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Australia's Aged Care Sector: Mid-Year Report 2022–23

For the 6 months ending

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UTS gratefully acknowledges financial support from StewartBrown to assist with establishment costs associated with this new publication.

Disclaimer

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

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

Australia's Aged Care Sector: Mid-Year Report 2022–23

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Tables and Figures

Table of Abbreviations

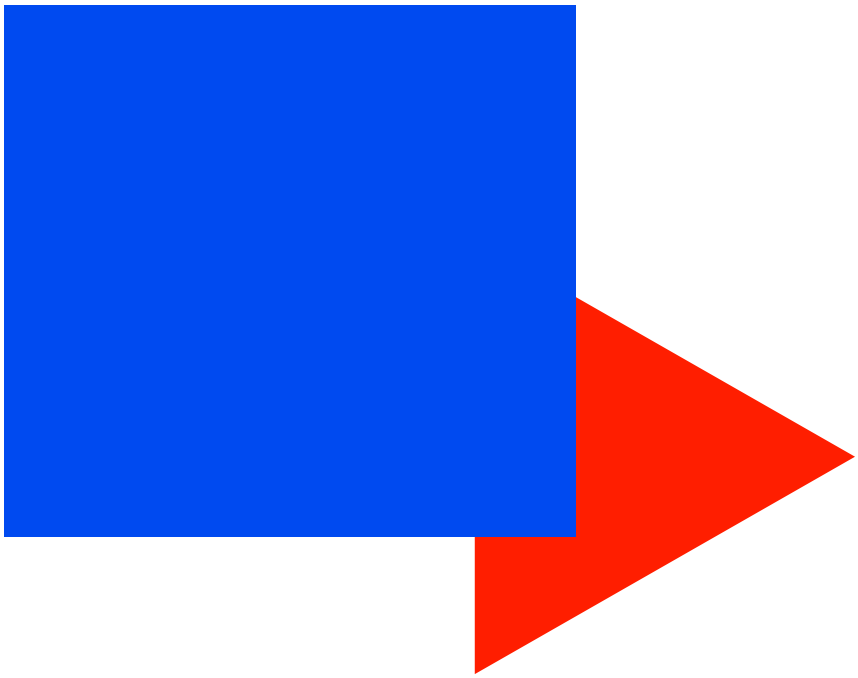
ABI	Australian Business Industrial
ACAR	Aged Care Approvals Rounds
ACCPA	Aged & Community Care Providers Association
ACFI	Aged Care Funding Instrument
ACFPS	Aged Care Financial Performance Survey
ACIA	Aged Care Industry Association
ACSA	Aged & Community Services Australia
ANMF	Australian Nursing & Midwifery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

Editorial Board Foreword

Welcome to the 2022-23 Mid-year Report on Australia's Aged Care Sector published by the UTS Ageing Research Collective (UARC).

Readers of earlier editions will notice that we have changed the structure of this report. The first section now provides a detailed analysis and commentary on current significant policy changes that are occurring in aged care. It also includes the results of our research into some of their impacts that may argue for subsequent modification of policy or its implementation. This new structure expands the scope and depth of the report's research results and responds to the positive feedback from readers that they look to UARC for this rigorous policy analysis.

The former Part 1 is now the second Part of the report. Part 2 retains its importance in providing readers with an overview of the performance of the sector for the first half of 2022–23, though the coverage is now more selective. It focuses primarily on the significant data results and trends that have policy and operational importance. There is also a broader range of information than had been included in previous editions. Nonetheless, the StewartBrown Aged Care Financial Performance Survey (ACFPS) data set remains an invaluable source of performance information and its granularity and timeliness far exceed that which the Department of Health and Aged Care is currently making available.



While there are many matters of great relevance covered in this mid-year report, the Editorial Board would like to draw your attention to the following four issues in particular. Each of them represents an important element of the progressive improvement of the sector's care and support for older Australians.

- Aged care wage increases are a 2023–24 Budget centrepiece. Wages are finally starting to correct the low remuneration that had beset the workforce. They will make the sector a more attractive place to work in, and in which to have a long-term worthwhile career caring for the older members of our community.
- UARC's latest research shows that meeting the latest requirements to provide round-the-clock registered nurses is proving to be an even greater challenge than the Government first thought.
- The unified Support at Home program has been deferred by another year. UARC encourages the Government to take the opportunity to create a fit for purpose program which incorporates the lessons it is learning from the disability care program.
- The long-term sustainability of aged care, and of the Government's overall fiscal policy, remain ongoing concerns. One piece of the puzzle may be addressed by the new taskforce if it takes a hard look at consumer contributions for direct care and the funding of everyday living and accommodation.

Finally, the new regulatory model is starting to take shape. Although ploughing through and responding to proposed regulatory policy and subsequent draft legislation may not excite some readers, the new aged care Act will have far reaching impacts on all stakeholders over the medium to longer term. Accordingly, we urge all readers to take a close interest in this issue and contribute to the legislative development whenever there is an opportunity to do so.

We hope you find this edition's greater focus on the pressing policy and operational issues facing aged care enhances the relevance of the report to you, no matter what part you play in the sector. As always, the Editorial Board and the UARC team encourage you to send us your feedback at: uarc_inquiries@uts.edu.au.

Professor Mike Woods (Chair)

On behalf of the Editorial Board and the UTS Ageing Research Collective
31 May 2023

Executive Summary

The 2022-23 mid-year financial results highlight the ongoing challenges in the Australian aged care sector. Despite sizable increases in Government funding since the Royal Commission, the operating results for services across the sector have continued to deteriorate. The required solutions are broader than just more taxpayer funding.

There are warning signs of distress amongst approved providers, yet their financial performance is a crucial gauge of the sector's financial health and ongoing viability. Disturbingly, almost two thirds of surveyed providers (64%) reported a negative mid-year Operating Result, with more than half now operating at a loss for two consecutive years. These financial concerns are most acute among providers servicing regional areas and those operating between two and six homes. Unless the margins of these providers improve, the risk of disruptive market exits that adversely affect communities persists.

In residential care, where financial challenges are the most acute, declining occupancy continues to erode the sector's financial performance. On average, homes currently lose $17.47 for each resident per day. UARC's research shows that for every 1% fall in occupancy, a home's average Operating Result will fall by a further $2.11 per resident per day.

There is also a widening disparity between profit-making and loss-making homes. This gap may close as more homes align their staffing with care minute targets. However, longer-term concerns about the viability of regional homes (i.e. in Modified Monash Model, MMM 2–4 areas) are likely to persist and warrant further attention.

The adequacy of direct care funding in residential care will depend on workforce availability and costs. UARC forecasts that for direct care, the 17.6% increase in AN-ACC funding, on average, should be sufficient to cover the costs of care minutes and the pay rise for direct care workers, but only if there is no further deterioration of workforce availability. Labour costs will continue to rise if homes rely on additional overtime and agency workers to fill staffing gaps, including around-the-clock care by registered nurses.

The staffing gaps are substantial. UARC estimates that only 9.8% of homes in the data set meet all three incoming minimum staffing standards, including service-level care minute targets for registered nurses and direct care and having a registered nurse on-duty 24 hours a day, 7 days a week. To meet these standards will require an estimated 12,520 additional full-time equivalent direct care workers, including 5,911 registered nurses.

The increasing losses in residential care are driven primarily by the poor financial outcomes of non-care services. On average, homes now lose $7.37 per resident per day from everyday living and $14.26 from accommodation services, which cannot be offset by the $4.17 margin they earn from direct care. Given that taxpayers primarily fund direct care, these latest results underscore the urgency of reforming the price and revenue settings for non-care services so that they can be delivered consistently and viably at the high quality that residents and the wider community expect.

The financial performance of the Home Care Packages program continues to decline. As of December 2022, the average Operating Result margin for providers of Home Care Packages has fallen to its lowest level, at just $0.93 per client per day. The Government's postponement of the unified Support at Home program until July 2025, alongside the development of the new regulatory model and aged care Act, provides an opportunity to address several pending issues in the new program design. The poor outcomes from delivering lower-level packages raise particular concerns about the viability of entry-level services, such as many of those provided under CHSP, in the future unified scheme.

Overall, the sector's long-term sustainability is fast reaching a critical point. The 2021 Intergenerational Report projected Government spending on aged care to reach 1.5% of GDP in 2035-36. Troublingly, it is now forecast to reach that level by next year, over a decade sooner than expected. This acceleration in spending will likely be driven by a combination of rising service costs and Australia's changing demographics, with over 1.8 million people projected to be 80 years and above by 2032-33.

Thus, there is an urgent need to create more equitable and fair payment arrangements for funding aged care overall and its component parts. Although older people, on average, pay up to 10% of the cost of their direct care, there are complex disparities in contribution rates. On the whole, taxpayers provide the vast majority of funding.

There is widespread support for rebalancing the contributions so that those with the financial capacity to pay make fair contributions to the cost of the services they receive, particularly for everyday living and accommodation services. These are on the agenda for the new Aged Care Sustainability Taskforce to explore.

Such a rebalancing will require careful assessment and calibration of policy settings, greater access to financial planning and a national conversation to ensure any changes have community acceptance and support. UARC looks forward to continuing to investigate these issues and providing robust evidence to inform this conversation.

The sustainability of the aged care sector is fast reaching a critical point, with Government spending exceeding earlier forecasts.

Part
1

Analysis and commentary

Part 1 of this report provides analysis and commentary on the most pressing issues facing the Australian aged care sector. Most pressing and longstanding are the continued financial viability and workforce concerns.

In relation to viability, particularly for residential aged care homes, approved providers continue to experience declining occupancy and incur sustained consecutive operating losses. UARC's recent research provides an update on the status of homes' direct care workforces in anticipation of the minimum standards coming into force this year – and the results are more concerning than has been thought to date.

Part 1 also reviews other major initiatives within the ongoing policy and reform agenda. This includes the Fair Work Commission pay rise case outcome, the development of the now further deferred Support at Home program, an initial analysis of the Star Ratings system and a review of recent legislative changes.

Part 1 concludes with an updated review of the sector's sustainability, noting that taxpayer funding will soon exceed forecasts projected in the 2021 Intergenerational Report. New announcements made in the Federal Budget 2023–24 are included in the Part 1 analyses where relevant.

Financial viability

Key messages

- Financial viability concerns persist, with over 63% of residential care homes now operating at a loss, with an average deficit of $17.47 per resident per day.

- UARC modelling of the overall increase in AN-ACC funding shows that it is sufficient to cover the cost of direct care, even with the new staffing requirements and pay rise, but with little additional surplus.

- The future viability of direct care services will depend on the resolution of current workforce shortages, as costs will continue to rise if homes rely more heavily on overtime and agency staffing.

- There is a widening gap between loss-making and profit-making homes. However, as this gap is being driven by lower direct care staffing by profit-making homes, it will likely close as homes increase their care minutes by October 2023.

- Occupancy is a critical driver of homes' financial performance. UARC research shows that for every 1% decline in occupancy, on average, a home's Operating Result will fall by $2.11 per resident per day.

- Over half of surveyed providers reported operating losses for two consecutive years, with those providers reporting substantially lower margins, liquidity and capital adequacy.

The results of the first half of the 2022-23 financial year confirm that financial viability concerns for aged care providers persist. As is set out in greater detail in Part 2, the latest results for December 2022 point to the following:

- The average financial performance of approved providers continues to deteriorate, with a median Operating EBITDA of just 1.8%, indicating they generate only $1.80 for every $100 of revenue earned.
- Over 63% of residential aged care homes are now operating at a loss, with an average deficit of $17.47 per resident per day.
- Home care services' margins continue to shrink, with falling package utilisation and rising expenditure.

This section complements the detailed analysis found in Part 2 and presents the results of UARC's investigation into four relevant and critical viability issues:

- The viability of residential aged care
- Loss-making aged care homes
- The financial impact of declining occupancy
- The financial state of approved providers

The financial viability of the in-home care sector is analysed later in Part 1, as are the financial and other impacts of the fully funded 15% increase in the wages of the direct care workforce.

The viability of residential aged care

As part of the Budget 2023–24, the Government has announced additional funding measures for residential aged care. The most prominent is a 17.6% increase in the AN-ACC base price from $206.80 in 2022-23 to $243.10 in 2023–24. This price increase intends to ensure sufficient funding to cover the additional costs of the 15% pay rise for aged care workers and other price increases since May 2022.[1]

Also, the basic daily fee (BDF) supplement ($10.00 per resident per day) previously included within AN-ACC has now been separately funded as a hotelling supplement ($10.80 per resident per day). The slight increase is to fund wage increases for heads chefs and cooks and inflation on expenditures.

Based on these changes, UARC has forecast homes' expected direct care result per resident per day for the next financial year (2023–24) (see Table 1).[2] Our analysis shows that with the increase of the AN-ACC base price, and subject to several critical assumptions about workforce availability and costs, the direct care revenue is likely to be sufficient to cover increased direct care expenditure. That expenditure includes the pay rise for direct care and lifestyle workers, wage growth for other personnel, a share of overall overhead costs, inflation and the additional cost of lifting staffing to meet the mandatory care minute targets.[3]

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1. https://www.health.gov.au/our-work/AN-ACC/funding-higher-wages-in-residential-aged-care
2. This modelling was completed using a subsample of 856 mature homes in the Aged Care Financial Performance Survey (ACFPS) that provided financial and workforce data for Q1 and Q2 2022-23. As AN-ACC only commenced on 1 October 2022, this analysis created a baseline of homes' current direct care revenue, expenditure and staffing for Q2 only (as distinct from year-to-date figures reported in Part 2 of this report). The 2023–24 figures were then forecast by line item, accounting for expected revenues and expenditure changes based on estimates from DoHAC (AN-ACC price, AN-ACC care minute allocations for 2023–24) and the ABS (inflation and wages growth).
3. This additional cost has been modelled for each home separately, using each home's Q2 direct care staffing levels (October – December 2022), casemix adjusted care minute targets, and average labour cost per hour worked.

Table 1: Forecast direct care result for 2023–24

	FY24 (forecast)
Direct care revenue	
Average direct care subsidies and supplements*	$255.70
Recurrent grants	$0.66
Total direct care revenue ($ per resident per day)	$256.36
Direct care costs at current staffing levels	
Direct care labour costs (current staffing levels)**	$176.23
Other care-related labour costs***	$28.48
Other direct costs of direct care****	$6.90
Administration costs of direct care ****	$17.71
Total direct costs at current staffing levels ($ per resident per day)	$229.31
Direct care result at current staffing levels ($ per resident per day)	**$27.05**
Additional costs to meet care minute targets *****	$25.33
Direct care result after staffing uplift ($ per resident per day)	**$1.72**

NOTES: *Average direct care subsidies have been calculated by increasing the average subsidies received in Q2 of FY23 by 17.6% (annual change in the AN-ACC price). **Assumes all direct labour costs are increased by 15%. ***Assumes that lifestyle workers' costs are increased by 15%, all other labour costs are increased by the rate of wages growth, forecast to be 4.2% p.a. ****Assumes costs increase at the rate of inflation, forecast to be 4.3% p.a. *****Additional cost to meet care minutes were calculated for each home, where the service-level care minutes staffing gaps at Q2 FY23 were multiplied by the home-level average labour cost per worked hour, increased by a further 15%.

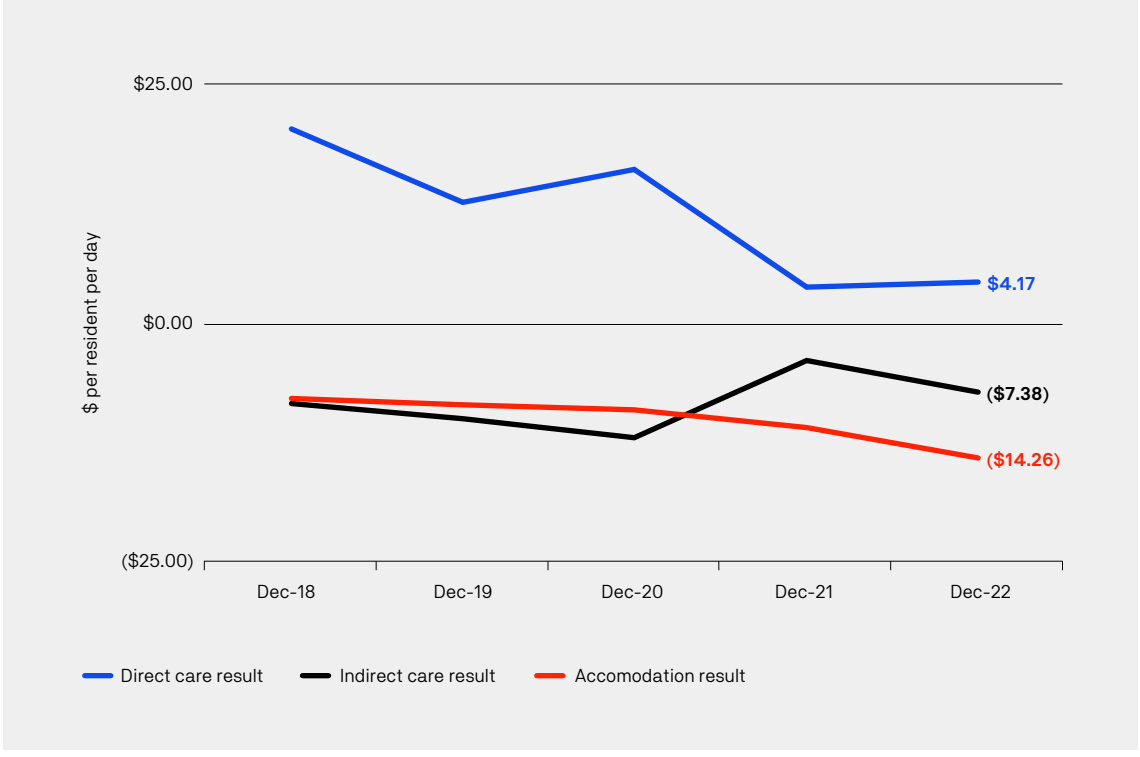
One of the most critical assumptions underpinning this forecast is the estimate of future labour costs. UARC's analysis assumes that homes will continue to use the same staffing model as they are currently using, with similar proportions of overtime, agency staffing and leave. However, if workforce shortages persist, including employing sufficient staff to cover the night shifts, homes will likely need to resort to more expensive staffing strategies to meet their minimum requirements, such as agency workers and overtime. Such patterns are emerging in the high reliance on agency registered nurses, as detailed later in the Workforce Issues section. UARC will continue to monitor this issue and its impact on our projections on sector viability and will provide an update in its full-year report for 2022-23.

One possible alternative scenario is staffing costs may stabilise if workforce pressures ease across the sector. For example, suppose providers can attract and retain a more stable direct care workforce, aided by the new wage increases. In that case, they may be able to reduce costs associated with agency staffing, unnecessary overtime, absenteeism and turnover.

Returning to the current analysis, Table 1 indicates that funding levels have been set at a level sufficient to cover the cost of direct care, there is 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.

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. As shown in Figure 1, homes have historically earned substantial margins from direct care services but have incurred losses for indirect care (everyday living) and accommodation.[4] In the case of indirect care, despite the introduction of the BDF supplement, the losses have resumed their previous pattern of growing deficits. For accommodation, the losses continue to grow at an increasing rate. Thus, as detailed in its previous reports, UARC urges urgent reform around the policy settings for these two areas to ensure the overall financial viability of residential aged care homes and the sustainability of the sector.[5]

Figure 1: Average net result of residential aged care services, by service area

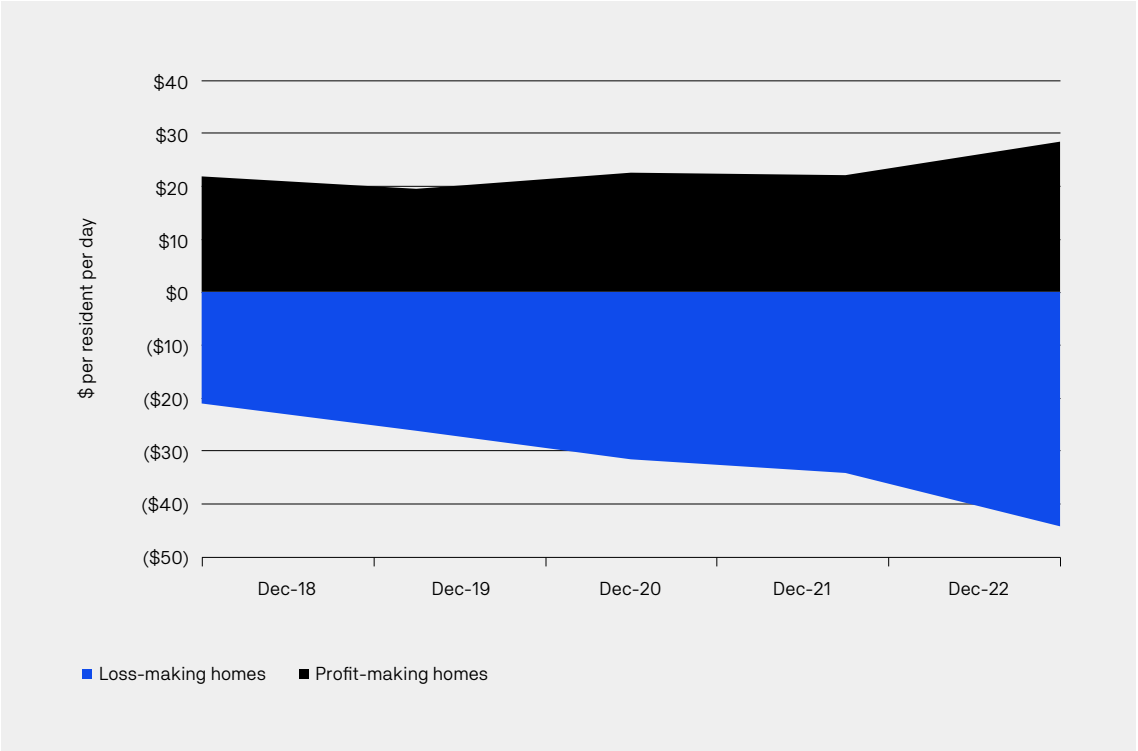


4. As in Part 2 of the report, figures for the net result of each service area are shown net of the allocation of administration overhead costs.
5. Woods, M., Sutton, N., McAllister G., Brown, D. & Parker, D. (2022). Sustainability of the Aged Care Sector: Discussion Paper. *UTS Ageing Research Collaborative*; Sutton, N., Ma, N., Yang, J.S., Lewis, R., Brown, D., Woods, M., McEwen, C., Parker, D. (2022) *Australia's Aged Care Sector: Full-Year Report* (2021–22).

Loss-making aged care homes

One of the more puzzling aspects of residential care services is the variability in operational performance. Figure 2 shows the long-term trend in financial outcomes of homes that generate operational surpluses compared to those that operate at a loss. There is a widening gap between these two groups. Whereas in December 2018, the difference in the average Operating Result was roughly $43 per resident per day, by December 2022, this has grown to nearly $73 per resident per day.

Figure 2: Average Operating Result, profit-making vs loss-making homes



Focusing on the most recent mid-year 2022-23 results, Table 2 reveals that this gap arises mainly in the financial outcomes of direct care services. While homes that reported an operating surplus in the first six months of the year earned an average of $34 per resident per day from direct care, loss-making homes lost $13 per resident per day. Also, while profit-making homes tend to break even for indirect care services and make modest losses for accommodation, their loss-making counterparts tend to incur large deficits in both these areas.

Furthermore, Table 2 shows that most differences in homes' financial outcomes arise from expenditure rather than revenue patterns. Although profitable homes enjoy an additional $9 in revenue per resident per day, their expenditure is $64 lower per resident per day than loss-making homes.

Partly this is because loss-making homes tend to have much higher rates of direct care staffing than profit-making homes, even though their direct care revenues are lower. On average, loss-making homes provide 195 minutes of direct care staffing per resident per day, compared to 172 minutes provided by profit-making homes. This difference may reflect temporary variations in staffing patterns. Direct care subsidies and average staffing rates should move closer into alignment when care minutes become mandatory in October 2023, which will likely reduce some of the margins of profit-making homes.

Also, loss-making homes tend to rely more heavily on expensive input resources, such as agency staff and externally contracted catering, laundry and cleaning. Furthermore, as detailed below, poor-performing homes tend to have much lower occupancy rates which, given the largely fixed level of expenses, increases the average expenditure per resident.

Table 2: Financial and operational differences between profit-making vs loss-making homes

	Profit-making homes	Loss-making homes
Average per resident per day ($)		
Direct care revenue	$211.64	$206.37
Direct care expenditure	$177.31	$219.80
Direct care result	**$34.33**	**($13.43)**
Indirect care revenue	$69.41	$68.13
Indirect care expenditure	$69.90	$79.54
Indirect care result	**($0.48)**	**($11.40)**
Accommodation revenue	$36.85	$34.45
Accommodation expenditure	$42.31	$53.84
Accommodation result	**($5.46)**	**($19.40)**
Total revenue	**$317.90**	**$308.95**
Total expenditure	**$289.52**	**$353.18**
Operating Result (per resident per day)	**$28.39**	**($44.23)**
Other characteristics:		
Registered nurse minutes per resident per day	28.2	33.6
Total direct care minutes per resident per day	171.6	194.7
Number of places	81.2	82.6
Number of homes run by the provider	22.4	18.2
Metropolitan location	69.0%	64.0%
Supported resident ratio	48.0%	44.0%
Occupancy rate	93.0%	89.0%

The home location is also a factor, with a higher proportion of profit-making homes in metropolitan locations. These homes are 32.9% less likely to be loss-making than non-metropolitan homes, holding constant their other characteristics.[6] UARC's research unpacks this trend in greater detail in Part 2.

Table 2 also indicates that homes' financial outcomes are influenced by the average characteristics of their resident profiles. For example, controlling for other factors, profit-making homes are more likely to have higher average direct care subsidies (indicating more residents with more complex care needs) and a higher supported resident ratio (indicating more residents with less financial means). While both cohorts can attract higher government subsidies for direct care and accommodation, further analysis is warranted to explore the viability of homes across all resident profiles.

Furthermore, in acknowledging that viability may extend beyond measures of short-term operating results, UARC will delve deeper into the other financial and operational circumstances of loss-making homes in future reports.

The financial impact of declining occupancy

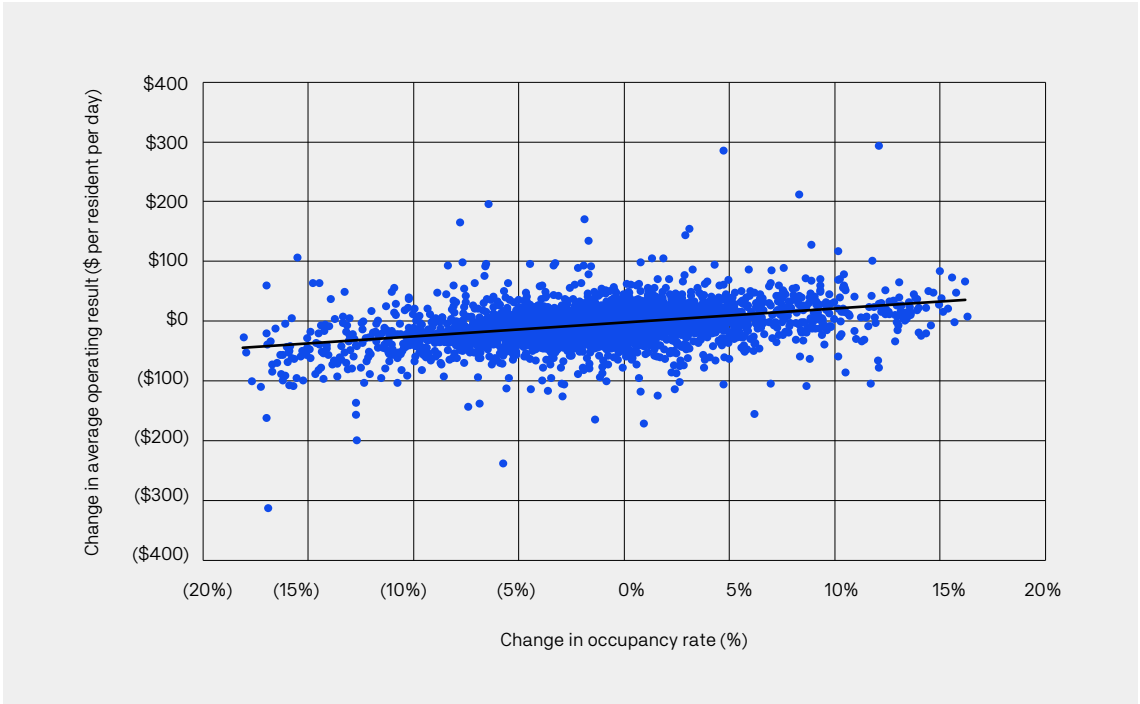
One of the most persistent factors explaining differences in homes' financial performance is their occupancy.[7] This is because while homes' revenue is highly sensitive to short-term changes in occupancy and resident mix, most of the costs involved in delivering residential aged care are fixed, at least over the short to medium term. These include costs of the physical infrastructure, administration and compliance, all of which must be incurred regardless of the number of beds occupied. Furthermore, unless there is a significant and ongoing shift in residents' needs or occupancy, homes find it difficult to radically alter the configurations and costs of their staff.

As reported in Part 2, in the last five years, homes' occupancy levels have been steadily declining across the sector, which has coincided with the long-term drop in operational returns from residential care.

To further investigate this association, UARC analysed how home occupancy rate changes influenced their subsequent financial performance.[8] Figure 3 shows this relation between homes' year-on-year change in occupancy rate and the year-on-year change in average Operating Result per resident per day, based on five years of data. It shows a robust trend, whereby more significant increases in occupancy coincide with larger increases in Operating Results, and vice versa.

6. UARC used multivariate analysis to estimate how a unit change of a characteristic influenced the probability of becoming a loss-making home, keeping other characteristics (e.g. home, resident and direct care characteristics) constant.
7. Occupancy is typically measured as the proportion of operational places in a home that are occupied by residents.
8. This analysis attempts to address concerns that both occupancy and financial outcomes might be driven by other factors, such as home characteristics and location. For example, see Australian Productivity Commission (2011). *Technical Paper on the changing dynamics of residential aged care.*

Figure 3: Year-on-year changes in occupancy and Operating Result



Furthermore, using multivariate analysis to control for other characteristics, it is possible to estimate how a percentage change in occupancy, on average, influences homes' subsequent performance, both overall and for their different service areas.[9] We find that each 1% fall in occupancy will reduce the Operating Result by an average of $2.11 per resident per day. This includes a $1.27 reduction in the direct care result, a $0.46 reduction in the Indirect Care Result and a $0.39 reduction in the Accommodation Result. Given the small margins of residential care reported in Part 2, these results show how even minor differences in occupancy can result in substantially different financial outcomes for aged care homes.

9. Multi-variate regression analysis was used to estimate the effect of the change in occupancy, controlling for other factors, including home size, supported resident ratio and yearly trends in financial performance.

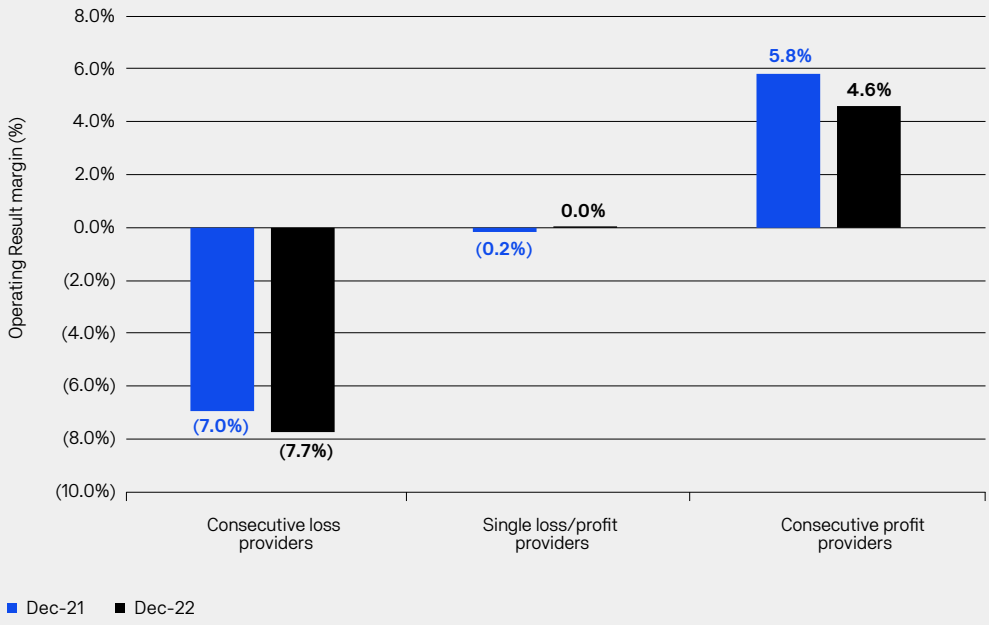
The financial state of approved providers

Although much attention focuses on the financial state of individual aged care homes or services, the overall financial state of approved providers is critical for understanding the sector's viability. This is because many approved providers earn income from other revenue streams (detailed in Part 2), enabling them to sustain losses in residential care, at least in the short to medium term.

The December 2022 results show that, in the first six months of this financial year, 64% of surveyed providers operated at a loss (measured as net operating profit before tax). To interrogate this result further, UARC analysed the persistence of providers' poor performance for the same six months over two financial years (i.e., December 2021 and December 2022).

Over half (51%) of surveyed providers reported operating losses for two consecutive years. By comparison, 24% of surveyed providers reported consecutive surpluses, and 25% achieved a surplus in one of the two years.

