



# Australia's Aged Care Sector: Full-Year Report 2021–22

For the 12 months ending  
30 June 2022



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#### **Disclaimer**

Parts of this report are based on the results of a data collection undertaken by StewartBrown within the aged care sector. Although the data set 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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**Australia's  
Aged Care Sector:  
Full-Year Report  
2021–22**

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# Table of Abbreviations

<b>ACAR</b>	Aged Care Approvals Rounds
<b>ACCPA</b>	Aged & Community Care Providers Association
<b>ACFI</b>	Aged Care Funding Instrument
<b>ACFPS</b>	Aged Care Financial Performance Survey
<b>ACSA</b>	Aged & Community Services Australia
<b>ANMF</b>	Australian Nursing & Midwifery Federation
<b>ANZSCO</b>	Australian and New Zealand Standard Classification of Occupations
<b>ASX</b>	Australian Securities Exchange
<b>BDF</b>	Basic Daily Fee
<b>CCIWA</b>	Chamber of Commerce and Industry of Western Australia
<b>CEDA</b>	Committee for Economic Development of Australia
<b>CHSP</b>	Commonwealth Home Support Programme
<b>COTA</b>	Council On The Ageing
<b>DAP</b>	Daily Accommodation Payments
<b>DOHAC</b>	Department of Health and Aged Care
<b>DSOA</b>	Disability Support for Older Australians
<b>EBITDA</b>	Earnings Before Interest, Taxes, Depreciation and Amortisation
<b>EBITDAR</b>	Earnings Before Interest, Taxes, Depreciation, Amortisation, and Restructuring and Rent
<b>FTE</b>	Full-Time Equivalent
<b>FWC</b>	Fair Work Commission
<b>GDP</b>	Gross Domestic Product
<b>HCP</b>	Home Care Package
<b>HSU</b>	Health Services Union
<b>IHACPA</b>	Independent Health and Aged Care Pricing Authority
<b>LASA</b>	Leading Age Services Australia
<b>MMM</b>	Modified Monash Model
<b>NDIS</b>	National Disability Insurance Scheme
<b>OPAN</b>	Older Persons Advocacy Network
<b>PCW</b>	Personal Care Worker
<b>RAD</b>	Refundable Accommodation Deposits
<b>RN</b>	Registered Nurse
<b>SCHCADS</b>	Social, Community, Home Care and Disability Services
<b>SIRS</b>	Serious Incident Response Scheme
<b>STRC</b>	Short Term Restorative Care
<b>TAFE</b>	Technical And Further Education
<b>UARC</b>	UTS Ageing Research Collaborative
<b>UWU</b>	United Workers Union

# Editorial Board Foreword

Welcome to the 2021-22 Full-year Report on Australia's Aged Care Sector. This is the second edition of the biannual report published by the UTS Ageing Research Collaborative (UARC). The report provides an independent assessment of the sector's performance across the 2021-22 financial year, commentary on the sector's key policy and operational issues and the results of new research into the aged care workforce.

The Editorial Board and authors noted that many interested parties responded positively to the report's first edition and that it was referenced in many publications and presentations. The Board acknowledges the academic excellence and commitment of the Report's lead authors, Dr Nicole Sutton and Dr Nelson Ma, as well as the invaluable contributions of the other authors. UARC's partnership with StewartBrown underpins the quality and data integrity of much of the Report, and that relationship continues to deepen.

This second edition chronicles the ongoing decline in the financial situation facing the sector's providers, of whom over 60% operated at a loss. The financial performance of residential aged care in particular is unsustainable, with 67% of homes operating at a loss. The sobering details are analysed in depth in the Report, as are several policy relevant conclusions.

On the policy front, UARC notes that many residential care providers have regularly criticised



The report presents readers with an independent assessment of the sector's performance across the 2021-22 financial year.

the inadequate indexation of direct care funding as being the primary reason for their declining overall performance. While the data supports this view at one level, this report's analysis shows that direct care revenues and expenditures in 2021-22 are now in broad balance. The analysis also demonstrates that the most significant loss-making activity has been, and still is, the unprofitable provision of accommodation but that it can no longer be cross-subsidised from direct care surpluses. Readers can expect future reports to explore improvements to the efficiency and funding of the accommodation side of the business.

The Report also explores the impact of AN-ACC and the starting price, as well as the role to be played by the Independent Health and Aged Care Pricing Authority (IHACPA) in reviewing the adequacy of direct care funding in the face of rising costs. The quality and transparency of IHACPA's advice to the Government will be closely monitored, as will the Government's response to that advice.

As widely anticipated, the new Labor Government's first Budget focused on delivering its election promises while not adding to expenditure beyond what it deemed necessary to address a range of immediate concerns. However, structural issues such as the impacts of demographic change also require attention and must be balanced against the need for budget repair. Aged care will not be exempt from ongoing fiscal conservatism, and the sector's viability depends on the sorts of policy settings and provider actions that UARC advocated in its Sustainability Discussion Paper released earlier this year.

The Report presents the results of UARC's latest research into one of the sector's most immediate and pressing issues – shortages across the aged care workforce. With staff reporting increased pressure, the greater use of overtime and agency staff has little longer-term merit. Solutions need to include, but reach beyond, significantly improved wages and conditions. Providers need to deliver services of high repute and develop supportive workplace cultures so that they are seen as employers of choice in an increasingly competitive labour market.

We welcome your feedback on this second edition and your suggestions for improving the Report's relevance to you. Please reach out to the Editorial Board and UARC team at: [uarc\\_inquiries@uts.edu.au](mailto:uarc_inquiries@uts.edu.au)

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**Professor Mike Woods (Chair)**

On behalf of the Editorial Board and the UTS Ageing Research Collaborative  
24 November 2022

# Executive Summary

**This 2021–22 Full-year Report on Australia’s Aged Care Sector is the second edition of the biannual report published by the UTS Ageing Research Collaborative (UARC).**

Independent analysis by UARC researchers of the June 2022 StewartBrown financial data shows that the performance of approved providers in 2021-22 has continued to deteriorate. Over 60% of providers reported a negative operating result (compared to 50% the year earlier), with an average annual operating deficit of \$3.2 million. Providers’ persistently low profit margins and returns on assets are unsustainable and thus pose an ongoing problem in ensuring older Australians receive the quality and quantity of subsidised care that they need.

The residential care situation is particularly challenging, with 67% of aged care homes operating at a loss. On average, each home lost \$16.13 per day for each resident under their care. Nationwide occupancy declined to 91.1%, contributing to homes’ poor financial returns as they struggled to recoup fixed and semi-variable staffing and other costs of delivering care. The worst financial performance continues to be reported by homes that are either smaller in size or located outside major cities.

In home care, the Operating Result declined to an average of \$3.42 per client per day, representing an average margin of just 4.1%. This decline was primarily due to a year-on-year revenue contraction, which was also reflected in falling rates of package utilisation and rising values of unspent funds. Looking forward, unification of four major in-home care programs provides an important opportunity to redesign services to meet older Australians’ needs while also reflecting the interests of providers and Australian taxpayers.

More detailed analysis of the financial issues within residential care reveals that successive years of accumulated operating losses have intensified viability concerns. Over the last three financial years, homes have lost an estimated \$2.75 billion, despite substantial inflows of additional taxpayer funding. There are varied reasons for these persistently poor outcomes, including declining occupancy, financial impacts of the COVID-19 pandemic and the low indexation of subsidies that have not kept pace with the rising costs of care.

Analysis by UARC researchers of the newly commenced AN-ACC funding model indicates that the initial price settings may not be sufficient to meet the inflationary and wage costs which have accelerated in 2022. While the new Independent Health and Aged Care Pricing Authority will address such issues, future direct care funding will likely be set much closer to a level of cost recovery, as has been the result for 2021-22. Homes will no longer be able to use surpluses from direct care to cross-subsidise losses they incur in other areas, as has occurred in prior years.

The financial viability of residential care will require particular reform of the funding and pricing settings for accommodation and indirect care services. The losses from accommodation services, which averaged \$12.23 per resident per day in 2021–22, currently represent approximately three-quarters of homes' total operating deficit. Structural reform of accommodation funding, such as a range of rental options, could better align the revenue streams to meet the costs of accommodation, including investment in more efficient and fulfilling residential environments. In providing indirect care services, homes lost an average of \$5.13 per resident per day in 2021–11, even after receiving the \$10 daily basic fee supplement. Given community expectations that homes continue to improve service quality, policy could attend to several existing proposals to improve the viability of these services.

With the new minimum direct care staffing requirements becoming mandatory next financial year, there will need to be a substantial staffing uplift. Analysis by UARC researchers shows that while more than three-quarters of homes have staffing sufficient to meet the 24/7 registered nurse on-site requirement, only 18.5% currently meet their incoming registered nurse care minutes target, and only 17.1% meet their total care minutes target. In combination, only 4.7% currently meet all three requirements. UARC estimates that meeting the incoming standards will require at least 17,953 additional direct care workers (FTE), including 6,922 registered nurses (FTE).

Aged care providers must also come to grips with a vast array of other policy and reform initiatives, including those contained in the Labor Government's recent legislation such as caps on fees in home care, additional public reporting requirements, and the Star Ratings system. Other issues include the Support at Home Program redesign and the Government's response to the Fair Work Commission wage case outcome. All of these matters will have both short-term and long-ranging impacts across the sector.

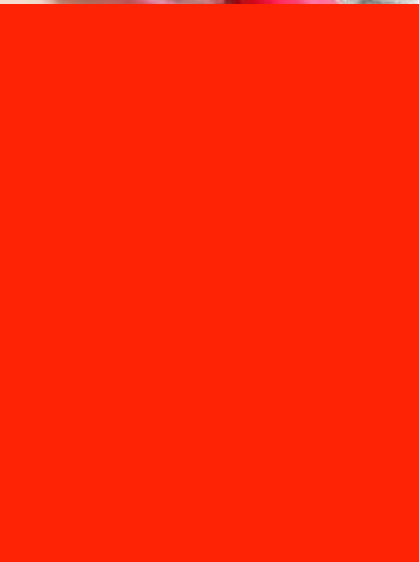
Finally, the aged care workforce challenges during the last financial year (2021-22) have resulted in both residential and home care providers reporting widespread skill shortages, particularly in direct care roles. The analysis conducted by UARC researchers shows that these shortages had varied impacts, including increasing the pressure on existing staff and greater time being spent on recruitment activities. One particular concern is the high staff turnover rates, averaging 37.6% per annum in residential care and 41.9% per annum in home care. With such challenging labour markets, many providers rely increasingly on non-standard employment models. These findings were complemented by an analysis of the long-term trend data that shows an acceleration of overtime and agency staffing in residential care and brokered staff in home care.

The heavy reliance on overtime and indirect employment poses potential problems for the continuity of care for residents, the financial viability of providers and the well-being of staff. However, our analysis also suggests that these employment trends are symptomatic of two fundamental challenges requiring urgent attention: chronic shortfalls of aged care workers and unsustainable levels of staff turnover. Improving the recruitment and retention of aged care workers will require sector-level changes, including award rates and training pathways, as well as organisational-level investments by providers to become employers of choice.

Over the last three financial years residential aged care homes have lost an estimated \$2.75 billion, despite substantial inflows of additional taxpayer funding.

Part  
**1**

# Analysis of the StewartBrown sector data set



Part 1 of this report analyses the June 2022 StewartBrown large-scale sector data set contributed to by aged care providers within Australia. StewartBrown conducts a subscription-based quarterly data collection and analysis, enabling aged care providers to track their performance over time and benchmark their operations against other providers.

The data covers the entire 2021–22 financial year. The analyses have been conducted at three levels:<sup>1</sup>



→ **Approved provider:** which reports on the financial outcomes of approved providers that 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 (HCPs).

The data set does not cover the care and support provided by state government-owned agencies, the Commonwealth Home Support Programme (CHSP), or other subsidised programs. From mid-2024, the Australian Government intends to amalgamate the HCP program and CHSP, together with Short-term Restorative Care and residential respite, into a single unified 'Support at Home' Program. The data set 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 the Appendix at the end of this report.

1. For example, many participant contributors to the data set 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.

# Approved Provider Analysis

## Overview

▶ The FY22 data set includes 249 approved providers, representing 17.1% of the 1,457 residential and home care services providers in Australia.

▶ The overall financial performance of participating providers continues to deteriorate. 61.5% of providers reported a negative Operating Result in 2021–22 with an average deficit of \$3.2m and a median return on assets of negative 1.6%.

▶ Providers reported an average Operating EBITDAR of \$607k in 2021–22 which is 44.2% lower than the prior year. The median EBITDAR profit margin was 0.9%.

▶ Employee expenses continue to grow, representing approximately 71.8% of total operating revenue.

▶ Providers' liquidity decreased slightly. However, the median ratio of cash to debt of 46.7% is still well above thresholds indicating prudential risk.



## 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.<sup>2</sup> Subsequent sections of Part 1 of this report will explore the outcomes for residential care and home care services separately.

**Table 1: Profile of contributing approved providers**

	FY22	FY21
Number of providers in data set	249	249
<b>Ownership</b>		
For-profit	10.0%	10.0%
Not-for-profit	90.0%	90.0%
<b>Staffing</b>		
Average number of staff (headcount)	640	633
Average number of full-time equivalent staff (FTEs)	407	399
<b>% of Providers with residential aged care homes</b>		
Average number of residential aged care homes	4	4
Average number of residential operational beds	345	348
<b>% of Providers with home care operations</b>		
Average number of home care packages	543	506

This section analyses the outcomes of 249 approved providers based in Australia who contributed to the June 2022 StewartBrown full-year data set. This represents 17.1% of the total 1,457 providers of residential and home care services in Australia as of June 2022.<sup>3</sup> As shown in Table 1 the majority (90.0%) of these providers are not-for-profit, and the remainder (10.0%) are private, for-profit providers. As of June 2022, contributing providers employed an average of 640 staff (407 FTE staff). Almost all (96.4%) offered residential aged care services, each operating an average of 4 homes and 345 beds. Just under half (45.0%) of providers offered home care services, up from 41.8% in June 2021, and serviced an average of 543 packages.

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

3. Department of Health and Aged Care (2022), *Operational providers, 30 June 2022*, Australian Institute of Health and Welfare.



## Approved Provider Analysis

# Financial performance

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

Table 2: Average profit and loss results for approved providers

	FY22	FY21
<b>Revenue</b>		
Service revenue (\$'000)	\$52,954	\$49,611
Investment revenue (\$'000)	\$535	\$941
Total operating revenue (\$'000)	\$53,489	\$50,552
<b>Expenses</b>		
Employee expenses (\$'000)	\$38,685	\$36,123
Depreciation and amortisation (\$'000)	\$4,129	\$3,767
Finance costs (\$'000)	\$583	\$410
Other expenses (\$'000)	\$13,255	\$12,012
Total operating expenses (\$'000)	\$56,651	\$52,312
<b>Operating Result (\$'000)</b>	<b>(\$3,163)</b>	<b>(\$1,760)</b>
Net non-recurrent income (\$'000)	\$1,269	\$1,963
<b>Total Result (\$'000)</b>	<b>(\$1,893)</b>	<b>\$203</b>
<b>Operating EBITDAR (\$'000)</b>	<b>\$607</b>	<b>\$1,088</b>
Net non-recurrent income (\$'000)	\$1,269	\$1,963
EBITDAR (\$'000)	\$1,876	\$3,051
<b>Ratios (Medians):</b>		
Operating Result Return On Assets (ROA)	(1.6%)	(0.9%)
Operating EBITDAR Return On Assets (ROA)	0.3%	0.5%
Operating EBITDAR Profit Margin (%)	0.9%	2.0%
Employee expenses (as % of operating revenue)	71.8%	71.6%
Depreciation expense (as % of property assets)	3.6%	3.5%



The results reported in Table 2 show that for the 2021–22 financial year, the overall financial performance of the surveyed approved providers has declined relative to the prior year. Specifically, providers reported an average Operating Result<sup>4</sup> deficit of \$3.2m for 2021–22, compared to an average deficit of \$1.8m in 2020–21. This resulted in a median return on assets of negative 1.6% in 2021–22 (compared to negative 0.9% in 2020–21). Overall, 61.5% of providers reported a negative Operating Result in 2021–22, up from 50.2% the year before.

The decline in the Operating Results is concerning, given that eligible providers have received increased funding from the basic daily fee supplement since July 2021. Declining profitability is thus attributable to the 8.3% year-on-year growth in total operating expenses, which outpaced the 5.8% annual increase in operating revenue.

Providers' employee expenses are the largest cost category, comprising approximately 71.8% of total operating revenue.<sup>5</sup> In the last financial year, total employee expenses grew by 7.1% from an average of \$36.1m in 2020–21 to \$38.7m in 2021–22, which outpaced the 2.0% annual growth in FTE staff. This suggests that providers are experiencing wage pressures and possible skill shortages (an issue described in Part 3).

Furthermore, depreciation and amortisation expenses grew by 9.6% to an average of \$4.1m per provider in 2021–22. The depreciation expense ratio of 3.6% (2021–22) suggests that providers are expensing long-term assets (including buildings, equipment and furniture), assuming an average remaining useful lifetime of approximately 27.5 years. This assumption likely underestimates providers' actual future capital infrastructure and financing needs.

The Operating EBITDAR<sup>6</sup> results for 2021–22 show that providers earned an average of \$607k for 2021–22, which was 44.2% lower than the prior year. Furthermore, the median EBITDAR profit margin decreased to 0.9% (2021–22) from 2.0% (2020–21), again indicating that provider costs have been growing faster than revenue.

- 
4. 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). By comparison, the Total Result shows the Operating Result net (i.e. inclusive) of non-recurrent revenues and expenses.
  5. These are self-reported figures from contributing approved providers, and while all efforts have been taken to ensure the integrity of the data, it should 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.
  6. 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. 'Operating EBITDAR' also excludes all provider-level revenue and expenditure, including fundraising revenue, revaluations, donations, capital grants and sundry revenue.



## Approved Provider Analysis

Providers' employee expenses comprise 71.8% of total operating revenue. Last financial year they grew by 7.1%, outpacing the 5.8% growth in revenue.

The median Operating EBITDAR return on assets declined to just 0.3% in 2021-22. This represents a very modest return on investment<sup>7</sup> and substantiates growing concerns about the sector's financial sustainability. These financial pressures are likely to persist, if not worsen, given the additional outlays required to meet community expectations for increased quality and safety and to implement the multiple initiatives within the sector's ongoing reform agenda.<sup>8</sup>

Table 3 shows the key financial indicators of contributing providers, first categorised by their profitability (i.e. the top and bottom quartiles based on Operating Results). This shows substantial variation in financial performance, as providers in the top quartile earned an average Operating Result of \$1.3m in 2021-22, compared to the average Operating Loss of \$12.4m for the bottom quartile. The Operating Result Return on Assets (ROA) for the top quartile was 1.6%, while the bottom quartile was negative 3.7%.

When splitting providers based on their size in terms of their turnover (i.e. revenue bands) and total assets, it appears that larger providers have fared worse in terms of their Operating Results. However, the Operating EBITDA results show that while most small and medium size providers (less than \$75m annual turnover, less than \$150m in total assets) have marginal average returns, the largest providers (more than \$75m in annual turnover and \$150m in total assets) achieved substantially higher average results for 2021-22. These differing trends point to the high costs associated with larger capital bases, specifically in the costs of depreciation (which are excluded from EBITDA, but included in Operating Results).

7. 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.

8. <https://www.agedcarequality.gov.au/sites/default/files/media/aged-care-reforms-overview-fact-sheet.pdf>



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

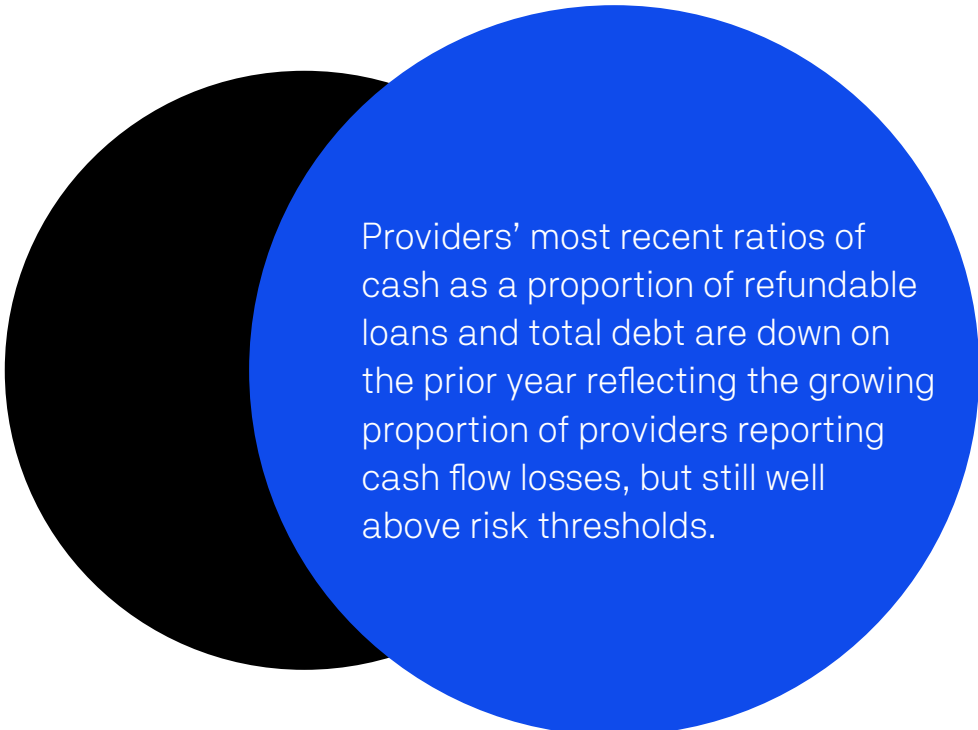
	Revenue							Total Assets			
	Data set average	Top Quartile	Bottom Quartile	<\$10m	\$10m-\$20m	\$20m-\$75m	>\$75m	\$25m	\$25m-\$50m	\$50m-\$150m	>\$150m
Number of providers in data set	249	62	62	87	68	50	44	71	52	65	61
<b>Operating Result ('000)</b>	<b>(\$3,163)</b>	<b>\$1,287</b>	<b>(\$12,395)</b>	<b>(\$468)</b>	<b>(\$901)</b>	<b>(\$2,945)</b>	<b>(\$12,233)</b>	<b>(\$205)</b>	<b>(\$983)</b>	<b>(\$1,388)</b>	<b>(\$10,353)</b>
Total Result (\$'000)	\$1,269	\$3,647	(\$10,140)	(\$303)	(\$343)	(\$2,549)	(\$6,687)	(\$28)	(\$819)	(\$851)	(\$6,091)
Operating EBITDA (\$'000)	\$607	\$3,581	(\$1,417)	(\$59)	\$2	\$75	\$3,462	\$63	(\$215)	\$274	\$2,294
EBITDA (\$'000)	\$1,876	\$5,940	\$838	\$106	\$560	\$471	\$9,008	\$240	(\$51)	\$812	\$6,556
<b>Ratios (Medians):</b>											
Operating Result Return On Assets (ROA)	(1.6%)	1.6%	(3.7%)	(1.6%)	(1.2%)	(1.6%)	(1.9%)	(1.0%)	(2.1%)	(1.7%)	(1.6%)
Operating EBITDAR Return On Assets (ROA)	0.0%	3.0%	(1.0%)	(0.2%)	0.3%	0.1%	0.8%	0.6%	(0.4%)	0.1%	0.7%
Operating EBITDA Profit Margin (%)	0.1%	8.6%	(2.9%)	(0.5%)	1.2%	0.2%	1.7%	2.2%	(1.7%)	0.8%	1.7%



## Liquidity and leverage

Balance sheet data from contributing approved providers gives an aggregate perspective on the value of their assets, liabilities and owners' equity, as well as their liquidity and leverage risk profiles.

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 refundable accommodation deposits (RADs). The Government has introduced a new Financial and Prudential Monitoring, Compliance and Intervention Framework, including expected minimum liquidity ratios, with the changes in effect from July 2023.<sup>9</sup> However, the need to manage liquidity risk must be balanced against sufficient investment in new capital assets such as equipment, property and buildings to provide high-quality aged care services into the future.



Providers' most recent ratios of cash as a proportion of refundable loans and total debt are down on the prior year reflecting the growing proportion of providers reporting cash flow losses, but still well above risk thresholds.

9. <https://www.health.gov.au/health-topics/aged-care/aged-care-reforms-and-reviews/financial-and-prudential-monitoring-compliance-and-intervention-framework>



Table 4: Average balance sheet figures for approved providers

	FY22	FY21
<b>Assets</b>		
Cash and Financial Assets (\$'000)	\$31,052	\$33,132
Operating assets (\$'000)	\$14,900	\$10,634
Property assets (\$'000)	\$123,841	\$119,289
Right of use assets (\$'000)	\$2,601	\$2,602
Intangibles - other (\$'000)	\$2,764	\$2,955
Intangibles - bed licences (\$'000)	\$2,297	\$2,769
<b>Total assets (\$'000)</b>	<b>\$177,456</b>	<b>\$171,380</b>
<b>Liabilities</b>		
Refundable loans - residential (\$'000)	\$55,229	\$53,670
Refundable loans - retirement living (\$'000)	\$42,308	\$37,946
Home care packages unspent funds liability (\$'000)	\$1,335	\$1,890
Borrowings (\$'000)	\$9,595	\$7,032
Other liabilities (\$'000)	\$17,702	\$17,195
<b>Total liabilities (\$'000)</b>	<b>\$126,170</b>	<b>\$117,733</b>
Net assets (\$'000)	\$51,286	\$53,647
Net tangible assets (\$'000)	\$46,225	\$47,924
<b>Ratios (Medians):</b>		
Net assets proportion % total assets	35.9%	37.3%
Property assets proportion % total assets	65.4%	63.8%
Cash + financial assets % refundable loans	48.3%	54.8%
Cash + financial assets % debt	46.7%	52.1%



## Approved Provider Analysis

Table 4 reports on approved providers' average balance sheet figures and median ratios. In 2021–22, the total asset base of providers grew by 3.5% to an average of \$177.5m from \$171.4m. The only growth was in operating assets and property assets, which increased by 40.1% and 3.8%, respectively. Cash and financial assets contracted by an average of 6.3% year-on-year.

The asset class with the most significant decline was bed licenses, which are down from an average of \$2.8m per provider in 2020–21 to \$2.3m by 2021–22. This likely reflects the ongoing impairment and write-down of these intangible assets in the lead up to the end of Aged Care Approvals Rounds (ACAR) in 2024.<sup>10</sup>

Table 4 also shows an increase in the total value of approved providers' liabilities, which grew by 7.2% to an average of \$126.2m by June 2022. The most prominent increase was in borrowings, which increased by 36.4% compared to the prior year. In contrast, the June 2022 results also show an annual 29.4% fall in providers' unspent fund liabilities, reflecting the changes in payment processes for home care services, as unspent funds are shifted to Services Australia.<sup>11</sup>

The balance sheet ratios reported in Table 4 show a slow deterioration in providers' leverage (net assets ratio) and liquidity (cash ratios). Net assets as a percentage of total assets declined from 37.3% to 35.9%, reflecting the negative Operating Results incurred during the year. The most recent median ratios of cash as a proportion of refundable loans (48.3%) and total debt (46.7%) are well above generally expected thresholds of 15–20% but down on the previous year. The drop in liquidity reflects the growing proportion of providers reporting cash flow losses.

10. <https://www.health.gov.au/initiatives-and-programs/competition-in-residential-aged-care>

11. While providers' liabilities of unspent funds have decreased, the total value of unspent funds of home care packages continues to increase (shown in the Home Care analysis below), with the balance now held by Services Australia.

Providers' median return on assets declined to just 0.3%, amid growing concerns about the sector's financial sustainability.

# Residential Care Analysis

## Overview

▶ The FY22 data set includes 1,202 aged care homes, which represents 45.0% of the 2,671 residential aged care homes in Australia.

▶ Homes that are either smaller in size or located outside major cities tend to have poorer financial performance.

▶ The financial performance of residential care homes has continued to decline. In 2021-22, over 67% of homes operated at a loss, with an average deficit of \$16.13 per resident per day.

▶ Occupancy has continued to fall across all states and territories to an average of 91.1%.

▶ The Operating Result breakdown shows that, on average, homes earn \$1.23 per resident per day from direct care while losing \$5.13 for indirect care and \$12.23 for accommodation services.

▶ Total direct care staffing time has increased marginally to an average of 178.0 minutes per resident per day. However, staffing levels are well short of requirements of minimum standards that will be mandatory in 2023-24.



## Residential aged care home profiles

The residential care analysis reports the average financial and workforce outcomes of participating residential aged care homes otherwise, referred to as nursing homes or residential aged care facilities.

**Table 5: Profile of residential aged care homes in the data set**

	FY22	FY21
Number of homes in data set	1,202	1,163
Total number of beds in data set	98,345	94,087
Average home size (number of beds)	81.8	80.9
<b>Ownership</b>		
For-profit	11.7%	10.0%
Not-for-profit	88.3%	90.0%
<b>Location</b>		
Major city	64.0%	63.9%
Inner regional	25.9%	25.9%
Outer regional, rural & remote	10.1%	10.2%

This section analyses the financial year results for 1,202 residential aged care homes in the FY22 (2021–22) StewartBrown data set.<sup>12</sup> The FY22 data set represents 45.0% of the 2,671 residential aged care homes in Australia and 44.7% of the 219,965 operational beds as of 30 June 2022.<sup>13</sup>

As shown in Table 5, the average size of each home in the data set was 81.8 beds in June 2022, marginally smaller than the national average of 82.4 beds.<sup>14</sup> Most (88.3%) of these homes are not-for-profit, and for-profit providers operate the remainder (11.7%). The weighting towards not-for-profit providers is due to the absence of several large listed for-profit providers from the survey (which are prevented from participating due to the Australian Securities Exchange listing rules) and the acquisition of for-profit homes by not-for-profit providers. State government-operated homes are also not included in the data set.

Regarding geographic location, the FY22 data set is generally consistent with the overall spread across the entire sector as of June 2022. In FY22, 64.0% of the homes were located in major cities (compared to 62.5% of the national total), with 25.9% in inner regional areas (compared to 24.3% of the national total) and 10.1% in rural and remote locations (compared to 13.2% of the national total).<sup>15</sup>

12. In total 1,313 residential aged care homes participated in the June 2022 StewartBrown survey, however as part of the data cleaning and analysis process 111 homes were excluded from the final sample either because of data integrity issues or because they were subject to substantial disruption to their operations, such as the case for homes that were newly built, undergoing major refurbishment or subject to sanction by the regulator. In the StewartBrown Aged Care Financial Performance Survey terminology, 'all homes' relates to the entire sample and 'mature homes' relates to the final sample, as used in the analysis in this report.

13. Department of Health and Aged Care (2022), *Aged care data snapshot—2022, Second release*, Australian Institute of Health and Welfare.

14. Department of Health and Aged Care (2022), *Aged care data snapshot—2022, Second release*, Australian Institute of Health and Welfare.

15. Department of Health and Aged Care (2022), *Aged care data snapshot—2022, Second release*, Australian Institute of Health and Welfare.



## Key performance indicator summary

Table 6: Key performance indicators of residential aged care homes

	FY22	FY21
Average Operating Result (per resident per day)	(\$16.13)	(\$8.55)
Average Operating Result (per bed per annum) *	(\$5,030)	(\$2,610)
Average Operating EBITDAR (per bed per annum) *	\$1,631	\$3,914
Average occupancy rate	91.1%	92.1%
Average direct care revenue (per resident per day)	\$195.12	\$199.24
Average direct care costs (as a % of average direct care revenue)	99.4%	93.1%
Average direct care minutes (per resident day)	178.0	174.4
Average supported ratio	45.4%	46.7%
Average of Full RADs/Bonds held at reporting date	\$395,526	\$374,036
Average of Full RADs/Bonds taken during period	\$442,580	\$427,036

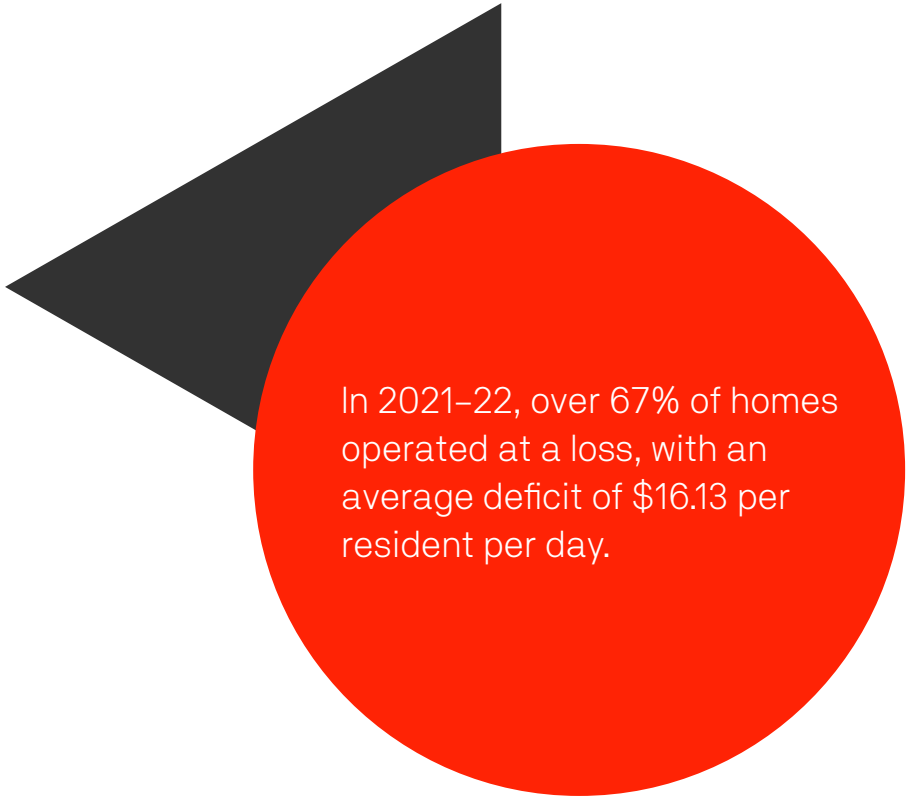
\* Per annum figures are the per bed day result for 365 days adjusted for the occupancy rate.



## Financial performance

The financial performance of aged care homes directly impacts the sector's overall sustainability. Although unprofitable homes may continue to operate if owned by larger providers that can cross-subsidise losses with margins earned elsewhere, this might not be possible for single home-operators or small-scale providers. Furthermore, regardless of provider scale, homes in financial distress are at greater risk of acquisition or closure, which may undermine reliable access to services for senior Australians, particularly those outside major cities.

Taking a longer-term perspective, if homes cannot generate reasonable operational returns, this will inhibit the investment in the sector needed to improve the quality and innovation of care services and to ensure the supply capacity to meet the needs of Australia's ageing population.

