UTS Ageing Research Collaborative (UARC)

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

For the year ending

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Disclaimer

Parts of this report are based on the results of StewartBrown's *Aged Care Financial Performance Survey*. 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: Full-Year Report 2022–23

Contents

Tables and figures

Table of abbreviations

ACAR	Aged Care Approvals Rounds
ACFI	Aged Care Funding Instrument
ACFPS	Aged Care Financial Performance Survey
ACQSC	Aged Care Quality and Safety Commission
AIHW	Australian Institute of Health and Welfare
BCT	Base Care Tariff
CEDA	Committee for Economic Development of Australia
CHSP	Commonwealth Home Support Progamme
COTA	Council On The Ageing
DAP	Daily accommodation payments
DoHAC	Department of Health and Aged Care
EBITDA	Earnings Before Interest, Taxes, Depreciation and Amortisation
FTE	Full-time equivalent
FWC	Fair Work Commission
GDP	Gross Domestic Product
IHACPA	Independent Health and Aged Care Pricing Authority
IGR	Intergenerational Report
MMM	Modified Monash Model
MPIR	Maximum Permissible Interest Rate
NDIS	National Disability Insurance Scheme
RAD	Refundable accommodation deposit
RN	Registered nurse
SB	StewartBrown
STRC	Short Term Restorative Care
UARC	UTS Ageing Research Collaborative

Editorial Board foreword

Welcome to the fourth edition of *Australia's Aged Care Sector* report – which analyses and provides commentary on the full-year results for 2022–23.

FY23 has witnessed a continuation of strained financial performance across both residential and home care. It has also seen many changes – in residential care funding and consumer information, new governance requirements and increased reporting across many dimensions of service delivery. More is to come, including the reveal of the report of the Aged Care Taskforce, the debate and intended passage of the new Aged Care Act and greater detail on the future Support at Home program.

In residential care, the financial performance for direct care services under the new AN-ACC funding model remains similar to the FY22 results, with homes on average being just above break-even. However, these results may mask a near-future turn down for many homes. The reason? The Government built into the current AN-ACC funding a capacity to meet the new mandatory staffing requirements. Yet, as the Part 1 analysis makes clear, many homes remain below their targets – and some are well below. An acceleration of staffing expenditure, especially via the more costly agency option, will quickly erode current positive margins for direct care.

The report's analysis of agency staffing highlights the rapid rise in their use and the premium providers currently have to pay. But aside from the negative impact on financial performance, two questions will deserve further consideration. First, why are so many skilled aged care workers making themselves available through the agency model rather than as direct internal employees? Second, how should the Independent Health and Aged Care Pricing Authority (IHACPA) and the Government consider temporary cost surges (if that is what the rise in agency staff utilisation proves to be) when setting new funding levels?

The financial results for accommodation and everyday living have always been negative for residential care, and they have both deteriorated further in FY23. It was pleasing to see that the Terms of Reference and Draft Principles released by the Aged Care Taskforce recognised these as the two priority issues if the sector is to move to a more sustainable platform.

From our analysis, the most important priority is for providers to offer accommodation services where residents want to live, at prices that cover costs and generate a modest return, and for the Government to increase its accommodation funding for supported residents commensurately.

The second most important priority is for the Government to allow the fee for everyday living services to reflect the cost of efficiently delivering services of an acceptable standard, and for that fee to be paid by residents with sufficient means to do so. The Government should focus its public subsidy on topping up the age pension contribution from those of lesser means.

While the Taskforce may bring some welcome rationality to the sustainability debate, UTS Ageing Research Collaborative (UARC) considers that the transparency of its processes fell short of best practice.

The financial performance of home care package providers also deteriorated in FY23, and there was a further increase in average unspent funds. Providers across the range of in-home care programs lack certainty about the forthcoming unified Support at Home program, noting that the unification of Home Care Packages and Short-Term Restorative Care is due to start in a little over 18 months. Advice on the service list and consumer contributions are part of the Taskforce remit, and it is hoped that the Departmental update in mid-December will shed further light on the subject. By then, the timeframe for IHACPA to develop its pricing advice will be quite condensed.

UARC's analysis of different classes of home care package providers may prove helpful to many of readers as part of your forward planning. One message from the analysis that is particularly salient for the Department is that smaller providers with a client profile more akin to Commonwealth Home Support Programme (CHSP) have the worst operating results. With around 800,000 CHSP clients merging into the Support at Home program from 1 July 2027, this must be factored into the program design and funding model.

The upcoming release of an exposure draft of the new Aged Care Act will be strongly welcomed. It is hoped that the Department has constructively addressed the many positive proposals contained in submissions from the sector by providing further clarity to the objectives of the aged care system and placing the future legislative framework on a sound foundation.

FY23 also saw the commencement of Star Ratings. While nearly all homes now receive overall ratings of acceptable or higher, ratings were much lower for the staffing sub-category. A matter worthy of consideration by providers and policy analysts is that in this initial period, homes which achieve 5 stars for staffing have the worst financial performance.

UARC is offering all readers (and the public in general – but please feel special) an early Seasonal present. It's a free, online new Star Rating Dashboard that enables all involved in aged care to interrogate the data at individual home and provider levels and higher levels of aggregation. Details are on page 64. We hope you find the Dashboard helpful, and we look forward to your feedback to help us progressively enhance its capabilities and usefulness.

We here at UARC remain grateful to our partners, StewartBrown, for providing ongoing access to their large de-identified *Aged Care Financial Performance Survey* dataset and for inviting us to present the results of our research at the annual StewartBrown Financial Forums around the country. As ever, this is a very important opportunity to engage directly with many of you and to discuss the 'where at' and 'where to' of aged care.

Keen readers will also note that our reporting of consumer sentiment has been expanded – thanks to a new collaboration with Kevin McCreton and colleagues who produce *The Catalyst Report*. It is a valuable source of insight into aged care and retirement living.

Summer is coming; for some readers, that is an opportunity for some well-deserved downtime. Many others will continue to provide high-quality care and support to the older members of our community and help them enjoy the festive season.

Our thanks to all of you.

Professor Mike Woods (Chair)

On behalf of the Editorial Board and the UTS Ageing Research Collective
7 December 2023

Executive Summary

During 2022-23, the Australian aged care sector faced significant challenges accompanied by regulatory and legislative change. The sector, particularly residential care, continues to grapple with financial strains. In the last 5 years, residential homes have lost an estimated $3.5 billion despite additional injections of nearly $4 billion in Government funding for direct care, everyday living and COVID-19 responses.

A critical task of the new Aged Care Taskforce is to review the funding arrangements for aged care. In residential care, immediate reform is necessary to restructure resident and taxpayer payments for everyday living and accommodation services. Such reforms must ensure sufficient revenue to fund growing service costs, including administration, which grew 14.1% in the last year alone.