Figure 4: Providers' financial outcomes over consecutive periods

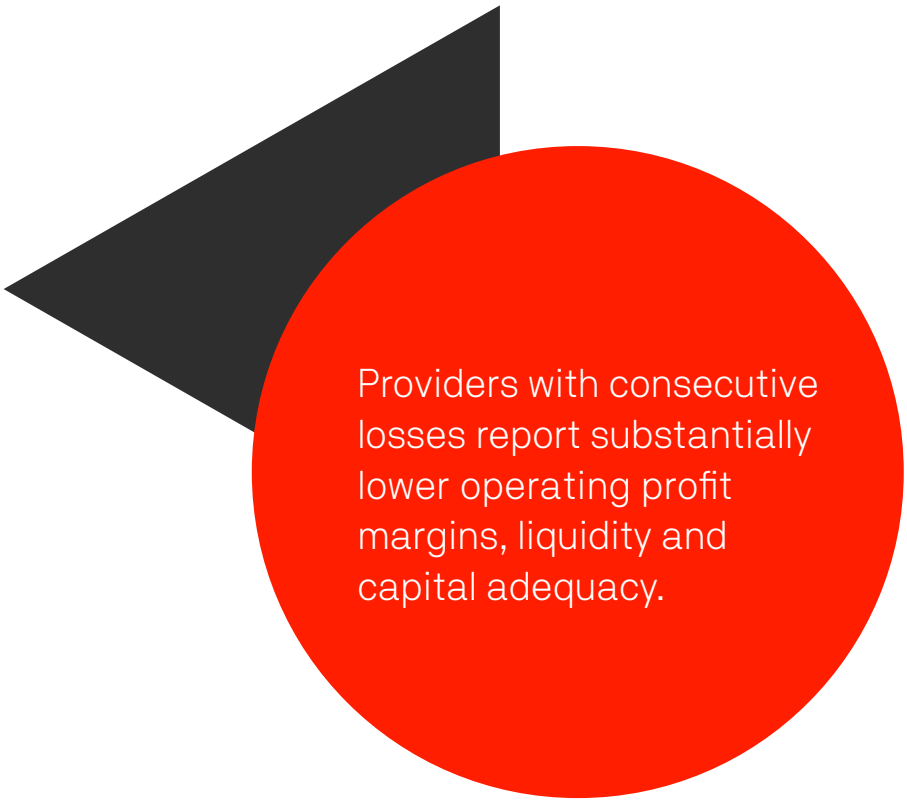


Providers with consecutive losses report substantially lower operating profit margins than those with either consecutive or alternating surpluses (Figure 4). They also exhibit different risk profiles, with substantially lower average liquidity and capital adequacy ratios than other providers. This implies that providers with persistent poor profitability are also at greater prudential risk.

In terms of their geographic spread, providers with operations predominantly in metropolitan locations were much less likely to sustain consecutive losses than their counterparts with operations either predominantly in regional homes or a mix of metropolitan and regional homes.

Furthermore, providers that were larger in scale experienced higher rates of consecutive losses. For example, 100% of surveyed providers that operated 20 homes or more reported two years of consecutive losses. By comparison, this proportion fell to 70% for providers that operated between 7 and 19 homes, 57% for providers with 2-6 homes, 44% for single-home providers and 22% for providers with no residential aged care homes. This trend points to possible diseconomies of scale that may accrue as providers grow and is also consistent with losses stemming from the provision of residential care services.

Regarding operational changes, providers with consecutive losses appear to have ramped up their offerings of home care packages (up by 39.2%, year-on-year) faster than providers with consecutive surpluses (up by 13.9%, year-on-year). Providers with consecutive losses also appear to have curbed expenditure, with smaller increases in staffing (FTE up by only 1.9%) compared to those with consecutive surpluses (increased FTE staffing by 6.0%).



Workforce issues

Key messages

- UARC's latest analysis shows that as of December 2022, only 9.8% of homes have sufficient staffing to meet all three incoming minimum standards.

- While most homes (78.9%) have sufficient staff to meet the 24/7 registered nurse requirement, only 38.9% currently meet their service-level targets for total direct care minutes, and only 21.0% meet their service-level targets for registered nurse minutes.

- Residential aged care homes will need at least 12,520 additional full-time equivalent direct care workers to meet all three requirements, including 5,911 full-time equivalent registered nurses.

- Homes are already increasingly relying on agency staff, particularly registered nurses, indicating ongoing challenges in recruiting and retaining enough direct care workers.

Workforce issues continue to be one of the most salient challenges across the sector, with aged care providers struggling to recruit and retain enough appropriately qualified and skilled care staff. As UARC reported in the full-year 2021-22 edition of the Sector Report, the skill shortages faced by providers are the result of a combination of factors, including pay disparities with other care sectors, the rapid expansion of the home care program, pandemic-related disruptions to worker migration and pressures on staff, and high levels of turnover and attrition.[10]

For this edition, UARC's analysis focuses on the three incoming minimum staffing standards in residential care, all of which will become mandatory this year. Our analysis addresses the following issues:

- The proportion of homes that meet the minimum requirements
- Estimating the size of the direct care staffing gap
- Recent trends in labour costs and employment modes

The proportion of homes that meet the minimum requirements

The minimum standards will require providers to ensure that:

1. a registered nurse is on-site and on-duty 24 hours a day, seven days a week (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 provides at least 40 minutes of that care (from 1 October 2023).

Furthermore, from 1 October 2024, the two 'care minutes' targets will increase to a sector average 215 minutes per resident per day for total direct care, including at least 44 minutes per resident per day from a registered nurse.

All homes must meet the 24/7 registered nurse on-site requirement unless eligible for an exemption.[11] The Government has proposed to amend the subordinate legislation, allowing for a 12-month exemption for a subset of homes, specifically those with 30 operational places or less and located in small rural towns, remote communities and very remote communities.[12]

Each home's total direct care and registered nurse care minute targets are adjusted to account for differences in the relative needs of their residents, as assessed using the AN-ACC classification ('service-level targets').[13] This means that homes with residents with more complex needs will need to meet a higher threshold for staffing time, whereas homes with residents with less complex needs will have a lower minimum requirement.

10. Sutton, N., Ma, N., Yang, J.S., Lewis, R., Brown, D., Woods, M., McEwen, C., Parker, D. (2022) *Australia's Aged Care Sector: Full-Year Report (2021–22)*.
11. Exempt homes must also demonstrate they have appropriate alternative clinical arrangements in place: https://www.health.gov.au/our-work/care-minutes-registered-nurses-aged-care/24-7-rns/exemption
12. Aged Care Legislation Amendment (Registered Nurses) Principles 2023 (Cth): https://www.health.gov.au/sites/default/files/2023-02/exposure-draft-and-explanatory-statement-aged-care-legislation-amendment-registered-nurses-principles-2023.pdf
13. https://www.health.gov.au/sites/default/files/2023-05/care-minutes-and-24-7-registered-nurse-responsibility-guide.pdf

In anticipation of these requirements, UARC has been tracking the direct care staffing of residential homes for several years.[14] Using the December 2022 results from StewartBrown's ACFPS data set, it is possible to provide an update on how homes' direct care staffing compares to requirements of the incoming standards for 2023. UARC has used the new care minute targets for AN-ACC that will apply from 1 October 2023, which were modified in May 2023.[15]

The analysis uses staffing data from 945 aged care homes, representing approximately 35.4% of homes in Australia.[16] The characteristics of this sample are consistent with the patterns of remoteness (MMM) and home size (number of beds) in the population of homes in Australia. However, there is some underweighting regarding homes in small rural areas (MMM6) with homes with 30 places or less, so care must be exercised when interpreting results relating to these sub-categories and the proportion of homes that may be exempt from the 24/7 registered nurse requirement.

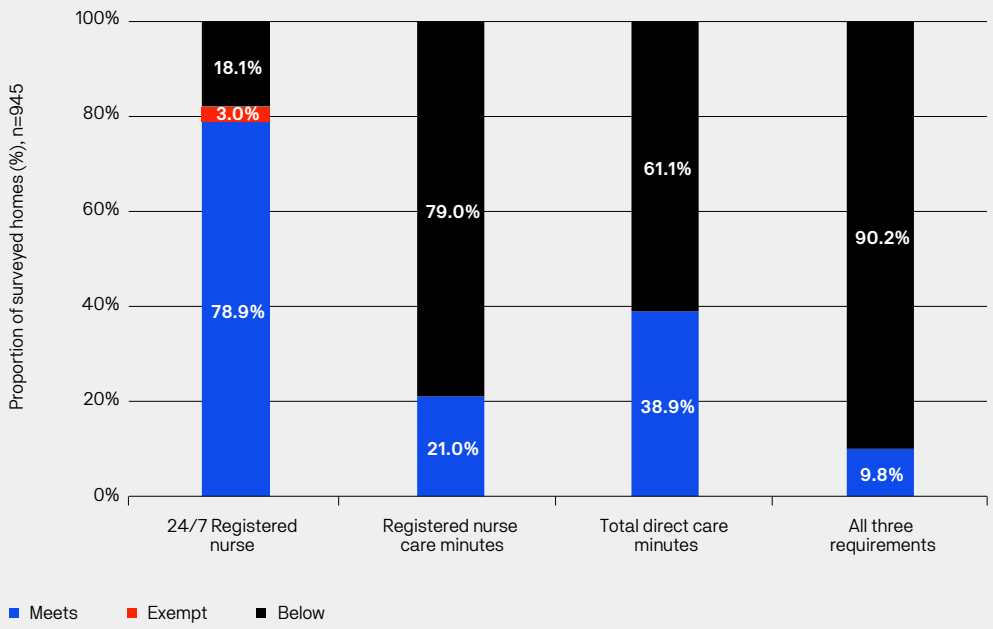
Another caveat is that the analysis relies on year-to-date figures (i.e. June-December 2022). This differs slightly from the approach used to calculate the Star Ratings, which separately assesses staffing for each quarter.[17]

Our analysis indicates that as of December 2022, only 9.8% of surveyed homes have sufficient direct care staffing to meet all three of the incoming requirements (the right column of Figure 5). Although this rate has improved since June 2022 (4.7%),[18] it points to the acute workforce challenges providers face in recruiting and retaining direct care staff.

In terms of the first requirement (left column in Figure 5), most (78.9%) of surveyed homes have sufficient staffing to meet the 24/7 registered nurse on-duty requirement. As a further 3.0% of homes will likely qualify for the exemption, 18.1% of surveyed homes will need to increase their registered nurse staffing to meet the 24/7 on-duty requirement.

14. Sutton, N., Ma, N., Yang, J.S., Rawlings-Way, O., Brown, D., McAllister, G., Parker, D., Lewis, R.(2022) *Considering the new minimum staffing standards for Australian residential aged care. Australian Health Review* 46, 391-397; Sutton, N., Ma, N., Yang, J.S., Lewis, R., McAllister G., Brown, D., Woods, M., (2022) *Australia's Aged Care Sector: Mid-Year Report (2021–22)*; Sutton, N., Ma, N., Yang, J.S., Lewis, R., Brown, D., Woods, M., McEwen, C., Parker, D. (2022) *Australia's Aged Care Sector: Full-Year Report (2021–22)*.
15. https://www.health.gov.au/our-work/care-minutes-registered-nurses-aged-care/changes-to-allocations
16. This sample is smaller than the December 2022 sample reported in Part 2 of this report as it only includes homes that provided data the AN-ACC classifications of their occupied bed days.
17. Year-to-date figures for Q2 of 2022-23 were used as they had higher data integrity than values relating to Q2 in isolation.
18. Sutton, N., Ma, N., Yang, J.S., Lewis, R., Brown, D., Woods, M., McEwen, C., Parker, D. (2022) *Australia's Aged Care Sector: Full-Year Report (2021–22)*.

Figure 5: Proportion of homes that meet the minimum staffing requirements



It is important to note that the 24/7 registered nurse results provide only an approximate measure of the adequacy of homes' staffing, as it relies on average staffing estimates across the period rather than singular instances when homes do not have a registered nurse on-site and on-duty. Furthermore, as this measure does not account for actual shifts worked, rostering constraints or any overlaps that may occur if two or more registered nurses are on-duty simultaneously, it is impossible to assess whether homes consistently provide around-the-clock care by a registered nurse.

Under the new legislation, homes will be required to report the total number of instances per month in which a registered nurse was not on-duty and on-site for every occasion of 30 minutes or more. Thus, these estimates likely overestimate the proportion of homes that meet the requirements. UARC anticipates that as homes' reporting of shift-level data matures, it will be possible to provide more precise modelling of homes' staffing throughout the day. The forthcoming full-year 2022-23 report will add further insight.

In terms of the two 'care minutes' requirements (the middle two columns in Figure 5), the December 2022 results show that most surveyed homes are still short of their service-level care minute targets for 2023. Only 38.9% have staffing sufficient to meet their service-level targets for total direct care minutes, and only 21.0% have sufficient staffing to meet their service-level targets for registered nurse minutes.

Figure 6 further disaggregates the care minutes results showing the proportion of surveyed homes classified according to the matrix algorithm used to calculate the Star Ratings.[19]

Figure 6: Proportion of homes classified using care minutes Star Ratings

	Total direct care					
Registered nurse care minutes	**Well below target (<90%)**	**Below target (90<100%)**	**Meets target (100<105%)**	**Above target (105<115%)**	**Well above target (>=115%)**	**Total**
Well below target (<75%)	★	★	★★	★★	★★★	
	15.9%	11.4%	4.7%	3.8%	3.1%	**38.8%**
Below target (75<100%)	★★	★★	★★	★★★	★★★	
	12.0%	12.4%	5.8%	5.3%	4.8%	**40.2%**
Meets target (100<115%)	★★	★★★	★★★	★★★	★★★★	
	2.2%	4.0%	1.5%	1.6%	1.2%	**10.5%**
Above target (115<125%)	★★★	★★★	★★★★	★★★★	★★★★	
	0.7%	1.0%	0.7%	1.4%	1.2%	**5.0%**
Well above target (>=125%)	★★★	★★★★	★★★★	★★★★★	★★★★★	
	0.4%	0.8%	1.2%	1.0%	2.1%	**5.5%**
Total	**31.2%**	**29.6%**	**13.9%**	**13.0%**	**12.3%**	**100.0%**

The graduated colours correspond to the Star Ratings, ranging from 1 star in the top left corner (coloured red) to 5 Stars in the bottom right corner (coloured blue). The aggregate results indicate the following breakdown of surveyed homes' direct care staffing with:

- 27% equivalent to 1 star, indicating significant improvement needed
- 41% equivalent to 2 stars, indicating improvement needed
- 22% equivalent to 3 stars, indicating acceptable quality of care
- 6% equivalent to 4 stars, indicating good quality of care
- 3% equivalent to 5 stars, indicating excellent quality of care

UARC notes that as part of the May Budget, the Government announced changes to care minute allocations for each AN-ACC class for permanent and respite residents. While the sector average remained unchanged (e.g. 200 minutes for total direct care, 40 minutes for registered nurses), the reallocations increased the target care minutes for residents with higher needs and reduced those with lower needs.[20]

19. https://www.health.gov.au/sites/default/files/2023-02/star-ratings-provider-manual.pdf
20. For example, a resident classified as in the highest AN-ACC Class for permanent residents (Class 13, Not mobile, lower function, higher pressure sore risk, with compounding factors) is now allocated 317 minutes of total direct care, whereas previously they were allocated 284 minutes. Likewise the allocation of registered nurse time for residents in this class has increased from 53 minutes per day to 57 minutes.

This adjustment is intended to better align the cost of direct care (i.e. the staffing time) with the AN-ACC subsidies across the different classes and reduce perverse incentives for providers to 'cherry pick' residents.[21]

It will also mean that homes with more residents with lower care needs will have lower care minute targets, reducing their direct care staffing needs. On average, these homes tend to be located outside major cities (i.e. in areas classified as MMM2-7). This adjustment should improve these homes' financial viability as their direct care subsidies remain proportionate to the AN-ACC price.

Conversely, homes with more residents with higher care needs (typical of many metropolitan homes) will now have higher care minute targets, further increasing their direct care staffing requirements.

The Department of Health and Aged Care (DoHAC) has signalled that the care minute allocations may change again as AN-ACC is refined over time, informed by the costing studies conducted by Independent Hospital and Aged Care Pricing Authority (IHACPA). In addition to achieving consistency between the cost of care and the direct care subsidies, it will be important to ensure that the allocations of care minutes accurately reflect residents' clinical needs and are not being adjusted to 'fit in' with the funding profiles.

Estimating the size of the direct care staffing gap

UARC has also updated its forecasts of the additional number of full-time equivalent staff needed to address the current direct care staffing gap. This analysis assumes an incremental approach as homes would first lift their registered nurse staffing to meet the 24/7 registered nurse on-site requirement in July, followed by further increases needed to meet their registered nurse care minutes target and total direct care target in October.[22]

Table 3: Additional staff required to address the direct care staffing gap

Additional full-time equivalent staff required to meet:	
Requirement 1: 24/7 registered nurse on site (registered nurses)	782
Requirement 2: Registered nurse care minute targets (registered nurses)	5,129
Requirement 3: Total direct care minutes (direct care workers)	6,609
Total estimated additional direct care workers required (FTE)*	**12,520**

*Estimates are calculated by developing national estimates of the staffing needs of homes currently below the three requirements (based on surveyed homes results for December 2022). These are transformed into FTE figures assuming each full-time worker works 38 hours per week, with 20 days annual leave and 10 days sick leave.

Our projections, summarised in Table 3, indicate that 782 full-time equivalent registered nurses will be required to meet the 24/7 registered nurse requirement in July 2023. In addition, homes will then require a further 5,129 full-time equivalent registered nurses to meet their registered nurse care minutes service-level targets and an additional 6,609 full-time equivalent direct care workers to meet the service-level targets total direct care in October 2023.

In aggregate terms, meeting all three requirements will require at least 12,520 additional direct care workers (FTE), including 5,911 registered nurses (FTE). In headcount terms, this equates to roughly 18,780 total direct care workers, including 8,867 registered nurses.[23]

Importantly, these estimates are net of any attrition from the sector, which means that a higher total number of aged care workers will be needed to account for workers that retire or leave aged care. The estimates also do not factor in any additional challenges in ensuring adequate registered nurse staffing across all shifts, particularly the overnight shift.

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

23. Based on the Aged Care Workforce Census 2020, each full-time equivalent worker is approximately 1.5 people in terms of headcount.

Recent trends in labour costs and employment modes

Table 4 takes the analysis further by providing insight into the likely cost and employment implications of meeting these requirements. It does so by comparing the December 2022 staffing characteristics of homes classified as either meeting or below the three incoming requirements.

Table 4: Staffing characteristics of homes below and meeting the minimum requirements

	Average labour cost per worked hour*			Reliance on agency staff	Reliance on overtime
	All staff	Internal staff	Agency staff		
Requirement 1: 24/7 registered nurse**					
Homes below	$83.90	$81.33	$109.60	24.4%	2.5%
Homes meet	$70.49	$68.91	$104.36	12.1%	3.5%
Requirement 2: registered nurse care minutes**					
Homes below	$74.80	$72.64	$114.47	14.2%	3.3%
Homes meet	$67.73	$67.27	$73.16	16.5%	3.1%
Requirement 3: Total direct care minutes***					
Homes below	$49.62	$50.00	$139.60	8.4%	3.2%
Homes meet	$48.14	$46.96	$79.86	9.4%	3.3%

* The labour costs paid are much higher than published award rates as they include wages and salaries (including above market rates) and on-costs such as superannuation, penalty rates, paid leave, casual loadings and overtime. ** Measures relate to registered nurses only. *** Measures relate to all direct care workers (registered nurses, enrolled nurses and personal care workers).

Overall, Table 4 shows that while homes' reliance on overtime remains relatively low (ranging between 2.5-3.5% of hours worked by internal staff), the reliance on agency staff is comparatively high (ranging between 8.4-24.4%), particularly compared to estimates in previous years.[24]

Table 4 also shows that the average labour costs paid for registered nurses (Requirements 1 and 2) and total direct care staff (Requirement 3) are substantially higher than the published award rates.[25] This is because internal staff labour costs include wages and salaries, on-costs such as superannuation, penalty rates, paid leave, casual loadings and overtime. Average labour costs also include the higher costs of agency staff, which can be substantially higher than internal staff costs.[26]

24. Sutton, N., Ma, N., Yang, J.S., Lewis, R., Brown, D., Woods, M., McEwen, C., Parker, D. (2022) *Australia's Aged Care Sector: Full-Year Report (2021–22)*.
25. Department of Health and Aged Care (2023), *Quarterly financial snapshot of the Aged care sector*.
26. In funding the Fair Work Commission outcome, the Government relies on similar measures of labour costs, to ensure the funding is sufficient cover staff on-costs.

In addition, Table 4 indicates that homes most at risk of not meeting the three new requirements tend to expend more per hour worked for care workers, with higher average labour costs for internal staff, agency staff and overall. The comparatively higher labour cost per hour paid by 'at risk' homes indicates that these homes are likely already paying above market rates to attract and retain staff.

Homes with 60 occupied places or less will receive additional ongoing funding to help cover the cost of meeting the 24/7 registered nurse requirement (24/7 supplement). While this funding may provide substantial inflows, homes are only eligible if they can find sufficient staff to meet the 24/7 requirement.

Finally, Table 4 highlights a high reliance on agency staffing across the sector. Agency staff comprise almost a quarter of registered nurse staffing in homes currently below the 24/7 registered nurse requirement. This suggests that homes are already experiencing challenges in attracting and retaining a sufficiently sized registered nurse workforce.

Fair Work Commission wage case

Key messages

- The full increase of 15% to the three modern awards considered by the Fair Work Commission will take effect from 30 June 2023.
- The 2023–24 Budget provided $11.3b over 4 years to fully fund the wages increase.
- An FWC decision on the work value case for non-direct care employees and award classification definitions and structures is still forthcoming.

Proceedings of the Fair Work Commission (FWC) continue in relation to the aged care wage case (formally referred to as 'Work value case – Aged care industry'). The Health Services Union (HSU) submitted this case to the FWC in November 2020, which was later joined by the Australian Nursing & Midwifery Federation (ANMF) and the United Workers Union (UWU).

In November 2022, the FWC's Stage 1 decision found in favour of a 15% increase in the minimum wages across the three associated modern awards. The decision affirmed the historical undervaluation of work in the sector, particularly regarding its gendered nature and the increasing complexity of work.[27]

The FWC's Stage 2 decision in February 2023 determined that the full 15% increase would take effect from 30 June 2023. Also, it determined that the 15% rise should apply to head chefs or cooks under the Aged Care Award and recreational activities and lifestyle officers under the Aged Care Award.[28]

For direct care workers employed under the award, the following indicates the increases to their weekly pay, that will apply from 1 July 2023:

- $189.70 for a registered nurse (Level 2, Nurses Award)[29]
- $143.70 for an enrolled nurse (Nurses Award)
- $134.30 for a personal care worker (Level 2, residential care, Aged Care Award)[30]
- $138.30 for a home care employee (Level 2, Social, Community, Home Care and Disability Services Industry Award (SCHADS))[31]

The 2023–24 Budget allocated an additional $11.3 billion over four years from 2023–24 to fund the 15% increase. A range of mechanisms will be employed to fund the increases, including:

- $8.5 billion to residential care via an increase in AN-ACC tariffs to cover the increased cost of direct care provision and the introduction of a new hotelling supplement to support higher wages for head chefs or cooks;
- $2.2 billion to the home care packages program via increased subsidies;
- $310m to the Commonwealth Home Support Programme via additional grant funding.

27. 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.
28. Asbury, I. C., O'Neill, B. M., & Bissett, C., (2023). 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., [2023] FWCFB 40. Fair Work Commission.
29. Asbury, I. C., O'Neill, B. M., & Bissett, C., (2023). Applications to vary modern awards – work value – aged care industry – Nurses Award 2020– interim increase – Determination – PR751294 – Nurses Award 2020, Fair Work Commission
30. Asbury, I. C., O'Neill, B. M., & Bissett, C., (2023). Applications to vary modern awards – work value – aged care industry – Nurses Award 2020– interim increase – Determination – PR751293 – Aged Care Award, Fair Work Commission
31. Asbury, I. C., O'Neill, B. M., & Bissett, C., (2023). Applications to vary modern awards – work value – aged care industry – Nurses Award 2020– interim increase – Determination – PR751296 – Aged Care Award, Fair Work Commission

The balance of additional funding has been allocated to the Transition Care Programme and the Short Term Restorative Care Programme, Veteran's Home Care Program and Community Nursing Services and indexation increases to targeted programs and Multi-Purpose Services.[32]

Not all aged care employees are paid in accordance with these three awards. Some Enterprise Bargaining Agreements specify pay rates for aged care employees above the minimum award wages. However, the Government expects all providers to pass on the additional funding in higher wages to relevant employees, even if they are already paying above the award threshold.[33] Providers will have to report expenditures on direct care labour as part of the quarterly financial reports, which will be published at a service-level from 2024.

The FWC decision to increase aged care worker wages has contributed to the substantial growth in forecast Government expenditure on aged care as a proportion of GDP, which will rise to 1.5% next year (2023–24) (discussed further in the section on Sector Sustainability). While increased government funding to support labour costs raises questions about the fiscal sustainability of the sector, increased wages will be an essential measure in addressing the sustainability of the workforce.[34] By reducing pay disparity with other parts of the care economy, higher wages are anticipated to improve the attraction and retention of appropriately qualified and skilled care staff within the sector.

Under the forthcoming Stage 3, the FWC will consider a minimum wage increase for non-direct care workers in aged care (e.g., administrative, cleaning and kitchen staff) and also consider classification definitions and structures in the awards.[35] This includes addressing relativities between the classifications and minimum rates of pay for personal care workers (under the Aged Care Award) and nursing assistants (under the Nurses Award), the appropriateness of creating a new personal care worker classification stream, and the potential impact of the increase on disability support workers also employed under the SCHADS Award.

The outcome of the Stage 3 decision was noted as a source of fiscal risk in the 2023-2024 Budget Outlook, which notes that the FWC will determine the size and nature of the final wage increase and therefor the level of additional expenditure cannot yet be quantified.[36] However, the note affirms the Government's commitment to fully funding the increases awarded by the FWC as it finalises the aged care industry's work value case.

32. Commonwealth of Australia (2023), Budget 2023-24, *Budget Strategy and Outlook, Budget Paper No. 1*, p.105.
33. Department of Health and Aged Care, webinar 16 May 2023.
34. Woods, M., Sutton, N., McAllister G., Brown, D. & Parker, D. (2022). *Sustainability of the Aged Care Sector: Discussion Paper*. UTS Ageing Research Collaborative.
35. Asbury, I. C., O'Neill, B. M., Bissett, C., (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 – Background Document 10 – Stage 3 Outstanding Issues., Fair Work Commission.
36. Commonwealth of Australia (2023), *Budget 2023-24, Budget Strategy and Outlook, Budget Paper No. 1*, p.304.

Support at Home program

Key messages

- The Government has deferred the start of the Support at Home program until July 2025.
- There has been a modest increase in the number of home care packages and additional funding for the 15% increase in direct care workers' wages.
- The Operating Result for home care services is worsening, with the margin reducing to an average of $0.93 per client per day.
- Financial outcomes are worse for providers offering lower-level packages, raising concerns about the viability of entry-level services, such as many of those provided under CHSP, in the future unified scheme.

The Government has postponed the commencement of the unified Support at Home program to 1 July 2025.[37] The 12-month deferral will provide additional time to respond to the feedback received through the consultation process to date and to progress the development of the ICT infrastructure and processes that will support the new program. It will also provide an opportunity to take on some of the lessons learnt in providing disability care services. Improvements in attracting and retaining the workforce due to the FWC ruling (see previous section) may also help alleviate current skill shortages that may be constraining the ability of providers to deliver the available packages.

Although the start of the new program has been deferred, the Government intends to implement the new Integrated Assessment Tool (IAT) and the proposed single assessment workforce as originally scheduled on 1 July 2024.[38] This will require merging the Aged Care Assessment Teams (ACAT), Regional Assessment Service (RAS) and AN-ACC assessment services to ensure a unified assessment process applies across all programs and services.

The current design of the IAT proposes eleven classifications of need, which are currently being refined after an initial trial.[39] Some of the challenges with the current tool design include the high proportion of participants (68%) assigned to classifications 1 and 2. These two classifications refer to minimal and minor physical issues, respectively, but do not differentiate between needs based on cognitive function. The tool will also be refined to ensure that the frequency of support needs (e.g. daily support with bathing and dressing compared to weekly domestic assistance) is reflected in the quantum of subsidy required.

Budget measures for home care

In the 2023–24 Budget, the Government announced funding for a further 9,500 home care packages. Although this represents a modest 3.7% increase over the total number of packages available at December 2022,[40] since December 2018, the total number of home care clients has grown by 152.4% (142,268 additional clients).[41] The expansion of the home care package program has seen the total number of people on the waiting list decline. For example, as of December 2022, 37,894 people were waiting on the National Priority System for a package at their approved level, which was 45% (68,429 packages) lower than the year before. The estimated waiting time is between 1-3 months across all package levels.

In total, the 2023–24 Budget allocated an additional $338.7m to fund initiatives to improve the home care system. This included the $166.8m commitment for additional packages as well as:

- $73.1m for the development of ICT to support the new program
- $71.5m for the home care pricing and costing research activities of IHACPA
- $15.7m for the establishment of the single aged care assessment workforce.

In addition, funding was provided to trial a new assistive technologies loan program in partnership with existing state-based programs. The full set of initiatives is available in Budget Paper No. 2.[42]

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37. Commonwealth of Australia (2023), *Budget 2023–24, Budget Strategy and Outlook, Budget Paper No. 1*, p.133.
38. Department of Health and Aged Care webinar, 18 May 2023.
39. Department of Health and Aged Care webinar, 18 May 2023.
40. Department of Health and Aged Care (2023), *Home care packages program, data report 2nd Quarter 2022-23*, Australian Institute of Health and Welfare.
41. 2017–18 HCP figures taken from the Productivity Commission's Report on Government Services which show that 93,331 people had a HCP as at 31 December 2018. The most recent estimate of HCP clients (235,599) is as of 31 December 2022.
42. Commonwealth of Australia (2023), Budget 2023–24, *Budget Measures, Budget Paper No. 2.* [available at https://budget.gov.au/content/bp2/index.htm]

Financial viability in the new program

The worsening Operating Results of home care package providers in the first half of 2022-23 provide a stark illustration of the importance of the continued viability of the sector for the delivery of aged care services at home. The December 2022 results, presented in full in Part 2, show that surveyed services achieved an average Operating Result of only $0.93 per client per day. The financial outcomes are still worse for providers offering lower-level packages (i.e., Level 1 and Level 2 packages).

UARC's findings put the spotlight on the viability of the forthcoming unified Support at Home program, given that currently, 75% of all home care services across the sector are delivered through the Commonwealth Home Support Programme and that approximately half of all CHSP clients receive only one service (see Table 5).[43] To the extent that funding for these clients will, in the new program, more closely resemble lower-level home care packages, the most recent financial results warn of the potential for much broader provider viability issues following the unified program's implementation.

Table 5: Participants and expenditure on home care programs, 2021-2022

Program	Number of participants	Percentage of participants	Annual government expenditure ($m)
Commonwealth Home Support Programme	818,228	75.27%	3,060.3
Home Care Packages	261,314	24.04%	4,401.9
Short Term Restorative Care	7,448	0.69%	74.6

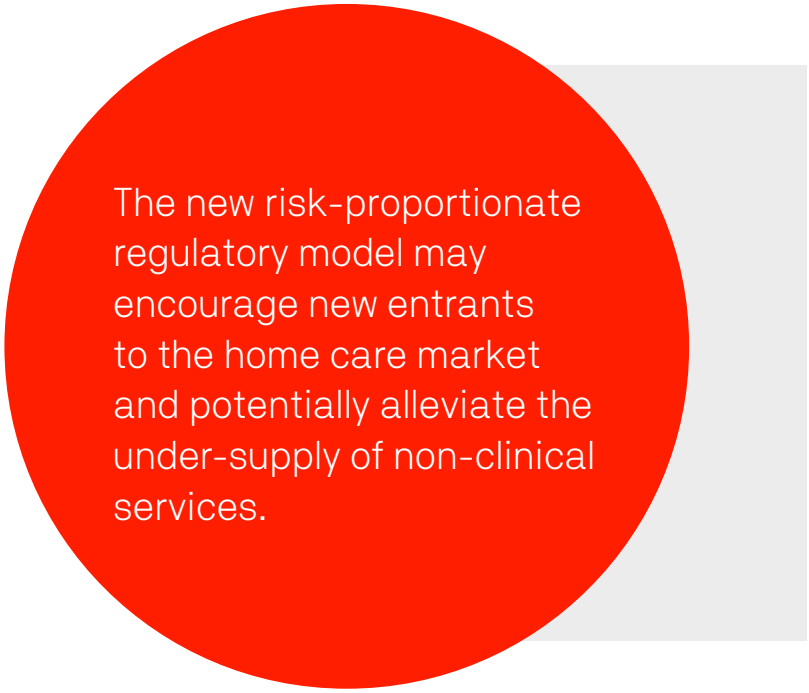
43. Department of Health and Aged Care (2022), *2021-22 Report on the Operation of the Aged Care Act 1997*, Australian Institute of Health and Welfare.

Intersection with the new regulatory model

Consultation on the development of the new program and the parallel development of the new regulatory model for aged care is ongoing. The new regulatory model will depart from the existing approved provider arrangements by requiring all service providers to register to be able to deliver Commonwealth subsidised services and then re-register at regular intervals.[44] This will enable the regulator to have ongoing touchpoints with providers rather than assessing suitability only at their market entry point.

The new regulatory model's risk-proportionate nature will likely significantly impact the home care services market. The introduction of six (proposed) categories of providers means that those who deliver services that are more readily available in the private market (such as home cleaning, meal delivery, garden maintenance, and transport) and which do not require clinical skills will have fewer specific provider responsibilities in light of the substantial coverage of existing regulatory requirements (e.g. state-based food safety standards, road transport regulation).

Reducing the aged-care-specific regulatory requirements for this specific category of services may encourage new entrants to the market and potentially contribute to alleviating any existing undersupply of non-clinical services within home care programs. A further significant change is that non-corporate entities (such as sole traders) will be able to register to provide a defined set of subsidised aged care services within the new system.