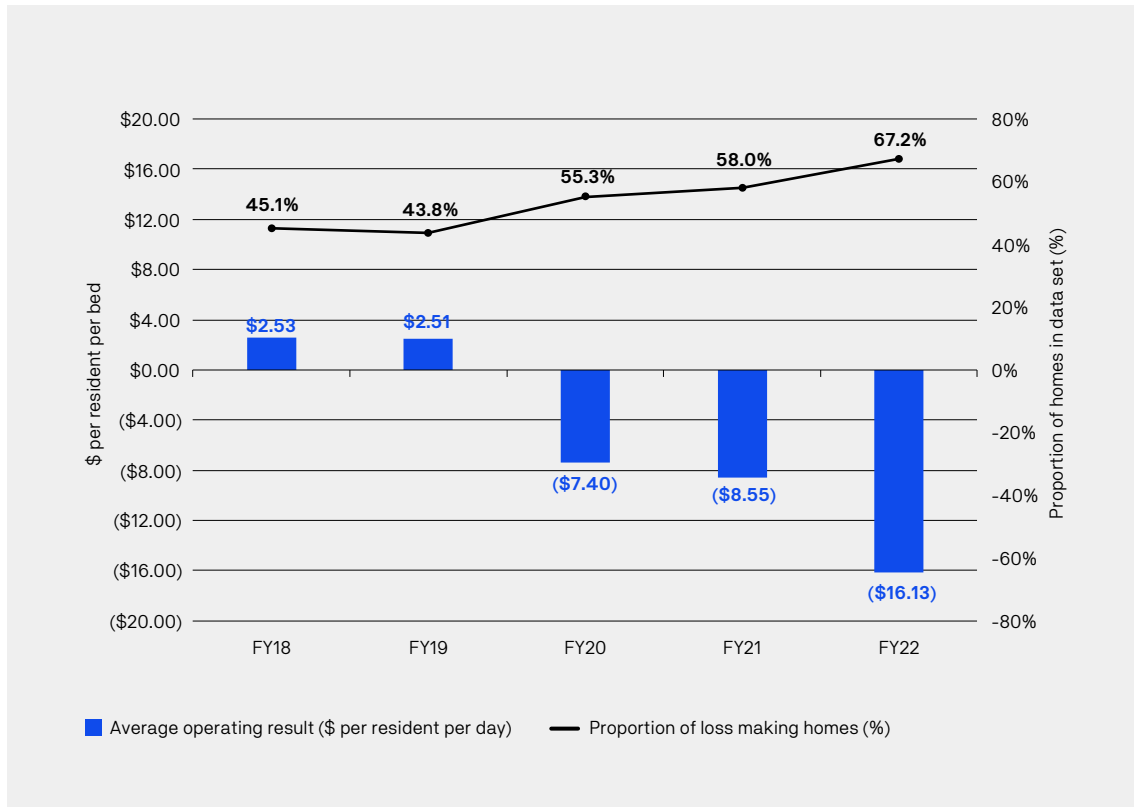


In 2021-22, over 67% of homes operated at a loss, with an average deficit of \$16.13 per resident per day.



## Residential Care Analysis

Figure 1: Average Operating Result and proportion of loss-making homes



In this context, Figure 1 shows that the worsening financial performance of residential aged care homes in 2021-22 is cause for concern. As shown in Figure 1, there has been a substantial decline in the financial performance of residential aged care homes.



When these results are extrapolated to a sector level, they indicate aggregate operating losses in the order of \$1.16bn for all residential aged care homes in 2021-22.<sup>16</sup> This is likely a conservative estimate as it projects the average Operating Result of mature homes only (i.e. excludes homes with disruptions to service delivery) and also does not include government-owned homes, which have lower rates of occupancy and worse financial performance.<sup>17</sup>

The results continue a five-year trend of worsening financial performance of residential aged care homes. Although there was some stabilisation in the previous financial year, the steep decline in 2021-22 has seen an acceleration of poor returns from operations and the proportion of homes operating at a loss. This trend has occurred despite the increase in government funding, with 99% of eligible residential aged care homes receiving the BDF supplement (an additional \$10 revenue per resident per day) since July 2021.<sup>18</sup>

The acceleration of poor returns from operations has occurred despite increases in government funding, including the basic daily fee supplement.

16. This figure has been estimated assuming 219,965 operational beds in Australia as of 30 June 2022, with an occupancy rate of 89.7% (based on the average occupancy rate of all homes in the StewartBrown data set for 2021-22). For sensitivity the average Operating Result was re-weighted according to population characteristics of Australian residential aged care homes (location and home size), however this did not materially alter the estimate (i.e., it caused a difference of less than 0.5%).

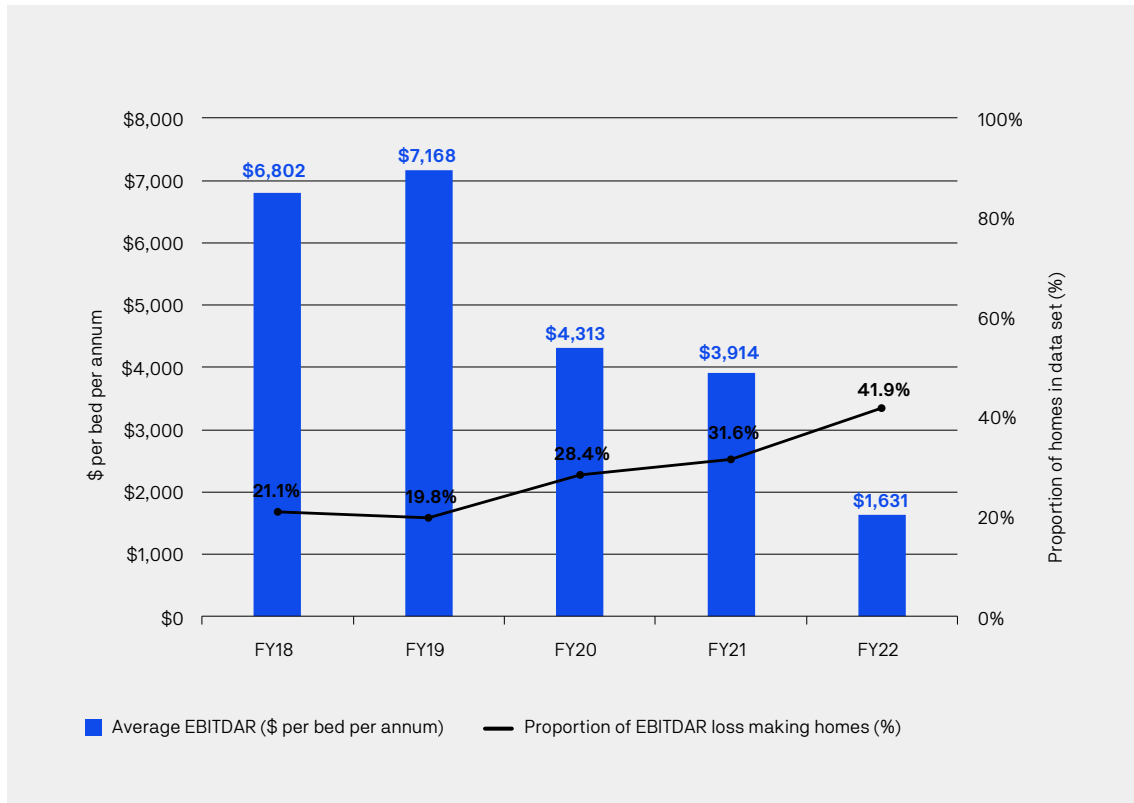
17. Our projections of prior years' sector results (based on mature homes only) are much more conservative compared to census data reported by the Department of Health and Aged Care. For example, our projection of sector operating losses for residential aged care in 2019-20 is \$519m (compared to losses of \$736m reported by DoHAC) and losses of \$594m for 2020-21 (compared to losses of \$854m reported by DoHAC).

18. Department of Health (2022). Food and Nutrition Report. Canberra, Australia.



## Residential Care Analysis

Figure 2: Average Operating EBITDAR and proportion of EBITDAR loss-making homes



Aged care homes' Operating EBITDAR<sup>19</sup> exhibits a similar trend (Figure 2). Operating EBITDAR declined by 58.3% relative to the last financial year, to an average of \$1,631 per bed per annum. In 2021–22, the proportion of homes recording an Operating EBITDAR loss<sup>20</sup> increased to 41.9%, up from 31.6% in 2020–21.

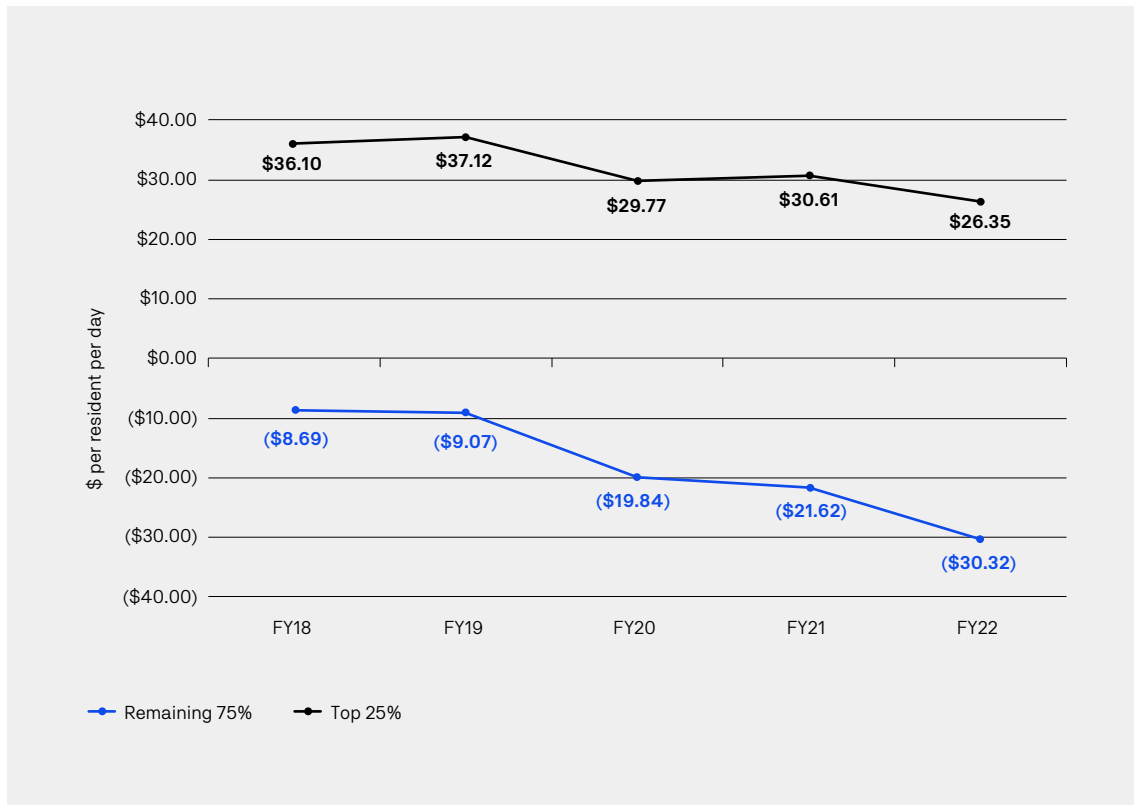
The rising proportion of homes recording Operating EBITDAR losses is concerning as this measure of profitability generally reflects the cash surplus that could cover costs of refurbishing buildings and equipment and improving service delivery models. Homes that record an Operating EBITDAR loss will need alternative sources of revenue to make such investments, such as investment revenues, fundraising revenues or returns from other homes or business streams operated by the provider. However, these alternative revenue streams may not be available to small-scale providers (i.e., those with only one or a small number of homes). In such circumstances, an Operating EBITDAR loss may necessitate a draw down on their asset base and jeopardise their long-term financial viability.

19. 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 operated under different corporate arrangements and financing policies. 'Operating EBITDAR' also excludes all provider-level revenue and expenditure, including fundraising revenue, revaluations, donations, capital grants and sundry revenue.

20. An Operating EBITDAR loss occurs when an aged care home's Operating EBITDAR is below zero.



Figure 3: Average Operating Result, top 25% vs remaining 75%



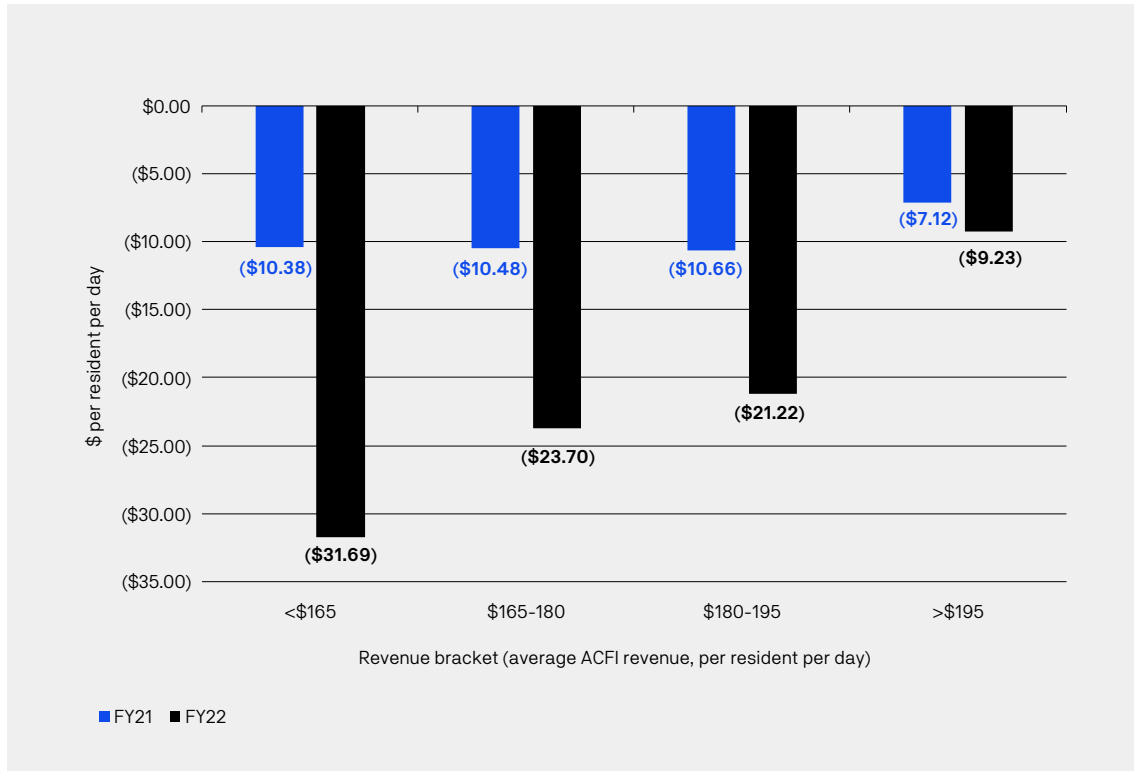
Although homes' financial performance has been declining on average, there remains substantial variation across the sector. Figure 3 shows, for example, trends in the profitability of the top 25% of homes (based on their Operating Results) compared to the remaining 75% of homes. This shows that the operating margin of the top 25% has been comparatively stable while the losses have accelerated for the remaining 75% of homes. This has caused a widening gap in financial outcomes, with homes in the top 25% earning, on average, \$57 more per resident per day in 2021–22.

Several factors could explain this variation in homes' financial results. For instance, as will be explored below, there are substantial differences in the Operating Results of homes of different occupancy levels, sizes and locations. In addition, top-performing homes may also benefit from more experienced managers, alternative business models and efficiencies in their built infrastructure.



## Residential Care Analysis

Figure 4: Average Operating Result, by direct care revenue



One emerging trend in the 2021–22 financial results is an association between the financial performance of aged care homes and the relative level of direct care subsidies for their residents. Homes that service residents with less complex assessed care needs generally have lower care costs and receive lower direct care (Aged Care Funding Instrument ‘ACFI’) subsidies.<sup>21</sup>

Figure 4 shows the average Operating Result per resident per day for homes split into different average ACFI revenue brackets.<sup>22</sup> In 2021–22 homes with the lowest levels of ACFI funding had the largest operating losses. Notably, no such association was evident in the average results for the prior financial year (2020–21). This would suggest that in the last financial year, the homes with the poorest Operating Results are those that service residents with the least complex assessed needs. Although this pattern may reflect other differences, such as home size and occupancy, it also may reflect differences in the adjustments to direct care staffing and quality initiatives. This emerging pattern warrants further analysis, particularly after the implementation of the new funding for direct care.

21. 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 with low needs across all three domains is \$64.72, whereas it is \$225.60 for a resident with high needs across all three domains. From 1 October 2022, ACFI will be replaced by a new funding model, based on the Australian National Aged Care Classification (AN-ACC) model. Further discussion about the impact of changes in funding are discussed in Part 2 of this report.

22. 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

Occupancy is an important indicator within the residential aged care sector, showing the extent to which an aged care home's beds are used (i.e., occupied) by older Australians. It indicates the expressed demand for residential aged care relative to its supply and, as noted 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 indicate consumer preferences for some aged care homes relative to others.

**Figure 5: Occupancy rate, by State**

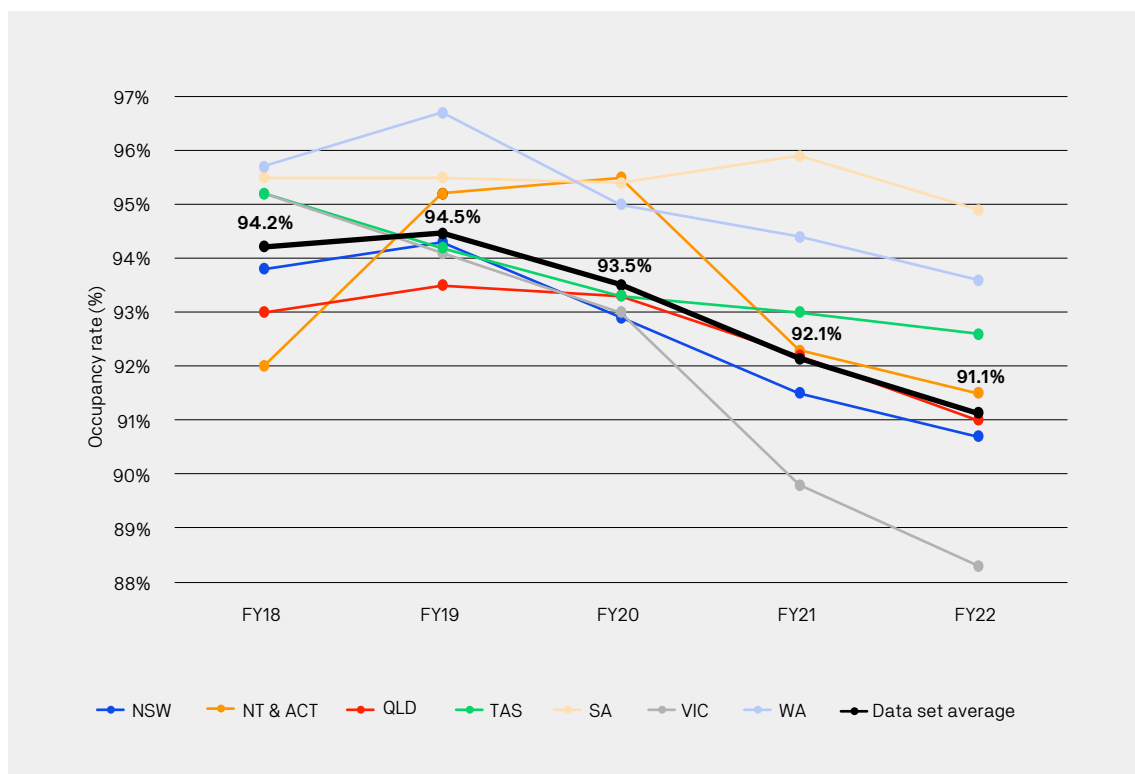


Figure 5 shows that in 2021-22, average occupancy rates declined in every state and territory.<sup>23</sup> The data set average occupancy rate has fallen consistently over the last three years, to 91.1% in 2021-22, down from 94.5% in 2018-19.

23. Occupancy measures the rate in which an aged care home's beds are actually used (i.e., occupied) by a resident. Consistent with the methodology used by StewartBrown, this report calculates occupancy in terms of the available beds within the data set of aged care homes, which excludes beds that have been allocated but are not actually operational. This measure of occupancy differs from the estimates published by DoHAC, which measures occupancy as the proportion of total allocated beds, including those that might not be operational.



## Residential Care Analysis

Some of the more recent falls in occupancy occurred in the states and territories particularly affected by COVID-19 outbreaks of Delta and Omicron, with average occupancy levels of 88.3% in Victoria, 90.7% in New South Wales, 91.5% in the Northern Territory and Australian Capital Territory and 91.0% in Queensland. However, the long-term downward trend across all states and territories potentially reflects a more prolonged structural shift in the demand for residential beds coinciding with the Government's release of more HCPs. Since 2017–18, the total number of allocated places in residential care has grown by 4.3% (9,150 allocated places),<sup>24</sup> while the total number of people with HCPs has grown by 127% (116,665 packages).<sup>25</sup>

Future occupancy rates will likely reflect the interaction between various supply and demand factors for residential care. Long-term demographic projections indicate that the demand for residential aged care will continue to grow as the number of senior Australians with complex care needs, such as dementia, increases over time.<sup>26</sup> This demand concentration is already evident in the growing proportions of current residents classified as having more acute and complex care needs.<sup>27</sup>

However, the long-term growth in demand may also be influenced by changes in consumer preferences for more home care services, as well as other initiatives that support older Australians to remain independent for longer, such as primary health, restorative and re-enablement support, and services that support informal carers including respite care.<sup>28</sup> In addition, following the removal of supply-side restrictions on bed licenses from 2024 onwards, occupancy levels are anticipated to be more responsive to residents' demands and providers' investments in supply.<sup>29</sup>

The continued decline in occupancy across aged care homes is concerning, as it is one of the most important drivers of their financial viability.

24. Department of Health and Aged Care (2022), *Comparison of Stocktake 30 June 2015 – 30 June 2022*. Australian Institute of Health and Welfare.

25. 2017–18 HCP figures taken from the Productivity Commission's Report on Government Services which show that 91,847 people had a HCP as at 30 June 2018. The most recent estimate of HCP clients (208,512) is as of 31 March 2022: Department of Health and Aged Care (2022), *Home care packages data report 1 January – 31 March 2022*.

26. Department of the Treasury (2021). *2021 Intergenerational Report: Australia Over the Next 40 Years*.

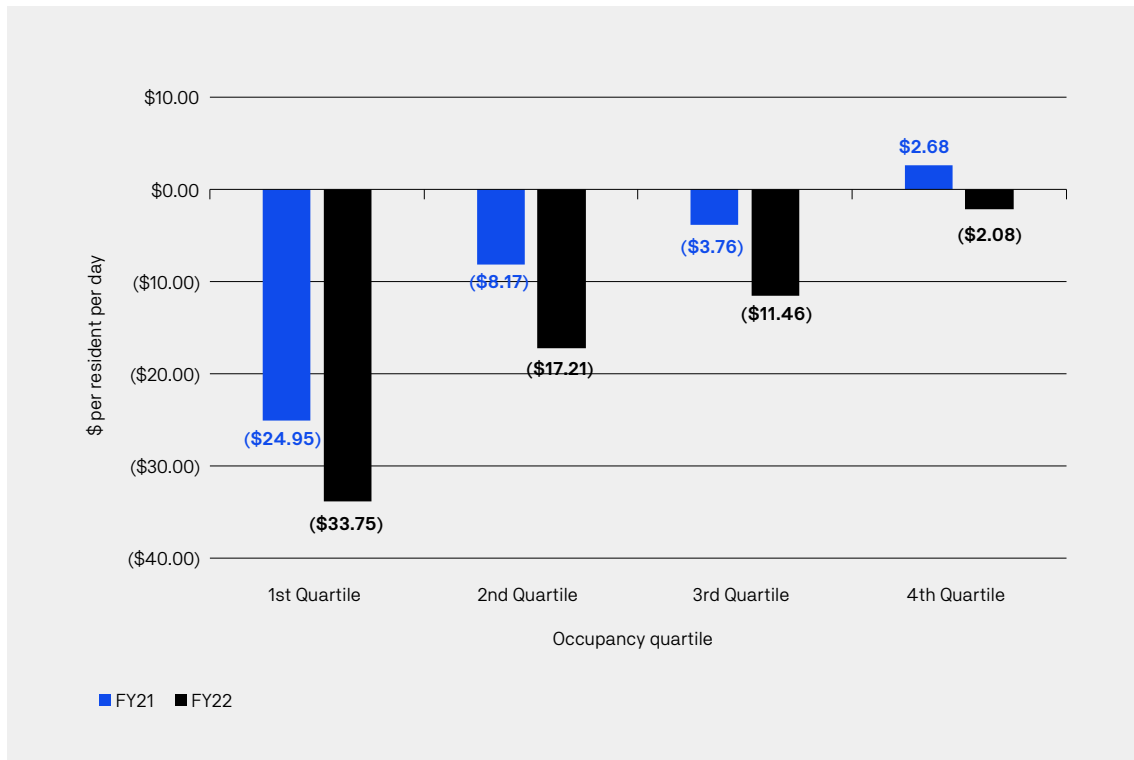
27. Between 2018 and 2022 the proportions of residents classified as having 'high' needs has grown across the categories of Activities of Daily Living (58.9% to 68.5%), Behaviours (64.1% to 68.3%) and Complex Health Care (53.0% to 58.2%). Department of Health and Aged Care (2022), *Aged Care Snapshot Series*. Australian Institute of Health and Welfare.

28. Woods, M., Sutton, N., McAllister G., Brown, D. & Parker, D. (2022). *Sustainability of the Aged Care Sector: Discussion Paper*. The University of Technology Sydney. <https://opus.lib.uts.edu.au/handle/10453/158194>

29. Woods, M. & Corderoy, G. (2020). *Impact Analysis: Alternative Models for Allocating Residential Aged Care Places*. CHERE, UTS and StewartBrown.



Figure 6: Average Operating Result, by occupancy



The decline in occupancy across the sector is concerning, as it is one of the most influential drivers of a residential aged care home's profitability. While homes' revenue is highly sensitive to short-term changes in occupancy and resident mix, most of the costs involved in delivering residential aged care are fixed. These include costs of the physical infrastructure, administration and compliance, all of which must be incurred regardless of the number of beds that are occupied. Furthermore, unless there is a significant shift in residents' needs or occupancy, homes cannot radically alter the configurations and costs of their staff.

To illustrate, Figure 6 shows the average Operating Result (per resident per day) of homes split into quartiles based on occupancy. This shows a clear association between occupancy and financial performance. Homes with the highest occupancy rates (far right column, with an average occupancy rate of 96.4%) incurred an average Operating Loss of \$2.08 per resident per day, while homes with the lowest occupancy rates (left column, with an average occupancy rate of 88.7%) incurred an average Operating Loss of \$33.75 per resident per day.



## Workforce

The aged care workforce, including staffing levels and the knowledge, skills and attributes of aged care workers, is a critical factor influencing the quality and safety of residential care services. It also affects the financial performance of homes, as staffing costs account for approximately 70% of all revenue.

Table 7: Staffing metrics of residential aged care homes

	FY22	FY21
Number of homes in data set (workforce analysis)	1,163	1,120
<b>Direct care minutes (per resident per day)</b>		
Registered nurses	27.9	26.7
Enrolled and licensed nurses	13.1	16.2
Personal care workers/other unlicensed care staff	136.1	129.8
Imputed agency care minutes *	0.9	1.7
Total direct care minutes (per resident per day)	178.0	174.4
<b>Other care-related minutes (per resident per day)</b>		
Care management	8.3	7.9
Allied health	4.9	6.1
Lifestyle	7.3	6.8
Total other care-related minutes (per resident per day)	20.5	20.8
<b>Average total care-related minutes (per resident per day)</b>	<b>198.5</b>	<b>195.3</b>

\* Imputed agency care minutes are estimated for homes that do not separately provide agency staffing data.

In 2021–22, there has been a modest increase in care-related staffing minutes across most roles compared to the prior year (see Table 7). Homes provided an average of 178.0 minutes of total direct care time<sup>30</sup> per resident per day, up from 174.4 minutes in 2020–21 (an increase of 2.1%).<sup>31</sup> This comprises moderate uplifts in the staffing minutes of registered nurses and personal care workers and decreases in the staffing minutes of enrolled and licensed nurses. Regarding other care-related roles, the average staffing levels increased for care management (up by 4.7% compared to 2020–21) and lifestyle roles (up by 7.4%). However, it decreased for allied health (down by 19.2%).

30. 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.

31. These staffing rates likely over-represent the growth in actual staffing levels, as there has been a fall in average occupancy during this time. 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.



The average staffing time of enrolled nurses has contracted for the third year in a row, despite their vital contribution to homes' skill mix.

In the coming year, homes will need to raise staffing levels to comply with the incoming minimum staffing standards. Although each home's minimum care minutes targets depend on the specific case mix of the residents' homes, on average, homes across the sector are expected to provide at least 200 minutes of direct care per resident per day, with at least 40 of those minutes provided by a registered nurse by 1 October 2023.<sup>32</sup> In addition, from 1 July 2023, all homes will be required to have a registered nurse on duty at all times. Furthermore, homes' care minutes will be assessed under the new star ratings, which are due to be published in December 2022.

To reach these sector averages, homes will need to increase registered nurse staffing by an average of 12.1 minutes per resident per day in the next year, with an additional increase of 10.8 minutes per resident per day from other direct care workers (i.e. personal care workers or enrolled nurses). Extrapolated to an annualised sector figure, these increases will require approximately 8,288 additional full-time equivalent registered nurses and 7,419 additional full-time equivalent personal care workers or enrolled nurses (not accounting for any attrition or turnover).<sup>33</sup> More precise modelling of the staffing needs of homes to meet the minimum requirements, accounting for home-level targets in care minutes and the impacts of the 24/7 registered nurse requirements, is provided in Part 2.

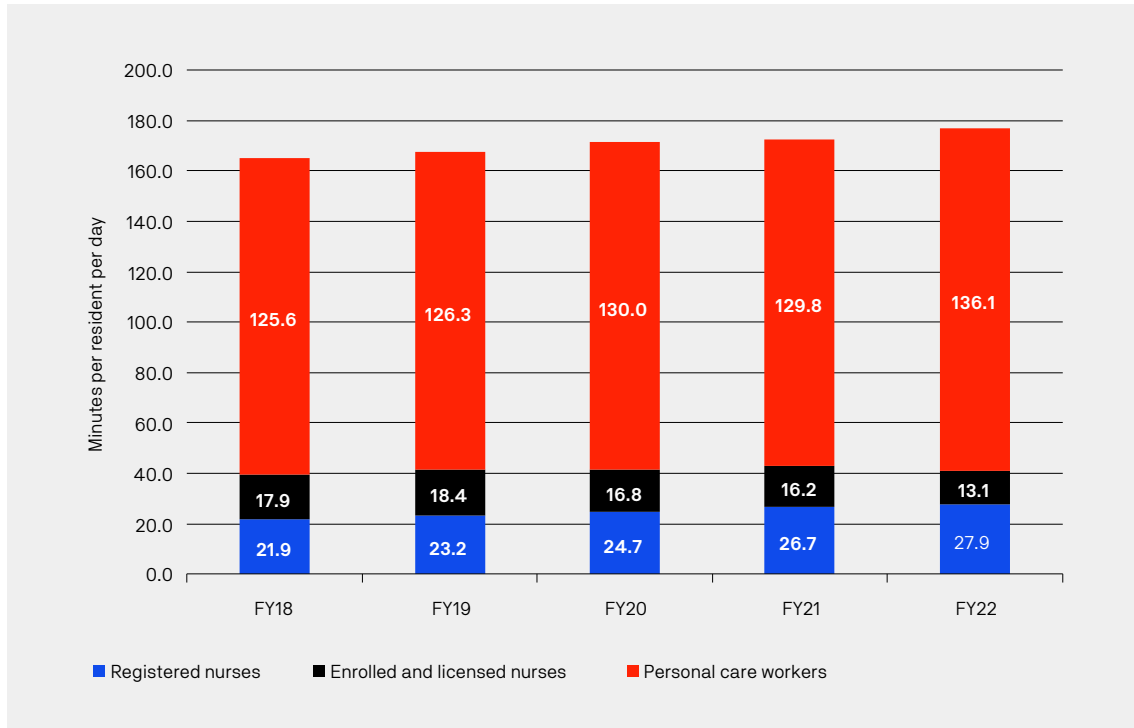
32. The care minutes targets are expressed as sector averages, with each home's minutes targets dependent on the relative care needs of its residents, as assessed under AN-ACC. Homes with a higher proportion of residents with more complex needs will have higher care minutes targets (for both total direct care and registered nurses), and vice versa for homes with residents with less complex needs. The care minutes targets will increase in 2024, to a sector average of 215 minutes of total direct care per resident per day, including 44 minutes per resident per day of registered nurse time.

33. This estimate assume 219,965 operational beds at an occupancy rate of 89.7%, with each full-time equivalent staff member working 1,748 hours per year.



## Residential Care Analysis

Figure 7: Direct care staffing minutes, by staff role



These required uplifts in the coming year far outpace the recent growth rate in direct care staffing. The five-year trend depicted in Figure 7 shows that while staffing levels have been increasing, the growth rate has been slow, at an average annual rate of approximately 1.7% per year since 2017-18. The slow growth in direct care staffing reflects the severe challenges that aged care providers have encountered in recruiting and retaining staff and constraints in their financial resources. As detailed in Part 3 of this report, many providers have experienced substantial skill shortages across direct care staffing roles and have had to rely more heavily on overtime and agency staff to ensure care delivery.

Figure 7 also shows the emergence of a concerning trend, whereby the rate of enrolled nurses has declined for the third year in a row, a fall of 28% since FY19. This decline (as well as the fall in allied health) is likely attributable to the specification of the incoming minimum staffing standards. By prescribing a minimum standard for total direct care time without ring-fencing provisions for enrolled nurses, homes may opt to adjust their staffing mix by replacing enrolled nurses with lower-waged personal care workers. This pattern is consistent with international evidence about the implementation of minimum standards in other jurisdictions, which shows that standards that focus on specific roles (e.g., registered nurses) can cause homes to divert resources away from other roles.<sup>34</sup> Given the vital contribution of enrolled nurses within the skill mix of aged care homes and as vital rural and remote workforces, these reductions in enrolled nurses could have negative implications for the quality and availability of care. Furthermore, this reduction may increase the workload pressures on registered nurses and disrupt future nursing staff career progression and skill development pathways.

34. Bowblis JR. Staffing ratios and quality: An analysis of minimum direct care staffing requirements for nursing homes. *Health Services Research* 2011; 46: 1495-516.



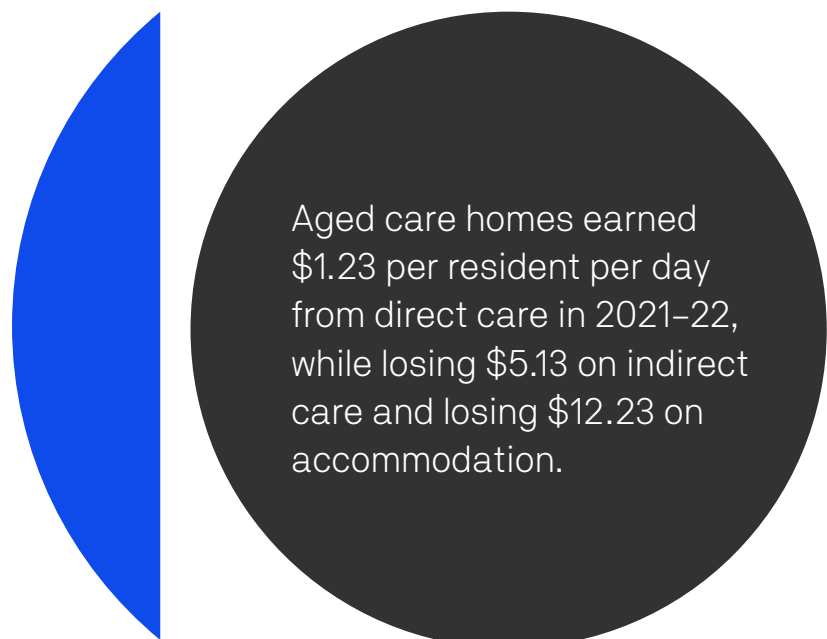
## Operating Result breakdown

This section provides a more detailed analysis of the revenue and expenses contributing to aged care homes' Operating Results. Specifically, the Operating Result is broken down into three activities, corresponding to the different services offered by aged care homes:

- direct care (personal and clinical care services)
- indirect care (food, cleaning, laundry, other amenities), previously referred to as 'everyday living'
- accommodation (provision and maintenance of buildings, equipment and other capital infrastructure)

Decomposing the Operating Result into these three activities (see Table 8) enables better identification of the revenue streams and cost components that influence the financial performance of aged care homes and can indicate areas for policy and 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.





