

Australia's Aged Care Sector: Mid-Year Report (2021-22)

For the 6 months ending

31 December 2021



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Disclaimer

Parts of this report are based on the results of a survey conducted by StewartBrown within the aged care sector. Although the survey is extensive, it does not provide a complete set of results for all aged care providers operating in the sector.

The authors have used all due care and skill to ensure the material is accurate as of the date of this report. UTS and the authors do not accept responsibility for any loss that may arise by anyone relying on its contents.

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Editorial Board Foreword

The Editorial Board of Australia's Aged Care Sector welcomes you, our readers, to this first edition of what is to become a biannual report on the delivery of subsidised aged care services to senior Australians in need. The focus of this first edition is the Mid-year Report (2021-22). The second edition will report on the full financial year 2021-22.

This series has been established to provide an independent assessment of the sector by the UTS Ageing Research Collaborative (UARC) at the University of Technology Sydney. It will have a broad policy scope and will analyse the performance of the sector from accounting, health economics and labour market perspectives. It will offer commentary on the key policy and operational issues impacting the delivery of subsidised aged care. From the second edition, it will also include the publication of policy relevant research.

At the core of this report's financial analysis will be aggregated, deidentified survey data which StewartBrown is making available to UTS as part of a broader partnership between the two organisations. As many readers will be aware, StewartBrown has been publishing its Aged Care Financial Performance Survey since 1995. Over the last two decades, the report has grown in volume and depth of coverage and is the largest benchmark data source in the aged care sector.

For many years the report has also been a key public information resource for providers, government, researchers and other stakeholders across the sector. StewartBrown has now decided to focus on its benchmarking reporting to aged care providers, and it is our challenge to respectfully build on the strong foundation constructed by Grant Corderoy and his team and to provide the wider audience with an objective, evidence-based analysis of the sector.

We are conscious that as the Australian population ages, the demand for care for senior Australians will continue to grow, but that it will need to evolve to better reflect the needs and preferences of its consumers and earn the support of the community. Although there have been significant reforms over the past decade there are many complex issues that have yet to be fully addressed. They include the fiscal sustainability of the publicly subsidised services, the maintenance of a viable sector of providers and the availability of a skilled and properly remunerated workforce. Our purpose in publishing this report is to provide a strong evidence base to underpin public debates on these issues and to guide decisions on future policy and operational reforms.

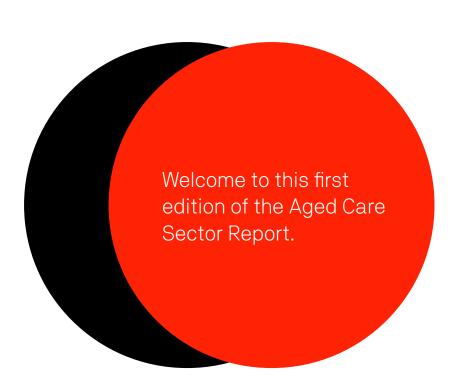
This first edition comes out at a time when the sustainable delivery of subsidised aged care is the overarching issue of concern, and there are some uncomfortable truths to be faced. These are brought together in the following Executive Summary, though we urge you to delve into the supporting detail in each of the report's sections. Although headlines attract the community's attention, a careful policy advisor, researcher or investor will find the detail worthy of your time to ponder.

The report's future editions will closely monitor the sector's sustainability, but it will also provide you with our perspectives on current developments in some of the more specific challenges as well as our take on where the policy reform agenda is, or should be, heading.

We look forward to your feedback on this first edition and to your suggestions as to how we can improve the report's relevance to you. Your input is most welcome and can reach the Editorial Board and UARC team at (email address: uarc_inquiries@uts.edu.au).

Professor Mike Woods (Chair)

On behalf of the Editorial Board and the UTS Ageing Research Collaborative 16 May 2022





Australia's aged care sector faces many complex issues concerning the quality of care delivered to senior Australians, the viability of aged care providers, the availability of skilled workers and the fiscal sustainability of publicly funded services. In this broader context, this report analyses the mid-year results for the first half of the 2021-22 financial year and provides commentary on major challenges and progress on policy reforms.

Many aged care service providers face increasing and acute threats to their financial viability. Continuing a medium-term trend, the financial performance of services in the first half of 2021-22 has worsened compared to the same period a year prior:

- □ Approved providers reported an average total operating deficit of \$339k across their aged care and other business streams for the first half of the 2021-22 year (down from a surplus of \$544k at Dec-20), a return on assets of negative 0.9% and a median EBITDAR profit margin of 2.1% (compared to 3.2% in Dec-20).
- □ Over 60% of residential aged care homes are operating at a loss, with an average deficit of \$11.34 per resident per day across all homes (more than double the average deficit of \$5.33 in Dec-20).
- ☐ The average operating result of home care services declined by 25.5% year on year, t o \$3.82 per client per day.

The poor financial performance of residential care homes has occurred despite the injection of funds through the Basic Daily Fee supplement and reflects the deterioration of several key drivers:

- □ Occupancy has continued to fall across the nation, to an average of 91.6%.
- ☐ Homes have been adversely affected by the end of most COVID-related financial support, despite the ongoing costs of proactive infection control measures.
- □ Operating results are comparatively worse in smaller homes, homes located outside the major cities and homes that serve residents with less complex care needs.
- ☐ The ubiquity of poor returns across the sector raises questions about the adequacy of the revenue streams, particularly as homes face increasing wage pressures and rising administration and compliance costs.

Although the Government has released more home care packages, home care providers' financial performance has declined year on year:

- □ Revenue appears to have stagnated at an average of \$71.35 per client per day, despite higher utilisation of the packages.
- □ Average operating costs have risen to 94.6% of revenue, with increases in care management and advisory, administration and support costs.
- ☐ The decline in financial performance has been most acute for providers with package mixes comprising more lower-level packages.

The mid-year workforce results indicate that providers have encountered further significant challenges in attracting and retaining sufficient numbers of aged care staff. This has been exacerbated by the COVID-19 pressures from furloughs, border lockdowns and staff diversions. Despite community expectations of substantial uplifts in staffing, in the first half of 2021-22, there has been:

- Slow growth of total direct care staffing rates in residential care, increasing by only 1.9% over the year before to an average of 178.0 minutes per resident per day, well below the sector average minimum standards of 200 minutes that will be mandatory by October 2023.
- □ A 1.6% annual decline in the direct care staffing in home care, to 3.80 hours per client per week, equivalent to 32.6 minutes per day.

Workforce problems are likely to worsen in the coming year with the release of more home care packages and the incoming minimum staffing standards in residential care. In the medium and longer-term, demographic change will reduce the proportion of the population in the labour force ages and competition for workers will increase.

Many of the challenges facing aged care are being targeted by a series of policy reforms, including a new funding model for residential care (AN-ACC), the design of a new Support at Home Program, new reporting and accountability requirements and announcements made in the Budget 2022-23 and the lead-up to the election. The outcome of the Fair Work Commission wage case will also be known, as will the response of the next government to funding the increase.

The report is structured in two parts. Part 1 analyses the results of the December 2021 StewartBrown survey, conducted with participating aged care providers within Australia for the first six months of the 2021-22 financial year. Part 2 provides further analysis of the current challenges and issues facing the sector, and provides commentary on the major initiatives in the policy reform agenda that are currently underway.

Providers continue to encounter significant challenges in attracting and retaining aged care staff.



Part 1 of this report provides analyses of the results of the December 2021 StewartBrown survey, conducted of participating aged care providers within Australia. StewartBrown conducts a subscription-based quarterly data collection and analysis survey, enabling aged care providers to track their own performance over time and benchmark their operations against other providers.

The data covers the first six months of the 2021–22 financial year. The analyses have been conducted at three levels:¹



Approved provider: which reports on the financial outcomes of approved providers who deliver subsidised aged care services. Approved providers can range substantially in scale and scope, from organisations that operate a single residential aged care home or home care service to those that operate multiple homes, home care services and other businesses such as retirement villages.



Residential care: which reports on the financial and workforce outcomes of subsidised residential aged care homes (otherwise known as nursing homes or residential aged care facilities).



Home care: which reports on the financial and workforce outcomes of home care service providers that offer subsidised services funded through home care packages.

The survey data does not cover the care and support provided through the Commonwealth Home Support Program (CHSP) or other subsidised programs. From mid-2023, the Australian Government intends to amalgamate the Home Care Package program and CHSP into a single unified Support at Home Program. The survey will be amended from that point in time to cater to the new program's design, funding, and reporting requirements.

Due to variations in methodology, the results reported in this report can vary in some minor respects from those reported by StewartBrown. An explanation of the methodology used is provided in an Appendix at the end of this report.

^{1.} For example, many survey participants operate a combination of residential and home care services, which means that their data is represented in all three levels of analysis of the report. By comparison, those providers which only operate residential aged care homes are only represented in the Approved Provider and Residential Care analysis.

Overview



The overall financial performance of surveyed approved providers has continued the declining medium-term trend, with providers reporting an average Total Result of a \$339k deficit for the first half of the 2021-22 financial year, compared to a \$544k surplus for the same period the year before.



In terms of their Operating Result (i.e. excluding COVID-related and non-recurrent income), the majority (62.8%) of providers continue to record negative returns, even with the increase in revenue from the Basic Daily Fee supplement for residential care services.



Many providers continue to maintain a high liquidity ratio, with cash and financial assets representing an average of approximately 20.5% of total assets.



Approved provider profiles

The analysis at the approved provider level examines the financial outcomes of organisations that provide residential and home care services and that may have other business streams.² Subsequent sections of this report will explore the outcomes for residential care and home care services separately.

Table 1: Profile of surveyed approved providers

	Dec-21	Dec-20
Number of providers in survey	234	234
Ownership		
For profit	10.3%	10.3%
Not for profit	89.7%	89.7%
Staffing		
Average number of staff (headcount)	613	610
Average number of staff (FTE)	401	393
% of Providers with Residential aged care homes	96.6%	96.6%
Average number of residential aged care homes	4	4
Average number of residential operational beds	338	335
% of Providers with Homecare operations	43.6%	41.9%
Average number of home care packages	447	402

This section analyses the outcomes of 234 approved providers based in Australia who participated in the December 2021 StewartBrown survey. As shown in Table 1, the majority (90%) of these providers are not-for-profit and the remainder (10%) are private, for profit providers. As of December 2021, providers each employed an average of 613 people (401 full-time equivalents). Almost all surveyed providers (97%) offered residential aged care services, each of which operates an average of 4 homes and an average of 338 operational beds in total. Just under half (44%) of providers offered home care services, servicing an average of 447 home care packages.

^{2.} Approved providers may also provide a range of other services, such as disability care, childcare and retirement living services.

Financial performance

The level of profit or loss made by approved providers gives an indication of the overall financial viability of organisations that provide subsidised aged care services to senior Australians.

Table 2: Average profit and loss figures for approved providers

	Dec-21	Dec-20
Revenue		
Service Revenue (\$'000)	25,395	23,697
Investment Revenue (\$'000)	263	429
Total Operating Revenue (\$'000)	25,658	24,126
Expenses		
Employee Expenses (\$'000)	18,216	17,123
Depreciation and amortisation (\$'000)	1,678	1,782
Finance Costs (\$'000)	165	173
Other Expenses (\$'000)	6,037	5,494
Total Operating Expenses (\$'000)	26,385	24,861
Operating Result (\$'000)	(727)	(736)
Net Non-Recurrent income (\$'000)	584	730
Total Result net non-recurrent income (\$'000)	(143)	(6)
Net COVID-19 income (\$'000)	(196)	550
Total Result (\$'000)	(339)	544
Operating EBITDAR (\$'000)	854	791
Net Non-Recurrent income (\$'000)	584	730
EBITDAR (\$'000)	1,437	1,521
Ratios (Medians):		
Operating Result return on assets (ROA)	-0.9%	-0.7%
Operating EBITDAR return on assets (ROA)	0.8%	0.9%
Operating EBITDAR profit margin (%)	2.1%	3.2%
Employee expenses (as % of operating revenue)	70.8%	70.6%
Depreciation expense (as % of property assets)	3.4%	3.4%

The results reported in Table 2 show that during the first six months of the 2021–22 financial year, the overall financial performance of the surveyed approved providers has declined on average relative to the same period a year ago, moving from making a small profit to incurring a loss. Specifically, the average Total Result³ was a \$339k deficit as of December 2021, compared to a surplus of \$544k reported in December 2020.

This decline in overall profitability was partly attributable to changes in COVID-related income and expenses and non-recurrent income and expenses. In the first six months of the 2020–21 financial year, COVID-19-related funding and expenses contributed an average net result of \$550k to providers' bottom line.⁴ In the first six months of this financial year, providers have lost an average of \$196k due to the withdrawal of COVID-related funding in July 2021 and their subsequent shortfall in income relative to COVID-19 expenses. Providers have also experienced a decline in net non-recurrent income, down from \$730k in December 2020 to \$584k in December 2021. This line item typically comprises revenues and expenses relating to revaluations, impairments, donations, fundraising, bequests, gains or losses on asset sales.⁵

However, even when excluding the effects of these two items, the Operating Result for the first half of the 2021–22 financial year show poor profitability outcomes. On average, surveyed providers recorded an Operating Loss of \$727k for the six months to December 2021 (compared to a loss of \$736k in December 2020) and the proportion of providers reporting a negative result has increased to 62.8% compared to 61.9% in the corresponding period in the 2020-21 financial year. Furthermore, there was a decline in the median return on assets of negative 0.9% in December 2021 (compared to negative 0.8% in December 2020).

The decline in the Operating Results⁶ is concerning given that eligible providers have been receiving increased funding from the Basic Daily Fee Supplement since July 2021. The decline likely also reflects the financial impact of the outbreak of the Delta and Omicron variants on both residential care and home care services and other business streams operated by the providers. These are explored in more detail in Part 2 of this report.

^{3.} This reflects the total net profit (before tax) earned from all revenues and expenses across their entire operations, including non-recurrent and COVID-related revenue and income and expenses.

^{4.} These are self-reported figures from surveyed approved providers, and while all efforts have been taken to ensure the integrity of the data, it be interpreted with some level of caution. For example, providers may have not split out COVID related income and expenses from results from normal operations, or may have used different categorisations of these figures.

^{5.} This change could reflect an acceleration of write-downs of intangible assets (bed licenses).

^{6.} Operating Result generally refers to the Net Profit Before Tax (NPBT) earned by an approved provider, but excludes non-recurrent revenues and expenses (i.e. excludes flows relating to revaluations, impairments, donations, fundraising, bequests, gains or losses on asset sales).



The Operating EBITDAR7 results for December 2021 show that providers earned an average of \$854k in the first half of the financial year, up slightly (7.91%) compared to the same period in December 2020. However, the median profit margin decreased to 2.1% in December 2021 from 3.2% in December 2020, indicating that, yet again, provider costs have been growing faster than revenue. For example, employee expenses grew 6.38% year on year, and now equate to 70.8% of operating revenue. This growth in expenses outpaced the 2.03% annual growth in full-time equivalent (FTE) staff, indicating that providers are encountering wage pressures and resort to alternative and more expensive sources of staffing, likely as a result of worker shortages. This issue is further explored in Part 2 of this report.

Providers reported a very modest Operating EBITDAR return on assets (0.8% in December 2021), considering that EBITDAR reflects the value generated by providers that is available to refurbish their asset base.8 Furthermore, the depreciation expense ratio of 3.4% (December 2021) suggests that providers are expensing long-term assets (including buildings, equipment and furniture) assuming a useful lifetime of approximately 29.4 years. This assumption likely underestimates providers' actual future capital infrastructure and financing needs.

^{7.} In general, Earnings Before Interest, Taxation, Depreciation, Amortisation and Rent (EBITDAR) is a measure of profitability that excludes several key line items relating to the corporate structure, financing arrangements and tax status of an organisation. It thus allows for a comparison of the profitability of homes owned and operated by providers, which may have different corporate arrangements as well as policies allocating these items to individual homes. For the analysis of residential aged care homes, 'Operating EBITDAR' also excludes all provider-level revenue and expenditure, including fundraising revenue, revaluations, donations, capital grants and sundry revenue.

^{8.} It is worth noting that while modest, the return of asset ratios are likely to be overestimated as most not-for-profit providers record assets at their cost, not replacement values.

