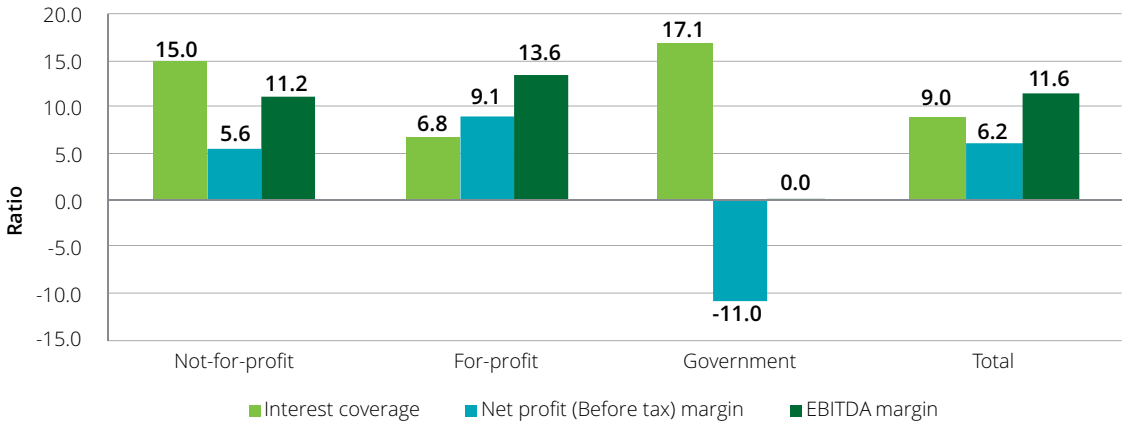


Chart 9.9: Operating performance ratios, by ownership type, 2015-16



As was the case in 2014-15, a higher proportion of for-profit providers was present in the top quartile of ranking by profit per resident (Chart 9.10 and 9.11). Thirty-seven per cent of for-profit providers were in the top quartile.

Also, as was the case last year, of the provider types in the top quartile, government providers performed the best[25], albeit with only 12 providers representing in the top quartile. Conversely, 59 per cent of government providers are present in the bottom ranked quartile for EBITDA per resident.

As was the case last year, there is some representation of all ownership types in each quartile.

ACFA notes that the organisational and operating structure of Government owned residential care providers, owned by state and local governments, is often quite different to that of the not-for-profit and for-profit providers. Government providers are often co-located with other health services such as hospitals and disability services and government providers often receive funding from state or local governments that affects revenue and thus profits. In addition, there are often differences in accounting practices that can distort GPFR's reporting of profitability depended on by ACFA for aggregate results of the residential care sector.

ACFA notes that without the government providers included, which represent 10 per cent of all residential care providers, the reported EBITDA of the remaining sector would be $524 or 5 per cent higher than the $11,134 reported. However, this average result shrouds the very diverse range of results within the Government owned group. This is highlighted in the fact that 58 of the 99 government providers are in the bottom quartile with average EBITDA of negative $21,025, while the 12 that are in the top quartile actually reported higher EBITDA per resident per annum of $27,565, which is higher than either the for-profit and not-for-profit providers in the top quartile. Further analysis of the financial performance of the sector with and without government providers is included at Appendix F.

The diverse range of results for the government owned sector was identified in ACFA's report on *Issues Affecting Rural and Remote Aged Care Providers* which was published in February 2016.

The report highlighted not only the difference in business models and accounting, but also the scale and location of these facilities. Government providers operate many of the rural and remote services and achieved an average facility EBITDA of negative $3,935 prpa in 2014-15 with only 39.5 per cent (17 from 43 facilities) reporting a positive EBITDA. This result was due to the significantly higher labour costs for care experienced by government facilities. Government facilities receive additional state/local government subsidies to offset the higher wages costs but there is still a significant short fall. Government facilities had the lowest average number of beds with 30, compared with an average of 42 beds for not-for-profit facilities across rural and remote locations.

ACFA recommends that further analysis of this sector might provide insights for future normalisation or commentary about the results in future years.

A higher proportion of metropolitan providers are present in the top quartile of ranking by EBITDA per resident compared with regional providers (Chart 9.12 and 9.13). Conversely, a higher proportion of regional providers was represented in the bottom quartile. However, as was the case with analysis based on ownership type, providers from all remoteness locations are present in each quartile.

25 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 9.10: Residential care provider average EBITDA per resident per annum 2015-16, by quartile (number or providers in parentheses) – by ownership type

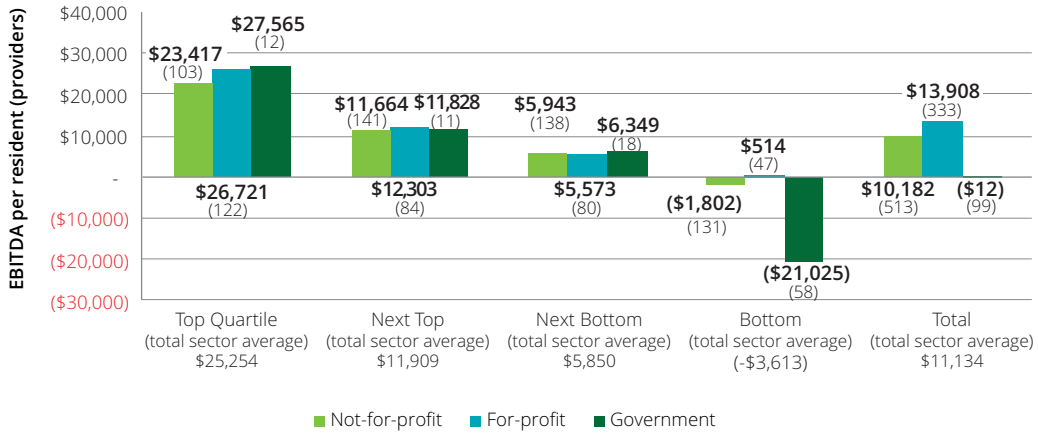


Chart 9.11: Residential care provider distribution between quartile of average EBITDA per resident per annum 2015-16 – by provider ownership type

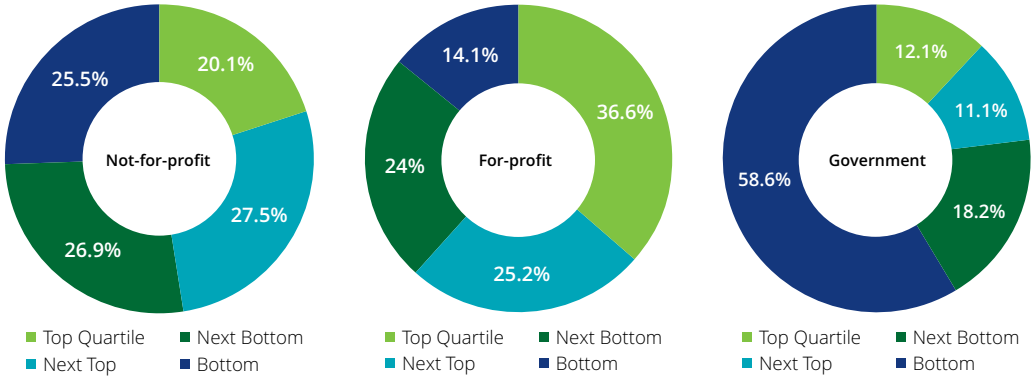


Chart 9.12: Residential care provider average EBITDA per resident per annum 2015-16, wby quartile (number of providers in parentheses) – by provider remoteness location

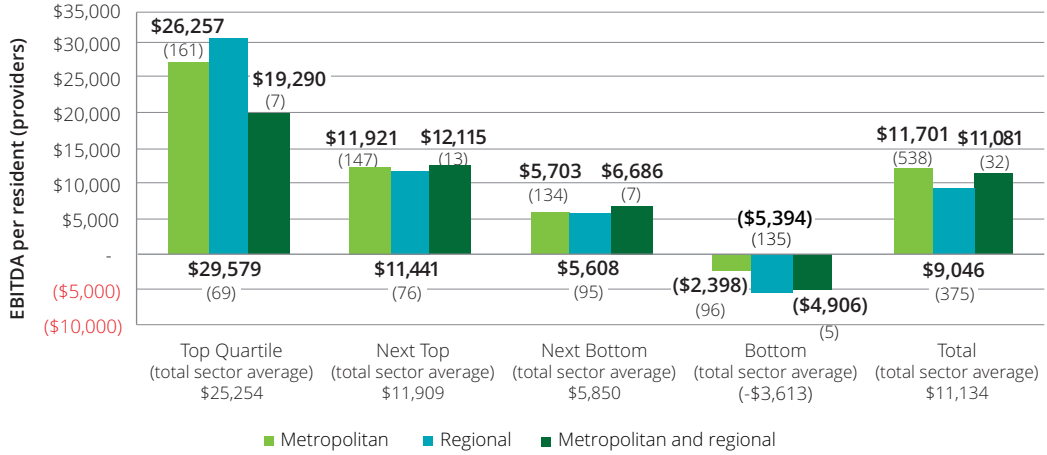
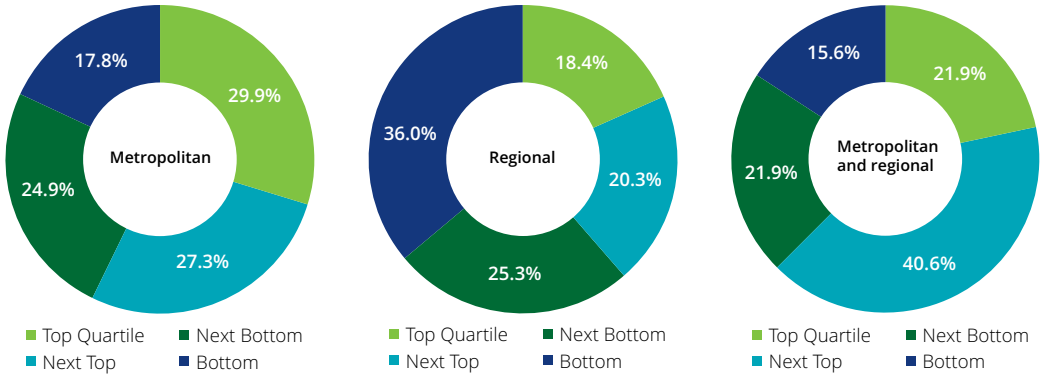


Chart 9.13: Residential care provider distribution between quartile of average EBITDA per resident per annum 2015-16 – by provider remoteness location



While there are only 19 providers who own more than 20 facilities, 14 of these are in the top two quartiles of ranking by EBITDA per resident (Chart 9.14 and Chart 9.15). This was also the case in 2014-15.

Around 64 per cent 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 57 providers who operate between seven and 19 facilities, 75 per cent are represented in the middle two quartiles.

Chart 9.14: Residential care provider average EBITDA per resident per annum 2015-16, by quartile (number of providers in parentheses)- by provider scale

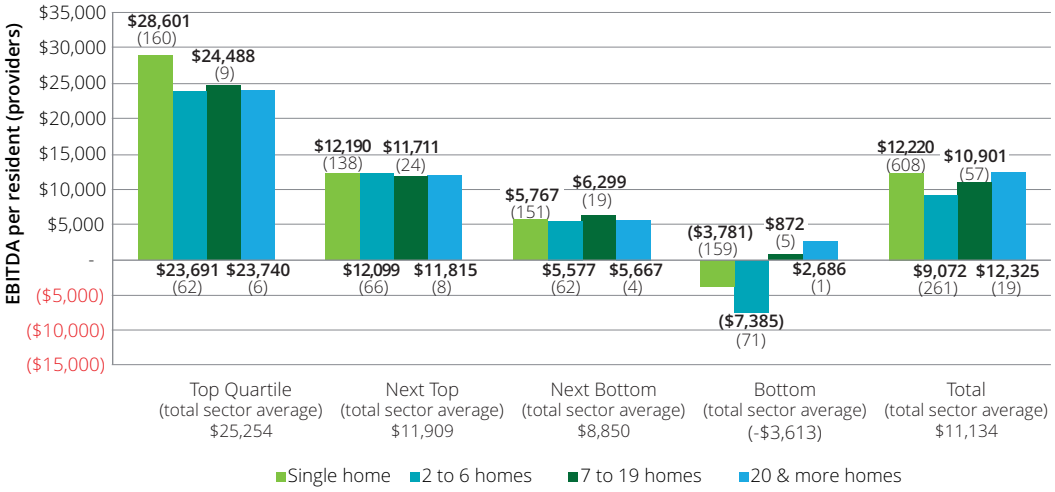
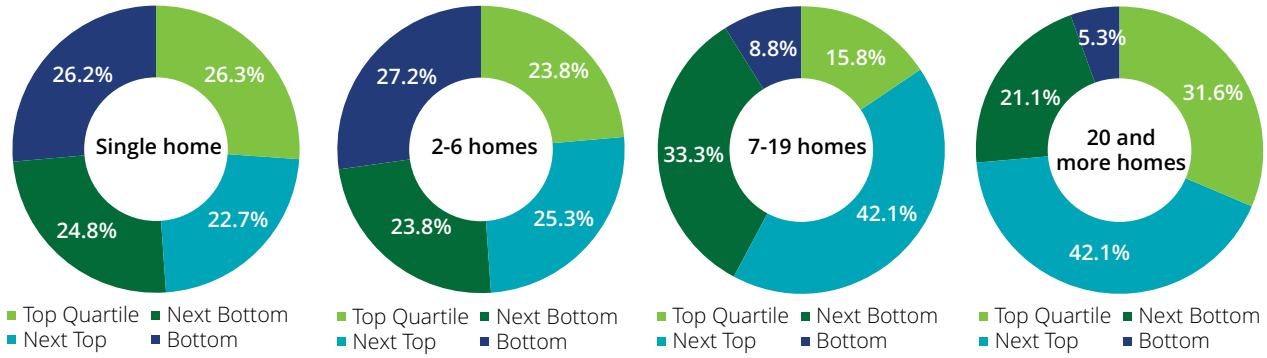


Chart 9.15: Residential care provider distribution between quartile of average EBITDA per resident per annum 2015-16 – by provider scale



9.3.4 Financial performance analysis 2016-17

The majority of financial analysis presented within this report is based on the 2015-16 financial results, using the most recent General Purpose Financial Reports prepared by residential care providers. ACFA does however have access to more recent financial performance results that have been provided by StewartBrown[26].