## Residential Care Analysis

**Table 8: Breakdown of average Operating Result**

	FY22	FY21
<b>Direct Care</b>		
Direct care revenue	\$195.12	\$199.24
Direct care expenditure:		
Direct care labour costs	\$138.89	\$129.68
Other labour costs	\$27.09	\$24.96
Other direct care costs	\$12.48	\$16.84
Allocation of administration costs (37.0%)	\$15.42	\$13.99
Total direct care expenditure	\$193.88	\$185.47
<b>Direct Care Result</b>	<b>\$1.23</b>	<b>\$13.77</b>
<b>Indirect Care</b>		
Indirect care revenue	\$65.92	\$54.47
Indirect care expenditure:		
Catering	\$34.51	\$32.83
Cleaning	\$9.74	\$9.13
Laundry	\$4.31	\$4.28
Other	\$8.48	\$7.93
Allocation of administration costs (33.6%)	\$14.00	\$12.70
Total indirect care expenditure	\$71.04	\$66.87
<b>Indirect Care Result</b>	<b>(\$5.13)</b>	<b>(\$12.40)</b>
<b>Accommodation</b>		
Accommodation revenue:		
Residents	\$12.59	\$12.65
Government	\$20.51	\$20.51
Total accommodation revenue	\$33.10	\$33.16
Accommodation expenditure:		
Depreciation	\$19.25	\$19.02
Property maintenance and rental	\$12.33	\$11.54
Other	\$1.50	\$1.40
Allocation of administration costs (29.4%)	\$12.25	\$11.11
Total accommodation expenditure	\$45.33	\$43.07
<b>Accommodation Result</b>	<b>(\$12.23)</b>	<b>(\$9.92)</b>
<b>Operating Result (per resident per day)</b>	<b>(\$16.13)</b>	<b>(\$8.55)</b>
<b>Operating Result (per bed per annum) *</b>	<b>(\$5,030)</b>	<b>(\$2,610)</b>
<b>Operating EBITDAR (per bed per annum) *</b>	<b>\$1,631</b>	<b>\$3,914</b>

\* Per annum figures are the per bed day result for 365 days adjusted for the occupancy rate.



## Direct care:

Direct care relates to providing personal and clinical care services, encompassing support with showering, dressing and toileting, wound management, medication administration, allied health, care management and nursing services. It also includes social care services, such as recreational activities and emotional support.

In 2021–22, aged care homes' direct care results<sup>35</sup> declined substantially. On average, homes earned \$1.23 per resident per day from direct care services in 2021–22, down from \$13.77 in 2020–21 (a fall of 91.1%). About a third of this contraction in the average direct care result is attributable to a fall in direct care revenue. In 2021–22 this was \$195.12 per resident per day, down from \$199.24 per resident per day in 2020–21. The revenue decline occurred even though direct care subsidies have increased by an average of 2.5% across surveyed homes, partly due to indexation (government subsidies and supplements were increased by 1.1% in 2021–22) and the rising average acuity of residents. The leading cause of the year-on-year change was the sharp decline in non-recurrent grant income, with the end of most COVID-19 pandemic payments.<sup>36</sup>

Also, direct care costs have increased substantially year-on-year, particularly relating to staffing. Compared to the prior year, direct care labour costs grew by 7.1%, and other labour costs grew by 8.5%. These increases reflect the increase in direct care staffing minutes described above and increases in the average wage rates paid to aged care workers. For example, the average hourly rates paid to registered nurses rose by 3.4% in 2021–22, which outpaced a 2.3% growth in wages across the broader health and care services sector.<sup>37</sup> The rising staff costs are likely reflect the difficulties in recruiting direct care employees and the reliance on more expensive strategies, such as overtime and agency staffing (detailed in Part 3).

35. 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, as well as an allocation of 37.0% homes' administrative expenditure.

36. Many providers still applied for COVID-19 related grants during 2021–22, and to ensure a matching of revenue and expenses, StewartBrown included accruals to record this revenue in the 2021–22 financial year. Nonetheless, overall COVID-19 related revenues fell compared to the prior financial year.

37. <https://www.abs.gov.au/statistics/economy/price-indexes-and-inflation/wage-price-index-australia/jun-2022#industry-wage-growth>



## Residential Care Analysis

Figure 8: Average direct care revenues and costs

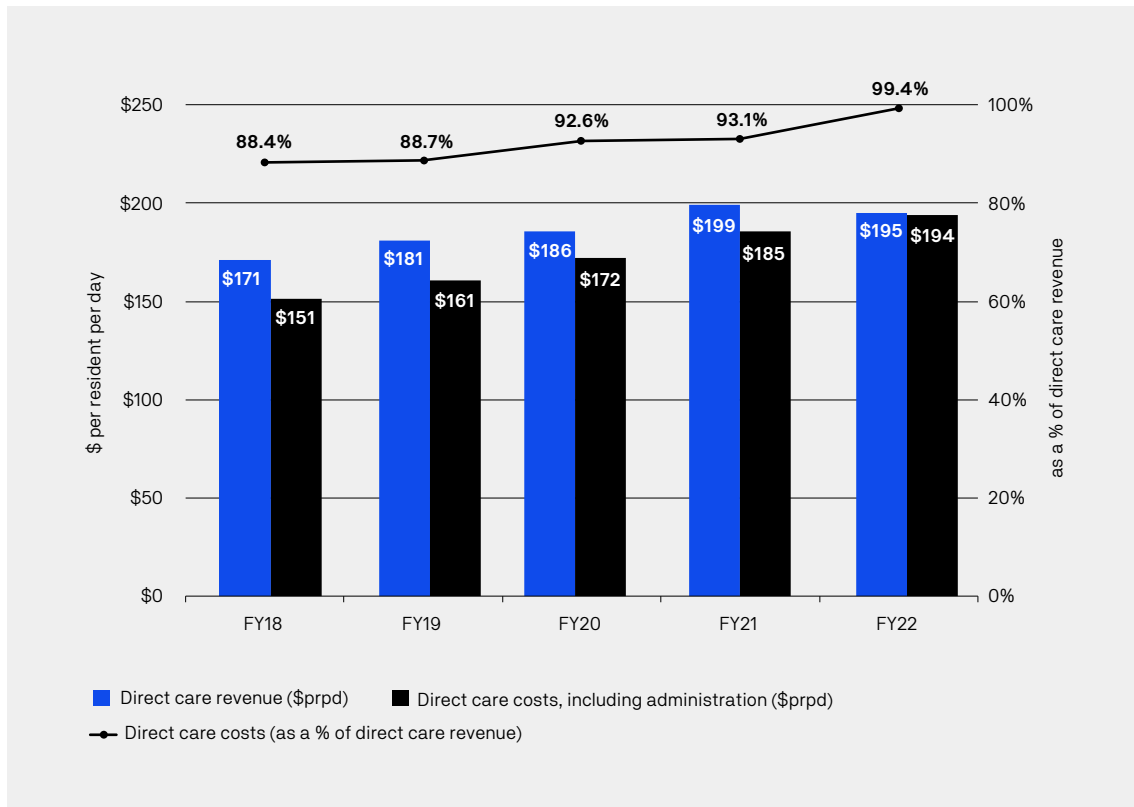


Figure 8 shows the recent trends in direct care revenues and costs, including the allocation of administration expenses. This shows how direct care revenues and expenses have converged, as the growth in direct care costs has outpaced the growth in direct care revenue. One of the main drivers of this trend is the ongoing difference between the rates in which direct care subsidies and supplements are indexed compared to growth in general operating costs and wages. For example, in 2021-22, direct care subsidies and supplements rose according to the indexation of COPO (1.1%),<sup>38</sup> which was below the rates of inflation (6.1%)<sup>39</sup> and wage price index (2.3%).<sup>40</sup>

As a result, the proportion of average direct care revenues spent on average direct labour care costs has increased to 99.4%, reflecting the marginal average direct care result of \$1.23 per resident per day in 2021-22.<sup>41</sup>

38. COPO stands for Commonwealth Own Purpose Outlays, which replaced Commonwealth Own Purpose Expenditure (COPE).

39. Inflation is measured using the Consumer Price Index, which rose by 6.1% in 2021-22 (ABS Statistics for June 2022)

40. The annual wage price index for health and social assistance changed by 2.3% in 2021-22 (ABS Wage Price Index Data for June 2022).

41. This ratio includes administration costs associated with direct care, noting in earlier reports administration has been excluded from some calculations.



### Indirect care:

Indirect care relates to providing hotel-like services, such as food, cleaning, laundry and other everyday living amenities. As shown in Table 8, the Indirect Care Result<sup>42</sup> has improved year-on-year. There has been a contraction in the average deficit from \$12.40 per resident per day (2020–21) to a deficit of \$5.13 (2021–22). This improvement is mainly attributable to an increase in revenue following the introduction of the BDF supplement in July 2021 (worth \$10 per resident per day). Nonetheless, indirect care costs have also increased by an average of 6.2% compared to the prior year, which closely matches the annual inflation rate for 2021–22.

### Accommodation:

The accommodation result shows the net revenues and expenses for providing physical infrastructure, including buildings and equipment.

In 2021–22, accommodation was the most significant contributor to homes' poor financial performance. This is consistent with a longer-term trend of operating losses in the provision of accommodation and significant cross-subsidisation from operating surpluses generated in direct care. On average, surveyed homes' Accommodation Result<sup>43</sup> was a deficit of \$12.23 per resident per day, representing a 23.3% decline from the \$9.92 average deficit per resident per day in 2020–21.

The poor outcomes relating to accommodation services have arisen because revenues from accommodation services have stagnated. As Figure 9 shows, the value of RADs has grown at a relatively modest pace, particularly in comparison to the growth in equivalent housing assets across Australia. For example, during the last financial year (2021–22), while median house prices increased by approximately 20% across Australia,<sup>44</sup> the price of new RADs only increased by 3.4%.<sup>45</sup> Furthermore, the average price is still well below the \$550k threshold at which providers must seek approval from the aged care quality regulator.<sup>46</sup> If RAD prices are low (and non-commensurate with market values of property outside aged care), this also constrains the revenue earned from daily accommodation payments (DAPs) from non-supported or partially supported residents who wish to pay rent rather than lodge a refundable lump sum. More broadly, the results suggest urgent reform is required to address the revenue streams for accommodation in residential care. This is discussed further in Part 2 of this report.

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

43. The Accommodation Result shows the net difference between accommodation revenue earned from either daily accommodation payments made from non-supported or partially supported residents, and government supplements for supported residents, 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.

44. StewartBrown collects housing price information from CoreLogic Australia.

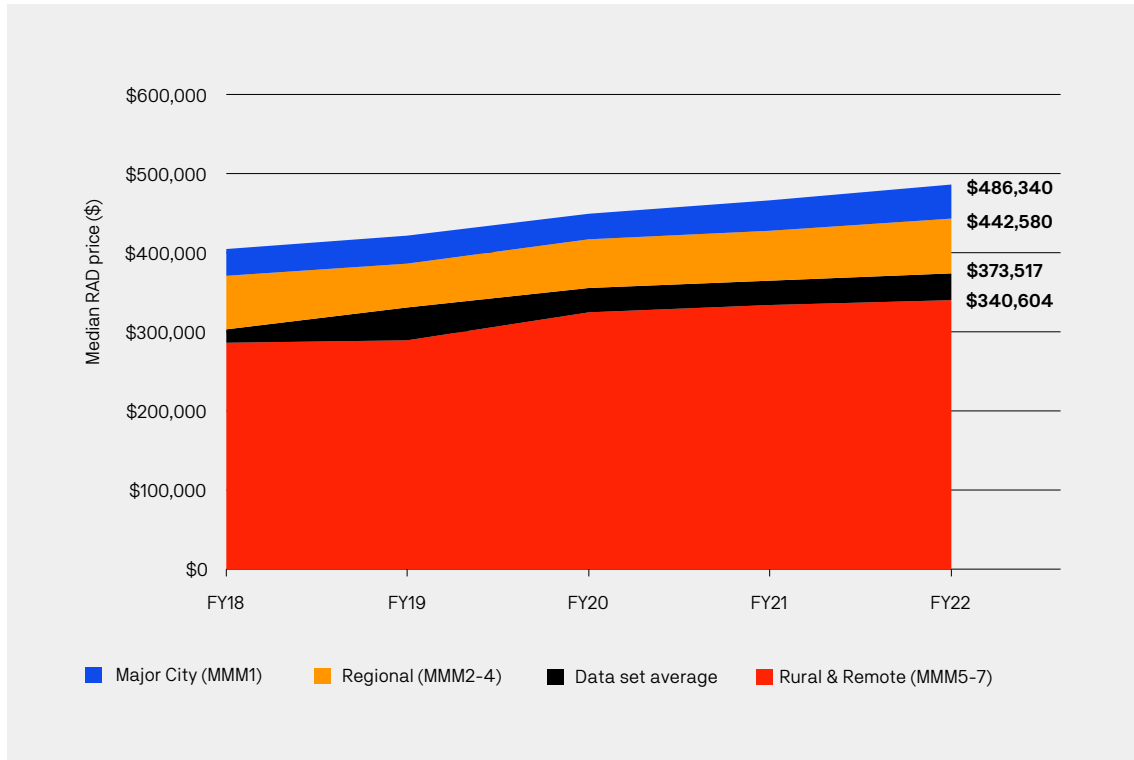
45. Note that the average price of new RADs is higher than the average price of all RADs currently issued. Unlike property values, existing RADs do not increase in value until a resident leaves and the home decides to increase the price for an incoming resident.

46. Previously this has been the Aged Care Pricing Commissioner, however this function will transfer to the IHACPA.



## Residential Care Analysis

Figure 9: Average price of new Refundable Accommodation Deposits, by location



The most significant accommodation-related cost is depreciation and amortisation, which is reflective of changes in homes' asset bases (i.e., through new or refurbished infrastructure) and accounting policies. While a minority of providers revalue their property assets, most depreciate based on cost. Of those, most providers depreciate based on 30–40 years of useful life, although a mid-life refurbishment is likely to occur after about 15–20 years.



### Administration expenditure:

In the above analysis, an allocation of administration costs has been included in calculating the net result for direct care, indirect care and accommodation. Table 9 shows the changes in the underlying expense items included in this allocation. This shows that administration costs have grown by 10.3%, from \$37.80 per resident per day (2020–21) to \$41.68 per resident per day (2021–22). This growth is higher than the inflation rate, which suggests that homes' administrative activities have expanded, likely reflecting the broader reform agenda described in Part 2 of this report.

**Table 9: Breakdown of average administrative costs**

	FY22	FY21
Administration recharges	\$25.67	\$23.27
Administration labour costs	\$7.86	\$7.08
Other	\$6.38	\$5.89
Insurance	\$1.45	\$1.27
Workers compensation	\$0.17	\$0.17
Quality & education	\$0.08	\$0.06
Payroll tax (administration staff)	\$0.03	\$0.02
Fringe Benefits Tax	\$0.03	\$0.03
<b>Total administration expenditure</b>	<b>\$41.68</b>	<b>\$37.80</b>
<b>Allocation to:</b>		
Direct care (37.0%)	\$15.42	\$13.99
Everyday living (33.6%)	\$14.00	\$12.70
Accommodation (29.4%)	\$12.25	\$11.11



## Results by location

In Australia, although most residential aged care homes are located in major cities, close to 40% are located in regional, rural or remote locations.<sup>47</sup> This geographic spread is essential in ensuring the accessibility of services to older Australians cross the country. However, due to varying local conditions (e.g., demand for services, availability of workers, costs of supplies and real estate values) and differences in government funding models and policies, homes in different locations tend to have different financial and workforce outcomes.

This report analyses these differences by examining the outcomes of homes by location. Homes are classified into three overarching categories – major city, regional, and rural and remote – using the Modified Monash Model (MMM) of remoteness. The Department of Health and Aged Care (DoHAC) uses the MMM classification to determine various subsidies and supplements for residential care services.<sup>48</sup>

**Table 10: Key performance indicators of residential aged care homes, by location**

	Major City (MMM1)	Regional (MMM2-4)	Rural & Remote (MMM5-7)
Number of homes in data set	765	317	120
Average home size (number of beds)	86.3	82.5	51.2
Average Operating Result (per resident per day)	(\$14.48)	(\$18.44)	(\$20.54)
Average Operating Result (per bed per annum)*	(\$4,450)	(\$5,915)	(\$6,386)
Average Operating EBITDAR (per bed per annum)*	\$2,454	\$80	\$480
Average Occupancy rate	91.0%	91.7%	90.5%
Average direct care revenue (per resident per day)	\$197.01	\$189.60	\$197.65
Average direct care costs (as a % of average direct care revenue)	99.5%	101.0%	99.1%
Average direct care minutes (per resident day)	176.5	177.2	189.8
Average supported ratio	44.2%	46.7%	49.6%
Average of Full RADs/Bonds held at reporting date	\$430,104	\$343,409	\$310,374
Average of Full RADs/Bonds taken during period	\$486,340	\$373,517	\$340,604

\* Per annum figures are the per bed day result for 365 days adjusted for the occupancy rate.

47. Department of Health and Aged Care (2022), *Aged care data snapshot—2022, Second release*, Australian Institute of Health and Welfare

48. <https://www.health.gov.au/health-topics/rural-health-workforce/classifications/mmm>



Table 10 shows that aged care homes in all locations had poor financial outcomes in 2021–22. However, homes in regional, rural and remote locations tended to have comparatively worse outcomes than those in major cities. In terms of their Operating Results, whereas homes based in major cities recorded an average loss of \$14.48 per resident per day, those in regional locations lost on average of \$18.44 per resident per day and homes in rural and remote locations recorded the most significant losses, at \$20.54 per resident per day. Likewise, while homes in major cities achieved an average operating EBITDA of \$2,454 per bed per annum, this was only \$480 per bed per annum for homes in rural and remote locations and just \$80 per bed per annum for those in regional locations.

**Figure 10: Average Operating Result, by location**

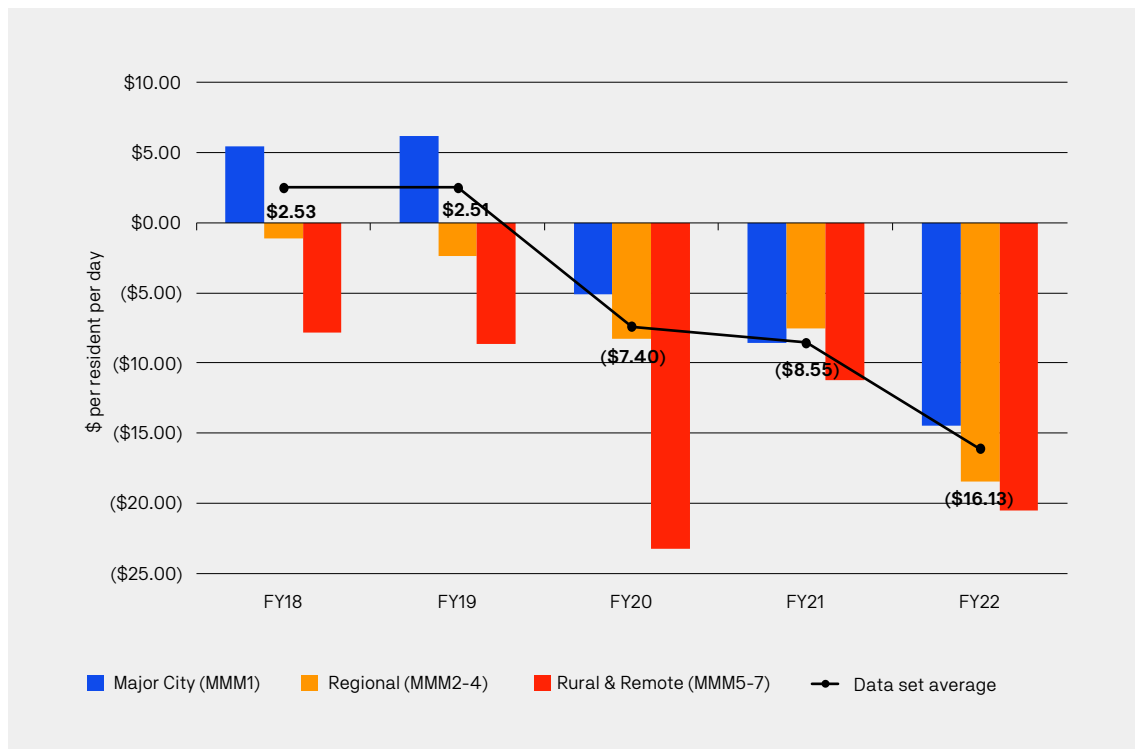
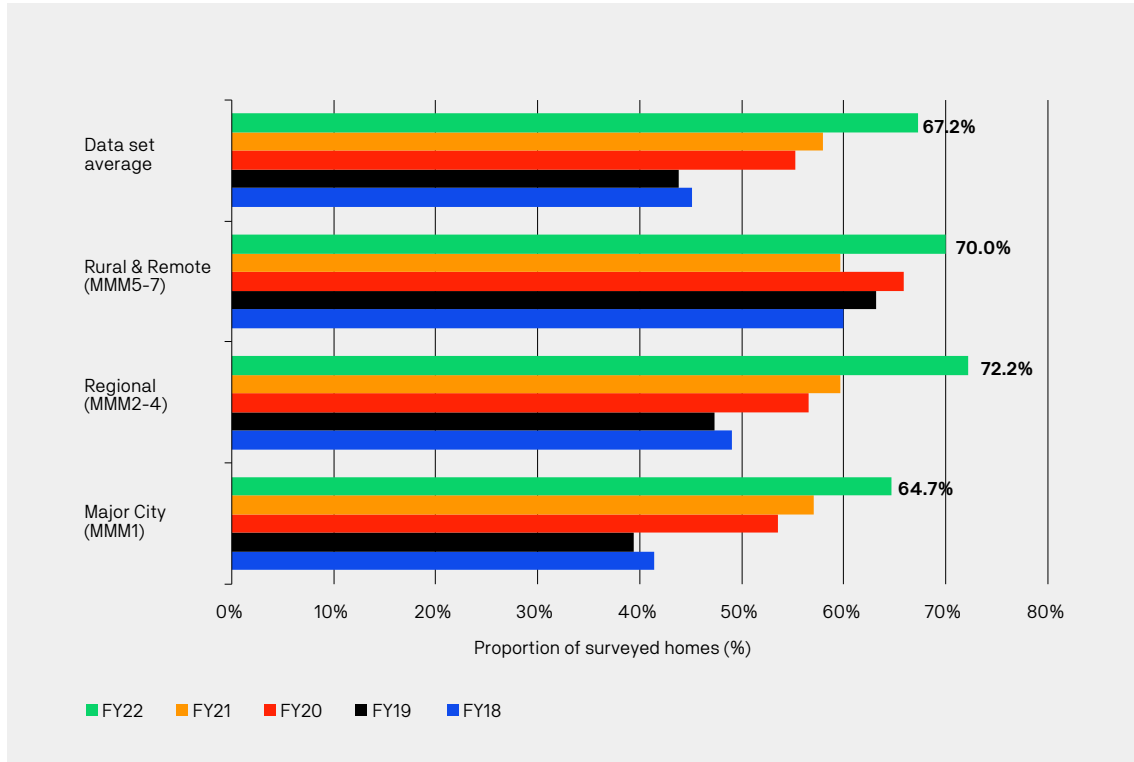


Figure 10 reveals the sustained trend of poor Operating Results of residential aged care homes over the past five years, particularly for those based outside major cities. Rural and remote homes experienced a brief uplift in performance in 2021–21, partly due to larger COVID-related funding provisions during that year. However, as with homes in other locations, their Operating Results dropped significantly in 2021–22.



## Residential Care Analysis

Figure 11: Proportion of homes operating at a loss, by location

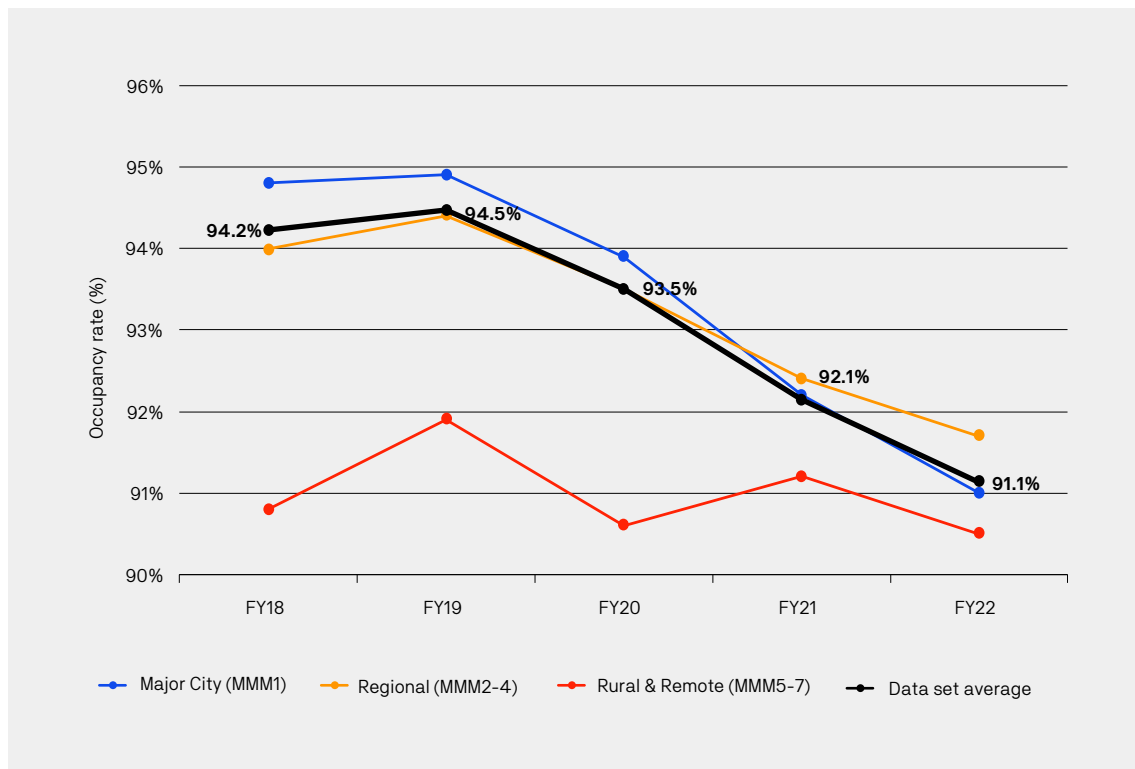


These trends are also evident in Figure 11, which shows that the proportion of homes operating at a loss grew across all locations. Once again, these results show that homes outside major cities tend to have worse financial performance. In 2021-22, 70.0% of homes in rural and remote locations operated at a loss, as did almost three in four (72.2%) homes in regional locations. By comparison, the proportion of homes operating at a loss was 64.7% in major cities.

In understanding why homes in regional, rural and remote locations are experiencing comparatively higher rates of financial distress, Table 10 reveals some crucial differences in their operating characteristics. For example, rural and remote homes tend to be much smaller (fewer beds) and have lower occupancy rates. Nonetheless, Figure 12 shows that the differences in occupancy rates have continued to close, as the occupancy of homes in major cities and regional locations have declined since 2018-19.



Figure 12: Occupancy rate, by location



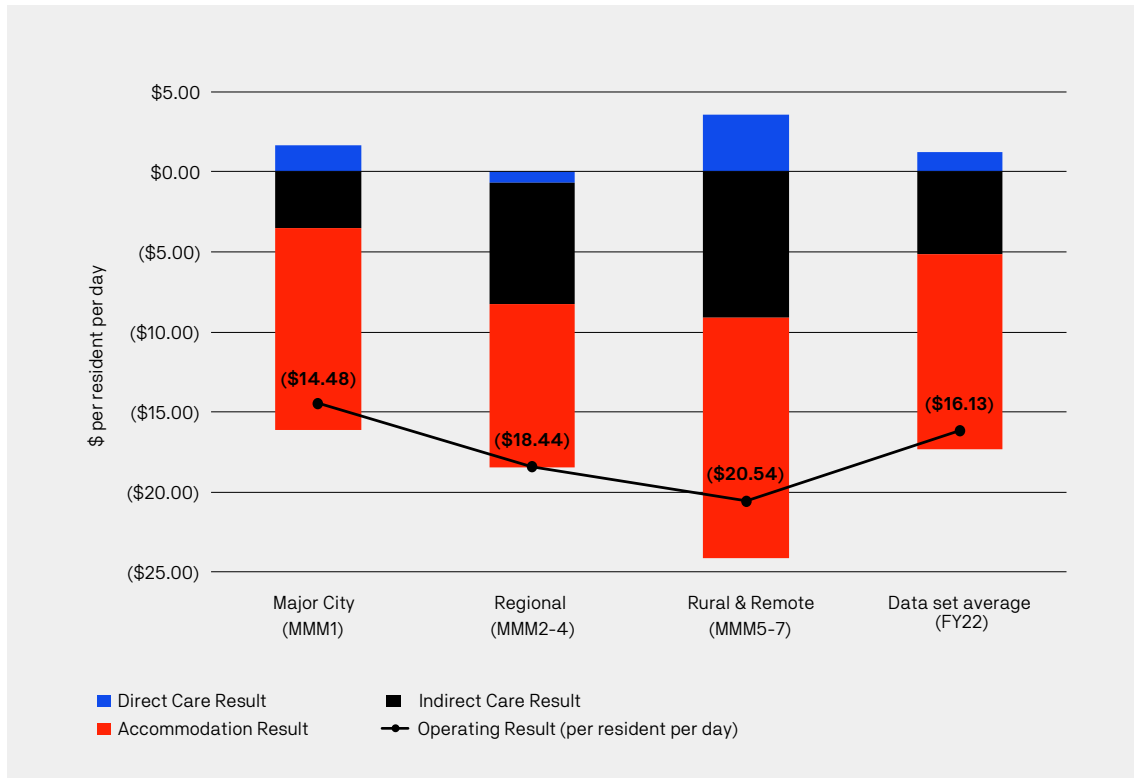
Digging deeper, the variation in homes' financial performance also stems from differences in the underlying business models for delivering residential care in different locations. Figure 13 shows the disaggregation of the homes' average Operating Result into the underlying three activities of residential care – direct care, indirect care and accommodation.<sup>49</sup> This shows that the smaller deficits of major city homes arise from their ability to generate a small margin from direct care and more minor losses from indirect care and accommodation than their non-metropolitan counterparts. By comparison, the regional homes, on average, operate at a loss across all three activities. Furthermore, rural and remote homes incur large deficits from accommodation and indirect care services, which far surpass the margins they earn on direct care.

49. As in the Operating Result breakdown analysis earlier, these results show the net revenue and expenses for each activity, including the allocation of overhead.



## Residential Care Analysis

Figure 13: Operating Result breakdown, by location



Looking more closely at direct care (the blue bands in Figure 13), homes vary because of differences in their average revenue streams. Homes in major cities earn \$197.01 per resident per day for direct care revenue, which is roughly equivalent to homes in rural and remote locations (\$197.65) but substantially higher than homes in regional areas (\$189.60) (see Table 11). These revenue variations reflect differences in resident mix, with homes outside the metropolitan centres servicing a more diverse cohort of residents, including more low-care residents that attract lower direct care subsidies under ACFI.<sup>50</sup> Furthermore, non-metropolitan homes have a higher supported resident ratio, meaning fewer residents with the financial capacity to pay means-tested care fees. Homes in rural and remote locations can offset some of these differences by accessing additional viability supplements. However, homes in regional locations may either be ineligible or receive supplements at a lower rate, thus resulting in their comparatively low rates of direct care revenue.

The indirect care results (the black bands in Figure 13), reflect some differences in revenue streams. Specifically, while all homes receive the same revenue from the BDF (and BDF supplement), homes in major cities, on average, earn more revenue from additional services. This may reflect differences in their residents' financial capacity and homes' capacity to navigate the complex regulatory settings around these service offerings. In addition, as detailed in Table 11, the differences in the indirect care results also arise because non-metropolitan homes incur higher average costs, such as for food, catering and laundry.

50. This will change with the introduction of the AN-ACC funding model, which includes higher base tariffs aimed at improving the funding for direct care for homes in MMM5-7 locations



Table 11: Breakdown of Operating Result, by location

	Major City (MMM1)	Regional (MMM2-4)	Rural & Remote (MMM5-7)	Data set average (FY22)
Number of homes in data set	765	317	120	1,202
<b>Direct Care</b>				
Direct care revenue	\$197.01	\$189.60	\$197.65	\$195.12
Direct care expenditure:				
Direct care labour costs	\$139.22	\$137.90	\$139.45	\$138.89
Other labour costs	\$28.05	\$25.15	\$26.06	\$27.09
Other direct costs	\$12.50	\$12.03	\$13.61	\$12.48
Allocation of administration costs (37.0%)	\$15.58	\$15.21	\$14.96	\$15.42
Total direct care expenditure	\$195.35	\$190.29	\$194.08	\$193.88
<b>Direct Care Result</b>	<b>\$1.66</b>	<b>(\$0.68)</b>	<b>\$3.56</b>	<b>\$1.23</b>
<b>Indirect Care</b>				
Indirect care revenue	\$66.75	\$64.52	\$64.32	\$65.92
Indirect care expenditure:				
Catering	\$33.98	\$35.26	\$35.97	\$34.51
Cleaning	\$9.90	\$9.35	\$9.76	\$9.74
Laundry	\$4.24	\$4.45	\$4.38	\$4.31
Other	\$7.98	\$9.20	\$9.71	\$8.48
Allocation of administration costs (33.6%)	\$14.15	\$13.81	\$13.58	\$14.00
Total indirect care expenditure	\$70.25	\$72.07	\$73.40	\$71.04
<b>Indirect Care Result</b>	<b>(\$3.50)</b>	<b>(\$7.55)</b>	<b>(\$9.08)</b>	<b>(\$5.13)</b>
<b>Accommodation</b>				
Accommodation revenue:				
Residents	\$13.21	\$11.72	\$10.92	\$12.59
Government	\$20.20	\$20.74	\$21.89	\$20.51
Total accommodation revenue	\$33.41	\$32.46	\$32.80	\$33.10
Accommodation expenditure:				
Depreciation	\$19.71	\$17.65	\$20.51	\$19.25
Property maintenance and rental	\$12.38	\$11.67	\$13.77	\$12.33
Other	\$1.58	\$1.25	\$1.66	\$1.50
Allocation of administration costs (29.4%)	\$12.38	\$12.08	\$11.88	\$12.25
Total accommodation expenditure	\$46.05	\$42.65	\$47.82	\$45.33
<b>Accommodation Result</b>	<b>(\$12.64)</b>	<b>(\$10.20)</b>	<b>(\$15.02)</b>	<b>(\$12.23)</b>
<b>Operating Result (per resident per day)</b>	<b>(\$14.48)</b>	<b>(\$18.44)</b>	<b>(\$20.54)</b>	<b>(\$16.13)</b>



## Residential Care Analysis

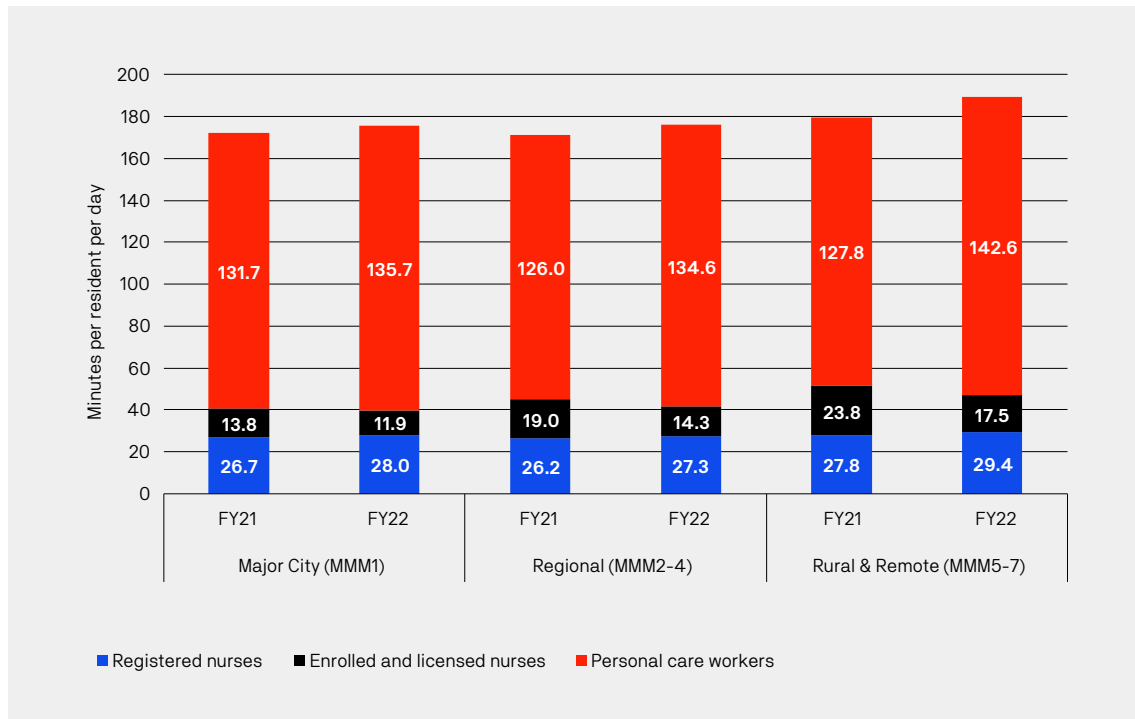
Regarding accommodation (the red bands in Figure 13), the results show that homes in major cities earn higher accommodation payments from non-supported residents,<sup>51</sup> whereas those in rural and remote locations receive high rates of government accommodation supplements. Table 11 also shows that the costs of providing accommodation are highest in rural and remote homes (\$47.82 per resident per day), followed by major cities (\$46.05) and then regional homes (\$42.65). This variation may reflect differences in property maintenance and rental expenses, capital infrastructure costs, and accounting depreciation policies.