44. Department of Health and Aged Care (2023) *A new model for regulating aged care, Consultation Paper No. 2 Details of the proposed new model.*

Program design considerations

The 2023–24 Budget also provided $0.7m to establish a new Aged Care Taskforce. Part of its purview will be to review funding arrangements across the sector, providing specific advice on consumer contributions and eligible services under the new Support at Home program.

UARC continues to advocate for a mixed funding model to support the viability of services in thin markets and those with high fixed costs.[45] For services in thin markets, such as services in rural and remote areas or for people with special needs, using an evidence-based loading would compensate for the higher variable delivery costs, with supplementary grant funding to serve as an availability payment.

In recognition of the higher fixed costs that some services incur (e.g. for centre-based day care and social support, delivered meals and transport), grant funding would facilitate the continuity of services that local government, community organisations and other businesses have regularly provided.

Nonetheless, in both instances, it is necessary to build appropriate incentives for efficiency and effectiveness into the program, together with performance transparency for provider accountability.

More design work is also required to balance flexibility with accountability in the program design. DoHAC's October 2022 discussion paper proposed a flexible pool, nominally of the value of 25% of total client funding. The value of the flexible pool is subject to ongoing debate, but this indicative value would seem to be excessively high. To put this into context, at 25% of the current combined program public expenditure, a sector-level flexible pool would equate to over $1.8 billion.

Given the lack of guidance or accountability for using these pool funds and the current 15% underutilisation of home care package funds (see Part 2), it would be prudent to consider other mechanisms for achieving flexibility that could reduce the need for such a substantial expenditure. Alternative mechanisms could include the ongoing evaluation and refinement of assessment processes to ensure the timely matching of the older person's needs and the services available within their care plans. Also, grant funding could support the viability of services that are often required on an unpredictable or emergency basis, including access to respite or restorative care.

45. Woods M; Lewis R; Brown D; Parker D; Sutton N; Rawlings-Way O; Sinclair D, 2022, S*upport at Home: response to the Department of Health and Aged Care Discussion paper* (October 2022)

Star Ratings

Key messages

- Over 90% of residential care providers as at December 2022 have 3 or 4 overall Star Ratings.

- Evidence from the United States indicates that Star Ratings can influence a home's market share and provide incentives to improve quality, particularly when there is local competition, but less so if they already had a high occupancy rate.

- Homes may face trade-offs between improving their Star Ratings and their financial viability, at least in the short term.

Star Ratings for residential aged care homes are now available to the community via My Aged Care.

The vast majority of aged care homes in Australia received a 3 or 4 overall Star Rating in each of the first two first quarters assessed under the new Star Ratings system. The October-December quarterly update shows a slight improvement compared to the initial ratings. The current distribution of ratings across the sector are:[46]

- 5 stars: 54 services (2%)
- 4 stars: 964 services (39%)
- 3 stars: 1,357 services (54%)
- 2 stars: 119 services (5%)
- 1 star: 6 services (<1%)

The 2023–24 Budget provided $139.9m to support the continuous improvement and enhancement of the Star Ratings and to expand the Quality Indicator program for in-home care services.

Star Ratings will support informed consumer choice about residential aged care by providing simplified, comparable information about homes' quality and safety. The twofold aim is to enable older people and their carers to identify and choose high-quality providers and incentivise providers to improve their quality to attract a viable customer base.[47]

International evidence on the introduction of Star Ratings

While it is too early in Australia's implementation of Star Ratings to assess the impact of this new system on consumer choice and provider behaviour, evidence from the experience of the United States Centre for Medicare and Medicaid Services (CMS) "Nursing Home Compare" (NHC) Star Ratings provide some insight into expected outcomes. The ratings commenced in 2008 to consolidate and simplify the complex quality information available to consumers. Nursing home ratings in the NHC system include data on three domains: state-level health inspections, case mix-adjusted staffing levels, and quality measures.[48]

46. Anika Wells media release 3 May 2023: Star Ratings system working to improve aged care | Health Portfolio Ministers and Aged Care.
47. Werner, R. M., Konetzka, R. T. & Polsky, D. (2016) Changes in Consumer Demand Following Public Reporting of Summary Quality Ratings: An Evaluation in Nursing Homes. *Health Services Research* 51, 1291–1309.
48. Konetzka, R. T., Yan, K. & Werner, R. M. (2021) Two Decades of Nursing Home Compare: What Have We Learned? *Medical Care Research and Review* 78, 295–310.

Consumer responses

Some evidence suggests that the introduction of Star Ratings in the United States NHC system was associated with changes in consumer demand. A simulated market study comparing nursing home admissions pre- and post-implementation demonstrated that in the two years after the introduction of Star Ratings, 1-star homes lost 8% of their market share while 5-star homes gained more than 6%.[49]

The causal effects of Star Ratings have also been demonstrated in a further study that assessed consumer choice between nursing homes with adjacent Star Ratings (e.g. 3 and 4 stars) and found that gaining an extra star leads to a relative increase in new admissions in the subsequent six months.[50] However, this effect was dependent on the baseline level of quality, with an increase from 1 star to 2 stars not associated with an effect on admissions. The increases in new admissions were larger in nursing homes that were not fully occupied and those in more competitive markets.

These effects suggest that consumers valued both summary measures of quality (composite Star Ratings) and specific quality measure ratings. Specifically, study participants reported that the ratings helped compare providers within a specific geographical market and to a state- and national-quality benchmark.[51]

However, a lack of transparency in how individual quality ratings were algorithmically aggregated to generate a composite Star Ratings was a source of confusion for consumers. This was especially the case when the weighting of individual measures in the composite did not align with the consumer's preferred weightings. This indicates a continuing need to inform and educate consumers about the availability and construction of the ratings for them to inform the decision-making of older people and their carers.

49. Werner, R. M., Konetzka, R. T. & Polsky, D. (2016) Changes in Consumer Demand Following Public Reporting of Summary Quality Ratings: An Evaluation in Nursing Homes. *Health Services Research* 51, 1291–1309.

50. Perraillon, M. C., Konetzka, R. T., He, D. & Werner, R. M. (2019) Consumer Response to Composite Ratings of Nursing Home Quality. *American Journal of Health Economics* 5, 165–190.

51. Schapira, M. M., Shea, J. A., Duey, K. A., Kleiman, C. & Werner, R. M. (2016) The Nursing Home Compare Report Card: Perceptions of Residents and Caregivers Regarding Quality Ratings and Nursing Home Choice. *Health Services Research* 51, 1212–1228.

Provider responses

There is less consistent evidence on how providers react to Star Ratings systems in terms of their quality improvements and reporting behaviour. Descriptive evidence from the United States shows upward trends in average Star Ratings over time. Further, it shows that outcomes for supported (Medicare/Medicaid-eligible) consumers were attributable to providers improving their quality (and ratings).[52]

However, a substantial body of research has shown that the likelihood of a nursing home improving at least some quality scores and taking actions toward quality improvement was higher in more competitive areas.[53] Nursing homes with high occupancy rates reported being less concerned about their scores.[54]

Differences may also be attributed to baseline levels of quality. A study of changes in staffing levels in response to an increase in staffing requirements found that providers at risk of losing a star responded by increasing their reporting staffing levels more so than those who met the new requirements. However, there was no corresponding increase in resident outcomes (measured as rates of pressure injuries). The authors suggest that these findings would be consistent with the at risk nursing home administrations hiring insufficient or ineffective staff or engaging in misleading reporting behaviour to increase the home's Star Ratings.[55]

Although it is difficult to predict how Australian providers and consumers will respond to the Star Ratings, the evidence from the United States experience suggests that incentives to improve quality will likely be higher for homes subject to greater local competition and with lower occupancy rates.

A further consideration may be the relative cost of improving Star Ratings, such as through investment in additional staffing. The direct care subsidies Australian providers receive are commersuarate with having staffing at, not above, the care minute target classifications under AN-ACC. While acknowledging that there are other domains in which homes may improve their Star Ratings (i.e. consumer experience, compliance, quality indicators), achieving a 4 or 5 star rating for staffing will likely require additional expenditure beyond what is funded under AN-ACC. Thus, at least in the short term, some homes may face trade-offs between improving their Star Ratings and financial viability.

52. Konetzka, R. T., Grabowski, D. C., Perraillon, M. C. & Werner, R. M. (2015) Nursing Home 5-Star Rating System Exacerbates Disparities In Quality, By Payer Source. *Health Affairs* 34, 819–827.
53. Konetzka, R. T., Yan, K. & Werner, R. M. (2021) Two Decades of Nursing Home Compare: What Have We Learned? *Medical Care Research and Review* 78, 295–310
54. Perraillon MC, Brauner DJ, Konetzka RT. (2019) Nursing Home Response to Nursing Home Compare: The Provider Perspective. *Medical Care Research and Review* 76(4):425-443.
55. Ody-Brasier, A. & Sharkey, A. (2019) Under pressure: Reputation, ratings, and inaccurate self- reporting in the nursing home industry. *Strategic Management Journal*. 40, 1517–1544.

Legislative update

Key messages

- The Government is anticipating that many of the provisions of the new aged care Act will take effect on 1 July 2024, with others, mainly relating to the new Support at Home program, to come into effect on 1 July 2025.

- The impact of the new legislation will be foundational and long lasting, and all stakeholders should actively participate in its development.

- The new legislation should set out the intended objectives of government intervention in the aged care sector. This would help reframe expectations and address the misunderstanding that people are automatically entitled to a wide range of taxpayer-funded services when they reach older ages.

- The Department has recognised that there is an opportunity to align a range of legislative provisions across several government-subsidised care services.

A new aged care Act

A core element of the reform agenda is a new aged care Act to replace existing laws, including the *Aged Care Act 1997* and the *Aged Care Quality and Safety Commission Act 2018*. The new Act will establish eligibility requirements for accessing aged care services; an assessment framework; the rights of older people seeking and receiving services; and oversight and accountability provisions.

The Department is anticipating that many of the new aged care Act provisions will take effect on 1 July 2024, with others, mainly relating to the new Support at Home program, to come into effect on 1 July 2025. Such timing, of course, is subject to the passage of the legislation through Parliament.

The 2023–24 Budget provided $81.9 million to develop and implement the new Act and $72.3 million to support a stronger Aged Care Regulatory Framework. In April this year, the Department released *A new model for regulating Aged Care, Consultation Paper No.2: Details of the proposed new model*.[56] The new model proposes to change:

- registration and suitability assessment of providers, with six categories of registration based on service types and associated risks;
- the obligations that providers must meet regarding the safety and quality of services, as well as financial and prudential risks; and
- the mechanisms for oversight of service provision, complaints processes and information available to older people.

This marks the beginning of an 8-week consultation period which closes on 23 June. Stakeholder responses will make a significant contribution to the drafting of the new Act. Although some people may see this as an arcane subject and the prospect of wading through many pages of draft legislation unappealing, the Act and subordinate regulation will establish all parties' rights and responsibilities. Hence UARC encourages all stakeholders to actively engage in Departmental consultations.

UARC agrees with adopting a relational approach between the parties by way of a more nuanced set of interfaces between the system administrator/s, regulator/s, providers (and their workforces) and older people receiving subsidised care. A regulatory framework built on this model will facilitate a more positive motivation of providers and drive the sought-after cultural change.

To date, a shortcoming in the consultation papers has been the lack of objectives for the aged care services subsidy scheme. It is necessary to articulate the intended outcomes of government intervention in the funding, delivery and regulation of essential services which provide care and support for older people in need (the outputs). This would help reframe expectations and move away from the misunderstanding that people are automatically entitled to a wide range of taxpayer-funded services when they reach older ages.

56. https://www.health.gov.au/resources/publications/a-new-model-for-regulating-aged-care-consultation-paper-2-details-of-the-proposed-new-model

The Government should commit to (and resource, including for baseline data collection) an ex-post evaluation of the new legislation. Such an evaluation would inform whether the new regulatory regime has been effective and efficient and has remained contemporary in light of changing circumstances as the aged care subsidy programs mature.

Another opportunity presented by the new Act is to improve the alignment of a range of legislative provisions across related care sectors (aged, disability and veterans' care). This issue is under consideration by the Department.

Legislation to establish the Inspector-General of Aged Care

The Inspector-General of Aged Care Bill was introduced in March 2023.[57] This Bill establishes the Inspector-General with statutory responsibilities to monitor, investigate and report on the Commonwealth's administration, regulation and funding of aged care. The Inspector-General is intended to focus on system-level issues and will not have the power to investigate individual complaints about aged care services.

UARC has raised several concerns with the draft legislation, and these were highlighted in the Parliamentary Library's Bills Digest. One matter is the use of the undefined term 'aged care systems' at the commencement of the Bill, even though more precise terminology has been used throughout the remainder of the proposed legislation. A second concern is using value-laden terms such as 'positive change' and 'recommendations for improvement' without the legislation specifying any criteria to guide the Inspector-General in their judgements.

UARC's submission proposes several other changes, such as enabling the Inspector-General to hold public hearings based on the publication of their draft reports.[58]

The legislation is expected to come into force in the second half of 2023. Ian Yates AM (ex-COTA CEO) has been appointed the Interim Inspector-General to undertake foundational work for the new office.

Legislation to enshrine the new Registered Nurse requirements for residential aged care

The Aged Care Legislation Amendment (Registered Nurses) Principles 2023 provides details about providers' exemptions from, and reporting about, the new requirement for residential care facilities to have at least one registered nurse on-site and on-duty 24 hours a day, from 1 July 2023.[59] Exemption applications opened in April 2023.

57. https://www.aph.gov.au/Parliamentary_Business/Bills_Legislation/Bills_Search_Results/Result?bld=r7004
58. https://www.uts.edu.au/sites/default/files/2023-02/UARC%20Draft%20Response%20%20Inspector-General%20Submission.pdf
59. https://www.legislation.gov.au/Details/F2023L00389

Sector sustainability

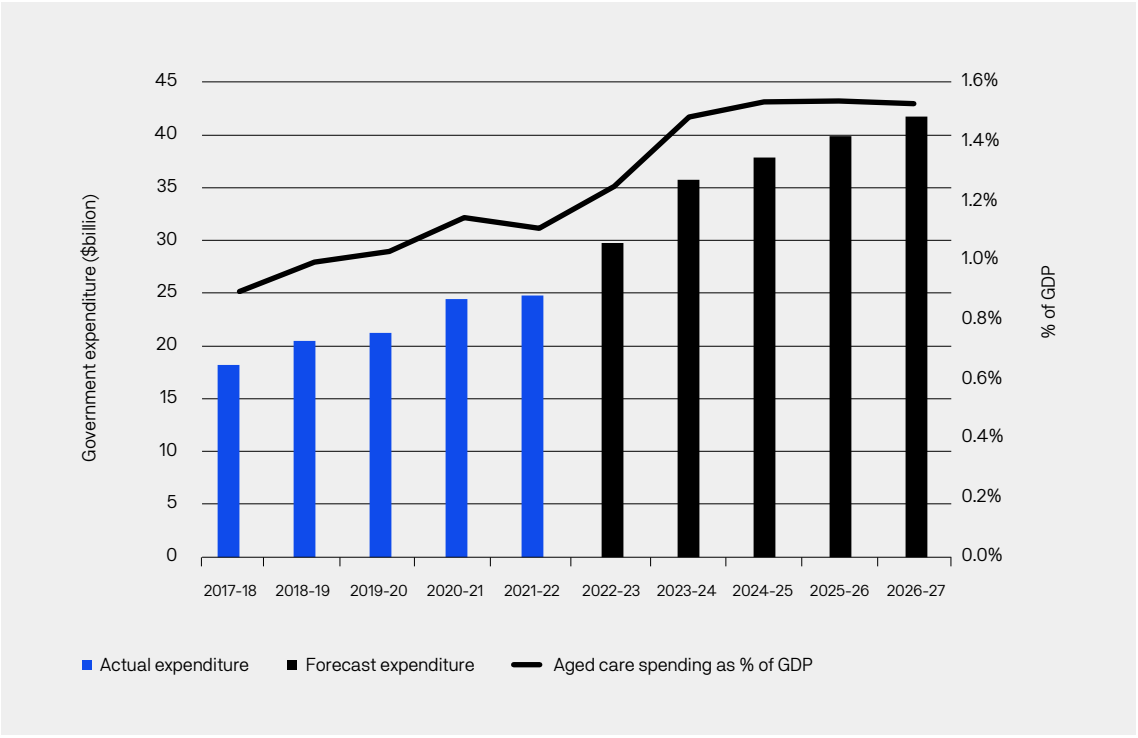
Key messages

- Government spending on aged care will reach 1.5% of GDP in 2023–24, more than a decade earlier that the 2021 Intergenerational Report predicted.
- The growth in spending reflects Australia's changing demographics, with more than 1.8 million people forecast to be aged 80 and above by 2032-33.
- Future spending will also be determined by changes in the cost of service delivery, which will be shaped by regulation and compliance, workforce pressures and community preferences and expectations.
- Older people receiving direct care services through the subsidised aged care programs contribute less than 10% of total care-related payments to providers, with taxpayers paying more than 90% of funding.
- The Government has annouced a new Aged Care Sustainability Taskforce to advise on aged care funding arrangements, including contributions from consumers.

In the 2023–24 Budget, the Government has provided for substantial increases in spending on aged care. In 2022–23, spending is expected to reach $29.7bn, growing to $41.7bn by 2026–27 (see Figure 7). Many of the initiatives have been assessed separately in other sections of this report, including additional funding for wage increases, additional home care packages and Budgetary support for the development of the regulatory model and proposed new legislation.

Taking a longer-term view, the nominal spending on aged care in the decade since the Royal Commission will more than double.[60] In real terms, the Government expects aged care spending to be one of the fastest-growing areas of expenditure, growing by 6.1% per year for the next decade.[61]

Figure 7: Government spending on aged care



60. Government expenditure on aged care is estimated as the total of several programs reported under the aged care sub-function Budget Paper 1 of the Federal Budget, including Aged Care Services, Veterans' Community Care and Support, Aged Care Quality and Access and information.

61. Commonwealth of Australia (2023), Budget 2023–24, *Budget Strategy and Outlook, Budget Paper No. 1*, p.98.

This growth in expenditure is also reflected in estimates of spending on aged care as a proportion of GDP.[62] Whereas before the Royal Commission, aged care spending was 0.9% of GDP, this year, it will be 1.2% of GDP and 1.5% next year (2023–24).

This pace of growth not only eclipses earlier budget forecasts but also exceeds Treasury's long-term predictions. The 2021 Intergenerational Report (IGR) forecast that aged care spending would reach 1.5% of GDP in 2035-36,[63] but it now appears the Government will reach this level of spending more than a decade earlier.

As the IGR foreshadowed, the acceleration in government spending reflects a range of additional funding commitments to implement additional reform priorities not fully developed in 2021. These include higher care subsidies to fund increased staffing levels, increased award rates for aged care workers, and expanded access to a new unified Support at Home program.

These substantial flows of additional government funding are important in addressing three key elements of a sustainable aged care sector within Australia, including the financial viability of providers, the sustainability of the workforce and social and community acceptance of the quality and safety of aged care services.[64] However, at the same time, the pace of spending also raises critical questions about the fiscal sustainability of the sector and the Government's overall Budgetary position.

Fiscal sustainability and the impact of the 2023–24 Federal Budget

Fiscal sustainability describes the extent to which taxpayers can afford to publicly fund services, both now and over the longer term. For this to be achievable, the budget must be balanced over the medium term. This means that any growth in government expenditure needs to be met by equivalent increases in government revenue, such as higher tax receipts, spending cuts or other savings.[65]

Thus, increases in expenditure on programs such as aged care, health, disability care and defence, together with significant interest payments, raise concerns about how taxpayers will fund such activities now and in the future. Climate change and the attendant need for abatement and adjustment will bring additional fiscal challenges.

The recent Budget Papers have forecast an underlying cash surplus of $4.2 billion (0.2% of GDP) in this current year (2022–23). A strong labour market and elevated commodity prices have underpinned the improvement across 2022–23 and 2023–24. However, the Budget is projected to return to an underlying cash deficit of $13.9 billion (0.5% of GDP) in 2023–24 and increased deficits over the following two years.[66]

62. The ratio of spending to GDP is adjusted for population changes, i.e. as nominal aged care expenditure per capita divided by nominal GDP per capita.
63. Commonwealth of Australia (2021), *2021 Intergenerational Report, Australia over the next 40 years*, Treasury, p.104
64. Woods, M., Sutton, N., McAllister G., Brown, D. & Parker, D. (2022). *Sustainability of the Aged Care Sector: Discussion Paper*. UTS Ageing Research Collaborative.
65. In cases whether there is a shortfall 'deficit', the Government can borrow additional funds through debt, however this means that future taxpayers bear the burden of increased interest and repayments.
66. Commonwealth of Australia (2023), *Budget 2023–24, Budget Strategy and Outlook, Budget Paper No. 1.*

On the expenditure side, one of the most significant changes from previous spending projections is the Budget's assumption that the Government can limit the growth of spending on disability care to ensure the NDIS can sustainably provide care and support for future generations of Australians with disability. The Forward Estimates assume an annual growth target for the total costs of the Scheme to be no more than 8% by July 2026, with further moderation of growth as the Scheme matures.[67]

UARC's 2022 Discussion Paper on the *Sustainability of the Aged Care Sector* drew attention to the increasing demand-side pressures arising from demographic and health changes in Australia's ageing population and community expectations for safer and higher quality care.[68] Also, supply-side constraints include workforce availability and the worsening financial performance of providers.

While one of the drivers is Australia's ageing population (as explained below), other drivers explain most ongoing cost increases – especially for health care. As the 2021 Intergenerational Report (IGR) explains, non-demographic growth factors such as rising incomes and technological advancement contribute to an increased quantity and quality of health services and products consumed and demanded.[69] Several international studies have found that changes in national income are often the most significant drivers of government spending on health.

It is worth noting that in June 2022, the Treasurer announced that the Government aimed to release a revised Intergenerational Report during 2023 with a broader scope than its predecessors.[70] To this end, a recent analysis of previous IGRs has proposed that in future, they be prepared with greater independence from politics, that they cover all Australian governments, that the analysis be more open and transparent and that there be a much wider 'wellbeing' approach to assessing long-term sustainability.[71]

In the following three sections of this report, we explore some of the major influences on the medium-term fiscal outlook for the aged care sector and their implications for its sustainability over the coming decade:

- Australia's changing demographics
- The rising cost of service delivery
- Creating equitable and fair payment arrangements.

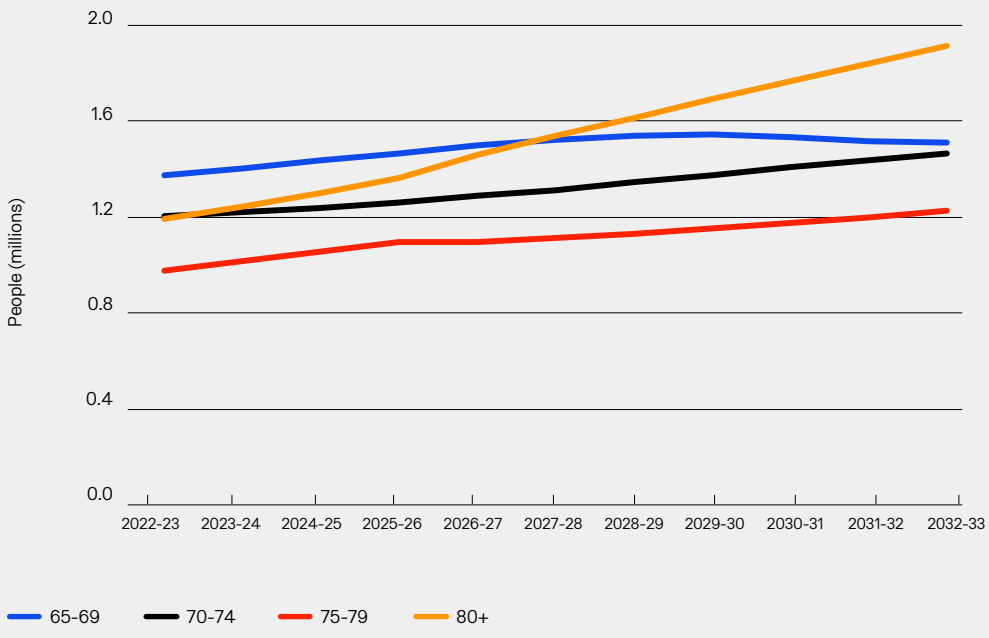
67. Commonwealth of Australia (2023), *Budget 2023–24, Budget Strategy and Outlook, Budget Paper No. 1*
68. Woods, M., Sutton, N., McAllister G., Brown, D. & Parker, D. (2022). *Sustainability of the Aged Care Sector: Discussion Paper*. UTS Ageing Research Collaborative.
69. Commonwealth of Australia (2021), *2021 Intergenerational Report, Australia over the next 40 years*, Treasury, p.104.
70. https://ministers.treasury.gov.au/ministers/jim-chalmers-2022/speeches/address-sky-news-and-australian-sydney.
71. Podger, A., Hall, J., Woods, M. (2023), *More than Fiscal: The Integerational Report, Sustainability and Public Policy in Australia*. ANU Press, Canberra.

Australia's changing demographics

One of the key drivers of the increase in aged care spending is Australia's changing demographics. Specifically, as the numbers and proportion of the population reach older ages, there will be increased demand for care and support services.

Most people who use subsidised aged care services are aged 80 and over. Currently, people in this age bracket represent 77% of all home care clients and 86% of people in residential care.[72] This age cohort will swell in the coming decade as a growing proportion of the Baby Boomer generation reaches their eighties.[73] As shown in Figure 8, by 2032–33, population forecasts indicate that more than 1.8 million people in Australia will be aged 80 and above, 720,000 more than today.

Figure 8: Australia's population forecast, people aged 65 and over



72. Productivity Commission (2023). *Report on Government Services – Section 14 Aged Care Services*.

73. Baby Boomers generally refer to people who were born between 1946 and 1965. Whereas in 2023, the oldest Baby Boomers will turn 77, by 2033 approximately 1.4 million Baby Boomers will be aged 80 and above. Data sourced from the Centre for Population, *2022 Population Statement*.

While many older people will remain independent as they age, health conditions such as dementia, frailty and chronic disease will drive the growth of demand for appropriate support and care services.

As most people prefer to remain in their own homes, most growth in demand is likely to focus on in-home care and support services. For the first time, as of June 2022, the total number of people receiving home care packages (215,743) eclipsed those in residential care (180,750). In coming years, the divergence is expected to widen further still. Although the intensity of services provided through the CHSP is much less, it still accounts for the vast majority of aged care clients, numbering 818,228 in 2021–22.[74]

The availability of appropriate community and home-based support will also likely curb the growth rate in the total quantum of funded places in residential care. However, the resident profile in aged care homes will continue to become more acute, comprising more people with complex care needs requiring intensive, around-the-clock care. For example, in just the last five years, the proportion of residents requiring substantial assistance with activities of daily living has grown by 9.6%.[75] As these services are the most resource-intensive, there will continue to be upward pressure on the cost of residential aged care.

The other gradual but persistent demographic shift will be the decline in the relative size of Australia's working-age population (those aged between 15–64). Today there are approximately 3.7 working-aged people for every person aged 65 and above. In a decade, this ratio will fall to 3.2. Consequently, as the demand for aged care services grows, the potential cohort contributing income taxes to pay for those service subsidies will decrease.[76] Simultaneously, the sector will face more intense competition for workers as demand for labour increases across the economy, putting upward pressures on wages and working conditions.

74. Department of Health and Aged Care (2022), *Aged Care Snapshot 2022 – third release*. Australian Institute of Health and Welfare.

75. 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.

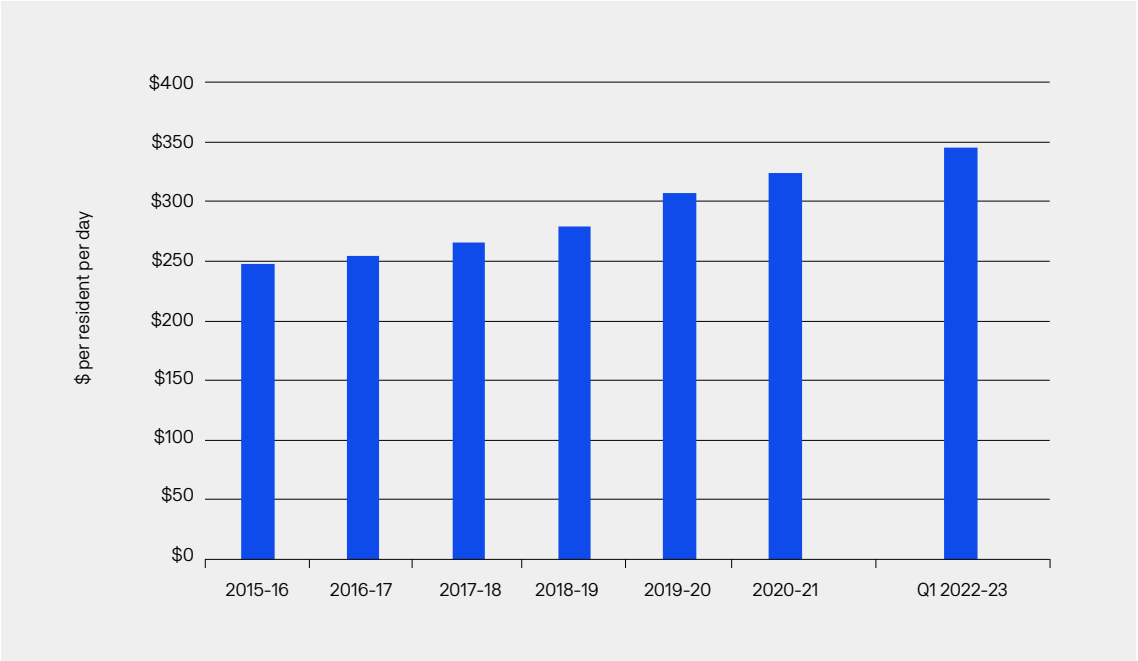
75. Woods, M., Sutton, N., McAllister G., Brown, D. & Parker, D. (2022). *Sustainability of the Aged Care Sector: Discussion Paper.* UTS Ageing Research Collaborative.

76. People aged 65 and may continue to contribute to Australia's taxation revenue, such as through income tax and levies on salaries or capital gains, as well as consumption-based taxes, such as the GST. However, as a cohort the rate of tax paid tends to be lower than people aged 64 and below.

The rising costs of service delivery

Aged care subsidy expenditures will also increase as service costs rise. For residential care, the average total expenditure per resident per day has steadily increased in recent years. Based on whole of sector figures (including first quarter results for 2022-23), since 2015-16 aged care costs have increased in nominal terms by 39.3% to $345 per resident per day (see Figure 9).[77] In real terms, this represents an average annual growth of 2.7% per year above the inflation rate since 2015-16.

Figure 9: Average expenditure on residential care per resident per day



Significantly, the Q1 2022-23 figures predate the introduction of minimum staffing requirements and the 15% pay rise in direct care labour costs. Thus, in the short term, average expenditure are likely to continue to grow to reflect both these incoming changes (including the additional care minute targets in 2024) as well as further administration costs relating to increased reporting around staffing, food and nutrition and financial performance, and monthly care statements.[78]

77. Department of Health (2022) *Financial report on the Australian Aged Care Sector 2020-21*; Department of Health and Aged Care (2023), *Quarterly Financial Snapshot of The Aged Care Sector.*

78. Department of Health and Aged Care (2023), *Stakeholder pack – Budget 2023–24*.

Creating equitable and fair payment arrangements

Another critical driver influencing the Budgetary cost of subsidised aged care services is the balance in funding responsibilities between taxpayers and the individuals who use aged care services ('consumers'). Although most older people pay something towards the cost of their care, on the whole taxpayers provide the vast majority of funding.

There are complex differences in what consumers pay for, depending on whether they receive care in a residential aged care home or their own home, as well as their individual financial means. To illustrate, Table 6 compares the funding sources for services under the home care package program and residential care. It shows that consumers receiving care services in their own homes typically fund the cost of their accommodation and everyday living expenses privately (noting that many receive support through the age pension, and some receive funding support via public housing, rental assistance and various concessional fees).

Similarly, many older people in residential aged care homes pay for most of their everyday living costs (catering, cleaning, laundry and utilities). These services are funded through a combination of residents' payments of the basic daily fee (set at 85% of the age pension), additional services fees, and the taxpayer-funded hotelling supplement. Again, it's important to note that many residents receive taxpayer support for these services through the age pension.

However, taxpayers fund more than half the payments for accommodation services in residential care. Individuals with financial means pay via fully refundable accommodation deposits (RADs), daily accommodation payments (DAPs) or a combination of the two. However, the Government pays a daily accommodation supplement for supported residents of low means, representing approximately 34% of all residents.[79]

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

Table 6: Funding sources for aged care services

		Home care package services		Residential care services	
		Funding sources		Funding sources	
Type of services	**Examples**	**Consumers**	**Taxpayers**	**Consumers**	**Taxpayers**
Direct care services	Nursing and clinical care personal care, specialised equipment and assistive supports	Basic daily fee Income-tested fee Private contributions	Home care package subsidy and supplements	Means-tested care fees	Direct care subsidies and supplements (including respite)
Everyday living services and amenities	Food, cleaning, laundry, utilities, transport	Personal payments for goods and services	Energy rebates Mobility allowance	Basic daily fee Additional services fees	Hotelling supplement
Accommodation services	Accommodation, repairs, maintenance	Own property Mortgage repayments Rental payments	Rental assistance Social housing	Fully refundable accommodation deposits (RADs) Daily accommodation payments (DAPs)	Accommodation supplement (supported residents only) Capital grants

These differences in what consumers are expected to fund privately (including from the age pension) make comparing aggregate contribution rates across different subsidised programs challenging. The most comparable measure of consumer contributions relates to direct care services. These include means-tested care fees for residential care, basic daily fees and income-tested fees for home care packages, and consumer fees for CHSP services.