Table 3: Average profit and loss figures for approved providers, by quartile, annual revenue and total assets

					Rev	enue			Total A	Assets	
	•	Top Quartile	Bottom Quartile	<10m	10m- 20m	20m- 75m	>75m	25m	25m- 50m	50m- 150m	>150m
Number of providers in survey	234	58	59	143	36	37	18	59	59	61	55
Operating Result ('000)	(727)	807	(3,214)	(187)	(147)	(1,649)	(4,278)	(95)	(345)	(191)	(2,407)
Total Result net non-recurrent income (\$'000)	(143)	2,183	(2,579)	(88)	86	(1,112)	955	65	(228)	(119)	(302)
Total Result (\$'000)	(339)	1,806	(2,815)	(119)	(31)	(1,334)	(653)	55	(265)	(221)	(971)
Operating EBITDA (\$'000)	854	2,629	(162)	92	595	1,072	6,975	41	(15)	458	3,097
EBITDA (\$'000)	1,437	4,005	473	190	828	1,610	12,208	202	102	530	5,202
Ratios (Medians):											
Operating result return on assets (ROA)	-0.9%	1.7%	-3.2%	-0.9%	-0.8%	-0.9%	-0.5%	-1.5%	-1.4%	-0.5%	-0.5%
Operating EBITDAR return on assets (ROA)	0.8%	2.9%	-1.0%	0.5%	0.9%	0.7%	1.5%	0.3%	0.1%	0.9%	1.2%
Operating EBITDA profit margin (%)	2.1%	10.3%	-2.8%	1.7%	3.4%	1.8%	4.4%	1.0%	0.1%	3.2%	3.9%

Table 3 shows the key financial indicators of surveyed providers, as split by quartiles of their operating results, as well as their annual revenue turnover and asset bases. These splits reveal that, although all groups of providers by sizes generate a positive EBITDAR return and that the largest providers generate the highest returns, most provider size groups are unable to generate a positive operating result on average. This could reflect the challenges of managing the costs of fixed assets across all of the providers where there is little alleviating benefit from greater economies of scale. Overall the ROA is negative 0.9%, with the top quartile of providers earning a ROA of only 1.7% and the bottom incurred an unsustainable result of negative 3.2%.

Liquidity and leverage

The balance sheet shows the average financial position of approved providers and gives an aggregate perspective on the value of their assets, liabilities and owners' equity, as well as their risk profile (as expressed in terms of the median provider liquidity and leverage).

Critically, approved providers must maintain access to sufficient liquid funds (i.e. cash, financial assets or lines of credit) to meet their short-term financial obligations, which include the refundable accommodation deposits and entry contributions contributed by residents. The Australian Government has introduced a new Financial and Prudential Monitoring, Compliance and Intervention Framework, including expected minimum liquidity ratios, with the changes to take effect from July 2023.9 However, the need to manage liquidity risk must be balanced with sufficient investment into new capital assets, such as equipment, property and buildings, to provide high quality aged care services into the future.



Department of Health, Financial and Prudential Monitoring, Compliance and Intervention Framework, available at: https://www.health.gov.au/health-topics/aged-care/aged-care-reforms-and-reviews/financial-and-prudential-monitoringcompliance-and-intervention-framework

Table 4: Average balance sheet figures for approved providers

	Dec-21	Dec-20
Assets		
Cash and Financial Assets (\$'000)	34,537	33,309
Operating Assets (\$'000)	9,215	8,355
Property Assets (\$'000)	117,118	111,472
Right of Use Assets (\$'000)	2,475	2,473
Intangibles - Other (\$'000)	2,723	3,397
Intangibles - Bed Licences (\$'000)	2,780	3,671
Total Assets (\$'000)	168,849	162,677
Liabilities		
Refundable Loans - Residential (\$'000)	53,912	50,667
Refundable Loans - Retirement Living (\$'000)	36,742	33,636
HCP Unspent Funds Liability (\$'000)	1,665	1,813
Borrowings (\$'000)	7,630	7,651
Other Liabilities (\$'000)	18,225	17,079
Total Liabilities (\$'000)	118,174	110,846
Net Assets (\$'000)	50,674	51,831
Net Tangible Assets (\$'000)	45,171	44,763
Ratios (Medians):		
Net assets proportion % total assets	37.1%	37.4%
Property assets proportion % total assets	63.0%	62.8%
Cash + financial assets % refundable loans	54.2%	56.8%
Cash + financial assets % debt	52.3%	52.8%

Table 4 reports on the average balance sheet figures (and median ratios) of approved providers. In the last year, the total asset base of providers grew by 3.79% to an average of \$168.8m from \$162.6m per provider. The asset classes of property and of cash and financial assets grew year on year and comprise the bulk of the asset value of most providers, at 63.0% and 20.5% of total assets at December 2021 respectively.

There was also a substantial contraction (24.3%) in the reported value of bed licenses, which are down from an average of \$3.7m per provider in December 2020 to \$2.8m by December 2021. This likely reflects the impairment and write-down of this class of intangible assets following the announcement of the imminent end of Aged Care Approvals Rounds (ACAR) from 2024. For example, some listed entities have announced their intention to write off the value of their bed licences over a three year period to 30 June 2024.

Table 4 also shows an increase in the total value of approved providers' liabilities, which grew by 6.61% to an average of \$118.2m by December 2021. Most of these liabilities comprise refundable loans, predominantly resident-contributed Refundable Accommodation Deposits, (with an average value of \$53.9m per provider in December 2021) as well as retirement living (\$36.7m).

The December 2021 results also show a year on year reduction in unspent Home Care Packages funds held by providers on behalf of home care clients. Across providers, the value of this liability fell by 8.12% over the last 12 months. This decline reflects the outcome of reforms to the payment processes for home care services, in which unspent funds will progressively be shifted to Services Australia.¹¹ This is explored further in the Home Care Analysis below.

The key balance sheet ratios (reported as median in Table 4) show little change in the latest financial year in providers' leverage (net assets ratio) or liquidity (cash ratios). The most recent median ratios of cash as a proportion of refundable loans (54.2%) and total debt (52.3%) are well above generally expected thresholds of 15–20%. This likely reflects prudential conservatism of surveyed providers in maintaining their liquid assets, but potentially also some hesitancy of providers in the investment climate surrounding aged care.

^{10.} https://www.health.gov.au/initiatives-and-programs/competition-in-residential-aged-care

^{11.} See Improved Payment Arrangements for Home Care: https://www.health.gov.au/health-topics/aged-care/aged-care-reforms-and-reviews/improved-payment-arrangements-for-home-care

Continuing a mediumterm trend, the financial performance of approved aged care providers has declined in the past year.

Residential Care Analysis

Overview



The financial performance of residential care homes on average has declined in the first half of 2021-22 relative to the same six months of 2020-21, even with the additional revenue from the Government-funded Basic Daily Fee supplement (\$10 per resident per day) which commenced in July 2021. This continues a medium-term declining trend.



Over 60% of surveyed homes are operating at a loss, with an average deficit of \$11.34 per resident per day



Occupancy has continued to fall across all states and territories, to an average of 91.6%



Direct care staffing time increased marginally, to a sector average of 178.0 minutes per resident per day. However, it is still well short of the levels required under the minimum standards by October 2023, which is a sector average of 200 minutes per resident per day.

Residential Care Analysis

Residential aged care home profiles

The residential care analysis reports on the average financial and workforce outcomes of surveyed residential aged care homes, which are sometimes referred to as nursing homes or residential aged care facilities.

Table 5: Profile of surveyed residential aged care homes

	Dec-21	Dec-20
Number of homes in survey	1,192	1,119
Total number of beds in survey	96,564	91,038
Average home size (number of beds)	81.0	81.4
Ownership		
For profit	11.1%	9.7%
Not for profit	88.9%	90.3%
Location		
Major City	64.0%	65.6%
Regional	25.6%	24.7%
Rural & Remote	10.4%	9.7%

This section analyses the outcomes of the 1,192 residential aged care homes that participated in the December 2021 StewartBrown survey, an increase on the 1,119 homes included the December 2020 sample. As shown in Table 5, the average size of each surveyed home was 81 beds in December 2021. The majority (88.9%) of these homes are not-for-profit and the remainder (11.1%) are privately owned. The larger weighting toward non-for-profit providers is due to the absence of several large listed for-profit providers from the survey. Most (64%) of the homes were located in major cities, with 25.5% in regional areas and 10.4% in rural and remote locations. 12

^{12.} Given this is survey data, these results cannot be taken to infer a change in the population of homes across the sector. For example, all recipients of funding from the Business Improvement Fund (which support small to medium providers in regional, rural and remote areas), are required to participate in the survey as part of their grant agreement, which increases their representation in the reported results.

Key performance indicator summary

Residential Care Analysis

Table 6: Key performance indicators of residential aged care homes

	Dec-21	Dec-20
	Dec-21	Dec-20
Average Operating Result (\$ per resident per day)	(11.34)	(5.33)
Average Operating Result (\$ per bed per annum)*	(3,437)	(1,461)
Average Operating EBITDAR (\$ per resident per day)	8.54	13.93
Average Operating EBITDAR (\$ per bed per annum)*	3,139	5,019
Average occupancy rate (%)	91.6%	92.4%
Average direct care revenue (\$ per resident per day)	193.70	201.00
Median direct care costs (as a % of direct care revenue)	90.4%	85.1%
Average direct care minutes (\$ per resident day)	178.02	174.72
Average supported ratio (%)	45.8%	46.4%
Average of full RADs held at reporting date (\$)	384,408	366,130
Average of full RADs taken during period (\$)	444,848	435,515
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^{*} Per annum figures are the per bed day result for 365 days adjusted for the occupancy rate.

Part 1: StewartBrown Survey Results

Financial performance

The financial performance of aged care homes directly impacts on the sustainability of the aged care sector. Homes that are not able to maintain financial viability are at risk of ultimately being withdrawn from (or transferred within) the sector, although those owned by large providers may continue to operate at a loss if this can be offset by margins earned across other parts of their businesses.

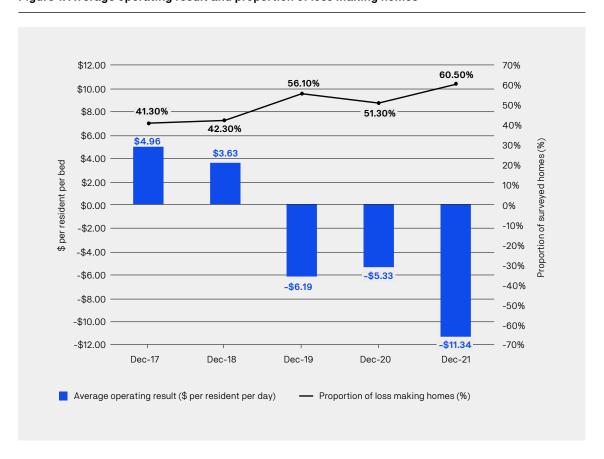
In the immediate term, home closures may leave some urban areas or whole towns without the services their senior citizens require. In the longer term, a lack of profitability affects future investment in the capacity of the sector to meet increasing demand from an ageing population, as well as improvements to the quality of care and support for innovation. Investment can include the bricks and mortar of new and refurbished residential facilities, as well as infrastructure such as technology, training, and a strong quality and governance framework.

Furthermore, if accommodation deposits are to continue to decline as a major form of financing in the future, then operating margins need to be sufficient to service interest on higher levels of long-term debt financing.



Residential Care Analysis

Figure 1: Average operating result and proportion of loss making homes



There has been a substantial decline in the financial performance of residential aged care homes in the first half of the 2021–22 financial year (see Figure 1). The December 2021 results show that the average Operating Result¹³ was a deficit (loss) of \$11.34 per resident per day, more than double the deficit of \$5.33 recorded in the six months to December 2020. There were 60.5% of all surveyed homes which recorded an operating loss¹⁴ for December 2021, an increase from 51.3% of homes for December 2020.

While the previous financial year (2020–21) saw a minor recovery from the year before it, this was due to an inflow of COVID-related funding revenue in the six months to December 2020 that was not necessarily aligned to COVID-related outlays, and which has largely ceased since June 2021. The steep decline of first half results for the 2021–22 financial year has seen a reversion to the medium-term trend of declining financial performance for aged care homes and is even more concerning given that 99% of eligible residential aged care homes have been receiving the Basic Daily Fee supplement (an additional \$10 revenue per resident per day) since July 2021. 15

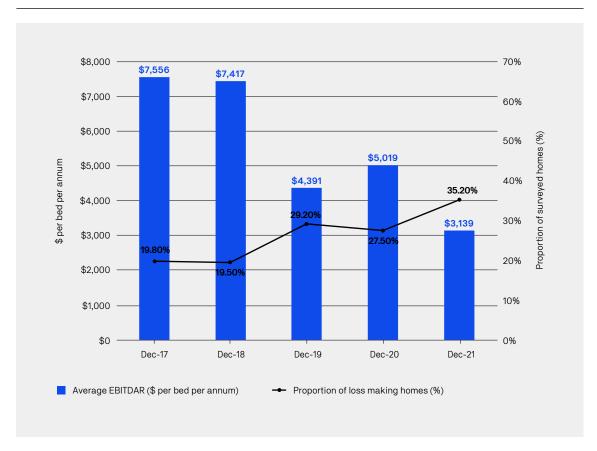
^{13.} Operating Result refers to the Net Profit Before Tax (NPBT) earned by a residential aged care home.

^{14.} An operating loss occurs when an aged care home's Operating Result (i.e. NPBT) is below zero.

Department of Health (2022). Food and Nutrition Report. Canberra, Australia. Available at: https://www.health.gov.au/sites/default/files/documents/2022/03/food-and-nutrition-report_0.pdf

Part 1: StewartBrown Survey Results





Aged care homes' Operating EBITDAR exhibits a similar trend (Figure 2). Operating EBITDAR declined by 37.5% relative to the December 2020 result, to \$3,139 per bed per annum. More than a third of homes (35.2%) recorded an Operating EBITDAR loss¹⁶, up from 27.5% for December 2020. Operating EBITDAR generally reflects the surplus generated by a home to refurbish buildings and equipment and invest in physical and service improvements. Thus, homes that record an Operating EBITDAR loss will need to draw on other revenue streams such as investment revenue, fundraising revenues or returns from other homes or business streams operated by the provider. For small-scale providers with only one or a small number of homes, an Operating EBITDAR loss may necessitate a draw down on their asset base and jeopardise their long-term financial viability.

^{16.} An Operating EBITDAR loss occurs when an aged care home's Operating EBITDAR is below zero.



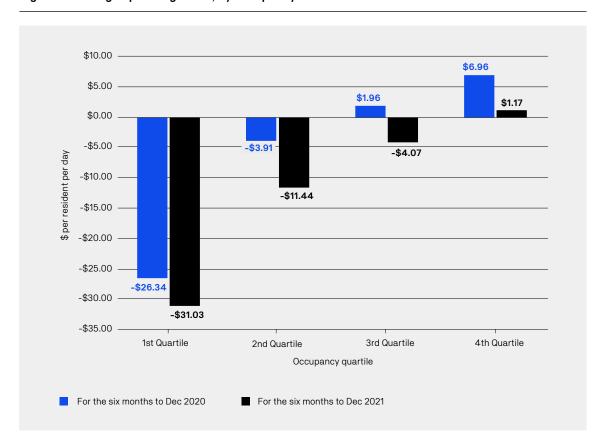
Residential Care Analysis

Figure 3: Average operating result, top 25% vs remaining 75%



There are several factors that influence whether homes make operating profits or losses. These include home location and size (further analysis of these factors is presented in later sections of this Part 1) as well as the management expertise and business model of the operator and the efficiency of the built infrastructure. Figure 3 shows that the profitability of the top 25% of homes (based on operating result) has been relatively stable over the last five years, but losses have continued to grow for the remaining 75% of homes. Compared to the bottom 75% of homes, the top 25% of homes by operating result are statistically more likely to be run by a for-profit provider (19.8% compared to 8.2%) and based in a major city (71.8% compared to 61.4%).

Figure 4: Average operating result, by occupancy

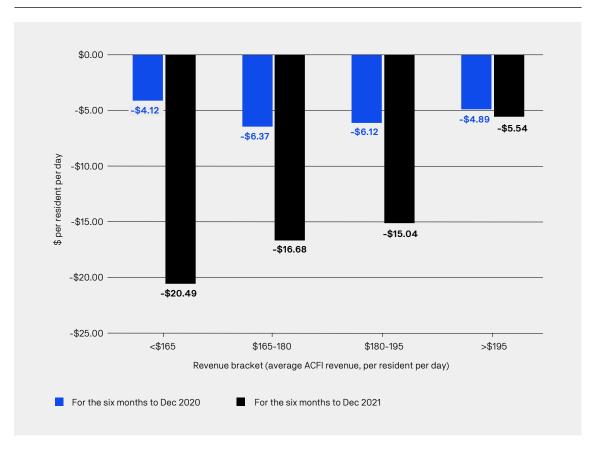


One of the most influential drivers of profitability is the occupancy level of an aged care home. Figure 4 shows the average Operating Result (per resident per day) of homes split into quartiles on the basis of occupancy levels. While homes with the highest occupancy rates (far right column) achieve a modest operating surplus of \$1.17 per resident per day, the homes with the lowest occupancy rates (left column) have an operating loss of \$31.03 per resident per day. Relatively small differences in occupancy levels between the quartiles produce these starkly different operating results. In December 2021, the occupancy rate at the 25th percentile (1st Quartile) was 89%, while the occupancy rate at the 75th percentile (4th Quartile) was 96.8%.