51. Non-supported and partially supported residents can opt to pay for their accommodation either upfront via a refundable accommodation deposit (RAD) or a daily accommodation payment (DAP), which is calculated by multiplying the equivalent RAD amount by an interest rate. Critically homes only earn revenue from DAP payments as RADs are refunded in full when a resident leaves or passes away. Further discussion about the viability problems arising from accommodation pricing is provided in Part 2.



Figure 14: Direct care staffing minutes, by staff role and location



On average, homes across all locations have increased their total direct care staffing time per resident per day compared to 2020–21. As shown in Figure 14, the highest staffing rates are in homes in rural and remote locations. However, this result may reflect other characteristics of these homes, which tend to have lower occupancy levels and much smaller sizes (i.e., fewer beds).<sup>52</sup>

There are differences in homes' average staffing mix in that non-metropolitan homes tend to have more care hours provided by registered and enrolled nurses. For example, on average, homes in MMM 5–7 areas provide 46.9 minutes per resident per day of time from enrolled and registered nurses (24.7% of average total direct care time), whereas homes in MMM 1 areas provide 39.9 minutes per resident per day (22.6% of average total direct care time). Even so, Figure 14 also shows that there have been substantial contractions in average enrolled nurse staffing time, including a decline of 24.8% in regional homes and 26.8% in rural and remote homes.

Rural and remote homes' higher relative staffing time and more nurse-centric staffing mix do not appear to translate into higher direct care labour costs. As shown in Table 11, homes in MMM 5–7 areas spend on average \$139.45 per resident per day on direct care labour costs, which is commensurate with the amounts spent on homes in MMM 1 areas (\$139.22), and only slightly more than homes in MMM 2–4 areas (\$137.90). Closer analysis shows this is because MMM 5–7 homes incur lower average hourly staffing rates for registered nurses and personal care workers compared to homes in other locations. These differences likely reflect localised labour market dynamics, which may influence the competitiveness of homes' wages and the use of more expensive staffing strategies, such as agency and overtime.

52. Staffing metrics which are measured as a rate per resident day will tend to 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 large-scale congregate living facilities, there is increasing interest in providing care in small group models or home-like environments. Smaller-scale housing may be configured in standalone homes, neighbourhoods or wings within standard buildings or cottage-like clusters within a larger development. Such models are seen as facilitating the provision of person-centred care, with greater flexibility in structuring the day and the activities available to residents. There is also some evidence that the quality of care can be higher in smaller homes.<sup>53</sup>

**Table 12: 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 data set	107	534	352	209
Average number of beds	28.8	58.1	96.8	144.3
Average Operating Result (per resident per day)	(\$22.02)	(\$16.54)	(\$14.33)	(\$15.10)
Average Operating Result (per resident per annum)*	(\$7,009)	(\$5,157)	(\$4,483)	(\$4,615)
Average Operating EBITDAR (per resident per annum)*	(\$949)	\$1,250	\$2,558	\$2,363
Average Occupancy rate	90.4%	91.6%	91.3%	89.9%
Average direct care revenue (per resident per day)	\$202.40	\$194.19	\$194.25	\$195.23
Average direct care costs (as a % of average direct care revenue)	101.5%	99.9%	99.3%	99.6%
Average direct care minutes (per resident day)	183.5	175.9	178.7	179.4
Average supported ratio	49.7%	47.5%	43.2%	41.7%
Average of Full RADs/Bonds held at reporting date	\$337,971	\$373,799	\$413,862	\$450,211
Average of Full RADs/Bonds taken during period	\$399,916	\$418,647	\$458,665	\$489,301

Nonetheless, the analysis of homes of different sizes (summarised in Table 12) reveals substantial differences in their operating characteristics and financial performance. As shown in Figure 15, smaller homes, on average, tend to have poorer financial results. In 2021-22, homes with fewer than 40 beds incurred substantially larger deficits than the data set average, with an average Operating Loss of \$22.02 per resident per day and an average Operating EBITDAR loss of \$949 per bed per annum.

53. 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.



**Figure 15: Average Operating Result, by home size**

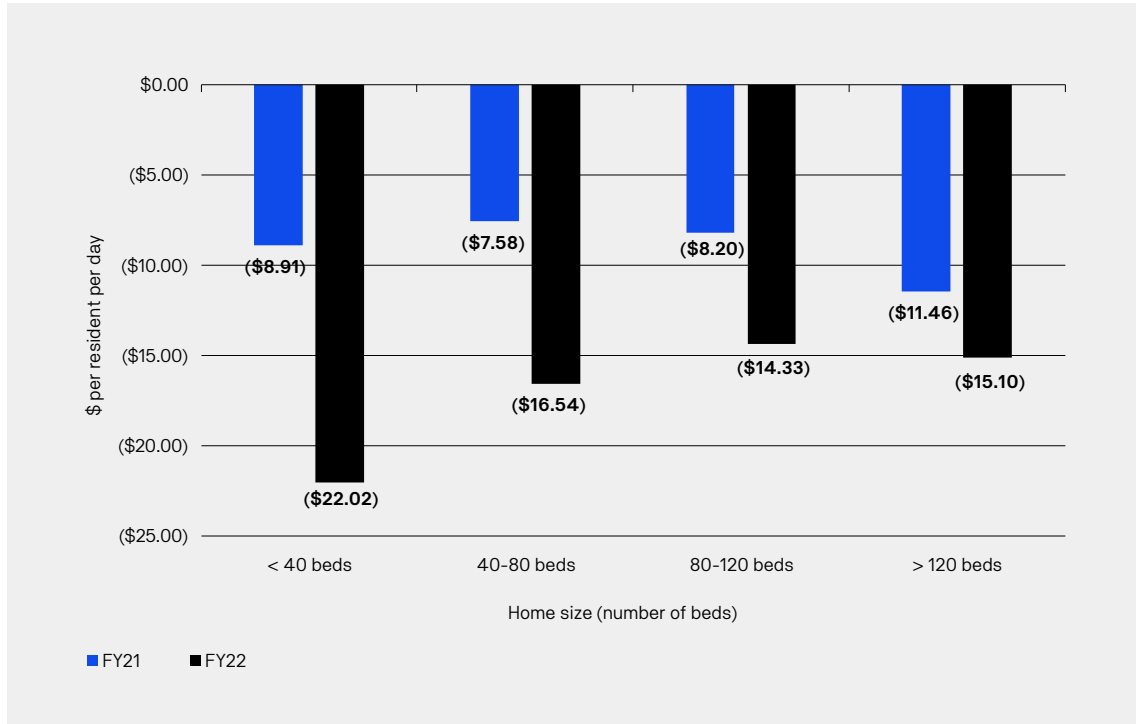
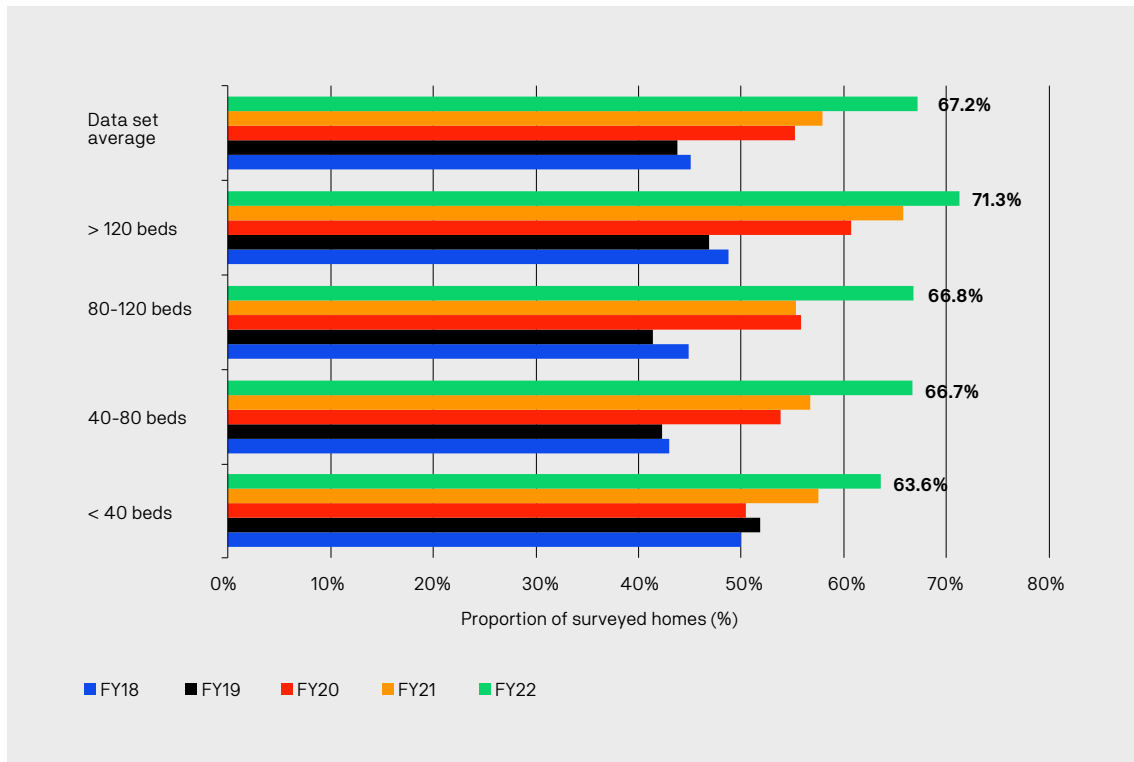


Figure 15 also shows that there is not a monotonic relationship between home size and profitability, in that very large homes (larger than 120 beds) may not benefit from economies of scale. The homes with the smallest operating losses tend to be between 80-120 beds in size. This size bracket generates the largest average Operating EBITDAR per bed per year (\$2,558), not graphed.



## Residential Care Analysis

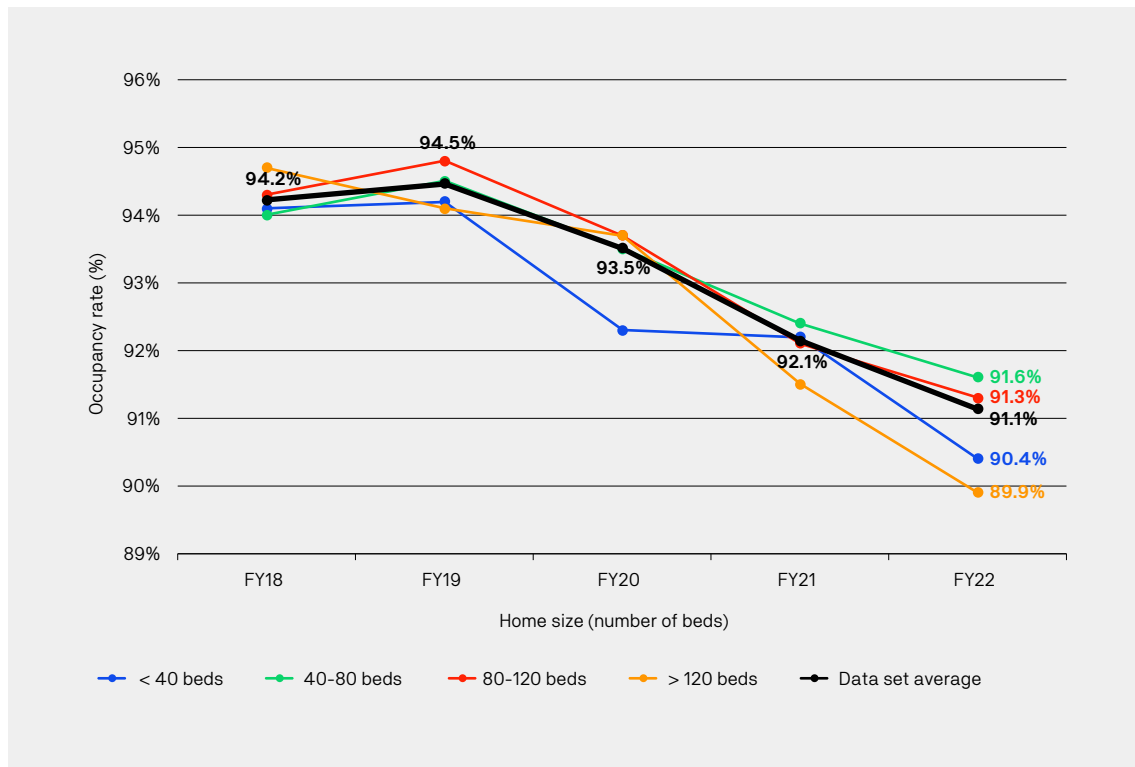
Figure 16: Proportion of homes operating at a loss, by home size



In addition, Figure 16, which shows the proportion of loss-making homes, suggests there is variation in the performance of homes within each size bracket. Although smaller homes (<40 beds) earn the lowest operating margins on average, it is the very large homes (more than 120 beds) that are more likely to be operating at a loss (71.3% in 2021–22). These results indicate that there may be substantial differences between the top and bottom performers in each size category.



Figure 17: Occupancy rate, by home size



Some of the patterns in profitability may reflect differences in occupancy across homes of different sizes. As Figure 17 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.

Table 13 provides a detailed breakdown of average operating revenues and expenses for homes in different size brackets. This reveals that one of the underlying causes of small homes' (<40 beds) Operating Results is the higher average costs they incur. For all three activities of residential aged care service delivery, homes in this size bracket incur the highest average expenditure per resident per day, particularly for care-related staffing, property maintenance and rental and administration costs. These additional costs more than offset the slightly higher average direct care subsidies that small homes earn.

The breakdown also shows the economies of scale for larger homes (80-120 and 120+ beds), which tend to incur lower average expenditure per resident, particularly for indirect care and accommodation. The limit of these economies is evident in the variation in administration costs, which are lowest on average for homes in the 80-120 size bracket.



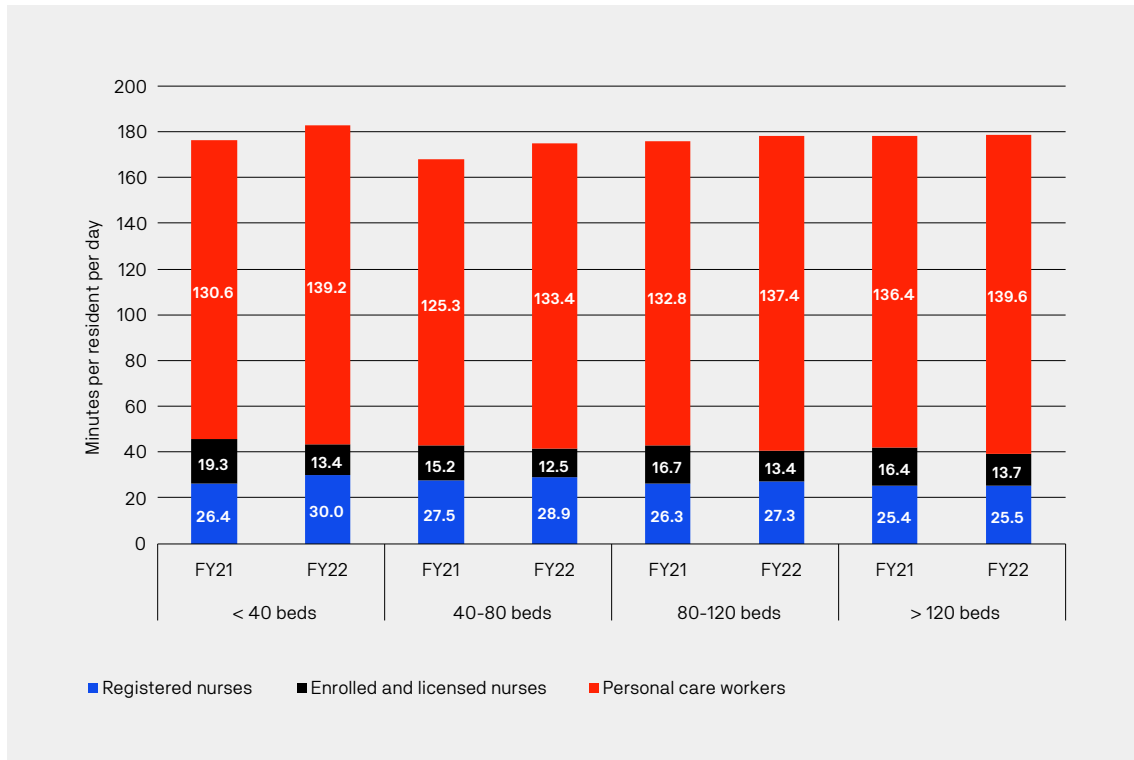
## Residential Care Analysis

Table 13: Breakdown of average Operating Result, by home size

	<40 beds	40-80 beds	80-120 beds	>120 beds	Data set average (FY22)
Number of homes in data set	107	534	352	209	1,202
<b>Direct Care</b>					
Direct care revenue	\$202.40	\$194.19	\$194.25	\$195.23	\$195.12
Direct care expenditure:					
Direct care labour costs	\$142.06	\$136.78	\$139.84	\$141.08	\$138.89
Other labour costs	\$30.85	\$27.39	\$25.93	\$26.35	\$27.09
Other direct costs	\$13.21	\$13.26	\$11.63	\$11.58	\$12.48
Allocation of administration costs (37.0%)	\$16.75	\$15.69	\$14.83	\$15.06	\$15.42
Total direct care expenditure	\$202.87	\$193.12	\$192.23	\$194.07	\$193.88
<b>Direct Care Result</b>	<b>(\$0.46)</b>	<b>\$1.07</b>	<b>\$2.02</b>	<b>\$1.17</b>	<b>\$1.23</b>
<b>Indirect Care</b>					
Indirect care revenue	\$64.79	\$65.36	\$66.43	\$67.07	\$65.92
Indirect care expenditure:					
Catering	\$33.95	\$34.69	\$34.34	\$34.65	\$34.51
Cleaning	\$8.73	\$9.64	\$10.06	\$9.98	\$9.74
Laundry	\$4.13	\$4.38	\$4.26	\$4.32	\$4.31
Other	\$9.67	\$8.46	\$8.30	\$8.17	\$8.48
Allocation of administration costs (33.6%)	\$15.21	\$14.25	\$13.47	\$13.67	\$14.00
Total indirect care expenditure	\$71.69	\$71.42	\$70.43	\$70.79	\$71.04
<b>Indirect Care Result</b>	<b>(\$6.89)</b>	<b>(\$6.06)</b>	<b>(\$4.00)</b>	<b>(\$3.74)</b>	<b>(\$5.13)</b>
<b>Accommodation</b>					
Accommodation revenue:					
Residents	\$11.09	\$12.00	\$13.18	\$13.88	\$12.59
Government	\$22.25	\$21.69	\$19.47	\$18.37	\$20.51
Total accommodation revenue	\$33.34	\$33.68	\$32.65	\$32.25	\$33.10
Accommodation expenditure:					
Depreciation	\$17.43	\$18.50	\$20.22	\$20.45	\$19.25
Property maintenance and rental	\$15.52	\$12.80	\$11.54	\$10.82	\$12.33
Other	\$1.75	\$1.47	\$1.44	\$1.55	\$1.50
Allocation of administration costs (29.4%)	\$13.31	\$12.47	\$11.78	\$11.96	\$12.25
Total accommodation expenditure	\$48.01	\$45.24	\$44.98	\$44.78	\$45.33
<b>Accommodation Result</b>	<b>(\$14.67)</b>	<b>(\$11.55)</b>	<b>(\$12.35)</b>	<b>(\$12.53)</b>	<b>(\$12.23)</b>
<b>Operating Result (per resident per day)</b>	<b>(\$22.02)</b>	<b>(\$16.54)</b>	<b>(\$14.33)</b>	<b>(\$15.10)</b>	<b>(\$16.13)</b>



**Figure 18: Direct care staffing minutes, by staff role and home size**



The total direct care time provided to residents has increased, year-on-year, across homes of all sizes. As shown in Figure 18, the largest 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 lower occupancy rates in smaller homes, as shown in Figure 17. As discussed elsewhere, Figure 18 shows a drop in the average enrolled nurse minutes across all home size categories.

# Home Care Analysis

## Overview

▶ The FY22 data set includes 60,630 home care packages, which represents 29.1% of the 208,512 home care clients in Australia.

▶ The financial performance of home care services declined by 38.7%, dropping to an average Operating Result of \$3.42 per client per day in 2021-22.

▶ While the average costs of providing home care have remained constant, revenues have declined by 3.1% compared to the prior year, to an average of \$69.80 per client day.

▶ Revenue utilisation has fallen to 85.0%, and the average unspent funds has increased to \$10,802 per package.

▶ The decline in revenue and profitability has been most acute for providers with package mixes containing more lower-level packages.

▶ Direct care time provided by internal staff has continued to fall to an average of 3.67 hours per client per week (31 minutes per day), while the proportion of direct care provided by third parties continues to grow.



## 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 HCPs. As noted earlier, the StewartBrown data set does not currently extend to CHSP, STRC and other service providers, though future changes will align with the proposed Support at Home Program from July 2024.

Table 14: Profile of home care services in the data set

	FY22	FY21
Number of home care services in the data set	391	417
Total number of packages in the data set	60,630	50,567
<b>Ownership</b>		
For-Profit	0.5%	0.5%
Not-For-Profit	99.5%	99.5%
<b>Location</b>		
Major City	57.5%	57.3%
Rural	42.5%	42.7%
<b>State</b>		
NSW	35.3%	36.0%
NT & ACT	1.8%	1.7%
QLD	30.9%	35.5%
SA	12.0%	11.3%
TAS	3.1%	2.9%
VIC	9.7%	6.7%
WA	7.2%	6.0%
Average number of funded packages per home care service	155	121
<b>Average package mix</b>		
% of Level 1 Packages	7.2%	11.2%
% of Level 2 Packages	38.1%	38.4%
% of Level 3 Packages	30.4%	25.1%
% of Level 4 Packages	24.3%	25.4%



## Home Care Analysis

This section analyses the outcomes from the Full-Year 2022 StewartBrown data set, which included 60,630 HCPs delivered by 391 home care service providers. This represents approximately 29.1% of the 208,512 HCP clients in March 2022,<sup>54</sup> and 17.2% of the 2,427 home care services in Australia in June 2022.<sup>55</sup> As shown in Table 14, almost all (99.5%) of these services are delivered by not-for-profit providers (noting that the data set does not include the large minority of HCP providers that are government agencies). Most (57.5%) providers were located in major cities, particularly in NSW (35.3%) and QLD (30.9%).<sup>56</sup> On average, the number of packages per service provider increased to 155 in 2021-22. 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.

The overall mix of packages across participating home care providers has changed slightly year-on-year. There has been a slight decrease in Level 1 and 4 packages and an increase in Level 3 packages, while Level 2 packages remained relatively constant. The survey package mix in the data set is consistent with sector-level statistics of the proportion of people in HCPs, by package level, reported by the DoHAC.<sup>57</sup>

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54. Department of Health and Aged Care (2022), *Home care packages program, data report 3rd Quarter 2021-22*, Australian Institute of Health and Welfare.

55. Department of Health and Aged Care (2022), *Aged care data snapshot—2022, Second release*, Australian Institute of Health and Welfare.

56. This location represents the best estimate of the location of the home care provider, as per the service listing, noting that in many instances this will represent the location of the provider rather than the package recipient.

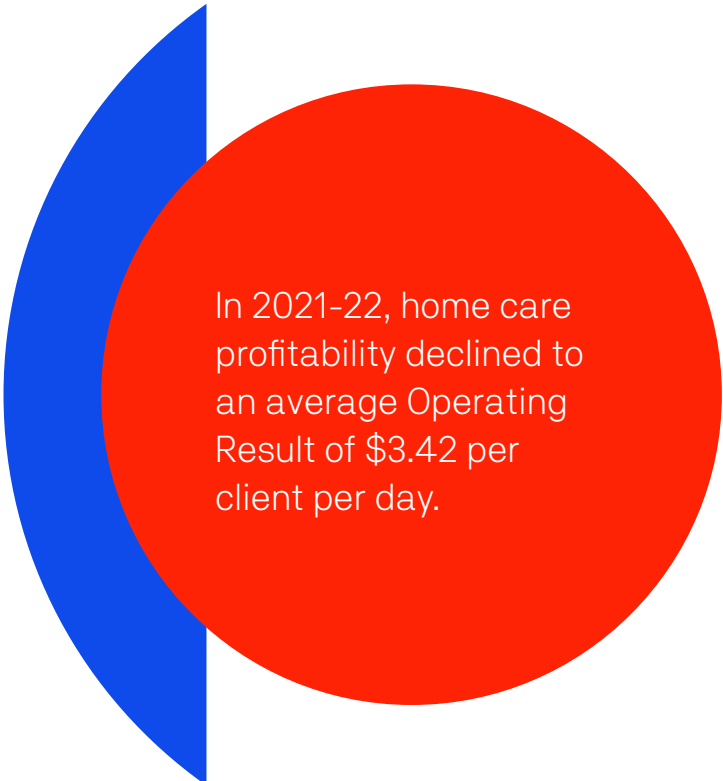
57. Department of Health and Aged Care (2022), *Home care packages program, data report 3rd Quarter 2021-22*, Australian Institute of Health and Welfare.



## Key performance indicator summary

Table 15: Key performance indicators of home care services

	FY22	FY21
Operating Result per client per day	\$3.42	\$5.58
Operating EBITDA per client per annum	\$1,446	\$2,179
<b>Revenue:</b>		
Revenue per client per day	\$69.80	\$72.02
Revenue utilisation rate	85.0%	87.3%
Unspent funds per package	\$10,802	\$9,592
<b>Costs:</b>		
Direct care and brokered services costs (as % of revenue)	58.4%	58.1%
Care management and advisory costs (as a % of revenue)	12.0%	11.0%
Administration and support costs (as % of revenue)	24.7%	22.7%
Profit margin (%)	4.1%	7.6%
Total staff hours per client per week	5.2	5.3



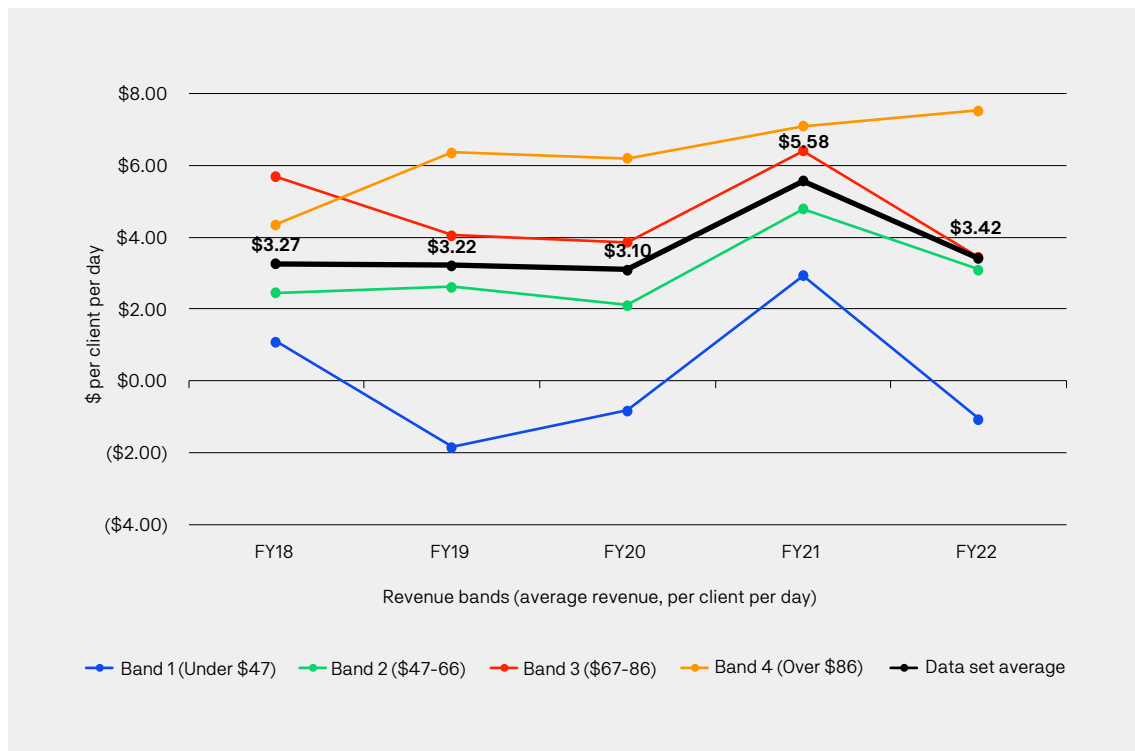
In 2021-22, home care profitability declined to an average Operating Result of \$3.42 per client per day.



## Financial performance

As in the case of residential care, the financial performance of home care service providers directly impacts the sustainability of the aged care sector. If home care providers cannot 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 19: Average Operating Result, by revenue bands**



In the 2021–22 financial year, the profitability of home care services declined substantially. As shown in Figure 19, on average, services achieved an Operating Result<sup>58</sup> of \$3.42 per client per day, a fall of 38.7% from \$5.58 per client per day the previous year.

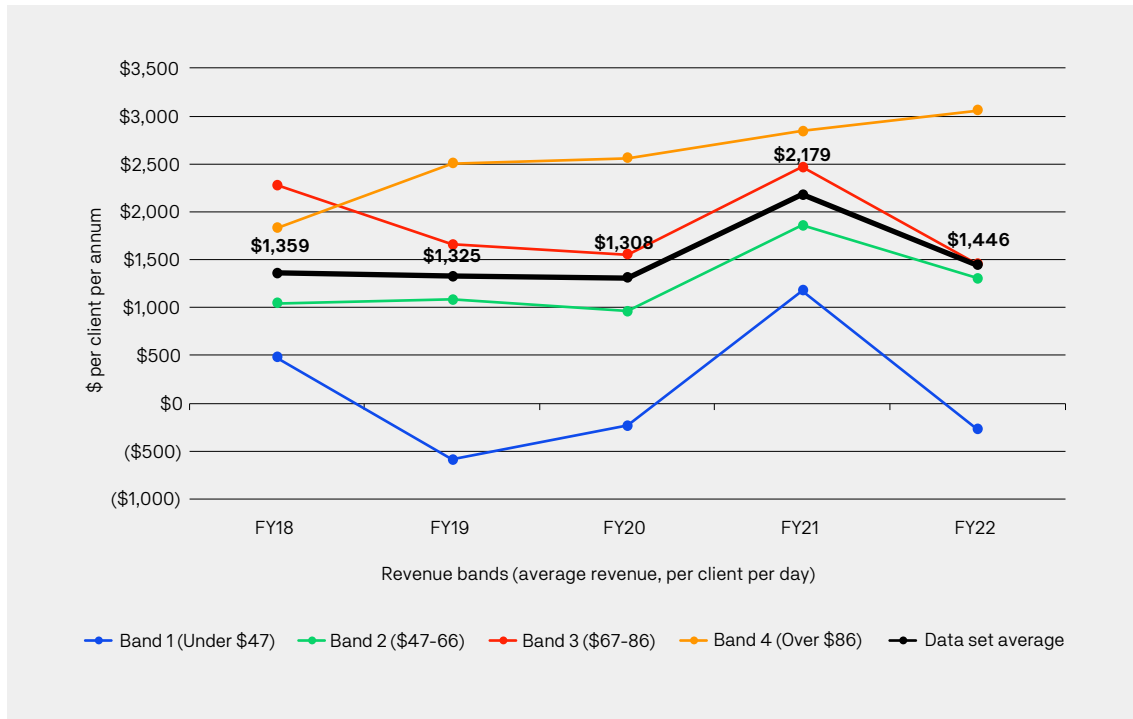
Figure 20 shows that in 2021–22 the operating EBITDA<sup>59</sup> was \$1,446 per client per annum, down from \$2,179 per client per annum in 2020–21. While this year-on-year decline in profitability appears steep, Figures 19 and 20 suggest that the 2021–22 result reverts to a similar profitability trend over the previous five years. Although home care providers do not incur the same capital outlays as in residential care, the persistently low profit margins (4.1% in 2021–22), represent an ongoing challenge.

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

59. 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.



**Figure 20: Average Operating EBITDA, by revenue bands**



Both Figures 19 and 20 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). 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.

The total value of the packages – comprising the Government subsidy and any income-tested co-contribution (which is netted from the Government subsidy) is as follows:

- **Level 1** – \$9,026 per annum (\$24.73 per day)
- **Level 2** – \$15,878 per annum (\$43.50 per day)
- **Level 3** – \$34,551 per annum (\$94.66 per day)
- **Level 4** – \$52,378 per annum (\$143.50 per day)<sup>60</sup>

Both graphs reveal substantial variation in the profitability of home care providers, with a clear relationship between services’ financial performance and revenue per client per day. For example, for Operating Results in 2021–22 (Figure 19), services classified as Band 4 (more higher-level packages) earned an operating surplus of \$7.53 per client per day, \$8.60 higher than those classified as Band 1, which made a loss of \$1.07 per client per day. The poor profitability of providers in the lower three bands raises concerns about the viability of lower-level HCPs, including the current business models of providers, particularly as the sector moves towards a unified Support at Home Program.

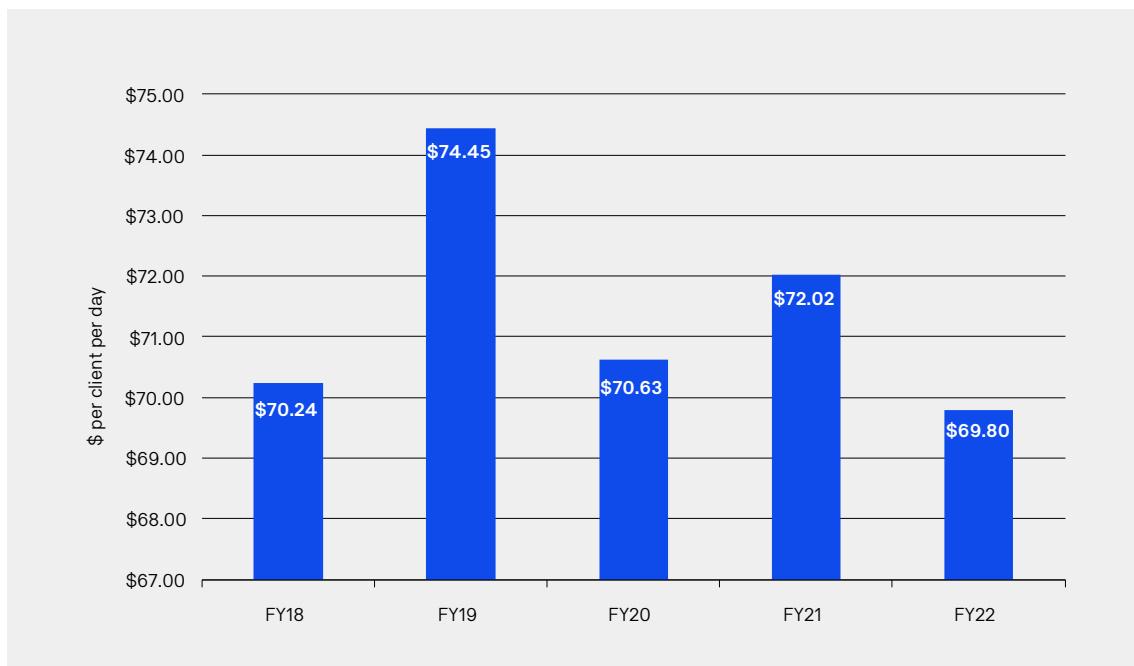
60. Department of Health, Aged Care Subsidies and Supplements from 1 July 2021.