IHACPA now closely monitors, and advises the Government on, homes' direct care funding. UARC's analysis reveals that in its first year, the new AN-ACC model delivered funding that, on average, resulted in a slim margin for direct care services. However, two caveats accompany this result. First, there is substantial variation between individual homes' direct care margins, with homes that service residents with less complex needs struggling to cover direct care costs. Second, although all homes received additional AN-ACC funding ahead of the commencement of mandatory care minutes, many homes still have yet to meet their targets and will need to increase their staffing expenditure within the revenue envelope. This staffing uplift will need to occur in an environment where agency staffing and sector wage growth are pushing labour rates upwards.

The financial performance of home care providers has also continued to deteriorate. In 2022-23, providers' average Operating Result reached a five-year low of $3.08 per client per day, reflecting stubbornly flat revenue growth coupled with rising service costs. Furthermore, revenue utilisation continues to fall, causing mounting unspent package funds.

Beneath these headline figures, this report also offers insight into where financial viability issues are most acute. In residential care, UARC has identified that the homes most likely to be experiencing financial distress tend to be: located in large and medium rural towns; smaller in size; experiencing declining occupancy; or operated by smaller-scale providers. Such results suggest market consolidation will continue as larger providers benefit from economies of scale.

For home care, the worst operating results were reported by smaller providers that predominantly service Level 1 and 2 package clients. UARC's analysis of the poor outcomes of this provider group raises concerns about the viability of entry-level home care services, such as many of those provided under CHSP, in the future unified Support at Home scheme. Recently, the Minister for Aged Care, the Hon Anika Wells MP, announced that the inclusion of CHSP has been deferred until July 2027.

As in previous years, workforce issues continue to plague the sector as providers struggle to recruit and retain sufficient numbers of appropriately qualified and skilled care staff. Despite increases in direct care staffing across residential care, as of March 2023, only one in five (21.4%) homes were meeting their registered nurse and total care minute targets. Also, while Department data indicates 86.0% of homes reported having a registered nurse on-site and on duty 24/7, UARC's shift-level modelling suggests more widespread issues in achieving the required coverage, particularly for staffing the overnight shift.

Furthermore, workforce pressures are now evident in a range of other metrics across the sector. For example, UARC's analysis shows that in the last year, residential homes have increased their reliance on high-cost agency staff and shifted their staffing mix away from ancillary staff roles. Also, there is some evidence of capacity constraints, with continued declines in home care package providers' staffing time and, for some residential homes, modest drops in occupancy.

As part of the Government's response to the Royal Commission, Australia now has a Star Ratings system that publishes comparable, up-to-date information about the quality of individual residential aged care homes. The latest available results indicate that 97% of residential care homes had an overall rating of acceptable or better (3 stars or higher), driven by high average ratings for compliance, resident experience and clinical quality.

However, there is still scope for improvement in the staffing domain, noting that many consumers may only consider homes rated at least 4 stars. UARC's preliminary investigation of the links to financial outcomes reveals that homes rated 3 stars overall achieved the best financial returns in 2022-23. Furthermore, there appears to be a financial cost associated with poor compliance ratings, and homes with the highest staffing ratings tend to have the worst financial performance.

The last 12 months have featured several major legislative and regulatory changes as the Government continues to implement its reform agenda. This edition of the report includes commentary on the drafting of the new Aged Care Act and associated regulatory model reform, the Fair Work Commission wage case, the commencement of the Office of the Inspector-General of Aged Care and the continued development of the Support at Home Program. Given the significance of these matters to the sector, UARC will continue to monitor their development and, as appropriate, provide commentary to inform future policy.

Returning to the Aged Care Taskforce, UARC supported the Draft Principles that indicate a willingness for the Government to focus on funding direct care and safety nets for older people with less financial means. Although it is not clear when the Taskforce report will be made public, recommended reforms will likely enable older people to make affordable personal contributions towards the everyday living and accommodation services they use. Carrying this principle through to the eventual design of the Support at Home program would see the Government funding almost all direct care, with clients having greater funding responsibility for domestic and home support. Developing a more equitable funding model is critical to ensuring the sustainability of quality aged care services that support older Australians, now and into the future.

In the last 5 years, residential homes have lost an estimated $3.5 billion, despite additional injections of nearly $4 billion in Government funding.

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.

Financial viability concerns remain at the forefront across residential and in-home care. With the Aged Care Taskforce soon to make its recommendations to Government, Part 1 provides detailed analyses of the current funding issues for residential care, including the first year of the AN-ACC funding model, regional disparities in financial outcomes and the effects of market consolidation. Part 1 presents a new analysis highlighting the diversity of outcomes of home care providers that range in their scale and diversification. This analysis anticipates the roll out of the new Support at Home program, which will now take place in two stages with the replacement of the Commonwealth Home Support Programme (CHSP) deferred until no sooner than 1 July 2027.

The second critical area is the aged care workforce. Part 1 provides evidence about the status of homes' direct care workforces vis-à-vis the care minute targets and 24/7 registered nurse requirement. Furthermore, it substantiates the workforce pressures experienced by providers in terms of increased agency use, capacity constraints and changes in their staffing mix.

With the introduction of Star Ratings, Part 1 presents a synopsis of homes' current quality ratings, contextualised with insights from consumer research and financial data.

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, the new Aged Care Act and the Inspector-General of Aged Care.

Part 1 concludes with an updated review of the sector's sustainability, synthesising key insights from the recent 2023 Intergenerational Report and UARC's recommendations to the Aged Care Taskforce. Part 1 concludes with an updated review of the sector's funding sustainability, synthesising key insights from the recent 2023 Intergenerational Report and UARC's recommendations to the Aged Care Taskforce.

Financial viability

Key messages

- Since FY19, the residential sector has lost at least $3.46 billion despite receiving nearly $4 billion of additional Government funding for direct care, everyday living services and COVID-19 responses.
- In its first year, AN-ACC delivered funding for direct care that, on average, exceeded costs by a small margin ($1.58 per resident per day). However, many homes still have to meet their direct care minute targets and will need to increase their staffing spending accordingly.
- UARC modelling shows substantial variation in AN-ACC funding outcomes, with homes that service residents with less complex needs struggling to cover direct care costs.
- Urgent reform around the resident and taxpayer funding models for everyday living and accommodation services is required, as homes' revenues consistently fall short of costs.
- Residential administration costs have accelerated further in the last two years, reaching an average of $47.55 per resident per day in FY23.
- Homes in medium rural towns (MMM4) are experiencing acute viability issues.
- The market for residential aged care has become increasingly consolidated over the last decade. UARC modelling finds evidence of economies of scale at both a provider and home-level, with larger providers delivering services at lower average costs.
- The financial performance of in-home care providers has continued to deteriorate in FY23, with smaller, entry-level, providers returning the poorest financial outcomes.

Financial viability concerns for aged care providers persist. As set out in greater detail in Part 2, the latest results for 2022–23 (FY23) reveal the following:

- The financial performance of approved providers remains low, with a median EBITDA of just 1.5%, indicating that providers generate only $1.50 for every $100 of revenue earned.
- On a per home basis, two out of three (66%) residential aged care homes reported an operating loss, with an average Operating Result of negative $19.56 per resident per day. While homes, on average, earn a small margin for direct care, they continue to incur losses for everyday living and accommodation services.
- Home care providers' financial performance continues to decline, with an average Operating Result of just $3.08 per client per day.