Based on statistics from DoHAC, there are significant differences in the care-related contributions from consumers across the three programs. As shown in Figure 10 which shows the contributions and government spending in aggregate, in 2020-21, residential consumers contributed $775m in means-tested care fees, compared to $96m contributions from home care consumers and $269m from CHSP consumers.

Figure 10: Government spending and consumer contributions for direct care, by program

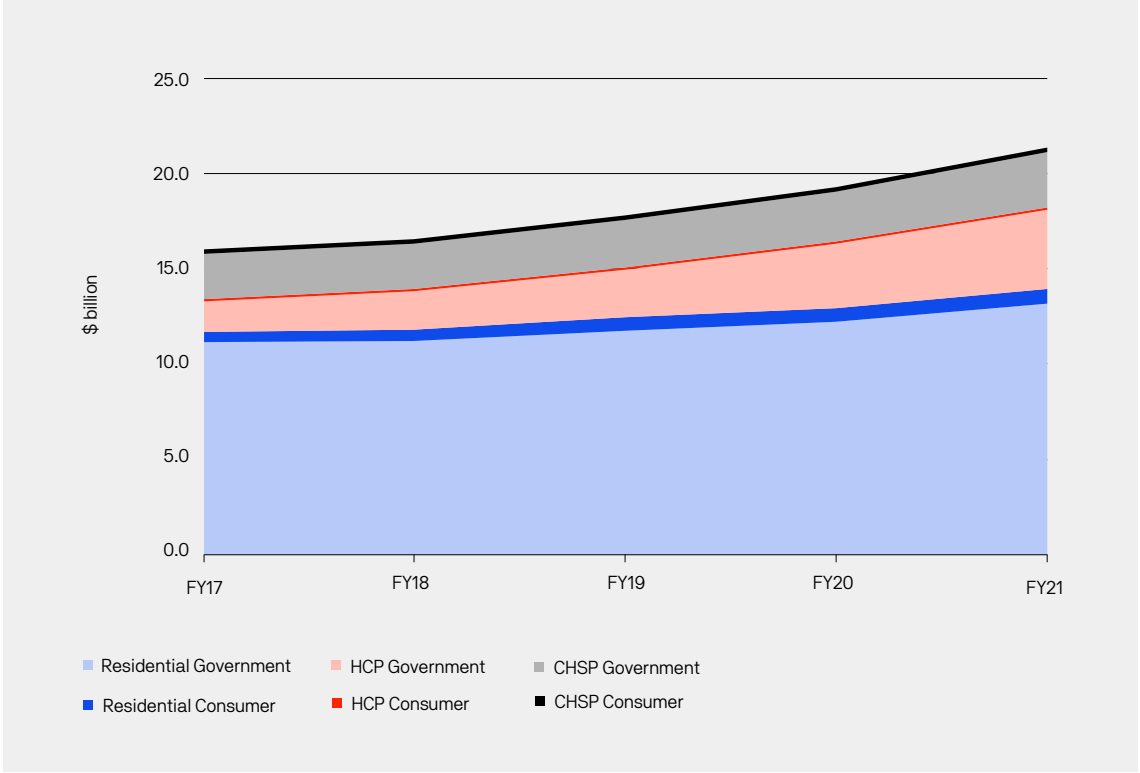
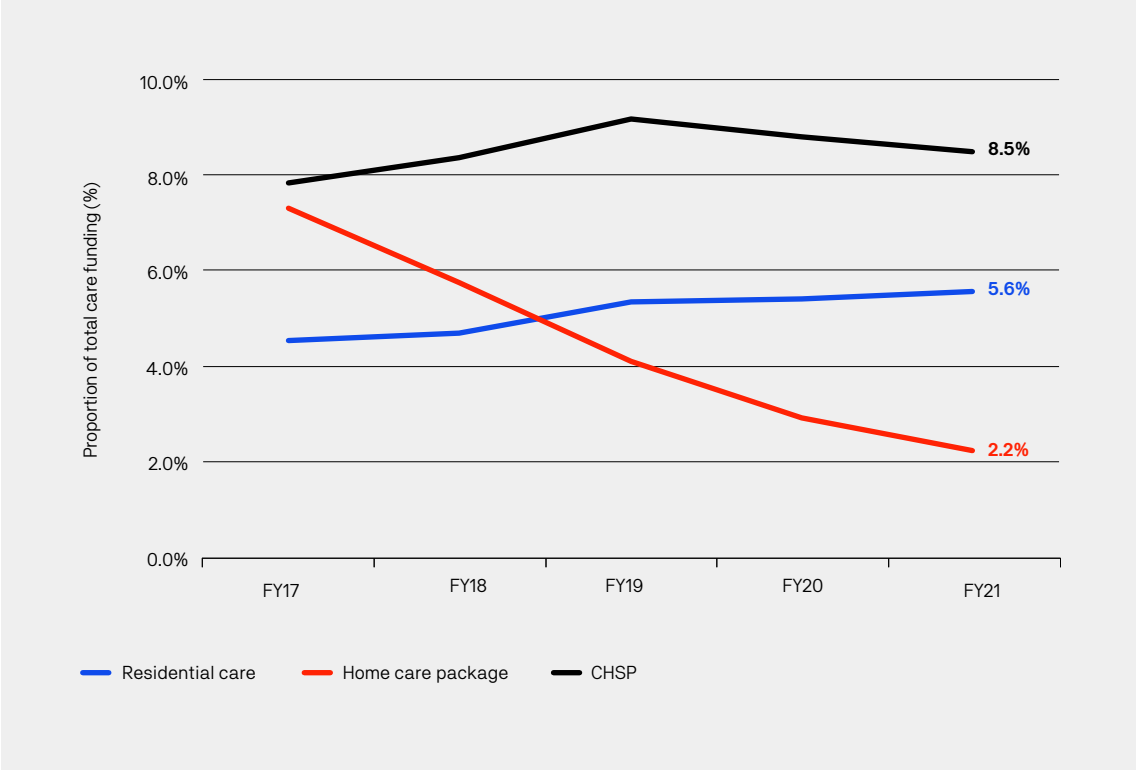


Figure 11 represents these results as rates proportionate to the total provider payments. This reveals that in 2020-21, residential consumers contributed approximately 5.6% of the funding for direct care services. In contrast, home care package clients contributed just 2.2% of funding, far less than the 8.5% contribution rate for CHSP services, even though the latter has less prescriptive fee guidelines.[80] Furthermore, the contribution rate for home care packages has fallen over the last five years, reinforcing earlier reports that providers are not charging consumers the basic daily fee.[81]

80. Figures based on data in the Department of Health and Aged Care (2022), *Financial Report on the Australian Aged Care Sector 2020-21*.
81. Aged Care Financing Authority (2021), *Ninth Report on the Funding and Financing of the Aged Care Sector*.

Figure 11: Consumer contributions to direct care services



Many stakeholders agree that for aged care to be fiscally sustainable, there will need to be wide-ranging reforms that improve the wellbeing of older people, improve the effectiveness and efficiency of the services and ensure the distribution of costs between taxpayers and consumers is equitable, both now and into the future.

UARC notes widespread support for rebalancing the contributions so that those with the financial capacity to pay make fair contributions to the cost of the services they use.[82] The Government has signalled its intent to move on such matters in the most recent Budget, announcing funding of $0.7m to establish a new Aged Care Taskforce, which will review aged care funding arrangements and develop options to make the system fair and equitable for all Australians. Its remit will include examining the level and form of consumer contributions.[83]

82. Aged Care Financing Authority (2021), N*inth Report on the Funding and Financing of the Aged Care Sector*. COTA Australia (2020), *Financing aged care, Submission to the Royal Commission into Aged Care Quality and Safety*; ACCPA (2023), *ACCPA Federal Government Pre-Budget Submission 2023–2024*; Tune, D. (2017), *Legislated Review of Aged Care 2017 Report*.

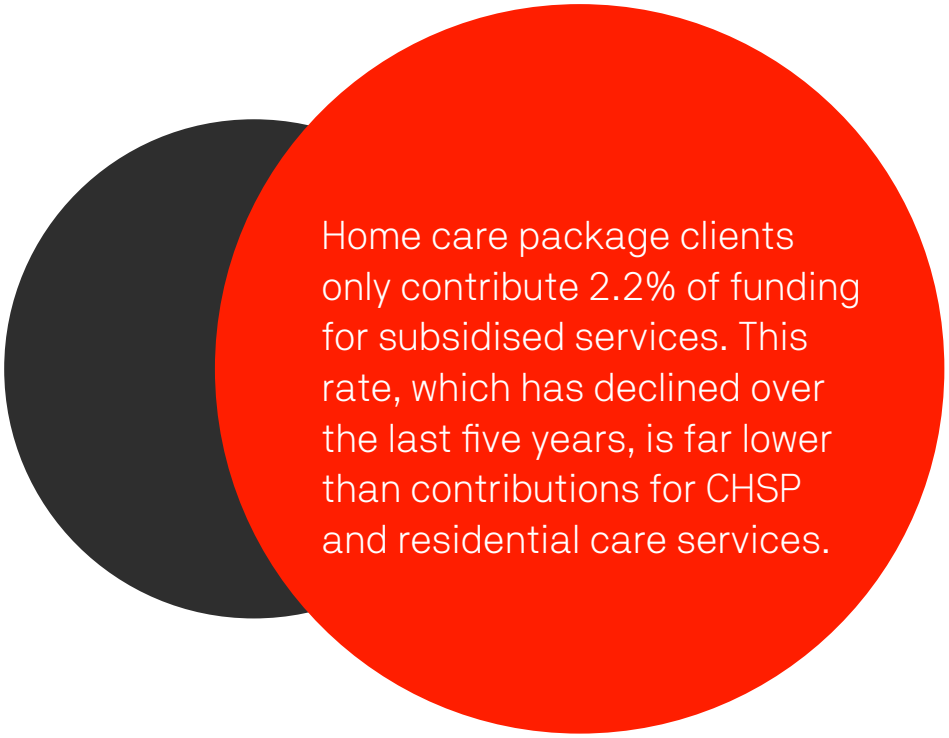
83. Commonwealth of Australia (2023), Budget 2023–24, *Budget Measures, Budget Paper No. 2*.

As outlined in UARC's recent Sustainability Discussion Paper, such a rebalancing will require the careful assessment and calibration of policy settings. Considerations will include means-testing assessments, co-contribution rates, pricing regulations and safety-net provisions that ensure that those of low means continue to access the high quality services they need.[84]

More broadly, there will need to be further development around financial planning services and financial products that allow older people to proactively plan and access their income and wealth to contribute to the cost of the services they use, again where they have the financial capacity to do so.[85] Such arrangements should be coupled with appropriate legal safeguards to mitigate risks of financial abuse.

Finally, adjustments to consumer contributions will only be successful if such changes have wide community acceptance and support. Recent evidence indicates that people may be willing to forgo inheritances so that their parents can enjoy a safe and comfortable retirement.[86] Such evidence reinforces earlier findings that people may be willing to make greater co-contributions to the cost of their and their family members' care, provided the services are of high quality.[87] However, such changes must occur within a broader national conversation about how aged care services will be funded.

In future editions of the Sector Report, UARC will explore each of these issues, providing robust evidence to inform this conversation.



84. Woods, M., Sutton, N., McAllister G., Brown, D. & Parker, D. (2022). *Sustainability of the Aged Care Sector: Discussion Paper*. UTS Ageing Research Collaborative.
85. Treasury (2020), *Retirement Income Review*; National Seniors Australia (2023), *Federal Budget Submission 2023 Supporting older Australians to build a better nation*.
86. Complispace (2023), *Towards the Tipping Point in Aged Care Funding*.
87. Ratcliffe J, Chen G, Cleland J, Kaambwa B, Khadka J, Hutchinson C, Milte R (2020) Australia's aged care system: assessing the views and preferences of the general public for quality of care and future funding. Caring Futures Institute, Flinders University, South Australia.

Part
2

Analysis of the StewartBrown sector data set

Part 2 of this report draws primarily on the December 2022 StewartBrown ACFPS data set contributed to by aged care providers within Australia. StewartBrown conducts a subscription-based quarterly data collection and analysis service, enabling aged care providers to track their performance over time and benchmark their operations against other providers. Where relevant, this data has been supplemented with references to available sector-wide statistics, such as those produced by the Department of Health and Aged Care and the Australian Institute of Health and Welfare.

The data covers the first six months of the 2022-23 financial year. To enable meaningful trend comparisons, previous years' figures relate to the same reporting period (i.e. 1 July – 31 December) of each year. The analyses have been conducted at three levels:[88]

Approved providers

Residential aged care homes

Home care package services

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.[89]

Due to variations in methodology, the results reported in this report differ in some minor respects from those reported by StewartBrown. An explanation of the methodology appears in an Appendix at the end of this report.

88. 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.

89. From mid-2025, the Australian Government intends to amalgamate the HCP program and CHSP, 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.

Approved provider analysis

Overview

- The overall financial performance of participating providers continues to be poor, as 63.9% of providers reported a negative mid-year Operating Result.

- Year-on-year for the same period, the average reported Operating Result was down by 33.5%, with a negative return on assets of minus 0.9%.

- Providers' median Operating EBITDA margin was just 1.8%, indicating that a given provider will generate just $1.80 for every $100 of revenue earned.

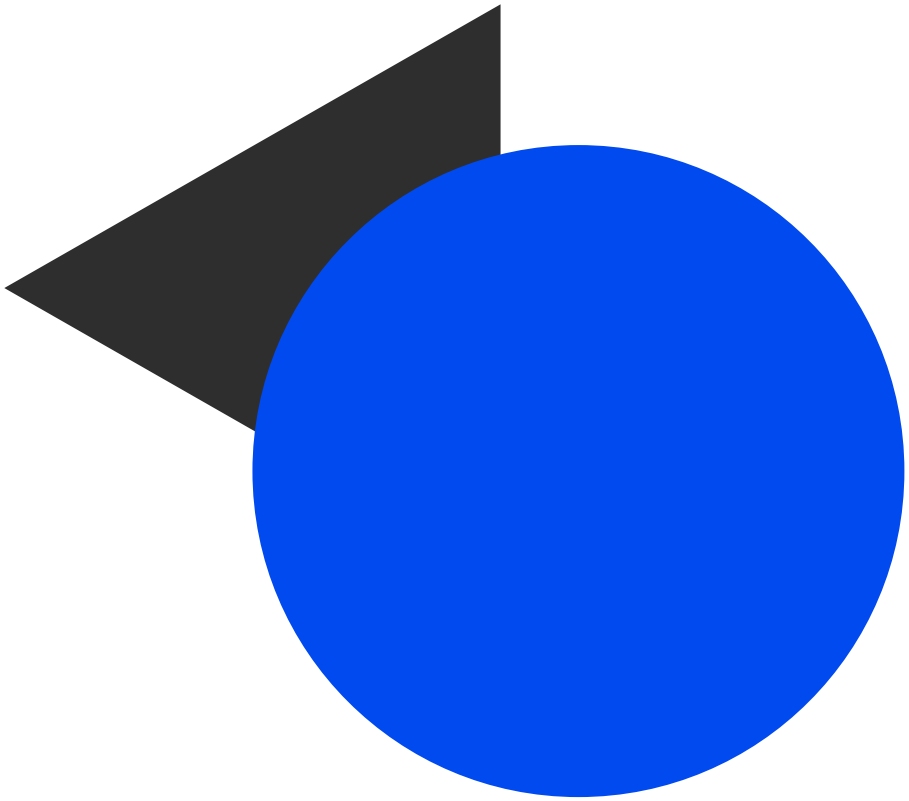
- Providers' liquidity decreased to a median ratio of 33.9%. However, liquidity and capital adequacy remain well above thresholds indicating prudential risk.

- Providers with the poorest financial outcomes operate small chains with 2-6 homes.

Approved provider profiles

The analysis at the approved provider level examines the financial outcomes of organisations that provide residential and home care services within Australia. These organisations may also operate a range of other business streams, such as home support and community care programs, disability care, childcare and retirement living. As such, the analysis provides a sense of the overall financial performance of the going concern entities that provide subsidised aged care services, noting that a more detailed analysis of their residential care operations and home care services follow later in Part 2.[90]

Furthermore, care should be taken when interpreting average (mean) results from a dataset containing a wide variation of provider scope, scale and outcomes. For example, a provider with 20 or more homes is weighted equally with a provider with only one home. Where appropriate, the analysis reports median (middle) values and includes a subsection where the results of providers of different scales and scopes are reported separately.



90. 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.

Approved providers

Table 7: Profile of contributing approved providers

	Dec-22	Dec-21
Number of providers in data set	216	216
Ownership		
For profit	8.8%	8.8%
Not for profit	91.2%	91.2%
Staffing		
Average number of staff (headcount)	589	573
Average number of full-time equivalent staff (FTEs)	389	378
Providers with residential aged care homes (%)	95.8%	95.4%
Average number of residential aged care homes	3.8	3.8
Average number of operational places	304	307
Location		
Metropolitan	49.0%	52.0%
Regional	43.1%	39.9%
Metropolitan and regional	7.8%	8.1%
Provider scale		
Single-home	51.4%	50.9%
2-6 homes	32.4%	32.4%
7-19 homes	9.3%	8.3%
20+ homes	2.8%	3.7%
Providers with home care operations (%)	44.0%	42.1%
Average number of home care packages	502	465
Providers with seniors housing (%)	61.6%	60.2%
Average number of retirement villages	5.6	5.7
Average number of retirement village units	259	257

This section analyses the outcomes of 216 approved providers who contributed to the December 2022 StewartBrown mid-year data set, representing 14.8% of Australia's 1,457 residential and home care package providers.[91] As shown in Table 7, most (91.2%) of these providers are not-for-profit, and the remainder (8.8%) are private, for-profit providers. As of December 2022, contributing providers employed an average of 589 people (389 FTE staff).

Almost all surveyed providers (95.8%) offered residential aged care services, each operating an average of 3.8 homes and 304 beds, of which about half (49.0%) are located in metropolitan areas.[92] The geographic spread of providers in the dataset is largely consistent with statistics for all residential care providers in Australia.[93]

As with the general trend amongst all residential care providers,[94] most (51.4%) providers in the dataset operate a single aged care home. However, the few providers that are larger in scale operate a substantial share of the total number of operational places. For example, as of December 2022, providers that operated 20 or more homes comprised only 2.8% of the total number of providers in the dataset but operated 24% of all the operational places.

Regarding other aged care services, as of December 2022, 95 of the surveyed providers (44.0%) offered home care services. The average number of home care packages per provider (502) is roughly double the average for the home care sector overall,[95] indicating that the dataset is weighted towards larger providers of home care services. In addition, 61.6% of providers offered seniors housing (also called retirement villages).

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

92. Location describes the geographic location and spread of the providers' residential care operations. Following the definitions used by the Department of Health and Aged Care in its *Quarterly Financial Snapshot of the Aged Care Sector*, a provider is classified as being "Metropolitan" if more than 70% of its homes are located in metropolitan areas; "Regional" if more than 70% of its homes are located in regional (non-metropolitan) areas; and "Metropolitan and regional" if between 30-70% of its homes are located in metropolitan areas.

93. According to the Department of Health and Aged Care's *Financial Report on the Australian Aged Care Sector (2020-21)*, 419 (50.5%) of all residential providers are located in metropolitan areas; 321 (38.7%) in regional areas; and 90 (10.8%) in metropolitan and regional areas.

94. The relative distribution of residential care providers in Australia, based on scale, is: single home (62.8%), 2-6 homes (27.8%); 7-19 homes (6.4%) and 20+ homes (3.0%). These statistics are reported in the Department of Health and Aged Care's *Financial Report on the Australian Aged Care Sector (2020-21)*.

95. As of December 2022, there are 235,599 HCP packages provided by 938 providers, which is equivalent to 251 HCPs per provider. Department of Health and Aged Care (2023), *Home care packages program, data report 2nd Quarter 2022-23*, Australian Institute of Health and Welfare.

Approved providers

Key performance indicators

Table 8: Key performance indicators of approved providers

	Dec-22	Dec-21
Number of providers in data set	216	216
Proportion of loss-making providers (Operating Result)	63.9%	63.9%
Proportion of loss-making providers (Operating EBITDA)	35.6%	28.2%
Ratios (Medians)		
Profit Margin (Operating Result)	(2.8%)	(3.0%)
Profit Margin (Operating EBITDA)	1.8%	3.0%
Return on Assets (Operating Result)	(0.9%)	(0.9%)
Return on Assets (Operating EBITDA)	0.6%	0.8%
Wages to revenue (%)	71.3%	71.2%
Median salary expense per FTE	$48,585	$44,858
Liquidity (%)	33.9%	37.3%
Capital adequacy (%)	34.8%	35.1%
Property assets as proportion of total assets	65.1%	64.3%

Financial performance

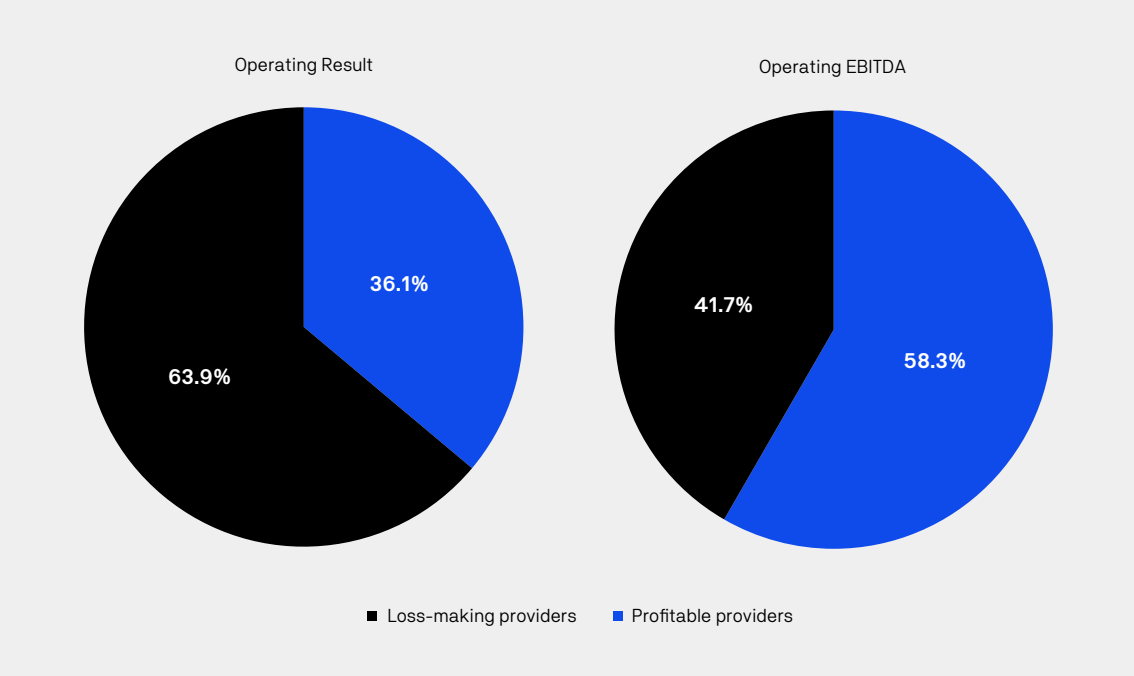
The level of profit or loss made by approved providers indicates the overall financial viability of organisations that provide subsidised aged care services to older people in Australia. However, this issue is often clouded by different measures of profitability, which reveal different aspects of organisations' financial performance.

The left panel of Figure 12 shows that nearly two-thirds (63.9%) of providers within the December 2022 dataset are operating at a loss. These providers reported a negative Operating Result[96] (also known as 'Net Profit Before Tax') for the first six months of the financial year as their total operating expenses exceeded their total operating revenue. This operating measure excludes the more volatile non-recurrent income and expenses, enabling more meaningful year-on-year comparisons.[97]

96. Operating Result generally refers to the Net Profit Before Tax (NPBT) earned by an approved provider, but excludes non-recurrent revenues and expenses. By comparison, the Total Result shows the Operating Result net (i.e. inclusive) of non-recurrent revenues and expenses.

97. Non-recurrent revenues and expenses refer to items including flows relating to revaluations, impairments, donations, fundraising, bequests, gains or losses on asset sales and write-off of bed licences.

Figure 12: Proportion of loss-making providers



A second measure of profit is the providers' Operating EBITDA[98] (Earnings Before Interest, Taxation, Depreciation and Amortisation). This measure allows for greater comparability between providers with different corporate structures, depreciation assumptions, financing arrangements and tax obligations. Furthermore, it tends to convey providers' profitability from operations, somewhat akin to cash flow. Like the Operating Result, it excludes non-recurrent items and all provider-level revenue and expenditure, including fundraising revenue, revaluations, donations, capital grants and sundry revenue.[99]

The right panel of Figure 12 shows that 41.7% of providers report an Operating EBITDA loss. Although this proportion is lower than the Operating Result figure, it is still cause for concern as it indicates that many surveyed providers are not generating a positive cash flow from their operations.

Table 9 shows participating providers' average profit and loss results for the first six months of the 2022-23 financial year. Overall, their financial performance has declined relative to the same period the year prior. The average reported Operating Result was down 33.5%, from a mid-year deficit of $1.2m in December 2021 to a mid-year deficit of $1.5m in December 2022. This resulted in a median profit margin of negative 2.8% and a return on assets of negative 0.9%.

98. 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.

99. When non-recurrent items are included, 35.6% of participating providers reported a negative total EBITDAR for December 2022.

Approved providers

Table 9: Average profit and loss results for approved providers

	Dec-22	Dec-21	Change (%)
Revenue			
Service revenue ($'000)	$26,470	$24,858	6.5%
Investment revenue ($'000)	$470	$274	71.9%
Total operating revenue ($'000)	$26,940	$25,131	7.2%
Expenses			
Employee expenses ($'000)	$19,445	$17,843	9.0%
Depreciation and amortisation ($'000)	$1,847	$1,738	6.2%
Finance costs ($'000)	$236	$265	(10.8%)
Other expenses ($'000)	$6,959	$6,443	8.0%
Total operating expenses ($'000)	$28,486	$26,289	8.4%
Operating Result ($'000)	**($1,546)**	**($1,158)**	**(33.5%)**
Net non-recurrent income ($'000)	$670	$804	(16.6%)
Total Result ($'000)	**($876)**	**($355)**	**(147.1%)**
Operating EBITDA ($'000)	**($114)**	**$413**	**(127.6%)**
Net non-recurrent income ($'000)	$670	$804	(16.6%)
EBITDA ($'000)	**$556**	**$1,216**	**(54.3%)**
Ratios (Medians)			
Profit Margin (Operating Result)	(2.8%)	(3.0%)	0.2%
Profit Margin (Operating EBITDA)	1.8%	3.0%	(1.2%)
Return on Assets (Operating Result)	(0.9%)	(0.9%)	0.0%
Return on Assets (Operating EBITDA)	0.6%	0.8%	(0.2%)
Wages to revenue (%)	71.3%	71.2%	0.1%
Median salary expense per FTE	$48,585	$44,858	8.3%

The average reported Operating EBITDA results likewise show providers' financial performance worsening. During the first six months of the 2022-23 financial year, the average Operating EBITDA was negative $114k, 127.6% lower compared to a $413k surplus a year prior.

Furthermore, the median Operating EBITDA profit margin decreased to 1.8% (December 2022) from 3.0% (December 2021). This comparatively small margin suggests that a given provider will generate just $1.80 of margin for every $100 of revenue earned before accounting for further costs relating to depreciation, amortisation, interest, tax and rent.

The median Operating EBITDA return on assets has declined to just 0.6% as of December 22. This modest (low) return on investment substantiates growing concerns about the sector's financial sustainability, especially as most not-for-profit providers report assets at their cost, not replacement values.

Providers' profitability has declined because costs have grown faster (8.4% year-on-year growth) than revenue (7.2% year-on-year growth). The largest area of expenditure continues to be employee wages, salaries and benefits, which account for 71.3% of total operating revenue.[100]

Wage pressures are evident in the growth of the median salary expense per full-time equivalent (FTE) employee, which grew 8.3% from $44,858 per FTE in December 2021 to $48,585 in December 2022.

Liquidity and capital adequacy

Approved providers' balance sheet figures provide an aggregate perspective on the value of their assets, liabilities and owners' equity, as well as their liquidity and capital adequacy risk profiles.

Approved providers must maintain access to sufficient liquid funds (i.e., cash, financial assets or lines of credit) to meet their debt obligations, which include repaying refundable accommodation deposits (RADs). Furthermore, providers are expected to maintain sufficient capital adequacy, which means they have sufficient net assets to absorb unexpected losses. The Government has introduced a new Financial and Prudential Monitoring, Compliance and Intervention Framework, with minimum liquidity and capital adequacy ratios expected as part of the new aged care Act.[101]

However, managing liquidity and capital adequacy risk must be balanced against sufficient investment in new and refurbished capital assets such as equipment, information systems, property and buildings that enable providers to provide high quality aged care services into future.

100. The wages to revenue ratio is calculated by dividing the total of salaries and employee benefits, including management fees, by total revenue.

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

Approved providers

Table 10: Average balance sheet figures for approved providers

	Dec-22	Dec-21	Change (%)
Assets			
Cash and Financial Assets ($'000)	$33,957	$35,587	(4.6%)
Operating assets ($'000)	$8,915	$8,164	9.2%
Property assets ($'000)	$120,406	$113,580	6.0%
Right of use assets ($'000)	$2,095	$2,300	(8.9%)
Intangibles – other ($'000)	$554	$859	(35.5%)
Intangibles – bed licences ($'000)	$1,032	$2,350	(56.1%)
Total assets ($'000)	$166,960	$162,840	2.5%
Liabilities			
Refundable loans – residential ($'000)	$50,160	$48,853	2.7%
Refundable loans – retirement living ($'000)	$41,613	$36,843	12.9%
Home care packages unspent funds liability ($'000)	$1,045	$1,793	(41.7%)
Borrowings ($'000)	$5,779	$6,290	8.1%
Other liabilities ($'000)	$17,134	$17,195	0.4%
Total liabilities ($'000)	$115,731	$110,975	(4.3%)
Net assets ($'000)	$51,229	$51,864	(1.2%)
Net tangible assets ($'000)	$49,643	$48,656	2.0%
Ratios (Medians)			
Liquidity (%)	33.9%	37.3%	(3.3%)
Capital adequacy (%)	34.8%	35.1%	(0.3%)
Property assets as a proportion of total assets	65.1%	64.3%	0.8%

Table 10 reports on approved providers' average balance sheet figures as of December 2022. It shows that providers' total asset base grew by 2.5% over the last 12 months. While cash and financial assets contracted, both operating and property assets increased.

The asset class with the most significant decline was bed licenses, with the average value declining by 56.1% between December 2021 and 2022. This likely reflects the impairment and write-down of these intangible assets during the period leading to the end of Aged Care Approvals Rounds (ACAR) in 2024. This rate of decline is likely to be much more pronounced for for-profit providers, who historically have tended to report a much higher value of bed licenses on their balance sheets. For example, as of June 2021, sector statistics show that bed licenses were valued at 9% of for-profit providers' total asset base, whereas for not-for-profits, they comprised only 3%.[102]

Regarding providers' debt position, Table 10 shows a 4.3% annual increase in the average value of total liabilities, driven up by increases in refundable loans and borrowings. The results also show a fall in providers' unspent fund liabilities. This reflects the outcome of the *Improved payment arrangements for home care policy*, whereby the unspent balance of home care clients' package subsidy is now predominantly held by Services Australia. Although providers no longer bear the liability, as the Home Care analysis later in Part 2 shows, the total value of unspent funds continues to grow.

The key balance sheet ratios show a slight deterioration in providers' liquidity[103] due to the contraction in cash coupled with increased liabilities. Although the ratio (33.9%) is well above the generally expected thresholds of 15-20%, the sector's long-term sustainability will be compromised if providers cannot generate cash flows from operations to sustain investment in assets and meet their financing obligations. The December 2022 results also show that capital adequacy[104] has remained steady, with only a slight 0.3% fall year-on-year.

102. Department of Health and Aged Care (2022), *Financial Report on the Australian Aged Care Sector 2020-21*.

103. Liquidity is calculated as the total of cash, cash equivalents and financial assets, divided by total liabilities minus lease liabilities.

104. Capital adequacy is calculated the net tangible assets divided by total tangible assets (i.e. intangible assets are excluded).

Approved providers

Analysis by provider type

As noted above, approved providers comprise a diverse range of organisational entities, from small providers that operate one aged care home or one home care service to large corporations that offer a diversified range of aged care services (residential, home care, CHSP) as well as retirement living, in multiple locations around the country.

This diversity of providers' scale and scope can make interpreting overall financial statistics somewhat challenging. To address this issue, UARC has developed the following typology (Figure 13). This differentiates providers based on the scale of their operations (the number of aged care homes they operate) and the diversification of their service offering (i.e. whether they offer residential care only, home care only, or a more diversified range of services to older people).[105]

Figure 13: Typology of approved providers by provider scale and service diversification

Number of residential aged care homes	Provider types	
20+	Large chain providers	
7–19	Medium chain providers	
2–6	Small chain providers (residential care only)	Small chain providers (diversified)
1	Single-home providers (residential care only)	Single-home providers (diversified)
0	Home care only providers	

Table 11 shows the key financial indicators of providers within the December 2022 dataset, as grouped by provider typology. These results show substantial variation in the financial performance of providers, with different patterns depending on the measure of profit used. Note that the large and medium chain categories have been combined for this report due to sample size restrictions.