For the nine months to March 2017, StewartBrown reports that residential care providers have seen a decline in average results for the 2016-17 financial year-to-date as ACFI changes made to date have taken effect. StewartBrown has identified at this stage, cost management is the key differentiator between those provider facilities that continue to show stable results and those whose results have declined.

StewartBrown results showed that average care results for the nine months to March 2017 were around 8 per cent lower than the results for 2015-16 and the facility EBITDA decreased by around 4 per cent over the same period. The StewartBrown results also showed a change in contribution to accommodation revenue with consumers currently contributing a larger share of accommodation income at 54 per cent, up from 52 per cent at June 2016, which in turn has decreased Government's share from 48 per cent in June 2016 to the current level of 46 per cent.

It is not possible, to directly compare the sector results presented for 2015-16 in this report with the StewartBrown results for the nine months to March 2017 because data collection methods and provider numbers and mix are not consistent. In addition, there is different treatment of non-operating revenue items. Nevertheless, the financial result reported by the StewartBrown survey population for the nine months to March 2017 could broadly reflect the trend experienced by the sector as a whole. However, the full impact of the 1 July 2016 ACFI changes and the progressive implementation of the other ACFI and indexation changes, together with the recent national wage case decision which increased minimum wages by 3.3 per cent, may be expected to contribute to a decline in financial performance over time.

9.4 Looking forward

As discussed earlier, the Government announced changes to the ACFI and indexation arrangements as part of the 2016 MYEFO[27] and 2016-17 Budget.

During 2015-16, real growth of expenditure per resident per day through the ACFI was 5.2 per cent compared with a Government budgeted growth of 3.2 per cent. This resulted in an increase to the Government's forecast expenditure for the four years 2015-16 to 2018-19 of over $1 billion. The Government responded by announcing changes to the ACFI and indexation following consultation with the sector. These changes took effect progressively from 1 July 2016. Overall growth in ACFI expenditure was forecast to be around 3 per cent (including 1.3 per cent indexation) following these changes.

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

The latest Departmental ACFI monitoring report is based on data to the end of January 2017. It shows that claims peaked in the lead up to 1 July 2016 when the first stage of changes took effect, and flattened in subsequent months. Claim amounts started to rise again in November and December 2016 prior to the second stage of changes taking effect on 1 January 2017, after which claim amounts decreased again.

The January report shows that the average ACFI subsidy per resident per day for the year to date was $172.56. If this rate of real growth continues for the remainder of 2016-17, annual real growth will be 1.9 per cent. This is slightly higher than the budget projection (1.7 per cent real growth), but significantly lower than the reported 5.2 per cent real growth in 2015-16.

26 StewartBrown collects detailed financial and supporting data from over 35 per cent of residential aged care facilities through its quarterly Aged Care Financial Performance Surveys.

27 Mid-Year Economic and Fiscal Outlook

10

Residential aged care: capital investment

10. Residential aged care: capital investment

This chapter provides an overview of capital investment in the residential aged care sector.

This chapter discusses:

- the sources of capital financing for the residential care sector, including the role of the Refundable Accommodation Deposits (accommodation bonds prior to 1 July 2014).
- key balance sheet metrics for 2015-16.
- current investment trends and future requirements.

On 30 June 2016, compared with 30 June 2015, the industry as a whole had:

- **Total assets of $40.7 billion**, up from $36.6 billion, this includes
  - $5.6 billion of cash assets, an increase of $441 million;
  - $11.5 billion of fixed assets, an increase of $781 million;
  - $23.6 billion of other assets, an increase of $2.9 billion, including
    - intercompany loans receivable of $3.6 billion; and
    - intangible assets of $3.4 billion.
- **Total liabilities of $29.8 billion**, up from $25.7 billion. This includes $21.9 billion of accommodation deposits held by industry, up from $18.2 billion;
- **Net assets of $10.9 billion**, an increase of $42 million;
- average return on equity in 2015-16 was 17.7 per cent, up from 16 per cent; and
- average return on assets in 2015-16 was 4.9 per cent, same as 2014-15.

ACFA Notes:

- $1.6 billion of new construction work was completed in 2015-16.
- the higher accommodation supplement for new and significantly refurbished facilities that came into effect on 1 July 2014 continues to provide positive incentives for investment in the sector.

10.1 Capital financing

Capital for residential aged care providers is comprised of:

- financing from equity investments;
- loans from financial institutions;
- interest free loans from residents in the form of lump sum Refundable Accommodation Deposits (bonds pre 1 July 2014);
- capital investment support from Government by way of capital grants for eligible projects; and
- equity investment and retained earnings.

10.1.1 Residents

Lump sum accommodation payments by residents contribute to funding of capital investment in residential care. Refundable Accommodation Deposits (RADs) act as an interest free loan to providers paid by residents, and play a significant role in financing the industry. At 30 June 2016, a total of $21.9 billion of accommodation deposits (including bonds) were held by providers. Accommodation deposits provide a source of interest income that is included in the other income reported by providers in the operating statement.

As an alternative to RADs, residents may pay Daily Accommodation Payments (DAPs) or a combination of a RAD and DAP. Prior to 1 July 2014 providers were restricted from charging an accommodation bond to residents in a high care place (unless it had extra service status). With the removal of the distinction between high and low care places on 1 July 2014, this restriction was lifted and providers can accept lump sum refundable deposits from all residents.

10.1.2 Australian Government

The Australian Government makes capital grants available for services that target communities and geographic areas where there may be insufficient access to capital from other sources. In 2015-16, $67 million (made available through the 2015 Aged Care Approvals Round (ACAR)) was allocated to 22 providers. A further $64 million was made available in the 2016 ACAR to be allocated in 2016-17.

Additionally, the higher accommodation supplement, payable where a room has been built or significantly refurbished since 1 April 2012, is encouraging investment in residential care. Although not strictly a form of capital for providers, it provides an increased rate of return on the capital invested.

10.1.3 Other sources of capital finance

Residential care providers also obtain capital finance from investors, financial institution loans and donations. ACFA does not have data across the sector on debt and equity financing, other than that reported in the aggregated balance sheets, which are discussed in this chapter.

10.2 Accommodation deposits

At 30 June 2016, refundable accommodation deposits (including bonds) totalling $21.9 billion financed 53.7 per cent of total assets of $40.7 billion and represented 73.5 per cent of liabilities ($29.8 billion) for the aged care industry.

At 30 June 2016, there were a total of 82,006 refundable accommodation deposits (including bonds) (73,324 in 2014-15), with an average value of $266,717 ($248,400 in 2014-15).

10.2.1 Accommodation deposit prices

Until and including the 2015 ACFA report, which reported on the 2013-14 financial year, ACFA reported the average price of new accommodation bonds.

As of 1 July 2014, new accommodation pricing arrangements came into effect. These changes included the following:

- Lump sum accommodation payments 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.

ACFA noted in last year's report that while average accommodation bond prices prior to the 1 July 2014 changes are not directly comparable with the value of RADs following these changes, they can be compared, having regard to the differences noted above, with average and agreed prices following 1 July 2014. It should be remembered that the and agreed prices can be a RAD, DAP or combination of the two, which is why there can be no direct comparison with bond prices prior to 1 July 2014.

Charts 10.1 and 10.2 show the average agreed prices since 1 July 2014 and the average new bond prices prior to 1 July 2014.

Chart 10.1: Average price of new accommodation bonds: 2009-10 to 2013-14 and average agreed accommodation prices (lump sum equivalent): 2014-15 to 2015-16 (thousands), by ownership type

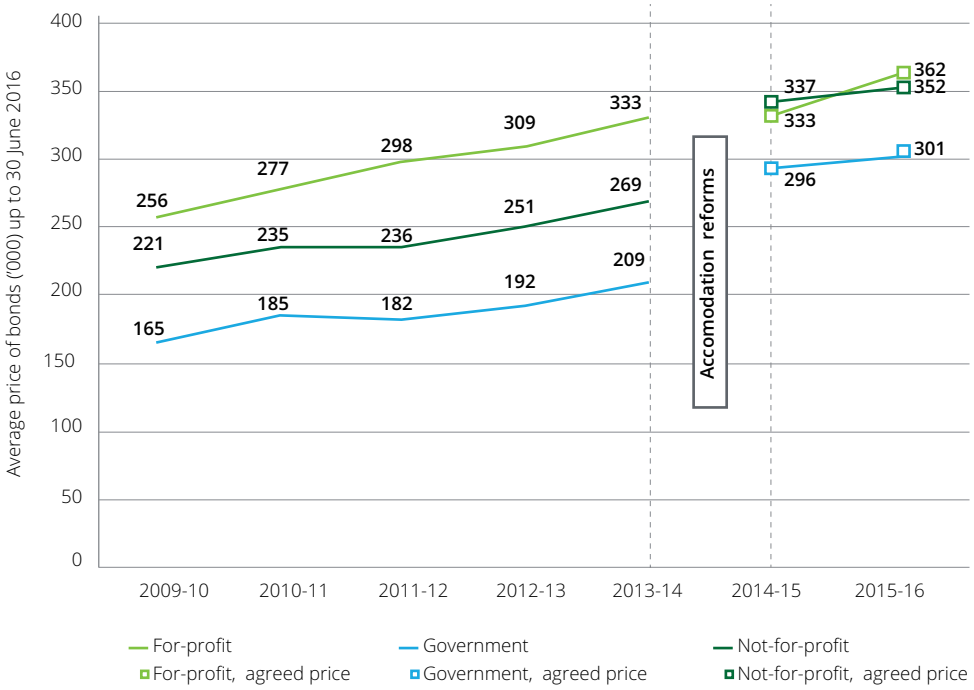
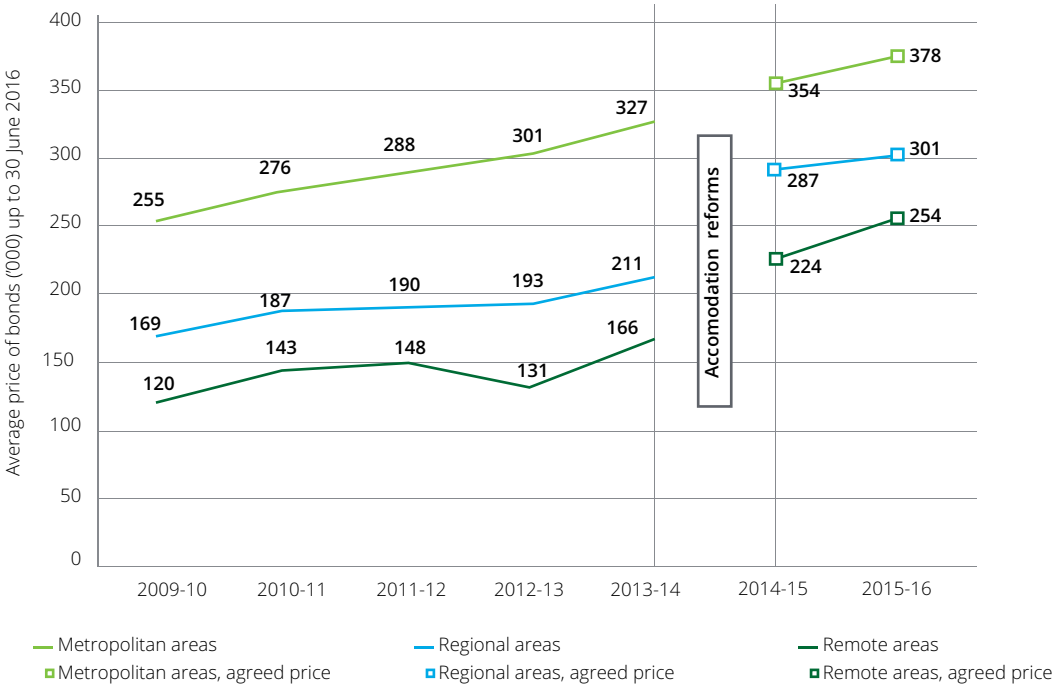


Chart 10.2: Average price of new accommodation bonds: 2009-10 to 2013-14 and average agreed accommodation prices (lump sum equivalent): 2014-15 to 2015-16 (thousands), by provider remoteness location



10.3 Financing status – balance sheet

This section focuses on the balance sheet of the residential aged care industry, showing the liabilities, assets and net assets. This is indicated in Figure 10.1.