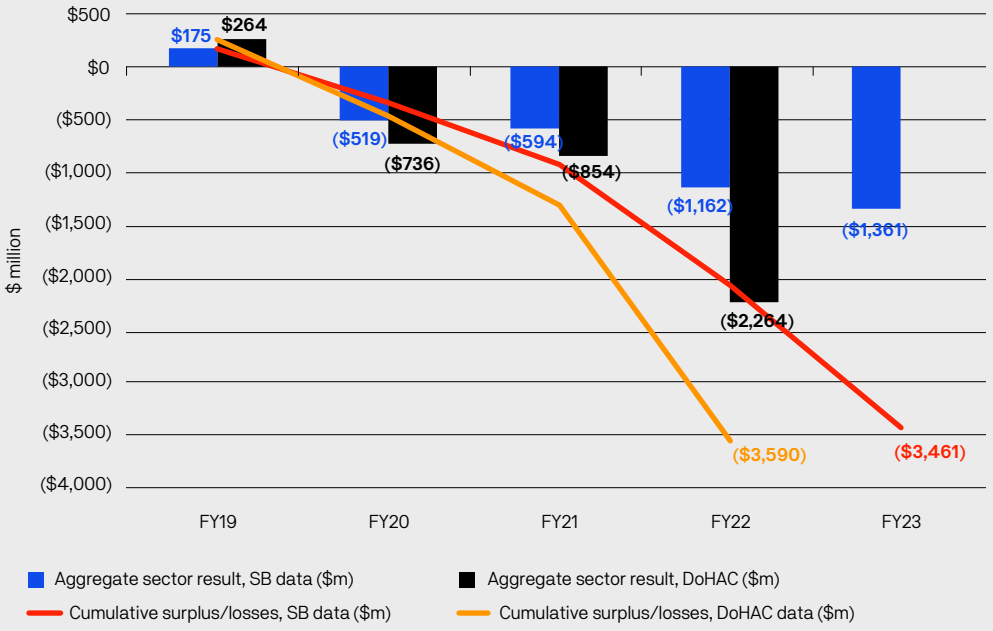
To add further insight into these poor sector results, this section presents detailed analyses and commentary about several pertinent topics:

- Sector losses in residential care
- The funding of residential aged care services
- Regional disparities of homes' financial outcomes
- Market consolidation of residential care
- Viability issues in home care

Sector losses in residential care

Despite substantial increases in Government funding, the FY23 financial performance of the residential aged care sector showed ongoing deterioration. On average, homes participating in StewartBrown's 2022–23 *Aged Care Financial Performance Survey* (ACFPS) lost approximately $20 for each of their residents, each day. This translates to an estimated total operating loss of $1.36 billion across the residential aged care sector for this financial year.[1] Cumulatively, over the last five years, Australian residential providers have lost at least $3.46 billion.

Figure 1: Financial results of residential aged care sector



These estimates are likely conservative and understate the true losses experienced across the sector. The StewartBrown ACFPS dataset only reports the outcomes of mature homes (i.e. excludes homes with disruptions to service delivery) and does not include government-owned homes.[2] Sector-wide figures reported by the Department of Health and Aged Care (the 'Department') show that in prior years, the sector has encountered even larger losses (see Figure 1), which is likely to be the outcome again for FY23.[3]

1. This figure has been estimated assuming 221,497 operational places in Australia as of 30 June 2023, with an occupancy rate of 86.1%.
2. Department of Health and Aged Care (2023), *Financial Report on the Australian Aged Care Sector 2021–22*.
3. Department figures represent the results from all residential providers, which include all residential aged care homes, including those with operational issues.

The sector losses encountered in residential care have occurred even after additional injections of nearly $4 billion in Government funding since FY20:

- Providers have received higher direct care funding under the new AN-ACC model, which lifted care funding by 10.6% or roughly $945 million since 1 October 2022.[4]
- Since 1 July 2021, homes have received the Basic Daily Fee supplement (now called the 'hotelling' supplement), worth approximately $660 million annually.[5]
- Since FY20, homes have received approximately $1.7 billion of COVID-related funding,[6] including COVID-19 workforce measures, supplements and various grants to reimburse providers for managing outbreaks and infection controls.[7]

Without these additional financial supports provided by Australian taxpayers, the sector would be in a much worse financial position than it finds itself. Nonetheless, these sector-level results attest to the culmination of several overarching challenges residential providers have faced over the last five years:

- **Declining occupancy rates:** coinciding with negative sentiments about the sector during the Royal Commission and pandemic and the increasing availability of home care services.
- **COVID-19 pandemic:** disrupting regular service delivery, exacerbating workforce shortages, depressing occupancy and increasing expenditure on infection control measures.
- **Persistent workforce shortages:** reflecting pressures caused by the pandemic and border lockdowns, increased demand for care workers across health, disability and community sectors, and introduction of minimum staffing standards in residential care.

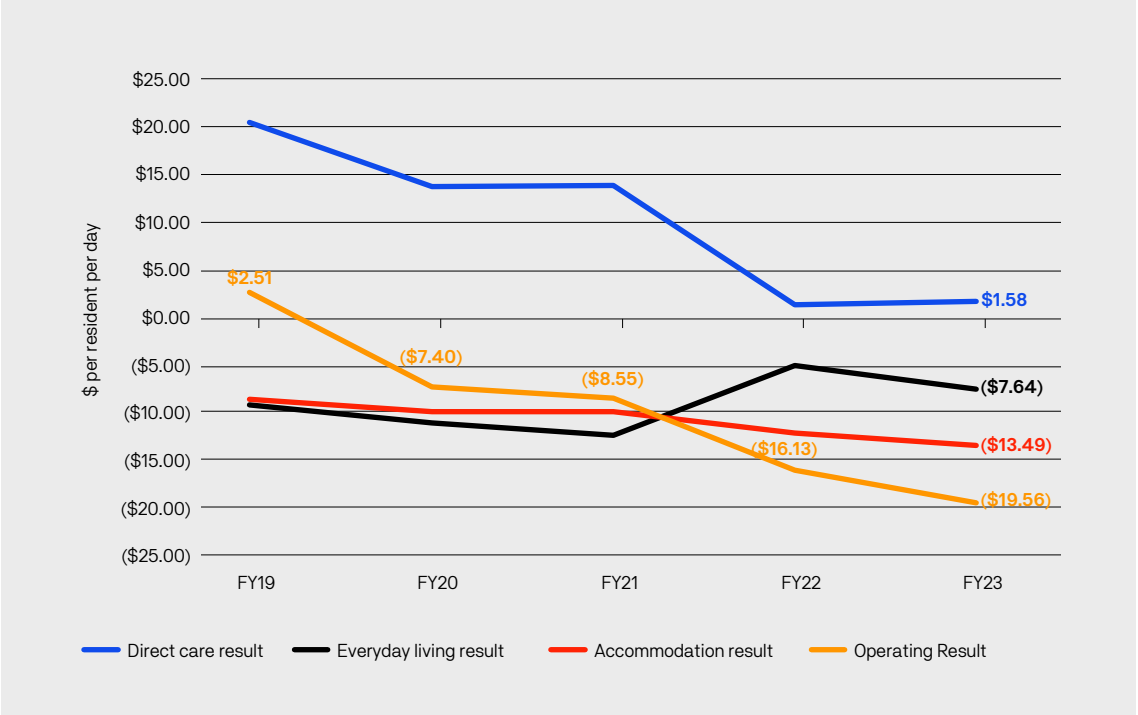
4. The introduction of AN-ACC in Q2 FY23 saw average care funding per resident per day increase 10.6% from $203.54 (Q1) to $225.11 (Q2), based on statistics reported by the Department in the Quarterly Financial Snapshot Aged Care Sector, October – December 2022. Noting that the total value of basic direct care subsidies in FY22 was $11.88bn, a 10.6% increase (over 9 months) equates to $945m.
5. Department of Health and Aged Care (2023), *Financial Report on the Australian Aged Care Sector 2021–22.*
6. This figure is based on data reported by the Department in the Financial Report on the Australian Aged Care Sector (2020-21 and 2021–22), as well as the Q3 FY23 Quarterly Financial Snapshot of the Aged Care Sector, with COVID-19 funding reported as $301.1m (FY20), $753.6m (FY21), $306.06m (FY22) and $316m (Q3, year-to-date, FY23)
7. For example, in FY21, COVID-19 funding included a one-off Residential Care Subsidy Increase, the workforce retention bonus and Jobkeeper. In addition, there have been a number of COVID-19 grants applicable to residential care including the COVID-19 Viability Fund, COVID-19 Aged Care Workforce Bonus Payments, the COVID-19 Aged Care Preparedness Packages and the COVID-19 Aged Care Support Program Extension grants.