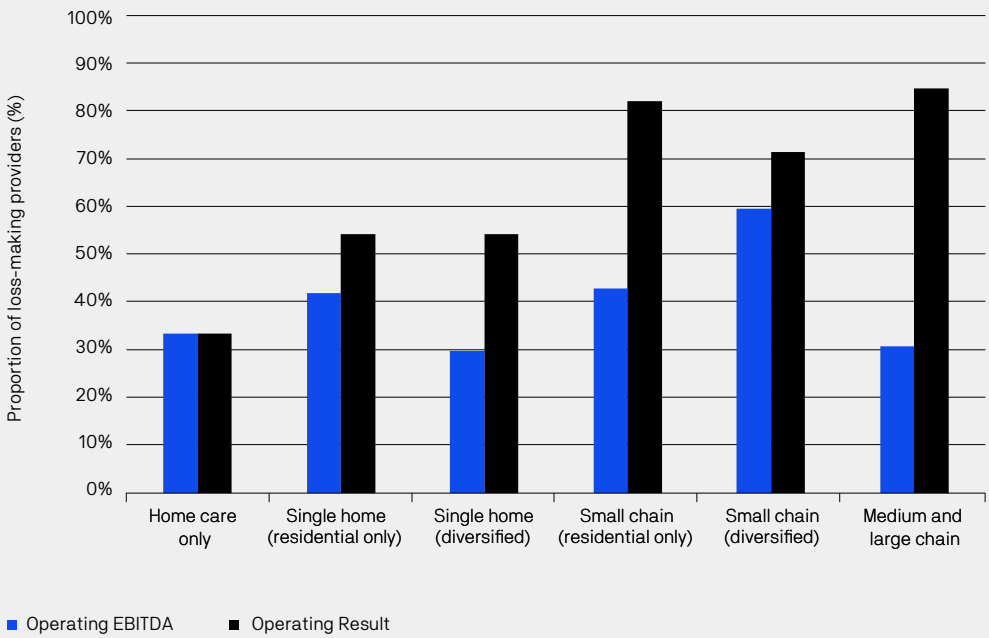
105. Diversification is measured by a providers' residential care revenue as a proportion of aged care service revenue. Providers that have more than 99% of their service revenue from residential care are classified as 'residential only', the remainder are classified as 'diversified'. Given that the vast majority of medium and large chains are diversified, these categories are only defined through their scale.

Table 11: Key performance indicators of approved providers, by provider type

	Home care only	Single-home (residential only)	Single-home (diversified)	Small chain (residential only)	Small chain (diversified)	Medium and large chain
Number of providers in data set	9	74	37	28	42	26
Financial performance						
Proportion of loss-making providers (Operating Result)	33.3%	54.1%	54.1%	82.1%	71.4%	84.6%
Proportion of loss-making providers (Operating EBITDA)	33.3%	41.9%	29.7%	42.9%	59.5%	30.8%
Profit Margin (Operating Result)	1.6%	(2.3%)	(2.0%)	(5.4%)	(4.8%)	(3.9%)
Profit Margin (Operating EBITDA)	3.3%	2.2%	4.7%	1.9%	(1.8%)	1.5%
Return on Assets (Operating Result)	0.6%	(0.8%)	(0.3%)	(1.7%)	(1.9%)	(1.4%)
Return on Assets (Operating EBITDA)	1.3%	0.8%	0.6%	0.4%	(0.1%)	0.6%
Liquidity (%)	92.5%	59.2%	39.6%	20.2%	23.5%	18.6%
Capital adequacy (%)	61.4%	37.3%	36.4%	15.6%	37.5%	30.3%
Staffing						
Average number of staff (headcount)	1,038	141	149	339	512	2,708
Average number of full-time equivalent staff (FTEs)	675	87	90	163	330	1,743
Wages to revenue (%)	64.1%	71.8%	69.0%	71.6%	73.7%	73.7%
Median salary expense per FTE	$48,197	$47,178	$45,659	$50,058	$50,284	$50,549

Approved providers

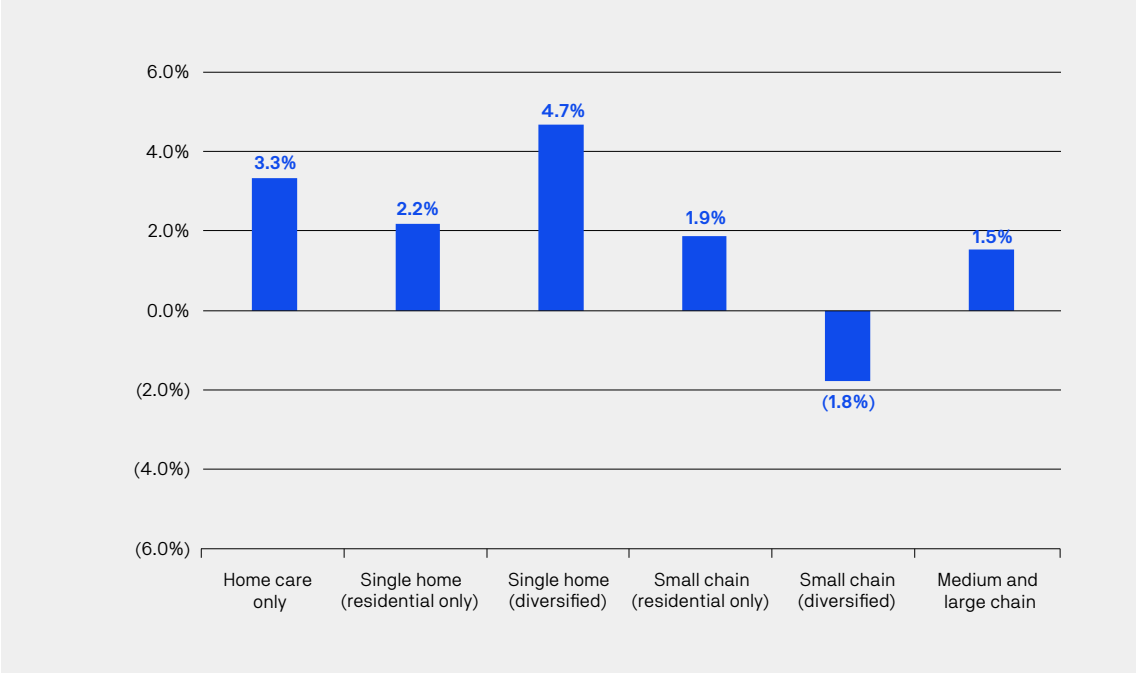
Figure 14: Proportion of loss-making providers, by provider type



In terms of operational performance, the most comparable measure of profit across providers is Operating EBITDA, as this removes the effects of differences in tax status, accounting assumptions and financing arrangements. According to this measure, the providers experiencing the greatest financial difficulty are 'small chain' providers (i.e., operating between two and six residential homes), particularly those delivering other aged care services. The blue columns in Figure 14 show that 59.5% of 'small chain diversified' providers reported a negative Operating EBITDA for December 2022, as did 42.9% of small chains which only deliver residential care.

Table 11 also indicates that small chain providers are most at risk from a liquidity and capital adequacy perspective, with median values approaching the minimum thresholds of 15–20%.

Figure 15: Operating EBITDA margin, by provider type



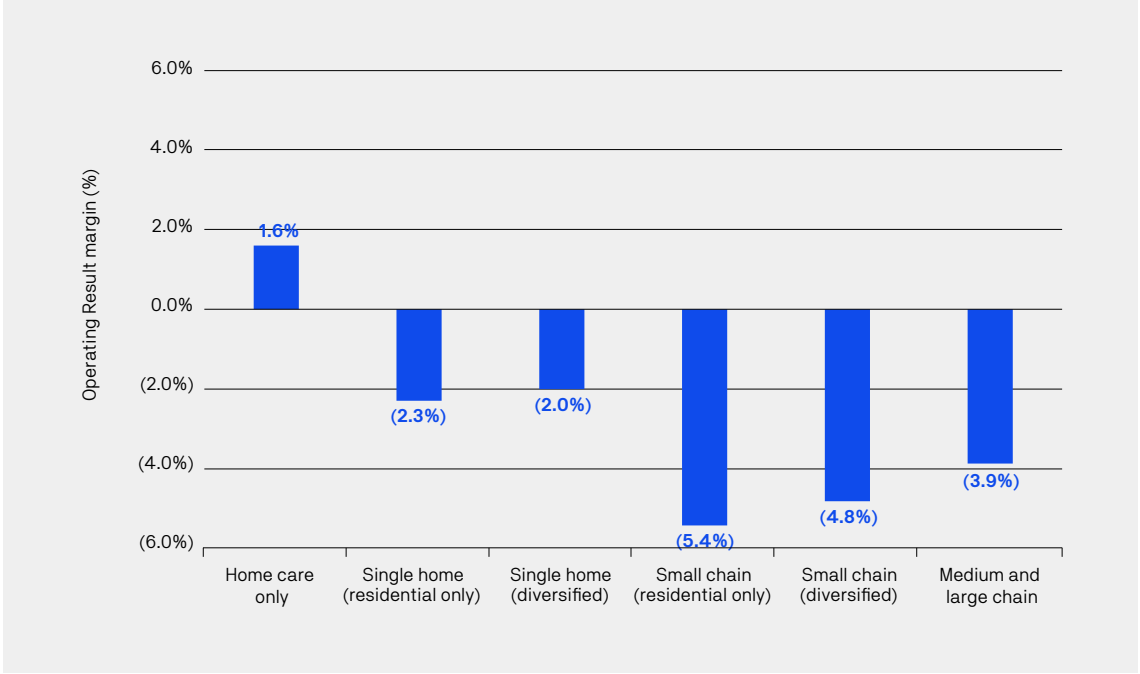
Likewise, as shown in Figure 15, the median Operating EBITDA margin of diversified small chain providers is negative 1.8%, whereas all other categories have a positive EBITDA profit margin. By comparison, only 30.8% of medium and large chain providers (most diversified) reported a negative Operating EBITDA, with a median profit margin of 1.5%.

However, as Operating EBITDA will mask the effects of different levels of investment in capital infrastructure, it is also helpful to consider measures of profit that include the cost of depreciation and amortisation. Figure 14 shows a slightly different pattern when profit is measured using Operating Result (Net Profit Before Tax). Whereas a high proportion of small chain providers, both residential and diversified, are operating at a loss (71.4–82.1%), so too are medium and large chain providers (84.6%).

This pattern is also reflected in Figure 16 which shows the median Operating Result margin by type. Specifically, the categories with the lowest operating profit margins are all chain providers operating two homes or more.

Approved providers

Figure 16: Operating Result margin, by provider type



There are two other notable trends in the preceding analyses. First, providers that do not have residential care homes ('home care only providers') tend to have better financial performance than most other categories, with lower rates of loss-making and higher rates of profit margins and return on assets. However, given the small sample size, this category's results should be interpreted cautiously.

Second, the financial performance of single-home operators tends to be higher than those that operate two or more homes, resulting in more favourable profit margins and returns on assets. This is particularly the case when profit is measured using Operating Result, which accounts for depreciation, interest and amortisation expenses. There may be several reasons for this, such as certain diseconomies of scale, particularly within smaller chains. There may also be some effect of 'survivor bias' where single-home providers with persistent negative returns are less likely than larger providers to absorb losses and continue operating. Nonetheless, this result warrants further investigation, particularly given the trend towards consolidation across the sector.

The providers experiencing the greatest financial difficulty are 'small chain' providers, which operate between two and six residential homes.

Residential aged care homes

Residential care analysis

Overview

- Residential aged care homes continue to report poor financial performance. In the first half of 2022-23, over 63% of homes operated at a loss, with an average deficit of $17.47 per resident per day. This is substantially worse than the deficit of $11.34 from a year prior. Homes' current poor performance continues a deteriorating long-term trend.

- Occupancy has continued to fall to a new low national average of 90.9%.

- Direct care staffing minutes have increased to an average of 186.2 minutes per resident per day. This is still short of the sector average 200 care minute target that will be mandatory from October 2023.

- Homes' poor average Operating Result is comprised of a small positive margin of $4.17 per resident per day for direct care services, consumed by larger losses for indirect care (loss of $7.37) and accommodation (loss of $14.26).

- In the last four years, administration costs have grown by 35.2%, far outpacing the indexation of taxpayer-funded aged care subsidies, inflation and wage growth.

- While the AN-ACC funding model has positively addressed some financial disparities for the most remote homes in the sector, that same model has contributed to regional homes experiencing acute financial viability concerns.

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. This dataset, comprising 1,099 homes,[106] represents 41.1% of Australia's 2,671 residential aged care homes and 41.0% of the 219,965 operational beds.[107]

Table 12: Profile of surveyed residential aged care homes

	Dec-22	Dec-21
Number of homes in data set	1,099	1,192
Total number of beds in data set	90,215	96,564
Average home size (number of beds)	82	81
Ownership		
For profit	11.2%	11.1%
Not for profit	88.8%	88.9%
Location		
Major city	64.1%	64.0%
Inner regional	25.3%	25.6%
Outer regional, rural & remote	10.6%	10.4%
Homes operated by providers of different scales		
Single home	11.2%	11.3%
2-6 homes	20.8%	22.5%
7-19 homes	27.0%	29.5%
20+ homes	40.9%	36.7%
Home size		
Less than 40 beds	9.5%	9.1%
40-80 beds	42.9%	45.5%
80-120 beds	30.4%	28.1%
More than 120 beds	17.2%	17.4%

106. In total 1,138 residential aged care homes participated in the December 2022 StewartBrown survey, however as part of the data cleaning and analysis process 39 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.

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

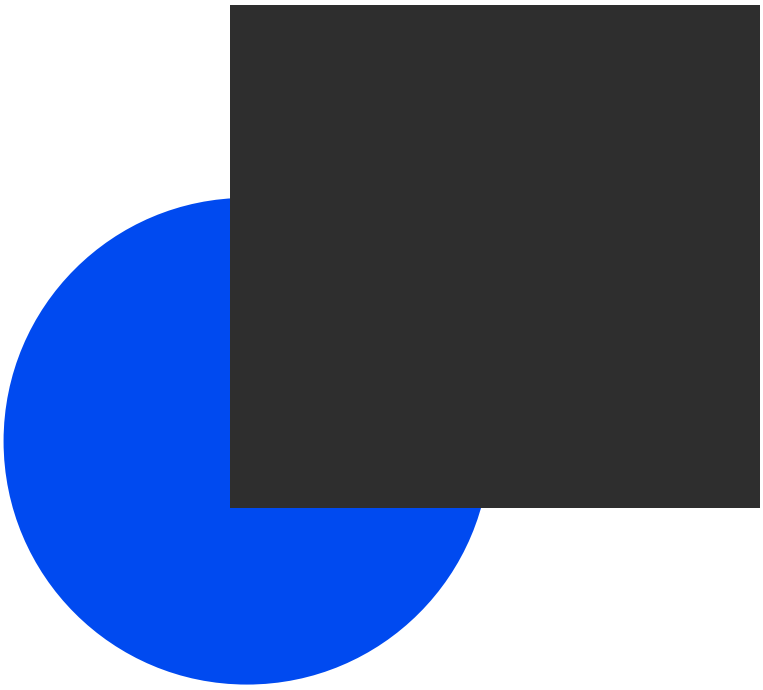
Residential aged care homes

As shown in Table 12, the average size of each home in the December 2022 dataset was 82 beds, comparable to the national average.[108] Most (88.8%) surveyed homes are not-for-profits.[109]

Regarding geographic location, the data set is generally consistent with the overall spread across the entire sector. 64.1% of the homes were located in major cities (compared to 62.5% of the national total), with 25.3% in inner regional areas (compared to 24.3% of the national total) and 10.6% in rural and remote locations (compared to 13.2% of the national total).[110]

Regarding the scale of the providers operating the aged care homes, the dataset is slightly weighted towards homes operated by larger providers. For example, while standalone single homes comprise 19.3% of all aged care homes nationally, they represent 11.2% of homes in the dataset. Conversely, while homes operated by large providers (20+ homes) comprise 34.4% of all homes nationally, they account for 40.9% of the dataset.[111]

Likewise, in terms of home size, the dataset is underweighted for small homes (less than 40 beds). These homes comprise 19.1% of all aged care homes nationally; however, they represent 9.5% of homes in the dataset. Nonetheless, the proportion of homes larger than 80 beds (47.6%) is similar to that in the national statistics (44.8%).[112]



108. Department of Health and Aged Care (2022), *Aged care data snapshot—2022, Third release*, Australian Institute of Health and Welfare.
109. The weighting towards non-for-profit providers is due to the absence of several large listed for-profit providers from the survey and the acquisition of for-profit homes by non-profit providers. State government-operated homes are also not included in the data set.
110. Department of Health and Aged Care (2022), *Aged care data snapshot—2022, Third release*, Australian Institute of Health and Welfare.
111. Note these statistics relate to population characteristics at June 2021, as reported in the *Financial Report of the Australian Aged Care Sector 2020-21*.
112. Note these statistics relate to population characteristics at June 2021, as reported in the *Financial Report of the Australian Aged Care Sector 2020-21*.

Key performance indicator summary

Table 13: Key performance indicators of residential aged care homes

	Dec-22	Dec-21
Operating Result (per resident per day)	($17.47)	($11.34)
Operating Result (per bed per annum) *	($5,323)	($3,437)
Operating EBITDA (per bed per annum) *	$1,975	$3,139
Proportion of loss-making homes (Operating Result)	63.1%	60.5%
Proportion of loss-making homes (EBITDA)	41.6%	35.2%
Occupancy rate	90.9%	91.6%
Supported resident ratio	45.3%	45.8%
Average direct care revenue (per resident per day)	$208.31	$193.70
Average direct care expenditure (per resident per day)	$204.14	$190.02
Direct care expense ratio	98.0%	98.1%
Average direct care minutes (per resident day)	186.2	178.0
Average of full RADs held at reporting date	$406,012	$384,408
Average of new full RADs taken during period	$459,096	$444,848

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

Financial performance

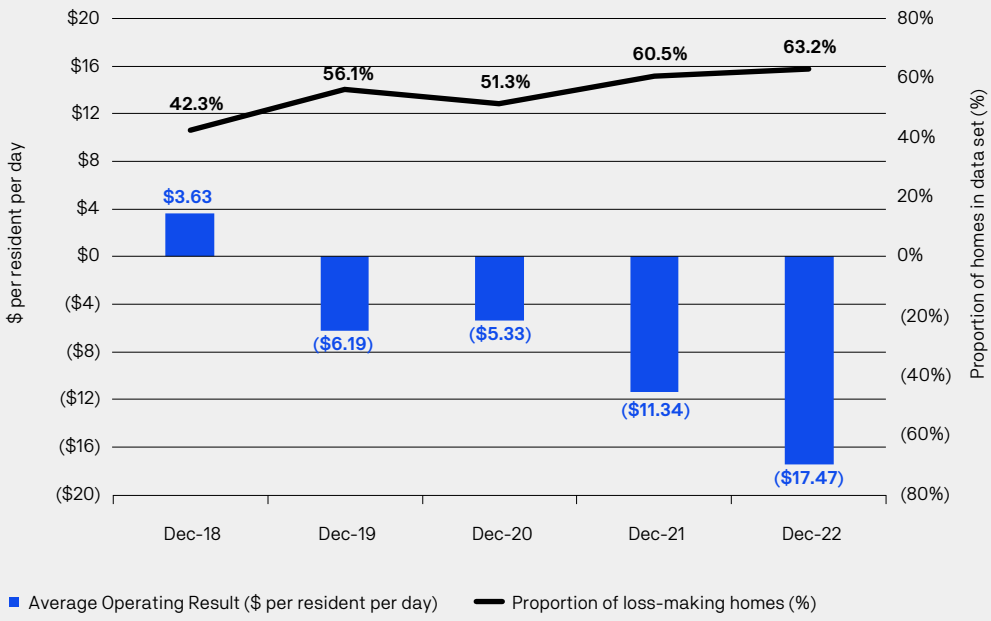
The financial performance of aged care homes directly impacts the sector's overall sustainability. Although unprofitable homes may continue to operate if owned by larger providers that can cross-subsidise losses with margins earned from providing other services such as home care, this might not be possible for single-home operators or small-scale providers. Furthermore, regardless of provider scale, homes in financial distress are at greater risk of closure, which may undermine reliable access to services for older people, 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 accommodation standards and to ensure the supply capacity to meet the needs of Australia's ageing population.

In this context, the worsening financial performance of residential aged care homes in 2022-23, compared to the previous year and over the last five years, is cause for considerable concern.

Residential aged care homes

Figure 17: Average Operating Result and proportion of loss-making homes



As shown in Figure 17 there has continued to be a substantial decline in the financial performance of residential aged care homes. The mid-year (December 2022) results show that, on average, homes' Operating Result[113] was a deficit (loss) of $17.47 per resident per day. This is an increase of over 50% compared to December 2021 ($11.34) and more than three times the deficit of $5.33 for the same period two years prior (December 2020).[114] In addition, as of December 2022, 63.2% of homes in the data set were operating at a loss[115], a further increase from 60.5% for the year prior.

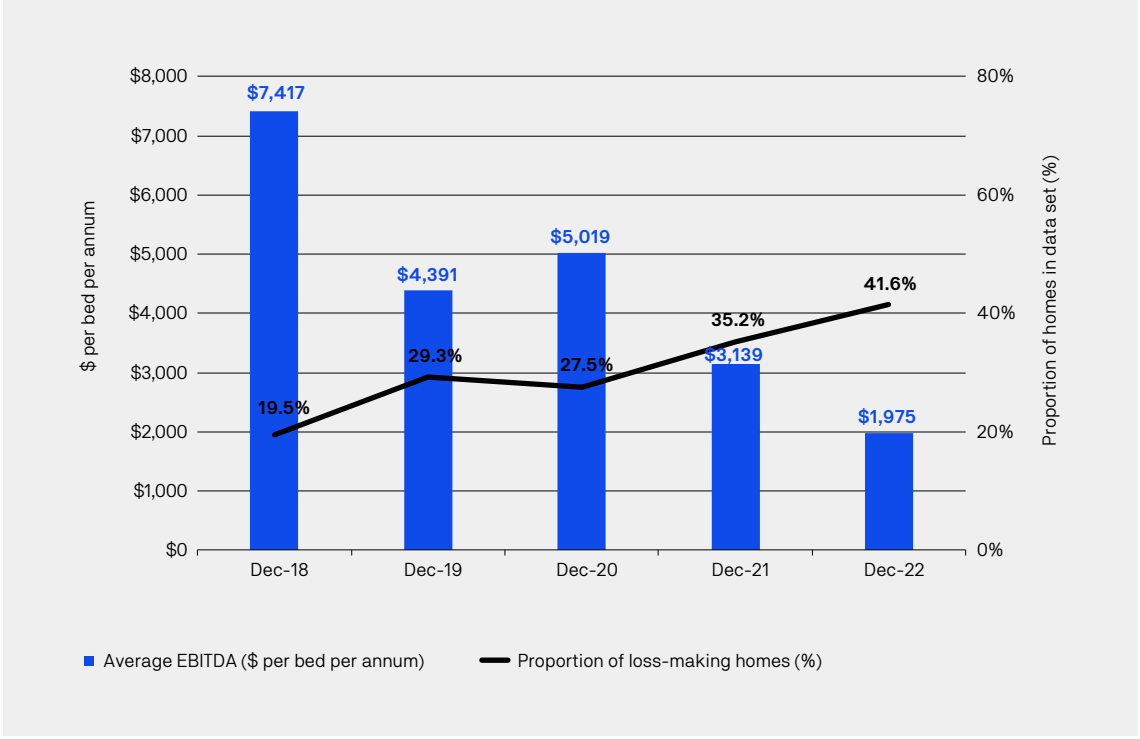
The results continue a long-term trend of worsening financial performance of residential aged care homes. Although there was some stabilisation in 2020-21 (partly due to additional pandemic-related funding flows), there have been declines since, despite substantial ongoing increases in government funding, such as through the BDF supplement and the new AN-ACC funding model.

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

114. The UARC estimate for average Operating Result (negative $17.47 per resident per day) is $1.49 lower than the StewartBrown estimate (negative $15.98 per resident per day). This difference arises from methodological differences in the way averages are calculated, where the UARC estimate reflects home-level average and the StewartBrown estimate reflects a bed-level average. The UARC estimate is lower as it gives relatively more weight to the poor financial results of small homes than have fewer beds. For more information please see the methodological guidance provided in Appendix.

115. An Operating Loss occurs when an aged care home's Operating Result (i.e., NPBT) is below zero.

Figure 18: Average Operating EBITDA and proportion of loss-making homes



Aged care homes' Operating EBITDA[116] has exhibited a similar trend over the last five years (Figure 18). Operating EBITDA declined by 37.1% relative to the same period year-on-year, to an average of $1,975 per bed per annum. As of December 2022, the proportion of homes recording an Operating EBITDA loss[117] increased to 41.6%, up from 35.2% in December 2021.

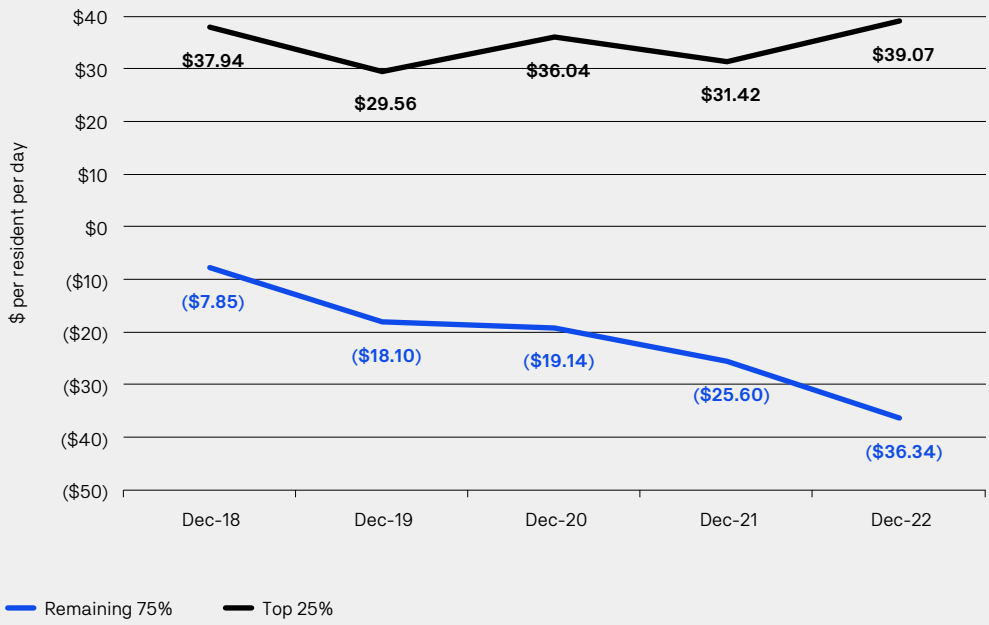
The rising proportion of homes recording Operating EBITDA losses is concerning as this measure of profitability generally reflects the cash surplus that could cover the costs of refurbishing buildings and equipment and improving service delivery models. Homes that record an Operating EBITDA loss will need alternative sources of revenue, capital or cash flows, such as investment and fundraising revenues or returns from RADs, 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 few homes). In such circumstances, an Operating EBITDA loss may necessitate a draw down on their asset base and jeopardise their long-term financial viability. In such cases, homes that lack access to sufficient cash or capital are at greater risk of closure.

116. 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.

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

Residential aged care homes

Figure 19: 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 19 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% varies marginally around a slightly rising trend, 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, $75.41 more per resident per day than the remaining 75% in the first six months of 2022-23.

As was discussed in Part 1, several factors could explain this variation in homes' financial outcomes. For instance, substantial differences exist in the Operating Results of homes of different occupancy levels, locations, ownership, and residents' care needs. In addition, top-performing homes may also benefit from more experienced managers, alternative business models and efficiencies in their built infrastructure. Furthermore, as noted in Part 1, the difference between the top 25% and the remaining 75% likely reflect temporary differences in direct care staffing levels. UARC anticipates that the margin of the top 25% will reduce as homes increase their staffing levels to align with the care minute targets by October 2023.

Occupancy

Occupancy is an important indicator within the residential aged care sector, indicating the expressed demand for residential aged care relative to its supply. At a more disaggregated level, occupancy may reveal consumer preferences for some aged care homes relative to others.

Figure 20: Occupancy rate

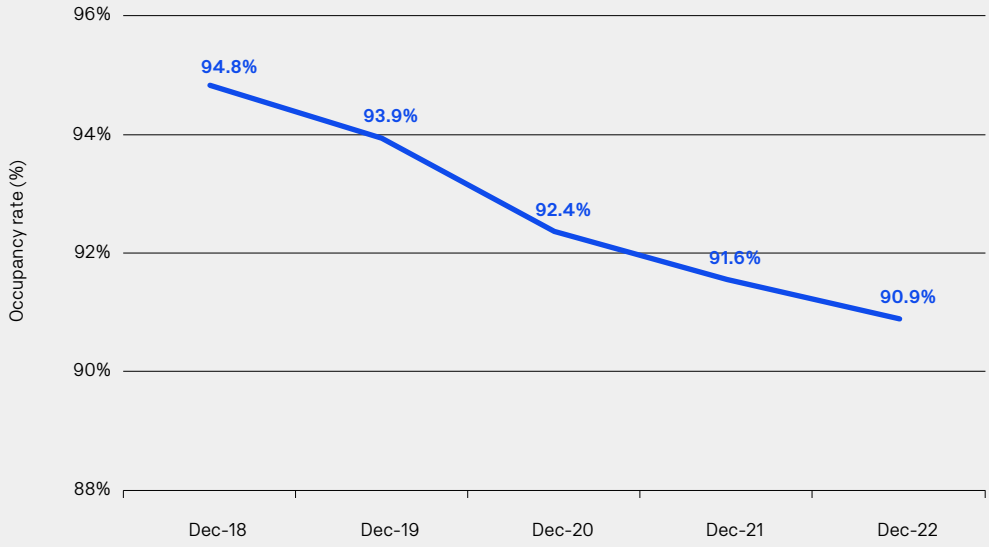


Figure 20 shows that the average occupancy rates have continued to decline, down to 90.9% as of December 2022.[118] This decline has been experienced in all states other than Victoria (which still has the lowest average occupancy) and not for the two territories states and territories.

The long-term downward trend 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),[119] while the total number of people with HCPs has grown by 156% (143,752 packages).[120]

118. 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.

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

120. 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 (235,599) is as of 31 December 2022.

Residential aged care homes

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 older Australians with complex care needs, such as dementia, increases over time.[121]

This demand concentration is already evident in the growing proportions of current residents classified as having more acute and complex care needs.[122] However, the long-term growth in demand may also be influenced by the realisation of consumers' preferences to receive 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.[123]

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' strategic investments in the location and quality of supply.[124]

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

122. 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.

123. 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

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

Workforce

The aged care workforce 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.

In the first six months of 2022-23, the total amount of direct care staffing has increased by 4.6% compared to a year prior (see Table 14). On average, homes provided an additional 8.2 minutes of total direct care time[125] per resident per day, up to 186.2 minutes as of December 2022.[126] This comprised uplifts in registered nurses and personal care workers but also a decline in the staffing minutes of enrolled nurses.

Table 14: Staffing metrics of residential aged care homes

	Dec-22	Dec-21
Number of homes in data set (workforce analysis)	1,093	1,165
Direct care minutes (per resident per day)		
Registered nurses	31.6	28.2
Enrolled and licensed nurses	13.1	16.3
Personal care workers/other unlicensed care staff	141.4	131.7
Imputed agency care minutes	0.2	1.9
Total direct care minutes (per resident per day)	186.2	178.0
Other care-related minutes (per resident per day)		
Care management	6.3	8.5
Allied health	5.9	5.3
Lifestyle	6.7	7.2
Total other care-related minutes (per resident per day)	18.9	21.1
Average total care-related minutes (per resident per day)	205.3	199.1

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

The average staffing time of other care-related roles contracted slightly year-on-year, from 21.1 minutes per resident per day in December 2021 to 18.9 minutes in December 2022. While allied health time increased slightly (to 5.9 minutes per resident per day in December 2022), both care management (6.3 minutes) and lifestyle roles (6.7 minutes) contracted.

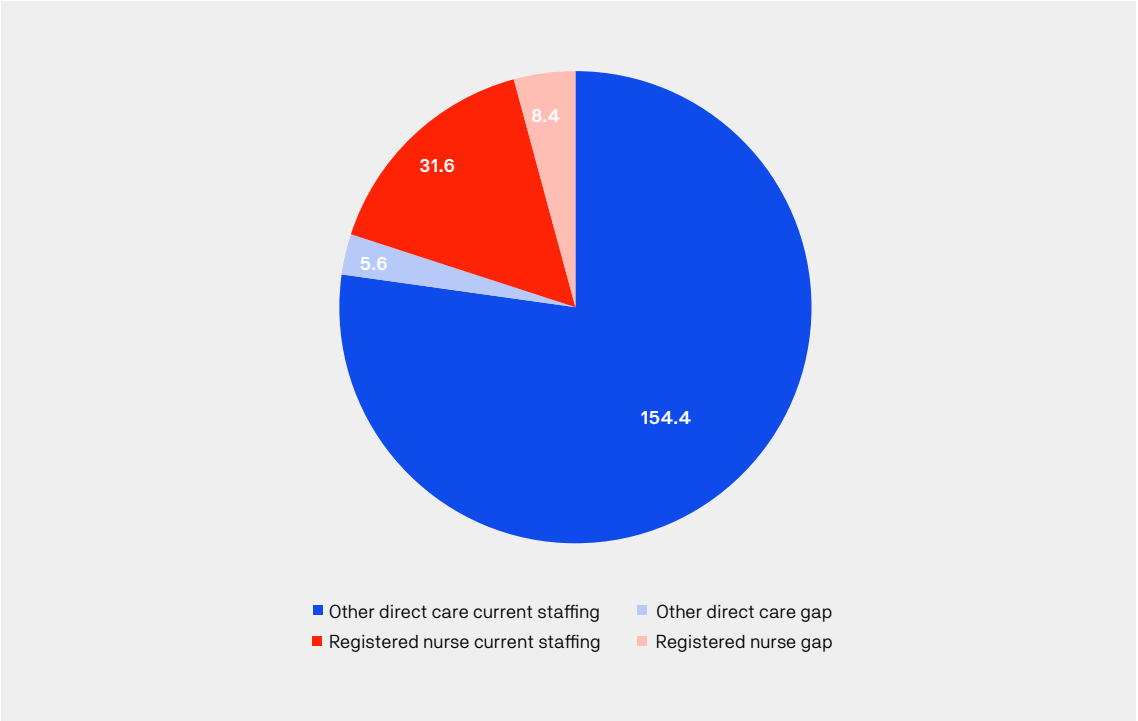
125. Direct care time is a measure of the staffing hours (both normal and overtime) of registered nurses, enrolled nurses, and personal care workers. To allow comparisons between homes, it is measured as an average rate per resident per day. It does not measure the actual time spent with each resident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

126. 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.