## Revenue analysis

The primary revenue sources for home care service providers are government subsidies for HCPs and any income-tested fees paid by clients.<sup>61</sup> Home care providers earn revenue (equivalent to their charges for services delivered) when the clients use their package funds. The services can include personal and nursing care, domestic and social support activities, home maintenance, and modifications to help support their independence.

Figure 21: Average revenue per client per day



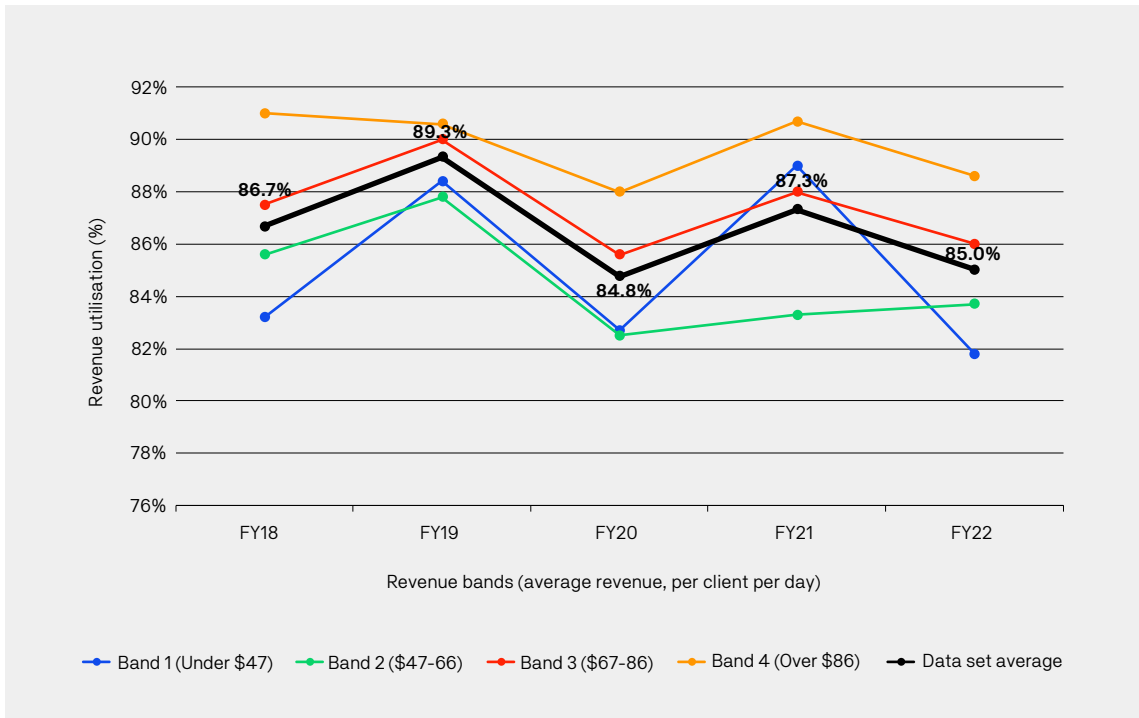
As shown in Figure 21, one of the main reasons for the decline in the profitability of home care providers is the decline in average revenue earned per client per day. In 2021–22, the average revenue per client day was \$69.80, which is 3.1% lower than the \$72.02 per client per day earned in 2020–21. The decline primarily reflects contractions of direct services revenue per client per day, although this was partially offset by increased revenue earned through brokered services. The overall revenue decline has occurred despite the indexation increases of HCP subsidies (approximately 1.1% per annum) and the slight increase in the proportion of Level 3 packages in the survey sample (see Table 14).<sup>62</sup>

61. Providers also earn revenue from additional government supplements as well as care co-contributions from home care recipients.

62. 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.



**Figure 22: Home care package utilisation rate, by revenue band**



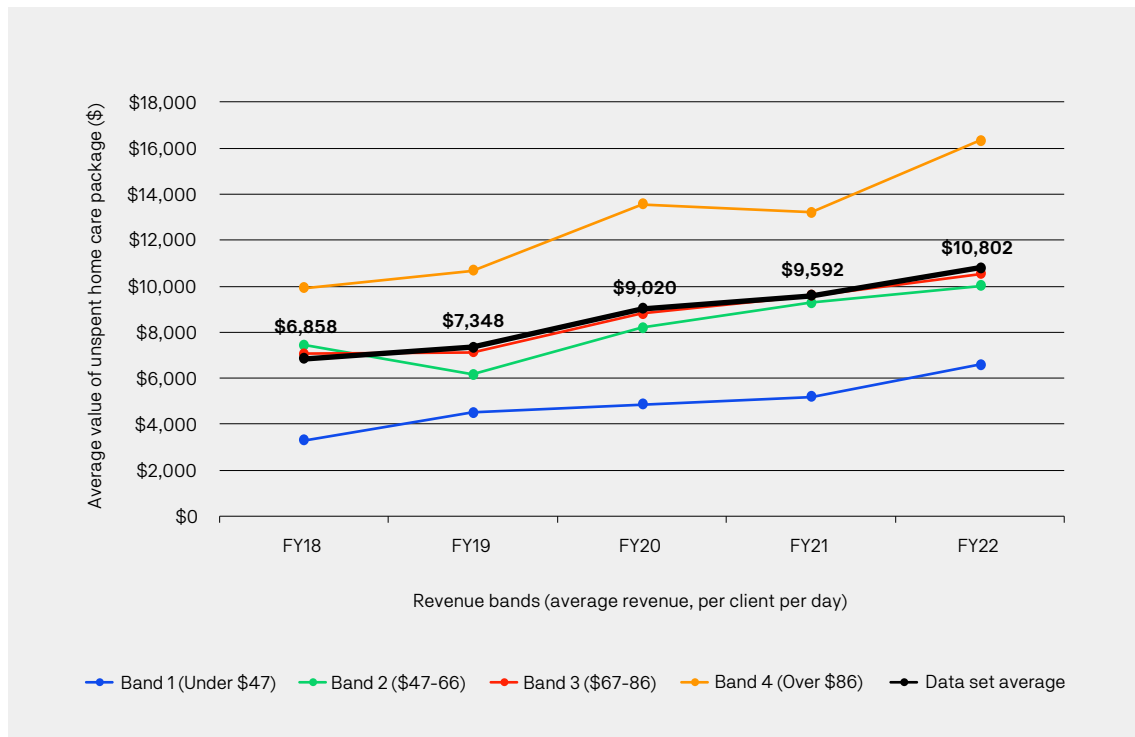
The declining revenue figures can be traced to the fall in revenue utilisation shown in Figure 22. Revenue utilisation represents the proportion of the allocated subsidies that home care clients use. Thus, all other things being equal, a drop in revenue utilisation will decrease revenue earned per client. As shown in Figure 22, the average revenue utilisation rate in 2021-22 across surveyed home care services was 85.0%, down from 87.3% the year prior. Furthermore, the most dramatic decline occurred within Band 1 providers, which saw revenue utilisation fall from 89.0% in 2020-21 to 81.8% in 2021-22. Looking back over the last five years, utilisation rates have been volatile and there has only been a small declining trend.

Declining utilisation could reflect a variety of factors. For example, it might reflect the hesitancy of providers to charge appropriate prices for the services they offer. Alternatively, it will also reflect the consumption patterns of home care clients and their willingness to use services up to the total value of their package subsidy. For example, utilisation may have been affected during COVID-19 outbreaks if clients opted to cancel or postpone home care services or cancelled the more intensive services (such as personal and nursing care), which attract higher revenue rates. Persistent low utilisation rates may also reflect problems in assessment (e.g., if clients receive a package that exceeds their actual need) or the lack of granularity in the four levels of home care funding, which may not precisely align with individual clients’ needs.



## Home Care Analysis

Figure 23: Average unspent funds per package, by revenue band



Lower revenue utilisation also influences measures of unspent funds, which represent the average accumulated value of the subsidy that a client has not used for home care services. Noting that the StewartBrown home care data set captures the unspent funds held by contributing providers and Services Australia,<sup>63</sup> Figure 23 shows that the average value of unspent funds has continued to increase to \$10,802 per package by June 2022. In addition, it appears to have grown across all revenue brackets, particularly for providers offering more lower-level packages (Band 1) and high-level packages (Band 4).

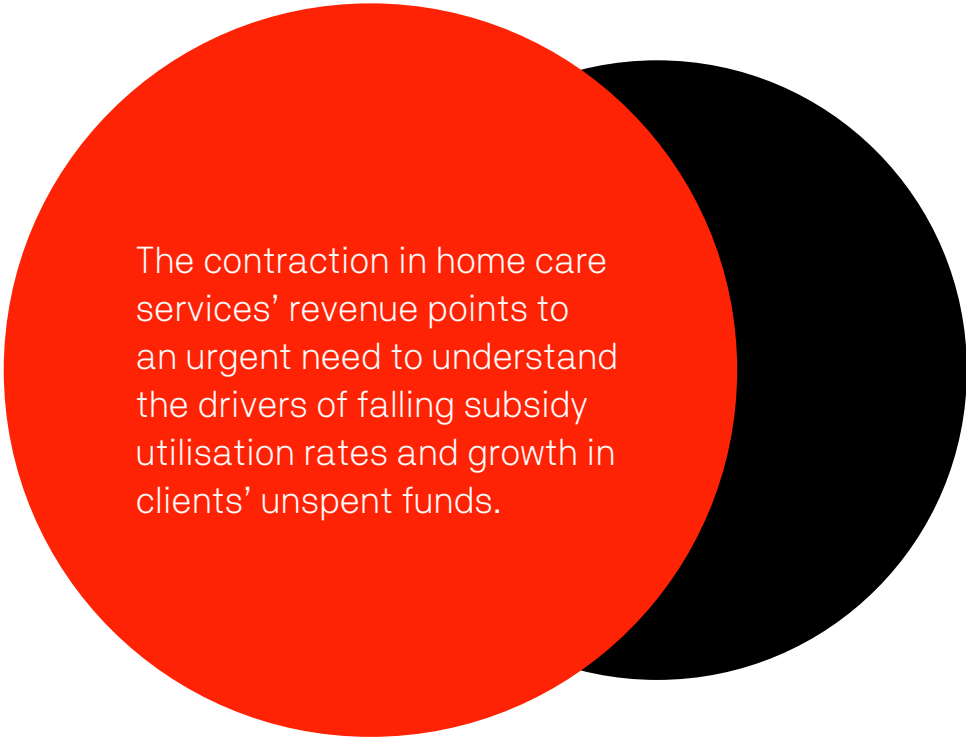
From a provider's perspective, unspent funds represent unrealised revenue and potential additional net surplus. Given the necessary fixed cost outlays in providing home care services, such as equipment, vehicles and administrative overheads, the growing levels of unspent funds represent a potential threat to their financial viability. In particular, the growth in unspent funds for Band 1 providers is somewhat perplexing. These providers offer more Level 1 and 2 packages with lower subsidy values that should be easier for clients to expend on relevant services.

63. From 1 February 2021 the Government introduced the 'improved Payment Arrangements' which adjusted the way Home Care Package funding was paid, first to funding in arrears (rather than in advance) and then only to acquit providers for the actual services and goods delivered. As part of this adjustment, clients' unspent funds will be progressively migrated to Services Australia. Further changes to payment arrangements are expected in the redesign of in-home care programs under the unified support at home program. Note that in the Approved Provider balance sheet figures (described earlier), the data set only contains the liabilities of unspent funds held by providers.



From a policy perspective, unspent funds represent an inefficient allocation of taxpayer monies, particularly while there remains a long waiting list for HCPs. StewartBrown estimates that at a sector level, the aggregate value of unspent funds is currently more than \$2.1bn.<sup>64</sup>

These trends suggest an urgent need to understand better the drivers of providers' declining revenue utilisation rates and the growth in clients' unspent funds. The aim should not necessarily be to ensure that the packages allocated under current arrangements are fully spent but rather that taxpayer funds are being allocated correctly to older Australians according to the program criteria and that providers can deliver the needed services in a viable manner.



64. StewartBrown (2022), *Aged Care Financial Performance Survey Report*.



## Cost analysis

Providers' expenditures in delivering home care services can be disaggregated into three basic categories:

- Direct care service provision (including services provided by third parties through subcontracted and brokered service arrangements).<sup>65</sup> This typically includes costs of staffing, consumables, travel and home modifications.
- Care management and advisory. This typically relates to the labour and transport costs of staff who help manage and coordinate services for clients, including managing the delivery of services from third parties.<sup>66</sup>
- Administration and support. This typically includes the costs of administration staff, centralised 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.

Total costs of providing home care have remained similar to the prior year. Providers incurred an average of \$66.41 per client per day, only marginally higher than the \$66.15 in 2020–21. Nonetheless, because of the decline in revenue per client per day, the rate of expenditure, as a proportion of revenue, increased compared to the prior year (see Figure 24). This resulted in a drop in the average operating margin from 7.6% in 2020–21 to 4.1% in 2021–22.

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65. 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.

66. In the new Support at Home program design, although there will be more options for self-management, there will also likely be a more prominent role for care managers, who will assist older Australians to coordinate the delivery of services from multiple providers.



**Figure 24: Home care cost categories as a proportion of revenue**

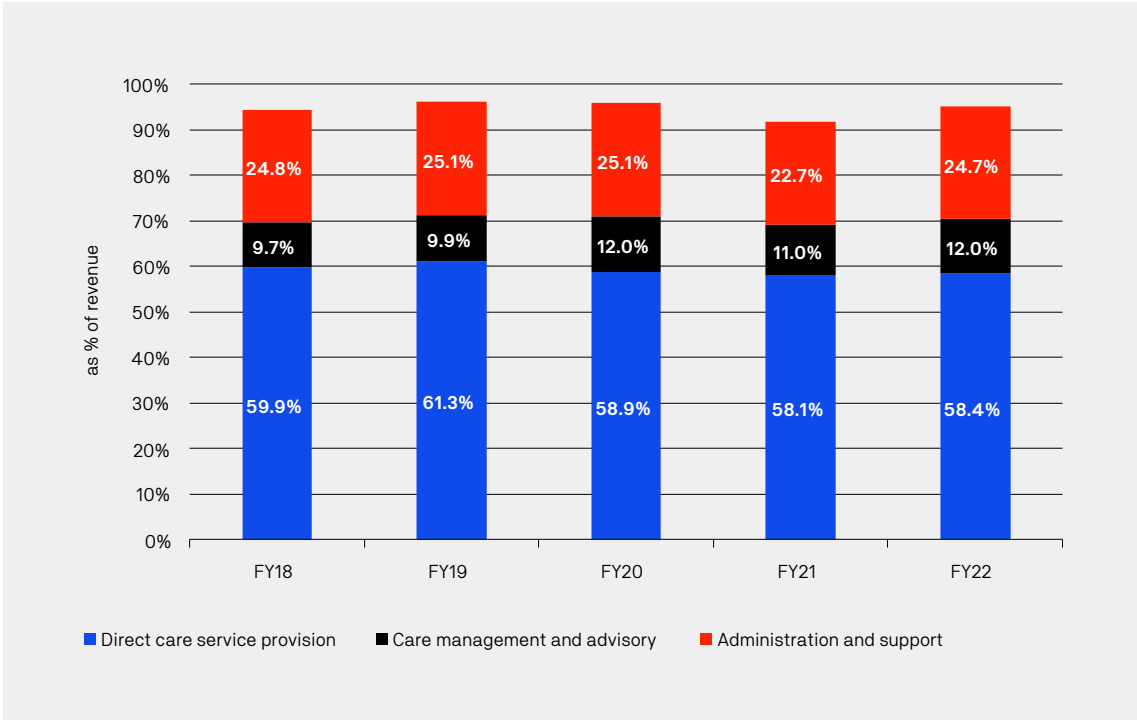
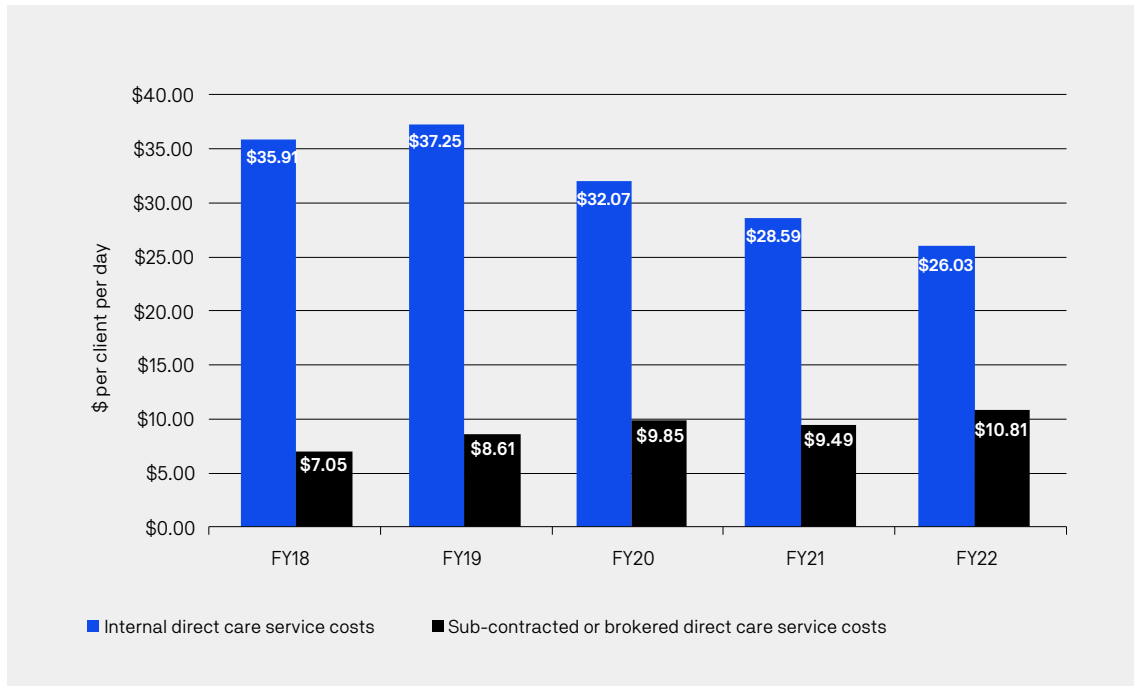


Figure 24 also shows a gradual change in the composition of home care providers’ expenditure across the three categories described above. Although more than half of the expenditure (58.4% in 2021–22) relates to direct care service provision, this proportion has fallen slightly since 2018–19. By comparison, the costs of care management and advisory have grown, while the costs of administration and support have remained steady. This data reflects increases in outlays relating to providing advice to clients and compliance activities and the need for providers to continue administration support, even when clients’ use of services has stagnated.



## Home Care Analysis

Figure 25: Average direct care costs, internal vs. sub-contracted services



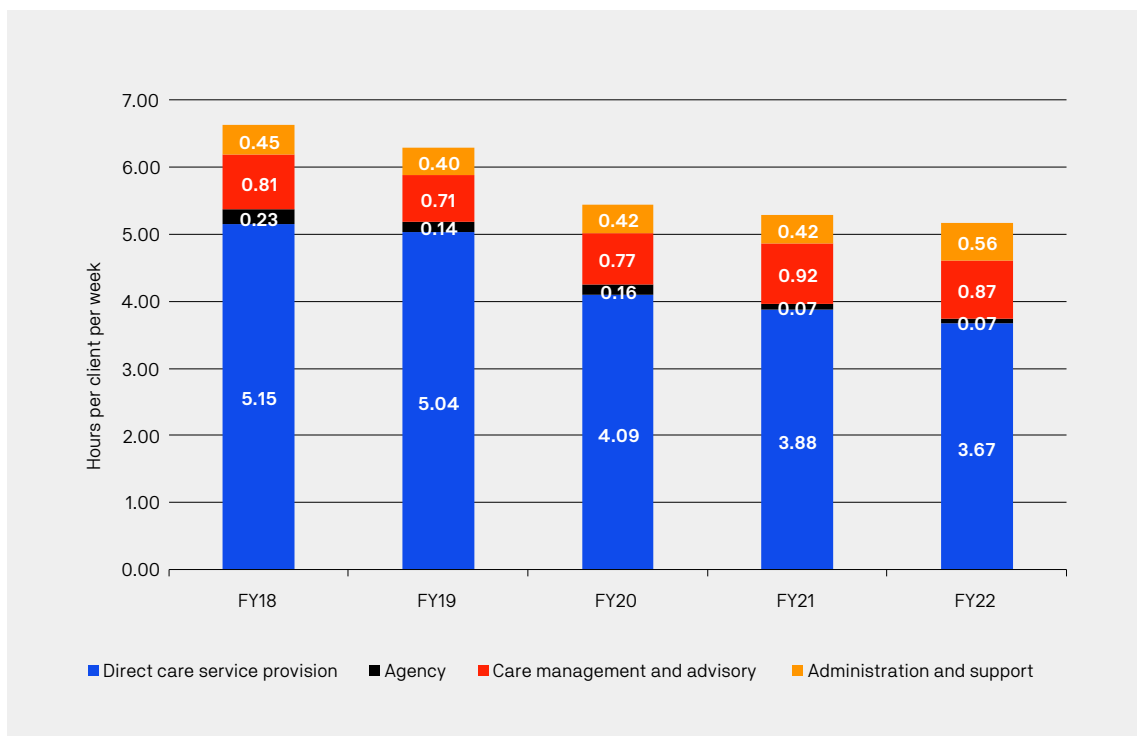
Looking more closely at the expenses within direct care service provision indicates an increasing trend of using third parties to deliver home care services. As Figure 25 shows, in the last financial year, the average amount of internal direct care expenditure has continued to decline (to an average of \$26.03 per client per day), while the amount spent on subcontracted or brokered services has continued to increase (to an average of \$10.81 per client per day). This trend could reflect a variety of factors. It may reflect consumers' preferences for providers that offer diverse service offerings with more self-management, providers' strategic choices in how they organise their business or potential difficulties in recruiting and retaining a stable internal workforce. From a provider's perspective, using third-party services may compromise efficiency by contributing to increased coordination and administration costs and possibly make it more challenging to maintain and ensure service quality.



# 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. As detailed in Part 3, home care providers, like those in residential care, have experienced significant challenges in attracting and retaining sufficient workers during the last financial year.

**Figure 26: Home care internal staffing hours per client per week, by staff category**



These experiences are also evident in the trend data of internal staffing shown in Figure 26.<sup>67</sup> In 2021-22, the total staffing in home care services declined to an average of 5.17 hours per client per week, which is 2.3% lower than in 2020-21. Although this decline is relatively minor compared to the steep fall that occurred in 2019-20, it nonetheless represents a concerning long-term trend of declining home care staffing hours per client.

Figure 26 also shows alternative patterns in various staffing categories. For example, while most categories have fallen, there has been a 31.5% increase in the average staffing time spent on administration and support, from 0.42 hours per client per week (25 minutes) in 2020-21 to 0.56 hours (33 minutes) in 2021-22.

67. This data excludes brokered and subcontracted staffing hours. Based on the cost analysis above, these third-party staffing hours are becoming a more significant component of home care delivery.



The average direct care time provided by internal staff has continued to decline to 3.67 hours per client per week. This trend may reflect service capacity constraints and increased reliance on brokered staff.

The internal staffing category of most concern is the direct care service provision, which has continued to decline. In 2020–21 internal direct care staffing time averaged 3.88 hours per client per week (approximately 33 minutes per day). In 2021–22 this fell to an average of 3.67 hours per client per week (approximately 31 minutes per day). Since 2017–18, the average internal direct care staffing time received by older Australians has fallen by 28.6%.

The decline in internal direct care staffing hours will have been partially offset by the increased use of brokered or subcontracted services to deliver direct care services (noting their staffing hours are not included in the workforce analysis depicted in Figure 26). This trend is explored in Part 3 of this report. Nonetheless, the quantum by which brokered staffing costs have increased does not fully account for the fall in internal direct care staffing since 2017–18.

The longer-term decline in staff time for care-related services may reflect capacity constraints as providers struggle to find enough suitable aged care workers to service the recent growth in the total number of HCPs over the last five years. For example, in June 2018, there were 91,847 people with a home care package, compared to the most recent estimate of 208,512 clients (in March 2022), representing a total growth of 127%.<sup>68</sup> A more detailed discussion of providers' recent experiences of skill shortages will be explored in Part 3 of this report.

68. Department of Health and Aged Care (2022), Home care packages report, Australian Institute of Health and Welfare.

The decline in financial performance has been most acute for home care providers offering more lower-level package mixes.

Part  
**2**

# Analysis and commentary

Part 2 of this report provides commentary on the issues facing the Australian aged care sector, placing the results of the 2021–22 financial year in the context of wider trends.

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### Current challenges and issues

It begins with an analysis of the acute challenge of sector financial viability and the sustainability of residential care services, and the incoming minimum staffing requirements, followed by commentary on the capping of home care advisory and administration fees.

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### Policy and reform agenda

This is followed by a summary of major policy initiatives currently underway, including:

- New aged care legislation
  - New Support at Home Program
  - Fair Work Commission's response to the wage case
  - Star Ratings system
  - October Budget update
-

# Current challenges and issues

## Financial viability and sustainability

The 2021-22 financial performance results provide evidence of the ongoing decline in the financial performance of the Australian aged care sector. For many providers, these financial outcomes represent increasingly acute threats to the financial viability of their aged care business streams, particularly in residential care.

To summarise, in 2021-22, the financial performance of aged care services worsened compared to the year prior across all three levels of analysis:

▶ Approved providers reported an average operating deficit of \$3.2m in 2021-22, almost doubling the average deficit of \$1.8m in 2020-21. This represented an operating return on assets of negative 1.6% and an EBITDAR profit margin of only 0.9% (compared to 2.0% in 2020-21).

▶ Two out of three (67%) residential aged care homes are operating at a loss, with an average deficit of \$16.13 per resident per day (almost double the average deficit of \$8.55 in 2020-21).

▶ The average operating profit of home care services declined by 38.7% year-on-year to \$3.42 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, smaller homes, homes located outside the major cities and homes that serve residents with less complex care needs.

Nonetheless, the negative Operating Results across all surveyed homes point to significant issues in the underlying model of providing residential care in Australia. Furthermore, the successive years in which residential aged care homes have incurred operating losses have eroded existing reserves of financial resources. Combining reported data from the DoHAC and projections from the 2021–22 StewartBrown data set, it appears that Australian residential care homes have incurred at least \$2.75bn of operational losses over the last three financial years.<sup>69</sup>

Some of the main drivers for these poor financial results in residential care have been:

- The Government's low rates of indexation of payments of subsidies and supplements, which have not kept pace with inflation or wage rate increases across the sector.
- The decline in occupancy, particularly since 2018-19, coinciding with the substantial expansion of the availability of HCPs.
- The financial impacts of the COVID-19 pandemic, which further depressed occupancy rates; disrupted regular service delivery; created workforce shortages necessitating more agency staff and overtime; and required additional net expenditure on reactive and proactive infection control measures.<sup>70</sup>
- The rising administrative and compliance costs (i.e., overheads) required to implement the various initiatives within the aged care sector reform agenda following the Government's response to the Royal Commission.
- The increased cost of staffing, resulting from both the required uplift in direct care staffing minutes per resident to meet the new minimum standards, and wage pressures arising from shortages of knowledgeable and skilled staff across the sector.
- Persistent financial deficits in providing indirect care and accommodation, despite the inflow of additional government funding from the BDF supplement.

The dynamics of how residential care services are funded will change with the new funding model for direct care. From October 1, 2022, the Australian National Aged Care Classification (AN-ACC) funding model replaced ACFI subsidies, homeless and viability supplements and the BDF supplement.

69. This figure includes the sector-level statistics of the aggregate Net Profit Before Tax provided by DoHAC of negative \$736m in 2019-20 and negative \$854m in 2020-21. The 2021-22 estimate (a \$1.162bn loss) is based on a projection of the average Operating Result from the StewartBrown data set, assuming 219,965 operational beds and an occupancy rate of 89.7%. The 2021-22 projection is likely to be conservative as it only includes mature homes (which excludes homes with disruptions), and also does not include state government-owned homes, which have lower rates of occupancy and worse financial performance.

70. Aged care providers have been able to access a range of COVID-related subsidies, payments and grants from the Government. However, the eligibility criteria around some of these grants do not necessarily cover the full extent of additional expenditure or losses of revenue incurred by providers taking proactive measures that prevent active COVID outbreaks, nor the additional workforce costs stemming from skill shortages.



## Current challenges and issues

Under AN-ACC, homes will receive a subsidy for the direct care of their permanent residents that differs from the ACFI formulation in that it includes:

- a base care tariff, reflecting the fixed cost of providing services. It varies depending on the location and service offerings of the homes<sup>71</sup>;
- variable funding based on the individual care needs of residents according to the AN-ACC classification; and
- a one-off transition payment for each newly admitted permanent resident.

The exact rate for each of these three components is determined relative to a national efficient price set by the Minister for Aged Care. The AN-ACC starting price from 1 October 2022 has been set at \$216.80 for 2022–23.<sup>72</sup> Modelling released during the Budget 2022–23 forecast that the average AN-ACC subsidy is expected to be \$225 per resident per day.

A key feature of the new funding model is that homes must also meet the new minimum direct care staffing requirements. Two of these requirements are tied directly to residents' assessed care needs under AN-ACC. This means that in addition to having a registered nurse on site at all times (from 1 July 2023), each home will need to ensure that both their total direct care minutes and registered nurse minutes meet their AN-ACC determined targets (from 1 October 2023).<sup>73</sup>

Following the October 2022–23 Budget, the DoHAC has announced that all homes under 60 beds will receive an additional supplement to help fund the requirement for a 24/7 registered nurse.<sup>74</sup>

There are several positive features in the shift to the new funding model. For example, the design of the base care tariffs will deliver higher funding rates to regional and remote providers and those providing specialised services.<sup>75</sup> These additional subsidies will help address the comparatively poor overall financial results of homes in MMM 5–7 (described in Part 1) and ensure continuity of access to residential care outside major cities. Further, the model gives transparency to the weighting for homes in different regions, enabling monitoring and future modelling and payment adjustments. One issue that warrants further attention is the relatively poor direct care results of homes located in MMM2–4, which on average, incurred a deficit from direct care services in 2021–22.

71. Homes located in MMM5, 6 and 7 receive a higher rate, as do homes that offer specialised services for homeless residents or Aboriginal or Torres Strait Islander peoples. Furthermore, homes in MMM 6 and 7 locations receive the subsidy on the basis of operational (not occupied) places, to provide more certainty in funding, regardless of occupancy.

72. <https://www.health.gov.au/sites/default/files/documents/2022/10/schedule-of-subsidies-and-supplements-for-aged-care-schedule-from-1-october-2022.pdf>

73. Sector-wide, the targets for 1 October 2023 will be 200 minutes per resident per day for total direct care and 40 minutes per resident per day. These targets will increase to 215 minutes and 44 minutes respectively by 1 July 2024. Each home's targets are determined by the relative acuity of their residents, as assessed under AN-ACC. Homes with more high needs residents will have targets above the sector-wide averages and homes with more low needs residents will have targets below. More detailed analysis about the staffing uplift required is provided in Part 3.

74. <https://www.health.gov.au/health-topics/aged-care/providing-aged-care-services/funding-for-aged-care-service-providers/247-registered-nurse-supplement>

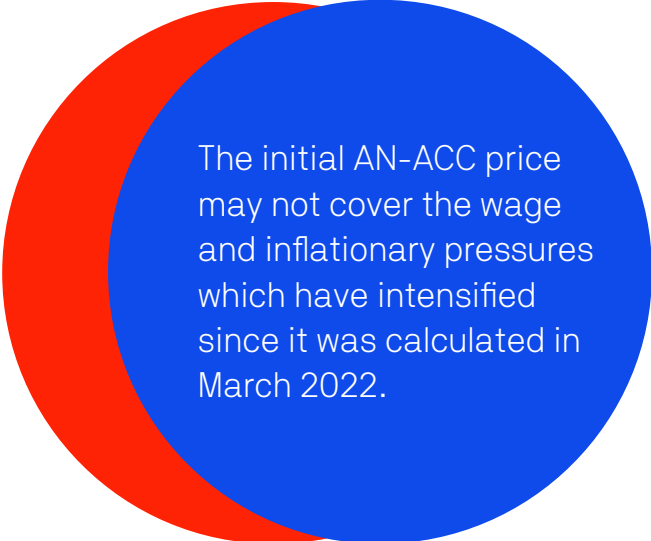
75. In a presentation at the 2022 ACCPA Conference, the DoHAC indicated that Standard (MMM5) homes will receive \$233 per resident per day under AN-ACC compared to \$182 under ACFI; Standard (MMM6 and 7) homes will receive \$290 compared to \$207; and Specialised Homeless homes will receive \$303 compared to \$227: <https://conference.accpa.asn.au/wp-content/uploads/2022/10/0900-Thu-HallC-Plenary4-Panel.pdf>



In addition, the new model may overcome the persistent indexation problems of having subsidy payments tied to COPO indexation. Instead, the Minister for Aged Care will have the discretion to set future subsidy increases based on advice from the new Independent Health and Aged Care Pricing Authority (IHACPA). This advice will be informed by annual reviews and costing studies conducted by IHACPA, which should lead to a better alignment between the subsidies and actual costs of delivering direct care. A critical feature of this new process will need to be that the advice provided by IHACPA to the Government is transparent and made publicly available.

AN-ACC also reduces the pre-existing financial disincentives to providers in offering residential respite services, highlighted in the Royal Commission and other prior reviews.<sup>76</sup> The subsidies for respite beds comprise variable funding based on residents' individual care needs according to the AN-ACC respite classification and a base care tariff set at the same rate as permanent residents. Providers will also receive more generous accommodation supplements for respite residents and now do not face caps on the number of respite days they offer.<sup>77</sup> Improving the financial support for residential respite will help ensure reliable access to these services that provide crucial support for informal carers. This will become increasingly important with the expansion of the home care package program as more older Australians receive care in their home.

However, concerns have emerged about the adequacy of the initial national efficient price set within the AN-ACC model to cover the wage and inflationary pressures which have intensified across the Australian economy since that initial price was calculated in March 2022. Table 16 estimates the forecast direct care revenues and costs for the coming financial year. This shows that with the introduction of AN-ACC, at this price, direct care revenues will increase by an average of \$19.88 per resident per day. However, approximately 40% of this increase (\$7.83 per resident per day) will be consumed by increases in direct care costs due to expected wage growth and inflation, even if staffing remains at its current levels.<sup>78</sup> The wage growth modelled in Table 16 does not include the outcomes of the Fair Work Commission wage case, which the Government has indicated will be funded separately.



The initial AN-ACC price may not cover the wage and inflationary pressures which have intensified since it was calculated in March 2022.

76. Carers Australia (2018), *Improving access to aged residential respite care*; Aged Care Financing Authority (2021), *Ninth Report on the Funding and Financing of the Aged Care Industry*; Aged Care Financing Authority (2018), *ACFA Report on Respite for Aged Care Recipients*; Royal Commission into the Quality and Safety of Aged Care (2021), *Final Report: Care, Dignity and Respect*.

77. The accommodation supplement for respite residents will not be discounted even if homes have less than 40% supported residents. This discount applies for permanent resident accommodation supplements.

78. In 2022-23, Treasury forecasts an annual increase in the wage price index of 3.75% and a consumer price index of 5.75%. Commonwealth of Australia (2022), Budget October 2022-23, Budget strategy and outlook, Budget Paper No. 1, p.6.

**Current challenges and issues**

Due to these rising costs, the forecast direct care result (\$13.29 per resident per day) may not be sufficient to cover the estimated cost of the incremental staffing required to meet the sector average care minute targets (estimated to be \$20.94 per resident per day). Note that this estimate conservatively assumes that homes will hire additional personal care workers to make up any time required to meet the total direct care minutes target. The cost of incremental staffing will be higher if homes maintain their current proportion of enrolled nurse time in uplifts of direct care minutes.