Funding residential aged care services

One of the key tasks of the Aged Care Taskforce is to review the funding arrangements for aged care, informed by a clear assessment of provider viability issues.[8] This subsection aims to deliver just that by explicating the current outcomes, policy settings and issues that shape the funding of residential care services.

At an individual home-level, the average financial position of homes has deteriorated over the last five years. Whereas in FY19, homes earned on average $2.51 per resident per day, they now lose an average of $19.56 per resident per day (see Figure 2).

Figure 2: Financial results of residential aged care homes, by service area



Also, Figure 2 clearly shows that the poor performance of homes reflects a fundamental change in their financial business model. Historically, homes could generate sizable surpluses from direct care services that could cross-subsidise their losses from everyday living and accommodation services. However, since FY22, direct care has operated closer to break-even, where subsidies are sufficient to cover the cost of direct care but with little additional surplus.

8. Aged Care Taskforce | PM&C (pmc.gov.au)

This outcome fulfils a policy objective to ensure providers spend their direct care funding on direct care services, thus improving transparency and provider accountability for taxpayer and resident funding of care services. However, doing so has removed homes' capacity to cross-subsidise losses incurred for everyday living and accommodation services.

The following subsections will explore the funding of each of these three service areas in residential care.

Direct care: the first year of the new AN-ACC funding model

In 2022–23, a new funding model was introduced to fund direct care services in residential homes. Starting 1 October 2022, the Australian National Aged Care Classification (AN-ACC) funding model replaced the Aged Care Funding Instrument (ACFI) subsidies and various homeless and viability supplements.

Under AN-ACC, homes now receive a subsidy for the direct care of their permanent and respite residents, which is calculated based on three components:

- a daily Base Care Tariff (BCT) reflecting the fixed cost of providing services;
- a daily variable subsidy, based on the individual care needs of residents according to the AN-ACC classification; and
- a one-off transition payment for each newly admitted permanent resident.[9]

The rate for these three components is calibrated relative to a national efficient price set by the Government, based on advice now prepared by the Independent Health and Aged Care Pricing Authority (IHACPA). The AN-ACC starting price from 1 October 2022 was set at $206.80 for FY23, with the average AN-ACC subsidy expected to be $215 per resident per day.[10]

A central feature of the AN-ACC funding model is an expectation that homes increase their direct care staffing to meet new minimum requirements. Specifically, from 1 October 2023, each home must meet service-level care minute targets for their registered nurses and total direct care staffing, with the precise level of those targets tied to their residents' care needs assessed under AN-ACC.[11] In addition, from 1 July 2023, homes need to ensure they have at least one registered nurse on-site and on duty at all times.[12]

In UARC's 2021–22 Full-Year Report, we forecast the estimated impact of AN-ACC on direct care revenues and costs for FY23 (summarised in Table 1). UARC anticipated that the rising direct care costs, particularly staffing, would potentially result in a funding shortfall for direct care (estimated at $7.65 per resident per day). However, Table 1 shows that this shortfall did not materialise. Instead, homes generated an average direct care result for FY23 of $1.58 per resident per day.

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9. Australian National Aged Care Classification funding model | Australian Government Department of Health and Aged Care
10. The first AN-ACC price was set by the Department and released at the May 2022–23 Budget. Both the starting price and average AN-ACC value are reported here excluding the $10 basic daily fee supplement.
11. Sector-wide, the targets for 1 October 2023 are 200 minutes per resident per day for total direct care and 40 minutes per resident per day. These targets will increase to 215 minutes and 44 minutes respectively by 1 July 2024. Each home's targets are determined by the relative acuity of their residents, as assessed under AN-ACC. Homes with more high needs residents will have targets above the sector-wide averages and homes with more low needs residents will have targets below.
12. Some homes are eligible for a 12-month exemption from this requirement, based on their size and location. This is detailed in the Workforce section in Part 1.

Table 1: Average direct care result (FY23), forecast and actual, per resident per day

	FY22 (actual)	FY23 (forecast)	FY23 (actual)	Variance (actual vs forecast)
Direct care revenue	**$195.13**	**$215.00**	**$214.74**	**($0.26)**
Direct care costs:				
Direct care labour costs	$138.89	$165.04	$161.32	($3.72)
Other care-related labour costs	$27.09	$28.11	$26.31	($1.80)
Other direct costs of direct care	$12.48	$13.20	$7.95	($5.25)
Administration costs of direct care	$15.42	$16.31	$17.59	$1.28
Total direct costs	**$193.88**	**$222.65**	**$213.17**	**($9.48)**
Direct care result	**$1.25**	**($7.65)**	**$1.58**	**$9.22**

As forecast, homes received a substantial boost in direct care funding, up 10% on the year prior (about $19.61 per resident per day). Nonetheless, homes' direct care costs were much lower than anticipated, growing at a similar pace as revenue.[13]

One reason direct care costs were lower than expected was the timing of the required uplift in direct care staffing.[14] In our initial forecast, UARC assumed that all homes below their targets would increase their direct care staffing time at the start of the year, coinciding with the start date for AN-ACC. However, the care minute targets only became mandatory on 1 October 2023, a full 12 months after AN-ACC funding commenced. As detailed later in the Workforce section of Part 1, many homes have either delayed or been constrained from lifting their direct care staffing to meet their care minute targets in FY23.