^{17.} Occupancy measures the rate in which an aged care home's beds are actually used (i.e. occupied) by a resident. This report calculates occupancy in terms of the available beds within the sample of aged care homes, which excludes beds that have been allocated by the Department of Health but are not actually operational.

Residential Care Analysis

Figure 5: Average operating result, by direct care revenue



There also appears to be a strong association between the financial performance of aged care homes and the relative level of ACFI funding for their residents. Homes that service residents with funding commensurate with less complex assessed care needs generally have lower care costs, and accordingly, receive lower ACFI subsidies¹⁸. Figure 5 shows the average Operating Result (per resident per day) for homes split into different average ACFI revenue brackets.¹⁹ This shows that for the six months to December 2020 (the prior year), the operating deficit was greater for homes that fell within the two middle ACFI revenue brackets. For the six months to December 2021, however, homes with the lowest levels of ACFI funding made the largest operating losses, with a trend of large losses across all brackets that reduce as ACFI funding increases.

^{18.} ACFI stands for Aged Care Funding Instrument, which is the primary subsidy paid by the government to cover the cost of personal and clinical care given to aged care residents. The rate paid to homes depends on the assessed complexity of each residents' needs across three domains (activities of daily living; behaviour; complex health care). For 2021-22, the subsidy paid for a resident will low needs across all three domains is \$64.72, whereas it is \$225.60 for a resident will high needs across all three domains.

^{19.} Homes are classified into different ACFI revenue brackets by calculating the average ACFI revenue across all residents, stated as a rate per resident day. Homes that fall into a higher ACFI revenue bracket will tend to have, on average, a mix of residents with higher care needs.

Occupancy

The occupancy rate of homes is an important indicator for the residential aged care sector. It demonstrates the expressed demand for residential aged care relative to its supply, and, as discussed above, is a critical driver of a home's profitability. At a more disaggregated level, occupancy can show regions of over or under-supply and can indicate consumer preferences for some aged care homes relative to others

Figure 6: Occupancy rate, by state



For the six months to December 2021, the sector saw a decline in the average occupancy rates of homes in every state and territory. As Figure 6 shows, whereas previously occupancy rates had been relatively stable nationally, the average occupancy rate has fallen consistently over the last three years, to reach 91.6% for December 2021, down from 92.4% in December 2020.

Some of the more recent falls in occupancy occurred in the States particularly affected by COVID-19 outbreaks, with average occupancy levels reduced to 88.4% in Victoria, 90.9% in the Northern Territory and ACT, 91.2% in QLD and 91.4% in NSW. However, the long-term downward trend across all States trend potentially reflects a more prolonged, structural shift in the demand for residential beds coinciding with the release of more home care packages by the Government.

Future occupancy rates will reflect the interaction of several factors. Long-term demographic projections indicate that the demand for residential aged care will continue growing as the number of senior Australians increases over time. Equally, with the removal of supply-side restrictions through the Aged Care Approvals Round, occupancy at the sector level will likely be more responsive to residents demands and providers' investments in supply.

Workforce

Residential Care Analysis

The aged care workforce, including staffing levels and the knowledge, skills and attributes of aged care workers, largely determines the quality of care received by aged care consumers, although Government policy and funding levels and provider management capabilities create the context within which the workforce operates.

Workforce is also a key factor that affects the financial performance of homes, as it accounts for around 80% of all direct care costs. The availability of workers with the appropriate knowledge, skills and attributes is therefore central to the performance and sustainability of the aged care sector.

Table 7: Staffing metrics of residential aged care homes

	Dec-21	Dec-20
Number of homes in survey (workforce analysis)	1,165	1,079
Direct care minutes (per resident per day)		
Registered nurses	28.2	26.3
Enrolled and licensed nurses	16.3	16.3
Personal care workers/other unlicensed care staff	131.7	130.6
Imputed agency care minutes implied	1.9	1.5
Total direct care minutes (per resident per day)	178.0	174.7
Other care-related minutes (per resident per day)		
Care management	8.5	8.5
Allied health	5.3	13.1
Lifestyle	7.3	0.0
Total other care-related minutes (per resident per day)	21.1	21.7
Average total care-related minutes (per resident per day)	199.1	196.4



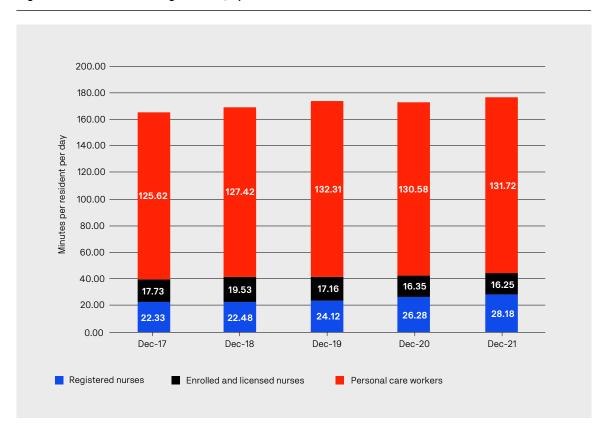
In the last year, direct care staffing time increased by 1.9% to an average of 178.0 minutes per resident per day.

There has been an increase in care-related staffing hours across most roles in the six months to December 2021 (see Table 7). Homes provided 178.02 minutes of total direct care time²⁰ per resident per day on average, up from 174.72 minutes for December 2020 (an increase of 1.9%). This comprises both a moderate uplift in the care provided by registered nurses (28.2 minutes per resident per day in December 2021 compared to 26.28 minutes in December 2020) and a small increase in care provided by personal care workers (131.7 minutes per resident per day in December 2021 compared to 130.56 minutes in December 2020).

These staffing increases have occurred during a period where more homes are incurring financial losses (as discussed above). Nonetheless, staffing levels remain well short of the incoming sector average minimum staffing standards of 200 minutes per resident per day, expected to be in force by 1 October 2023. To reach the minimum care time standards, aged care homes overall will have to increase total care staffing by 12.4% (an average of 22 minutes per resident per day), and registered nurse staffing by 41.8% (an average of 11.8 minutes per resident per day).

^{20.} Direct care time is a measure of the staffing hours (both normal and overtime) of registered nurses, enrolled nurses, and personal care workers. To allow comparisons between homes, it is measured as an average rate per resident per day. It does not measure the actual time spent with each resident (which would require sophisticated and expensive tracking systems), but provides an approximation based on the total normal and overtime hours worked by staff.

Figure 7: Direct care staffing minutes, by worker classification



Despite community, political and regulatory pressure to lift staffing rates, Figure 7 shows a slowing of the rate of growth in direct care staffing time. In the three years up to December 2019, total direct care minutes grew by an annual average of 3.18% per annum. ²¹ By comparison, in the two years since (and subsequent to the onset of the COVID-19 pandemic), total direct care minutes have grown by only 0.74% per annum. This slow growth has occurred across a time period where there has been an increase in the assessed care funding needs (ACFI) of residents, ²² meaning there are more residents with more complex care needs. In addition, the rates of staffing per resident day over-represents the growth in actual staffing over the last three years, as there has been a fall in average occupancy during this time. ²³ This slowdown likely reflects the difficulty aged care homes are experiencing in attracting and retaining care staff. These issues will be explored in Part 2 of this report.

^{21.} Agency care minutes are excluded due to their small size relative all other direct care minutes (1.04% or less).

^{22.} Over the last five years the average ACFI revenue has grown faster than the rate of COPE, indicating homes are servicing more residents with more complex care needs.

^{23.} As staffing metrics are measured at a rate per resident day, they will increase if the number of resident days fall, even if the total number of staff stay constant.



Figure 7 also shows that while there was growth in staffing time of enrolled nurses for the first two years of the period, this has declined in the subsequent three years. This recent reduction may be attributable to the incoming minimum staffing standards. International evidence in regard to the implementation of minimum standards in other jurisdictions shows that standards that focus on specific roles (e.g. registered nurses) can cause homes to divert resources away from others.²⁴ By prescribing a minimum standard for total direct care time without any ringfencing provisions for enrolled nurses, homes may opt to adjust their staffing mix by replacing enrolled nurses with lower-waged personal care workers. Any reduction in enrolled nurses could have negative implications for the quality of care. Furthermore, this reduction may increase the workload pressures on registered nurses and disrupt the career progression and skill development pathways for future nursing staff.



Enrolled nurses staffing time has declined. This may increase the workload pressures on registered nurses and disrupt the career progression and skill development pathways for future nursing staff.

^{24.} Bowblis JR. Staffing ratios and quality: An analysis of minimum direct care staffing requirements for nursing homes. Health Services Research 2011; 46: 1495-516. doi:10.1111/j.1475-6773.2011.01274.x

Results by location

Residential Care Analysis

In Australia, location is an important factor which affects access to health and aged care services. A stated goal of the current aged care reform program is that "all Australians ... feel confident about accessing high quality and safe aged care, where and when they need it".²⁵

In order to track the capacity of the sector to provide residential aged care services where needed, this report analyses the performance of residential aged care homes by location. The aged care homes have been allocated across three locations – major city, regional, and rural and remote – as classified according to the remoteness settings of the Australian Bureau of Statistics. Further analysis using the Modified Monash Model of remoteness (used by the Department of Health) is provided in Part 2 of this report.

Table 8: Key performance indicators of residential aged care homes, by location

	Major City	Regional	Rural & Remote
Number of homes in survey	763	305	124
Average home size (number of beds)	85.94	76.29	62.27
Average Operating Result (\$ per resident per day)	(9.15)	(16.12)	(13.08)
Average Operating Result (\$ per bed per annum)*	(2,699)	(5,165)	(3,725)
Average Operating EBITDAR (\$ per resident per day)	11.39	2.08	6.86
Average Operating EBITDAR (\$ per bed per annum)*	4,089	942	2,693
Average Occupancy rate	91.5%	92.3%	90.0%
Average direct care revenue (\$ per resident per day)	196.08	187.69	193.79
Median direct care costs (as a % of direct care revenue)	88.9%	90.4%	91.6%
Average direct care minutes (per resident day)	177.7	176.2	184.7
Average supported ratio	44.8%	45.3%	53.1%
Average of Full RADs/Bonds held at reporting date	419,431	331,430	289,766
Average of Full RADs/Bonds taken during period	488,245	367,424	344,660

 $^{^{\}star}$ Per annum figures are the per bed day result for 365 days adjusted for the occupancy rate.

 $^{25.\} Department of \ Health, Aged \ Care \ Reforms, available \ at: \ https://www.health.gov.au/initiatives-and-programs/aged-care-reforms$

The above Table 8 shows that aged care homes in all locations are, on average, operating at a loss. However, their financial performance varies substantially in terms of remoteness. In the six months to December 2021, homes based in major cities operated at an average loss of \$9.15 per resident per day. Homes in rural and remote locations recorded a loss of \$13.08 per resident per day, while homes in inner regional locations recorded the greatest losses, operating at a loss of \$16.12 per resident per day.

One of the major drivers of this variation is differences in the relative assessed care funding needs of residents and the amount of ACFI revenue. Homes in the major cities earn \$196.08 per resident per day compared to the \$187.69 per resident per day earned by inner regional homes. Homes outside the metropolitan centres appear to be servicing a more diverse cohort of residents, including more people with lower care needs but a greater reliance on aged care homes to meet their needs. In addition, while homes in rural and remote locations are able to access additional viability supplements (revenue), which aim to offset higher costs of providing care, homes in inner regional locations may either be ineligible or may receive supplements at a lower rate.

Although a second common driver of financial performance is the level of occupancy, in this instance regional aged care homes have, on average, the highest occupancy. This is analysed further, below, and contrasts to their lower operating result as noted above.

A more detailed analysis of the revenue and cost structures affecting regional, rural and remote providers is included in Part 2 of this report.

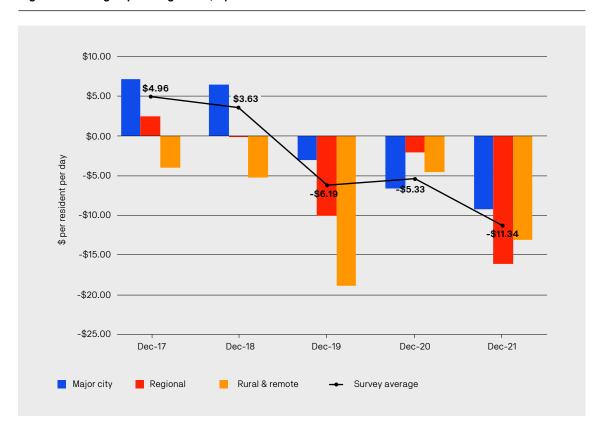
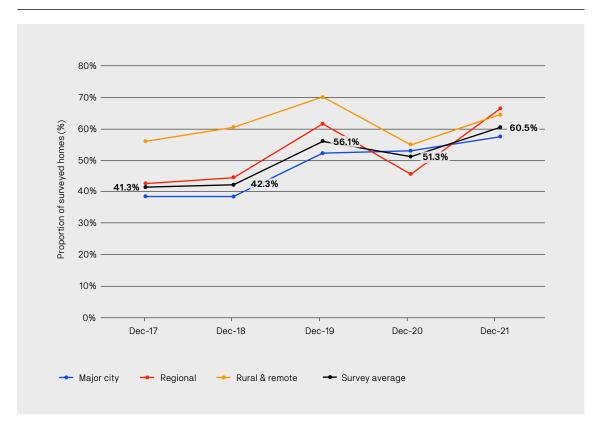


Figure 8: Average operating result, by location

Figure 8 reveals the sustained poor operating results of aged care homes across the last three years, particularly those located outside the major cities. Both regional and rural and remote homes had a brief resurgence in Operating Results in the 2020-21 financial year, however, the operating result dropped significantly again in the first half of 2021-22.

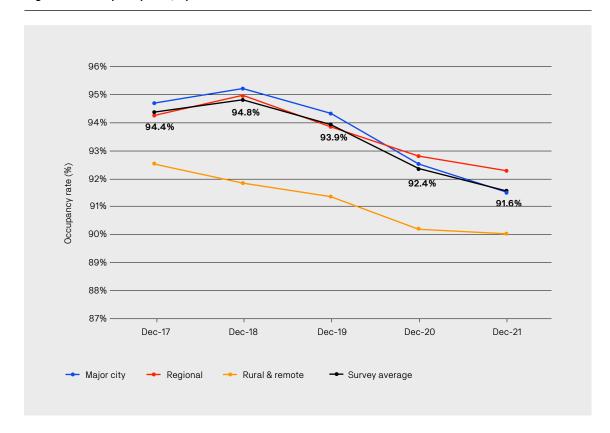
Figure 9: Proportion of homes with an operating loss, by location



This same pattern is evident in Figure 9, which shows the proportion of homes operating at a loss by region. The proportion of homes incurring an operating loss fell by about 15 percentage points in both regional and rural and remote areas in the 2020–21 financial year, but rose significantly again in the first half of 2021–22. As of December 2021, the proportion of homes operating at a loss was 66.6% for regional locations, 64.5% in rural and remote locations, compared to 57.4% in major cities.

Part 1: StewartBrown Survey Results

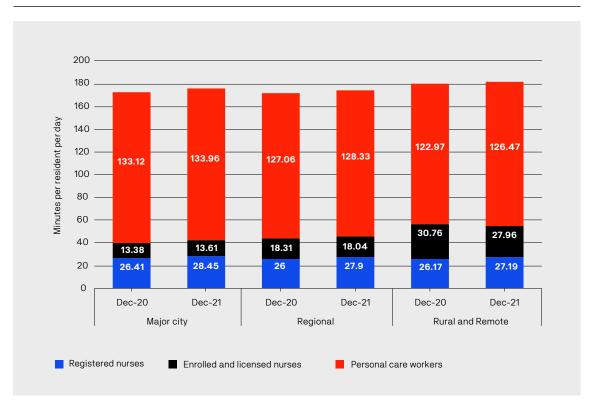
Figure 10: Occupancy rate, by location



Another factor that varies by location is average occupancy (Figure 10). In keeping with the trend for prior years, homes in rural and remote locations have a much lower average occupancy rate (on average 90.0%) compared to their counterparts in the major cities (91.5%) and regional centres (92.3%). In the thin markets of rural and remote locations, there is significant community value in having access to available beds in comparatively nearby aged care homes. However, this may result in lower average occupancy for homes in these locations.

As is evident from the preceding analyses, there is a complex inter-relationship between operating results, occupancy and location.