Residential aged care homes

As discussed in Part 1, in 2023, 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 from 1 October 2023.[127] In addition, from 1 July 2023, all homes will be required to have a registered nurse on-duty at all times, with exemptions for some homes based on location and size.

Figure 21: Average direct care minutes per resident per day, current staffing and estimated gap

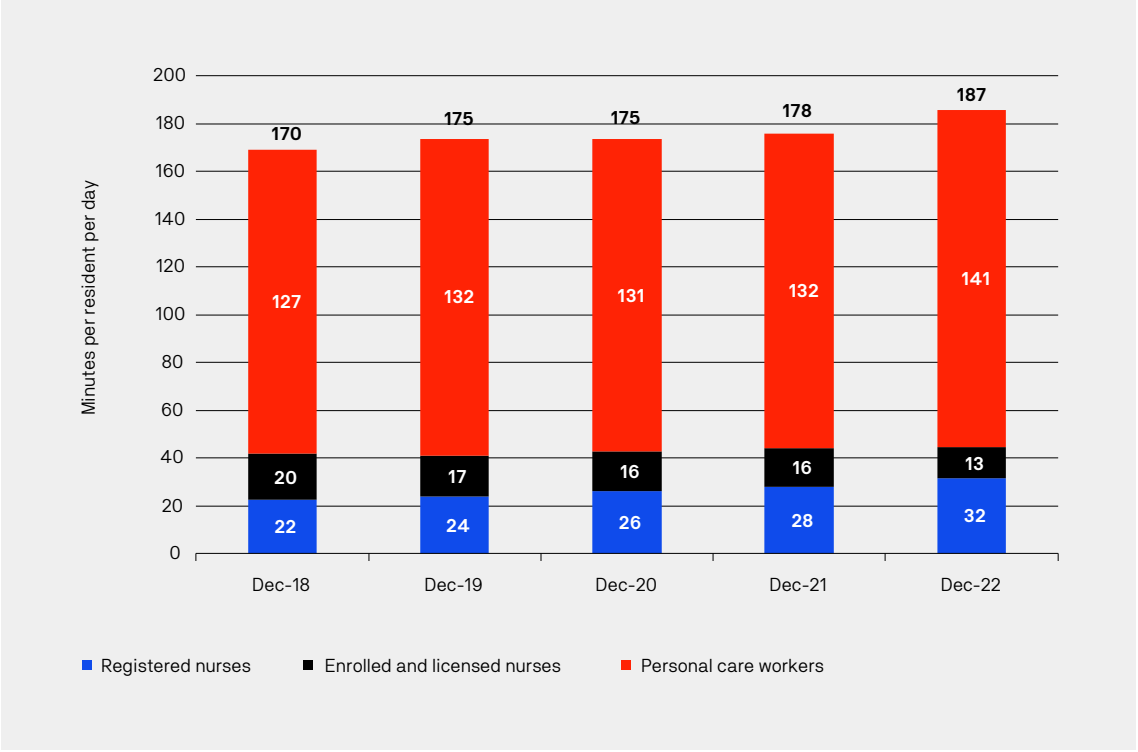


As shown in Figure 21, to reach these sector averages, homes will need to increase registered nurse staffing by an average of 8.4 minutes per resident per day, with an additional increase of 5.6 minutes per resident per day from other direct care workers (i.e. personal care workers or enrolled nurses).

More detailed 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 1.

127. 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.

Figure 22: Direct care staffing minutes, by staff role



The five-year trend depicted in Figure 22 shows that the slow growth in staffing has accelerated in the last twelve months. For example, on average, the total direct care time increased by 5.1% year-on-year to December 2022, with a 12.1% increase in average registered nursing time and a 7.3% increase in personal care workers' time.

However, while the pace of growth for personal care workers is on track to meet the total direct care minutes target, reaching the sector average for registered nurses will require a further uplift of 26.6%. As discussed in Part 1, aged care providers will likely continue to encounter substantial challenges in recruiting and retaining registered nurse staff to meet the minimum standards and to be able to cover every shift every day.

Figure 22 also shows the continuation of a concerning trend, whereby the rate of enrolled nurses has declined for the fourth year, a fall of 33% since December 2018. This decline is likely attributable to the incoming minimum staffing standards specification, which does not specifically ring-fence provisions for enrolled nurses. 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.

Residential aged care homes

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 the three services offered by aged care homes:

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

Decomposing the Operating Result into these three areas (see Table 15) 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 the respective revenues and expenditures. This approach also accounts for the need for each revenue stream to contribute to the overhead costs of operating an aged care home, noting that no specific revenue stream is associated with administrative overheads.

Table 15 shows that in December 2022, homes' poor average Operating Result is comprised of a small margin from direct care services, consumed by larger losses incurred from indirect care and accommodation services.

Homes' poor average Operating Result is comprised of a small margin from direct care, which is consumed by larger losses from indirect care and accommodation services.

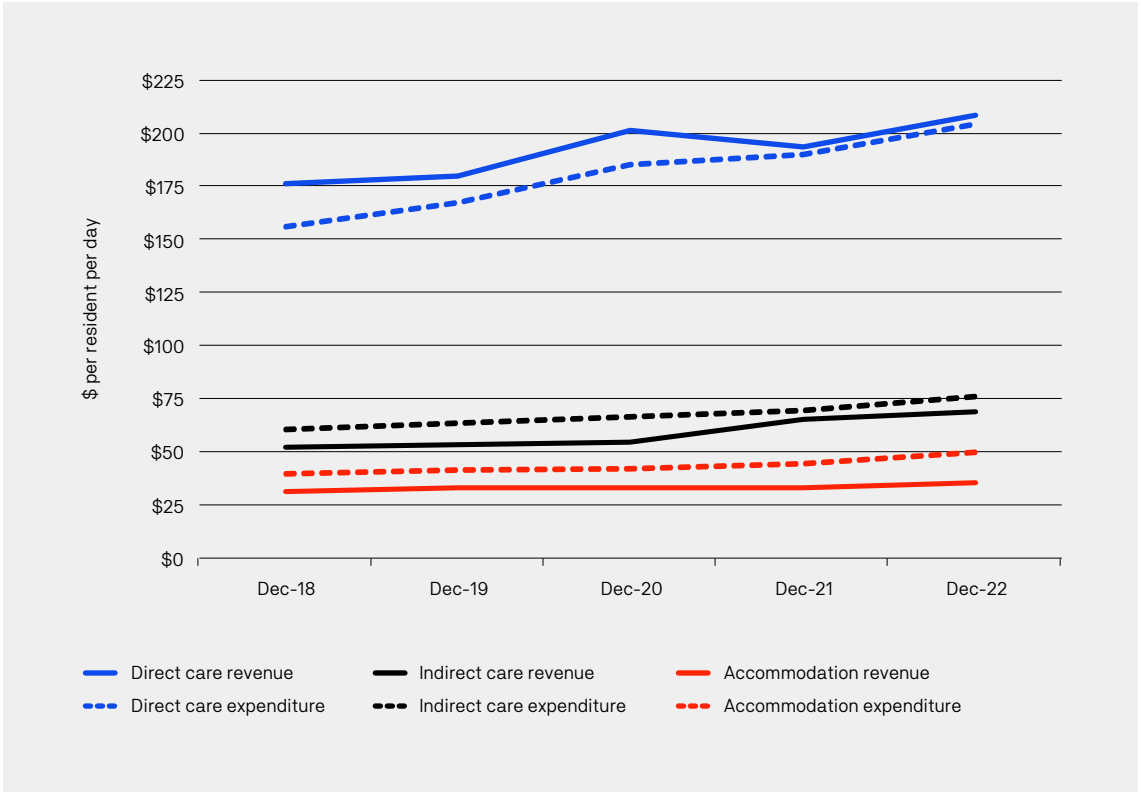
Table 15: Breakdown of average Operating Result

	Dec-22	Dec-21
DIRECT CARE		
Direct care revenue		
Residents	$6.82	$7.68
Government	$201.48	$186.01
Total direct care revenue	$208.31	$193.70
Direct care expenditure		
Direct care labour costs	$153.61	$135.10
Other labour costs	$27.36	$26.79
Other direct care costs	$6.18	$13.22
Allocation of administration costs (37.0%)	$17.11	$14.91
Total direct care expenditure	$204.26	$190.02
Direct Care Result	**$4.17**	**$3.68**
INDIRECT CARE		
Indirect care revenue		
Residents	$58.68	$55.39
Government	$9.94	$9.97
Total indirect care revenue	$68.61	$65.18
Indirect care expenditure:		
Catering	$36.79	$33.76
Cleaning	$10.14	$9.32
Laundry	$4.48	$4.25
Utilities	$7.94	$7.32
Other	$1.09	$1.00
Allocation of administration costs (33.6%)	$15.54	$13.54
Total indirect care expenditure	$75.98	$69.19
Indirect Care Result	**($7.37)**	**($4.00)**
ACCOMMODATION		
Accommodation revenue		
Residents*	$14.02	$12.63
Government	$21.31	$20.36
Total accommodation revenue	$35.33	$32.99
Accommodation expenditure:		
Depreciation	$21.42	$19.05
Property maintenance and rental	$12.95	$11.73
Other	$1.64	$1.38
Allocation of administration costs (29.4%)	$13.60	$11.85
Total accommodation expenditure	$49.61	$44.01
Accommodation Result	**($14.26)**	**($11.02)**
Operating Result (per resident per day)	**($17.47)**	**($11.34)**
Total revenue (per resident per day)	**$312.25**	**$291.87**
Total expenditure (per resident per day)	**$329.85**	**$303.22**

*Accommodation revenue from residents only includes daily accommodation payments (DAPs) and does not include imputed interest relating to refundable accommodation deposits (RADs)

Residential aged care homes

Figure 23: Average revenue and expenditure, by service type



This breakdown is also depicted in Figure 23, which shows recent trends in average revenues and expenditures of each service type, including the allocation of administrative costs. These trends are analysed in more depth below, but in summary:

- The surplus (positive margin) from direct care services was largely eliminated by December 2021, which has continued into December 2022.
- The deficit (negative margin) from indirect care services had become smaller by December 2021 following the introduction of the BDF supplement but is widening again.
- The deficit (negative margin) for accommodation services continues to increase.

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.

The December 2022 results show a slight improvement in the aged care homes' direct care results.[128] On average, homes earned $4.17 per resident per day from direct care services (with 98.0% of direct care revenues spent on direct care costs), up slightly from $3.68 in December 2021.[129]

As shown in Figure 23, direct care revenues and expenses have converged by December 2021, as the growth in direct care expenditure outpaced the growth in direct care revenue.

Previously, one of the main drivers of this convergence was the relatively low growth in direct care subsidies and supplements which were indexed at rates less than the growth in general operating costs and wages.[130] However, the December 2022 results show that introducing the new AN-ACC funding model has preserved a slight margin of (about 2.0%) in direct care.[131]

Even so, as AN-ACC is also tied to direct care minutes targets, the costs of direct care services have also increased year-on-year, particularly in terms of staffing. Table 15 above shows that compared to December 2021, the direct care labour expenditure has grown by $18.51 per resident per day (13.7%). This increase represents more staffing time per resident (as described above) and higher wage rates.

Figure 24 shows the median labour cost per hour worked by role. This shows that compared to the prior year, the cost of employing registered nurses has grown by 9.6%, enrolled nurses by 5.5% and personal care workers by 4.8%. Figure 24 also indicates that these hourly rates have accelerated in the past two financial years, coinciding with provider experiences of much more acute staff shortages, as reported in UARC's full-year 2021-22 report.

128. The Direct Care Result represents the net difference between from revenue and costs directly associated with care services. It includes direct care subsidies, supplements and grants from the government and means-tested care fees) 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.

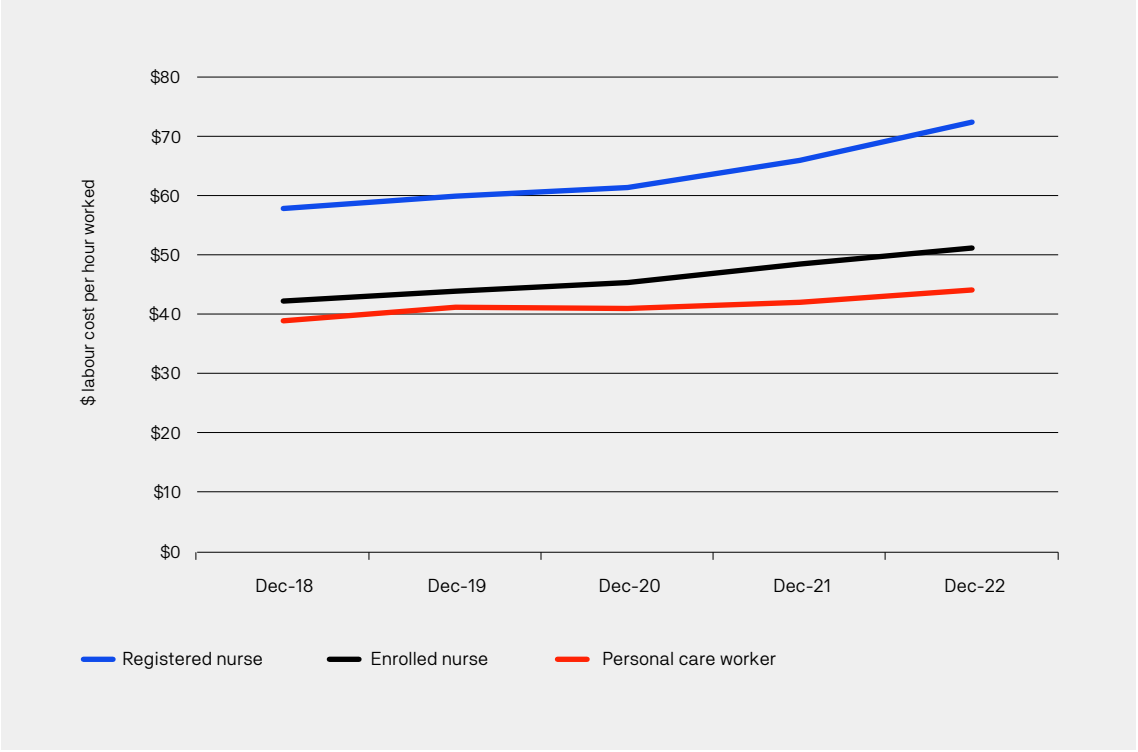
129. The direct care expenses ratio is calculated by dividing total direct care expenditure by total direct care revenue.

130. For example, in 2021-22, direct care subsidies and supplements were indexed at 1.1%, which was below the annual rates of inflation (6.1%) and wage price index (2.3%).

131. On average, homes have earned an additional $16.31 per resident per day from direct care subsidies in the first six months of the 2022-23 financial year, compared to the same period a year previous. Most of this relates to the additional funding commenced on 1 October 2022 (i.e. for the second quarter of 2022-23), although it may also reflect gradual increases in the average acuity of residents over time.

Residential aged care homes

Figure 24: Median labour cost per worked hour, by staff role



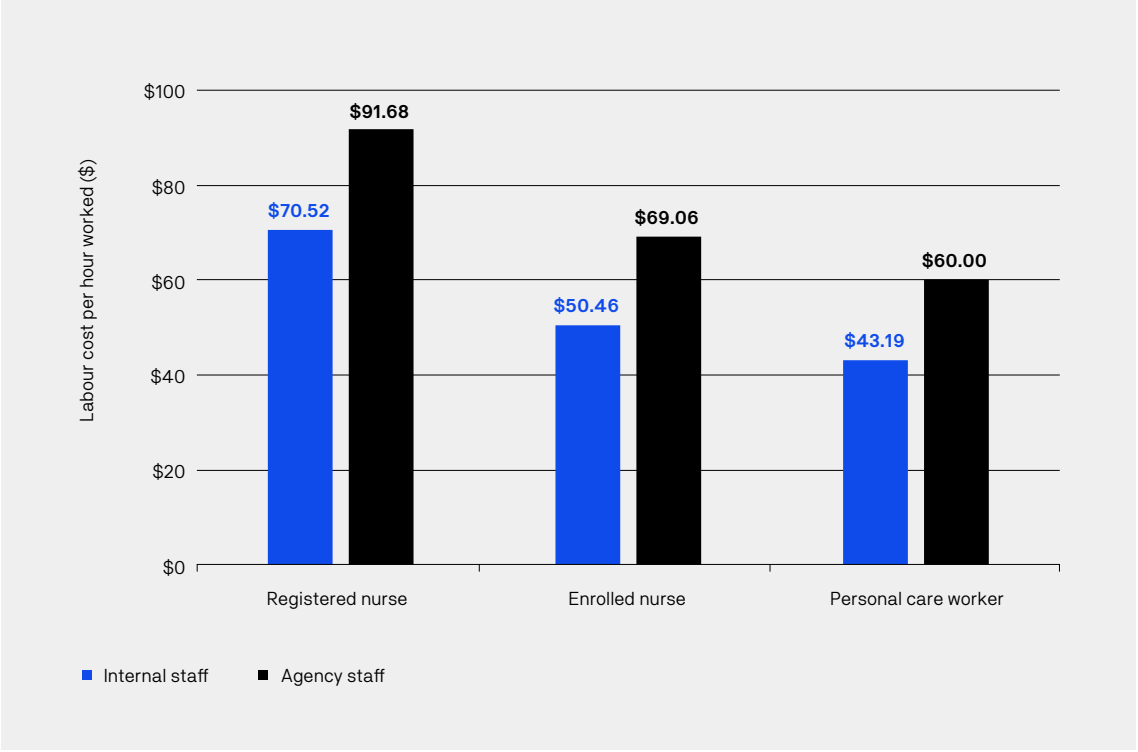
Notably, the labour rates depicted in Figure 24 are much higher than the award rates for these roles and the average contractual rates published in DoHAC's quarterly snapshot.[132] Partly this is because Figure 24 shows the expenditure per hour worked, including normal and overtime hours. More significantly, however, is that the award and contractual rates describe the minimum hourly staff rate, whereas Figure 24 shows homes' actual expenditure on labour, which also includes:

- On-costs, such as mandatory superannuation contributions, leave provisions and casual loadings.
- Penalty rates paid for overtime, noting that, on average, overtime represents 2-3% of internal employees' worked hours.
- Higher costs of agency and externally contracted staff.

The effect of agency staffing is worth unpacking further. As shown in Figure 25 the median cost per hour worked differs substantially between internal and agency staff. As of December 2022, the cost of agency direct care staff, per hour worked, was 30% higher for registered nurses, 37% higher for enrolled nurses and 39% higher for personal care workers.

132. Department of Health and Aged Care (2023), *Quarterly Financial Snapshot of the Aged Care Sector*.

Figure 25: Labour cost of internal vs agency staff



Furthermore, the gap between the rates paid for agency and internal staff is widening. As shown in Table 16, although the hourly cost increased for all staff roles in the last year, the growth rates in the cost of agency staff far outpaced that of internal staff.

Table 16: Median labour cost per hour worked, by staff role

	Dec-22	Dec-21	Change (%)
Internal staff			
Registered nurse	$70.52	$65.65	7.4%
Enrolled nurse	$50.46	$47.52	6.2%
Personal care worker	$43.19	$41.57	3.9%
Agency staff			
Registered nurse	$91.68	$77.00	19.1%
Enrolled nurse	$69.06	$59.59	15.9%
Personal care worker	$60.00	$51.29	17.0%

Residential aged care homes

Homes are more likely to bear the additional costs of agency staff as they increasingly rely on these external workers to deliver direct care. On average, agency staffing as a proportion of total hours worked represents 13.7% of registered nurse time, 13.0% of enrolled nurse time and 8.8% of personal care worker time. These rates reflect homes' ongoing needs for temporary workers during COVID-19 outbreaks, but also, as outlined in Part 1, to meet the incoming minimum requirements.

This combination of increased reliance on agency staff and the premium paid for their services has seen homes' average expenditure on agency staff, per resident per day, more than double in the last year alone and grow four-fold over the last five years.

Indirect care

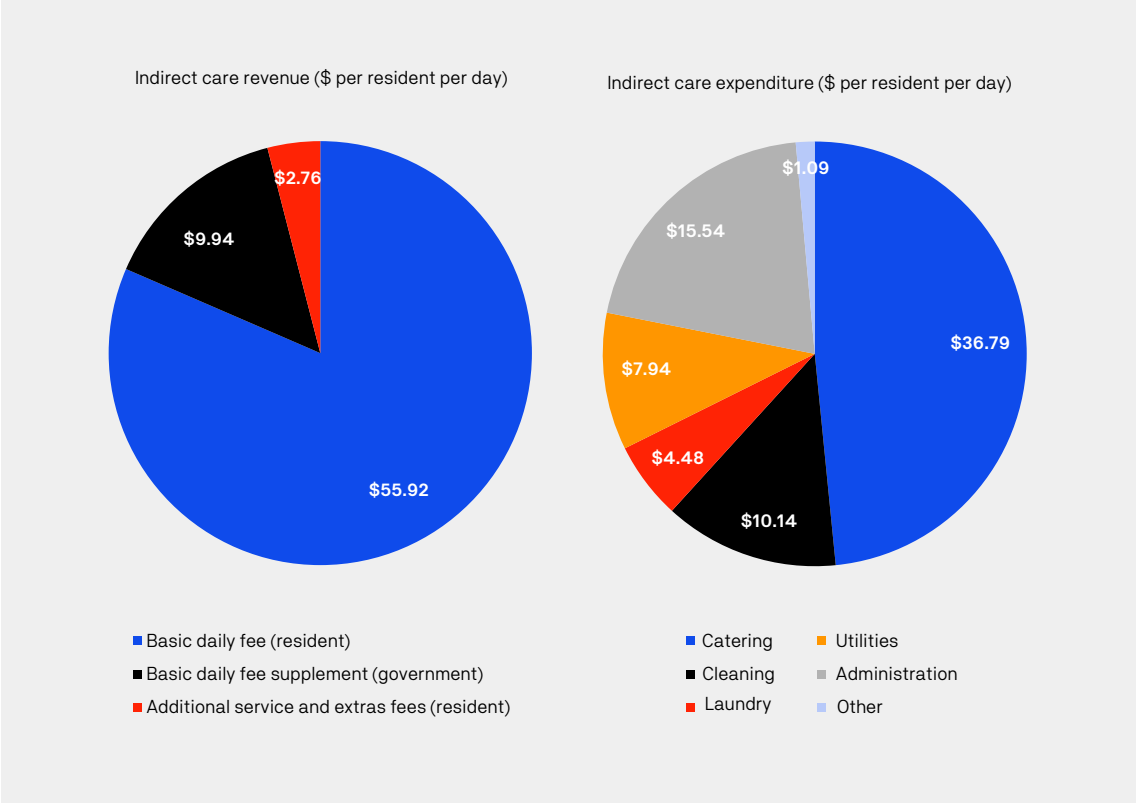
Indirect care relates to providing hotel-like services, such as food, cleaning, laundry and other everyday living amenities. As shown in Table 15, the Indirect Care Result[133] has declined year-on-year. Homes now lose, on average, $7.37 per resident per day (compared to losing $4 per day in December 2021).

This decline has occurred because while revenue has increased steadily, it has been outpaced by the growth in expenditure. Referring to the left panel of Figure 26, indirect care's most significant revenue component is the basic daily fee collected from residents. This is capped at 85% of the age pension, regardless of the means of each resident. Thus, it grows at the same rate as the age pension, which is pegged at the inflation rate.

By comparison, the expenditure on indirect care services grew by 9.8% in the same period. The right panel of Figure 26 shows the main categories of expenditure. The most significant area of expenditure is catering and food, which averaged $36.76 per resident per day in December 2022. Year-on-year expenditure on catering has increased by 9.0%, driven mainly by increases in the labour costs of internal kitchen staff and expenditure on food supplies.

133. 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.

Figure 26: Components of indirect care revenue and expenditure



Considering the longer-term trend, the December 2022 results see a reversal of some of the positive impacts of the new BDF supplement introduced last year. This additional taxpayer-funded subsidy, which commenced in July 2021, increased funding for indirect care services by $10 per resident per day (approximately $723m annually). As shown in Figure 23 (see earlier), this additional funding closed the gap between revenue and costs, shrinking the deficit derived from losses in the provision of indirect care services.

However, despite this additional funding, the December 2022 results have seen the indirect care deficit grow again. This suggests that more structural reform of the funding of indirect services is required, such as greater regulatory clarity on permissible additional services and an increase in the basic daily fee cap for non-supported residents.

Accommodation

The Accommodation Result[134] shows the net revenues and expenses for providing and maintaining the physical infrastructure of aged care homes, which includes buildings, vehicles and equipment.

In the first six months of the 2022-23 financial year, homes lost an average of $14.26 per resident per day in providing accommodation services. From a financial perspective, this service type represents the most significant area of concern within the business model of providing residential care, constituting about 80% of the average total operating losses. Furthermore, the degree of losses from accommodation services is likely underestimated, as one of the main expense items, depreciation, understates the true cost of replacing or refurbishing physical infrastructure.[135]

One of the main reasons that homes struggle to break even in providing accommodation services arises from problems in how these services are funded. The Government provides approximately 60% of the funding in the form of a set daily supplement paid on behalf of low means 'supported' and 'partially supported' residents, ranging from $27-$65 per resident per day.[136]

The remaining 40% is paid through accommodation fees paid by non-supported residents who opt to pay rent, referred to as 'daily accommodation payments' (DAPs). Individuals who pay for their accommodation using a refundable lump sum, known as a 'refundable accommodation deposit' (RADs), don't pay rent and have the full nominal value of their lump sum returned at the end of their stay. They do, however, forgo any interest earnings on those funds.[137]

The price of the rent payments (DAPs) is calculated according to the Maximum Permissible Interest Rate applied to the agreed RAD value.[138] Thus, the revenue that providers earn for accommodation services depends, in part, on the RAD value (i.e. the price) that they agree with incoming residents for their rooms.

134. 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.

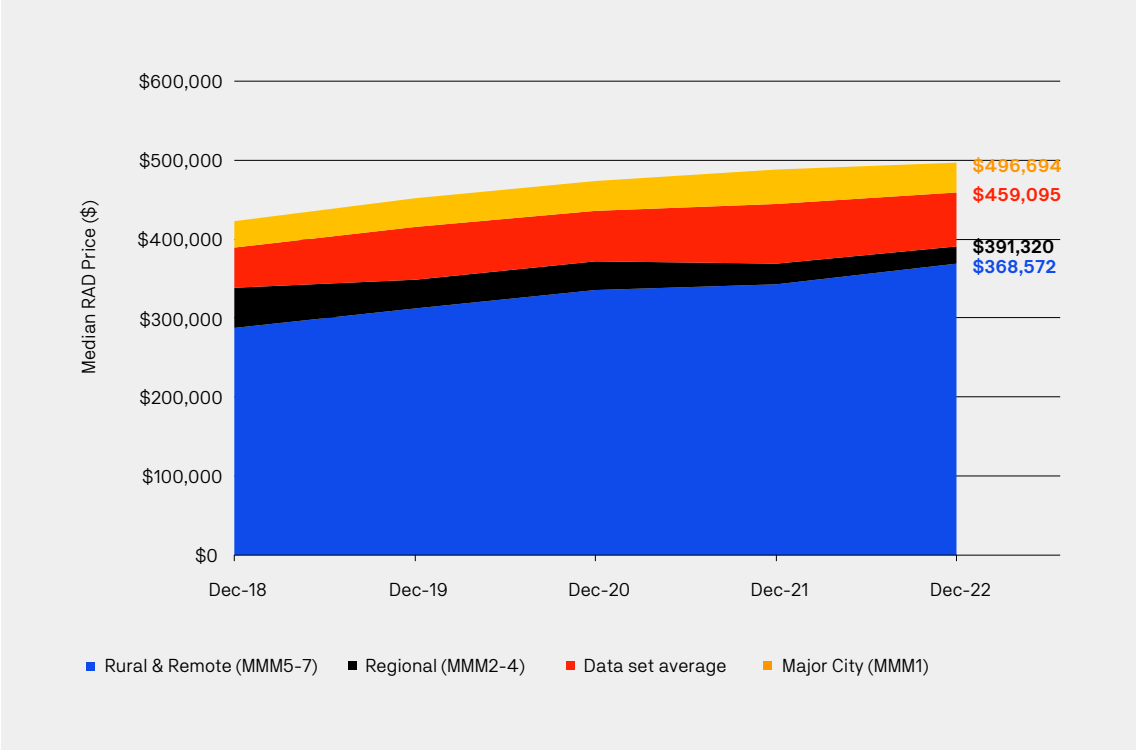
135. The most significant accommodation-related cost is depreciation and amortisation, which is reflective of changes in homes' asset bases (i.e., through new or refurbished infrastructure) and accounting policies. While a minority of providers revalue their property assets, most depreciate based on 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.

136. Department of Health and Aged Care (2023). *Schedule of Subsidies and Supplements for Aged Care.*

137. The operational revenue for accommodation represented in this section do not include any imputed value of the equivalent interest for RADs.

138. This is also referred to as the 'maximum permissible interest rate' or MPIR. As of April 2023, the MPIR is 7.46% per year. For example, a resident paying a DAP for a room worth $500,000, would pay $500,000 x 7.46% ÷ 365 = $ 102.19 per day.

Figure 27: Average price of new Refundable Accommodation Deposits, by location



As Figure 27 shows, over the five years, the median value of RADs has grown at a relatively modest pace, particularly in comparison to the growth in equivalent housing assets across Australia. For example, in the 12 months to December 2022, while the median house price increased by approximately 12.0% across Australia,[139] the price of new RADs only increased by 3.2%.[140] Furthermore, the median price in all regions, including metropolitan areas, is still well below the $550k threshold at which providers must seek approval from IHACPA.[141]

These low RAD prices (which are not commensurate with market values of property outside aged care) constrain the revenue earned and contribute to a growing deficit for accommodation services and the overall Operating Results of providers. This suggests that urgent reform is required to address the revenue streams for accommodation in residential care.

139. StewartBrown collects housing price information from CoreLogic Australia.

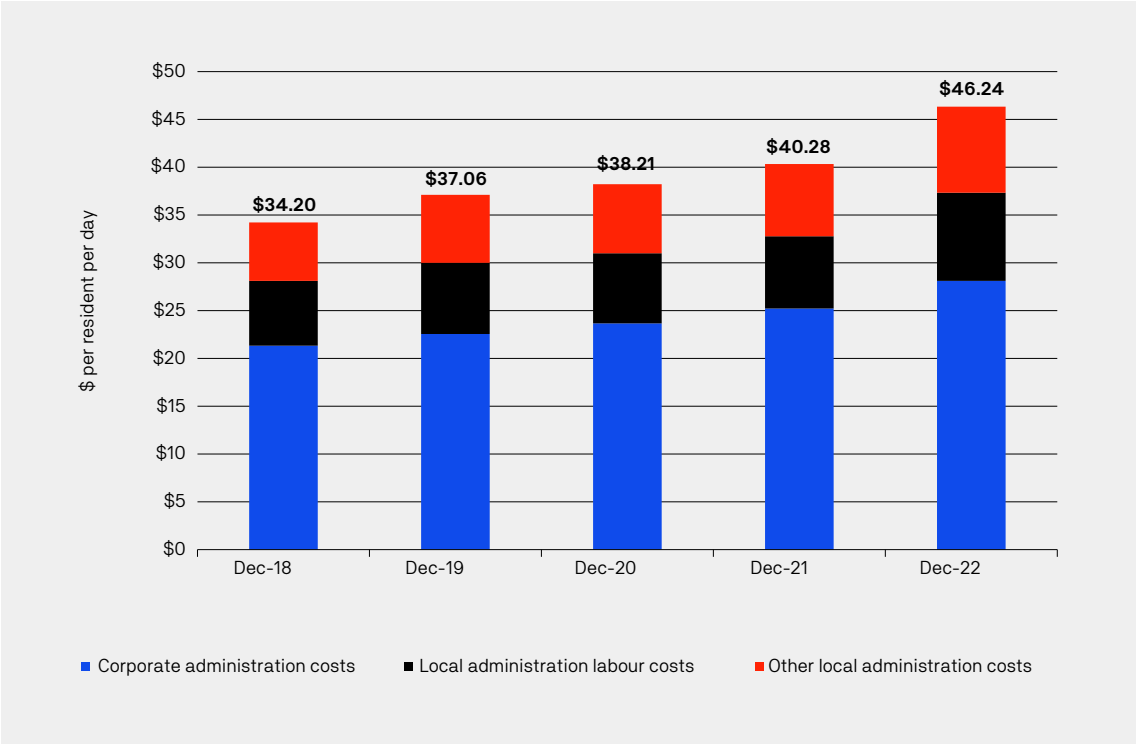
140. Note that the average price of new RADs is higher than the average price of all RADs currently issued. Unlike property values, existing RADs do not increase in value until a resident leaves and the home decides to increase the price for an incoming resident.

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

Administration overhead costs

In the above analysis, an allocation of administrative overhead costs has been included in calculating the net result for direct care, indirect care and accommodation. Figure 28 shows the trend in the underlying expense items included in this allocation. In December 2022, total administrative costs were, on average, $46.24 per resident per day, comprising $28.12 for the corporate administration costs (i.e. an apportion of the provider's corporate head office costs or organisation-wide administration costs), $9.23 for local administration labour and $8.89 for other local administration costs.[142]

Figure 28: Administration overhead costs, per resident per day



Furthermore, administration overhead costs have continued growing and are 35.2% higher than in December 2018. They have accelerated over the last year, up 14.8% for December 2022 compared to December 2021, with the most significant jump in the costs of local administration staff.