As such, during FY23, homes have received a temporary transitional financial benefit, receiving higher AN-ACC funding from 1 October 2022, without having to make proportional increases in their direct staffing until the targets become mandatory 12 months later.

Looking forward, UARC's analysis has identified two emergent issues that warrant further attention as AN-ACC continues to be refined and updated by the Government based on the IHACPA's advice.

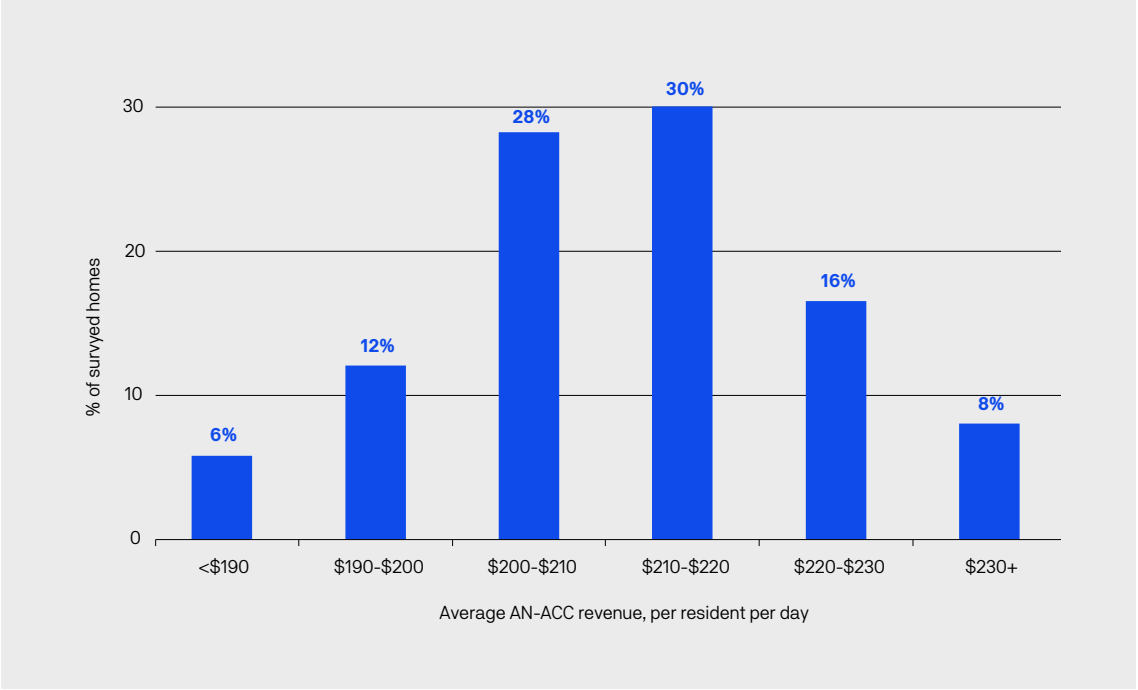
First, several key areas of expenditure appear to be growing faster than initially forecast. For example, administration costs grew by 14.1%, exceeding the inflation rate for the year. Also, homes have encountered rising input prices for direct care labour, driven by an increasing reliance on agency workers. As will be explored later in Part 1, the median hourly rate for all direct care workers grew by 6% in the last year and 9% for registered nurses, noting that this wage growth precedes the 15% increase arising from the Fair Work Commission (FWC) work value case. If homes have to pay these rates (or higher) to make up any remaining staffing gaps to meet their care minute targets, this could quickly eliminate the current slim margin for direct care.

13. UARC's initial forecast should be interpreted with several modelling caveats in mind. First, the FY23 forecast for revenue did not account for the timing of the AN-ACC funding start date in October 2022 or the additional revenue homes may have received from the AN-ACC transitional fund. Second, the FY23 forecast for direct care labour was based on sector-wide, not service-level targets for care minutes. Third, the FY23 forecast assumed that all homes below the sector-wide target in FY22 would lift their staffing to meet those targets for the duration of FY23.

14. There also appears to have been a slight contraction in labour costs of other care staff. Likewise, there was a contraction in other direct costs, most of which related to the reimbursement of COVID-19 expenses.

Second, although homes, *on average*, earn a slim margin from direct care, there is substantial variation in the direct care margins across the sector. UARC has modelled the direct care margins of homes, split into six groups based on the average AN-ACC funding received.[15] Due to how the variable component of AN-ACC funding is calculated, this grouping gives an approximate indication of the relative complexity of the care needs of each home's resident profile according to the AN-ACC classification system.[16]

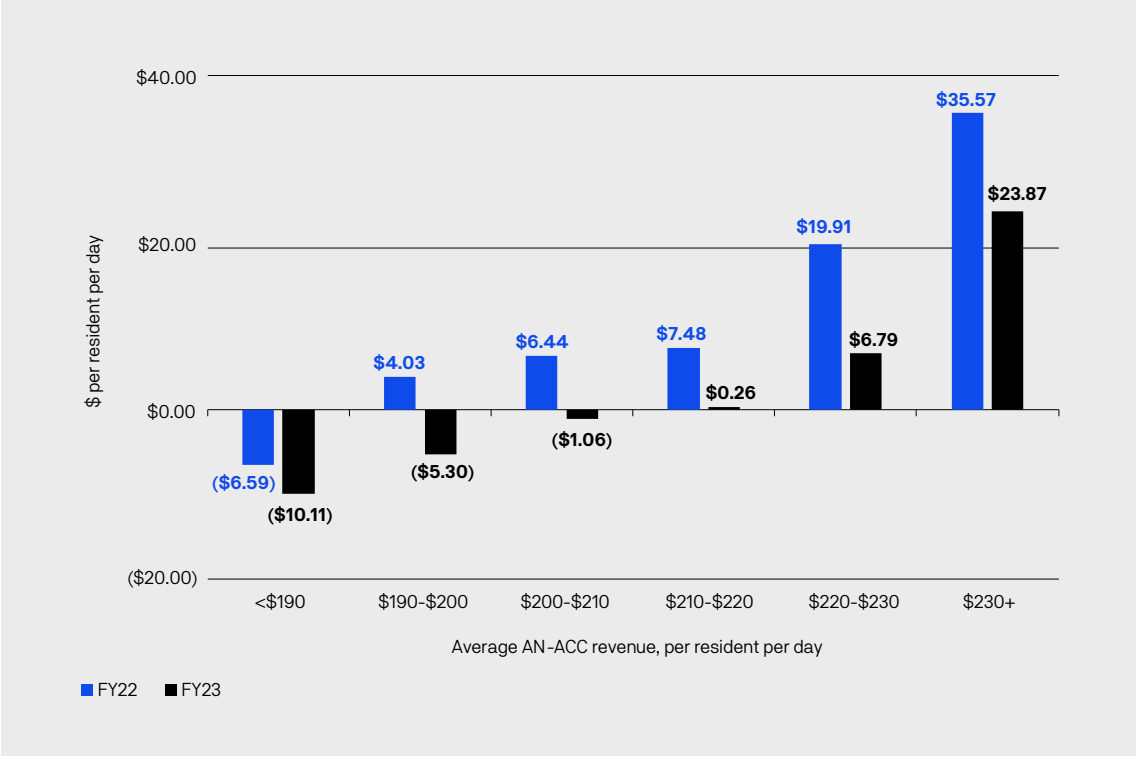
Figure 3: Distribution of homes by average AN-ACC revenue, per resident per day



As depicted in Figure 3, more than half of surveyed homes (58%) received an average of between $200 and $220 per resident per day in direct care subsidies and supplements. Nonetheless, depending on their location, service offering and resident profile, AN-ACC funding for homes varied widely, from an average of less than $190 per resident per day to over $230 per resident per day.