Figure 11: Direct care staffing minutes, by worker classification and location



Homes across all locations have increased, on average, their total direct care staffing time per resident per day compared to the same period in 2020–21. As shown in Figure 11, there are relatively small differences in total direct care staffing between homes in different locations, with homes in rural and remote locations having slightly higher levels. This result may be driven by other characteristics of these homes, which tend to have lower occupancy levels and smaller average sizes.²⁶

However, there is a significant compositional difference in that homes in rural and remote locations tend to have more care hours provided by enrolled nurses. Even so, Figure 11 also shows that there has been some contraction of enrolled nurses in rural and remote homes between the two six-month periods. The average enrolled nurse staffing time has fallen 9.1% between December 2020 and December 2021, and has been offset predominantly by increases in personal care workers. This is indicative of a substitution effect and associated cost saving by providers.

^{26.} Staffing metrics which are measured as a rate per resident day will tend be higher for homes that have fewer residents (either as a result of a smaller size or lower occupancy rate or both), as a result of having a minimum amount of fixed staffing levels.

Results by home size

While the dominant model for residential aged care in Australia has been largescale congregate living facilities, there is increasing interest in providing care in small group or home-like environments.

Smaller-scale housing can be constructed as standalone homes or operate in cottage-like clusters as part of a larger development. Small group models, whether or not as part of larger facilities, are seen as facilitating the provision of person-centred care, with greater flexibility as to the structuring of the day and the activities available to residents. There is also some evidence that quality of care can be higher in smaller homes. ²⁷

In terms of financial viability, and irrespective of whether small group models are adopted, analysis of the survey data shows that mid-range homes with 40 to 120 beds generate a better operating performance than smaller homes.²⁸ The Royal Commission noted that large developments, providing they are well designed, can offer efficiencies of scale, have improved capacity to recognise diversity and are able to have clusters of different types of activities at the home.²⁹

Table 9: Key performance indicators of residential aged care homes, by home size

	<40 beds	40-80 beds	80-120 beds	>120 beds
Number of homes in sample	108	542	335	207
Average number of beds	29.0	57.6	96.5	144.4
Average Operating Result (\$ per resident per day)	(20.83)	(9.41)	(10.85)	(12.27)
Average Operating Result (\$ per bed per annum)*	(6,249)	(2,843)	(3,336)	(3,688)
Average Operating EBITDAR (\$ per resident per day)	(2.30)	9.00	10.62	9.60
Average Operating EBITDAR (\$ per bed per annum)*	(340)	3,316	3,773	3,464
Average supported ratio	50.0%	47.9%	43.8%	41.6%
Average direct care revenue (\$ per resident per day)	198.17	192.45	194.83	192.81
Median direct care costs (as a % of direct care revenue)	91.7%	88.4%	89.4%	90.4%
Average direct care minutes (per resident day)	185.4	174.5	179.0	181.8
Average supported ratio	50.0%	47.9%	43.8%	41.6%
Average of Full RADs/Bonds held at reporting date	331,289	360,822	402,071	442,819
Average of Full RADs/Bonds taken during period	414,597	418,241	455,583	485,350

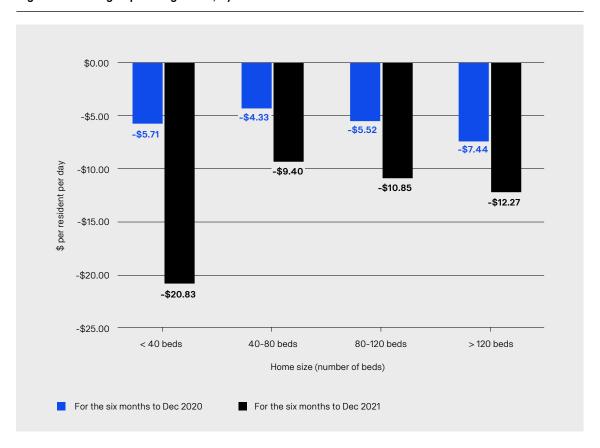
^{27.} University of Queensland (2020) The cost of residential aged care. Research Paper 9 prepared for the Royal Commission into Aged Care Quality and Safety; National Ageing Research Institute (2020) Inside the system: aged care residents' perspectives. Research Paper 13 prepared for the Royal Commission into Aged Care Quality and Safety.

^{28.} StewartBrown (2021) Aged Care Sector Report. For the 12 months ended June 2021, p. 14.

^{29.} Royal Commission into Aged Care Quality and Safety (2021) Final Report. Vol 3A.

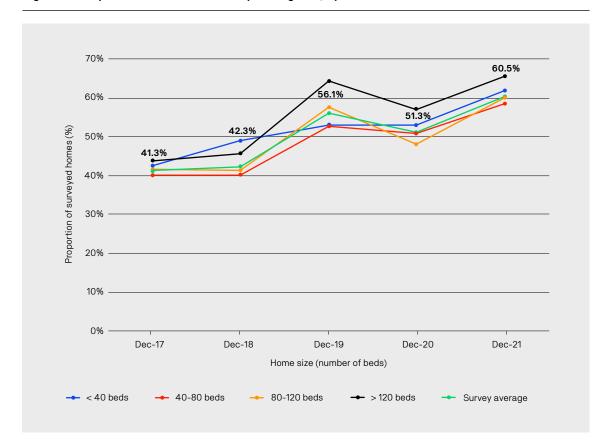


Figure 12: Average operating result, by home size



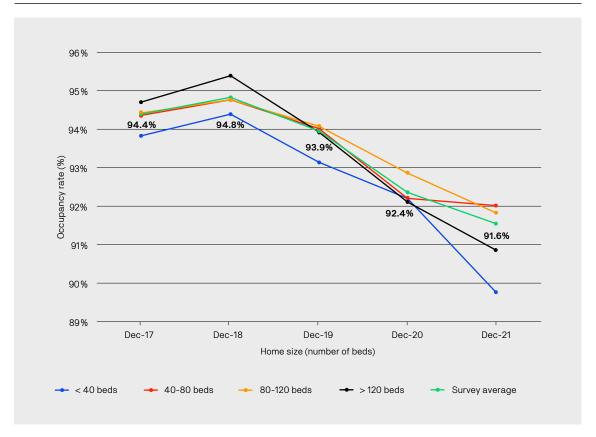
The data demonstrates differences in the average financial performance of aged care homes according to their size (Figure 12). For the period to December 2021, homes with fewer than 40 beds have substantially greater losses, with an average operating loss of \$20.83 per resident per day. The home size bracket with the least level of losses is 40-80 beds, with increasing level of loss as home sizes increase beyond that size.

Figure 13: Proportion of homes with an operating loss, by home size

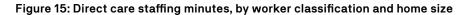


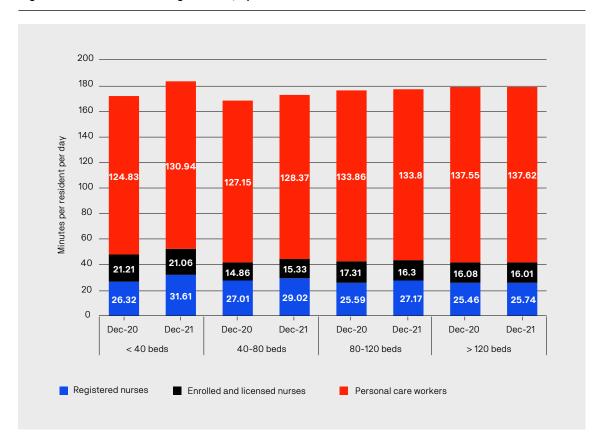
Broadly consistent with the story in Figure 12, Figure 13 shows that the two size brackets with the highest proportion of homes operating at a loss are at either end of the size range. Specifically, both very large homes (more than 120 residents) and small homes (less than 40 residents) have a higher proportion of loss-making homes than homes of between 40 and 120 residents.

Figure 14: Occupancy rate, by home size



The patterns in profitability can likely be explained, in part, by differences in occupancy across homes of different sizes. As Figure 14 shows, although occupancy fell, on average, across homes of all sizes, the lowest occupancy levels occurred in small (<40 beds) and very large (120+ beds) homes.





The total direct care time provided to residents has increased, year on year, across homes of all sizes. As shown in Figure 15, the biggest increases in staffing time occurred in homes of smaller sizes (i.e <40 beds and 40-80 beds), whereas homes of larger sizes only had marginal increases in direct care time. One relevant factor is likely to be the changing occupancy rates in smaller homes, as shown in the preceding Figure 14. Given that staffing levels are relatively fixed, especially in the short-term, a drop in occupancy actually results in the availability of greater staff hours per remaining resident per day.

The poor financial

- performance of residential care homes raises questions about the adequacy of revenue streams as they face increasing wage
- pressure and rising administration and compliance costs.



Operating result breakdown

This section provides a more detailed analysis of the revenue and costs of the operating results for aged care homes. Specifically, the Operating Result is broken down into three areas corresponding to the different services offered by aged care homes:

- □ direct care (personal and clinical care services)
- □ everyday living (food, cleaning, laundry and other amenities)
- □ accommodation.

Decomposing profit into these three areas enables a better identification of the revenue streams and cost components which are driving trends in the financial performance of aged care homes, and can indicate areas for policy or management focus.

Following the methodology used in previous sector reports produced by StewartBrown, administrative costs have been allocated across the three areas, to allow for a meaningful comparison between revenue and costs. The results for each of the three areas in the following table are shown both before the allocation of administrative expenses and after (the net result).





Table 10: Breakdown of average operating result of residential aged care homes

	Dec-21	Dec-20
Direct Care		
Direct Care Revenue	193.70	201.00
Direct Care Expenditure:		
Direct care labour costs	139.56	131.89
Other labour costs	22.32	19.44
Other direct costs	13.22	19.56
Total direct care expenditure	175.10	170.89
Direct Care Result (before administration costs)	18.58	30.1
Allocation of administration costs (37%)	14.91	14.14
Net Direct Care Result (\$ per resident per day)	3.68	15.97
Everyday Living		
Everyday Living Revenue	65.18	54.30
Everyday Living Expenditure:		
Catering	33.76	32.43
Cleaning	9.32	8.99
Laundry	4.25	4.1:
Other	19.02	18.54
Total everyday living expenditure	66.35	64.08
Everyday Living Result (before administration costs)	(1.17)	(9.79
Allocation of administration costs (33.6%)	13.54	12.84
Net Everyday Living Result (\$ per resident per day)	(14.71)	(22.63
Accommodation		
Accommodation Revenue:		
Residents	12.63	12.69
Government	20.36	20.17
Total accommodation revenue	32.99	32.86
Accommodation Expenditure:		
Depreciation	19.05	18.24
Property rental	0.83	1.02
Other	1.57	1.04
Total accommodation expenditure	21.45	20.30
Accommodation Result (before administration costs)	11.53	12.56
Allocation of administration costs (29.4%)	11.85	11.23
Net Accommodation Result (\$ per resident per day)	(0.31)	1.33
Operating Result (\$ per resident per day)	(11.34)	(5.33
Operating Result (\$ per bed per annum)*	(3,437)	(1,461
Operating EBITDAR (\$ per bed per annum)*	3,139	5,019

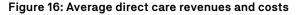
 $^{^{\}star}$ Per annum figures are the per bed day result for 365 days adjusted for the occupancy rate.

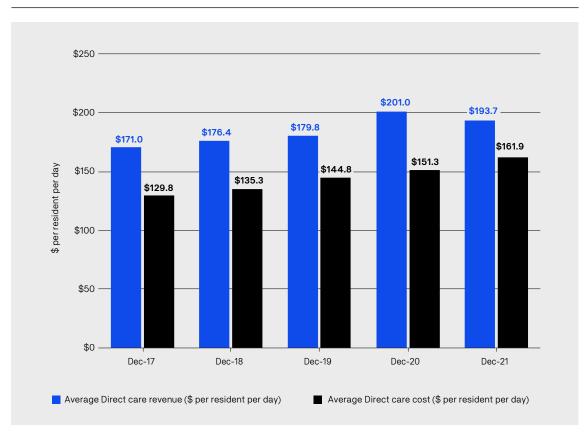
Direct Care Result

Overall the Net Direct Care Result³⁰ has further deteriorated for the December 2021 period compared to the same period in the previous year. As shown in Figure 16, this is because of an increase in the average direct care costs and a fall in average direct care revenue per resident per day. Notably, average direct care revenue has decreased even though subsidies rates have increased, through indexation, by 1.1%.³¹

One of the main drivers of this result has been the end of most COVID-19 grants and subsidies as of 1 July 2021, which has not been matched by corresponding drops in COVID-19 expenditure (see Part 2 of this report for further discussion). In term of major cost drivers, there has been a 6.7% increase in care-related labour costs (~\$10 per resident per day), with significant increases in the labour cost of registered nurses, personal care workers, and agency staff.

Looking at the longer-term trend in Figure 16, the growth in direct care revenue per resident per day has been outpaced by the growth in direct care costs per resident per day across the last five years. Since 2016–17, direct care revenues have grown by an average of 13.3% whereas direct care costs have increased by 24.7%.





³⁰ The Direct Care Result represents the net result from revenue and expenses directly associated with care. It includes ACFI and Supplements (including means-tested care fee) revenue less total care expenditure, and this includes an allocation of workers compensation and quality and education costs. The Net Direct Care Result also includes an allocation of 37.0% homes' administrative expenditure.

^{31.} Department of Health, Aged Care Subsidies and Supplements from 20 September 2021, available at: https://www.health.gov.au/sites/default/files/documents/2021/09/schedule-of-subsidies-and-supplements-for-aged-care-schedule-from-20-september-2021.pdf



Everyday living result

The Net Everyday Living Result³² has improved, with a contraction in the average deficit of \$22.63 per resident per day for December 2020 to a deficit of \$14.71 for December 2021.³³
This improvement is largely attributable to an increase in revenue following the receipt of the Commonwealth's Basic Daily Fee supplement from July 2021 (\$10 per resident per day). Notably, the inflow of the BDF supplement has been directed mainly at reducing the significant ongoing losses on the provision of these services. The supplement is received by providers who have agreed to report quarterly on their food and nutrition expenditure, and on the quality of daily living services they provide to residents.

In a separate StewartBrown survey of 496 residential homes, the total cost of in-house food, supplements and consumables was found to be \$13.57 per resident per day for the first half of the 2021–22 financial year.

Accommodation result

In the first half of the financial year 2021–22 there has been a slight contraction in the Net Accommodation Result.³⁴ There have been minimal changes in the accommodation revenue overall, which has been outpaced by increases in accommodation expenditure. The predominant expenditure growth has been in depreciation and amortisation, which could either be reflective of increases in homes' asset bases (i.e. through new or refurbished infrastructure), or changes in accounting policies, such as an acceleration of the amortisation of bed licenses. In addition, while a minority of providers revalue their property assets, most depreciate on the basis of cost. Of those, most providers depreciate on the basis of 30–40 years of useful life, with a midlife refurbishment likely to occur after about 15–20 years. Further investigation finds a 5.3% increase in depreciation and amortization costs relative to the prior year for homes which are undertaking a refurbishment, relative to a 1.2% increase for non-refurbishing homes.

Administration expenditure

Year on year, administration costs have increased on average by 5.4%, faster than the rate of inflation, rising to an average of \$40.29 per resident per day in the six month period to December 2021. This likely reflects the fact that during this period providers have faced increased compliance and reporting costs, with the expansion of several new transparency, reporting and accountability regimes. These are described in Part 2.

^{32.} The Everyday Living Result includes revenue from Basic Daily Fee, the Basic Daily Fee supplement as well as extra or optional service fees. The main cost categories include hotel services (catering, cleaning, laundry), utilities, motor vehicles and regular property & maintenance (includes allocation of workers compensation premium and quality and education costs to hotel services staff). The Net Everyday Living Result also includes an allocation of 33.6% of homes' administrative expenditure.

^{33.} Note that these results are net of allocation of administrative costs. Without the allocation, the Everyday Living Result is still in deficit in 2021 (\$1.19 per resident per day).

^{34.} The Accommodation Result shows the result of accommodation revenue (DAPs/DACs/Accommodation supplements) and expenses related to capital items such as depreciation, property rental and refurbishment costs. The Accommodation Result also includes an allocation of 29.4% homes' administrative expenditure.



Table 11: Breakdown of average administrative expenditure of residential aged care homes

	Dec-21	Dec-20
Administration Costs:		
Administration recharges	24.70	23.69
Administration labour costs	7.80	7.32
Other	6.05	5.71
Insurance	1.42	1.21
	0.19	0.17
Quality & education	0.07	0.06
Payroll tax (administration staff)	0.03	0.04
Fringe Benefits Tax	0.02	-
Total administration expenditure (\$ per resident per day)	40.29	38.21
Allocation to:		
Direct care (37%)	14.91	14.14
Everyday living (33.6%)	13.54	12.84
Accommodation (29.4%)	11.85	11.23

Home Care Analysis

Overview



The financial performance of home care services declined by 25.5%, dropping to an average operating result of \$3.82 per client per day.



The decline in profitability has occurred despite an increase in revenue utilisation of home care packages to an average rate of 88.0%. While average revenue has plateaued, costs have increased, particularly those relating to care management and advisory, administration and support.



The decline in profitability has been most acute for providers with package mixes comprising more lower level packages.