This funding gap may be offset by the timing difference between the start of AN-ACC funding on 1 October 2022 and the date when care minutes become mandatory on 1 October 2023. However, homes will be under pressure to increase their direct care staffing in the interim, given that their current staffing will be assessed under the new Star Ratings system, with ratings to be published in December 2022. They are also likely need to increase staffing in advance, to ensure they have sufficient staff by the time targets become mandatory. This scenario could result in a funding shortfall for direct care. If this were to eventuate, it would compound the existing financial viability issues relating to the provision of indirect care and accommodation services, which will be addressed later in this sub-section.

**Table 16: Forecast direct care revenue and costs under AN-ACC funding model**

	FY22 (actual)	FY23 (forecast)	Difference
<b>Direct care revenue:</b>			
Average ACFI subsidies and supplements	\$195.12		
Average AN-ACC subsidy		\$225.00	
Minus BDF supplement (used for indirect care)		(\$10.00)	
Total direct care revenue (\$ per resident per day)	\$195.12	\$215.00	\$19.88
<b>Direct care costs at current staffing levels:</b>			
Direct care labour costs (current staffing levels)	\$138.89	\$144.10	\$5.21
Other care-related labour costs	\$27.09	\$28.11	\$1.02
Other direct costs of direct care	\$12.48	\$13.20	\$0.72
Administration costs of direct care	\$15.42	\$16.31	\$0.89
Total direct costs at current staffing levels (\$ per resident per day)	\$193.88	\$201.71	\$7.83
<b>Direct care result at current staffing levels (\$ per resident per day)</b>	<b>\$1.24</b>	<b>\$13.29</b>	<b>\$12.05</b>
Additional costs to meet uplift to in care minutes*		\$20.94	\$20.94
<b>Direct care result after staffing uplift (\$ per resident per day)</b>	<b>\$1.24</b>	<b>(\$7.65)</b>	<b>(\$8.89)</b>

\* The additional direct care labour costs have been estimated by comparing current average staffing minutes with the sector-wide average targets (as described in Part 1 of this report), multiplied by the FY22 average hourly rate paid to registered nurses (\$63.81) and personal care workers (\$40.63) and a forecast wage price index for 2022-23 of 3.75%. This estimate does not account for individual home differences in care minute targets, nor does it account for the cost of uplifts required to meet the 24/7 nurse requirement. It also provides a conservative estimate of the cost of the staffing uplift, as it does not include higher wage rates incurred if homes maintain the same proportion of enrolled nurses within their additional direct care minutes. It is also important to note that although care minutes targets are not mandatory until October 2023 (FY24), provider care minutes will be assessed under the Star Ratings system (to be published in December 2022), and providers will be recruiting staff to meet their targets well before the implementation date.



IHACPA will likely address issues about the appropriate price of AN-ACC relative to the costs of the inputs as part of ongoing costing studies, particularly in the lead up to when care minutes become mandatory. As Table 16 shows, an issue that will require further attention will be the rising administration costs of direct care services and the extent to which these are funded under AN-ACC.

Continued investigation of the underlying fixed costs of delivering care is also warranted. As detailed in Part 1, the financial performance of aged care homes is sensitive to changes in occupancy. This arises from an asymmetry between the fixed costs of many inputs (including staff) and the high variability of revenue streams tied to the number and case mix of residents. This may constrain homes' ability to match revenue variation with commensurate changes to their cost base. Future research on the emerging trends may demonstrate the need for a higher value for the base care tariff and a lower weighting for variable costs.

In addition, there may also be a need to consider the workforce productivity implications of creating such a tight nexus between direct care funding and direct care staffing time. There is a risk that it overlooks the positive outcomes and cost efficiencies some providers may otherwise obtain through alternative staffing and care models, which use different and potentially innovative combinations of staff and technology in their care delivery.

Nonetheless, an intended outcome of IHACPA's advice and the Government's funding decisions is that future subsidies will be sufficient to cover the cost of direct care but with little additional surplus. This will fulfil a policy objective to ensure providers spend their direct care subsidies on direct care provision, thus improving transparency and provider accountability for taxpayer and resident funding of care services.<sup>79</sup> Doing so will remove homes' capacity to cross-subsidise losses incurred in providing indirect care and accommodation services, as has been the case for many years. Thus, urgent reform around the policy settings of these two activities is required to ensure the overall financial viability of residential aged care homes and the sustainability of the sector as a whole.

In terms of indirect care, a critical issue is the current pricing arrangements around everyday living services.<sup>80</sup> The regulation of the Basic Daily Fee essentially caps the prices homes can charge for base-level services, such as food, laundry and cleaning, regardless of residents' capacity to pay or the quality or diversity of those services.<sup>81</sup> Furthermore, as the results in Part 1 show, average revenue is insufficient to cover the costs of current services, notwithstanding the additional supplement of \$10 per resident per day and the community expectations that homes offer higher quality services, especially concerning food and nutrition.

79. In a presentation at the 2022 ACCPA Conference, the DoHAC provided modelling showing the increase proportion of subsidy funding on direct care under AN-ACC compared to ACF: <https://conference.accpa.asn.au/wp-content/uploads/2022/10/0900-Thu-HallC-Plenary4-Panel.pdf>

80. Aged Care Financing Authority (2021). *The role of the Basic Daily Fee in Residential Aged Care*.

81. Indirect care 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.



## Current challenges and issues

Although homes can also earn revenue from providing 'additional services', such as pay-TV, alcohol with meals, hairdressing, additional leisure activities 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.<sup>82</sup>

Two proposed alternatives that could improve the viability of indirect care services are either the deregulation of the basic daily fee for non-supported residents<sup>83</sup> or raising the maximum amount providers can charge for ordinary living amenities.<sup>84</sup> Both options would allow homes to earn a reasonable return from offering quality services according to residents' needs and preferences. However, under either option, there may need to be a taxpayer subsidy for supported residents to meet the cost of any amount above a set basic daily fee.

Reform around accommodation pricing is also critical, given that in 2021–22 the average deficit from accommodation services comprised approximately three-quarters (75.8%) of the total average operating losses in residential care. These losses arise from several persistent issues whereby revenue has not kept pace with rising costs.

Approximately 46% of residents in Australia are supported (i.e. deemed to have low means), with higher proportions in regional and remote locations.<sup>85</sup> In providing accommodation services for fully supported residents, revenue is capped at the supplement rates paid by the Government.<sup>86</sup>

Non-supported residents can pay for their accommodation through either a refundable accommodation deposit (RAD), also known as a lump sum, or through a daily accommodation payment (DAP) equal to the maximum permissible interest rate (MPIR) multiplied by the equivalent RAD value of their accommodation, or a combination of both.<sup>87</sup> As noted in Part 1, one of the issues is that there has been slow growth in RAD values that is not commensurate with the value of other property assets in the wider market. This could be addressed, in part, by implementing the recommendation from the Tune Review that the RAD review limit be raised above the current price of \$550k.

A broader issue is the disparity between non-supported residents paying for accommodation under different methods. DAP-paying residents currently pay a rental payment, whereas RAD-paying residents (who are refunded the full nominal value of their deposit when they leave the home) ostensibly receive accommodation rent-free. Their only cost is the opportunity cost of the after-tax value of the interest forgone on the value of the RAD during their stay. This raises an equity concern, as those who have the means to pay a lump sum upfront may incur a much lower cost than those who pay a DAP. Furthermore, from a provider's perspective, there is no operational income stream for accommodation services for residents who pay under the RAD option, which also constrains their ability to access debt financing as an alternative to the capital backing provided by RADs.

82. Aged Care Financing Authority (2021). *Ninth Report on the Funding and Financing of the Aged Care Industry*.

83. Tune, D.M. (2017). *Legislated Review of Aged Care*.

84. Royal Commission into Aged Care Quality and Safety. (2021). *Final Report: Care, Dignity and Respect*.

85. Department of Health and Aged Care (2022). *Financial Report on the Australian Aged Care Sector 2020–21*, p.53

86. Residents that a partially supported pay for accommodation at a reduced rate (i.e. a part RAD or DAP). For fully supported residents the maximum accommodation supplement is currently \$63.14 per day; <https://www.health.gov.au/sites/default/files/documents/2022/10/schedule-of-subsidies-and-supplements-for-aged-care-schedule-from-1-october-2022.pdf>

87. The current MPIR is 6.31%.



StewartBrown has recommended a structural adjustment to the model of accommodation pricing.<sup>88</sup> The proposal is that RAD residents be required to make a deferred rental payment, to be deducted from the value of the RAD when they leave. Their modelling of this proposal shows that such an adjustment could substantially impact the returns from accommodation services and the overall viability of residential aged care homes.

As a final comment in this sub-section on Financial Viability and Sustainability, UARC notes that on 4 November 2022, the DoHAC published its Financial Report on the Australian Aged Care Sector (FRAACS) for 2020–21. The stated aim of this report is “to build the capacity and transparency of the aged care sector, and help older Australians, their families and carers make informed decisions about their care”.<sup>89</sup>

UARC welcomes the release of this report, which provides a comprehensive resource for understanding the financial state of the sector and maintaining continuity with data provided previously by the Aged Care Financing Authority. Including CHSP, residential and home care provider data is helpful, particularly in the lead up to the new unified Support at Home program. Furthermore, the report benefits from a wide range of supplementary datasets that the DoHAC can access, adding relevant contextual evidence that may assist in understanding trends within the financial results.

Finally, the inclusion of census data within FRAACS provides a valuable reference point to validate the previously available analyses of the 2020–21 financial year using the StewartBrown dataset. The results and trends are relatively consistent, noting that the StewartBrown dataset tends to show more conservative financial performance estimates, owing to the sample considerations described above in Part 1. Given these points, any reductions in the time lag between the end of the financial year and the release of the relevant FRAACS would be highly desirable.

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88. StewartBrown (2022), *Aged Care Financial Performance Survey Report*, p.8.

89. Department of Health and Aged Care (2022). *Financial Report on the Australian Aged Care Sector 2020–21*, p.4.



## Minimum staffing requirements in residential care

In the coming year, residential aged care providers will need to expand their direct care workforce to meet the incoming minimum staffing standards. In line with its election promises, the new Labor Government has legislated to implement the mandatory standards recommended by the Royal Commission in full,<sup>90</sup> meaning providers will have to ensure:

1. a registered nurse is on site and on duty 24 hours a day (from 1 July 2023)
2. residents receive, on average across the sector, at least 200 minutes of total care per day (from 1 October 2023); and
3. a registered nurse must provide at least 40 minutes of that care (from 1 October 2023).

Each home's total direct care and registered nurse care minute targets have been adjusted to account for differences in the relative needs of their residents, as assessed using the AN-ACC shadow assessments. This means that 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. All homes will have to meet the 24/7 registered nurse on-site requirement unless granted a specific exemption.

The DoHAC recently announced that approximately 191 rural and remote homes (MMM 5-7) with 30 approved beds or less, would be eligible to apply for a one-off exemption, lasting only 12 months.<sup>91</sup>

UARC has analysed an additional de-identified data set from a separate survey conducted by StewartBrown in 2022, which included estimates of homes' staffing and home-specific proposed care minute targets as of June 2022.<sup>92</sup> This survey data included 924 aged care homes, with sample characteristics in terms of ownership, remoteness (MMM), and home size (number of beds) largely consistent with those of the population of homes in Australia.

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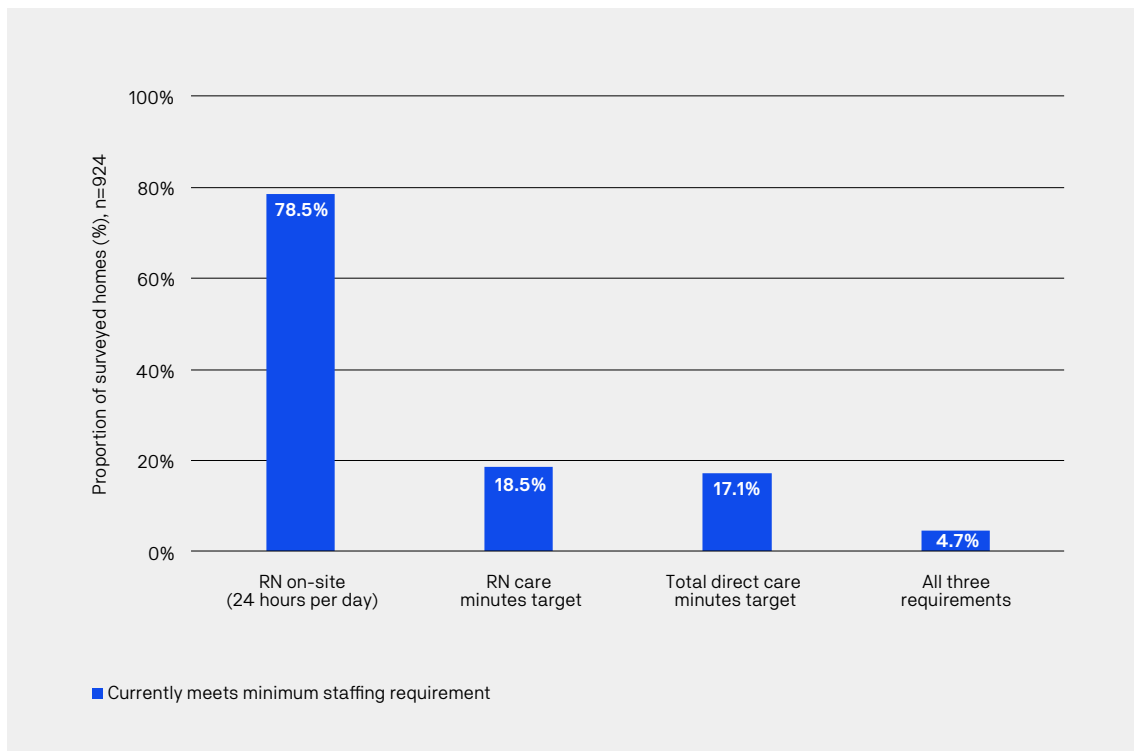
90. The Labor Government expanded the initial Government response to the Royal Commission, by extending the on-site registered nurse requirement to 24 hours a day (previously only morning and night shifts) and higher sector average care minute targets for 2024, including 215 total direct care minutes per resident per day, including 44 minutes from registered nurses. This implements Recommendation 86 of the Royal Commission in full.

91. <https://www.health.gov.au/initiatives-and-programs/aged-care-247-registered-nurse-requirement>

92. This data set was provided to UARC in de-identified form.



**Figure 27: Proportion of homes that meet the minimum staffing requirements**



This analysis first examined the proportion of surveyed homes with staffing at or above the three incoming requirements for 2023 for each home's specific targets. The results of this analysis, depicted in Figure 27, show that as of June 2022, most (78.5%) surveyed aged care homes have average registered nurse staffing time sufficient to meet the 24/7 on-site requirement.<sup>93</sup> However, only 18.5% currently meet their registered nurse care minutes target, and only 17.1% have staffing at or above the level of their total care minutes target.

When all three requirements are assessed simultaneously, only 4.7% of surveyed homes currently have direct care staffing sufficient to meet all three requirements.

93. The analysis likely overstates the proportion of homes that currently meet the 24/7 registered nurse requirement, as the analysis does not account for actual shifts worked, rostering constraints or any overlaps that may occur if two or more registered nurses are on-duty at the same time.



## Current challenges and issues

Table 17: Proportion of homes that meet the minimum staffing requirements

	RN care minutes (Meets)		RN care minutes (Below)		
	24/7 RN (Meets)	24/7 RN (Below)	24/7 RN (Meets)	24/7 RN (Below)	
Total direct care minutes (Meets)	4.7%	0.8%	8.9%	2.8%	17.1%
Total direct care minutes (Below)	12.2%	0.9%	52.7%	17.1%	82.9%
	18.5%		81.5%		

Table 17 shows the combinations of the three standards that surveyed homes were at or below. In the top left corner, Table 17 shows, like the preceding figure, that only 4.7% of homes meet all three requirements. In the bottom right, it also shows that 17.1% of homes are below all three requirements. A further 56.4% of homes (0.9%, 52.7% and 2.8%) are below two requirements.

It also confirms that the primary challenge for most homes is meeting the care minutes targets. For example, of the homes that meet their registered nurse care minutes target, only 1.6% (0.8% and 0.9%) are below the 24/7 requirement. By comparison, with homes that meet the 24/7 registered nurse requirement, more than 60% (8.9% and 52.7%) will still need further registered nurse time to meet their care minutes requirement.

UARC also analysed the additional staffing required to meet the incoming minimum standards. This incremental analysis assumed that homes would first lift their registered nurse staffing to meet the 24/7 registered nurse on-site requirement in July, followed by any further increases needed to meet their registered nurse care minutes target and, finally, their total direct care target. By structuring the requirements sequentially, the analysis counted only the incremental staffing time required, having met earlier requirements.<sup>94</sup>

94. For example, if a home increases its registered nurse staffing time to meet the 24/7 registered nurse requirement, it may as a consequence meet its registered nurse care minutes and/or total direct care minutes targets.

**Table 18: Incremental staffing analysis to meet incoming minimum standards**

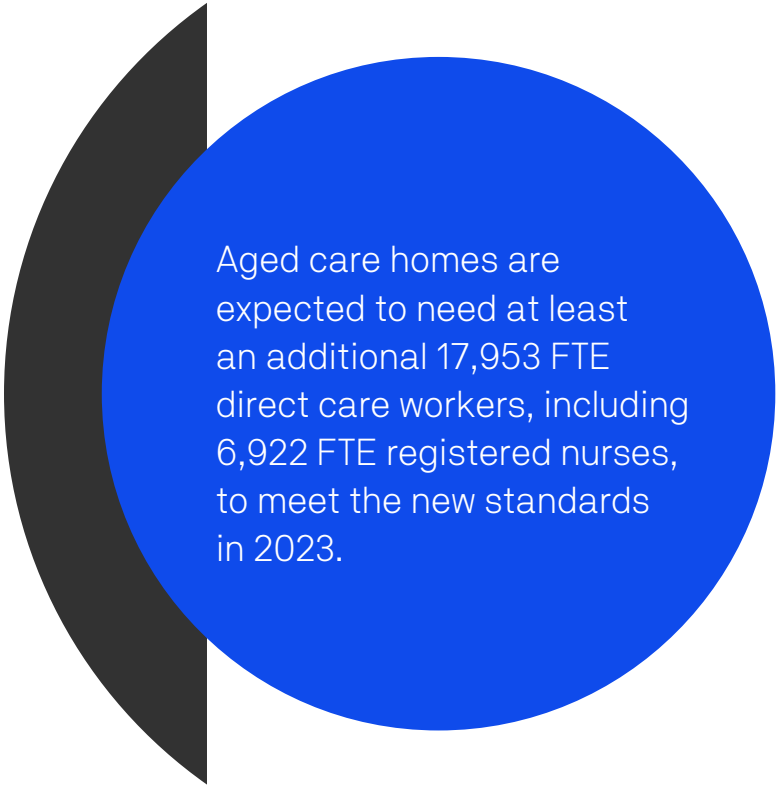
<b>Requirement 1 (R1): 24/7 registered nurse on site</b>	
Proportion of homes below requirement*	21.5%
Average additional RN hours per day to meet the requirement**	9.2
Total aged care homes in Australia (June 2022)	2,671
Estimated additional RN hours required (hours p.a.)	1,930,571
<b>Estimated additional RNs required to meet R1 (FTE)***</b>	<b>1,104</b>
<b>Requirement 2 (R2): Registered nurse care minutes</b>	
Proportion of occupied beds below requirement****	81.1%
Average additional RN minutes per resident per day to meet the requirement**	10.4
Total operational residential care places in Australia (June 2022)	219,965
Occupancy rate	89.7%
Estimated additional RN hours required (hours p.a.)	10,169,644
<b>Estimated additional RNs required to meet R2 after meeting R1 (FTE)***</b>	<b>5,818</b>
<b>Requirement 3 (R3): Total direct care minutes</b>	
Proportion of occupied beds below requirement****	69.5%
Average additional direct care minutes per resident per day to meet the requirement**	23.1
Total operational residential care places in Australia (June 2022)	219,965
Occupancy rate	89.7%
Estimated additional direct care hours required (hours p.a.)	19,281,867
<b>Estimated additional direct care workers required to meet R3 after meeting R1 &amp; R2 (FTE)***</b>	<b>11,031</b>
<b>Total estimated additional direct care workers required to meet R1, R2 &amp; R3 (FTE)</b>	<b>17,953</b>

\*Percentage of surveyed homes (n=924) that have less than an average of 24 RN hours per day. \*\*Average of only homes that would be below the requirement, including any additional time to meet previous requirements. \*\*\*Assumes FTE full-time equates to 38 hours per week, with 20 days annual leave and 10 days sick leave. \*\*\*\*Percentage of occupied beds in surveyed homes (n=924) that are below home-specific targets for RN care minutes or total direct care minutes, including any additional time to meet previous requirements

Table 18 shows the result of this analysis. It shows that the 21.5% of homes estimated to be below the 24/7 nurse requirement, would need to lift their registered nurse staffing by an average of 9.2 hours per day. Projecting this to an annualised sector figure, this is equivalent to approximately 1,104 full-time equivalent registered nurses.<sup>95</sup>

In addition to the uplift to meet the on-site requirement, homes would then require a further 5,818 full-time equivalent registered nurses to meet their registered nurse care minutes targets. Finally, a further 11,031 full-time equivalent direct care workers will be needed to meet the total direct care minutes targets.

95. To project these figures to a sector level, the average additional hours per day was multiplied by the total number of homes in Australia and the proportion estimated to be below the requirement. Hours were converted to FTE, assuming 38 hours a week.

**Current challenges and issues**


Aged care homes are expected to need at least an additional 17,953 FTE direct care workers, including 6,922 FTE registered nurses, to meet the new standards in 2023.

In aggregate, residential aged care homes are expected to need at least 17,953 additional direct care workers (FTE), including 6,922 registered nurses (FTE), to meet the incoming standards in 2023.

These estimates will likely be a conservative projection of the aged care homes' staffing needs. The analysis does not account for minimum shift lengths, rostering constraints, or necessary overlaps or handover time between registered nurses between shifts. It also does not model how homes may manage the dynamics of changes in their staffing requirements. These will fluctuate with short-term changes in occupancy, residents' assessed complexity of care needs or resident mix as individuals with varying care needs leave and enter the home. It also does not account for uplifts relating to the higher targets in 2024.

As a point of reference, the DoHAC has recently estimated that there is currently a shortfall of approximately 11,800 registered nurses. This includes a pre-existing shortfall of 2,000 nurses extrapolated from the 2020 Aged Care Workforce Survey, 8,944 to meet the care minutes requirement and 849 to meet the 24/7 requirement.<sup>96</sup>

The UARC estimate is also below that provided by CEDA, which projected an annual shortfall of 30,000 to 35,000 direct care workers. The CEDA estimate also accounted for the sector's attrition, estimated to be approximately 65,000 workers a year.<sup>97</sup>

An important caveat is that it is not possible to assess compliance with legislation that has not yet been implemented. However, despite this limitation, it is reasonable to conclude that there will need to be a significant increase in staffing levels across the sector to meet these requirements.

As detailed in Part 3, providers' readiness to meet the new staffing requirements is being challenged by widespread experiences of skill shortages across residential and home care.

96. Disclosed by the DoHAC at Senate Estimates Committee for Community Affairs, November 10, 2022.

97. Committee for Economic Development of Australia (2022). *Duty of care: Aged care sector in crisis*.



## Capping of home care advisory and administration fees

Among the reform measures passed by Parliament in October 2022 is a proposal to cap home care providers' fees for care management and package administration. Schedule 2 of the Aged Care Amendment (Implementing Care Reform) Act 2022 adds a requirement to the Aged Care Act that providers comply with such requirements as are specified in the User Rights Principles concerning the prices charged by the approved provider for, or in connection with, the provision of care or services to the care recipient. The new requirements will come into effect from 1 January 2023.

The stated aim of this measure is to increase transparency for consumers and to ensure more funds are available to meet the direct needs of home care recipients.<sup>98</sup> In introducing the Bill, the Minister for Aged Care suggested that this measure would reduce the high level of administration and management charges for home care. The proposal responds to evidence presented to the Royal Commission that care and package management fees make up as much as 50% of care recipients' package expenditure.<sup>99</sup>

Concerns about this change have been raised by providers and by members of the crossbench in their consideration of the proposal. A recent analysis by the Aged & Community Care Providers Association (ACCPA), based on data published by the DoHAC, notes that average care management and package management fees are already lower than the average costs of providing these services. Results presented in Part 1 of this report show that administration and care management costs continue to make up significant proportions of provider expenditure as a percentage of revenue (24.7% and 12.0%, respectively, in 2021–22). Implementing price caps will not necessarily affect the cost of providing care management and package administration costs but will limit providers' ability to recoup these amounts from package funds.<sup>100</sup>

Current legislation already prevents home care providers from charging business costs as a separate charge<sup>101</sup> and requires that prices and costs be kept to a reasonable amount and that they are clearly specified in a care recipient's home care agreement. All prices and fees associated with common care and services must be provided to the Department in a notice, and any variation between the notice and home care agreement must be explained.

In the debate on the Bill, crossbenchers expressed concerns about the limited transparency of the proposal and the reliance on as yet unseen subordinate legislation (in the form of future changes to the User Rights Principles 2014) to give effect to the price caps. Crossbenchers and providers have also pointed out that the proposed amendment to the Aged Care Act does not relate specifically to capping fees for care management and package administration, as has been widely identified, but rather can apply to all home care fees.

Any price caps on fees will likely be an interim measure until the new Support at Home program is implemented in 2024. While the Minister has ruled out the implementation of a price schedule for HCPs, citing the challenges in setting reasonable fees for aged care services, the development of a comprehensive service list and associated schedule of efficient prices is a key feature of the proposed Support at Home reforms (discussed later in Part 2).<sup>102</sup>

98. Revised explanatory memorandum, Aged Care Amendment (Implementing Care Reform) Bill 2022 (Cth).

99. Royal Commission into Aged Care Quality and Safety (2021), *Final Report: Care, Dignity and Respect*, Volume 2, p63.

100. Hicks, T., and Speirs, T., (2022), *Home care fees and choice: analysis of data on fees and market share*, ACCPA.

101. User Rights Principles 2014 (Cth) (3B).

102. Department of Health (2022) *Support at Home Program Overview*.



# Policy and reform agenda

## Review of the new aged care legislation

The introduction of new aged care legislation was a clear priority on the first business day of the 47th Parliament, with two bills presented: the Aged Care and Other Legislation Amendment (Royal Commission Response) Bill 2022, and the Aged Care Amendment (Implementing Care Reform) Bill 2022. The Government is also developing a new Aged Care Act.

The first piece of legislation, the Royal Commission Response Bill, was passed by the Parliament on 2 August 2022, has received Royal Assent and is now an Act. It provides a legislative framework for nine “time-critical” measures that respond to the recommendations of the Royal Commission into Aged Care Quality and Safety Final Report.<sup>103</sup>

This Act introduces the Australian National Aged Care Classification (AN-ACC), which replaced the ACFI as the model for calculating residential aged care subsidies from 1 October 2022 (see earlier in Part 2 for additional discussion).

The Act also established a requirement that the DoHAC publish star ratings for residential care services based on quality and other available information. This is discussed in more detail later in Part 2.

A further measure in the Act is a new requirement that approved providers and their aged care workers and governing persons adhere to a Code of Conduct, with substantial enforcement powers now held by the Aged Care Quality and Safety Commissioner, including civil penalties and banning orders. The Code of Conduct remains under development, but the DoHAC has indicated that this will be based on the NDIS Code of Conduct Rules 2018 to increase harmonisation between the sectors.<sup>104</sup>

103. Explanatory memorandum, Aged Care and Other Legislation Amendments (Royal Commission Response) Bill 2022 (Cth).

104. An exposure draft of the new Code of Conduct was recently published for consultation: <https://www.health.gov.au/sites/default/files/documents/2022/09/exposure-draft-of-the-aged-care-quality-and-safety-commission-amendment-code-of-conduct-and-banning-orders-rules-2022.pdf>



Other measures in the Royal Commission Response Act include:

- An extension of the residential care Serious Incident Response Scheme (SIRS) into home care (and flexible care delivered in a home or community setting) from 1 December 2022.<sup>105</sup>
- New governance responsibilities for approved providers, which have new requirements about the memberships of governing bodies and the establishment of new consumer and clinical advisory bodies. It also includes measures to improve leadership, transparency and accountability of providers' governing bodies and key personnel.<sup>106</sup>
- New enforceable powers for the Secretary or Commissioner to request information or documents relating to the use of RADs, as well as an increase in the period of liability to five years for offences relating to the misuse of these funds.
- An expanded remit of the renamed IHACPA to include the provision of advice on aged care pricing and costing matters.
- Interim arrangements related to the use of restrictive practices, where a care recipient does not have capacity to consent and state and territory laws do not clearly provide for a person to consent on the care recipient's behalf.
- Other provisions for interdepartmental information sharing and disclosure.

The second piece of legislation, the Aged Care Amendment (Implementing Care Reform) Bill 2022, was passed by Parliament on the 27th of October and has now also received Royal Assent and become an Act.

This further set of measures included the 24/7 registered nurse on site requirement. The feasibility of this requirement was the subject of substantial debate in both the House of Representatives and the Senate, given the challenges faced by providers in maintaining sufficient registered nurses on staff. The circumstances in which an exemption may be granted will be specified in future changes to the Quality of Care Principles. It is expected that exemptions will be granted for homes co-located with a health service with registered and enrolled nurses and for homes in rural, regional and remote areas where the provider has been unable to recruit sufficient staff.<sup>107</sup> An amendment to the initial Bill now requires that any exemptions granted to the 24/7 registered nurse requirement be made publicly available, with information including provider and home name, period of exemption, conditions that apply, and any other information specified in the Quality of Care Principles.

105. This means that approved providers will need to ensure they prevent and manage incidents, use incident data to drive quality improvement and maintain a sufficient incident management system to notify the Aged Care Quality and Safety Commission of reportable incidents: [https://www.agedcarequality.gov.au/sites/default/files/media/sirs\\_draft\\_sirs\\_home\\_services\\_provider\\_guidelines\\_3110.pdf](https://www.agedcarequality.gov.au/sites/default/files/media/sirs_draft_sirs_home_services_provider_guidelines_3110.pdf)

106. <https://www.agedcarequality.gov.au/providers/provider-governance>.

107. The DoHAC recently announced that only homes based in rural and remote areas (MMM 5-7) with 30 approved beds or less will be eligible to apply for a one-off 12-month exemption for the 24/7 RN requirement.



## Policy and reform agenda

This Bill also included the relevant provision relating to home care fees (see earlier discussion), providing the legislative instrument to cap charges associated with services delivered under HCPs and preventing providers from charging clients an exit amount.

Finally, the Implementing Care Reform Act included provisions that would further increase the amount of publicly available information about aged care services. Specifically, it included a provision enabling the Secretary to publish financial information, care time provided, key personnel details, and information about the service's staffing. While also subject to subordinate legislation, the Government has advised that the information which must be published will include: how much is spent on care, nursing, food, maintenance, cleaning, administration and profits of approved providers of residential care.<sup>108</sup> Notably, this legislation will remove existing protections around identifying individuals who are key personnel.

A third major legislative reform underway is the drafting of a new Aged Care Act, which will replace the *Aged Care Act 1997* and the *Aged Care Quality and Safety Commission Act 2018*.<sup>109</sup> The Act is intended to be 'rights-based', placing older Australians' rights at the centre of the aged care system.

The new Act will provide a legislative framework that will facilitate many of the reforms already underway, including the creation of a single entry point and assessment framework for accessing aged care services, supporting the delivery of aged care services, new oversight and accountability arrangements, and changes to the regulation of aged care. As yet, there is little public information or discussion about the proposed new Act, but it will likely have far and long-reaching implications for aged care in Australia.

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108. Revised explanatory memorandum, Aged Care Amendment (Implementing Care Reform) Bill 2022 (Cth).

109. Detail on the aims and progress of the new Aged Care Act is available: <https://www.health.gov.au/initiatives-and-programs/aged-care-reforms/aged-care-legislative-reform>




## Support At Home Program

The Support at Home Program will consolidate four existing programs – the CHSP, Short Term Restorative Care (STRC), the HCP program, and residential respite.

While the previous Government intended to commence the new program in July 2023, this has been moved back to 1 July 2024 by the new Labor Government to enable further consultation with stakeholders after the release of the “Support at Home Program Overview” discussion paper. This is a positive development given our commentary in the mid-year Australian Aged Care Sector Report, which expressed concern over the speed and size of the transition and the potential for disruptive consequences for both senior Australians receiving care and providers delivering care.

A recent commentary published by UARC raised several issues for further consideration.<sup>110</sup> The first is that the design of the Support at Home Program should be guided by a framework of principles that focus on independence and wellness and be consistent with the broader reform agenda. A set of reform objectives are now included in the Discussion Paper released by the Department on 18 October 2022.



Design of the new Support at Home program needs to rebalance funding to increase consumer charges from those who can afford to contribute more.

110. Lewis, R., Woods, M., Brown, D., Parker, D., Sutton, N., & McAllister, G. (2022). *Support at Home: a Commentary on the design of the proposed unified program*. UTS Ageing Research Collaborative: <https://www.uts.edu.au/uarc/news/report-support-home>



## Policy and reform agenda

Other issues for consideration relate to roles, responsibilities and accountabilities within the proposed multi-provider model. The proposal for clients to be able to engage multiple service providers and self-manage their care is consistent with supporting consumer choice and control. However, this increases the level of complexity with service provision and raises questions over how assessors, care managers and one or more providers will each be held accountable and to what extent they have control over the final care outcomes.

Within the proposed model, a single assessment pathway will result in the development of an Individualised Support Plan by an independent Assessor and the older Australian. This separation of the initial care planning process from the delivery of care may reduce provider conflicts of interest, but raises questions about how the disjuncture between assessment and delivery will be addressed when parties' expectations diverge.

Support at Home proposes a new Classification Framework, which includes restorative care as a dedicated service classification. The addition of a comprehensive service list has the potential to improve the transparency and consistency of services. However, it runs the risk of over-specification of services, thus reducing consumer choice and control. The likelihood of changes in older Australians' needs and circumstances, and a corresponding need for greater flexibility in the individualised support plans and consequent delivery of services, has been recognised as a key issue in the Department's October Discussion Paper.

One of the challenges with the Classification Framework is how the assessment of needs for, funding of, and delivery of social supports for services such as meals, transport, and social support, will be proportionate to the inherent simplicity of these services. Another potential challenge with the use of individualised support plans, rather than individual budgets or block funding models, for specific service entitlements, is that while this approach may prevent the accumulation of unspent funds, it may nonetheless deliver the unintended consequences of a mismatch between funding and needs satisfaction, and unnecessary consumption toward the end of the allocation period.

The newly established IHACPA will determine the pricing of services. This reflects a transition to a fixed fee-for-service model. While this has the potential to create transparency, it also limits the ability of providers to compete on price and to enable differences in cost structures to be reflected in different market settings, particularly in thin markets.

A final issue to consider is getting the mix right between government subsidies for those with low means who need support and those who have the capacity to contribute to the services they receive. More detail on the above issues can be found in *Support at Home: A commentary on the design of the proposed unified program*.<sup>111</sup>

111. Lewis, R., Woods, M., Brown, D., Parker, D., Sutton, N., & McAllister, G. (2022). *Support at Home: a Commentary on the design of the proposed unified program*. UTS Ageing Research Collaborative: <https://www.uts.edu.au/uarc/news/report-support-home>



## Fair Work Commission wage case outcome

In November 2020, an application was submitted to the Fair Work Commission (FWC) by the Health Services Union (HSU) and later supported by the Australian Nursing & Midwifery Federation (ANMF) and the United Workers Union (UWU). The joint application sought to address the underpayment of the aged care workforce through a 25% wage increase, which would help reflect the value of the work and redress the wage disparity with other sectors.

In response to the joint application, the FWC received submissions and heard testimony from various stakeholders, including the Australian Government, aged care providers, unions and experts. The Government's submission supported re-evaluating aged care workers' wages, recognising the increased skills and attributes required to perform the work. It also committed to providing "funding to support any increases to award wages made by the Commission in this matter and that will help deliver a higher standard of care for older Australians".<sup>112</sup> The Aged Care Sector Stakeholder Consensus Statement agreed that the "wages in the aged care sector need to be significantly increased because the work of aged care workers has been historically undervalued for a range of reasons and has not been properly assessed".<sup>113</sup> A joint statement from employers did not support a blanket 25% increase but agreed to the need to "properly set" and review the minimum rates in the awards.<sup>114</sup>

The FWC's review of the case resulted in a decision favouring a wage increase.<sup>115</sup> The decision, released on November 4, 2022, recognised the need to address inequity, noting the gendered nature of the work, and acknowledged the increased complexity of aged care work.