15. This modelling was conducted using the 2022–23 StewartBrown residential care dataset, comprising 1,197 homes (45.3% of all homes nationally).
16. It only provides an approximation of care need complexity, as homes' average AN-ACC funding will also be affected by the fixed funding (i.e. base care tariff), reflecting their location and service offering, as well as one-off transition costs, reflecting the relative resident turnover rate.

Figure 4: Direct care result, by average AN-ACC revenue, per resident per day

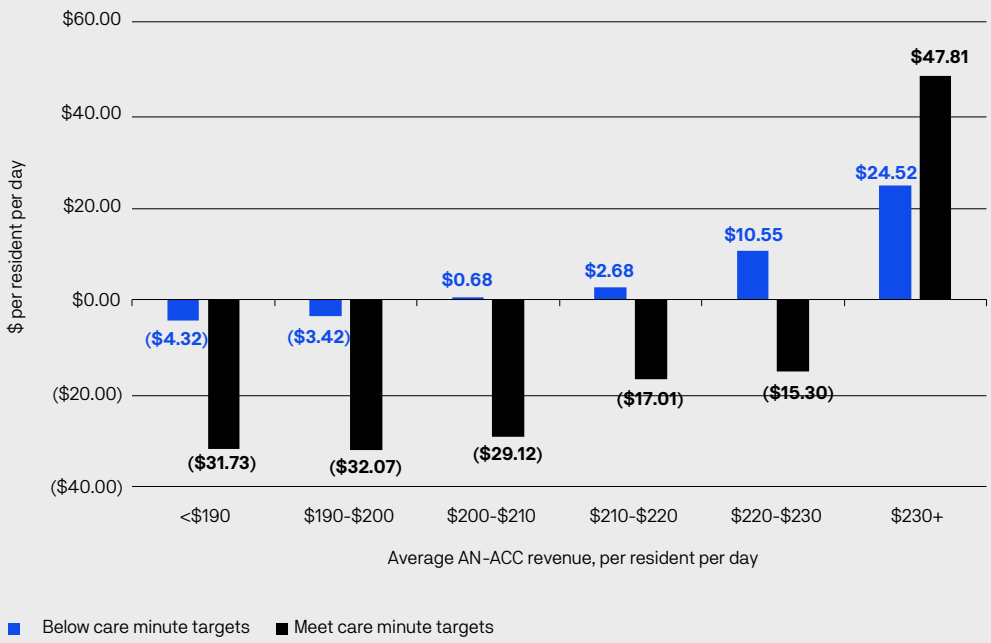


UARC's modelling reveals a clear association between the margin homes make from direct care and the level of AN-ACC funding they receive (see Figure 4). On average, homes with lower AN-ACC funding (i.e., more residents with less complex care needs) struggled to meet direct care costs in FY23. In contrast, on average, those with higher AN-ACC funding (i.e., more residents with more complex needs) earned a significant margin. Furthermore, this association appears to have persisted year-to-year, irrespective of whether homes have been funded predominately under ACFI (FY22) or AN-ACC (FY23).

Noting that the transitional effects of AN-ACC (described above) may influence these results, UARC examined the FY23 results separately for homes that, as of Quarter 4 FY23, have direct care staffing sufficient to meet their incoming care minute targets and those still below.[17] This approach provides insight into the future viability of direct care (i.e. once the care minutes become mandatory) for homes receiving different levels of AN-ACC funding.

17. This modelling was conducted on 955 homes that participated in the StewartBrown residential aged care dataset for both Q3 and Q4 of FY23. The analysis compared their direct care staffing reported for April – June 2023 with their service-level targets for 1 October 2023 published by the Department of Health and Aged Care. Homes were classified as 'meet' if their staffing was at or above both their care minute targets for registered nursing and total direct care: Care minutes targets in residential aged care by service | Australian Government Department of Health and Aged Care

Figure 5: Direct care result, by average AN-ACC revenue and care minute targets, per resident per day



Unsurprisingly, this analysis depicted in Figure 5, shows that, on average, homes still below their care minute targets have better direct care margins. For example, those receiving an average of $200–$210 per resident per day or higher appeared to generate a direct care surplus in FY23, and those with lower AN-ACC funding but were also below their care minutes targets were close to break-even.

However, homes already meeting their direct care minute targets had much poorer direct care outcomes across all groups. Except for homes earning the very highest AN-ACC rates, homes currently meeting their care minute targets incurred substantial losses in direct care for FY23, between, on average, $15.30 and $32.07 per resident per day.

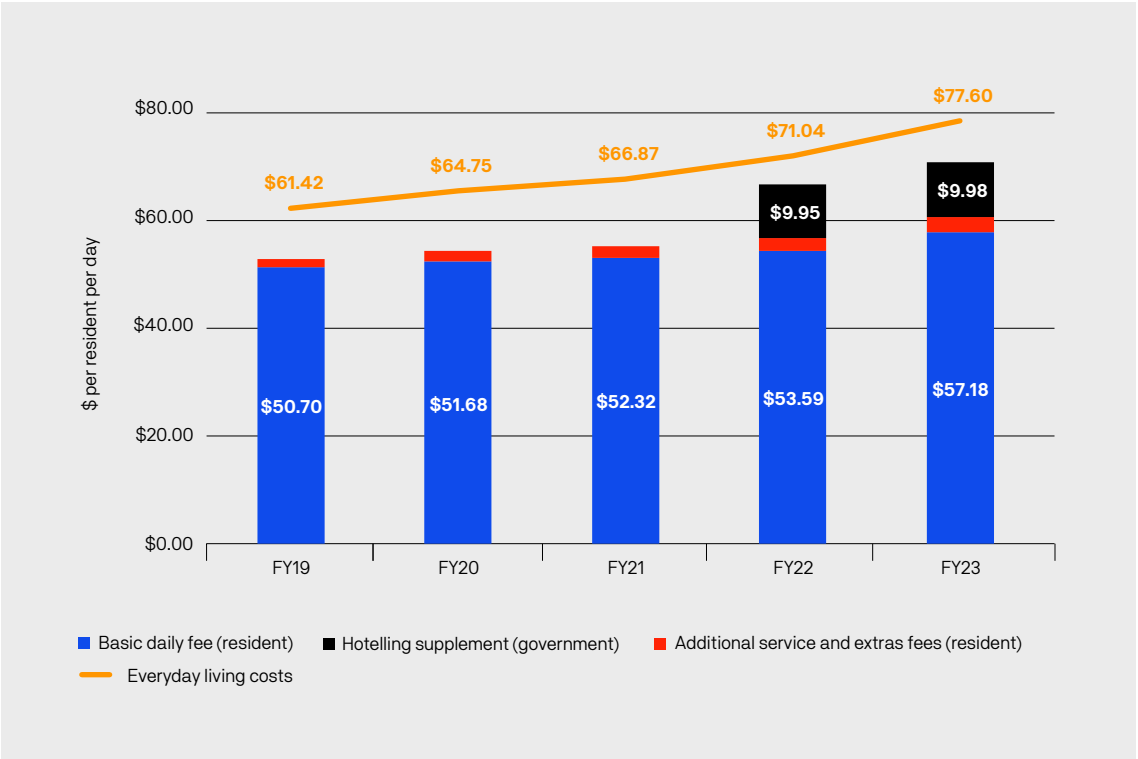
Although AN-ACC funding will increase again in FY24, rising 17.6% to a base price of $243.10, these findings reinforce concerns about the future adequacy of AN-ACC funding rates to meet the rising direct labour costs, particularly for homes servicing more low-care residents. As IHACPA and the Government continue to refine the AN-ACC funding model over time, they should aim to ensure greater parity in the direct care outcomes of homes, regardless of their resident profile, location or specialist service offering.