Although overall staffing levels has stabilised, direct care staffing time has continued to fall. As of December 2021, home care clients received an average of 3.80 hours of direct care per week (33 minutes per day), which is 32.1% lower than 5.60 hours clients received, on average, five years ago.



Home Care Analysis

Home care service profiles

The home care analysis reports on the financial and workforce outcomes of home care service providers that offer subsidised services funded through home care packages. As noted earlier, the StewartBrown survey does not currently extend to providers of the CHSP services, though changes will be made to align with the proposed Support at Home Program from July 2023.

Table 12: Profile of surveyed home care services

	Dec-21	Dec-20
Number of home care services in survey	378	401
Total number of packages in survey	55,821	43,081
Ownership		
For-Profit	0.5%	0.5%
Non-Profit	99.5%	99.5%
Location		
Major City	58.5%	56.1%
Rural	41.5%	43.9%
State		
NSW	34.9%	34.2%
NT & ACT	1.9%	1.7%
QLD	31.7%	36.7%
SA	13.0%	12.0%
TAS	2.9%	3.0%
VIC	8.7%	5.0%
WA	6.9%	7.5%
Average number of funded packages per home care service	147.7	107.4
Package mix		
% of Level 1 Packages	9.8%	12.2%
% of Level 2 Packages	37.1%	37.3%
% of Level 3 Packages	27.6%	23.0%
% of Level 4 Packages	25.4%	27.6%

This section analyses the outcomes from the December 2021 StewartBrown survey, which included 55,831 home care packages provided by 378 home care services. As shown in Table 12, the vast majority (99.5%) of these services are delivered by not-for-profit providers. Most (58.5%) of the services were located in major cities, particularly in NSW (34.9%) and QLD (31.7%). On average, the number of packages per service increased in the one year by 38% to 147.7 packages in December 2021. Some of this increase can be attributable to the growth in the number of packages, but may also reflect differences in how providers reported their programs in the data collection.

Looking across the entirety of all home care packages included in the survey, the package mix changed slightly year on year. There was a slight decrease in the proportion of Level 1 and 4 packages, increases in the proportion of Level 3 packages, whilst Level 2 packages remained relatively constant. The package mix across the survey in Table 12 is largely consistent with sector-level statistics of the proportion of people in home care packages, by package level, reported by the Department of Health.³⁵

Key performance indicator summary

Table 13: Key performance indicators of home care services

	Dec-21	Dec-20
Operating result (\$ per client per day)	3.82	5.13
Operating EBITDA (\$ per client per annum)	1,590	2,041
Revenue:		
Revenue (\$ per client per day)	71.35	71.17
Revenue utilisation rate	88.0%	84.2%
Unspent funds per package (\$)	9,976	10,076
Costs:		
Direct care and brokered services costs (as % of revenue)	57.8%	57.8%
Care management and advisory costs (as a % of revenue)	12.3%	10.9%
Administration and support costs (as % of revenue)	24.8%	23.9%
Profit margin (%)	4.4%	6.8%
Total staff hours per client per week	5.34	5.29

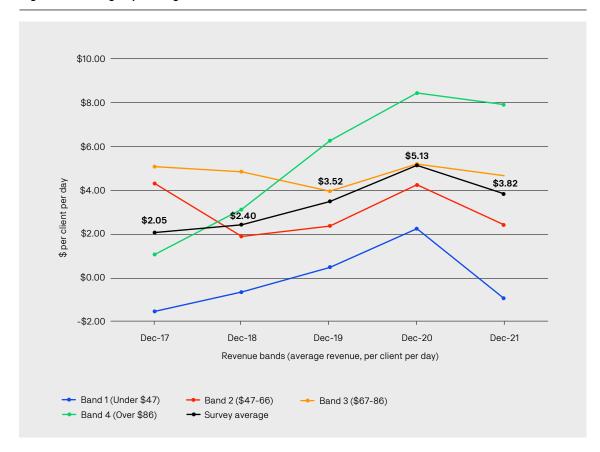
^{35.} Department of Health, Home care packages program, data report 2nd Quarter 2021-22, available at: https://www.gen-agedcaredata.gov.au/www_aihwgen/media/Home_care_report/Home-Care-Data-Report-2nd-Qtr-2021-22.pdf

Home Care Analysis

Financial performance

As in the case of residential care, the financial performance of home care service providers is directly related to the sustainability of the aged care sector. If home care providers are unable to maintain financial viability they will exit the sector, leaving service gaps for consumers. In this section, we report on the profitability of home care providers, including trends over time.

Figure 17: Average operating result



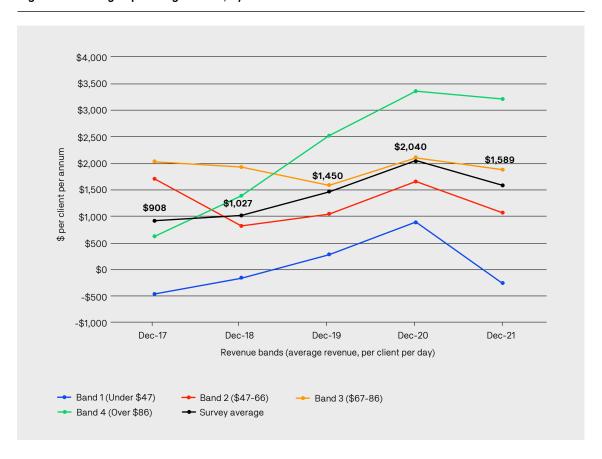
In the six months to December 2021, the profitability of home care services declined compared to the same period in 2020. As shown in Figure 17, on average services achieved an operating result³⁶ of \$3.82 per client per day, down from \$5.13 per client per day the previous year. Figure 18 shows that operating EBITDA³⁷ was \$1,589 per client per annum, down from \$2,040 per client per annum in December 2020. However, over the last five years, both Figures 17 and 18 show a small, but positive medium-term trend of improving profitability of home care services.

^{36.} Operating Result refers to the Net Profit Before Tax (NPBT) earned by a home care service provider.

^{37.} EBITDA represents calculation of earnings before Interest, Taxation, Depreciation, and Amortisation. It can provide for a comparison of the profitability of services operated by providers which have different financing arrangements. 'Operating EBITDAR' also excludes all provider-level revenue and expenditure, including fundraising revenue, revaluations, donations, capital grants and sundry revenue.

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Figure 18: Average operating EDITDA, by revenue bands



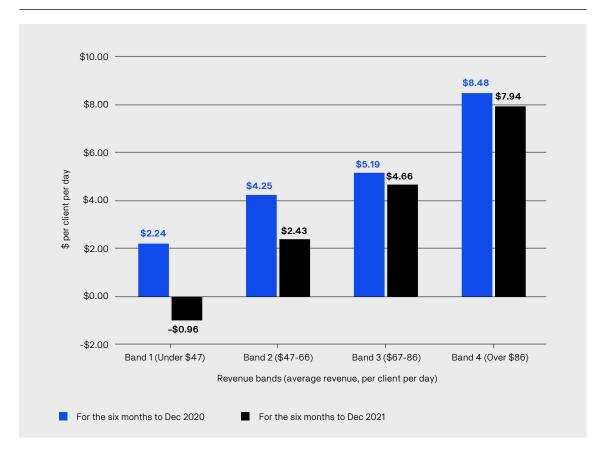
Both Figures 17 and 18 show the trends in profitability by service providers classified into different revenue band brackets, based on the average revenue earned per client day. These bands provide some approximation of providers' package mixes, which encompass different combinations of packages at the four different levels (i.e. Level 1, 2, 3 and 4). The total value of the packages - comprising the government subsidy and any income tested co-contribution (which is netted from the government subsidy) - varies substantially as follows (in effect from September 2021 to March 2022):

- □ **Level 1** \$9,026 per annum
- □ **Level 2** \$15,878 per annum
- □ **Level 3** \$34,551 per annum
- □ **Level 4** \$52,378 per annum³⁸

Thus, providers classified as Band 1 will tend to provide more Level 1 and 2 packages, whereas those classified as Band 4 will offer more Level 3 and 4 packages.

^{38.} Department of Health, Aged Care Subsidies and Supplements from 1 July 2021, available at: https://www.health.gov.au/sites/default/ files/documents/2021/06/schedule-of-subsidies-and-supplements-for-aged-care-schedule-from-1-july-2021_1.pdf

Figure 19: Average operating result, by revenue band



The results also show a clear distinction in the profitability of providers that offer different package mixes, approximated by the four revenue band brackets. For example, as shown in Figure 19 service providers in the two higher revenue brackets (Bands 3 and 4) achieve significantly higher profit margin (\$4.66 and \$7.94 per client per day respectively). Providers in the two lower revenue brackets achieved significantly smaller returns, with Band 2 providers earning an average of \$2.43 per client day and Band 1 making a loss of \$0.96 per client day. The poor profitability of providers in the lower bands raises concerns about the viability of lower level home care packages, including the current business models of providers, particularly as the sector moves towards a unified support at home program that brings together the CHSP and the Home Care Package program.

In order to understand the underlying drivers of these poor profitability results, the following sections will analyse the revenue and cost structures of surveyed home care services.

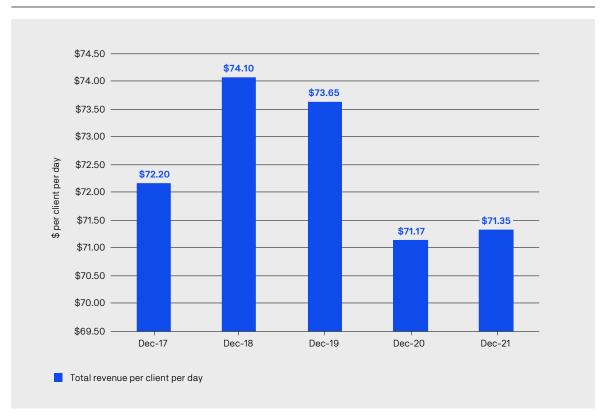
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Revenue analysis

The primary revenue source for home care service providers are government subsidies for home care packages, as well as any income tested fees paid by clients, which are assigned to individuals assessed at Levels 1 to 4, as noted above.³⁹

Home care service providers earn revenue (equivalent to their charges for services delivered) to individual clients when the clients use their package funds. The services can include personal and nursing care, domestic and social support activities, and home maintenance and modifications to help support their independence.

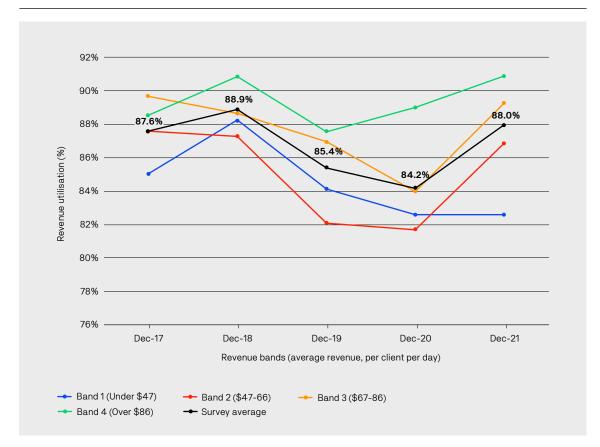




One of the factors contributing to the lower profitability of home care providers is the stagnation of revenue growth. The results for the first six months of this financial year show that the average revenue earned by home care services has plateaued. As shown in Figure 20, the average revenue per client day was \$71.35 as of December 2021, compared to \$71.17 in December 2020, and represent a real terms decline. There was also relative stability of providers package mix which, as shown in Table 13 earlier, remained largely consistent in terms of the proportion of packages offered at different levels year-on-year.

^{39.} Providers also earn revenue from additional government supplements as well as care co-contributions from home care recipients.



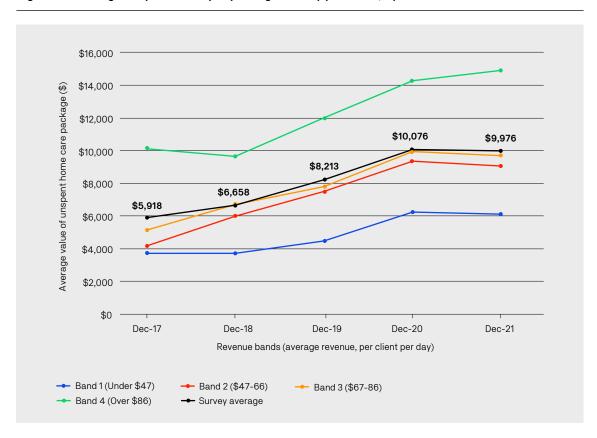


Somewhat counter-intuitively, the low level of revenue growth has also occurred in the context of an increase in the average revenue utilisation across surveyed home care services. Revenue utilisation represents the rate in which home care clients use their allocated subsidy, so an increase in revenue utilisation should result in an increase in revenue earned per client. As shown in Figure 21, the average revenue utilisation rate as of December 2021 across surveyed home care services was 88.0%, up from 84.2% the year prior and a return to levels achieved in the 2018–19 December half year.⁴⁰

Figure 21 shows that there is substantial variation in utilisation rates across providers who fall into different revenue brackets. Providers in Bands 3 and 4 achieved substantially higher utilisation rates in December 2021 (89.3% and 90.9% respectively) compared to those in Bands 1 and 2 (82.6% and 86.9%). Furthermore, while the utilisation of Bands 2, 3 and 4 providers improved year on year, this was not the case for Band 1 providers, which remained the same. This result suggests that providers offering more Level 1 and 2 packages face ongoing challenges in encouraging clients to make full use of their allocated subsidies, and adds to the evidence of poor viability for providers of those two package levels.

^{40.} All else being equal, a significant increase in the proportion of higher-level packages would cause the average revenue per client per day to increase. Note that the average package mix across the surveyed home care providers is largely consistent with sector-level statistics of the proportion of people in home care packages, by package level, reported by the Department of Health, Home care packages program, data report 2nd Quarter 2021-22, available at: https://www.gen-agedcaredata.gov.au/www_aihwgen/media/Home_care_report/Home-Care-Data-Report-2nd-Qtr-2021-22.pdf

Figure 22: Average unspent funds per package held by providers, by revenue band



From 1 February 2021 the Australian Government introduced the 'Improved Payment Arrangements' which moved to Home Care Package funding in arrears. From 1 September 2021 the next stage was to only fund providers for the actual care, services and goods they delivered each month to care recipients. The Government is taking responsibility for managing care recipients' Home Care Package funds. This will lead to a progressive reduction in the level of unspent funds held by providers. Further changes to payment arrangements are currently proposed to be implemented from July 2023 with the introduction of the unified 'Support at Home' program, which will eliminate unspent funds.⁴¹

Unspent funds, whether held by providers or the Government, represent the average value of the assigned subsidy, per package, which has not been used by the client for home care services. While from a provider's perspective, the level of unspent package funds represents unrealised income, from a policy perspective, it represents an inefficient allocation of taxpayer monies, particularly whilst there remains a long waiting list for home care packages. As Figure 22 shows, up until this financial year, there has been a significant growth in the value of unspent funds over the long-term.

The StewartBrown survey captures only the level of unspent funds held by providers, and in the first six months of 2021–22 financial year that level of funds has, on average dropped slightly from \$10,076 per package to \$9,976. The values in December 2021 also may not include the unspent funds now held on behalf of consumers by Services Australia, and thus could understate the total value of unspent funds by home care clients.

^{41.} Department of Health (2022) Support at Home Overview, available at: https://www.health.gov.au/resources/publications/support-at-home-program-overview

Cost analysis

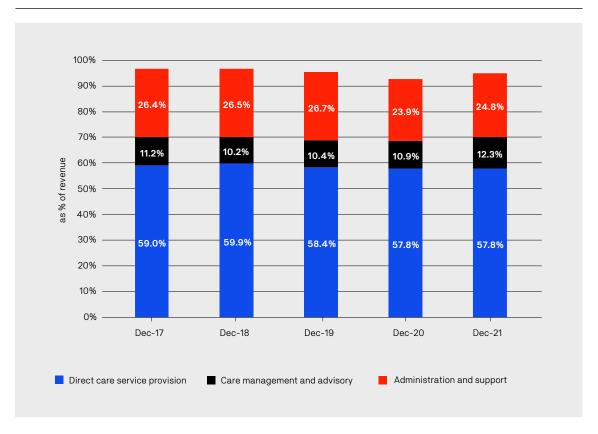
Providers' expenditures in providing home care services can be broken down into three basic categories:

- □ **Direct care service provision** (including services provided by third parties through sub-contracted and brokered service arrangements). This typically includes costs of staffing, consumables, travel and home modifications.
- □ Care management and advisory. This typically includes the costs of staffing and transport expenses relating to managing the care for the clients.
- Administration and support. This typically includes the costs of administration staff, scheduling of services, education and quality control, insurance, utilities, rent, information technology, interest and motor vehicles and other 'back-office' costs relating to the provider organisation running its services.