Figure 10.1: Residential aged care funding/financing sources, 2015-16

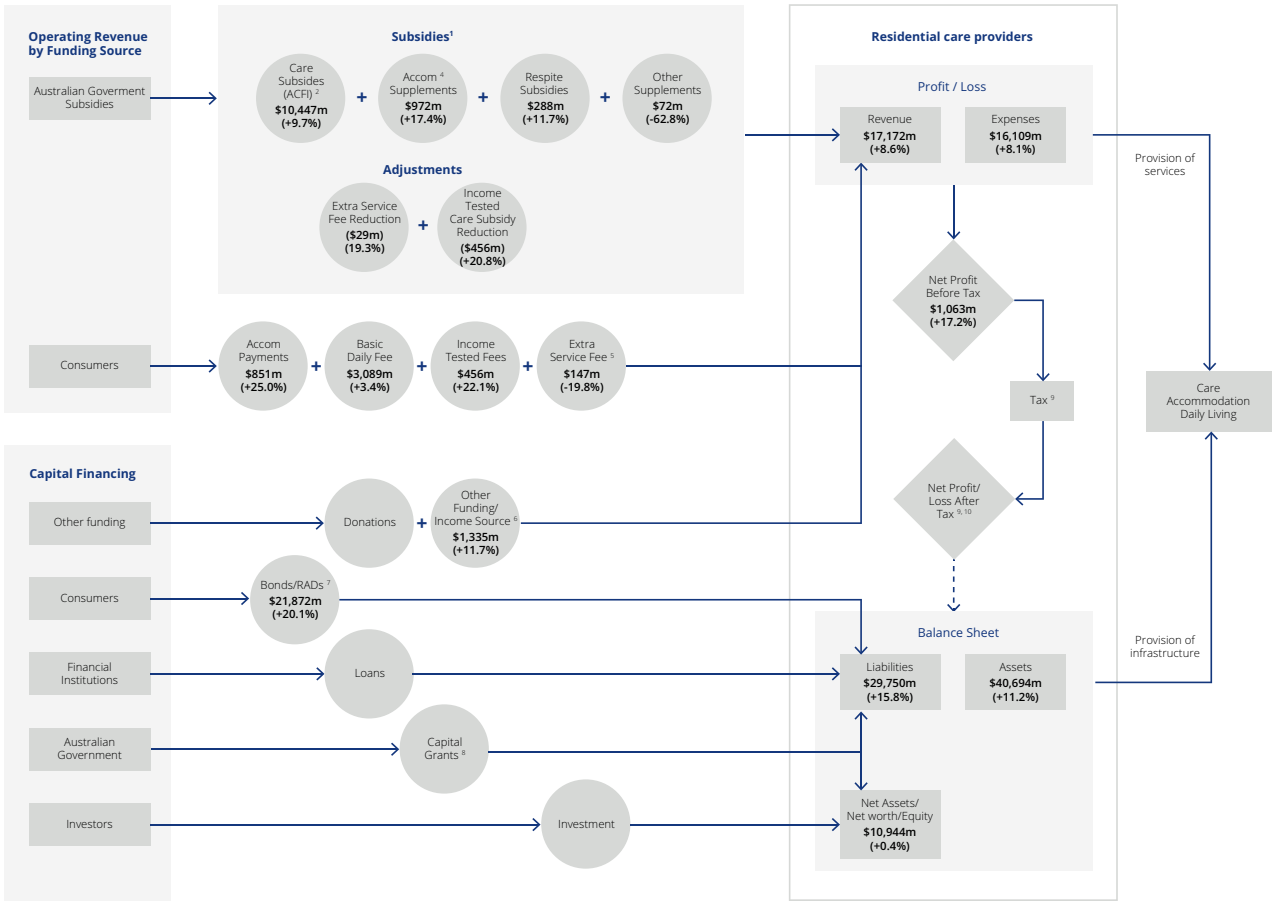


Table 10.1 shows the balance sheet of residential care providers for 2015-16 compared with 2014-15. Table 10.2 shows the balance sheet for the five years since 2011-12.

At 30 June 2016, the industry as a whole had total assets of $40.7 billion (an increase of $4.1 billion from 2014-15). Cash and fixed assets increased by 8.5 and 7.3 per cent respectively while other assets[28] increased by 13.9 per cent. ACFA notes that other assets have increased by $2.9 billion. Related party loans receivable and intangible assets equate to approximately 30 per cent of the other assets held by the sector and increased by $0.6 billion or 8.5 per cent. ACFA also notes that 79 per cent of the increase in accommodation deposits during the year has been invested across the other assets held.

Total liabilities were $29.8 billion (compared with $25.7 billion in 2014-15). This includes the $21.9 billion of accommodation deposits held by industry (up from $18.2 billion in 2014-15).

The sector overall had net equity of $10.94 billion in 2015-16, up from $10.90 billion in 2014-15.

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 include secured and unsecured lenders, creditors and provisions, represent 19 per cent of total asset financing.

28 Other assets includes trade and other (lump sum accommodation deposit and other) receivables, related party receivables, inventory, intangibles, other current assets and non-current assets

Table 10.1: Balance sheet of residential care providers, 2014-15 and 2015-16

Assets/liabilities	2014-15 ($million)	2015-16 ($million)	Change ($million)	Change (%)
Cash assets	$5,170	$5,611	$441	+8.5
Fixed assets	$10674	$11,455	$781	+7.3
Other assets	$20,742	$23,629	$2,887	+13.9
Total assets	**$36,586**	**$40,694**	**$4,108**	**+11.2**
Accommodation deposits	$18,213	$21,872	$3,659	+20.1
Other liabilities	$7,472	$7,878	$406	+5.4
Total liabilities	**$25,685**	**$29,750**	**$4,065**	**+15.8**
Net worth/quity	**$10,901**	**$10,943**	**$42**	**+0.4**

Table 10.2: Balance sheet of residential care providers, 2011-12 to 2015-16

Assets/ liabilities	2011-12 ($ million)	2012-13 ($ million)	2013-14 ($ million)	2014-15 ($ million)	2015-16 ($ million)
Cash assets	$3,239	$3,942	$3,558	$5,170	$5,611
Fixed assets	$8,046	$9,372	$10,238	$10,674	$11,455
Other assets	$16,767	$17,539	$19,866	$20,742	$23,629
Total Assets	**$28,052**	**$30,853**	**$33,662**	**$36,586**	**$40,694**
Refundable accommodation deposits	$12,966	$14,295	$15,611	$18,213	$21,872
Other liabilities	$5,474	$6,369	$6,883	$7,472	$7,878
Total liabilities	**$18,440**	**$20,664**	**$22,494**	**$25,685**	**$29,750**
Net Worth/ Equity	**$9,613**	**$10,189**	**$11,168**	**$10,901**	**$10,944**
As % of total assets					
Refundable accommodation deposits	46.2%	46.3%	46.4%	49.8%	53.7%
Other liabilities	19.5%	20.6%	20.4%	20.4%	19.4%
Total liabilities	**65.7%**	**67.0%**	**66.8%**	**70.2%**	**73.1%**
Net Worth/Equity	**34.3%**	**33.0%**	**33.2%**	**29.8%**	**26.9%**

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.

10.3.1 Balance sheet analysis by ownership type

Assets and liabilities have been analysed by ownership type in order to identify differences between not-for-profit, for-profit and government providers (Tables 10.3 and 10.4).

At 30 June 2016, the not-for-profit providers (who hold 56 per cent of places in the sector) had total assets of $21.4 billion (53 per cent of total industry assets), up from $19.2 billion in 2014-15. The for-profit providers (39 per cent of places), had total assets of $17.7 billion which equates to 44 per cent of total industry assets, up from $15.8 billion in 2014-15.

As was the case in 2014-15, the for-profit sector had the highest proportion of liabilities among ownership types ($15.3 billion). This was made up of $10.2 billion in accommodation deposits (46 per cent of total industry accommodation deposits) and $5.2 billion in other liabilities (66 per cent of total industry other liabilities).

Government providers had by far the highest net worth/equity as a proportion of assets with 68 per cent followed by the not-for-profit providers (35 per cent). For-profit providers had the lowest net worth/equity as a proportion of assets with 13 per cent, which 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.

Table 10.3: Balance sheet, by ownership type, at 30 June 2016 ($m)

	Not-for-profit ($m)	For-profit ($m)	Government ($m)	Total ($m)
Total Assets ***funded by:***	$21,370	$17,715	$1,609	$40,694
Refundable Accommodation Deposits	$11,281	$10,162	$429	$21,872
Other liabilities	$2,609	$5,184	$85	$7,878
Total liabilities	**$13,890**	**$15,346**	**$514**	**$25,685**
Net Worth/Equity	**$7,480**	**$2,369**	**$1,095**	**$10,944**
As a % of Total Assets				
Refundable Accommodation Deposits	52.8%	57.4%	26.7%	53.7%
Other liabilities	12.2%	29.3%	5.3%	19.4%
Total liabilities	65%	86.7%	32%	73.1%
Net worth/equity	35.0%	13.4%	68.1%	26.9%
Total	**100%**	**100%**	**100%**	**100%**

Table 10.4: Balance sheet, by ownership type, 2014-15 and 2015-16

			Change	
	2014-15	2015-16	$ p.r.p.d.	%
Not-for-profit				
Cash assets	$3,159	$3,637	$478	+15.1
Fixed assets	$6,463	$7,157	$694	+10.7
Other assets	$9,568	$10,577	$1,009	+10.5
Total assets	**$19,191**	**$21,370**	**$2,179**	**+11.4**
Accommodation deposits	$9,535	$11,281	$1,746	+18.3
Other liabilities	$2,432	$2,609	$177	+7.3
Total liabilities	**$11,968**	**$13,890**	**$1,922**	**+16.1**
Net worth/equity	**$7,223**	**$7,480**	**$257**	**+3.6**
For-profit				
Cash assets	$1,882	$1,867	-$15	-0.8
Fixed assets	$3,704	$3,882	$178	+4.8
Other assets	$10,193	$11,965	$1,772	+17.4
Total assets	**$15,779**	**$17,715**	**$1,936**	**+12.3**
Accommodation deposits	$8,329	$10,162	$1,833	+22.0
Other liabilities	$4,944	$5,184	$240	+4.9
Total liabilities	**$13,273**	**$15,346**	**$2,073**	**+15.6**
Net worth/equity	**$2,506**	**$2,369**	**-$137**	**-5.5**
Government				
Cash assets	$129	$107	-$22	-17.1
Fixed assets	$507	$416	-$91	-17.9
Other assets	$981	$1,087	$106	+10.8
Total assets	**$1,617**	**$1,609**	**-$8**	**-0.5**
Accommodation deposits	$349	$429	$80	+22.9
Other liabilities	$96	$85	-$11	-11.5
Total liabilities	**$445**	**$514**	**$69**	**+15.5**
Net worth/equity	**$1,172**	**$1,095**	**-$77**	**-6.6**

A notable difference is in the net worth/equity shown by the not-for-profits compared with the for-profits.

At 30 June 2016, not-for-profit providers had total assets of $21.4 billion and a net worth/equity of $7.5 billion, whereas for-profit providers had total assets of $17.7 billion and net worth/equity of $2.4 billion.

Other assets include related party loans receivable and intangible assets.

The for-profit sector reported other assets of $12.0 billion and held the highest balance of related party loans receivable totalling $3.4 billion in 2015-16, an increase of 7.7 per cent on 2014-15. Intangible assets was another significant asset balance for the for-profit sector totalling $2.9 billion during 2015-16, an increase of 8.6 per cent. Related party loans receivable and intangible assets formed more than 35 per cent of the total assets held by the for-profit sector in 2015-16.

The not-for profit sector reported other assets of $10.6 billion and held $0.2 billion in related party loans receivable and $0.5 billion in intangible assets in comparison.

Given the regulated permitted uses of RADs (bonds pre 1 July 2014), the build-up of categories of assets other than fixed assets is noteworthy. A formal review of the use of RADs and bond financing is part of the annual focus of the Department of Health in their examination of Annual Prudential Compliance Statements.

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.

The sector overall had net equity of $10.94 billion in 2015-16, up from $10.90 billion in 2014-15.

10.3.2 Balance sheet performance ratios

Balance sheet ratios are calculated from the financial results and performance of providers. Balance sheet ratios provide an indication of the financial health of providers across the sector through analysis of their levels of profitability, liquidity, efficiency as well as their net worth.

Balance sheet performance ratios – Definitions

Current Ratio

Current ratio is a measure of an organisations ability to meet its short term obligations (current liabilities) from its current assets. The current ratio measures an organisation's liquidity and provides an indication of risk that the organisation may not be able to meet its short term obligation as and when they fall due. It is calculated by dividing current assets of an organisation by its current liabilities.

Organisations generally 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 requirement to categorise accommodation deposits as current liabilities[29] on the balance sheet means that the current ratio needs to be treated with great caution and considered in line with other financial indicators when being relied upon as a measure of liquidity for aged care organisations.

Net Assets Value

The net assets value provides an indication of the value of an organisation. The net assets value is determined by taking the total assets of an organisation and subtracting the total liabilities. A low net assets value or a decrease in the value over time indicates higher levels of financial risk for lenders and consumers.

Debt Ratio

The debt ratio is calculated by dividing an organisations total liabilities by its total assets and provides an indication of the degree of financing of an organisation. Within the aged care sector, total liabilities will consist of an organisation's refundable accommodation deposits as well as other secured and unsecured debt balances.

29 The requirements for the presentation of financial statements is set out in AASB 101 and paragraph 69(d) relates to liabilities where there is no right to defer settlement of the liability for at least 12 months after the reporting period. The average length of stay of a resident is three years and as a result, the liability for repayment of an accommodation deposit can extend beyond 12 months after year end if the resident is still in care.

An organisation's total assets will include cash and asset balances to which the refundable accommodation deposits may have been applied. As total liabilities increase as a proportion of total assets, the higher levels of debt could reflect the use of additional borrowings used to fund an organisation's improvements and expansions.

Debt to Equity Ratio

The debt to equity ratio provides an indication of the level of gearing of an organisation. The debt to equity ratio is determined by taking the interest bearing debt and dividing it by the organisation's equity. A debt to equity ratio above 2.0 indicates an increased level of financial risk as growth has been financed through additional borrowings and the organisation will be exposed to higher levels of interest repayments.

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. Generally, the higher the EBITDA to total assets ratio, the better the level of return generated from the organisation's total assets.

EBITDA to total equity/net worth/net assets ratio

The EBITDA to total equity ratio measures the operating return generated from an organisation's total equity or their net assets. The ratio is a measure of financial performance and is calculated by dividing an organisation's earnings, before interest, tax, depreciation and amortisation (EBITDA) by the organisation's total equity or net asset position. Generally, the higher the EBITDA to total equity ratio, the greater the level of return on the owners' contribution and retention of earnings over time.

As illustrated in Chart 10.3, the current ratio and EBITDA to total assets ratios remained relatively stable between 2014-15 and 2015-16. This is the same as reported in last year's report where they had been similar to 2013-14. The EBITDA to Equity/net worth/ net assets ratio did however increase from 16.0 to 17.7 in 2015-16. This indicates an improvement in the level of profit derived across the net assets of the sector, and follows an increase from 14.3 in 2013-14.

Chart 10.4 illustrates the balance sheet ratios by provider type.

As was reported in previous annual reports, government providers had the highest current ratio (0.81) compared with not-for-profit providers (0.58) and for-profit providers (0.37). While the current ratio has increased for not-for-profits (0.55 in 2014-15), it has decreased for the for-profit providers (0.41 in 2014-15). Ordinarily a current ratio which is less than 1.0 indicates an organisation has insufficient assets to meet their obligations when they become due and payable. Refundable accommodation deposits can become repayable at any time and are classified as current liabilities. Providers do not have the right to defer settlement of the liabilities for at least 12 months after the reporting date, although in practice, the repayment period for accommodation deposit balances will vary in line with each resident's tenure. This means that the current ratio result should be used with great caution and considered in line with other financial results in the residential aged care financial analysis.