Everyday living: revenue still insufficient to meet costs

One of the ongoing reasons for residential care homes' poor financial outcomes is that they continue to generate operational losses from everyday living services, averaging $7.63 per resident per day in FY23.

The long-term trend depicted in Figure 6 shows that homes' expenditure on everyday living services (including catering, cleaning and laundry) has been consistently higher than homes' revenues.

Figure 6: Everyday living revenue and costs, per resident per day



The funding gap has persisted even with the substantial increase (28.5%) in revenue for everyday living in the last two years. Revenue was boosted in FY22 when the Government introduced the Basic Daily Fee supplement (now called the 'hotelling' supplement), worth $10 per resident per day, which applied to all residents irrespective of their financial circumstances. Also, the Basic Daily Fee revenue collected from residents has increased due to indexation.[18]

These results suggest that further structural reform of the funding of everyday living services is required. A review by IHACPA of the costs of providing everyday living services is warranted to ensure the price settings of everyday living revenue streams, including the Basic Daily Fee and hotelling supplement, are sufficient to meet service costs. In addition, the current Aged Care Taskforce has signalled its intent to explore options to reform personal contributions for everyday living services (Draft Funding Principle 3). UARC's position on consumer contributions is discussed later in Part 1 (see Sector Funding).

18. The basic daily fee is capped at 85% of the single-age pension, which is pegged to inflation and thus grew by 6.7% in FY23.

Accommodation: largest area of operational losses

Accommodation services have been, and remain, the most significant viability concern in residential care. In FY23, homes lost an average of $13.49 per resident per day in providing accommodation services, which constituted the largest area of operational losses.

Among the reasons homes struggle to break even in providing accommodation are problems with how these services are funded through government supplements and resident accommodation fees.

Government supplements for supported residents

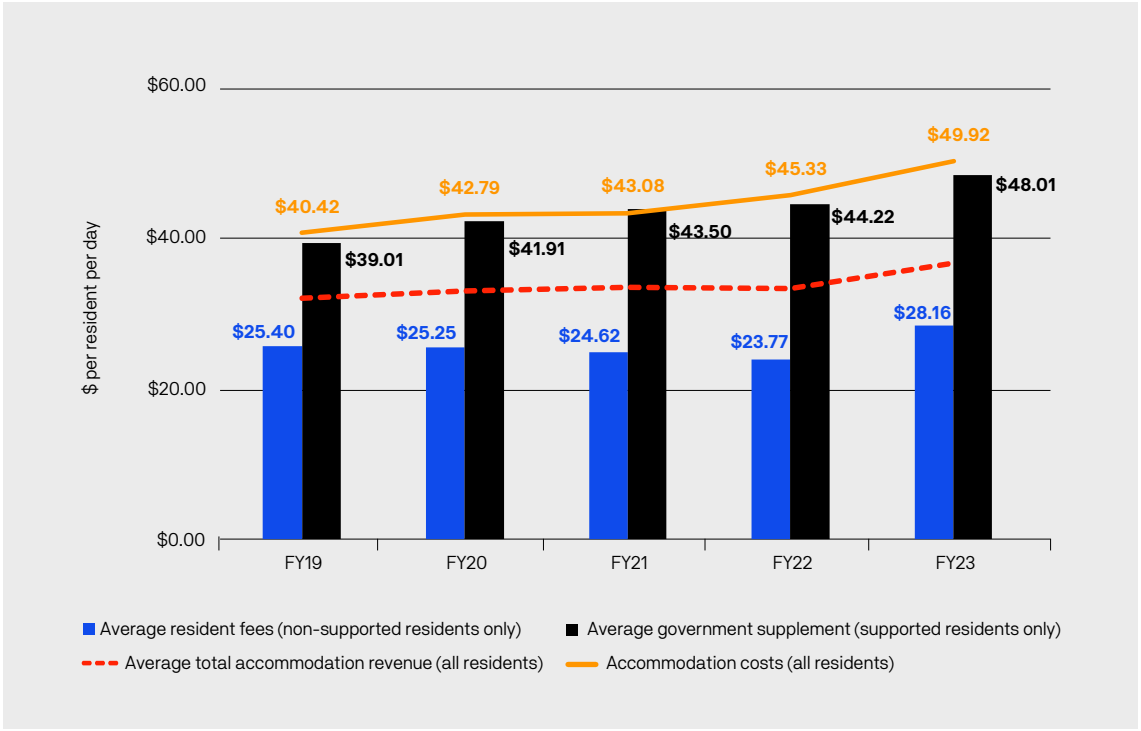
On average, about 60% of homes' total revenue for accommodation is currently funded through government supplements paid on behalf of low-means residents (i.e. those are classified as either 'supported' or 'partially supported'). In FY23, the average supported resident ratio for a home in the StewartBrown dataset was 45.5% (i.e. approximately 46 residents out of 100 were classified as supported or partially supported).[19]

The precise value of the supplement paid to each home varies, depending on whether a home's building is newly built or refurbished and the extent to which the home meets a minimum ratio of low-means residents.[20] Homes may only receive the maximum value of the supplement (currently $65.49 per resident per day for newly built or refurbished homes since April 2012) if they maintain at least 40% of their places for low-means residents.[21]

Over the last five years, the average value of government supplements received for supported residents has often fallen below the average daily cost of accommodation services.

19. This estimate, based on the StewartBrown residential care dataset, is slightly higher than the estimate reported by the Productivity Commission (2023) *Report on Government Services*, which reported that in 2021–22, 39.8% of permanent new residents or all resident care days were classified as concessional, assisted, supported or low means.
20. The value of the supplement paid is also lower for residents classified as 'partially supported', who also make some contributions towards the cost of their accommodation.
21. The supplement is reduced by 25% for homes that have fewer than 40% of their residents classified as supported or concessional.