Figure 23: Home care categories of expenditure, as % of revenue



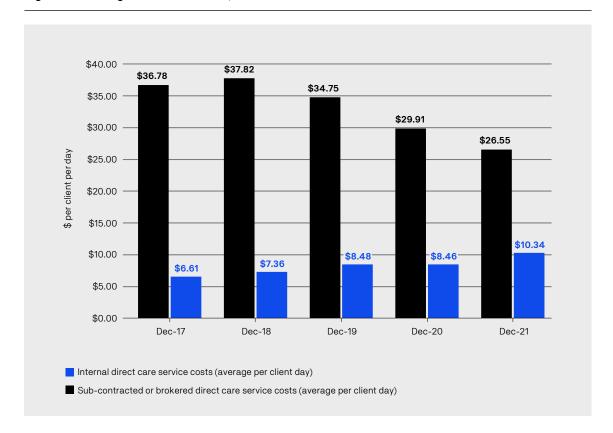
As shown in Figure 23 more than half of the expenditure of home care services (57.8% in December 2021) typically relates to the provision of care services, either directly by the provider or through a third party, such as a subcontractor or brokered arrangement.⁴² By comparison 12.2% relates to care management and advisory and 24.8% relate to administration and support.

In terms of the year-on-year changes, home care service providers' cost base has increased as a proportion of revenue. This likely explains the decline in profitability for December 2021 described earlier in this section. While direct care service provision costs have remained steady, in the last year the costs of administration and support, as well as care management and advisory have grown. This data reflects both increases in outlays relating to providing advice to clients and compliance activities, as well as the need for providers to continue administration support, even during periods when clients use of services have stagnated (particularly in lower level packages).

However, over the last five years, there has been a marginal fall in providers' costs and thus increase in profit margin. Figure 23 shows that over the medium term the proportion of revenue spent on direct care services and administration and support has been slowly reducing, while expending more on care management and advisory.

^{42.} Sub-contractor and brokered service arrangements occur when third parties are engaged to provide services to the client. Common examples include when providers use a brokered labour hire company to provide client services on a permanent basis, or when gardening, home maintenance or allied health services are provided by a subcontractor. It also includes when a third party is engaged to install home modifications that support the independence of home care clients.

Figure 24: Average direct care costs, internal vs sub-contracted services



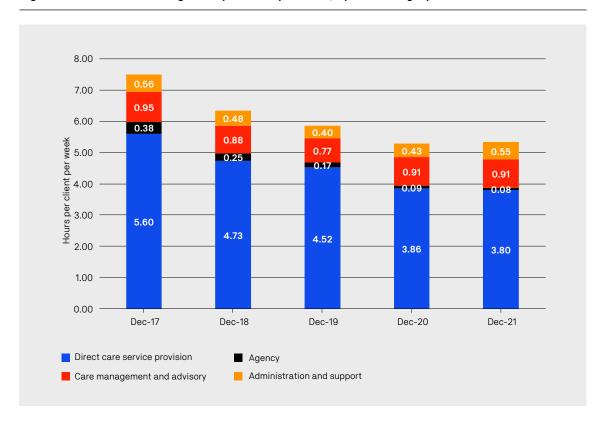
Another factor contributing to the decline of home care services' profitability relates to the extent to which services are provided directly (internally) or through third parties. As Figure 24 shows, in the last financial year the average amount of internal direct care expenditure has continued a long-term declining trend, whilst the amount spent on subcontracted or brokered services has continued to increase. While the trend has been ongoing for much longer than the COVID-19 pandemic, it may reflect the increasing difficulty that many providers are having in recruiting and retaining a stable internal workforce. From a providers' perspective, the third-party services typically return a lower margin and thus may be adding to the decline in their overall profitability.

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Workforce

As already noted, the availability of a sufficient workforce, with the appropriate knowledge, skills and attributes, is central to the performance of the aged care sector. This section examines key workforce factors within the home care sector.

Figure 25: Home care staffing hours per client per week, by staff category



Compared to the 2020-21 financial year, Figure 25 shows that in the six months to December 2021 the total staffing for home services increased slightly from 5.29 to 5.34 hours staffing hours per client per week. This represents some degree of stabilisation of the previous steep fall in total staffing hours from at least 2017.

Figure 25 shows an increase in staffing time relating to administration and support activities this financial year, relative to most prior years. Specifically, the average staffing time spent on administration and support increased by 27.8% from 0.43 hours per client per week (25.8 minutes) in December 2020 to 0.55 hours (33 minutes) in December 2021.

However, the December 2021 results in Figure 25 show a decrease in the amount of direct care staffing time falling from an average of 3.86 hours per client per week (Dec 2020) to 3.80 hours per week (Dec 2021), or approximately 33 minutes per day.

Although the latest decline in direct care staffing time is relatively small (1.6%) compared to prior years, it continues a long-term trend. In the last five years, average direct care staffing time has fallen by 32% compared to levels in December 2017.

The longer-term decline in staff time for care-related services in home care coincides with substantial growth in the total number of people in home care packages across Australia. For example, five years ago in December 2017 there were 77,918 people in a home care package compared to 198,109 people in December 2021. In the last year, the number of people in home care packages grew by 24.3% (38,770 people) since December 2020. Thus, one of the likely causes of the decline in staffing is capacity constraints as providers struggle to find enough suitable aged care workers to service this growth. The more recent decrease in direct care staffing may also reflect a contraction in use of some services by clients, particularly during the pandemic. Further analysis is warranted to disentangle whether supply or demand factors (or a combination of both) are causing declines in staffing time.





Part 2 of this report provides commentary on the issues facing the Australian aged care sector.



Current challenges and issues

This section places the results from the first six months of the 2021-22 financial year in the context of wider trends to provides more in-depth analysis about the most acute current challenges across the sector, including:

- ☐ Financial viability and sustainability
- □ Workforce shortages
- □ Financial impact of COVID-19
- ☐ Financial pressures in regional, rural and remote residential care.



Policy and reform agenda

This is followed by a summary of major initiatives underway within the policy reform agenda including:

- ☐ The new funding model for residential care (AN-ACC)
- ☐ Fair Work Commission wage case
- ☐ The new Support at Home Program
- □ New reporting and accountability requirements
- □ Budget 2022-23 and election commitments.

Current challenges and issues

Financial viability and sustainability

In terms of the viability of the aged care sector, the 2021–22 mid-year results described in Part 1 of this report indicate that many Australian aged care providers are facing increasing and potentially near-term threats to the financial viability of their aged care business streams.

In the first six months of the 2021–22 financial year, the financial performance of aged care services have worsened compared to the same six month period in 2020–21, across all three level of analysis:

- □ Approved providers reported an average total operating deficit of \$339k across the totality of their businesses (down from a surplus of \$544k at Dec-20), a return on assets of negative 0.9% and a median EBITDAR profit margin of just 2.1% (compared to 3.2% in Dec-20)
- □ Over 60% of residential aged care homes are operating at a loss, with an average deficit of \$11.34 per resident per day (compared to a deficit of \$5.33 in Dec-20)
- ☐ The average operating profit of home care services fell by 25.5% year on year, to \$3.82 per client per day.

In residential care, where the financial viability issues are most acute, the worst operating losses were reported by homes with lower occupancy and low average ACFI revenue per resident, as well as those that were smaller in size and located in regional, rural and remote communities.

Nonetheless, the poor mid-year profit results from the majority of homes across the range of characteristics suggest there are significant concerns in terms of the fundamental adequacy of the level of funding and associated business models of residential care.

Figure 26: Breakdown of average operating result of residential care for December 2021, before and after administration allocation

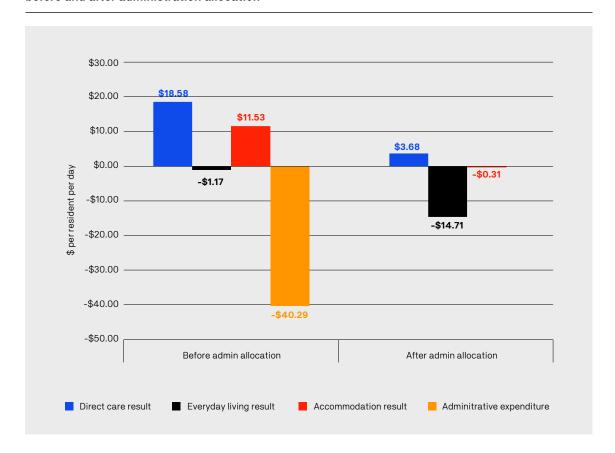


Figure 26 shows the year on year breakdown of the average operating result of residential care homes, which was a deficit of \$11.34 per resident per day for the first half of the 2021–22 financial year. This breakdown (which is as reported in Table 10 on page 50), shows the net impact on operating profit of returns from direct care, everyday living, accommodation and administration expenditure.

The left hand set of bars shows the results before the allocation of administration expenditure. Before that allocation, the homes on average generated \$11.53 of margin, per resident per day from accommodation activities and \$18.58 from direct care, whereas they lost \$1.17 per resident per day from everyday living activities. The left column also indicates that on average, administration costs \$40.29 per resident per day, which is not funded through any separate revenue streams.

While some witnesses to the Royal Commission considered that aged care homes should deliver personal and clinical care to senior Australians on a cost neutral basis, but be able to generate a reasonable return from their other operational activities, others and the Commissioners themselves did acknowledge the need for homes to return sufficient margins to provide returns for investments by providers in the infrastructure required to improve the quality of care.

As will be discussed later in this report, the initial introduction of AN-ACC will increase care subsidies. However, that increase is expected to be consumed by required increases in direct care staffing minutes and the wage rates of the workforce for many providers, leaving little available to fund other improvements in quality of care and quality of life.

Current challenges and issues

This analysis has separately highlighted the financial challenges posed by current pricing arrangements around everyday living services, where regulation largely caps the revenue that homes can earn from the Basic Daily Fee.⁴³ Even so, there are strong community expectations that homes offer higher quality services, especially food and nutrition. However, even after the BDF supplement, the revenues for everyday living are not sufficient to cover the costs of current services. This means that homes may need to cross-subsidise from net savings from care services, which could compromise the quality of care provided, or alternatively draw on capital reserves or other business revenues of the providers, which could pose long-term financial viability issues.⁴⁴

Although homes can also earn revenue from providing 'additional services', such as pay-TV, alcohol with meals, hairdressing and other non-standard personal services, these have been hampered by a lack of clarity in government guidelines about allowable service offerings and their pricing.⁴⁵

The mid-year 2021–21 results suggest urgent reform is necessary around the pricing of ordinary and additional living amenities. Two recent alternative options that have been proposed are the deregulation of the basic daily fee for non-supported residents⁴⁶ or raising the maximum amount providers can charge for ordinary living amenities.⁴⁷ However, as noted in previous StewartBrown analysis, "a major issue is in relation to supported residents who, by majority, do not have the financial means to pay for additional services, or indeed pay a higher Basic Daily Fee". Accordingly, there may be a need for a taxpayer subsidy for supported residents to meet the cost of any amount above the basic daily fee.

The poor mid-year results suggest that there are significant concerns about the funding and business models of residential care.

^{43.} Everyday living revenue comprises the Basic Daily Fee which is capped at 85% of the Age Pension, the Basic Daily Fee supplement funded since July 2021 of an additional \$10 per resident per day, and fees for additional services over and above those prescribed by legislation.

^{44.} Aged Care Financing Authority (2021). The role of the Basic Daily Fee in Residential Aged Care.

^{45.} Aged Care Financing Authority (2021). Ninth Report on the Funding and Financing of the Aged Care Industry

^{46.} Tune, D.M. (2017). Legislated Review of Aged Care

^{47.} Royal Commission into Aged Care Quality and Safety. (2021). Final Report: Care, Dignity and Respect.

Figure 26 also highlights problems in the current arrangements for the pricing of accommodation payments and supplements in the low-interest environment that has prevailed to date. The December 2021 results support broader calls for accommodation pricing reform, including around the Maximum Permissible Interest Rate (MPIR) used to calculate the Daily Accommodation Payments (DAPs).

Looking across the sector more broadly, both residential and home care services are encountering increases in cost categories that are not directly linked with government funding or other revenue streams. This is evident, for example, in the persistence of COVID-related expenses (e.g. in PPE, infection control, testing of staff, costs associated with furloughed staff, supervising visitors), or the increases in administrative costs related to expanded quality, compliance and reporting activities. These costs are unlikely to recede in the future as they represent structural changes in the fundamental activities and operations required to provide aged care services that meet regulatory standards and community expectations of transparency and quality.

A further longer-term pressure centres on the capital financing necessary to fund major refurbishments and new infrastructure. Modelling reported by Aged Care Financing Authority suggests that there will be the need for refurbishment of 60,000 beds and an addition of 79,000 new places over the next decade.⁴⁸ This will require capital investment of an estimated \$55 billion. Investment in new technology, equipment, process improvement to increase quality of care, efficiencies and reduce operating costs will require further capital investment. However, the poor operational returns from aged care services makes attracting capital investment difficult, which will be an ongoing challenge moving forward.

The above pressures raise concerns about the longer-term sustainability of the current aged care system. A paper to be released in the near future by UARC will identify four significant dimensions of sustainability:

- 1. Fiscal sustainability being the taxpayer affordability of public funded services: now and over the longer term. As noted below, the drivers of the costs of aged care, including demographic and budgetary structural issues, make this a very real concern into the future.
- 2. Financial sustainability encompassing provider viability and confidence to invest: at sector level and for thin markets. The analysis provided in Part 1 demonstrates the very real financial pressures on providers, yet without a viable sector, senior Australians who rely on the publicly subsidised services will suffer from a reduced supply of care and support.
- 3. Workforce sustainability the ongoing availability of sufficient labour force with right skills, knowledge and attributes. Again, this report provides ample evidence of the current problems in accessing a highly capable workforce, and suggests the outlook is even more fraught.
- **4. Societal sustainability** the community being satisfied with the quality and safety of care and support for senior Australians in need while also considering that the costs and benefits of the system are distributed equitably and fairly across consumers, taxpayers and providers.

Current challenges and issues

In terms of fiscal sustainability, a principle driver of the demand for care and support to senior Australians is the demographic ageing of the population together with the health status of the elderly. Long term estimations of population growth suggest that the number of persons 85 and older will more than triple to 2.9 million by 2060 along with increasing levels of care needed for dementia and other chronic conditions.⁴⁹

Public expenditure on subsidised aged care is expected to increase from the current funding level of \$24.5 billion this financial year to \$33 billion in 4 years time and the 2021 Intergenerational Report projects that the expenditure will nearly double from 1.2% of GDP to 2.1% of GDP by 2060. Furthermore, the number of people of working age (who are also the source of personal income tax) will decline as a proportion of the Australian population, adding further pressure to the costs of attracting a sufficient and capable workforce. Over the same 40 year projection period, it is expected that the Australian Government will have continuous Budget deficits and its debt by the end of the period will approximate one third of annual GDP, thus severely constraining the fiscal scope to meet rising costs of aged care and other services.

To add to the downside, these projections seem to be conservative given the assumptions made in the IGR Report about the halting of current spending commitments and the lack of inclusion of costs associated with reform in the future, let alone the absence of realistic costing for climate change or the possibility of increased spending on defence. Another analysis suggests that aged care expenditure will increase at 7% per annum over the next 20 years and peak even higher, at 2.95% of GDP by 2050 (Actuaries Institute Green Paper).

These trends indicate that governments and oppositions need to accept that there is a significant challenge to each of the four dimensions of sustainability of the aged care services in Australia, and to enter into a meaningful and multi-layered discourse with industry stakeholders, senior Australians and the community more generally on the changes that will be required.

High on the agenda should be support for the personal health and independence of people as they age, so as to reduce the rate of growth of demand for aged care services, improvements to the effectiveness and efficiency of the services being delivered and establishment of more equitable funding where consumers, who have the capacity to pay, make fair contributions to the cost of the services they need, whilst maintaining appropriate safety nets for those with limited income and wealth.

Australia's aged care sector faces complex issues concerning the quality of care, the viability of providers, the availability of skilled workers and the fiscal sustainability of publicly funded services.

Workforce shortages

The aged care sector has been experiencing growing workforce challenges for a number of years, and these have been exacerbated by, but not due only to, the COVID pandemic. Looking into the future, both the demographics of an ageing population and expectations that staffing levels and wages must rise are likely to intensify workforce issues for providers.

The mid-year results reported in Part 1 of this report demonstrate that the first six months of 2021–22 have presented acute workforce challenges for aged care providers. Specifically, there has been:

- □ Slow annual growth of total direct care staffing minutes in residential care, increasing by only 1.9% over the year compared to December 2020, to an average of 178.0 minutes per resident per day.
- □ A further decline in the direct care staffing time in home care, though at a slower rate than the trend of the last five years. The latest fall was 1.6% from an average of 3.86 hours per client per week in December 2020 to 3.80 hours in December 2021. Over the last five years, direct care staffing hours per client per week in home care have fallen by 32.1%.