The average debt ratio across the sector increased slightly to 0.73 (0.70 in 2014-15) and is a medium term performance indicator. The debt ratio shows the proportion of organisational assets that are financed through debt. A ratio of more than 1.0 indicates that an organisation has a higher debt level than the value of its assets. In terms of average debt ratio, the for-profit providers reported 0.87 (up from 0.84 in 2014-15) with not-for-profit providers reported 0.64 (up from 0.62 in 2014-15) and government providers reported 0.31 (up from 0.27 in 2014-15).

A significant difference remains in the proportion of EBITDA to total assets for the for-profit (5.3 per cent) and not-for-profit providers (4.9 per cent) compared with the government providers (-0.4 per cent). The for-profit providers also have a considerably higher proportion of EBITDA to equity/net worth/net assets (39.5 per cent) compared with the not-for-profit providers (13.5 per cent) and government providers (-0.6 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 10.3: Balance sheet performance ratios, 2014-15 and 2015-16

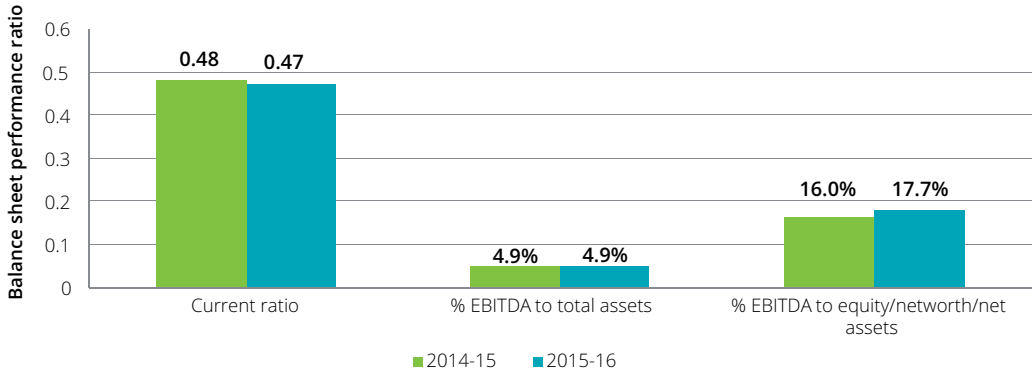


Chart 10.4: Balance sheet performance ratios at 30 June 2016, by provider type

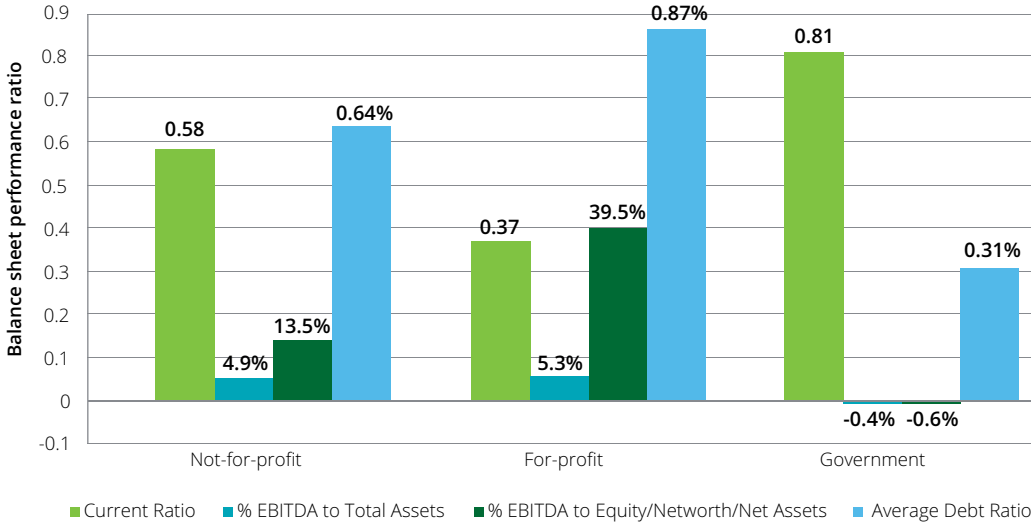
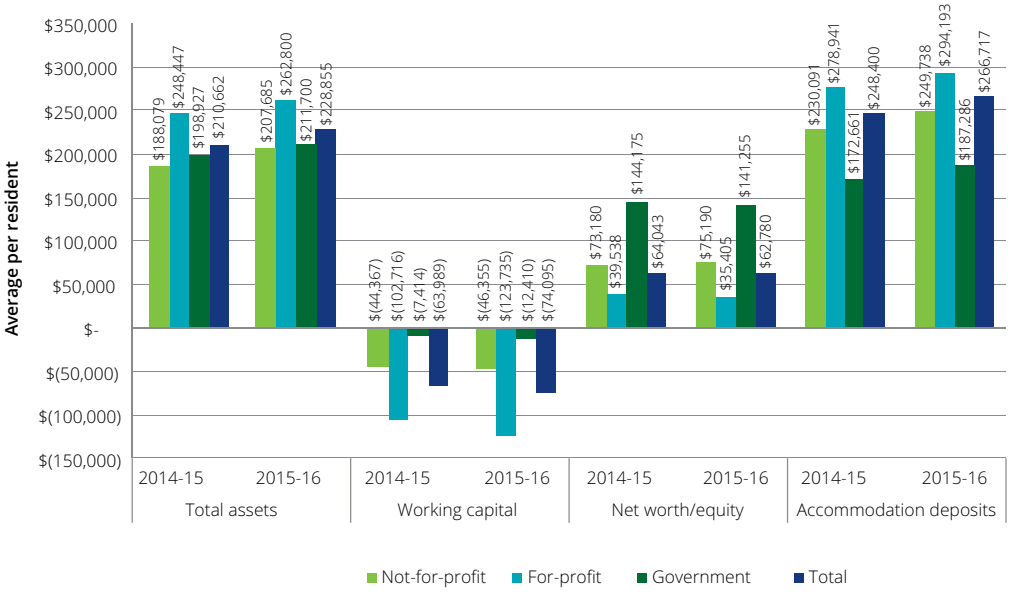


Chart 10.5 shows the balance sheet metrics by ownership type in 2015-16 compared with 2014-15. For the whole of sector, the average for all accommodation deposits held increased to $267,000 per resident from $248,000 in 2014-15, an increase of 8 per cent. This metric measures the average value of all bonds (pre 1 July 2014) and accommodation deposits (post 1 July 2014) that a providers hold.

Chart 10.5: Average balance sheet metrics by resident 2014-15 and 2015-16, by provider type



10.4 Investment requirements

The Department of Health has provided its updated estimates of the sector's annual investment requirement for residential care over the next decade, based on the Government's current target provision ratio. These estimates are based on several key assumptions:

- the current service provision targets continue;
- the cost of construction continues to grow at about 2.4 per cent each year[30]; 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 83,500 places 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 33,667 new places that came online over the previous decade, as shown in Chart 10.6.

At the same time, the sector will need to rebuild a substantial proportion of its current stock. Assuming that a quarter of the current stock of buildings is rebuilt at an even rate over the next decade, the Department estimates that the investment requirement of the sector over the next decade to be in the order of $35 billion.

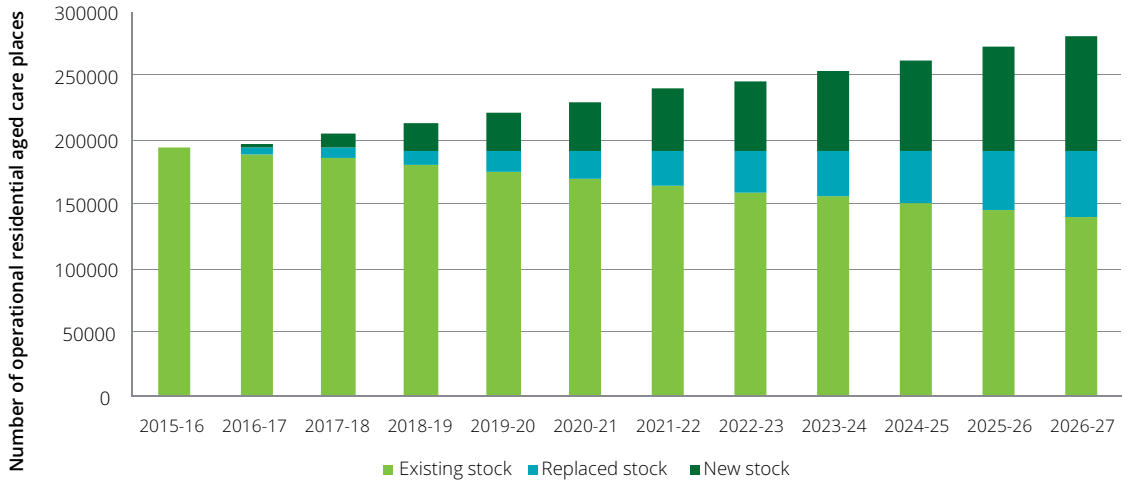
This increase in investment will require several inputs in order to be met, including:

- continued subsidised operational funding from the Commonwealth on behalf of supported residents;
- consumer contributions to operational funding;
- capital financing from residents (in the form of refundable accommodation deposits), providers, investors and financiers and the Commonwealth;
- industry wide access to detailed medium term demographic forecasts to ensure correct siting of future facilities; and
- availability of greenfield sites for the construction of new aged care homes in the areas needed.

Chart 10.7 shows the investment needed over the next decade to construct the new aged care places required to cater for the impact of the baby boomer generation on the number of places generated under the provision ratio. Over the next decade, there is a steep ramp up from $2.8 billion needed in 2016-17 to around $4.2 billion in 2026-27.

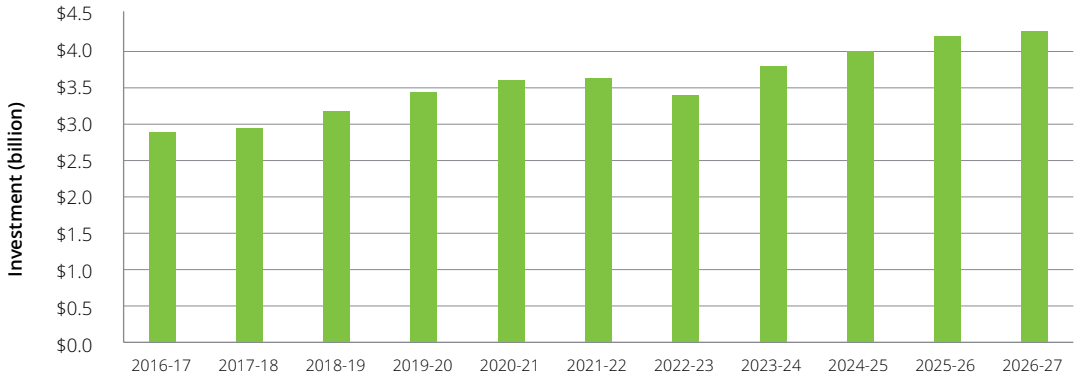
The pattern in annual investment, including the slight contraction in the early 2020s, reflects the underlying growth in the 70 years and over population and most notably the large number of births in 1946.

Chart 10.6: Number of operational residential aged care places required in the next decade



30 The Department derived estimates of the full cost of constructing an aged care home based on the 2015-16 Report on the Operation of the *Aged Care Act 1997* and Rawlinsons (2017) Construction Cost Guide. Perth: Rawlinsons. Trends in aged care construction costs are derived from Rawlinsons (2017) and Producer Price Indexes. Cat. No. 6427.0

Chart 10.7: 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 STRC places which comprises two places per 1000 people aged 70 and over within the target ratio. As noted in Chapter 5, 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.

As at 30 June 2016 there were 35,124 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 provisionally allocated places in the development pipeline, demand by providers for new places is strong, with 45,053 places sought by providers in the 2016 ACAR, (a 15 per cent increase on the 2015 ACAR) compared with the 10,000 places advertised.

10.4.1 Recent trends in investment in the residential care sector

As noted in last year's annual report, investment trends have been improving since the 1 July 2014 reforms.

The 2016 Survey of Aged Care Homes estimated that a total of $1.6 billion in new building, refurbishment and upgrading work was completed during 2015-16, involving about 24 per cent of all homes. The amount of new building work in progress at the end of June 2016 was estimated at $2.9 billion, involving about 17.8 per cent of all homes.

In 2015-16 there was a decrease of $184 million (11 per cent) in completed new building, refurbishment and upgrading work compared with 2014-15. However, there was an increase of $900 million (43 per cent) in work-in-progress during the same period. ACFA notes that the total spend on building activity was 18 per cent higher in 2015-16 at over $4.5 billion, compared with around $3.8 billion reported in 2014-15 (Chart 10.8).