142. 'Corporate administration costs' represent an apportion of the provider's corporate head office costs or organisation-wide administration costs; 'local administration labour costs' represent the wages and on-costs for administration and clerical staff employed directly by the residential care home; and 'other local administration costs' include all other administration costs, including quality, education & compliance costs, workers compensation, other insurance, payroll tax, fringe benefits tax, advertising for staff, accounting fees, accreditation costs, audit fees, computer expenses, consulting fees, general expenses, legal fees, postage, printing, recruitment, subscriptions, telephone and travel costs.

Figure 29: Cumulative growth in administrative costs

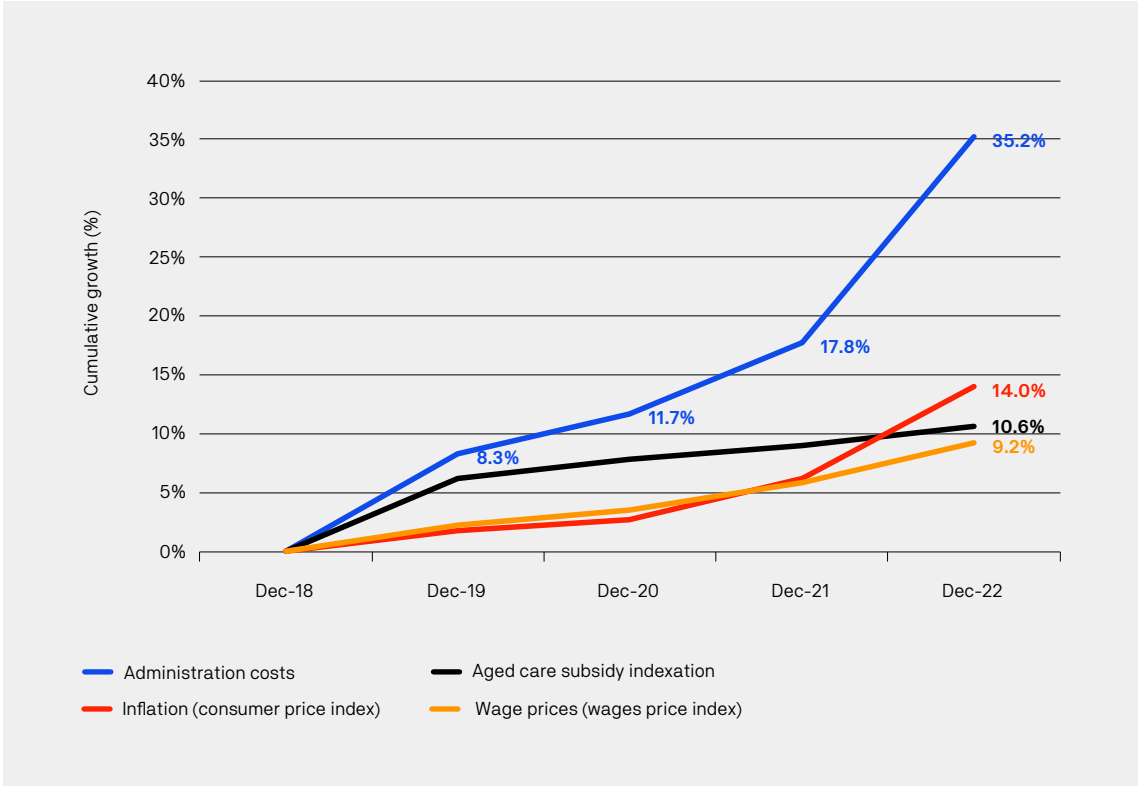


Figure 29 puts the cumulative growth of homes' average administration overhead costs in context, comparing it to the cumulative increases in inflation, wages and the indexation of aged care subsidies.

This shows that in the last four years, the growth in administration costs (35.2%) has far outpaced the indexed increase in taxpayer-funded aged care subsidies (10.6%).[143] Furthermore, it has also grown much faster than the prices of consumer goods (14.0%)[144] and wages (9.2%).[145] This suggests that a substantial proportion of the growth in administrative costs is attributable to non-price effects. This likely includes the increase in the time and scope of administrative activities as homes have implemented additional measures to comply with new quality and safety measures, including changes to their operations and enhanced reporting to Government.

143. Before AN-ACC, direct care subsidies and supplements rose according to the indexation of 'Commonwealth Own Purpose Outlay' (COPO), which replaced Commonwealth Own Purpose Expenditure (COPE).

144. Inflation is measured using the Consumer Price Index, based on ABS Statistics for December 2022.

145. The annual wage price index for health and social assistance was measured using ABS Wage Price Index Data for December 2022.

Results by location

In Australia, although most residential aged care homes are in major cities, close to 40% are in regional, rural or remote locations.[146] This geographic spread is essential in ensuring the accessibility of services to older Australians across the country. However, due to varying local conditions (e.g., demand for services, availability of workers, costs of supplies, socio-demographic factors and real estate values) and differences in the application of government funding models and policies according to location, homes in different locations tend to have different financial and workforce outcomes.

This report analyses these differences by examining the outcomes of homes classified into three overarching categories – major city, regional, and rural and remote – using the Modified Monash Model (MMM) of remoteness. The DoHAC uses the MMM classification to determine various subsidies and supplements for residential care services.[147]

Table 17: Key performance indicators of residential aged care homes, by location

	Major City (MMM1)	Regional (MMM2–4)	Rural & Remote (MMM5–7)
Number of homes in sample	705	287	107
Average home size (number of places)	87	82	49
Operating Result (per resident per day)	($14.41)	($25.88)	($15.12)
Operating Result (per bed per annum)*	($4,264)	($8,125)	($4,782)
Operating EBITDA (per bed per annum)*	$3,185	($1,104)	$2,263
Proportion of loss-making homes (Operating Result)	60.3%	70.0%	63.6%
Proportion of loss-making homes (EBITDA)	36.9%	51.9%	44.9%
Occupancy rate	91.4%	90.2%	89.2%
Supported resident ratio	44.2%	46.5%	49.3%
Average direct care revenue (per resident per day)	$208.01	$203.82	$222.35
Average direct care expenditure (per resident per day)	$203.67	$204.65	$205.87
Direct care expense ratio	97.9%	100.4%	92.6%
Average direct care minutes (per resident day)	186.1	184.1	193.1
Average of full RADs held at reporting date	$442,897	$352,080	$306,461
Average of new full RADs taken during period	$496,694	$391,320	$368,572

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

146. Department of Health and Aged Care (2022), *Aged care data snapshot—2022, Third release*, Australian Institute of Health and Welfare.
147. https://www.health.gov.au/health-topics/rural-health-workforce/classifications/mmm

Table 17 shows that aged care homes in all locations had poor financial outcomes in the first six months of 2022-23. However, homes in regional locations (MMM2-4) tend to have comparatively worse outcomes than those in other locations. For example, 70.0% of surveyed homes in regional locations were operating at a loss, compared to 60.3% of homes in major cities and 63.6% in rural and remote locations.

Likewise, regarding their average Operating Result, homes in regional locations recorded an average loss of $25.88 per resident per day, compared to a $14.41 average loss by city-based homes and a $15.12 average loss by homes in rural and remote locations.

Figure 30: Average Operating Result, by location

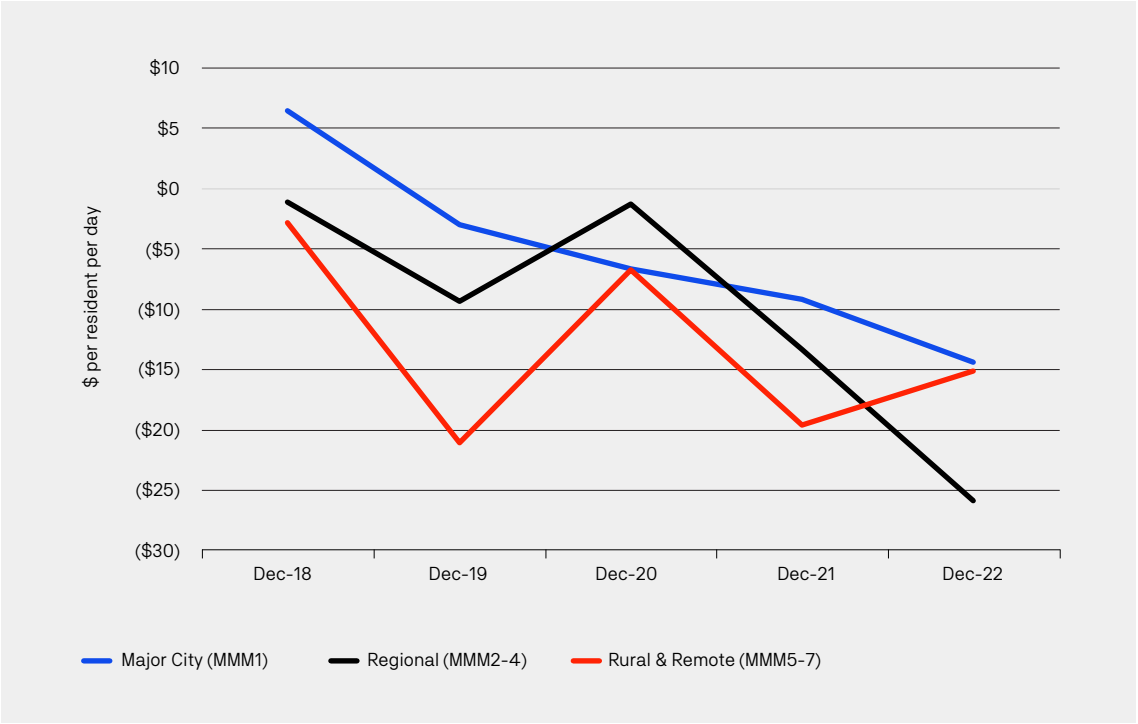
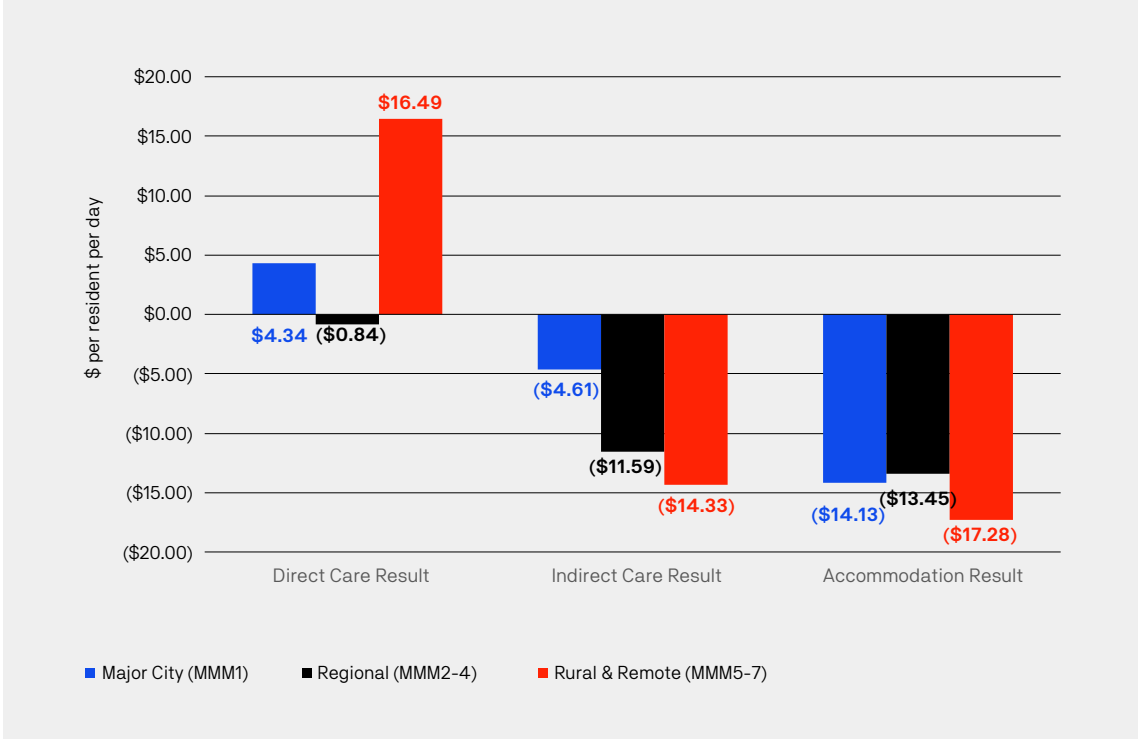


Figure 30 reveals the sustained trend of poor Operating Results of residential aged care homes over the past five years, particularly for those outside major cities. It also shows that homes outside the major cities tend to have much more variation in their year-to-year results. For example, whereas homes in major cities have experienced a consistent decline in their financial performance, regional, rural and remote homes experienced a brief uplift in 2021–21, partly due to larger COVID-related funding provisions during that year, before further declines in the last two years.

A newly emergent trend in the December 2022 results is the difference between regional (MMM2-4) and rural and remote (MMM-7) homes. Historically rural and remote homes have had worse financial outcomes. However, in the most recent period, regional homes are experiencing the most acute financial challenges.

Residential aged care homes

Figure 31: Operating Result breakdown, by location



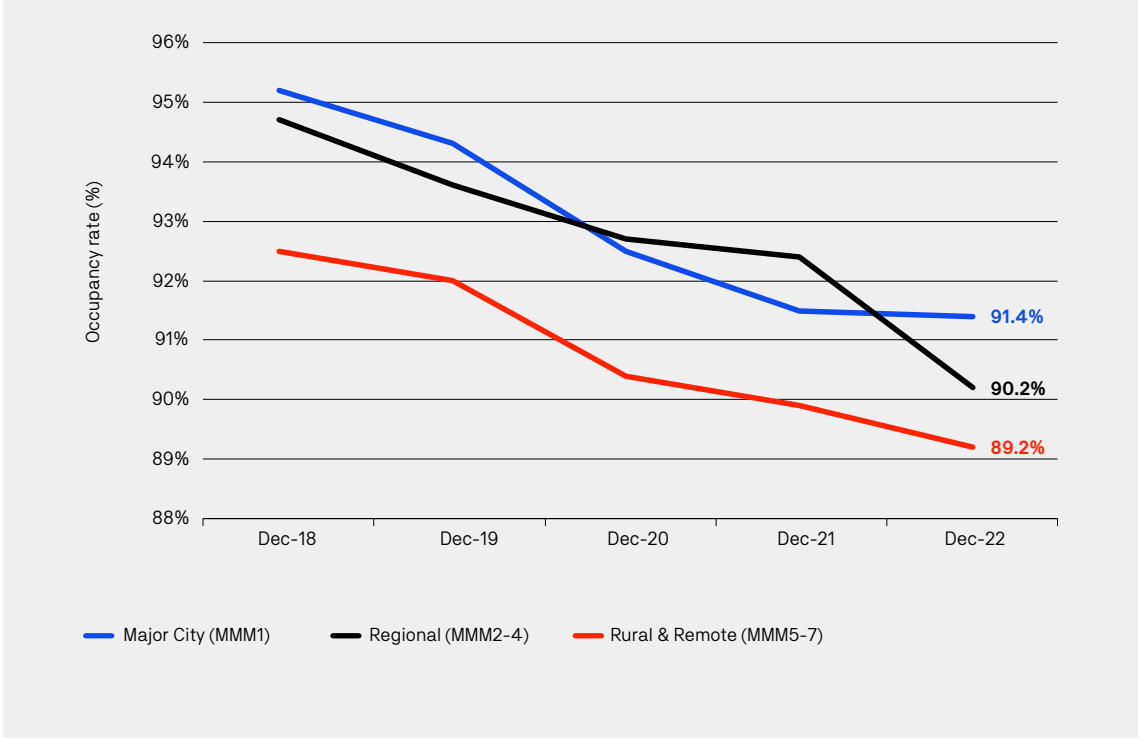
To help explain this trend, it is useful to disaggregate the homes' average Operating Result into the three underlying service areas of residential care – direct care, indirect care and accommodation.[148] As depicted in Figure 31 one of the significant causes for regional homes comparatively poor outcomes is the differences in the direct care result. Specifically, while homes in metropolitan and rural, and remote locations generate a margin from direct care services ($4.34 and $16.49 per resident per day, respectively), regional homes have a deficit of $0.84 per resident per day.

One contributing factor is the different funding flows under the AN-ACC, whereby homes in MMM5-7 areas tend to attract higher direct care subsidies than those in other locations. For example, the December 2022 results show that for direct care subsidies, homes in rural and remote areas earned an average of $213.58 per resident per day, compared to $199.01 for homes in the cities areas and $197.28 for homes in regional areas.

Partly this is because, under AN-ACC, the subsidy rates are higher for rural and remote homes, which are paid a higher base care tariff, particularly if they provide services to Aboriginal or Torres Strait Islander care recipients. In addition, the base care tariff is paid to remote homes (MMM6-7) based on operational places rather than occupied beds days and thus are not affected by falls in occupancy. As Figure 32 shows, although rural and remote homes continue to have the lowest occupancy, regional homes have also experienced a sharp decline since December 2021.

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

Figure 32: Occupancy rate, by location



The other contributing factor that explains the patterns in the direct care result is the difference in the resident profiles between homes in different locations. Homes outside the metropolitan centres tend to service a more diverse cohort of residents, including more low-care residents, that attract lower direct care subsidies. Non-metropolitan homes also tend to have a higher supported resident ratio, meaning fewer residents with the financial capacity to pay means-tested care fees. Whereas AN-ACC addresses these demographically-based funding disparities for MMM5-7 homes through higher base care tariffs (discussed above), no such concessions exist for regional homes.

Another notable difference in the operating models of homes in different locations is the smaller deficit of metropolitan homes in delivering indirect care services (the middle columns in Figure 31). 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 willingness to pay for additional services and homes' ability to navigate the complex regulatory settings around these service offerings. In addition, as detailed in Table 18, the differences in the indirect care results also arise because non-metropolitan homes incur higher average costs, such as for food, catering and laundry.

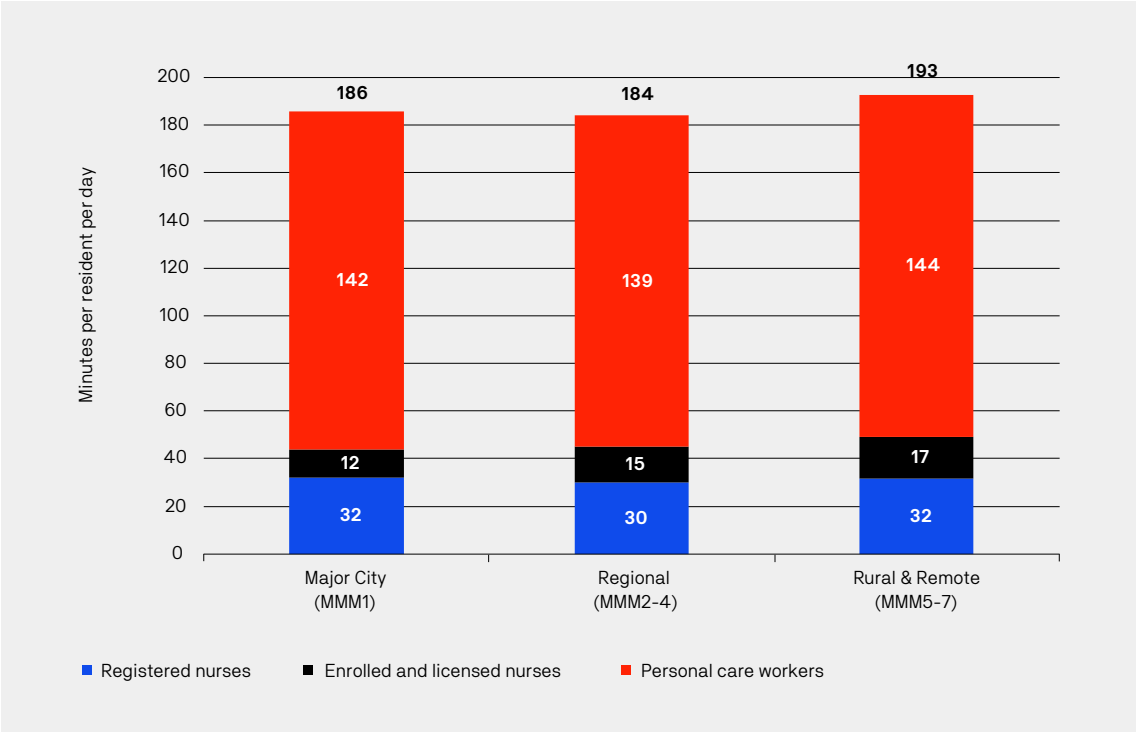
Residential aged care homes

Table 18: Breakdown of Operating Result, by location

	Major City (MMM1)	Regional (MMM2-4)	Rural & Remote (MMM5-7)
Number of homes in data set	705	287	107
DIRECT CARE			
Direct care revenue			
Residents	$7.51	$5.54	$5.75
Government	$200.50	$198.28	$216.60
Total direct care revenue	$208.01	$203.82	$222.35
Direct care expenditure			
Direct care labour costs	$153.08	$153.46	$157.47
Other labour costs	$27.94	$26.53	$25.67
Other direct costs	$5.91	$7.55	$4.30
Allocation of administration costs (37.0%)	$16.82	$17.20	$18.76
Total direct care expenditure	$203.75	$204.74	$206.20
Direct Care Result	**$4.34**	**($0.84)**	**$16.49**
INDIRECT CARE			
Indirect care revenue			
Residents	$59.79	$56.87	$56.23
Government	$9.95	$9.92	$9.91
Total indirect care revenue	$69.74	$66.78	$66.05
Indirect care expenditure			
Catering	$36.12	$37.92	$38.22
Cleaning	$10.16	$10.14	$9.98
Laundry	$4.48	$4.55	$4.34
Utilities	$7.27	$9.00	$9.50
Other	$1.03	$1.15	$1.29
Allocation of administration costs (33.6%)	15.28	15.62	17.03
Total indirect care expenditure	$74.34	$78.38	$80.36
Indirect Care Result	**($4.61)**	**($11.59)**	**($14.33)**
ACCOMMODATION			
Accommodation revenue			
Residents	$14.76	$13.20	$11.35
Government	$20.78	$21.67	$23.83
Total accommodation revenue	$35.54	$34.87	$35.19
Accommodation expenditure:			
Depreciation	$21.71	$20.83	$21.12
Property maintenance and rental	$12.91	$12.36	$14.71
Other	$1.69	$1.48	$1.74
Allocation of administration costs (29.4%)	$13.36	$13.66	$15.04
Total accommodation expenditure	$49.67	$48.33	$52.61
Accommodation Result	**($14.13)**	**($13.45)**	**($17.27)**
Operating Result (per resident per day)	**($14.41)**	**($25.88)**	**($15.12)**
Total revenue (per resident per day)	**$313.29**	**$305.47**	**$323.59**
Total expenditure (per resident per day)	**$327.76**	**$331.45**	**$339.17**

In terms of accommodation, all homes incur substantial losses. However, Table 18 shows that homes in major cities earn higher accommodation payments from non-supported residents. In contrast, those in rural and remote locations receive high rates of government accommodation supplements. It also shows that the costs of providing accommodation are highest in rural and remote homes ($52.47 per resident per day), followed by major cities ($49.67) and then regional homes ($48.32). This variation may reflect differences in property maintenance and rental expenses, capital infrastructure costs, and accounting depreciation policies.

Figure 33: Direct care staffing minutes, by staff role and location



In terms of direct care staffing, the highest rates are in homes in rural and remote locations (see Figure 33). 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).[149]

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 49 minutes per resident per day from enrolled and registered nurses compared to 44 minutes in homes in major cities.

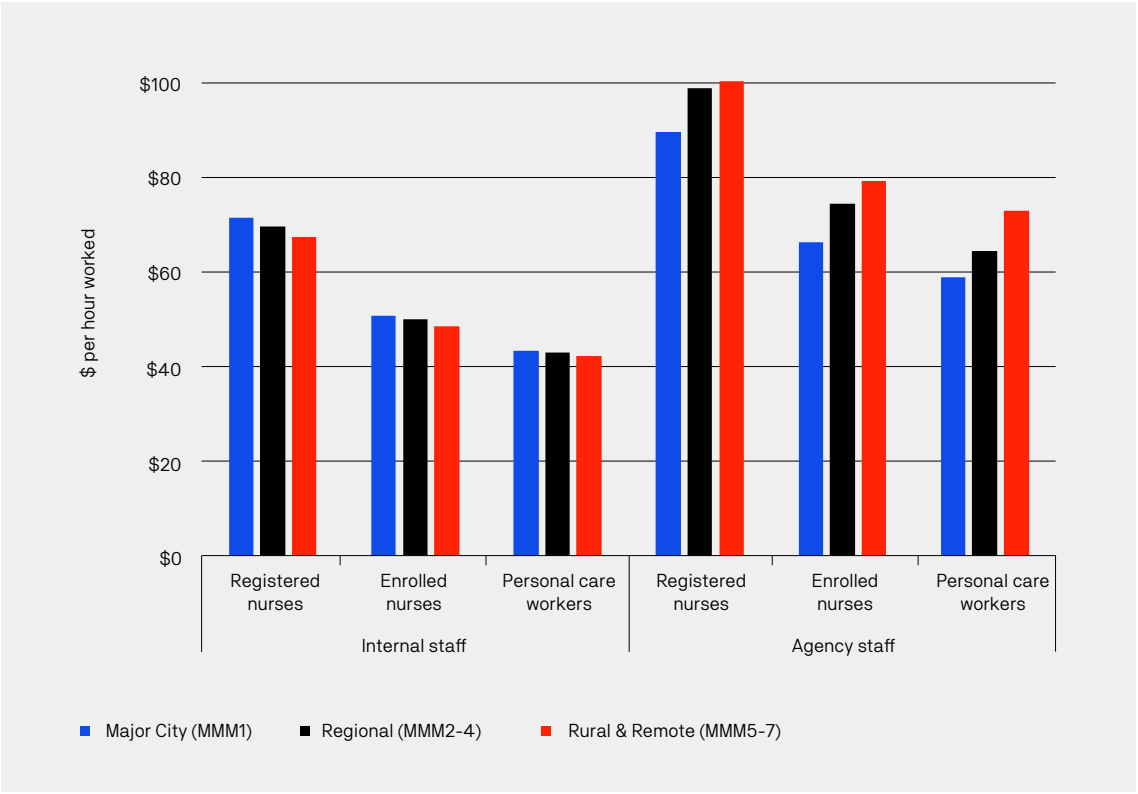
Another critical difference is the cost of direct care staff. Figure 34 shows the median labour cost per hour worked by staff role (including employment mode) and location. It shows that for internal staff (i.e. direct employees of the aged care homes), there are only slight cost differences between homes in different locations. Generally, homes in major cities incur a higher hourly labour cost for internal direct care staff.

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

Residential aged care homes

However, homes outside the major cities tend to pay much higher rates for agency staff. For example, homes in rural and remote locations tend to pay 10.5% more per hour worked for agency registered nurses than homes in major cities. This premium is even higher for enrolled nurses (17.5%) and personal care workers (22.1%).

Figure 34: Median labour cost per hour worked, by location



Results by home size

In Australia, the size of residential aged care homes is typically measured by the number of operational places (i.e. beds) within a given facility. Across the sector, the average home size is 82 places, however, this can range widely from as small as two places to as large as places.[150]

Due to the many fixed costs of operations, homes' financial outcomes can vary widely by size, as explored below. However, as home size often correlates with their location (i.e. many smaller homes are located in non-metropolitan areas), these results should be read in tandem with those in the prior section.

Table 19: Key performance indicators of residential aged care homes, by home size

	<40 places	40–80 places	80–120 places	>120 places
Number of homes in sample	104	472	334	189
Average home size (number of places)	29	58	97	144
Operating Result (per resident per day)	($26.65)	($15.94)	($16.75)	($17.53)
Operating Result (per bed per annum) *	($8,729)	($4,848)	($5,098)	($5,030)
Operating EBITDA (per bed per annum) *	($1,961)	$2,064	$2,606	$2,805
Proportion of loss-making homes (Operating Result)	68.3%	61.9%	63.2%	63.5%
Proportion of loss-making homes (EBITDA)	57.7%	41.3%	38.9%	38.1%
Occupancy rate	90.3%	91.2%	91.2%	90.0%
Supported resident ratio	49.5%	47.5%	43.7%	40.6%
Average direct care revenue (per resident per day)	$224.06	$207.66	$206.15	$205.08
Average direct care expenditure (per resident per day)	$222.59	$201.93	$202.69	$202.08
Direct care expense ratio	99.3%	97.2%	98.3%	98.5%
Average direct care minutes (per resident day)	200.5	181.1	188.0	188.1
Average of full RADs held at reporting date	$354,637	$381,435	$424,330	$460,895
Average of new full RADs taken during period	$399,598	$432,948	$468,224	$508,890

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

Our analysis of homes of different sizes (summarised in Table 19) reveals substantial differences in operating characteristics and financial performance of homes in December 2022. For example, the smallest homes (less than 40 places) tend to have considerably poorer financial results than larger homes. On average, these smaller homes are more likely to be operating at a loss and have lower Operating Results and Operating EBITDA. More specifically, in the first six months of 2022-23 homes with fewer than 40 places incurred an average Operating Loss of $26.65 per resident per day and an Operating EBITDA deficit of $1,961 per bed per annum.

150. Department of Health and Aged Care (2022), *Aged Care Service List—2022*, Australian Institute of Health and Welfare.

Residential aged care homes

Figure 35: Average Operating Result, by home size

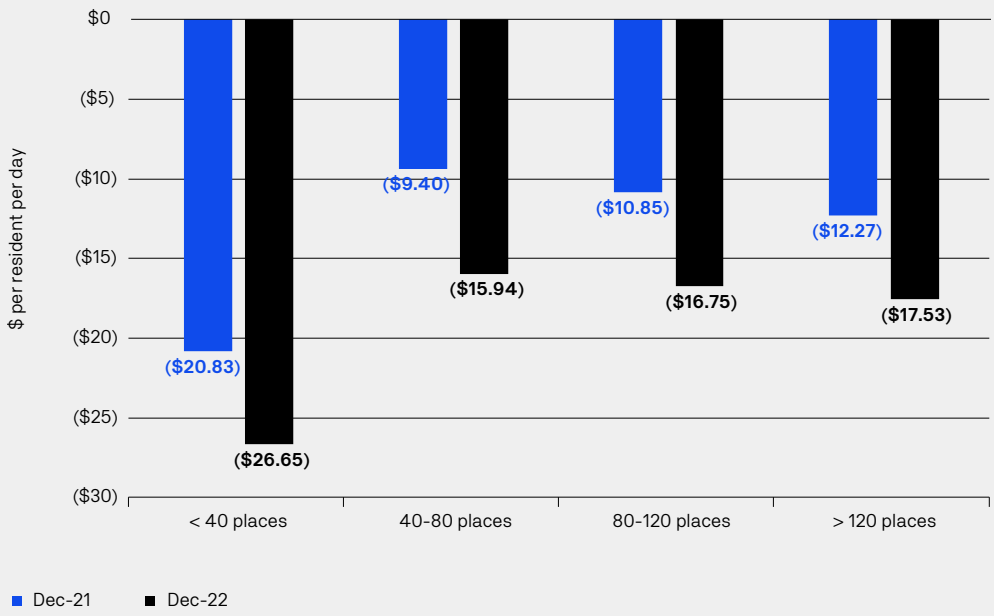
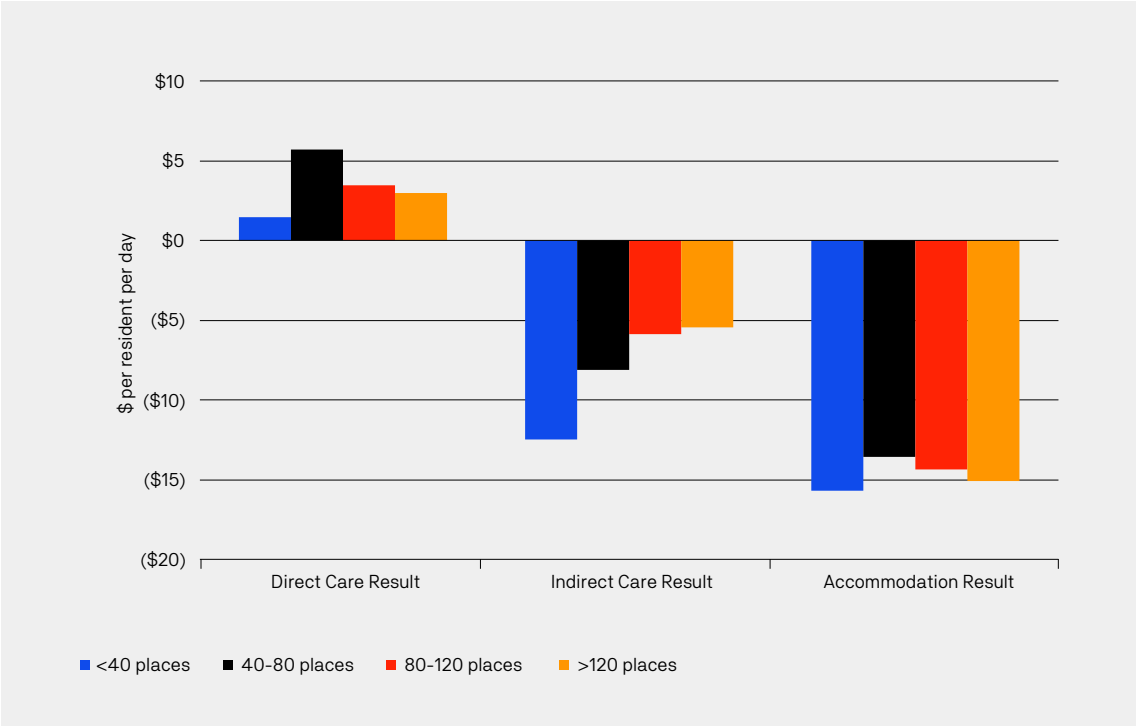


Figure 35 also shows that there is not a monotonic relationship between home size and profitability. Although the worst financial outcomes are concentrated within the smallest home size category, large homes (larger than 120 places) may not benefit from economies of scale. The homes with the smallest operating losses tend to have between 40-80 places.