Although staffing time metrics are affected by various range of factors, such as aged care home occupancy or the demand for home care services that have different staffing requirements, the results align with reports from industry of significant staffing shortages across the sector.

Workforce shortages have been a perennial challenge within the aged care sector, which is a labour intensive activity. Some of the pre-existing long-term challenges in attracting and retaining quality staff have included poor renumeration and competition for care workers from other sectors, such as the higher comparative award rates being offered in the disability sector. Other long-term issues have been around working conditions including rostering and consistency of working hours, as well as poor perceptions about aged care work in terms of opportunities for career progression, poor training outcomes and negative public perceptions of the industry.⁵⁰

Over the last 18 months, these longer-term challenges have been compounded by the effects of the COVID-19 pandemic which has disrupted the supply of aged care workers:

- □ Border lockdowns have disrupted overseas migration pathways, an important source of aged care workers.
- □ Outbreaks of the Delta variant and then Omicron have reduced the number of available staff across the sector, with more staff away sick, furloughed or required to self-isolate.
- ☐ The supply of health care workers has been diverted towards COVID-related services and responses more generally, including in contact tracing, vaccination roll-outs and testing services.
- □ Working within aged care during the pandemic has placed substantial pressure on current aged care staff, potentially increasing the level of turnover. A recent survey conducted by the Australian Nursing and Midwifery Federation found that 21% of aged care staff reported planning to leave their position within the next 12 months and a further 37% of respondents saying they planned to guit the sector within the next one to five years.⁵¹

The demand for aged care workers will continue to grow as more senior Australians, with more complex health needs, seek to access aged care services. More workers are also required to meet community expectations for an improvement in the quality and safety of care services. At the same time, with demographic ageing, the cohorts in the workforce ages (largely 15 to 64), will be a reducing proportion of the population overall.

In the immediate future, providers' will need to expand their residential care workforce in the lead up to the incoming minimum staffing standards. In response to the Royal Commission⁵² the Government has committed to implementing three new mandatory standards from 1 October 2023:

- 1. providers must ensure residents receive, on average across the sector, at least 200 minutes of total care per day;
- 2. at least 40 minutes of that care must be provided by a registered nurse; and
- 3. a registered nurse must be on site for morning and afternoon shifts each day.⁵³

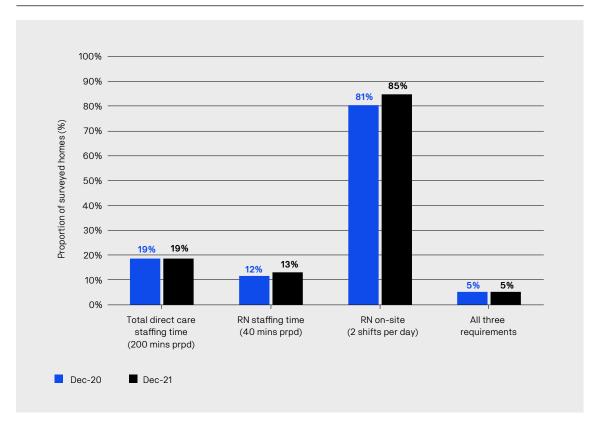
The exact minimum requirements for each residential aged care home will be adjusted to account for differences in the relative needs of their residents, as assessed using the AN-ACC classifications. Homes with residents with more complex needs will be required to meet a higher threshold for staffing time, whereas homes with residents with less complex needs will have a lower minimum requirement.

^{51.} Peters M.D.J., Marnie C.M. (2022). Australian Nursing and Midwifery Federation National Aged Care COVID-19 Survey 2022. Australian Nursing and Midwifery Federation.

^{52.} Recommendation 86 of the Royal Commission into Aged Care Quality and Safety. Final Report: Care, Dignity and Respect. Canberra: Commonwealth of Australia; 2021. Available at: https://agedcare.royalcommission.gov.au/publications/final-report

^{53.} Australian Department of Health. Australian Government Response to the Final Report of the Royal Commission into Aged Care Quality and Safety. Canberra: Commonwealth of Australia; 2021. Available at: https://www.health.gov.au/resources/publications/australian-government-response-to

Figure 27: Residential aged care homes with staffing above the sector average minimum staffing requirements



A simplified analysis which assumes that each home would need to meet the minimum requirements, irrespective of their AN-ACC assessment, is presented in Figure 27, which shows the proportion of surveyed homes that have staffing levels at December 2020 and December 2021 sufficient to meet each of the three incoming minimum standards, as well as all three requirements in combination.⁵⁴

As of December 2021, 85% of surveyed homes have sufficient staff to meet the RN on-site requirement but only 19% currently provide more than 200 minutes direct care time per resident per day and only 13% provide 40 minutes or more of RN time per resident per day. Furthermore, the far-right columns of Figure 27 show that only 5% of surveyed homes have a direct care workforce above all three thresholds in combination.

An important caveat is that there is insufficient data to assess the adequacy of each individual home's staffing, which will depend on their assessed AN-ACC scores. Nor is it possible to assess compliance with legislation that has not yet been implemented. However, despite these limitations, it is reasonable to conclude that there will need to be a significant increase in staffing levels across the sector.

^{54.} Note that no adjustment has been made for relative casemix levels of homes, although the expectation is at an industry level, the minimum standards will represent the average requirements across the sector. In addition, the requirement about the RN on-site for 2 shifts per day has been assessed based on whether a home had in excess of 16 RN hours per day. This is a generous test as it does not account for whether there was overlap in RN shifts or what shift these hours were worked. Therefore, Figure 27 likely overstates the number of homes exceeding the RN on-site requirement.

Only a small proportion of the sector currently meets all three requirements because different homes tend to fall behind on different standards. For example, while smaller homes tend to be able to meet the care time (minutes per day), they struggle to meet the RN on-site requirement, and vice versa for larger homes. Compared to larger homes (\geq 120 beds), smaller homes (< 40 beds) are more likely to meet the RN (29.6% vs 5.5%) and care (28.7% vs 21.5%) time (minutes per day) requirements, but less likely to meet the RN on-site requirements (39.8% vs 99.5%). Overall, smaller homes were more likely to meet all three requirements relative to their large home counterparts (13.8% vs 2.4%).

Other factors affecting staffing levels include the efficiency of the management and operation of individual homes, the design of the layout and fittings of homes and the availability of other revenue streams to cross subsidise an increase in direct care hours. More broadly, the Australian Government itself has acknowledged that current care funding is insufficient to meet the new standards and has committed an additional \$3.4 billion over three years specifically for that purpose.

Providers' readiness to meet staffing requirements over the coming years will be further challenged in the case that the federal opposition wins the upcoming election. If elected, the Australian Labor Party has committed to implementing the Royal Commission recommendations in full, requiring providers to:

- ensure residents receive, on average, at least 215 minutes of total care per day (by October 2024)
- 2. ensure that at least 44 minutes of that care must be provided by a registered nurse day (by October 2024); and
- 3. a registered nurse must be on site 24 hours a day (by July 2023).55

Analysis of the staffing metrics reported by surveyed homes as of December 2021 (similar to above), shows that only 10% of homes provide more than 215 minutes of total direct care time; 10.5% provide more than 44 minutes of registered nurse time and 71% could meet the RN onsite 24 hours a day requirement. Only 3% of surveyed homes have a direct care workforce above all three of Labors' thresholds in combination.

In addition, the challenges in attracting and retaining sufficient numbers of staff are likely to worsen in the future as home care providers' needs for aged care workers increase following the release of more Home Care Packages and an ongoing need for residential care for those needing 24/7 care. As of December 2021, 198,109 people were assigned a home care package, and following the announcements made in the 2021–22 Budget, the Government has committed to increasing this to 275,597 by June 2023 (39.1% increase over 18 months). ⁵⁶ The Grattan Institute has estimated an immediate need for 58,000 more carers by 2024–25. ⁵⁷

Looking further ahead, the Committee for Economic Development of Australia (CEDA) has estimated that to meet Australia's direct-care workforce needs by 2030 there will need to be a net increase of around 170,000 workers.⁵⁸ This equates to a required average annual growth rate in the number of direct care workers of approximately 7.1%.

^{55.} Australian Labor Party, Better Care, available at: https://www.alp.org.au/policies/a-nurse-in-every-nursing-home

^{56.} Department of Health, Home care packages program, data report 2nd Quarter 2021-22, available at: https://www.gen-agedcaredata.gov.au/www_aihwgen/media/Home_care_report/Home-Care-Data-Report-2nd-Qtr-2021-22.pdf

^{57.} Duckett, S. and Swerissen, H. (2021). Unfinished business: Practical policies for better care at home. Grattan Institute.

^{58.} Committee for Economic Development of Australia (2021) Duty of Care: Meeting the Aged Care Workforce Challenge.

Current challenges and issues

The financial impact of COVID-19

In the early stage of the pandemic, the Government provided COVID-specific funding to providers in the form of both targeted sector support and grants made available to the wider community. This support provided some financial relief, with COVID revenues exceeding COVID expenditure for residential providers in 2019–20 and 2020–21⁵⁹.

These temporary financial supports have been largely withdrawn since July 2021. As reported in Part 1 of the report, providers experienced a large decline in their financial performance relating to COVID-related income and expenses during the six months to December 2021. Specifically, COVID expenditure exceeded COVID revenues for age care service providers, with an overall net deficit of \$196k per provider reported for the first half of this financial year.

Specific grants remain available⁶⁰ to support residential providers in COVID 'hotspots' or those experiencing an active COVID outbreak. These grants provide reimbursement of additional eligible costs incurred as a result of the isolation of residents or staff members. However, additional costs incurred to prepare for and prevent outbreaks are excluded under this program.

This means that providers that have been proactive in managing infection control and are successful in avoiding outbreaks of COVID are unable to recoup this additional expenditure or losses of revenue through access to grants and subsidies. Proactive measures include providing Rapid Antigen Tests for staff use, purchasing additional personal protective equipment (PPE), and reducing income from scaling back residential respite services. Ongoing impacts include higher use of agency staff and additional hours worked to accommodate the furloughing of staff who are required to isolate and the implementation of single-site staffing initiatives. Some clients of home care services have been reported as seeking to minimise their potential exposure to infection by reducing their use of in-home services.

^{59.} See FY20 and FY21 Residential Care Reports.

^{60.} COVID-19 Aged Care Support Program Extension until 31 March 2022 and Support for Aged Care Workers in COVID-19 until 31 June 2022.

Financial pressures in regional, rural and remote residential care

As reported in Part 1, the financial performance of homes varies substantially by their geographic location (or degree of remoteness), with a general trend showing poorer performance of aged care homes outside the metropolitan centres.

To further understand the effects of location, analysis was conducted using the more granular classifications of remoteness of the Monash Modified Model (MMM). Within the MMM model, MM1 refers to metropolitan areas while MM2-7 are used to designate regional and rural locations of increasing remoteness.

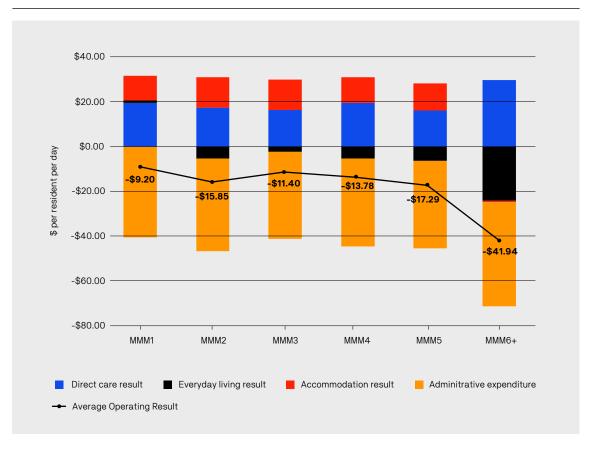
Table 14: Breakdown of average operating result of residential aged care homes, by MMM remoteness

	MMM1	MMM2	мммз	MMM4	ммм5	MMM6+	Survey average
Number of homes in survey	760	92	129	84	117	10	1,192
Breakdown of Operating Resu	It (\$ per res	ident per d	ay):				
Direct Care Revenue	196.11	191.20	187.84	186.83	187.72	236.29	193.70
Direct Care Expenditure	176.79	174.00	171.60	167.52	171.69	206.76	175.11
Direct Care Result	19.32	17.19	16.24	19.32	16.03	29.53	18.58
Everyday Living Revenue	66.14	63.17	64.13	63.24	63.30	62.82	65.18
Everyday Living Expenditure	65.01	68.56	66.48	68.71	69.69	87.07	66.35
Everyday Living Result	1.13	(5.39)	(2.35)	(5.47)	(6.39)	(24.25)	(1.17)
Accommodation Revenue	33.25	33.33	32.17	31.83	31.95	42.54	32.99
Accommodation Expenditure	22.34	19.58	18.55	20.22	19.78	43.30	21.49
Accommodation Result	10.97	13.76	13.61	11.61	12.17	(0.76)	11.53
Administration Expenditure	(40.61)	(41.41)	(38.90)	(39.24)	(39.11)	(46.47)	(40.29)
Average Operating Result (\$ per resident per day)	(9.20)	(15.85)	(11.40)	(13.78)	(17.29)	(41.94)	(11.34)

NOTE: for this analysis, administrative costs are treated as a separate line item and have not been allocate to Direct Care, Everyday Living or Accommodation results.

As with the analysis presented in Part 1, the average operating result across all location categories is negative, with the smallest net loss per resident per bed day attributable to homes in metropolitan areas (MM1). While the analysis presented in Part 1 suggested that homes in regional locations recorded greater losses than those in rural and remote locations, breakdown of this trend by MMM category presents a more nuanced pattern in which homes in large and medium rural towns (MM3 and MM4) recorded a smaller loss per resident per bed day than homes in either regional centres (MM2), or small rural and more remote locations (MM5-7).

Figure 28: Breakdown of average operating result of residential care for December 2021, by remoteness (MMM)



NOTE: for this analysis, administrative costs are treated as a separate line item and have not been allocate to Direct Care, Everyday Living or Accommodation results.

Across all locations, the main source of operating margin is direct care provision. Higher direct care results per resident per day were recorded by homes in metropolitan areas (\$19.32), medium rural towns (\$19.32) and remote areas (\$29.53), but with varying drivers. Homes in metropolitan and remote areas receive higher care subsidies, due in the former case to a more concentrated high care need cohort and in the latter to the availability of viability supplements. This is in contrast to homes in medium rural towns, which receive the lowest care subsidies but have proportionately lower expenditure on the delivery of ACFI services.

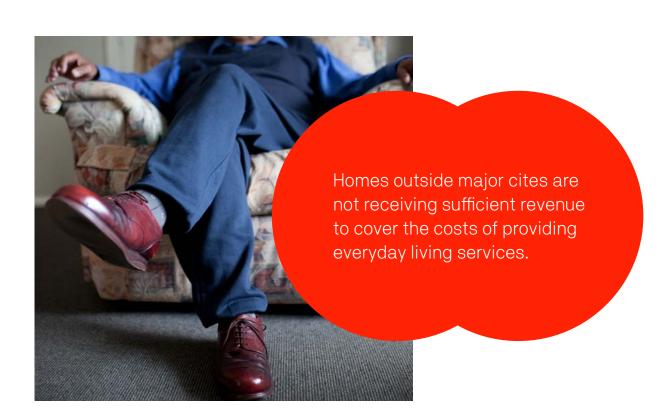
Accommodation provides a secondary source of operating margin for homes in all locations except for remote areas. This margin is lower for metropolitan areas, which appears to be the result of higher accommodation expenditure which is not fully recovered through proportionally higher accommodation revenue. Despite access to higher accommodation revenues, the

few homes in the sample in remote and very remote areas incur still higher accommodation expenditure and record a negative accommodation result of (\$0.76) per resident per day.

Homes in metropolitan areas achieve a small surplus of \$1.13 from their everyday living operations, while homes in all other locations are not receiving sufficient revenue to recover the costs of everyday living, which are higher outside metropolitan centres. These results incorporate the Basic Daily Fee Supplement, which is now being received by 99% of homes, and without which everyday living results would have been markedly poorer.

With the exception of those homes in remote locations (MMM6+), all homes incur a similar cost of administration. This cost, which is not directly factored into the specific revenue streams, currently exceeds the net operating margin generated by direct care, daily living and accommodation in all location categories. This result suggests that there are consistent problems with the funding and business models of residential care that are not fully attributable to location.

Breakdown of operating results by MMM location category and operating activity provides a contrast to popular narratives which suggest providers are able to profit from activities related to everyday living, while remaining cost-neutral in the delivery of direct care. This analysis suggests that providers across all locations make little to no margin on everyday living and that direct care provides the highest contribution to provider margins – albeit insufficient to return a positive operating result.



Policy and Reform Agenda

A new funding model for residential care (AN-ACC)

The Australian National Aged Care Classification (AN-ACC) funding model will replace the Aged Care Funding Instrument (ACFI) from 1 October 2022.