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 10.8: Residential aged care building activity, 2013-14 and 2015-16

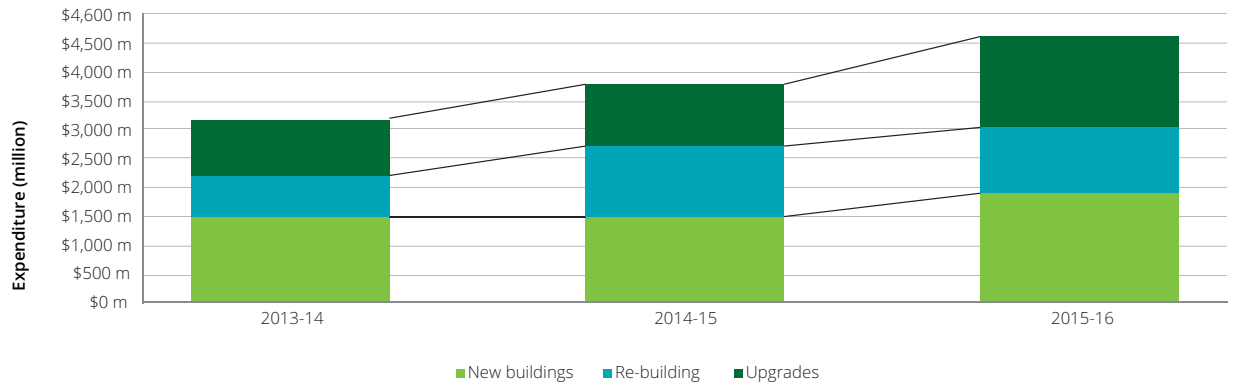
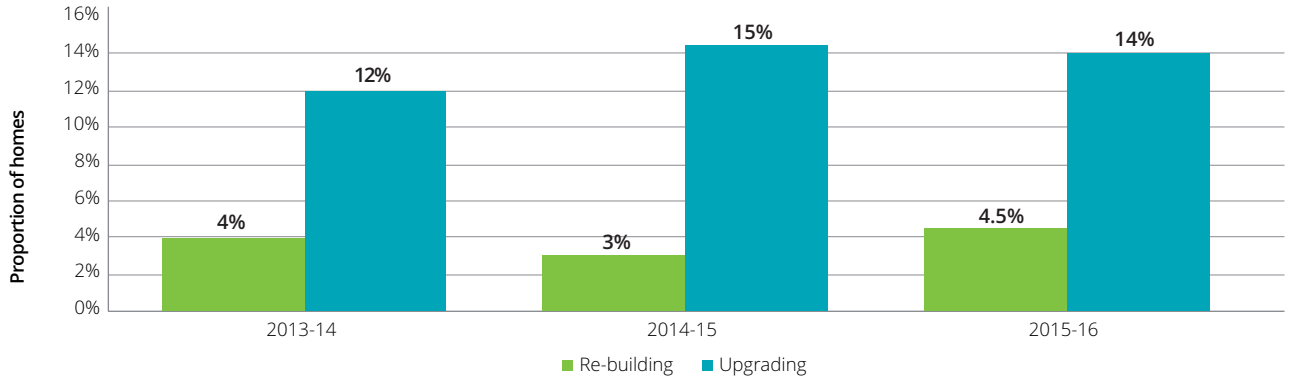


Chart 10.9: Proportion of homes planning to either upgrade or rebuild in 2013-14 and 2015-16



10.4.2 Building and construction statistics

Chart 10.9 shows the proportion of homes planning to either rebuild or upgrade over the period 2013-14 to 2015-16. The proportion across 2014-15 and 2015-16 is relatively stable.

As was the case in last year's report, building statistics data from the Australian Bureau of Statistics are showing strong signs of investment in the sector. There were 395 building approvals for aged care homes in the 12 months up to the end of February 2017, up from 372 for the same period up to February 2016 (Chart 10.10).

The value of building approvals has decreased, with average monthly total building approvals for aged care services in the 12 months to February 2017 being $149 million per month, compared with $168 million (per month) in the previous 12 months (Chart 10.11).

Chart 10.10: Residential aged care building approvals, 2011-12 to 2016-17

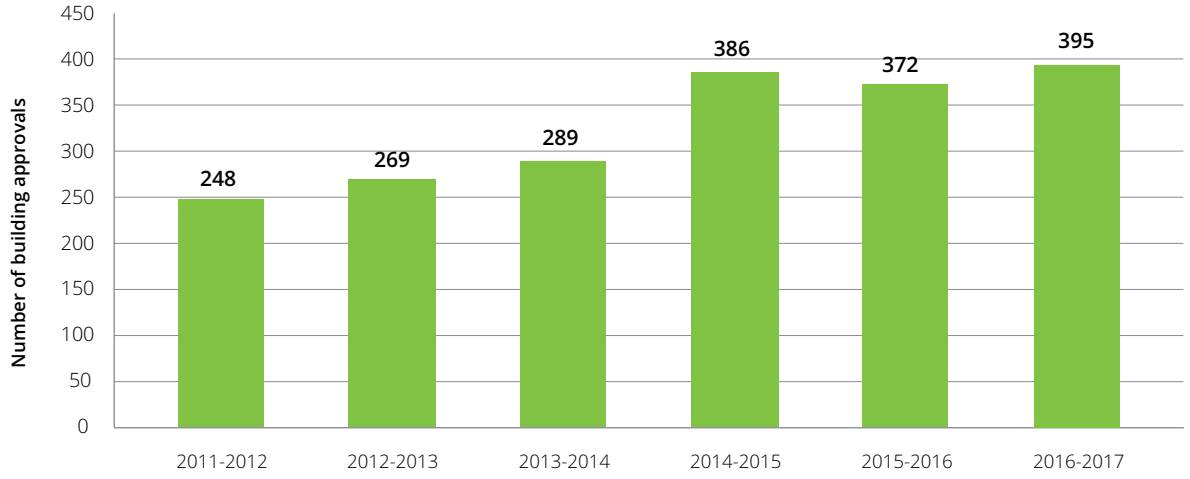
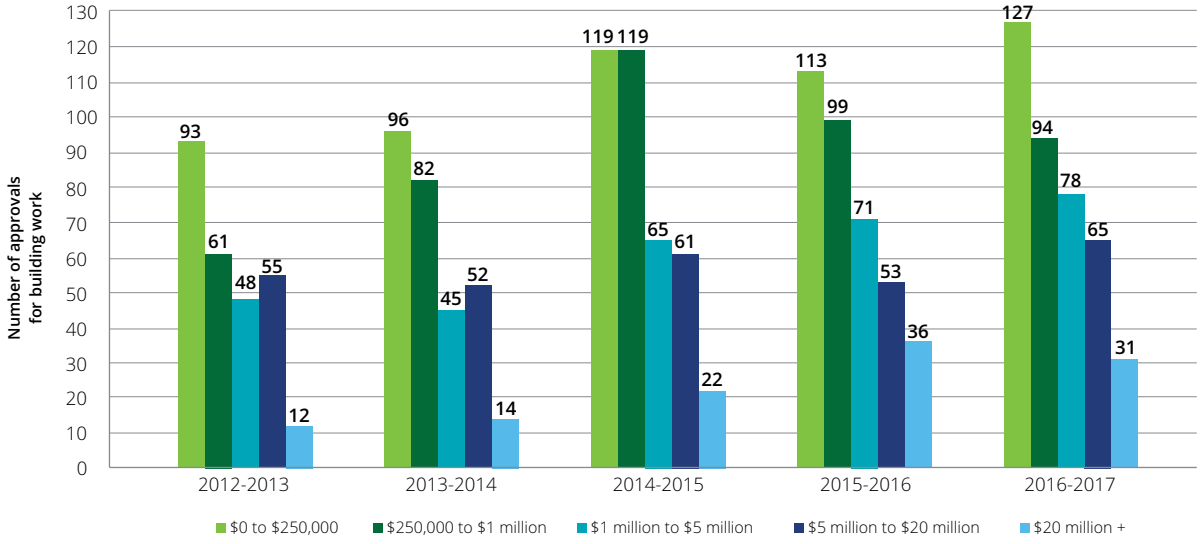


Chart 10.11: Number of building approvals by value of building work, 2012-13 to 2016-17



Note: Dates are from March to February

Appendices

Appendix A: ACFA Membership

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	Professor Graeme Samuel AC	Vice Chancellor's Professorial Fellow, Monash Business School, Monash University
Member	Mr John Pollaers	Chair of the Australian Industry and Skills Committee (AISC)
Member	Dr Mike Rungie (commenced 31 December 2016)	Former CEO, Aged Care Housing Group
Member	Ms Susan Emerson (commenced 31 December 2016)	Director, Helping Hand Aged Care
Member	Ms Louise Biti (commenced 31 December 2016)	Director, Aged Care Steps
Member	Ms Mary Patetsos (ceased 31 December 2016)	Director, Aged Care Housing Group
Member	Ms Lee Thomas (ceased 31 December 2016)	National Secretary, Australian Nursing and Midwifery Federation
Member	Ms Julie Campbell-Bode (ceased 31 December 2016)	Former Chief Executive Officer, Heartlands Seniors Finance

Representatives

ACFA position	Name	Organisation
Representative	Ms Margot McCarthy	Deputy Secretary, Ageing and Aged Care Group, Department of Health
Representative	Ms Kim Cull	Aged Care Pricing Commissioner
Representative	Ms Lee Steel	Manager, Health and Disability Social Policy Division, Department of the Treasury

Appendix B: Work completed by ACFA to date

Work	Date of completion
2017 Annual Report on Funding and Financing of the Aged Care Sector	Provided to Minister in July 2017. Published in August 2017.
Application of the Base Interest Rate	Provided to Minister in May 2017. Published in June 2017
Bond Guarantee Scheme	Provided to Minister in April 2017. Published in May 2017.
Report to Inform the 2016-17 Review of Amendments to the *Aged Care Act 1997*	Provided to Minister in May 2017. Published in June 2017.
Access to Residential Care by Supported residents	Provided to Minister in January 2017. Published in February 2017.
2016 Annual Report on Funding and Financing of the Aged Care Sector	Provided to Minister in July 2016. Published in August 2016.
Report on Issues Affecting the Financial Performance of Rural and Remote Providers, Residential and Home Care	Provided to Minister in January 2016. Published in February 2016.
2015 Annual Report on Funding and Financing of the Aged Care Sector	Provided to Minister in July 2015. Published in August 2016.
Report on Factors Influencing the Financial Performance of Residential Aged Care Providers	Provided to Minister in May 2015. Published in June 2015.
Report on Improving the Collection of Financial Data from Aged Care Providers	Provided to Minister in September 2014. Published in October 2014.
Reports on the Impact of Financial Reforms on the Aged Care Sector	First monthly report – 6 August 2014 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 in July 2014. Published in August 2014.
Supported Residents Data Book	Provided to Minister in April 2014. Published in May 2014.
Interim advice to the Minister on Improving the Collection of Financial Data from Aged Care Providers	Provided to Minister in July 2013. Published in August 2013.
First Annual Report (2013) on the Funding and Financing of the Aged Care Sector	Provided to Minister in June 2013. Published in July 2013.
Estimation of the possible impacts on revenue and balance sheet funding from changes to accommodation payment arrangements	ACFA's advice and KPMG modelling provided to Minister in May 2013. Published in May 2013.
The framework for setting accommodation payments in residential aged care	Final ACFA advice provided to Minister in November 2012. Government announced its position in December 2012. Further advice on the method for determining a RAD and a DAP using a MPIR provided to Minister on 17 May 2013. Government announced its position on 23 May 2013.

Appendix C: ACFA's stakeholder engagement

ACFA holds meetings and forums with representatives from the investment and financing industries, providers and consumers. This engagement is been critical to ACFA's understanding of the key issues, developments and challenges facing the industry.

Investors

In September 2016, ACFA held Roundtables in Sydney and Melbourne with members of the investment and financing community to share the findings of its 2016 annual report and to hear their views on key issues facing the sector.

Over 50 representatives from various organisations participated in the roundtables and a diverse range of issues and views were discussed regarding current and future investment in aged care, workforce issues and the availability of land and the challenges in developing that land into aged care facilities.

Providers

In 2015-16, ACFA liaised closely with the provider peaks including:

- Leading Age Services Australia;
- Aged and Community Services Australia;
- Catholic Health Australia;
- The Aged Care Guild; and
- Uniting Care.

Other stakeholders

ACFA presented at various forums during 2015-16. Stakeholder engagement continues to be a vital activity to inform ACFA's ongoing work and advice to Government. Forums included:

- The Aged and Community Services state and regional forums
- 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 Victoria rural Mini Conference
- The 2016 International Federation on Ageing 13th Global Conference
- The Aged and Community Services Australian Finance Forum Symposium
- The Leading Age Services Australia Victoria and Tasmania State Congress 2016

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 2016

State/ Territory	Aged Care Planning Region	Total Operational Places						
			Home care[2]					
		Residential care[1]	Low care	High care	Total home care	Total residential + home care	Total restorative care[3]	Grand total
NSW	Central Coast	3,686	1,080	479	1,559	**5,245**	**115**	**5,360**
	Central West	2,006	530	195	725	**2,731**	**37**	**2,768**
	Far North Coast	3,723	996	396	1,392	**5,115**	**77**	**5,192**
	Hunter	6,086	1,684	668	2,352	**8,438**	**107**	**8,545**
	Illawarra	4,090	1,205	501	1,706	**5,796**	**85**	**5,881**
	Inner West	4,401	1,057	378	1,435	**5,836**	**90**	**5,926**
	Mid North Coast	4,264	1,182	449	1,631	**5,895**	**82**	**5,977**
	Nepean	2,290	619	266	885	**3,175**	**48**	**3,223**
	New England	1,910	595	259	854	**2,764**	**38**	**2,802**
	Northern Sydney	8,853	2,173	831	3,004	**11,857**	**108**	**11,965**
	Orana Far West	1,637	452	178	630	**2,267**	**38**	**2,305**
	Riverina/Murray	3,039	815	331	1,146	**4,185**	**106**	**4,291**
	South East Sydney	8,017	2,109	765	2,874	**10,891**	**170**	**11,061**
	South West Sydney	6,693	1,761	739	2,500	**9,193**	**112**	**9,305**
	Southern Highlands	2,376	642	266	908	**3,284**	**63**	**3,347**
	Western Sydney	5,157	1,512	643	2,155	**7,312**	**102**	**7,414**
	NSW	**68,228**	**18,412**	**7,344**	**25,756**	**93,984**	**1,378**	**95,362**
Vic	Barwon-South Western	4,395	1,077	427	1,504	**5,899**	**85**	**5,984**
	Eastern Metro	10,747	2,796	1,195	3,991	**14,738**	**155**	**14,893**
	Gippsland	3,070	840	349	1,189	**4,259**	**42**	**4,301**
	Grampians	2,410	643	257	900	**3,310**	**63**	**3,373**
	Hume	3,051	819	334	1,153	**4,204**	**73**	**4,277**
	Loddon-Mallee	3,699	968	425	1,393	**5,092**	**101**	**5,193**
	Northern Metro	6,683	2,040	753	2,793	**9,476**	**117**	**9,593**
	Southern Metro	12,427	3,176	1,308	4,484	**16,911**	**227**	**17,138**
	Western Metro	5,475	1,545	620	2,165	**7,640**	**137**	**7,777**
	Vic	**51,957**	**13,904**	**5,668**	**19,572**	**71,529**	**1,000**	**72,529**
Qld	Brisbane North	3,879	953	392	1,345	**5,224**	**130**	**5,354**
	Brisbane South	5,827	1,470	539	2,009	**7,836**	**131**	**7,967**
	Cabool	3,234	947	377	1,324	**4,558**	**10**	**4,568**
	Central West	116	54	16	70	**186**	**0**	**186**
	Darling Downs	2,366	730	281	1,011	**3,377**	**52**	**3,429**
	Far North	1,816	554	270	824	**2,640**	**38**	**2,678**
	Fitzroy	1,527	435	169	604	**2,131**	**30**	**2,161**