However, this result seems somewhat driven by the additional capital costs of larger homes. When the effects of depreciation and interest are excluded, such as in Operating EBITDA, the largest homes tend to deliver the strongest operating margins (see Table 19).

Figure 36: Operating Result breakdown, by home size



When homes' average Operating Result is disaggregated into the three service areas (see Figure 36), it becomes apparent that one of the main reasons that small homes (<40 places) have such poor returns is their relatively large losses incurred from indirect care services (shown in the middle columns).

This is partly because small homes earn less revenue from additional service fees than larger homes, noting that many of these homes are located outside major cities. For example, in December 2022, homes with less than 40 places earned, on average, $1.58 per resident per day from additional service fees compared to $4.36 per day for homes with more than 120 places. However, small homes also appear to incur higher costs for indirect care services, on average about $5 more per resident on expenses such as catering, utilities and administration.

This pattern that small homes incur higher average costs per resident is not restricted to indirect care. The detailed breakdown in Table 20 shows that for all three areas of residential aged care service delivery, homes in this size bracket incur the highest average expenditure per resident per day. Compared to homes in the next size bracket (40-80 places), the smallest homes spend an additional $29.58 per resident per day. These additional costs more than offset the slightly higher average direct care subsidies that small homes earn.

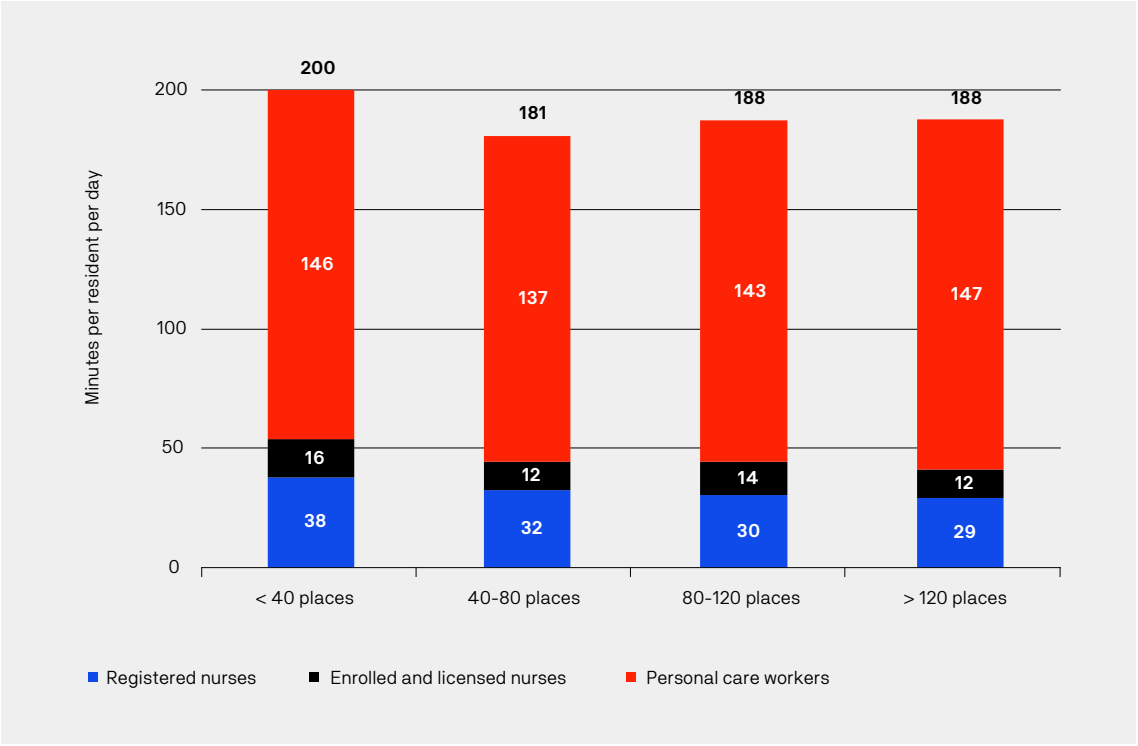
The breakdown also reveals the similarity of expenditure patterns for homes in the three larger categories (40 places and more). These homes have virtually the same average daily expenditure per resident for all three service areas. The only difference between these three categories is slight variations in their revenue streams. For example, whereas homes with 40-80 places tend to attract slightly higher direct care subsidies and government accommodation supplements, the largest homes (120+ places) earn more from means-tested care fees, additional service fees and residential accommodation payments.

Residential aged care homes

Table 20: Breakdown of average Operating Result, by home size

	<40 places	40–80 places	80–120 places	>120 places
Number of homes in data set	104	472	334	189
DIRECT CARE				
Direct care revenue				
Residents	$6.41	$6.25	$6.84	$8.45
Government	$217.64	$201.41	$199.32	$196.63
Total direct care revenue	$224.06	$207.66	$206.15	$205.08
Direct care expenditure				
Direct care labour costs	$167.04	$150.81	$153.42	$153.55
Other labour costs	$30.63	$20.17	$18.21	$17.64
Other direct costs	$4.65	$5.98	$6.35	$7.22
Allocation of administration costs (37.0%)	$19.18	$17.30	$16.66	$16.27
Total direct care expenditure	$221.50	$194.26	$194.64	$194.68
Direct Care Result	**$1.47**	**$5.73**	**$3.46**	**$3.00**
INDIRECT CARE				
Indirect care revenue				
Residents	$57.79	$57.74	$59.49	$60.08
Government	$9.96	$9.98	$9.83	$10.01
Total indirect care revenue	$67.76	$67.70	$69.31	$70.08
Indirect care expenditure:				
Catering	$37.92	$36.86	$36.18	$37.08
Cleaning	$9.84	$9.88	$10.50	$10.31
Laundry	$4.25	$4.54	$4.35	$4.73
Utilities	$9.69	$7.76	$7.90	$7.51
Other	$1.07	$1.07	$1.09	$1.10
Allocation of administration costs (33.6%)	17.41	15.71	15.13	14.78
Total indirect care expenditure	$80.18	$75.82	$75.15	$75.51
Indirect Care Result	**($12.44)**	**($8.13)**	**($5.84)**	**($5.44)**
ACCOMMODATION				
Accommodation revenue				
Residents	$12.89	$13.26	$14.66	$15.41
Government	$25.02	$22.23	$20.29	$18.76
Total accommodation revenue	$37.92	$35.49	$34.95	$34.17
Accommodation expenditure				
Depreciation	$19.70	$20.17	$22.47	$23.63
Property maintenance and rental	$16.86	$13.49	$12.05	$11.01
Other	$1.79	$1.64	$1.56	$1.70
Allocation of administration costs (29.4%)	$15.38	$13.74	$13.23	$12.93
Total accommodation expenditure	$53.73	$49.04	$49.31	$49.27
Accommodation Result	**($15.65)**	**($13.54)**	**($14.37)**	**($15.10)**
Operating Result (per resident per day)	**($26.65)**	**($15.94)**	**($16.75)**	**($17.53)**
Total revenue (per resident per day)	**$329.74**	**$310.85**	**$310.41**	**$309.33**
Total expenditure (per resident per day)	**$355.41**	**$319.12**	**$319.10**	**$319.46**

Figure 37: Direct care staffing minutes, by staff role and home size



Regarding the direct care staffing time, the small homes (fewer than 40 places) tend to have higher average care minutes rates per resident per day. As of December 2022, these homes, on average, provided 200 direct care staffing minutes per resident per day, which correspondingly is the sector-wide average target level, and 38 minutes of registered nurse care minutes. However, as these rates will reflect changes in occupancy and fixed staffing requirements (including the 24/7 registered nurse), care should be exercised in comparing staffing rates across homes of different sizes.

Home Care Analysis

Overview

- The financial performance of home care services declined to an average Operating Result of $0.93 per client per day in the six months to December 2022, following a short-term peak of $5.13 for December 2020. The profit margin for home care services was just 1.4%, with 99% of the packages in the data set being delivered by the not-for-profit sector.

- While the average costs of providing home care have remained unchanged over the two years to December, revenues have declined by 3.9% compared to the prior year, to an average of $68.56 per client day.

- Revenue utilisation has fallen to 84.5% from 88.0%, and the average unspent funds has increased by over $1,200 to $11,212 per package.

- Direct care time provided by internal staff has continued to fall to an average of 3.37 hours per client per week (29 minutes per day). Since December 2018, the average internal direct care staffing time received by older Australians has fallen by 28.7%.

Home care service profiles

The home care analysis reports on the financial and workforce outcomes of home care service providers that offer subsidised services funded through home care packages (HCPs). The services can include personal and nursing care, domestic and social support activities, home maintenance, and other supports in the home and community. 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 new Support at Home program for the delivery of in-home care from July 2025.

Table 21: Profile of home care services in the data set

	Dec-22	Dec-21
Number of home care services in the data set	261	378
Total number of packages in data set	60,102	55,822
Ownership		
For Profit	0.8%	0.5%
Not for Profit	99.2%	99.5%
Location		
Major City	62.5%	58.5%
Rural	37.5%	41.5%
State		
NSW	34.1%	34.9%
NT & ACT	2.3%	1.9%
QLD	26.8%	31.7%
SA	15.3%	13.0%
TAS	4.2%	2.9%
VIC	13.4%	8.7%
WA	3.8%	6.9%
Average number of funded packages per home care service	230.3	147.7
Package mix		
% of Level 1 Packages	6.8%	9.8%
% of Level 2 Packages	39.8%	37.1%
% of Level 3 Packages	31.9%	27.6%
% of Level 4 Packages	21.5%	25.4%

This section analyses the outcomes from the December 2022 StewartBrown data set, which included 60,102 HCPs, or approximately 25.5% of the 235,599 HCP clients in December 2022.[151] As shown in Table 21, almost all (99.2%) of the 261 services in the data set 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 (62.5%) providers were located in major cities, particularly in NSW (34.1%) and QLD (26.8%).[152] The large increase in the number of packages per service provider increased (from 147.7 in December 2021 to 230.3 in December 2022) is mainly attributable to differences in how providers reported their programs in the data collection.[153]

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.[154]

Key performance indicator summary

Table 22: Key performance indicators of home care services

	Dec-22	Dec-21
Operating Result per client per day	$0.93	$3.82
Operating EBITDA per client per annum	$514	$1,590
Revenue		
Revenue per client per day	$68.56	$71.35
Revenue utilisation rate	84.5%	88.0%
Unspent funds per package	$11,212	$9,976
Costs		
Direct care and brokered services costs (as % of revenue)	58.4%	57.8%
Care management and advisory costs (as a % of revenue)	12.5%	12.3%
Administration and support costs (as % of revenue)	27.7%	24.8%
Profit margin (%)	1.4%	5.4%
Total staff hours per client per week	5.5	5.3

151. Department of Health and Aged Care (2023), *Home care packages program, data report 2nd Quarter 2022-23*, Australian Institute of Health and Welfare.

152. 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.

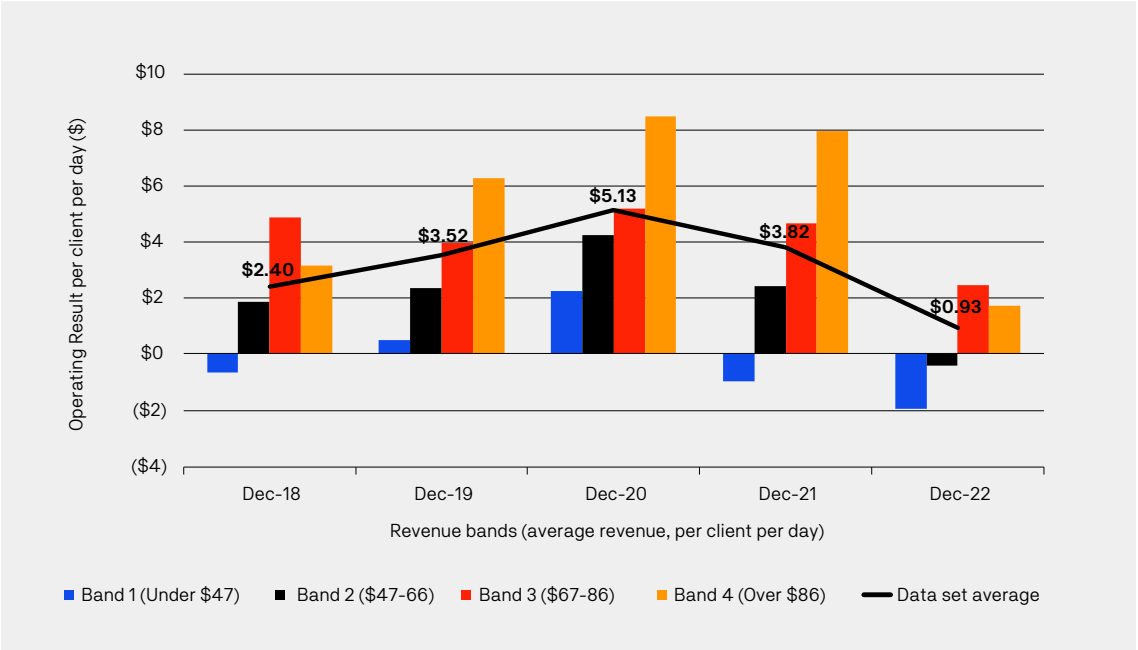
153. The total number of unique home care providers was 99 in the December 2021 sample and 87 in December 2022.

154. Department of Health and Aged Care (2023), *Home care packages program, data report 2nd Quarter 2022-23*, Australian Institute of Health and Welfare.

Financial performance

The results from the first half of the 2022-23 financial year show a worsening of the financial performance of home care providers. As shown in Figure 38, on average, services achieved an Operating Result[155] of $0.93 per client per day, down compared to $3.82 a year prior. This represents a year-on-year decline of 75.7%, and means that the profit margin in providing home care services is now, on average, only 1.4%. Put another way, for every $100 of services delivered, the provider earns only $1.40.

Figure 38: Average Operating Result, by revenue bands



Figures 38 also 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 – $9,180 per annum ($25.15 per day)
- Level 2 – $16,148 per annum ($44.24 per day)
- Level 3 – $35,129 per annum ($96.27 per day)
- Level 4 – $53,268 per annum ($145.94 per day)[156]

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

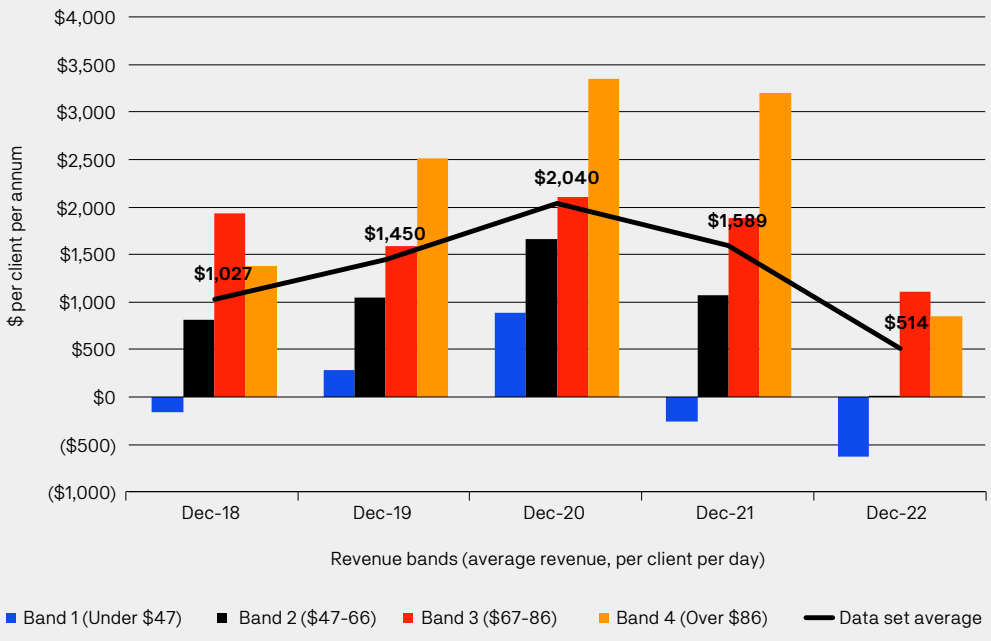
156. Department of Health, Aged Care Subsidies and Supplements from 1 October 2022.

This breakdown shows that the decline in profitability has affected providers across all Bands. However, the sharpest declines in this latest period have occurred in services classified as Band 4 (more higher-level packages). As of December 2022, these services earned an average operating surplus of only $1.73 per client per day, compared to $7.94 in December 2021 and $8.48 in December 2020. Profitability for Band 1 providers declined to a negative $1.96 in the December 2022 period.

In addition, Figure 38 shows that, on average, providers classified as Bands 1 and 2 are operating at a loss. These poor returns raise concerns about the viability of lower-level HCPs, including the current business models of providers, particularly as the sector moves towards the Support at Home program that will bring together the CHSP and the HCP program (discussed in Part 1).

Figure 39 shows equivalent figures for the expected Operating EBITDA[157] earned per client per annum. Based on the first half of the financial year, providers are projected to earn an average Operating EBITDA of $514 per client per annum, down from $1,589 as of December 2021.

Figure 39: Average Operating EBITDA, by revenue bands



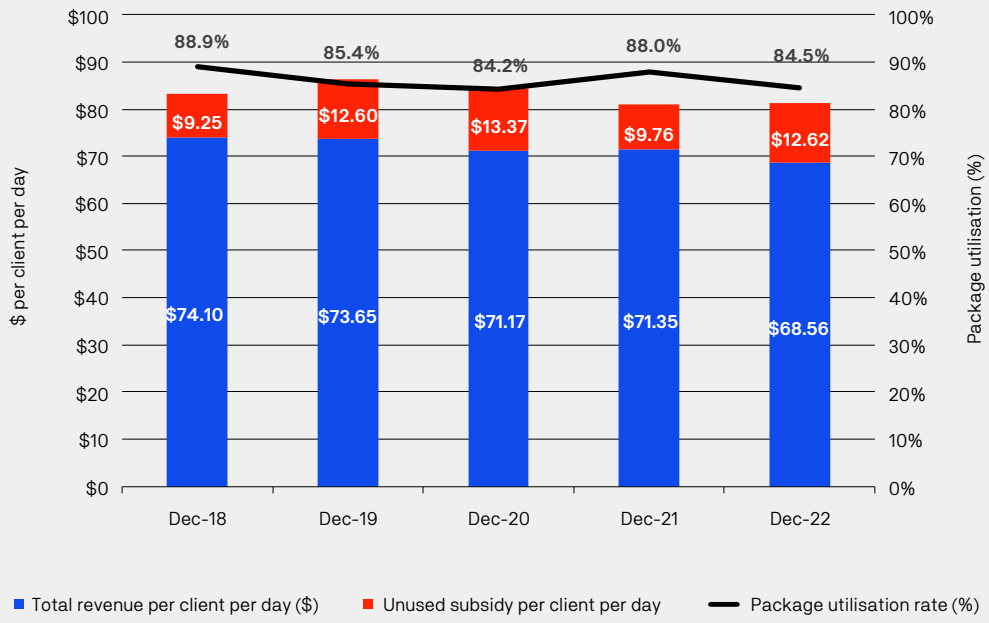
Considering the longer-term trends, both Figures 38 and 39 indicate that while home care providers' profitability improved between 2018-2020, it has since declined. Both graphs suggest that providers' profitability is, on average, the lowest in five years, raising significant concerns for the ongoing viability of the sector.

157. 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 EBITDA' also excludes all provider-level revenue and expenditure, including fundraising revenue, revaluations, donations, capital grants and sundry revenue.

Revenue analysis

The primary revenue sources for home care service providers are government subsidies for HCPs and any income-tested fees paid by clients.[158] Home care providers earn revenue (equivalent to their charges for services delivered) when the clients use their package funds.

Figure 40: Average revenue per client per day



As shown in Figure 40, the main reason for the decline in the profitability of home care providers is the reduced average revenue earned per client per day. As of December 2022, the average revenue per client day was $68.56, which is 3.9% lower than the year before, and 7.5% lower than in December 2018.

The decline mainly reflects a fall in the average revenue earned from direct services, although this was partially offset by increased revenue earned through brokered services, care management and package management.[159] Revenue declines have occurred despite the slight change in weighting toward higher-level packages among survey participants.

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

159. In addition, two smaller counterveiling factors are the indexation increase in the value of the HCP subsidy rates (which increased 1.7% compared to the year before), and the year on year change in the package mix of surveyed providers, which on average, decreased potential revenue earned by 1.4%.

Home care package services

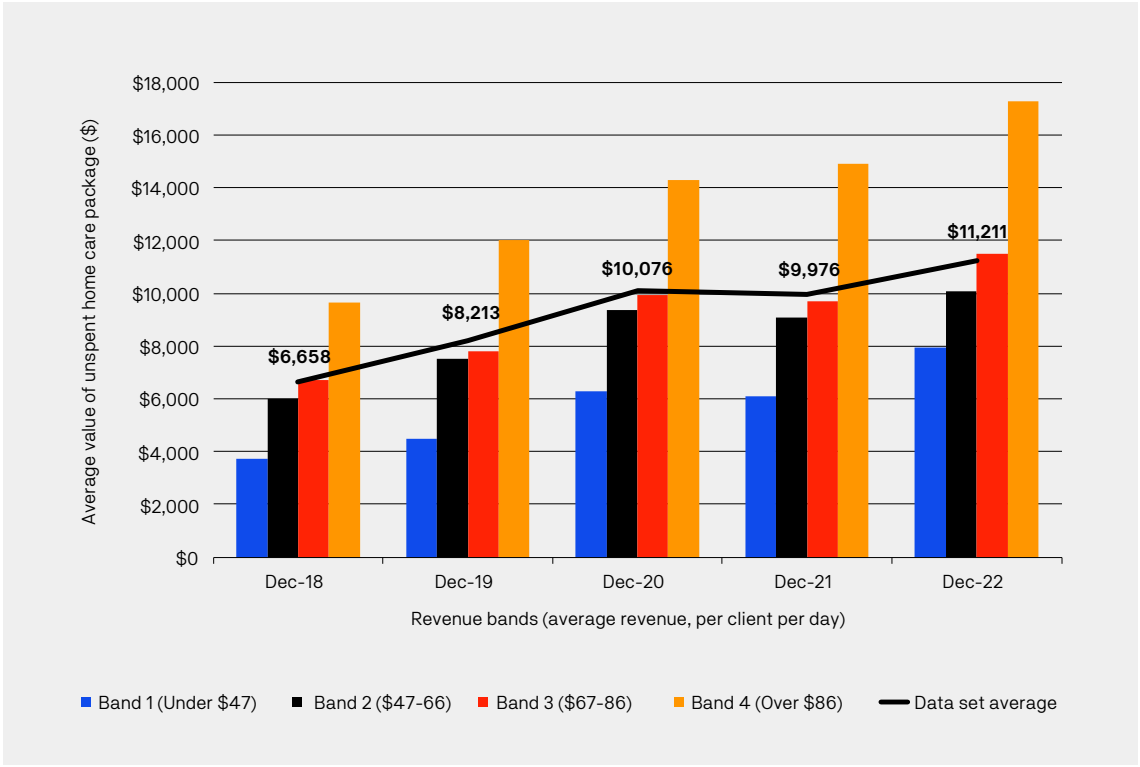
Figure 40 also reveals a decline in the average revenue utilisation rate in December 2022 to 84.5%, 3.5% lower than the year prior. Revenue utilisation represents the proportion of the allocated subsidies that home care clients use. On the supply side, declining utilisation likely reflects ongoing workforce shortages being experienced by providers, who may not have sufficient workers to meet the increased demand for services. The trends depicted in Figure 40 have occurred during a period when the total number of home care packages has grown substantially across the sector, from 93,331 clients in December 2018 to 235,599 clients in December 2022.[160]

Alternatively, on the demand side, declines in revenue utilisation can also reflect changes in 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 will drop if clients cancel or postpone home care services. 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.

Revenue utilisation has continued to decline, which likely reflects several factors including workforce availability, consumption patterns and program design issues.

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

Figure 41: Average unspent funds per package, by revenue band



Lower revenue utilisation also increases the 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 both contributing providers and Services Australia,[161] Figure 41 shows that the average value of unspent funds has continued to increase to $11,211 per package by December 2022. This growth has increased across all revenue brackets.

From a provider's perspective, unspent funds represent unrealised revenue and, consequently, unrealised 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. 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 the aggregate value of unspent funds is currently more than $2.4bn at a sector level.[162]

Understanding the drivers of declining revenue utilisation and the growth in clients' unspent funds is an important input to the design of the new program for delivering in-home care. These trends suggest a need to improve the timeliness and accuracy of eligibility assessments, provide better support for clients in making use of the services they are assessed as requiring, and a pricing regime allowing providers to deliver the needed services in a viable manner.

161. 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.

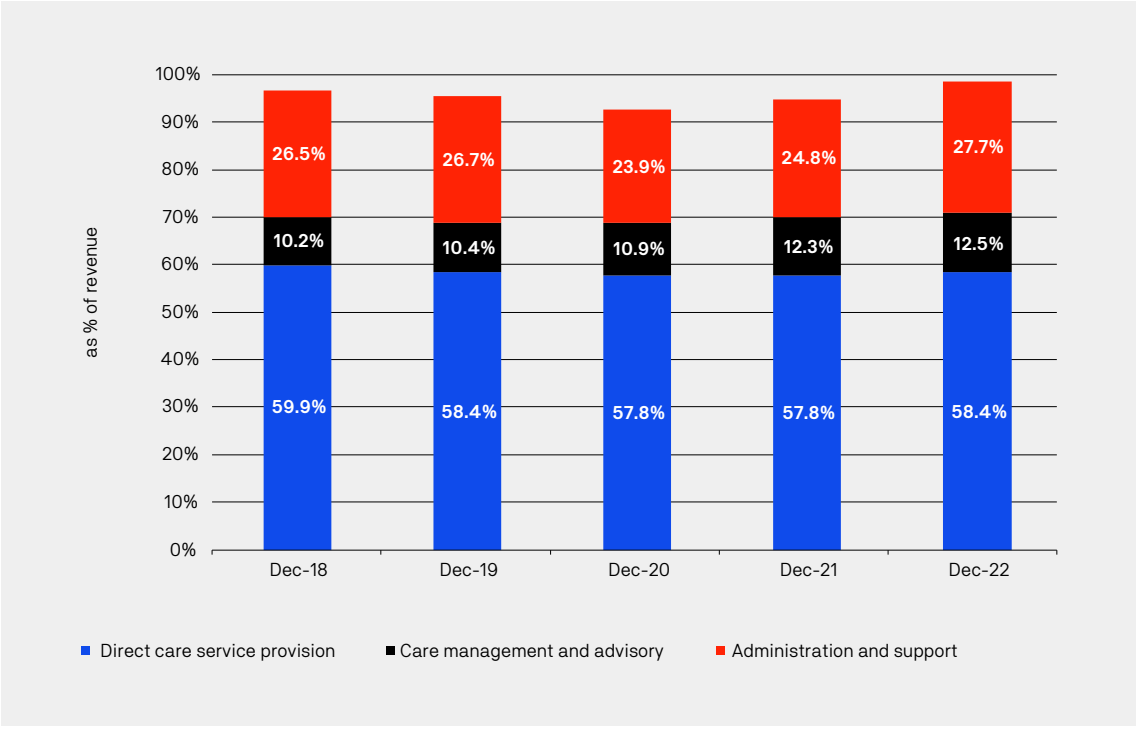
162. StewartBrown (2023), *Aged Care Financial Performance Survey Report for December 2022.*

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).[163] 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.[164]
- 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.

Figure 42: Home care provider expenditure categories as a proportion of revenue



163. 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.

164. 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 42 shows that the composition of home care providers' expenditure across the three categories described above has continued to change. The proportion of expenditure on direct care service provision has remained steady, equivalent to 58.4% of revenue. By comparison, expenditures on care management and advisory, as well as administration and support, have grown from a combined proportion equivalent to 34.8% of revenue in December 2020 (the lowest in the latest five-year period) to a high of 40.2% in December 2022.

Figure 43: Average direct care costs, internal and sub-contracted services

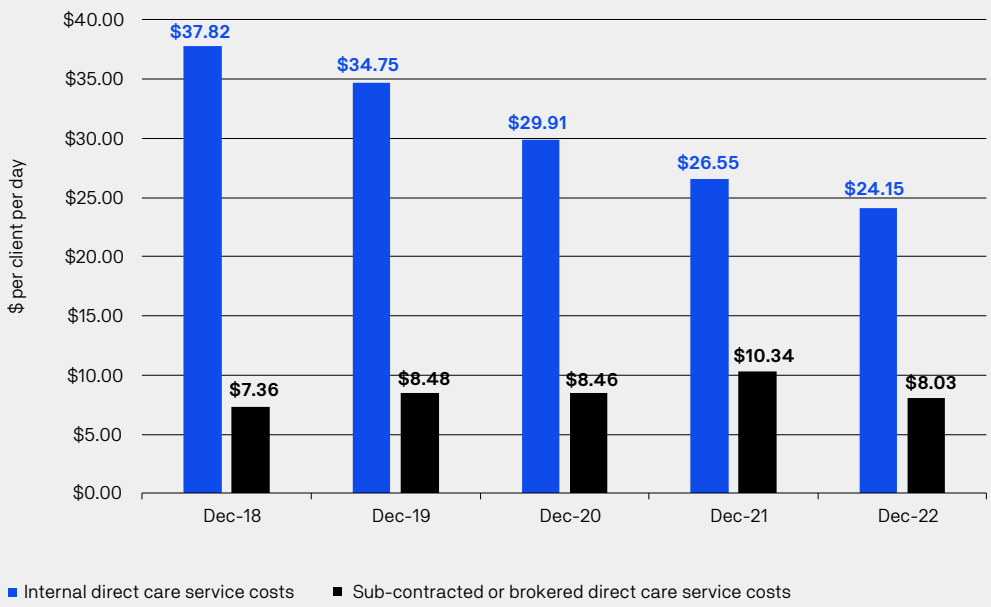
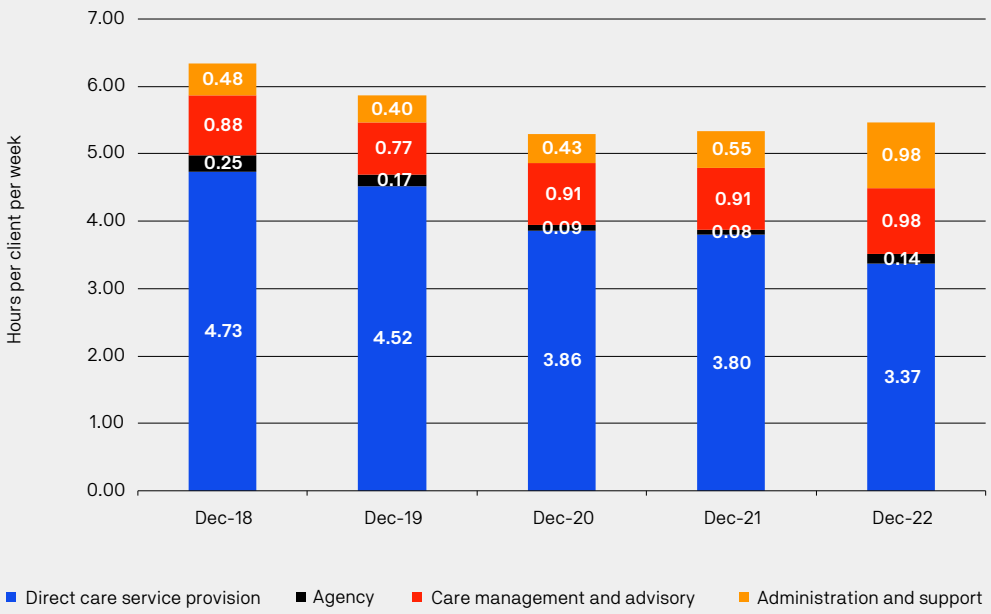


Figure 43 shows a breakdown of direct care service provision expenditure, distinguishing between expenditure on services provided internally (i.e. by the home care provider) and on subcontracted or brokered services. It reveals a slight attenuation of a longer-term trend towards using third parties to deliver home care services. While expenditure on services delivered internally declined (to $24.15 per client per day), so too did the value of subcontracted services ($8.03 per client per day).

Workforce

The significant expansion of the HCP program over the last five years, coupled with the increased demand for workers in residential care, disability and other care sectors, has created substantial challenges for home care providers in attracting and retaining sufficient workers with appropriate knowledge, skills and professional attributes in recent years, including for the last financial year.

Figure 44: Home care internal staffing hours per client per week, by staff category



These experiences are evident in the trend data for internal staffing shown in Figure 44.[165] This shows that in the first six months of 2022-23, while the total staffing hours per client per week for home care services increased slightly, the time spent on direct care service provision continued to decline. Specifically, as of December 2022, internal staff provided direct care service time averaged 3.37 hours per client per week (approximately 29 minutes per day). Since December 2018, the average internal direct care staffing time received by older Australians has fallen by 28.7%.

165. 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 longer-term decline in staff time for care-related services likely reflects capacity constraints as providers struggle to find enough suitable aged care workers to meet growth in the total number of HCPs over the last five years in a competitive labour market. As shown in Figure 43, the cost of subcontracted or brokered direct care service provision has remained relatively constant since December 2018, resulting in a declining proportion of internal direct care costs.

Figure 44 also shows that the time spent on administration and support has grown substantially in the last year, from 0.55 hours per client per week (33 minutes) in December 21 to 0.98 hours (59 minutes) in December 2022.

The longer-term decline in staff time for care-related services likely reflects capacity constraints as providers struggle to find enough suitable aged care workers to meet growth in the total number of home care packages.

Editorial board

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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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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.

Professor Nola Ries

Professor Nola Ries is a Professor with the UTS Faculty of Law. She leads research on law, regulation and ethics with the UTS Ageing Research Collaborative. Nola is a co-founder of the Dementia Law Network, an active member of the Australian Association of Gerontology and qualified as a lawyer in Australia and Canada.

Professor Michael Woods

As above

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., EBITDA) 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

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