The Australian Government's stated aims of the new funding model are to: better match funding to residents' needs; create more independence in assessment; provide a new methodology for changes in prices, indexation and costs; and to allow for the distribution of funding uplifts, including the Basic Daily Fee supplement, additional care minutes funding and increases in respite funding.

Government decisions on the levels of funding for AN-ACC, and on the requirements of consumers with the capacity to pay to make higher co-contributions, will be the primary determinants of whether these aims are achieved. In the Australian Government Budget 2022–23 a base price of \$216.80 for AN-ACC was announced, with the average AN-ACC subsidy expected to be \$225 per resident per day. This represents an increase of 16.2% on the average ACFI revenue that homes received (\$193.70 per resident per day) in Dec-21.

During 2021 and 2022, shadow assessments are being conducted for all aged care residents to determine the variable component of the AN-ACC funding. Following the transfer from ACFI to AN-ACC on 1 October 2022 it is expected that from July 2023 the annual changes in AN-ACC prices will be informed by advice from the proposed new pricing authority. Pending passage through Parliament, the existing Independent Hospital Pricing Authority (IHPA), is to be renamed the Independent Hospital and Aged Care Pricing Authority (IHACPA), with responsibility to advise on aged care pricing issues for both residential and at home care.

The impact of the announced increase in funding for providers may not be as significant as the level of increase suggests.

- □ It is expected that the funding uplift will be largely consumed by increases in total direct care staffing minutes to meet the minimum staffing standards in force by October 2023. In the intervening period, the sector will need to increase total direct care by an average of 22 minutes per resident per day (approximately 12.4%) and RN minutes by 11.8 minutes (41.8%).
- ☐ The AN-ACC amount already includes the \$10 uplift in the Basic Daily Fee announced as part of the 2021–22 Budget, which will need to be allocated against everyday living costs to help reduce the losses on that activity.
- □ In the coming 18 months, providers potentially face further increases in staffing costs if award rates are raised as a result of the Fair Work Commission case and if new requirements to have an RN on-site 24/7 are introduced. That is, these two factors have not been incorporated into the initial AN-ACC price and would have to be funded separately if implemented.

The Government has also committed to ensuring that the AN-ACC funding model Base Care Tariffs increase funding and support to regional, rural and remote services, reflecting their additional costs of care delivery.

The Government's aims for AN-ACC, as reported at the start of this section, are unlikely to succeed if the level of public funding and consumer co-contributions, together with any increases in effectiveness of the services and efficiency of delivery, do not match the expected increases in costs.



Fair Work Commission wage case

A case to vary minimum wages for aged care employees is currently being considered by the Fair Work Commission.

The application by the Health Services Union and the Australian Nursing and Midwifery Federation was first made in 2020 in regard to the Aged Care Award 2010, and modified in 2021 to include those parts of the Nurses Award 2010, and the Social, Community, Home Care and Disability Services Industry Award 2010, that apply to employees in the aged care sector. Among the grounds cited in the application to increase the minimum wage for aged care employees is that this variation would give effect to Recommendation 84 (titled "Increases in award wages") of the Royal Commission into Aged Care Quality and Safety Final Report.

The hearing of evidence by the Fair Work Commission is scheduled from 26 April 2022 to 11 May 2022, with an oral hearing on 6 and 7 July 2022 and a decision is expected subsequently.

If successful in full, this application would have the effect of increasing the minimum wage for personal care workers and nurses in both residential and home care by 25%. For a full-time, entry level personal care worker paid the minimum amount specified by the award this would result in an increase in base weekly wages from \$834.60 to \$1,043.30. For a full-time, specialist personal care worker, base weekly wages would increase from \$973.40 to \$1,216.80.

The policy elements of this application and its outcome are many and varied. Whatever the outcome, the Australian Government will need to decide on the additional funding that it provides and whether that meets the full impact of the Commission's ruling. Another policy implication is the sustainability of the aged care workforce, as noted above, which is under pressure in part due to currently poor pay and conditions, and yet those pressures would grow if the wage increase is insufficient for the sector to be competitive for labour. Equally, fiscal sustainability will be under greater strain if the increase in public funding is significant, whilst provider viability pressures would be exacerbated if revenue fails to cover any increases in cost.



Policy and reform agenda

Support at Home **Program**

The Government has announced that the Support at Home Program will replace the Commonwealth Home Support Program (CHSP), the Home Care Packages (HCP) Program, Short-term Restorative Care (STRC) and residential respite programs from July 2023.

Key features of the proposed unified program include a single assessment system using a new Integrated Assessment Tool, which provides input into the development of an Individualised Support Plan for each care recipient. Services included in each Plan will be populated from a new Service List, with subsidies set by the Government according to service type and incorporated into a price schedule. A Point of Delivery Payment Platform is being developed to facilitate the real-time payment of both subsidies and client contributions.

Given the start date of July 2023, the Department of Health is consulting with key stakeholders in 2022. In January 2022 the Department released its 'Support at Home Program Overview' which outlines some of the key challenges with current arrangements and describes a generalised proposed design of the new program.⁶¹ While the program seeks to combine the different non-residential care programs, the program overview raises several concerns.

First is there is some confusion over the roles and responsibilities of assessors, care managers, providers, and client self-management. There are questions around the alignment between assessment and delivery, the relationship between assessors and care managers, and the policies and procedures to be followed in the case of inappropriate assessment or when reassessment is necessary. Furthermore, an understanding of the needs of the client may be problematic given the limited exposure that assessors will have as opposed to care providers. Related to this is the risk associated with the reduction in the role of a care manager, in particular clinical management. The danger is that personal care will be provided via a 'gigeconomy' model which raises quality and accountability issues.

A second concern relates to the challenge and complexity of the provision of services, given that the inflexibility of the system as currently designed has the potential to reduce the provision of individualised care. A third concern relates to the proposed integrated payment model mechanism for collecting contributions, with unanswered questions about the extent to which the Government will be able to take on this task which is currently undertaken by providers.

A final concern is the process and speed of transition, given the size of the reform and the significant potential for disruptive consequences for both senior Australians who are receiving care and providers who deliver the care. To date, there is limited guidance available in regard to the process for transitioning existing clients from CHSP and HCP arrangements onto the new Support at Home Program.

^{61.} Department of Health (2022), Support at Home Program Overview, available at: https://www.health.gov.au/sites/default/files/ documents/2022/01/support-at-home-program-overview.pdf

New reporting and accountability requirements

The Government has introduced a range of new reporting measures as part of its response to the Royal Commission and the implementation of the aged care reform package. These will require several additional information inputs from approved providers, and while greater transparency and accountability are generally positive initiatives, they also come at a cost by consuming more staff time and financial resources relating to administration and compliance activities.

First, approved providers who receive the new Basic Daily Fee Supplement of \$10 per day per resident, effective from 1 July 2021, must enter into an undertaking with the Department of Health and report quarterly on their food and nutrition expenditure, and the quality of daily living services provided to residents.

Second, from 1 July 2023 there will be a Quarterly Financial Reporting regime. The key changes involve the collection and reporting of residential segment income and expense statements at the facility level; the collection and reporting of additional items relevant to prudential compliance and viability; and consolidated group level segment reporting. This will include information about direct care revenue, expenses and staffing hours (in both residential and home care), approved provider consolidated balance sheets and profit and loss statements, as well as information about expenditure on food and living services. The new requirements relating to residential income and expense statements mean that providers have to capture and report expense data in more detail than currently required and at the facility level.

Third, the new Star Rating system is being developed in order to provide improved consumer information. It will combine data from mandatory quality indicators; service compliance ratings; consumer experience; and staff minutes of care (drawn from the Quarterly Financial Reports and Aged Care Financial Reports). The Department of Health has also foreshadowed the possibility of incorporating more data items into the Star Rating. Star Ratings will be published from the end of 2022.

Finally, the Australian Government will require providers to provide a monthly care statement to residents and their families, outlining the care they have received and any significant changes or events during the month. This was initially planned to come into effect in July 2022. However, based on feedback from industry groups about the lead times required to implement appropriate systems and practices, the Department of Health has advised that a staged approach will now occur, including an initial pilot stage.

Budget 2022–23 and election commitments about aged care

The Australian Government's Budget 2022–23 included announcements for a modest range of additional aged care measures, to extend upon the \$18.8bn package of spending announced the year before. The most significant additional measures relating to the five pillars of reform included:

- □ \$345.7m (over 4 years) to embed on-site pharmacists and community pharmacy services within residential aged care homes from 1 January 2023. This is a response to Recommendations 38 and 64 of the Royal Commission, which aimed at improving the provision of allied health practitioners within residential care and in particular address problems in medication use and management.
- □ \$49.5m (over 2 years) to provide an additional 15,000 low and fee-free training places in aged care courses from January 2023 through JobTrainer. This complements the 33,800 training places announced in the 2021–22 Budget.
- □ \$32.8m (over 4 years) to provide additional clinical placements for students in the care and support sectors. This includes \$14.9m to address barriers to clinical placements in the care and support sector, with the intent to attract 5,250 more nurses, as well as \$14.3m to expand the Rural Health Multidisciplinary Training (RHMT) Program.
- □ \$22.1m (over 3 years) to trial multidisciplinary outreach services for residential care, with multidisciplinary care teams and access to hospital-based specialists, allied health and palliative care specialists.
- □ \$21.6m further funding for the Third Party Quality and Assessment Workforce to undertake quality audits in residential care and increase quality and safety assessments.
- □ \$20.1m further funding to the AN-ACC Transition Fund (bringing the total to \$73.4m) to assist providers who may need financial support to adjust to the new residential care funding model. Over the next two years, eligible providers will be able to apply for support from the Fund through non-competitive grants.
- □ \$18.3 million over 2 years from 2021 22 to extend arrangements for the third party Quality Assessor surge workforce to conduct residential aged care site audits.
- □ \$10.8 m for the Cross Agency Taskforce on Regulatory Alignment to improve the alignment of regulation between aged, disability and veterans' care sectors, recognising that many providers service at least one other part of the sector.
- □ \$6.9m for a national Co-Operative and Mutual Enterprises Support Program to support and grow aged care organisations owned and run by members.
- □ \$6.1m to continue the initial rollout of Department of Health regional teams
- □ \$5.4m to support continued consultation activities on the new Support at Home Program, focusing specifically on the new regulatory framework for aged care.



In addition, the Budget also included additional funding measures related to COVID-19 pandemic. These included:

- □ \$215.3m to provide COVID-19 related bonuses of up to \$800 to eligible aged care workers in residential and at home care in 2022.
- \$124.9m to extend the Aged Care Support Extension Program grant until 31 December 2022, where providers may apply for reimbursement of eligible expenditure incurred in managing direct impacts of COVID-19 outbreaks within their homes, and access surge workforces.
- □ \$50.4m (over 4 years) for 4000 training places for aged care RNs to become Authorised Nurse Immunisers (ANIs), so as to help dispense vaccinations within residential aged care homes.
- □ \$37.6m (over 2 years) to support 2,900 aged care nurses to access infection prevention and control training.
- \$22.1m for PCR testing within residential aged care homes until 30 September 2022.
- □ \$7.9m for Primary Health Networks (PHNs) to deploy medical deputies, nurse practitioners and practice nurses to conduct home visits to COVID-19 positive patients in residential aged care homes.

Policy and reform agenda

In his budget reply, Anthony Albanese announced several further elements of the federal opposition's plan for improving aged care. If elected, the Labor Party has committed to the following:

- □ \$2.5bn to increase the minimum staffing standards, by requiring an RN to be onsite 24 hours a day, 7 days a week from July 2023. Labour has also committed to implementing the recommendation from the Royal Commission that total direct care time be at least 215 minutes per resident per day, with 44 minutes provided by an RN, by October 2024.
- ☐ Supporting the aged care workers' case before the Fair Work Commission and a commitment to fund the outcome.
- □ Establishing a national registration scheme for personal care workers from mid-2023, including requirements for ongoing training, criminal history screening, English proficiency and a new code of conduct.
- ☐ Implementing a direct employment preference from January 2023 that prioritises providers' use of regular workers over temporary staff.
- □ New mandatory aged care food standards
- ☐ Mandatory public reporting by residential care providers of a breakdown of their expenditure on care, nursing, food, maintenance, cleaning, administration.
- □ A new General Duty of Care, including a compensation regime, criminal and civil penalties for breaches of care.
- □ Improving the complaints process, including a new aged care complaints commissioner within the Aged Care Quality and Safety Commission by late 2022, as well as new legal protections for whistle blowers and complainants.
- Increasing investigative powers for the Aged Care Quality and Safety Commission, including powers to enter and remain in an aged care facility at any time and access documents and records.
- □ Introducing a cap on Home Care administration and management fees and a requirement that home care providers to issue recipients with a monthly breakdown of fees and services delivered.

Appendix: Methodology

The numbers provided in this report for aged care providers, homes or services are calculated at the unit specified in the sample summary each section and aggregated using simple averages or medians as stated. Ratios are calculated using the same methodology and the average of the ratio will not perfectly correspond to the average numbers included in the ratio.

Numbers applicable to all providers (e.g., service revenue) and totals (e.g., EBITDAR) are averaged across only those aged care providers, homes or services that provide data for that line item, which may differ from the headline sample size provided. All other measures are averaged across all the homes in the particular group that incur the cost. The average by line item is particularly useful for line items such as contract catering, cleaning and laundry, property rental, extra service revenue and administration fees as these items are not supplied by all survey participants. Below is a detailed description of the methodology for each section.



Provider analysis

For aged care providers, provider-level averages are calculated by using the aggregate total of any one-line item across all providers, and dividing by the number of providers in the sample.

Residential care analysis

For residential care, all facility-level averages are calculated, in general, by using the aggregate total of any one-line item across all aged care homes in the group, and dividing by the number of aged care homes in the sample. For many line-items, the facility-level raw data is first transformed into a rate per occupied bed day, by dividing the raw data submitted for any one-line item by the occupied bed days for that aged care home. For example, the facility-level average for contract catering would be calculated by first transforming the raw total amount submitted for that line item into a rate per occupied bed day for each aged care home, and then used to calculate the average rate per occupied bed day across all homes in the sample.

Home care analysis

For home care, all service-level averages are calculated, in general, by using the aggregate total of any one-line item across all home care services, and dividing by the number of home care services included in the sample. For many line-items, the service-level raw data is first transformed into a rate per client days, by dividing the raw data submitted for any one-line item by the number of client days for that home care service. For example, the service-level average for sub-contracted and brokerage costs would be calculated by first transforming the raw total amount submitted for that line item into a rate per client day for each home care provider, and then used to calculate the average rate per client day across all services in the sample.

Editorial board

Professor Michael Woods (Chair)

Mike is a Professor at the UTS Centre for Health Economics Research and Evaluation, focusing on aged care. He was a former Deputy Chair of the Productivity Commission and has held appointments to Government Boards, health and aged care policy reviews, multilateral development agencies and foreign government reform programs.

Professor David Brown (Deputy Chair)

Professor David Brown is Professor of Management Accounting in the UTS Business School. His research focuses on the design and use of accounting systems for decision making in organisations with an interest in business models and determinants of performance. He has published research internationally.

Grant Corderoy

Grant is the Senior Partner at StewartBrown and would be regarded as being one of the foremost financial and policy authorities for aged and community services in Australia.

Professor Deborah Parker

Professor Deborah Parker is a Professor of Nursing Aged Care (Dementia) in the Faculty of Health at UTS. Her primary research is in palliative care for older people. She has published and is recognised both nationally and internationally. Her research incorporates her clinical background. She is former President of Palliative Care NSW and is a member of the Palliative Care Nurses Association, Australian Association of Gerontology and the Australian College of Nursing.

Research team

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Dr Nicole Sutton is a Senior Lecturer in management accounting at the UTS Business School. Her research examines the design and use of accounting systems to support decision making within and across organisations. She has published research internationally. In 2019, she joined the Management Committee of Palliative Care NSW as Treasurer.

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Dr Nelson Ma is a senior lecturer in financial accounting at the UTS Business School. His research focuses on understanding the drivers of financial outcomes in organizations and the role of institutions in assuring the quality of financial outcomes of publicly listed companies. He has published research internationally.

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Dr Jin Sug Yang is a researcher in the UTS Business School, having completed his PhD at UTS and his research interest is in financial accounting, corporate governance and aged care. He is currently involved in several projects investigating the business model and financial outcome of Australian aged care providers.

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Dr Rachael Lewis is a lecturer at the UNSW Business School. She conducts research into the role of management accounting in shaping managerial cognition. She specialises in understanding how managers think and make decisions, with a particular interest in the development of expertise. Her PhD research examined the use of performance measurement and other management systems in an aged care setting.

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Dr Gillian McAllister is a Senior Researcher at the UTS Business School. Her research interests examine organisational practices and structures along with public policy development and impact. She has extensive experience on both research and consulting.

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