Total Operational Ratios						
	Home care[2]					
Residential care[1]	Low care	High care	Total home care	Total residential + home care	Total restorative care[3]	Grand total (planning ratio)
69.1	20.3	9.0	29.2	**98.4**	**2.2**	**100.5**
90.8	24.0	8.8	32.8	**123.7**	**1.7**	**125.3**
83.1	22.2	8.8	31.1	**114.1**	**1.7**	**115.8**
81.0	22.4	8.9	31.3	**112.3**	**1.4**	**113.7**
72.8	21.5	8.9	30.4	**103.2**	**1.5**	**104.7**
92.8	22.3	8.0	30.2	**123.0**	**1.9**	**124.9**
80.0	22.2	8.4	30.6	**110.6**	**1.5**	**112.1**
76.4	20.6	8.9	29.5	**105.9**	**1.6**	**107.5**
81.7	25.5	11.1	36.5	**118.2**	**1.6**	**119.9**
93.0	22.8	8.7	31.6	**124.5**	**1.1**	**125.7**
81.0	22.4	8.8	31.2	**112.2**	**1.9**	**114.1**
79.4	21.3	8.7	30.0	**109.4**	**2.8**	**112.2**
87.9	23.1	8.4	31.5	**119.4**	**1.9**	**121.3**
77.5	20.4	8.6	28.9	**106.4**	**1.3**	**107.7**
79.3	21.4	8.9	30.3	**109.6**	**2.1**	**111.7**
69.0	20.2	8.6	28.8	**97.8**	**1.4**	**99.1**
81.1	**21.9**	**8.7**	**30.6**	**111.7**	**1.6**	**113.3**
91.7	22.5	8.9	31.4	**123.1**	**1.8**	**124.9**
81.0	21.1	9.0	30.1	**111.0**	**1.2**	**112.2**
78.8	21.6	9.0	30.5	**109.3**	**1.1**	**110.4**
85.0	22.7	9.1	31.7	**116.7**	**2.2**	**118.9**
81.9	22.0	9.0	31.0	**112.9**	**2.0**	**114.8**
79.0	20.7	9.1	29.8	**108.8**	**2.2**	**110.9**
78.4	23.9	8.8	32.8	**111.2**	**1.4**	**112.5**
83.6	21.4	8.8	30.2	**113.7**	**1.5**	**115.2**
79.0	22.3	8.9	31.2	**110.2**	**2.0**	**112.2**
81.8	**21.9**	**8.9**	**30.8**	**112.6**	**1.6**	**114.2**
90.3	22.2	9.1	31.3	**121.6**	**3.0**	**124.6**
87.8	22.2	8.1	30.3	**118.1**	**2.0**	**120.1**
73.6	21.5	8.6	30.1	**103.7**	**0.2**	**103.9**
97.0	45.2	13.4	58.5	**155.5**	**0.0**	**155.5**
72.9	22.5	8.7	31.2	**104.1**	**1.6**	**105.7**
62.1	18.9	9.2	28.2	**90.2**	**1.3**	**91.5**
87.0	24.8	9.6	34.4	**121.5**	**1.7**	**123.2**

State/ Territory	Aged Care Planning Region	Total Operational Places				Total residential + home care	Total restorative care[3]	Grand total
		Residential care[1]	Home care[2]					
			Low care	High care	Total home care			
	Logan River Valley	1,822	572	271	843	**2,665**	**15**	**2,680**
	Mackay	911	263	123	386	**1,297**	**9**	**1,306**
	North West	146	130	16	146	**292**	**0**	**292**
	Northern	1,634	498	208	706	**2,340**	**62**	**2,402**
	South Coast	4,966	1,199	558	1,757	**6,723**	**96**	**6,819**
	South West	245	108	28	136	**381**	**0**	**381**
	Sunshine Coast	3,801	1,106	575	1,681	**5,482**	**66**	**5,548**
	West Moreton	1,182	439	231	670	**1,852**	**34**	**1,886**
	Wide Bay	2,452	818	343	1,161	**3,613**	**60**	**3,673**
	Qld	**35,924**	**10,276**	**4,397**	**14,673**	**50,597**	**733**	**51,330**
WA	Goldfields	267	65	53	118	**385**	**0**	**385**
	Great Southern	514	171	131	302	**816**	**0**	**816**
	Indian Ocean Territories	0	0	0	0	**0**	**0**	**0**
	Kimberley	169	103	40	143	**312**	**0**	**312**
	Metropolitan East	2,405	879	544	1,423	**3,828**	**25**	**3,853**
	Metropolitan North	4,134	1,210	913	2,123	**6,257**	**188**	**6,445**
	Metropolitan South East	3,138	810	590	1,400	**4,538**	**25**	**4,563**
	Metropolitan South West	3,680	1,132	832	1,964	**5,644**	**73**	**5,717**
	Mid West	394	211	111	322	**716**	**15**	**731**
	Pilbara	76	55	14	69	**145**	**0**	**145**
	South West	1,217	348	299	647	**1,864**	**20**	**1,884**
	Wheatbelt	561	222	136	358	**919**	**0**	**919**
	WA	**16,555**	**5,206**	**3,663**	**8,869**	**25,424**	**346**	**25,770**
SA	Eyre Peninsula	517	160	72	232	**749**	**2**	**751**
	Flinders & Far North	227	162	40	202	**429**	**1**	**430**
	Hills, Mallee & Southern	1,622	477	195	672	**2,294**	**41**	**2,335**
	Metropolitan East	3,130	679	244	923	**4,053**	**98**	**4,151**
	Metropolitan North	3,542	732	353	1,085	**4,627**	**107**	**4,734**
	Metropolitan South	3,771	942	369	1,311	**5,082**	**80**	**5,162**
	Metropolitan West	2,820	698	240	938	**3,758**	**8**	**3,766**
	Mid North	375	94	43	137	**512**	**2**	**514**
	Riverland	453	145	62	207	**660**	**2**	**662**
	South East	730	186	81	267	**997**	**2**	**999**
	Yorke, Lower North & Barossa	1,430	341	142	483	**1,913**	**4**	**1,917**
	SA	**18,617**	**4,616**	**1,841**	**6,457**	**25,074**	**347**	**25,421**

Total Operational Ratios						
	Home care[2]					
Residential care[1]	Low care	High care	Total home care	Total residential + home care	Total restorative care[3]	Grand total (planning ratio)
59.7	18.7	8.9	27.6	**87.3**	**0.5**	**87.8**
83.1	24.0	11.2	35.2	**118.3**	**0.8**	**119.1**
88.4	78.7	9.7	88.4	**176.8**	**0.0**	**176.8**
74.7	22.8	9.5	32.3	**106.9**	**2.8**	**109.8**
87.4	21.1	9.8	30.9	**118.3**	**1.7**	**120.0**
79.3	34.9	9.1	44.0	**123.3**	**0.0**	**123.3**
74.6	21.7	11.3	33.0	**107.6**	**1.3**	**108.9**
56.4	20.9	11.0	31.9	**88.3**	**1.6**	**89.9**
57.9	19.3	8.1	27.4	**85.4**	**1.4**	**86.8**
76.0	**21.7**	**9.3**	**31.0**	**107.0**	**1.5**	**108.5**
67.6	16.5	13.4	29.9	**97.4**	**0.0**	**97.4**
61.6	20.5	15.7	36.2	**97.8**	**0.0**	**97.8**
0.0	0.0	0.0	0.0	**0.0**	**0.0**	**0.0**
116.5	71.0	27.6	98.6	**215.0**	**0.0**	**215.0**
69.1	25.2	15.6	40.9	**110.0**	**0.7**	**110.7**
68.3	20.0	15.1	35.1	**103.4**	**3.1**	**106.5**
81.1	20.9	15.3	36.2	**117.3**	**0.6**	**117.9**
67.2	20.7	15.2	35.8	**103.0**	**1.3**	**104.3**
59.5	31.9	16.8	48.6	**108.1**	**2.3**	**110.4**
69.5	50.3	12.8	63.1	**132.7**	**0.0**	**132.7**
68.1	19.5	16.7	36.2	**104.2**	**1.1**	**105.4**
65.6	26.0	15.9	41.9	**107.5**	**0.0**	**107.5**
69.9	**22.0**	**15.5**	**37.5**	**107.4**	**1.5**	**108.8**
78.5	24.3	10.9	35.2	**113.8**	**0.3**	**114.1**
114.6	81.8	20.2	102.0	**216.7**	**0.5**	**217.2**
72.2	21.2	8.7	29.9	**102.2**	**1.8**	**104.0**
106.3	23.1	8.3	31.3	**137.6**	**3.3**	**141.0**
85.0	17.6	8.5	26.0	**111.0**	**2.6**	**113.6**
86.5	21.6	8.5	30.1	**116.6**	**1.8**	**118.4**
100.3	24.8	8.5	33.4	**133.6**	**0.3**	**133.9**
85.2	21.4	9.8	31.1	**116.4**	**0.5**	**116.8**
80.8	25.9	11.1	36.9	**117.8**	**0.4**	**118.1**
82.6	21.1	9.2	30.2	**112.8**	**0.2**	**113.1**
87.0	20.8	8.6	29.4	**116.4**	**0.2**	**116.7**
89.0	**22.1**	**8.8**	**30.9**	**119.9**	**1.7**	**121.6**

State/ Territory	Aged Care Planning Region	Total Operational Places						
		Residential care[1]	Home care[2]			Total residential + home care	Total restorative care[3]	Grand total
			Low care	High care	Total home care			
Tas	North Western	1,055	297	122	419	**1,474**	**25**	**1,499**
	Northern	1,439	427	185	612	**2,051**	**30**	**2,081**
	Southern	2,506	711	281	992	**3,498**	**54**	**3,552**
	Tas	**5,000**	**1,435**	**588**	**2,023**	**7,023**	**109**	**7,132**
ACT	ACT	2,473	721	560	1,281	**3,754**	**58**	**3,812**
	ACT	**2,473**	**721**	**560**	**1,281**	**3,754**	**58**	**3,812**
NT	Alice Springs	207	319	41	360	**567**	**4**	**571**
	Barkly	25	70	5	75	**100**	**1**	**101**
	Darwin	337	340	151	491	**828**	**20**	**848**
	East Arnhem	15	108	14	122	**137**	**1**	**138**
	Katherine	111	125	15	140	**251**	**3**	**254**
	NT	**695**	**962**	**226**	**1,188**	**1,883**	**29**	**1,912**
Total		**199,449**	**55,532**	**24,287**	**79,819**	**279,268**	**4,000**	**283,268**

Notes:

1. **Residential care** includes 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 Aged Care Programme.
2. **Home care** (High care) includes Home care Level 3 and Level 4 places only. Home care (Low care) includes Home care Level 1 and Level 2 places and the flexible Home care places in the: Multi-Purpose Service (MPS) Programme, Aged Care Innovative Pool Programme and the National Aboriginal and Torres Strait Islander Flexible Aged Care Programme.
3. **Restorative care** includes places in the Transition Care Programme and the Short-Term Restorative Care Programme. As at 30 June 2016, restorative care includes places in the Transition Care Programme only. New places in the Short-Term Restorative Care Programme will progressively become available from 2016-17.

Note: The ratios in the above table were calculated using revised population projections for June 2016 which are based on the 2012 ABS Estimated Resident Population. These population projections are customised projections prepared for the Department of Health (DoH) by the ABS, according to the assumptions agreed to by DoH. Due to rounding, individual ratios may not sum to the totals.

Total Operational Ratios						
	Home care[2]					
Residential care[1]	Low care	High care	Total home care	Total residential + home care	Total restorative care[3]	Grand total (planning ratio)
70.3	19.8	8.1	27.9	**98.2**	**1.7**	**99.8**
72.7	21.6	9.3	30.9	**103.6**	**1.5**	**105.1**
82.8	23.5	9.3	32.8	**115.5**	**1.8**	**117.3**
76.8	**22.0**	**9.0**	**31.1**	**107.9**	**1.7**	**109.6**
76.5	22.3	17.3	39.6	**116.2**	**1.8**	**118.0**
76.5	**22.3**	**17.3**	**39.6**	**116.2**	**1.8**	**118.0**
138.3	213.1	27.4	240.5	**378.8**	**2.7**	**381.4**
55.4	155.2	11.1	166.3	**221.7**	**2.2**	**223.9**
49.9	50.4	22.4	72.7	**122.6**	**3.0**	**125.6**
49.3	355.3	46.1	401.3	**450.7**	**3.3**	**453.9**
136.2	153.4	18.4	171.8	**308.0**	**3.7**	**311.7**
70.8	**98.0**	**23.0**	**121.0**	**191.8**	**3.0**	**194.7**
79.7	**22.2**	**9.7**	**31.9**	**111.6**	**1.6**	**113.2**