The outcome of the case will be implemented through a three-staged approach. Stage 1 determined an interim increase of 15% in the modern award minimum wages applicable to direct care workers (personal care workers, enrolled nurses and registered nurses) employed under the three relevant awards. Stage 2 will provide additional information about the timing and phasing of the increase. During Stage 2, the FWC will seek further submissions to help conclude their "consideration of the interim increase in modern award minimum wages applicable to direct care employees".<sup>116</sup> In Stage 3, the FWC will consider a possible increase over the Stage 1 decision, potential wage increases for non-direct care workers (e.g., administrative, cleaning and kitchen staff), and issues of classification definitions and structures in the awards.

112. Commonwealth Government (2022). Fair Work Commission Matter Numbers AM2020/99; AM2021/63; AM2021/65 Work Value Case – Aged Care Industry Submissions of The Commonwealth. Commonwealth Government, p. 2.

113. ACSA et al. (2021). Aged Care Sector Stakeholder Consensus Statement. Facilitated by Aged Care Workforce Industry Council, p. 2. The statement was organised by the Aged Care Workforce Industry Council and signed by Aged & Community Services Australia (ACSA), Aged Care Industry Association (ACIA), Aged Care Reform Network, ANMF, Carers Australia, Council on the Ageing (COTA), Federation of Ethnic Communities' Councils of Australia (FECCA), HSU, Leading Age Services Australia (LASA), National Seniors Australia, Older Persons Advocacy Network (OPAN) and UWU.

114. ACSA, Leading Age Services Australia & Australian Business Industrial (2022). In The Fair Work Commission Submissions: Work Value Case – Aged Care Industry (AM2020/99; AM2021/63; AM2021/65). Australian Business Lawyers & Advisors (ABLA), p. 17.

115. Ross, I. J. K., Asbury, I. C., & O'Neill, B. M. (2022). Applications to vary modern awards – work value – Aged Care Award 2010 – Nurses Award 2020 – Social, Community, Home Care and Disability Services Industry Award 2010 – Decision., [2022] FWCFB 200. Fair Work Commission, p. 297.

116. Ross, I. J. K., Asbury, I. C., & O'Neill, B. M. (2022). Applications to vary modern awards – work value – Aged Care Award 2010 – Nurses Award 2020 – Social, Community, Home Care and Disability Services Industry Award 2010 – Decision., [2022] FWCFB 200. Fair Work Commission, p. 297.



## Policy and reform agenda

This joint application for increased wages is a significant case, and its outcome has several implications for policy, funding and worker conditions, including and beyond aged care. There remains some ambiguity about how the Government's commitment to funding the increase will be enacted, for example, whether it will include on-costs. The October 2022–23 Budget indicated that funding for the award rate changes had been set aside in a Contingency Reserve, which is estimated to be \$3.8b in 2023–24.<sup>117</sup>

## Star Ratings system

As part of the Government's response to the Royal Commission, a new Star Rating system will be implemented by the end of 2022.<sup>118</sup> The star ratings will first apply to residential care, with information to be published on My Aged Care.<sup>119</sup> The intent of the system is to enable senior Australians and their families to make meaningful comparisons of the quality and safety performance of services and providers.

Each residential aged care home will be given an overall star rating out of a possible five stars, as well as ratings against four underlying sub-categories, including consumer experience interviews, service compliance ratings, direct care staffing minutes and quality indicators. Further detail about each of these sub-categories is outlined in Table 19, and a detailed provider manual is available on the DoHAC website.<sup>120</sup>

The scale has been calibrated to represent the following ratings:

- 1 star – 'significant improvement needed'
- 2 stars – 'improvement needed'
- 3 stars – an 'acceptable' quality of care
- 4 stars – a 'good' quality of care
- 5 stars – an 'excellent' quality of care

To calculate the overall star rating, each of the four sub-categories are multiplied by the weightings described in the table, and then rounded to the closest whole star. Significantly, if an aged care home receives 1 or 2 stars for service compliance, then its overall rating will be capped at that level, irrespective of the ratings in other sub-categories.

117. Chalmers, J. et al. (2022) Budget October 2022-2023 -Budget Strategy and Outlook: Budget Paper No. 1, Commonwealth of Australia, p.202.

118. In 2022, the implementation of the ratings was legislated in Aged Care and Other Legislation Amendment (Royal Commission Response) Bill 2022.

119. In 2021, the Government accepted Recommendation 24 of the Royal Commission, agreeing to publish star ratings about residential aged care by the end of 2022, with an original intent to expand to in-home care by 2024.

120. <https://www.health.gov.au/sites/default/files/documents/2022/11/star-ratings-provider-manual.pdf>

**Table 19: Sub-categories of the Star Ratings system in residential care**

Sub-category	Weighting	Underlying information	Data source
Consumer experience reports	33%	Consumer experience interviews with approximately 20% of all current aged care residents, based on a standardised set of questions about their lived experience of residential aged care	Consumer interviews conducted by a consortium comprising IQVIA, Access Care Network Australia and Health Consult
Service compliance ratings	30%	Ratings of homes' compliance with the Aged Care Quality Standards, currently used in the 'dot ratings' on My Aged Care	Quality assessments, reviews and monitoring visits conducted by Aged Care Quality and Safety Commission
Care minutes	22%	Quarterly data about total direct care staffing minutes and registered nurse minutes	Quarterly Financial Reports and Aged Care Financial Reports
Quality indicators	15%	Quarterly measures of pressure injuries, physical restraints and unplanned weight loss (with other quality measures to be added in future)	National Aged Care Mandatory Quality Indicator Program

The Star Ratings will be published for all residential aged care homes on the MyAgedCare website from December 2022, including the overall ratings, the sub-category ratings, and the underlying information uses to calculate the ratings, such as care minute targets, information about compliance issues and quality indicator scores. The DoHAC has indicated that over time, historical information will remain available so that readers can view trends in homes' quality performance. New homes or homes that transfer ownership will not have ratings displayed for approximately 12 months.

Consumer groups have been mainly supportive of the implementation of the system. In their view, the Star Ratings system provides greater transparency about homes' quality in a way that is easy to understand and helps inform consumer choice.<sup>121</sup>

However, provider groups have expressed several concerns about the timelines of publishing the ratings. The DoHAC has indicated that aged care providers will be able to preview their ratings at least a week before the system goes live. However, there is a concern that a week is not sufficient time to review, investigate and resolve any issues before they are made public. In addition, the timeline presents a very tight window for providers to prepare appropriate communication to inform residents, their families and aged care workers about their ratings, which will be essential to minimise unnecessary confusion or distress.

Another set of issues concern the way the staffing sub-category will be assessed. Specifically, the ratings are calibrated so that homes with staffing that meets their care minutes targets will receive 3 stars and to receive higher, homes need to provide staffing above their targets. For example, only homes that exceed their registered nurse minutes by 25% will be eligible for a possible 5 star rating.<sup>122</sup> Based on the analysis presented earlier in Part 2, only a very small minority of homes are likely to achieve a 3 star rating, with even fewer at a 4 or 5 star level.

Furthermore, the December 2022 staffing star rating will be based on the degree to which homes' staffing levels were above or below their care minute targets between 1 July and 30 September 2022. However, the targets are not mandatory until October 2023 and homes only started receiving AN-ACC subsidies to fund the staffing uplift from 1 October 2022. Furthermore, it is not clear how homes will resource staffing levels at a 5 star level, given the existing viability issues and calibration of the initial starting price of the AN-ACC subsidies.

Finally, there are also questions about how consumers may interpret star ratings, given their prevalence in other industries, such as hotels and restaurants. There is the risk that consumers may negatively interpret the quality of homes rated as 3 stars, even though to achieve this rating will require homes to meet regulatory requirements for staffing and service compliance, the national average (or better) for quality measures and positive consumer experience reports. One way this could be addressed is by reviewing the nomenclature for the top three ratings, so as to indicate that a 3 star rating is 'good' rather than 'acceptable'.

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121. <https://www.cota.org.au/wp-content/uploads/2021/04/Post-ACRC-Final-Report-Joint-Statement-by-12-Aged-Care-Consumer-Organisations-ENDORSED-10-04-2021.pdf>

122. <https://www.health.gov.au/sites/default/files/documents/2022/11/star-ratings-provider-manual.pdf>

## October Budget update

The Australian Government's 2022-23 October Budget begins to implement the policy platform promised by the Labor Party during the recent election. It was framed in the context of mounting international geopolitical and economic pressures, natural disasters, higher interest rates and rising energy bills. Domestic inflation is expected to outpace wage rises in the immediate future. Given the Government's long-term structural budget deficit and high gross debt, fiscal repair will be at the forefront of policy for many years.

This challenging fiscal context translated into aged care, where the October Budget focused on meeting pre-election commitments without spending more on the sector than was necessary. The additional \$3.9bn funding over the next four years focused on four issues: (1) fair and responsive residential and in-home services, (2) targeted assistance for older Australians, (3) a valued and qualified workforce and (4) transparency and accountability in the sector.

The headline item was an additional \$2.5 billion expenditure over four years to increase the quality and quantity of residential aged care through additional direct care staffing, above that already committed to by the previous Government. Specifically, it will be used to fund the 24/7 registered nurse requirement, which has been brought forward a year to 1 July 2023, and the staffing uplifts to reach the higher care minute targets for 2024.

Other aged care budget measures announced include:

- \$312.5 million over four years on information and communication technologies to generate publicly available financial reports detailing revenues and expenses for care, accommodation and everyday living. This funding will also be used to improve technology platforms for aged care providers to report information relevant for General Purpose Financial Statements, the Star Rating system and Care Statements.
- \$68.5 million over four years to develop the Strengthening Regional Stewardship of Aged Care network to identify and respond to issues in regional and rural services.
- \$53.5 million until December 2023 to fund the Disability Support for Older Australians (DSOA) program to support older Australians with a disability who are not eligible for the NDIS.
- \$43.8 million over three years for a transition fund to support residential aged care providers adjust to the AN-ACC funding model.
- \$38.7 million over four years for an Inspector-General of Aged Care to provide independent oversight of the sector, identify and solve systemic issues to improve services and report to Parliament.
- \$26.1 million over four years to improve services for First Nations peoples, and older Australians from diverse communities, living with dementia and based in regional areas.
- \$23.1 million over one year for further research and consultation into the design a new in-home aged care program. This includes the trial of the new aged care assessment tool, a costing study by the IHACPA and the establishment of an advisory body to advise on service subsidies.
- \$9.9 million over two years to establish an Aged Care Complaints Commissioner to manage and investigate complaints against aged care providers.
- \$5 million over three years for staff training, dietician assessments, reporting requirements and a food nutrition standard with the Maggie Beer Foundation to improve food standards in aged care homes.
- \$3.6 million over one year to establish a registration scheme for personal care workers that involves compliance with a Code of Conduct, worker screening and ongoing training.

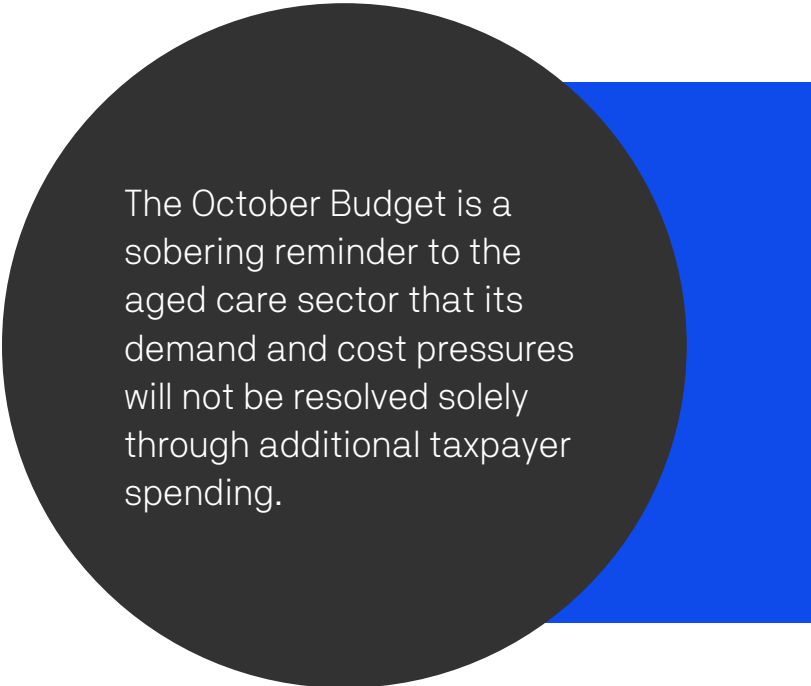
In addition, the October Budget included other funding measures relevant to aged care, including:

- \$810 million to cover claims for additional costs associated with COVID-19 outbreaks and \$34.9 million for in-reach testing arrangements in aged care homes until 31 December 2022.
- \$185.3 million to expand the health and aged care workforce in rural and remote areas, including a program to improve staff retention, provision of support services for nurses and midwives, and funding to attract, support and retain rural health professionals. This includes 15,000 fee-free TAFE places reserved for aged care.

The Budget's Statement of Risk notes that the Government has made a provision in the Contingency Reserve to support wage rises for aged care workers arising from the FWC's decisions in the Aged Care Work Value case. A second risk arises from the Government's Accommodation Payment Guarantee Scheme, while the Budget notes that the Government may levy all approved providers holding bonds, entry contributions and RADs to meet any shortfall in the event of a payout under the scheme.

The Labor Government's first Budget is broader in focus than prior budgets. Budget Paper No.1 contains the framing of a more holistic view of the community's quality of life, and the Government has committed to publishing a well-being statement in 2023. The challenge for those committed to improving the quality of life of older Australians is to engage with the Government to ensure that the well-being indicators are relevant to the lives of Australia's seniors. They could range from the more familiar measures of poverty, health and longevity to those of insecure housing and homelessness, social isolation, under-employment and age discrimination.

The October Budget is also a sobering reminder to the aged care sector that its demand and cost pressures will not be resolved solely through additional taxpayer spending. UARC's blueprint for a more sustainable aged care sector, released in June this year, assumes even greater relevance in this context.<sup>123</sup> In essence, adopting a broader range of primary care services could reduce the growth rate of demand for aged care services, subsidies could be directed to those more effective services, and aged care funding could be rebalanced with more contributions from those with higher means. Equally, providers need to improve the efficiency of the delivery of services. UARC will continue to monitor and report on these matters in future Aged Care Sector Reports.



The October Budget is a sobering reminder to the aged care sector that its demand and cost pressures will not be resolved solely through additional taxpayer spending.

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123. Woods, M; Sutton, N; McAllister, G; Brown, D; Parker, D., (2022), *Sustainability of the Aged Care Sector: Discussion Paper*, UTS Ageing Research Collaborative.

Part  
**3**

# Aged care in focus: Workforce

# Background

**Part 3 of this report presents the results of a research project investigating an issue in-depth. Following discussions with providers and other sector participants, the challenge of maintaining a suitably skilled and qualified workforce was selected as the topic for this report's 'Aged care in focus' section.**

Maintaining a suitably skilled and qualified workforce, which is a critical factor in providing safe and quality care, has emerged as one of the key challenges facing aged care service providers in 2022. As stated in the Productivity Commission's study report on aged care employment, quality of care cannot be separated from the individuals and the workforce that provide that care.<sup>124</sup>

Discussions on shortages in the aged care workforce are occurring in an environment where the Government is undertaking substantive reform in the aged care sector. The demand for aged care workers is intensifying in the lead up to the incoming minimum standards, which will increase direct care staffing requirements for most providers. Moreover, workforce issues have been compounded by the COVID-19 pandemic and associated border lockdowns, the rapid expansion of the HCP program, and competition for workers from other care sectors.

The current aged care workforce is estimated to represent 370,000 full-time equivalent (FTE) workers. More than 70% of workers are in direct care roles (e.g., 75.2% in residential care, 79.7% in HCPs program and 77.6% in the Commonwealth Home Support Programme), with the majority of those staff being personal care workers.<sup>125</sup> The Committee for Economic Development of Australia (CEDA) projected that, over the next decade, the aged care workforce would need an additional 30,000 to 35,000 direct care workers each year to meet the increasing demand for care.<sup>126</sup> Furthermore, the National Care and Support Workforce Strategy predicts that by 2025–26, shortages will be felt most acutely in the categories of personal and support workers.<sup>127</sup>

Given the significance of these challenges, it is essential to understand the experiences of providers and workers, how they are managing in the current environment and their suggestions for what needs to be done to address these challenges. In what follows, we present providers' experiences of workforce challenges during the past financial year (2021–22).

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124. Productivity Commission. October 2022, *Aged care employment Study report*. Australian Government.

125. Department of Health and Aged Care (2022), *Financial report on the Australian aged care sector 2020–21*.

126. Committee for Economic Development of Australia (2022), *Duty of care: Aged care sector in crisis*.

127. Australian Government (2022), *Aged Care Workforce Action Plan: 2022–2025. Growing a skilled workforce to deliver high quality care for senior Australians*.

# Methodology

This research project draws on data from two sources. The first is quarterly workforce measures that are part of StewartBrown's Aged Care Financial Performance data set. The second data source was a bespoke survey conducted by StewartBrown in July 2022, specifically focusing on providers' experiences of skill shortages during the 2021-22 financial year.<sup>128</sup>

The survey collected information about the extent of skill shortages and turnover by roles across both residential and home care. It also measured providers' perceptions about the causes of the shortages, organisational impacts, mitigating strategies, future expectations and possible recommendations for addressing these challenges in the future.

Questions were designed to align with existing data collection processes, including questions asked in earlier iterations of the Aged Care Workforce Census and terminology used in the Aged Care Quarterly Financial Report. Furthermore, the questionnaire allowed participants to leave qualitative commentary on their responses. All data collected by StewartBrown was provided to the UARC research team in a de-identified, aggregated form.

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128. In total, 81 responses were collected from 78 unique providers, that operated a total of 543 residential aged care homes and 162 home care services.

# Results

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## Providers' perceptions and experiences

This results section first explores providers' perceptions and experiences of current workforce challenges in four key areas:

- Recent experiences of skill shortages
  - Causes of skill shortages
  - Organisational impacts of skill shortages
  - Strategies to address skill shortages
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## Longer-term trends

The analysis then examines longer-term historical trends in several workforce strategies:

- Residential care: use of overtime and agency workers
  - Home care: reliance on brokered staff
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## Future analysis

Finally, the analysis presents a synthesis of provider's perspectives relating to the future, specifically their:

- Expectations about future skill shortages
  - Recommendations for addressing workforce issues
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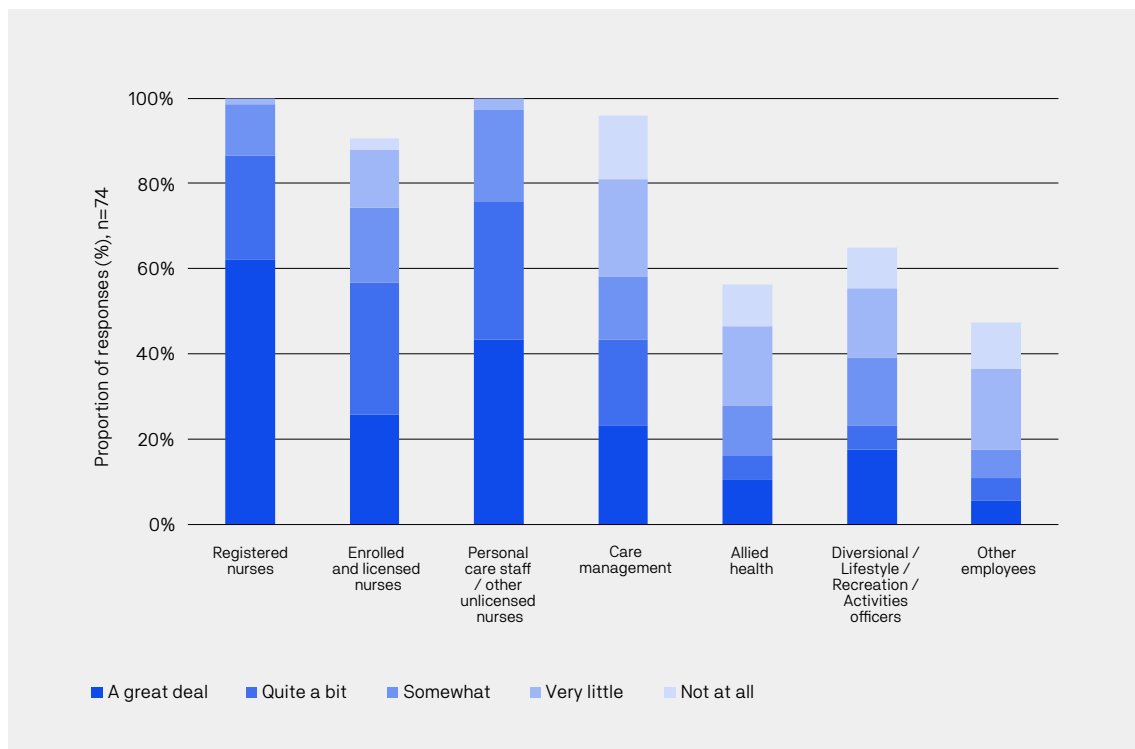
## Provider experiences of skill shortages

Within the bespoke workforce survey, providers were asked to indicate the extent to which they had experienced skill shortages during the last financial year (2021–22) across different staffing roles, separately for residential and home care.

### Residential care

In residential care, many providers experienced significant staff shortages, particularly in direct care staffing roles.

Figure 28: Experiences of skill shortages in residential care, by staff role



As shown in Figure 28, residential care providers were most significantly affected by skill shortages in the three categories of staff that align with direct care staffing care minutes:

- Close to 87% of respondents were significantly affected by shortages in registered nurses (62.2% 'great deal' and 24.3% 'quite a lot').
- More than 75% were significantly affected by shortages in personal care workers and other unlicensed nurses (43.2% 'a great deal' and 32.4% 'quite a lot').
- 57% of providers were significantly affected by shortages in enrolled and licensed nurses (25.7% 'great deal' and 31.1% 'quite a lot').

In terms of staff turnover rates during the year, data gathered from participating residential care providers indicated an overall annual staff turnover rate of 37.6% (see Table 20). While turnover was relatively consistent across different staffing roles, it was most acute in registered nurses, diversional therapy roles, and enrolled and licensed nurses

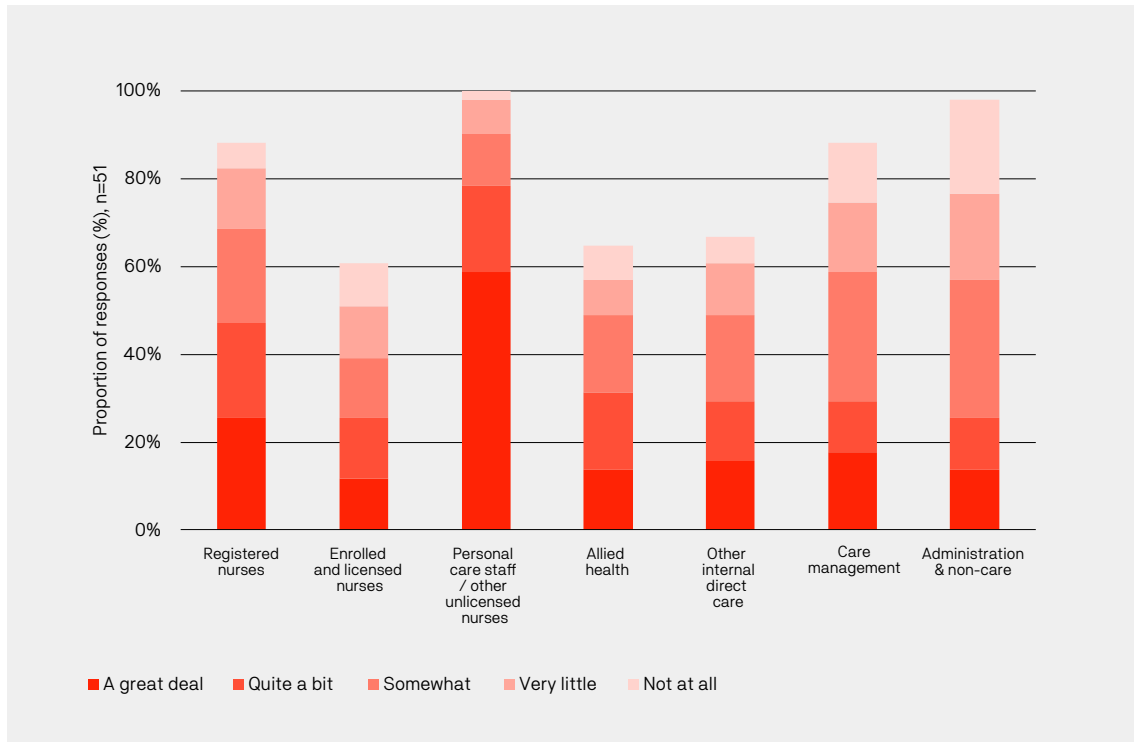
**Table 20: Turnover rates, by role, in residential care 2021-22**

Staff role	Turnover rate
Registered nurses	45.1%
Enrolled and licensed nurses	39.2%
Personal care staff / other unlicensed nurses	34.2%
Care management	35.6%
Allied health	30.3%
Diversional/Lifestyle/ Recreation/ Activities officer	40.7%
Overall	37.6%

### Home care

In home care, providers reported less severe skill shortages than in residential care. As shown in Figure 29, the most significant shortages were concentrated around two roles:

- Nearly 80% of home care providers reported being significantly affected by personal care workers and other unlicensed nurses (58.8% 'a great deal' and 19.6% 'quite a lot').
- Approximately 47% of providers experienced significant shortages of registered nurses (25.5% 'a great deal' and 21.6% 'quite a lot').

**Figure 29: Experiences of skill shortages in home care, by staff role**

In terms of staff turnover, data gathered indicated an overall annual staff turnover rate of 41.9% within participating home care providers in 2021–22 (see Table 21). In terms of specific roles, the highest turnover rates were in personal care workers and administration and non-care roles and other indirect care roles (see 2).

**Table 21: Turnover rates, by role, in home care 2021–22**

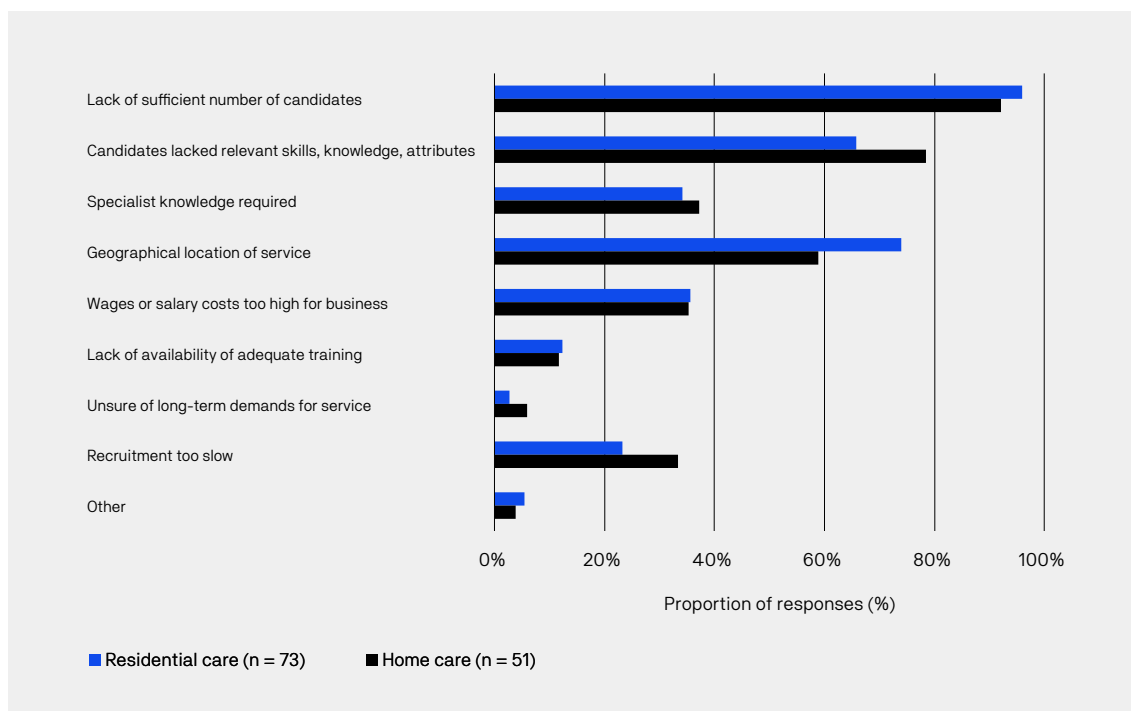
Staff role	Turnover rate
Registered nurses	27.8%
Enrolled and licensed nurses	24.4%
Personal care staff / other unlicensed nurses	48.8%
Allied health	22.0%
Other internal direct care	39.9%
Care management	24.6%
Administration and non-care	45.2%
Overall	41.9%

## Causes of skill shortages

Survey respondents were asked to identify the underlying causes of skill shortages. In the questionnaire, they could select more than one of the response options and also nominate other factors not listed. The results are presented in Figure 30.

In terms of the perceived causes of skilled shortages, the most common provider responses across both home care and residential care indicated problems in finding sufficient numbers of workers or workers with appropriate skills, as well as geographical constraints. These issues outweighed other concerns, such as wage costs, specialist training needs, demand uncertainty, lack of training opportunities or the pace of recruitment processes.

**Figure 30: Causes of skill shortages in residential and home care**



As shown in Figure 30, the pattern in reported causes is relatively similar across both residential and home care, with the same three issues reported as the top three causes:

- Lack of sufficient number of candidates: 95.9% of residential care respondents; 92.2% of home care respondents
- Geographical location of service: 74.0% of residential care respondents; 58.8% of home care respondents
- Candidates' lacked relevant skills, knowledge, and attributes: 65.7% of residential care respondents; 78.4% of home care respondents

## Impacts of skill shortages

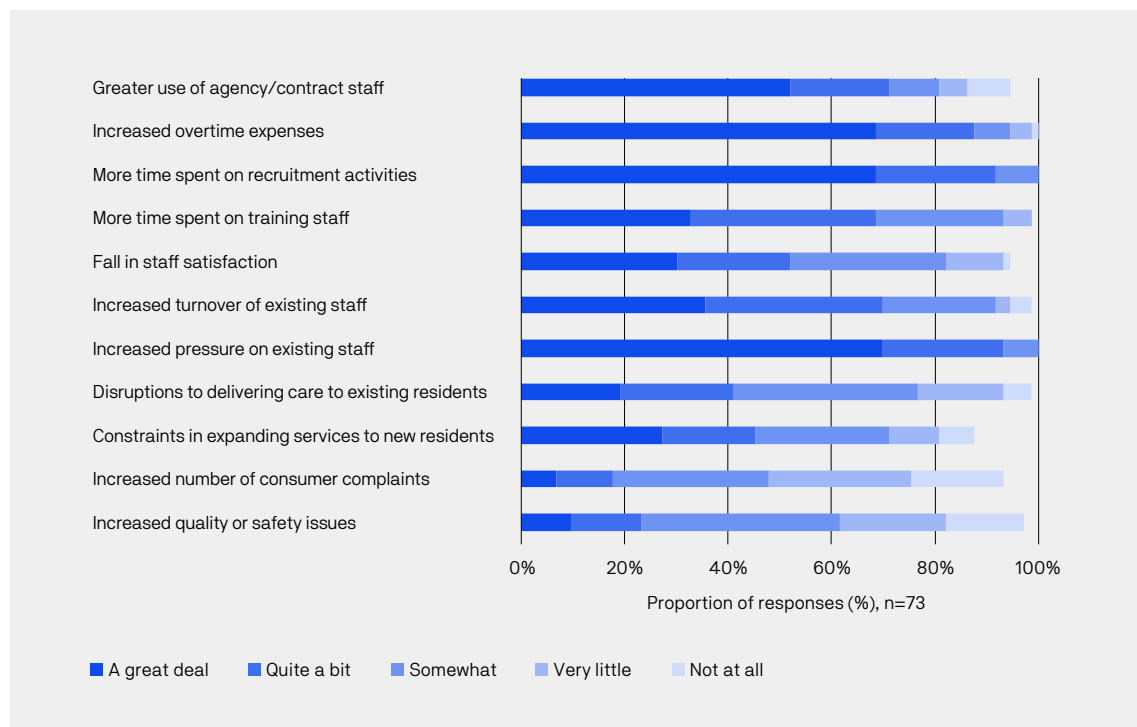
Survey respondents were also asked to identify the impacts of skill shortages for their organisation. As with the previous question, respondents could select more than one of the response options, and also nominate other factors not listed.

### Residential care

In terms of residential care (see Figure 31), some of the most significant impacts of shortages were felt by existing staff:

- More than 93% reporting significant increases in pressure ('great deal' 69.9% and 'quite a bit' 23.3%)
- Almost 70% reporting significant increases in turnover ('great deal' 35.6% and 'quite a bit' 34.2%)
- More than two-thirds reporting significant increases in time spent on training staff ('great deal' 32.9% and 'quite a bit' 35.6%)
- More than half reporting significant falls in staff satisfaction ('great deal' 30.1% and 'quite a bit' 21.9%)

Figure 31: Impacts of skill shortages in residential care



The other major type of impact of skill shortages appears to relate to providers' recruitment and workforce management:

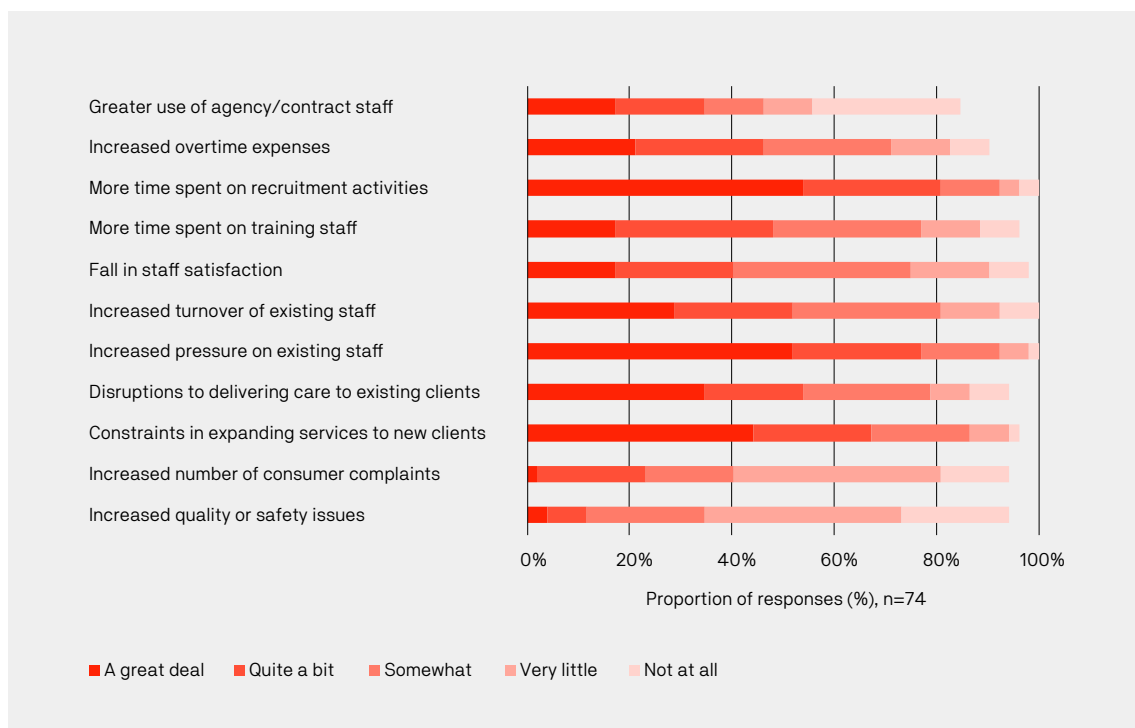
- Approximately 92% of respondents indicated their organisation was spending substantially more time on recruitment activities ('great deal' 68.5% and 'quite a bit' 23.3%).
- Close to 90% of organisations are increasingly relying on overtime ('great deal' 68.5% and 'quite a bit' 19.2%) to deliver care services.
- More than two-thirds of providers reported making substantially greater use of agency and contracted staff ('great deal' 52.1% and 'quite a bit' 19.2%) to deliver care services.