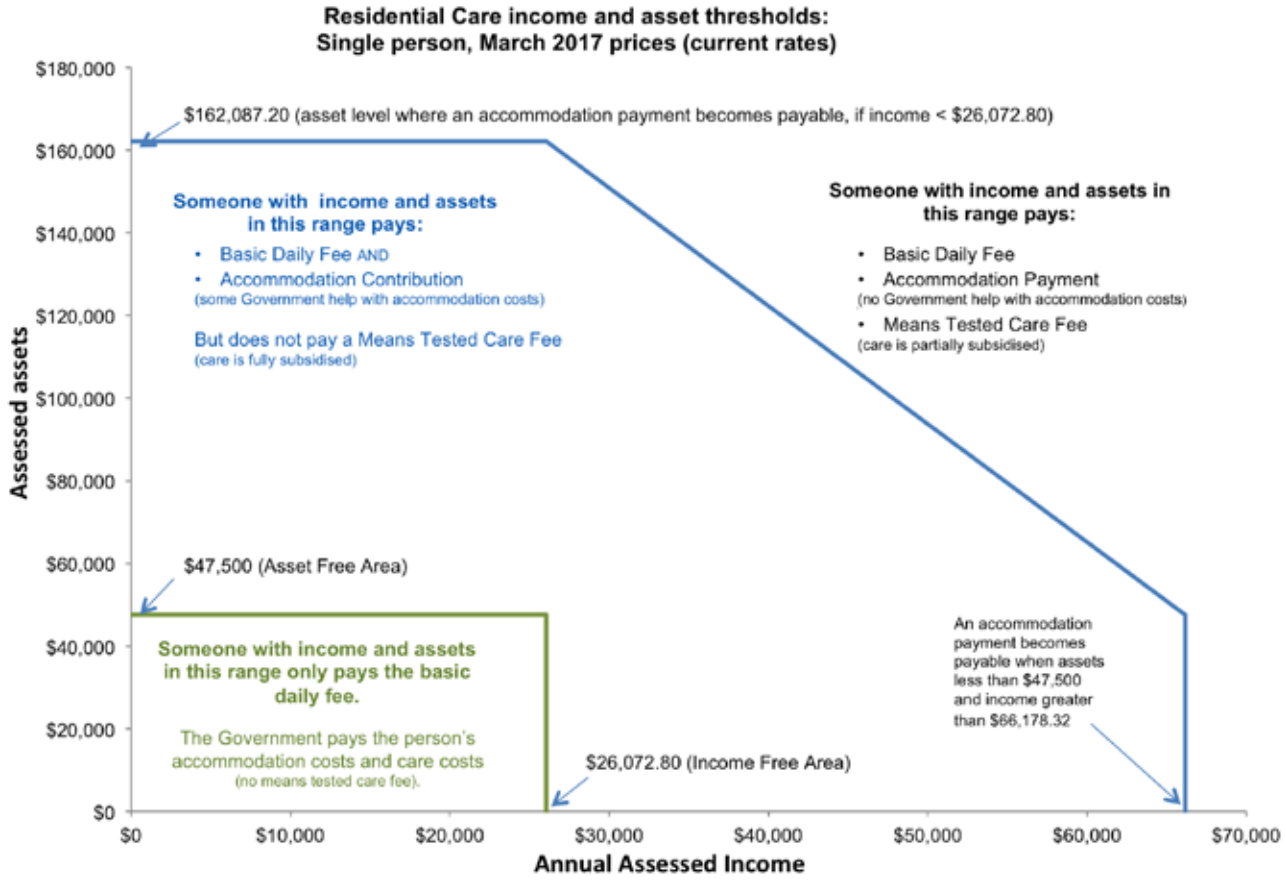
Appendix E: Means testing arrangements

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 $5,276.08 for part-pensioners and $10,522.18 for non-pensioners (March 2017 rate). A lifetime cap of $63,313.28 per consumer currently applies for care contributions across home care and residential care (March 2017 rate). Full pensioners are not required to contribute to their care costs and may only be required to pay the basic daily fee.

Figure E1: Current income testing for home care (post 1 July 2014)



Residential aged care

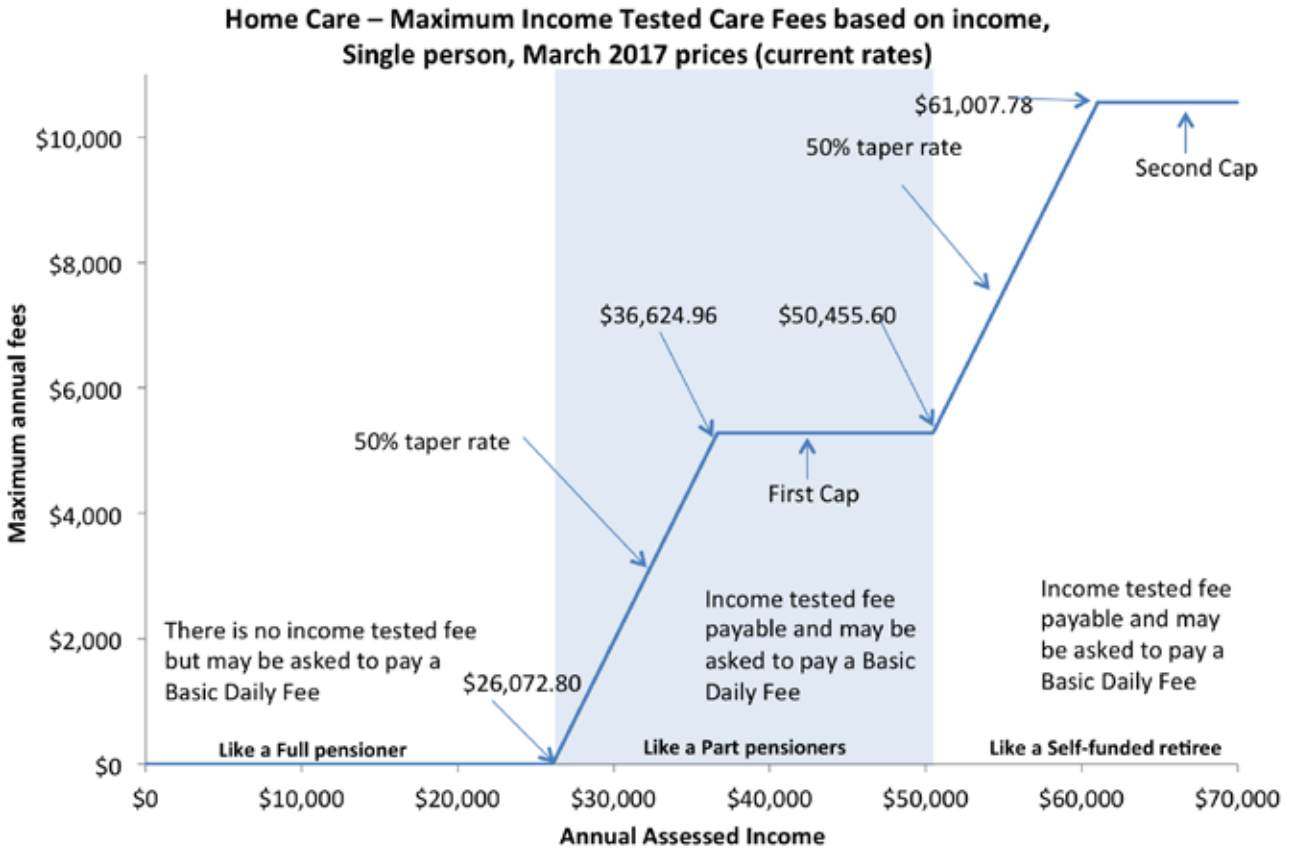
Changes to residential care from 1 July 2014 introduced more comprehensive means testing arrangements by way of a combined assets and income assessment and a new fees structure.

Annual and lifetime caps were also introduced, with an annual cap of $26,380.51 applying to the means-tested care fee and a lifetime cap of $63,313.28 for care contributions (March 2017 rate).

Figure E.2 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 performance with government owned providers included and excluded, 2015-16

	Totals			Averages (per provider)		
	All providers (949)	Government providers (99)	Providers excl government (850)	All providers	Government providers	Providers excl government
Total Revenue	$17,171.8 m	$928.8 m	$16,243.1 m	$18.1m	$9.4m	$19.1m
EBITDA	$1,984.9m	($98.1m)	$1,984.9	$2.1m	($1.0m)	$2.3m
EBITDA p.r.p.a	$11,134	($12)	$11,658			
NPBT	$1,062.8m	($86.6m)	$1,149.4m	$1.1m	($0.9m)	$1.4m
NPBT p.r.p.a	$5,962	($10,835)	$6,751			
EBITDA margin	+11.6%	0%	+12.2%			
NPBT margin	+6.2%	(11.0%)	+7.1%			
# with + EBITDA	790	49	741			
# with +NPBT	653	31	622			

Appendix G: Financial ratios by provider ownership type

Table G.1: Financial ratios of total sector by provider type, 2015-16

	Not-for-profit	For-profit	Government	Total
Accommodation bonds	$11,281	$10,162	$429	$21,872
No of providers	513	333	99	945
EBITDA	$10,182	$13,908	-$12	$11,134
Capital structure				
T. Assets P.R.P.A	$207,685	$262,800	$211,700	$228,855
No of Bonds	45,170	34,543	2,293	82,006
Avg Bond P.R.	$249,738	$294,193	$187,286	$266,717
Net Worth P.R.P.A.	$75,190	$35,405	$141,255	$62,780
Wrk Cap P.R.P.A.	-$46,355	-$123,735	-$12,410	-$74,095
Non.Curr Liab as % of T.Assets	14.4%	13.6%	4.5%	13.7%
Bonds as % of T. Assets	53.0%	57.5%	25.9%	53.9%
Net Wth as % T.Assets	36.2%	13.4%	68.8%	27.4%
Viability				
Current Ratio	0.58	0.37	0.81	0.47
Interest Coverage	15.0 Times	6.8 Times	17.1 Times	9.0 Times
NPBT Margin	5.6%	9.1%	(11.0%)	6.2%
Occupancy	93.7%	90.9%	89.7%	92.4%
%EBITDA to T. Assets	4.9%	5.3%	(0.4%)	4.9%
%EBITDA to Net Worth	13.5%	39.5%	(0.6%)	17.7%
Bond Asset Cover (T.A.)	**1.9 Times**	**1.7 Times**	**3.9 Times**	**1.9 Times**

Table G.2: Financial ratios for not-for-profit providers, 2015-16

	Top	Next top	Next bottom	Bottom	Total
No of providers	103	141	138	131	513
EBITDA	$23,417	$11,664	$5,943	-$1,802	$10,182
Capital structure					
T. Assets P.R.P.A	$243,090	$196,370	$184,325	$254,770	$207,685
No of Bonds	8,332	16,093	14,980	5,765	45,170
Avg Bond P.R.	$252,287	$244,787	$244,331	$273,927	$249,738
Net Worth P.R.P.A.	$92,710	$71,175	$62,050	$95,265	$75,190
Wrk Cap P.R.P.A.	-$67,525	-$41,975	-$39,785	-$45,990	-$46,355
Non.Curr Liab as % of T.Assets	7.8%	16.5%	15.2%	16.2%	14.4%
Bonds as % of T. Assets	46.8%	55.6%	56.2%	49.7%	53.0%
Net Wth as % T.Assets	38.1%	36.1%	34.2%	37.3%	36.2%
Financial ratios					
Current Ratio	0.51	0.58	0.60	0.63	0.58
Interest Coverage	40.2 Times	19.2 Times	18.3 Times	-0.5 Times	15.0 Times
NPBT Margin	18.3%	6.7%	2.2%	(8.3%)	5.6%
Occupancy	95.4%	94.4%	92.5%	92.5%	93.7%
%EBITDA to T. Assets	9.6%	5.9%	3.2%	(0.7%)	4.9%
%EBITDA to Net Worth	25.3%	16.1%	9.6%	(1.9%)	13.5%
Bond Asset Cover (T.A.)	**2.1 Times**	**1.8 Times**	**1.8 Times**	**2.0 Times**	**1.9 Times**

Table G.3: Financial ratios of government providers, 2015-16

	Top	Next top	Next bottom	Bottom	Total
No of providers	12	11	18	58	99
EBITDA	$27,565	$11,828	$6,349	-$21,025	-$12
Capital structure					
T. Assets P.R.P.A	$229,585	$151,475	$222,285	$227,030	$211,700
No of Bonds	456	465	411	961	2,293
Avg Bond P.R.	$181,903	$172,888	$202,588	$190,263	$187,286
Net Worth P.R.P.A.	$154,030	$79,570	$170,455	$146,730	$141,255
Wrk Cap P.R.P.A.	-$24,820	$1,095	-$10,585	-$15,330	-$12,410
Non.Curr Liab as % of T.Assets	3.7%	9.8%	3.5%	3.7%	4.5%
Bonds as % of T. Assets	28.5%	36.6%	18.8%	26.1%	25.9%
Net Wth as % T.Assets	67.0%	52.6%	76.7%	69.6%	68.8%
Financial ratios					
Current Ratio	0.63	1.02	0.77	0.80	0.81
Interest Coverage	65.2 Times	104.8 Times	8.6 Times	-15.8 Times	17.1 Times
NPBT Margin	(3.4%)	8.6%	(0.6%)	(26.9%)	(11.0%)
Occupancy	93.3%	94.3%	86.3%	88.6%	89.7%
%EBITDA to T. Assets	11.5%	7.8%	2.9%	(9.7%)	(0.4%)
%EBITDA to Net Worth	17.2%	14.9%	3.7%	(14.3%)	(0.6%)
Bond Asset Cover (T.A.)	**3.5 Times**	**2.7 Times**	**5.3 Times**	**3.8 Times**	**3.9 Times**

Table G.4: Financial ratios of for-profit providers, 2015-16

	Top	Next top	Next bottom	Bottom	Total
No of providers	122	84	80	47	333
EBITDA	$26,721	$12,303	$5,573	$514	$13,908
Capital structure					
T. Assets P.R.P.A	$308,425	$253,310	$249,295	$194,180	$262,800
No of Bonds	11,105	12,142	7,250	4,046	34,543
Avg Bond P.R.	$308,154	$295,233	$268,464	$298,856	$294,193
Net Worth P.R.P.A.	$53,290	$22,630	$43,070	$9,125	$35,405
Wrk Cap P.R.P.A.	-$147,095	-$110,230	-$146,000	-$55,845	-$123,735
Non.Curr Liab as % of T.Assets	12.9%	16.2%	7.2%	36.8%	13.6%
Bonds as % of T. Assets	52.4%	62.1%	50.8%	79.2%	57.5%
Net Wth as % T.Assets	17.3%	8.9%	17.3%	4.6%	13.4%
Financial ratios					
Current Ratio	0.32	0.42	0.23	0.65	0.37
Interest Coverage	13.6 Times	4.9 Times	3.8 Times	0.4 Times	6.8 Times
NPBT Margin	18.8%	7.0%	2.4%	(2.2%)	9.1%
Occupancy	92.7%	91.3%	89.7%	87.6%	90.9%
%EBITDA to T. Assets	8.7%	4.9%	2.2%	0.3%	5.3%
%EBITDA to Net Worth	50.2%	54.7%	12.9%	5.7%	39.5%
Bond Asset Cover (T.A.)	**1.9 Times**	**1.6 Times**	**2.0 Times**	**1.3 Times**	**1.7 Times**

Appendix H: Residential aged care funding sources

Table H.1: Summary of funding amounts for subsidy and supplements in residential aged care, 2015-16

Type of payment	$(million)
Basic Care subsidies	
Permanent	10,507.7
Respite	264.4
Conditional adjustment payment	0.0
Sub total	**10,772.1**
Primary care supplements	
Oxygen	16.5
Enteral feeding	6.3
Payroll tax	0.0
Respite incentive	29.0
Sub total	**51.8**
Hardship	
Hardship	5.2
Accommodation supplements	
Accommodation supplement	845.7
Hardship accommodation	3.6
Transitional accommodation Supplement	22.3
Concessional	64.0
Accommodation charge top-up	2.1
Pensioner supplement	36.3
Sub total	**974.0**
Viability Supplement	
Viability	35.6
Supplements relating to grand parenting	
Transitional	6.0
Charge exempt	3.8
Basic daily fee	0.6
Sub total	**10.4**
Other supplements	
Veterans'	1.8
Homeless	7.6
Sub total	**9.4**
Reductions	
Means testing reduction	-455.7
Other	-30.5
Sub total	**-486.2**
TOTAL	**11,372.3**

Appendix I: Residential aged care subsidy and supplements rates

Table I.1: ACFI rates ($ per day), 2015-16 to 2017-18

ACFI	2015-16	2016-17	2017-18
Activities of daily living (ADL)			
Low	$36.11	$36.65	$36.65
Medium	$78.62	$79.80	$79.80
High	$108.92	$110.55	$110.55
Behaviour (BEH)			
Low	$8.25	$8.37	$8.37
Medium	$17.10	$17.36	$17.36
High	$35.66	$36.19	$36.19
Complex Health Care (CHC)			
Low	$16.25	$16.37	$16.37
Medium	$46.27	$46.62	$46.62
High	$66.82	$67.32	$67.32
Interim rate for new residents pending ACFI assessment	$55.39	$56.22	$56.22

Daily residential respite subsidy rates	2015-16	2016-17	2017-18
Low	$44.78	$45.45	$46.09
High	$125.58	$127.46	$129.24

Table I.2 Residential care supplements table, 2015-16 to 2017-18

Residential care	2015-16	2016-17	2017-18
Oxygen supplement*	$10.98	$11.12	$11.35
Enteral Feeding supplement – Bolus*	$17.39	$17.62	$17.99
Enteral Feeding supplement – Non-bolus*	$19.54	$19.79	$20.21
Adjusted Subsidy Reduction	$12.66	$12.85	$13.03
Conditional Adjustment Payment	-	-	-
Veterans' supplement	$6.78	$6.88	$6.98
Homeless supplement	$15.49	$15.72	$15.94
Dementia and Severe Behaviours supplement	-	-	

* These supplements are payable in respect of eligible residential respite care recipients.

Table I.3: Residential aged care supplements (accommodation and hotel related)

Residential care	20/03/16	20/09/16	20/03/17
Higher Accommodation supplement – newly built or significantly refurbished services	$54.29	$54.39	$55.09
Accommodation supplement – services that are not newly built or significantly refurbished but do meet set building requirements	$35.37	$35.44	$35.90
Accommodation supplement – services that are not newly built or significantly refurbished and don't meet set building requirements	$29.74	$29.79	$30.17
Concessional resident supplement (concessional and assisted residents) – newly built or significantly refurbished services	$54.29	$54.39	$55.09
Concessional resident supplement (concessional residents) – services that are not newly built or refurbished	$21.63	$21.67	$21.95
Concessional resident supplement (assisted residents) – services that are not newly built or significantly refurbished	$8.90	$8.92	$9.03
Transitional Accommodation supplement – residents who entered low level care after 19 March 2008 and before 20 September 2011			
After 19 March 2008 and before 20 September 2010	$8.11	$8.12	$8.22
After 19 September 2010 and before 20 March 2011	$5.41	$5.41	$5.48
After 19 March 2011 and before 20 September 2011	$2.70	$2.71	$2.74
Transitional supplement	$21.63	$21.67	$21.95
Basic Daily Fee supplement	$0.56	$0.56	$0.57
Respite supplement – high level is equal to or greater than 70% of the specified proportion of respite care for the approved provider.	$88.70	$88.87	$90.01
Respite supplement – high level is less than 70% of the specified proportion of respite care for the approved provider.	$52.13	$52.23	$52.90
Respite supplement – low level	$37.19	$37.26	$37.74

Table I.4: Residential aged care viability supplement

Residential aged care viability supplement*	2015-16	2016-17	2017-18
2017 Scheme Services			
Eligibility score of 100		$53.22	$56.09
Eligibility score of 95		$47.17	$49.95
Eligibility score of 90		$42.35	$45.06
Eligibility score of 85		$36.31	$38.94
Eligibility score of 80		$30.22	$32.76
Eligibility score of 75		$23.03	$25.47
Eligibility score of 70		$16.74	$19.09
Eligibility score of 65		$11.47	$13.75
Eligibility score of 60		$9.38	$11.63
Eligibility score of 55		$6.27	$8.48
Eligibility score of 50		$4.18	$6.36
Eligibility score of 45 # Eligibility score of 40 # Less than a score of 40		$0.00 $0.00 $0.00	$0.00 $0.00 $0.00
Safety net – former 1997, 2001 or certain 2005 scheme services viability supplement is $1.93			

Note: the Modified Monash Model classification scale was implemented on 1 January 2017

*These supplements are payable in respect of eligible residential respite care recipients.

Residential aged care Viability supplement*	2015-16	2016-17	2017-18
2005 Scheme Services			
Eligibility score of 100	$49.94	$50.69	$51.40
Eligibility score of 95	$44.26	$44.92	$45.55
Eligibility score of 90	$39.73	$40.33	$40.89
Eligibility score of 85	$34.07	$34.58	$35.06
Eligibility score of 80	$28.35	$28.78	$29.18
Eligibility score of 75	$22.69	$23.03	$23.35
Eligibility score of 70	$18.21	$18.48	$18.74
Eligibility score of 65	$12.47	$12.66	$12.84
Eligibility score of 60	$10.21	$10.36	$10.51
Eligibility score of 55	$6.82	$6.92	$7.02
Eligibility score of 50	$4.55	$4.62	$4.68
Eligibility score of 45 #	$0.00	$0.00	$0.00
Safety net – former 1997 or 2001 scheme services: viability supplement	$1.87	$1.90	$1.93

*These supplements are payable in respect of eligible residential respite care recipients.

Appendix J: Residential aged care financing structures and balance sheets

Table J.1: Distribution of average lump sum accommodation deposits by ownership and earnings before interest, taxes, depreciation and amortisation quartile, 2015-16

	Top	Next top	Next bottom	Bottom	Total
Not-for-profit					
No. of providers	103	141	138	131	513
No. of providers that held deposits	99	137	135	124	495
Proportion of permanent residents that paid deposits in facilities, where deposits were held	45.8%	45.7%	43.4%	47.3%	45.1%
Average deposits per resident	$252,287	$244,787	$244,331	$273,927	$249,738
For-profit					
No. of providers	122	84	80	47	333
No. of providers that held deposits	121	82	77	45	325
Proportion of permanent residents that paid deposits in facilities, where deposits were held	53.2%	54.2%	48.2%	51.9%	52.2%
Average deposits per resident	$308,154	$295,233	$268,464	$298,856	$294,193
Government					
No. of providers	12	11	18	58	99
No. of providers that held deposits	12	11	18	49	90
Proportion of permanent residents that paid deposits in facilities, where deposits were held	34.8%	33.2%	21.0%	33.3%	30.4%
Average deposits per resident	$181,903	$172,888	$202,588	$190,263	$187,286
Total					
No. of providers	237	236	236	236	945
No. of providers that held deposits	232	230	230	218	910
Proportion of permanent residents that paid deposits in facilities, where deposits were held	49.3%	48.6%	43.9%	47.1%	47.2%
Average deposits per resident	$281,861	$264,964	$251,301	$275,827	$266,717

Appendix K: Home care revenue and expenditure

Table K.1: Revenue and expenditure by ownership type, quartiles by NPBT, 2015-16

	Top Quartile	Next Top	Next Bottom	Bottom	Total
Not-for-profit					
No of providers	70	79	85	75	309
Government care subsidies	$70.06	$60.60	$58.70	$66.61	$64.08
Client contribution	$6.39	$6.86	$6.19	$7.14	$6.69
Other income	$11.37	$5.32	$4.18	$1.46	$5.45
Total expenses	$68.22	$66.89	$67.65	$79.14	$70.71
Net Profit Before Tax	$22.55	$6.91	$2.30	($3.47)	$6.79
For-profit					
No of providers	19	13	11	11	54
Government care subsidies	$75.78	$57.39	$62.35	$54.09	$67.40
Client contribution	$6.42	$4.32	$7.20	$6.45	$6.15
Other income	$12.88	$1.65	$1.25	$13.38	$8.76
Total expenses	$59.80	$56.72	$68.34	$86.85	$63.78
Net Profit Before Tax	$36.45	$8.82	$2.68	($9.41)	$20.00
Government					
No of providers	22	20	14	25	81
Government care subsidies	$58.59	$48.35	$53.78	$51.75	$53.01
Client contribution	$3.32	$4.41	$5.39	$4.31	$4.33
Other income	$10.08	$2.93	$0.46	$2.21	$4.09
Total expenses	$57.52	$47.84	$56.96	$61.46	$55.20
Net Profit Before Tax	$16.98	$8.50	$2.66	($2.70)	$7.20
Total					
No of providers	111	112	110	111	444
Government care subsidies	$69.93	$59.33	$58.45	$65.24	$63.39
Client contribution	$6.12	$6.51	$6.17	$6.94	$6.45
Other income	$11.48	$4.92	$3.62	$1.91	$5.58
Total expenses	$66.01	$64.66	$66.62	$78.28	$68.88
Net Profit Before Tax	$24.17	$7.15	$2.36	($3.62)	$7.82

Table K.2: Revenue and expenditure by ownership type, per package, quartiles by NPBT, 2015-16

	Top quartile	Next top	Next bottom	Bottom	Total
Not-for-profit					
No of providers	70	79	85	75	309
T. Rev per Pkg	$22,394	$18,802	$17,260	$18,406	$19,224
T. Exp per Pkg	$16,831	$17,042	$16,692	$19,249	$17,540
NPBT Per Pkg	$5,563	$1,760	$567	($844)	$1,685
For-profit					
No of providers	19	13	11	11	54
T. Rev per Pkg	$22,737	$17,749	$18,260	$13,602	$19,774
T. Exp per Pkg	$14,126	$15,361	$17,572	$15,255	$15,054
NPBT Per Pkg	$8,611	$2,388	$688	($1,653)	$4,720
Government					
No of providers	22	20	14	25	81
T. Rev per Pkg	$22,976	$14,539	$17,250	$15,061	$17,270
T. Exp per Pkg	$17,740	$12,345	$16,480	$15,752	$15,277
NPBT Per Pkg	$5,236	$2,194	$771	($691)	$1,992
Total					
No of providers	111	112	110	111	444
T. Rev per Pkg	$22,490	$18,370	$17,322	$17,982	$19,119
T. Exp per Pkg	$16,462	$16,542	$16,729	$18,855	$17,170
NPBT Per Pkg	$6,027	$1,829	$593	($872)	$1,949

Appendix L: Home care subsidies and supplements

Table L.1: HCP Subsidies per day, 2015-16 – 2017-18

HCL	2015-16 subsidy	2016-17 subsidy	2017-18 subsidy
Level 1	$21.71	$22.04	$22.35
Level 2	$39.50	$40.09	$40.65
Level 3	$86.84	$88.14	$89.37
Level 4	$132.01	$133.99	$135.87

Table L.2: Home care supplement amounts per day, 2015-16 – 2017-18

Home care supplements	2015-16	2016-17	2017-18
Dementia and Cognition and Veterans' supplement (10% of basic care subsidy)			
Level 1	$2.17	$2.20	$2.24
Level 2	$3.95	$4.01	$4.07
Level 3	$8.68	$8.81	$8.94
Level 4	$13.20	$13.40	$13.59
Other			
EACH-D Top Up supplement	$2.62	$2.66	$2.69
Oxygen Supplement	$10.98	$11.12	$11.35
Enteral Feeding supplement – Bolus	$17.39	$17.62	$17.99
Enteral Feeding supplement – Non–bolus	$19.54	$19.79	$20.21
Home Care Viability supplement – Modified Monash Model classification			
MMM 1,2,3	-	-	$0.00
MMM 4	-	-	$1.04
MMM 5	-	-	$2.29
MMM 6	-	-	$15.16
MMM 7	-	-	$18.20
Home Care Viability supplement – ARIA value viability supplement amount			
ARIA Score 0 to 3.51 inclusive	$0.00	$0.00	$0.00
ARIA Score 3.52 to 4.66 inclusive	$5.22	$5.30	$5.37
ARIA Score 4.67 to 5.80 inclusive	$6.27	$6.36	$6.45
ARIA Score 5.81 to 7.44 inclusive	$8.77	$8.90	$9.02
ARIA Score 7.45 to 9.08 inclusive	$10.53	$10.69	$10.84
ARIA Score 9.09 to 10.54 inclusive	$14.73	$14.95	$15.16
ARIA Score 10.55 to 12.00 inclusive	$17.68	$17.95	$18.20

Note: the MMM classification scale was implement on 1 January 2017

Table L.3: Summary of Australian Government payments by subsidies and supplements of home care, 2015-16

Supplement	2015-16
Dementia and Cognition supplement	$21.7m
The Veterans' supplement	$0.2m
The Oxygen supplement	$1.8 m
Enteral Feeding supplement	$0.5m
Viability supplement	$7.2m
Hardship supplement	$0.2m

Appendix M: 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 2016 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 amount for 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 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 95 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 2016 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 N: Notes for Figure 9.2 and Figure 10.1

- The flow chart is composed from General Purpose Financial Reports (GPFRs) 2015-16, 2015-16 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 2015-16.
- 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 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 2015-16.
- 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 care providers.
- The donations, loans and investment amount received by the residential 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 O: 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 2016* 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

The National Aged Care Workforce Census and Survey – The Aged Care Workforce, 2016 Final Report, Commonwealth of Australia, Canberra

Department of Health (Australia), 2016, 2015-16 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)

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