Providers also indicated that the skill shortages were having a moderate impact on residents and the delivery of care. Almost half indicated that shortages were creating constraints in expanding services to new residents, and approximately 40% indicated they were causing disruptions to delivering care to existing residents. Nonetheless, only a minority of providers indicated that this had translated into substantial increases in the number of consumer complaints (17.8%) or quality or safety issues (23.3%).

## Home care

The impacts of skill shortages were more varied in home care (see Figure 32). Compared to residential care, a smaller proportion of home care providers experienced negative effects of skill shortages during the 2021-2022 period. Nonetheless, some types of impacts appeared to affect most home care providers in terms of existing staff, recruitment and service delivery.

**Figure 32: Impacts of skill shortages in home care**



In terms of the impacts of skill shortages on existing staff:

- More than three-quarters of respondents indicated significant increases in pressure ('great deal' 51.9% and 'quite a bit' 25.0%)
- More than 50% reporting significant increases in turnover ('great deal' 28.8% and 'quite a bit' 23.1%)
- Almost half reporting significant increases in time spent on training staff ('great deal' 17.3% and 'quite a bit' 30.8%)

Furthermore, more than 80% of providers were impacted by the shortages in the form of additional time spent on recruitment activities ('great deal' 53.8% and 'quite a bit' 26.9%).

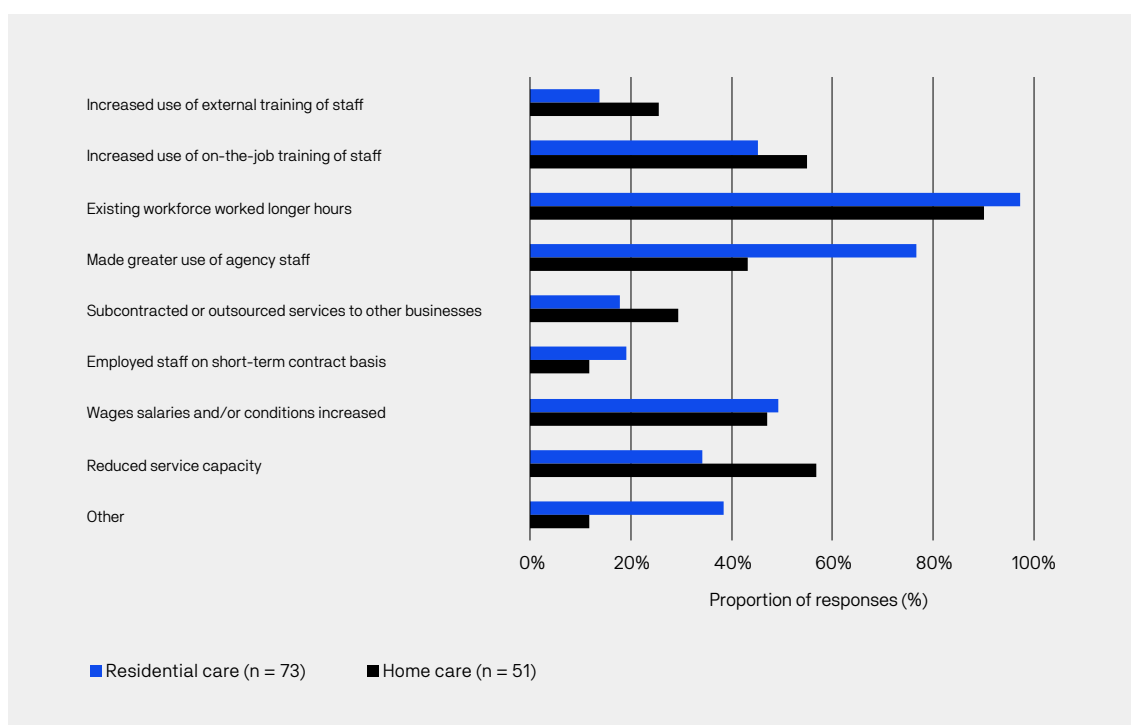
Finally, with impacts on service delivery, more than two-thirds of home care providers reported substantial constraints on expanding services to new HCPs ('great deal' 44.2% and 'quite a bit' 23.1%) and more than half reported significant disruptions to services to clients. However, as in residential care, only a small minority reported that this translated into increased complaints (23.1%) or quality and safety issues (11.5%).

## Strategies to address skill shortages

Survey participants also provided information about the strategies they used, across both residential and home care, to address skill shortages in the last financial year (see Figure 33).

Across both residential and home care, the most widely used strategy was to rely on overtime, with 97.3% of residential care respondents and 90.2% of home care respondents reporting that their existing workforce worked longer hours.

**Figure 33: Strategies to address skill shortages in residential and home care**



Other common strategies used in residential care included:

- Increasing the use of agency staff (76.7%)
- Increasing wages and improving work conditions (49.3%)
- Increasing on-the-job training (45.2%)

In comparison, the most widely used strategies (after overtime) to address skill shortages in home care were:

- Reducing the service capacity (56.9%)
- Increasing on-the-job training (54.9%)
- Increasing wages and improving work conditions (47.1%)

## Residential care: use of overtime and agency workers

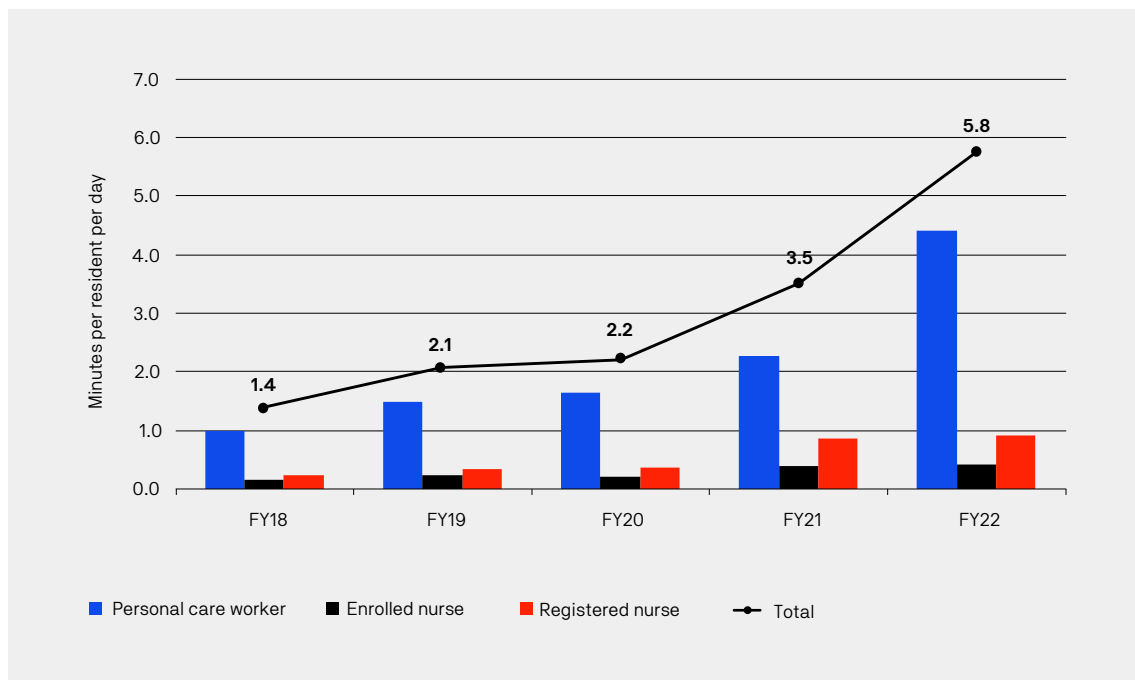
This section explores long-term trends in two of the most commonly used strategies described above by residential care providers to address skill shortage: the use of overtime and agency staff in the provision of direct care.

The analysis of long-term trends is based on workforce data collected routinely by StewartBrown in large-scale sector data set, as analysed in Part 1 of this report. The dataset contains workforce outcomes of approximately 1,100 residential aged care homes.

The results show trends of annual home-level averages of staffing time, measured as minutes per resident per day, broken down by direct care worker classification.

During the last five years, there has been a steady increase in the use of overtime in direct care roles within residential aged care homes. As shown in Figure 34, overtime has increased for registered nurses, enrolled nurses and personal care workers.

**Figure 34: Overtime staffing in residential care, by staff role**

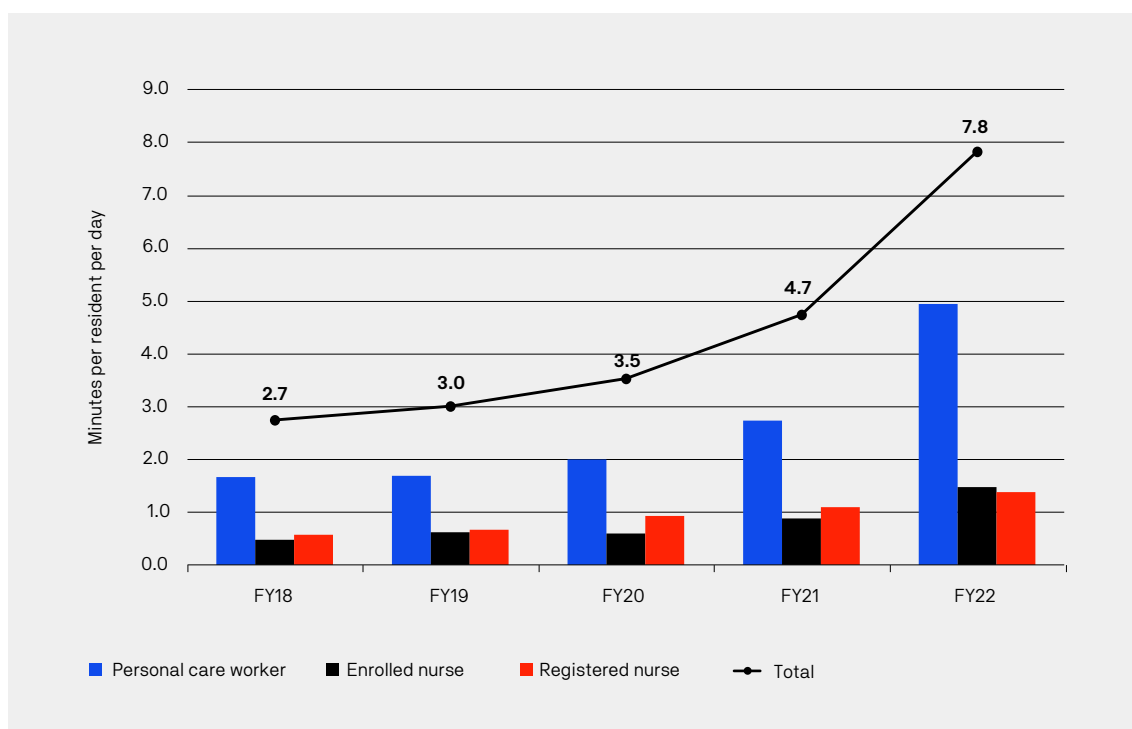


Homes' average total direct care overtime has tripled since 2017-18, from 1.40 minutes per resident per day to 5.75 minutes by 2021-22. Over these five years, the largest growth in overtime has been within personal care workers (0.99 minutes per resident per day in 2017-18 to 4.45 minutes in 2021-22) followed by registered nurses (0.25 minutes in 2017-18 to 0.92 minutes in 2021-22) and enrolled nurses (0.16 minutes in 2017-18 to 0.42 minutes in 2021-22).

The growth in overtime appears to have accelerated in the two most recent years, coinciding with the COVID-19 pandemic. Since 2019-20, personal care worker overtime has more than doubled (growth of 169%), and it has roughly doubled for registered nurses (growth of 152%) and enrolled nurses (growth of 104%).

In the last five years, there has also been a substantial increase in residential aged care homes' use of agency staff across all direct care roles.

**Figure 35: Agency staffing in residential care, by staff role**



As shown in Figure 35, homes' use of direct care agency staff grew by 185%, on average over the last five years, from 2.7 minutes per resident per day in 2017-18 to 7.8 minutes in 2021-22. During these five years, the most significant increases in agency staffing have involved personal care workers (which grew, on average 39% per year), followed by enrolled nurses (41%) and registered nurses (27%).

As with overtime, the growth in agency staffing has accelerated in recent years, with a 66% year-on-year increase in 2021-22 alone. The most substantial increases occurred among personal care workers (80%), followed by enrolled nurses (67%) and registered nurses (27%).

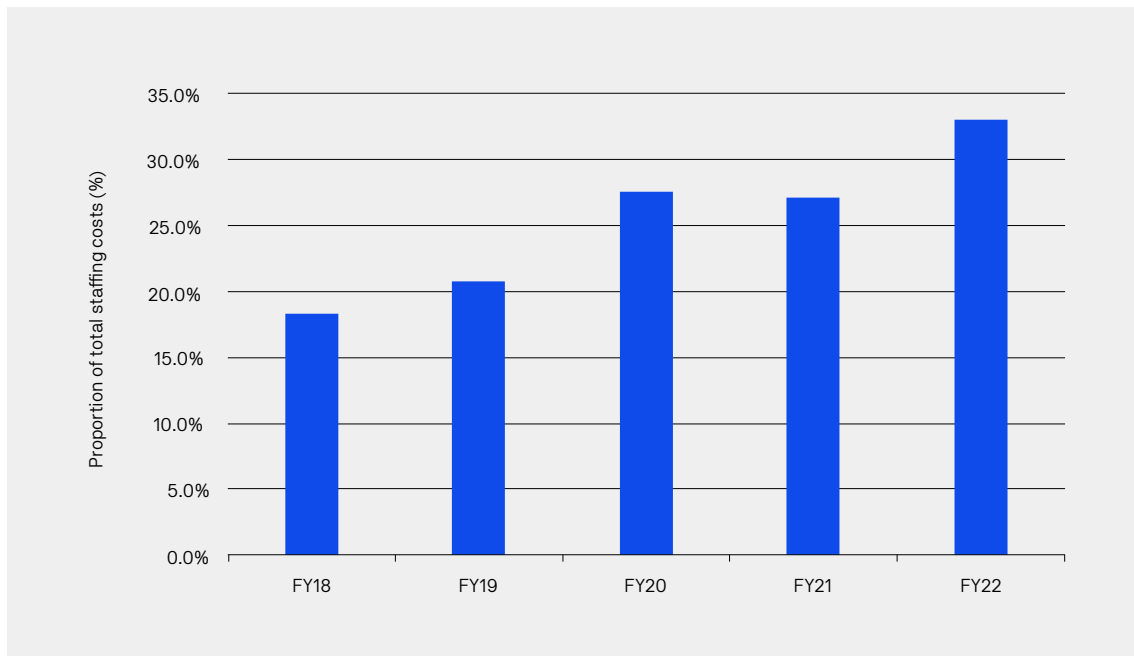
Overall, the five-year trends in the use of overtime and agency staffing document a growing reliance on non-fixed staffing to help deliver direct care services and corroborate providers' reported experiences of skill shortages described above.

## Home care: reliance on brokered staff

This section explores trends in the use of subcontracted and brokered staff in direct care delivery by home care providers. Consistent with the residential care analysis, this analysis draws on routine data collected by StewartBrown, which includes data from over 500 home care services.

The analysis examined the five-year trend in the proportion of total direct care staffing costs spent on externally contracted and brokered staff by home care providers.

**Figure 36: Subcontracted and brokered services as a proportion of total staffing costs in home care**



As shown in Figure 36, the proportion of direct care costs from brokered staff increased from 18.2% in 2017–18 to 33.0% in 2021–22. Although this trend appears more moderate than agency staffing in residential care, home care providers rely much more heavily on external workers in their care delivery. Analysis of the factors predicting the types of home care services most likely to use subcontracted or brokered staff indicated that services in the top 25% were more likely to be based in metropolitan areas and offer fewer HCPs overall (i.e., a smaller provider) or fewer Level 3 HCPs.<sup>129</sup>

129. Multivariate statistical analyses were performed to identify the determinants of a service being in the top quartile of brokered staff in 2021–22.

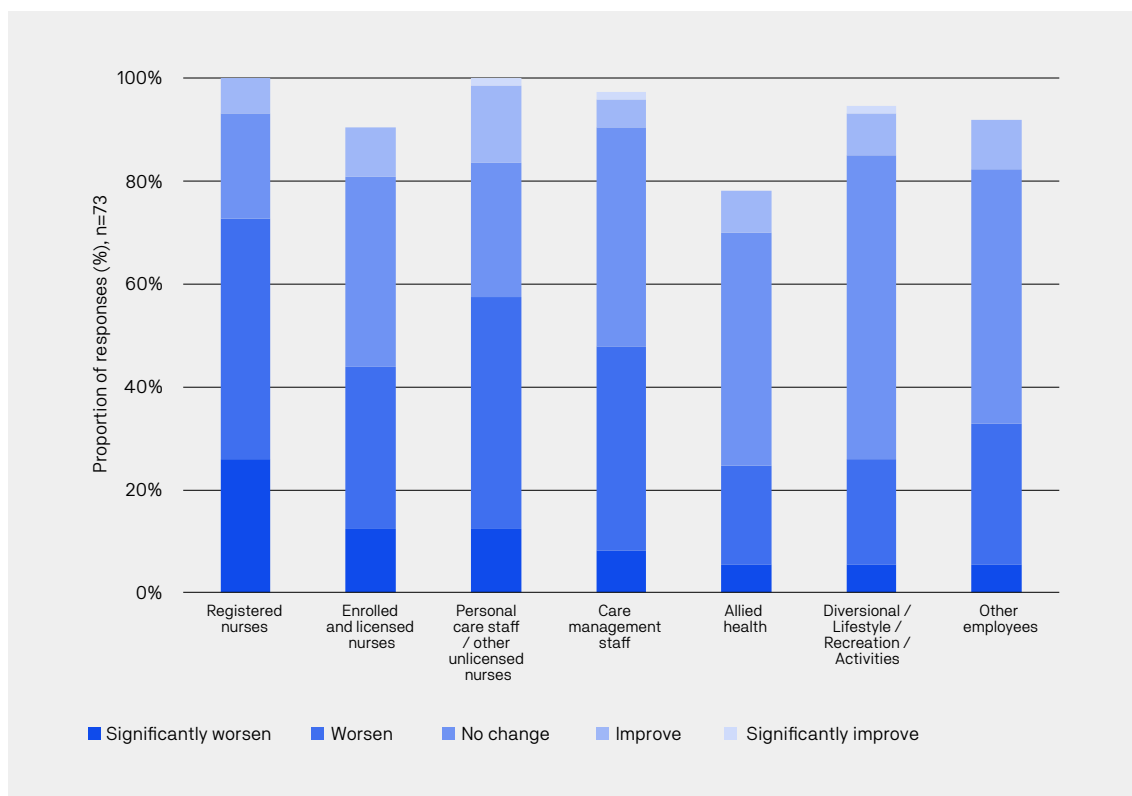
The model was specified as a logistical regression with the dependent variable being a binary variable if the service had total brokered costs as a percentage of direct care costs in the 75th percentile of services. For simplicity, all independent variables are specified in binary form with variables included for the following characteristics of interest: location (Metropolitan, Rural), higher overall packages (75th percentile of total packages) and a higher level 1, level 2, level 3 and level 4 packages (above the 50th percentile of proportionate packages for each level).

## Expected future staffing shortages

Turning to the future, providers were asked to indicate the extent to which they expected skill shortages to worsen or improve in the coming financial year (2022-23).

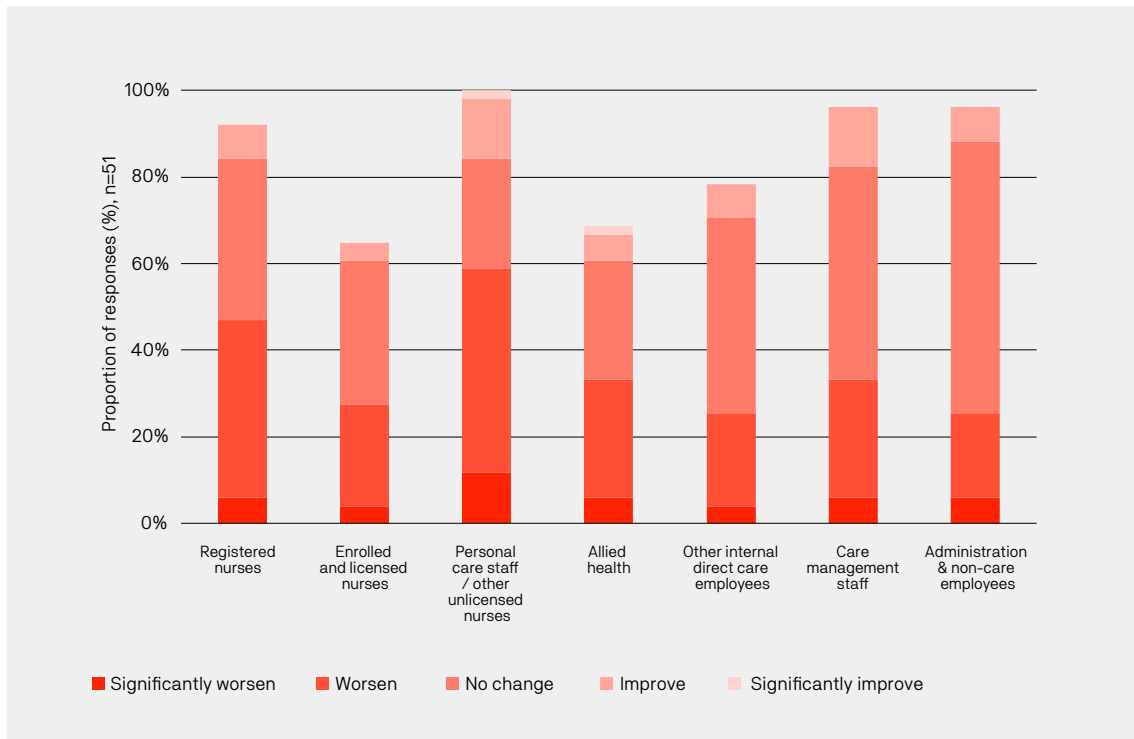
In residential care, only a small minority of providers anticipated skill shortages would improve next year across all categories of staffing roles (see Figure 37). Most expected either no change from the current situation or a worsening outlook.

**Figure 37: Future expectations of skill shortages in residential care, by staff role**



The outlook appears particularly concerning in terms of direct care roles. Large proportions of respondents expected skills shortages to worsen for:

- Registered nurses (72.6%)
- Personal care workers (57.5%)
- Care managers (47.9%)
- Enrolled nurses (43.8%)

**Figure 38: Future expectations of skill shortages in home care, by staff role**

In home care, providers also anticipated worsening skill shortages in 2022-23, particularly in direct care roles (see Figure 386). For example, 58.8% anticipated worsening shortages for personal care workers, 47.1% for registered nurses, 33.3% for allied health and 27.5% for enrolled nurses. Most expected no change concerning other staff, including administration and non-care roles (62.7%), care managers (49.0%), other direct care (45.1%).

More than 90%  
of residential and  
home care providers  
relied on increased  
overtime to address  
skill shortages in  
2021–22.

## Participants' recommendations for workforce challenges

Respondents to the survey provided many suggestions to address the sector's workforce challenges, which coalesced along three themes.

### Recruitment pools and processes

Several recommendations focused on increasing the recruitment pools and improving the recruitment processes. Most respondents suggested improvements to migration programs to ensure better access to skilled and graduate migrant workforces.

*By adding nursing and care staff ANZSCO [Australian and New Zealand Standard Classification of Occupation] codes to the Skills Occupation List and fast-tracking visas.*

Respondents also recommended more support for older workers wishing to return to the workforce through tax and pension incentives, as well as increases in the number of trainees and volunteers. In addition, some providers suggested resourcing a temporary 'surge workforce' ready to deploy when needed, especially in priority skills.

*Support older (65+) RNs [Registered Nurses] to return to the workforce or work in the aged care sector while keeping pension benefits.*

### Training and career opportunities

The second set of recommendations focused on training and career opportunities. These included suggestions to provide more training opportunities, including in-house training, aged care-specific courses, longer placements in aged care homes and career pathways, such as apprenticeship opportunities.

*Having nursing students do some placement within an aged care facility to let them see what an RN does.*

For many providers, changes to the educational programs and pathways needed to be made in conjunction with improving the sector's image. Indeed, to make the work more attractive to prospective workers and students, respondents stated that there was a need to improve the poor reputation of the aged care sector. For this, it was suggested that the industry and Government work together to promote the work as a viable career option and show the value of caring for older people in society.

*The Aged Care industry as a sector has to make aged care attractive to prospective employees, and this does not mean just higher pay rates, it includes changes to working conditions and the perception of the industry.*

## Government funding, wage growth and regulation


The third set of recommendations pertained to changes to award wages, government funding and regulatory systems. Numerous respondents suggested increasing government pricing and subsidy schemes to make the aged care sector more viable and competitive. Several respondents also recommended funds be provided to subsidise aged care nursing courses and other practice-based training programs. As a priority, respondents recommended increased funds to improve the aged care workers' wages, tax relief benefits and retention bonuses.

*Hopefully, the Fair Value Work Case will have an impact on wages in the industry as long as it is supported by government funding.*

Improving aged care workers' pay was seen as important in enabling recruitment to the sector and overcoming wage disparities with other care sectors. It would also reflect and reinforce the value of aged care work.

*Personal care skills to be recognised for value to society and paid accordingly.*

Respondents also highlighted the importance of having positive and supportive interactions between the Government and industry stakeholders. Suggestions included that the Government collaborate with providers on policy development and key sector definitions, support providers in meeting regulatory reporting requirements and alleviate the bureaucratic burden associated with compliance. This set of suggestions implied the need for a more trusting relationship between government and industry, which, in turn, would allow providers greater control over what and how care should be delivered and what constitutes quality care.



The Aged Care industry as a sector has to make aged care attractive to prospective employees, and this does not mean just higher pay rates, it includes changes to working conditions and the perception of the industry.

# Summary of results

## Skill shortages

- For residential care providers, the most significant shortages were in direct care roles. During the 2021–22 financial year, the staff turnover rate across surveyed homes was 37.6% and relatively consistent across different staffing roles.
- Home care providers' most significant skill shortages were for personal care workers. During the 2021–22 financial year, the staff turnover rate across surveyed home care services was 41.9%.

## Causes of shortages

- The most common causes of shortages were difficulties finding enough workers to fill vacancies and a lack of available staff with the appropriate knowledge, skills and attributes.

## Impact of shortages

- The two most significant reported impacts of skill shortages across residential and home care providers were the increased pressure on staff and increased time spent on recruitment activities.

## Mitigating strategies

- More than 90% of residential and home care providers relied on increased overtime to address skill shortages.
- Most residential care providers also increased their reliance on agency staff, whereas home care providers increased their use of brokered staff and reduced service capacity.

## Future expectations of shortages

- Many residential and home care providers expected skill shortages to worsen in 2022-23, especially in direct care roles.

## Provider recommendations for improvement and change

- Providers suggested that workforce challenges may be addressed through initiatives that improve recruitment pools and processes, training and career opportunities, and funding and regulatory support.

# Implications

Our research results show that substantial skill shortages are causing aged care providers to increasingly turn to non-standard and indirect forms of employment, particularly for direct care roles. In residential care, agency staffing and overtime have accelerated, particularly in the last two years. Similarly, home care providers are increasingly relying on subcontracted or brokered services to meet the needs of home care package recipients.

These trends coincide with an increasing policy interest in the employment models used within aged care. In the Royal Commission's Final Report, Commissioner Briggs recommended that providers be required to preference the direct employment of staff who provide personal care and nursing services.<sup>130</sup> The Government has endorsed the recommendation, which it reaffirmed in the October 2022-2023 budget measures.<sup>131</sup> UARC's existing research shows that reliance on agency staff in residential care is associated with poorer quality of care outcomes and that a skilled and stable workforce provides a higher quality of care for residents.<sup>132</sup>

However, a recent Productivity Commission study concluded that there was no evidence that preferencing direct employment would improve quality outcomes at a sector level.<sup>133</sup> Instead, the report noted that the current skills shortages make such a preferencing unrealistic at best and, at worst, would risk eroding the aged care workforce and contributing to poorer care outcomes.

In our view, heavy reliance on indirect employment poses problems for the continuity of care for residents, the financial viability of providers and the well-being of staff. However, our analysis also suggests that the increase in indirect employment is symptomatic of two broader, structural problems: significant staff shortages and high staff turnover.

Our findings add to the growing evidence base of the chronic shortfall of aged care workers, and that the current workforce is insufficient to meet growing demand and increasing requirements. Providers' pessimistic expectations that direct care skill shortages will likely worsen are supported by the analysis in Part 2, which indicates that at least 17,953 additional direct care workers (FTE), including 6,922 registered nurses (FTE), will be needed to meet the incoming minimum standards.

Recent statements by the DoHAC suggest that the priority policy focus is on ensuring sufficient registered nurses, yet our survey findings show providers encountering shortages across all direct care roles.

130. Royal Commission into Aged Care Quality and Safety. (2021). Final Report: Care, Dignity and Respect.

131. Chalmers, J. et al. (2022) Budget October 2022-2023 -Budget Measures: Budget Paper No. 2, Commonwealth of Australia, p.125.

132. Ma, N., Sutton, N., Yang, J.S., Rawlings-Way, O., Brown, D., McAllister, G., Parker, D. & Lewis, R. (2022), 'The quality effects of agency staffing in residential aged care', *Australasian Journal on Ageing*, doi:10.1111/ajag.13132; Brown, D.A., Ma, N., Yang, J.S., Sutton, N., McAllister, G., Parker, D., Rawlings-Way, O. & Lewis, R.L. (2022), 'The impact of business model workforce configurations on value creation and value appropriation in the Australian aged care sector', *Australian Journal of Management*, doi:10.1177/03128962221109279

133. Productivity Commission. October 2022, Aged care employment Study report. Australian Government

In addition, the high turnover rates reported in this study reflect an increase over those previously reported in the 2020 Aged Care Workforce Census, with 37.6% turnover in residential care (compared to 29% in the 2020 Census) and 41.9% in home care (compared to 34% in the 2020 Census).<sup>134</sup> These figures do not equate to attrition from the sector, as a portion of turnover will represent staff movements between providers. Nonetheless, staff turnover comes with increased costs of onboarding and training new hires, loss of skills and institutional knowledge, and risks associated with compromised continuity of care. Furthermore, poor staff retention places increased pressure on the remaining staff, eroding work conditions and staff satisfaction, triggering further exits and exacerbating skill shortages.

Improving the recruitment and retention of aged care workers will require changes initiated at both sector and organisational levels. A critical structural change will be the increase in award wages following the Fair Work Commission case, with the DoHAC expecting it to halve the current sector shortfall in staff. The interim decision to increase award rates also recognises the historical undervaluing of aged care work and workers, acknowledging that the undervaluation is likely to be gender-based and due to the “invisibility” of the skills involved in feminised industries, such as care work. Thus, the wage increases will not only help reduce the wage disparity with parts of the health and care economy but may also assist in improving the standing and attractiveness of the sector as a whole.

There is also a critical need to improve and support suitable career pathways for aged care workers. The National Skills Commission notes that while pathways for staff in higher skill level classifications (such as registered nurses) are reasonably well articulated, this is not the case for staff with lower skill levels, such as personal care workers.<sup>135</sup> At these levels, staff investment in developing skills, knowledge and qualifications is not linked to career progression, expanded responsibilities or the possibility of pay increases. Of particular note is the role of enrolled nurses, which can act as a ‘stepping stone’ into more established career pathways but whose role in residential aged care appears under threat by the introduction of minimum staffing minutes.

Finally, at an organisational level, there remains substantial scope for providers to differentiate themselves as employers of choice. By improving staff’s employment conditions, work environments, and career and skill development, providers may find it easier to attract and retain high-quality workers. Such investments may include paying above-award wages, increasing staff and management training beyond that necessary for the induction of new staff, providing personal development programs and career pathways, involving all staff in roster planning and building a positive corporate ethos. Although devoting resources to such initiatives may be difficult in the current challenging financial environment, they may also attenuate the costs and risks of shortages and turnover in an increasingly competitive Australian labour market.

The ongoing development of an appropriately valued and sustainably developed aged care workforce will be of crucial importance to the ability of the sector to care for older Australians with respect and dignity.

134. Department of Health (2021) 2020 Aged Care Workforce Census Report

135. National Skills Commission (2022). Care Workforce Labour Market Study

Improving the recruitment and retention of aged care workers will require changes initiated at both sector and organisational levels.

## Editorial Board

### Professor Michael Woods (Chair)

Professor Mike Woods 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.

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### Professor David Brown (Deputy Chair)

Professor David Brown is a Professor of Management Accounting at the UTS Business School and co-director of the UTS Ageing Research Collaborative (UARC). His research focuses on the design and use of accounting systems for decision-making in organisations with a focus on business models and determinants of performance.

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### Grant Corderoy

Grant Corderoy is the Senior Partner at StewartBrown and leads their Consulting division. Grant has a longstanding commitment to the aged care, community service and not-for-profit sector and regularly contributes to the financial policy, sustainability direction and viability of these sectors in consultation with the Department, peak bodies, providers and consumer advocates.

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### Professor Deborah Parker

Professor Deborah Parker is a Professor of Nursing Aged Care (Dementia) in the Faculty of Health at UTS and co-director of the UTS Ageing Research Collaborative (UARC). 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 the former President of Palliative Care NSW and is a member of the Palliative Care Nurses Association, and the Australian Association of Gerontology and the Australian College of Nursing.

## Research team

### Dr Nicole Sutton

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 and regularly comments about aged care funding, workforce and reform. She is the Treasurer of Palliative Care NSW.

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### Dr Nelson Ma

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 organisations and the role of institutions in assuring the quality of financial outcomes of publicly listed companies. He has published research in numerous international journals.

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### Dr Jin Sug Yang

Dr Jin Sug Yang is a researcher in the UTS Business School, having completed his PhD at UTS. 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

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 Celina McEwen

Dr Celina McEwen is a sociologist and anthropologist of professional practice and education. She has conducted research in universities in Australia and France across several fields and disciplines. Her most recent focus has been on the aged care sector workforce, leadership diversity practices, and workplace learning. She is currently a Researcher in the UTS Ageing Research Collaborative (UARC).

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### Professor David Brown

As above

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### Professor Michael Woods

As above

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### Professor Deborah Parker

As above

# 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 of each section and aggregated using averages or medians as stated. Ratios are calculated using the same methodology.

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 using the aggregate averages 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 home-level averages are calculated, in general, by using the aggregate of all averages 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 home-level raw data is first transformed into a rate per occupied bed day. For example, the home-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 averages 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 subcontracted 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.

## Methodological variation between UARC and StewartBrown

Despite using the same underlying dataset, UARC and StewartBrown analyses often return minor variations due to a difference in methodology concerning the unit of analysis in which averages are calculated.

Both analyses express most items as a rate per individual, for example, EBITDA per client per annum, staffing minutes per resident per day, and Operating Result per resident per day. The intent of expressing the results as rates is to account for the effects of organisational size differences and provide comparable metrics across organisations.

In general, StewartBrown calculates these rates by taking the aggregate line item values across all providers in the dataset (e.g. the total EBITDA for all home care services in their sample) and dividing by the aggregate of all individuals (e.g. the total number of clients for home care services in their sample). This approach provides the average profitability of any given individual, bed or client.

By comparison, UARC first calculates the rate for each organisation (e.g. EBITDA per client per annum for each home service) and then calculates the average of that rate across all services in the dataset. This approach provides the average profitability of any given provider, service, aged care home.

Owing to this methodological difference, the average rates calculated by StewartBrown and UARC will vary, particularly when there are differences in the performance of homes or services of different sizes within the sample.

To ensure integrity in data transfer and analysis, UARC replicates the StewartBrown analysis, reconciles figures to StewartBrown's published results and reviews all line items individually to identify erroneous sources of variation.



# For more information

UTS Ageing Research Collaborative (UARC)

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