Figure 7: Average value of accommodation revenue, by source, per resident per day



To give a sense of how this funding compares to the cost of accommodation, Figure 7 shows the average value of government supplements received per day per supported resident.[22] This shows that over the last five years, the average revenue earned by homes for supported residents has often fallen below the average cost per resident per day. For example, in FY23, homes earned, on average, $48.01 per supported resident per day, less than the cost of providing accommodation ($49.92 per resident per day). These results suggest that the pricing of the Government's accommodation supplement should be increased to meet the costs of accommodation services for supported residents while also delivering a reasonable margin for providers to remain viable and support future investment.

22. This rate has been calculated by weighting homes' average government supplement revenue (per resident per day) by their supported resident ratio.

Accommodation fees paid by non-supported residents

The remaining 40% of homes' accommodation revenue is generated from accommodation fees paid by non-supported residents. Figure 7 also models the value of accommodation fees earned by homes, stated as a daily rate per non-supported resident.[23] In FY23, these averaged $28.16 per non-supported resident per day. These fees are far below homes' average accommodation costs.

Accommodation fees are much lower than the equivalent value of the government supplement because of a combination of three factors:

1. The choice of payment method
2. The price that providers agree with incoming residents for their room
3. The value of the Maximum Permissible Interest Rate (MPIR) when a resident enters a home

First, in terms of the choice of payment, non-supported residents can opt to pay either rent, referred to as 'daily accommodation payments' (DAPs), a refundable lump sum, known as a 'refundable accommodation deposit' (RADs), or a combination of the two.

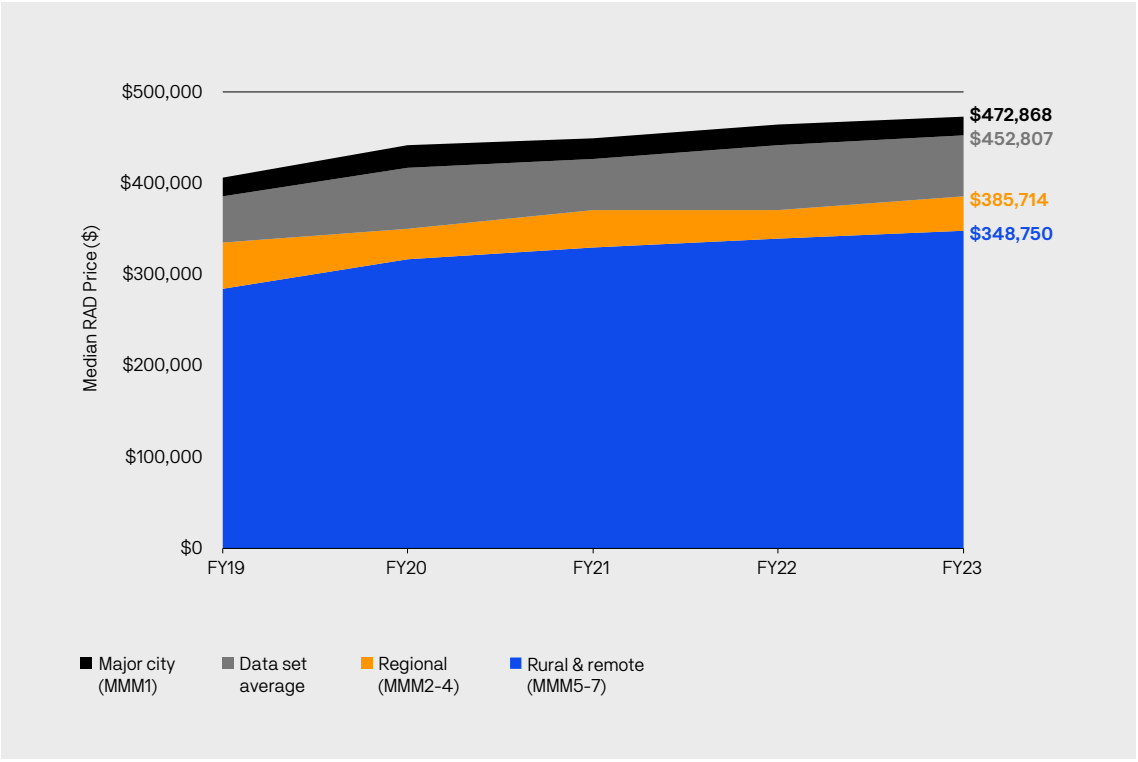
Individuals who opt to pay via a RAD don't pay rent and have the full nominal value of their lump sum returned at the end of their stay.[24] From the provider's perspective, while they earn operational revenue (rent) from DAP and combination payers, they do not from full-RAD payers.[25] Although the proportion of RAD payers has slowly been decreasing in recent years, they still represent a sizable segment of non-supported residents.[26]

It's important to note that while RADs do not contribute to homes' operational revenue, many providers value the receipt of RADs to finance their capital expenditure and finance refunds of previous lump-sums.

Second, the rent payments (DAPs) price is calculated as a set percentage of the agreed RAD value of an incoming resident's room. Figure 8 shows that providers have only sought very modest price growth over five years, particularly in comparison to the growth in equivalent housing assets across Australia. 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 (noting this threshold has not changed since the introduction of RADs in 2014).

23. This rate has been calculated by weighting homes' average accommodation fee revenue (per resident per day) by the inverse of their supported resident ratio. Note this represents the average fees collected from all non-supported residents, regardless of their choice of payment.
24. RAD payers bear the opportunity cost of forgoing any interest earnings on those funds.
25. The operational revenue for accommodation represented in this section does not include any imputed value of the equivalent interest for RADs.
26. The Department reports that in 2021–22, 31% of new residents chose to pay via a lump sum.

Figure 8: Median price of new Refundable Accommodation Deposits, by location



Third, DAP prices are also determined at entry by a set interest rate called the Maximum Permissible Interest Rate (MPIR). As the MPIR has been set with reference to prevailing interest rates, the low-interest environment experienced in the past has also kept DAP values low.[27] Although the MPIR has recently increased with interest rates (now 8.15%), these changes will only apply to the DAP prices paid by new residents, meaning there will be a lag effect before the uplift is reflected in higher accommodation revenue. Furthermore, this method of calculating DAPs has caused a misalignment between the value of rent payments for residential aged care accommodation and other forms of accommodation, such as private units and dwellings.

27. Correspondingly the MPIR has increased with interest rates. For example, as of 1 October 2023, the MPIR was 8.15%, double that of 2021–22.

Administration costs: rising compliance and governance responsibilities

Another source of financial pressure for residential providers is the rising costs of administration, which have accelerated in the last two years. On average, the StewartBrown dataset reports that homes spent $47.55 per resident per day on administration in FY23, compared to $34.61 in FY19.[28]

Figure 9: Cumulative growth in administration costs in residential care

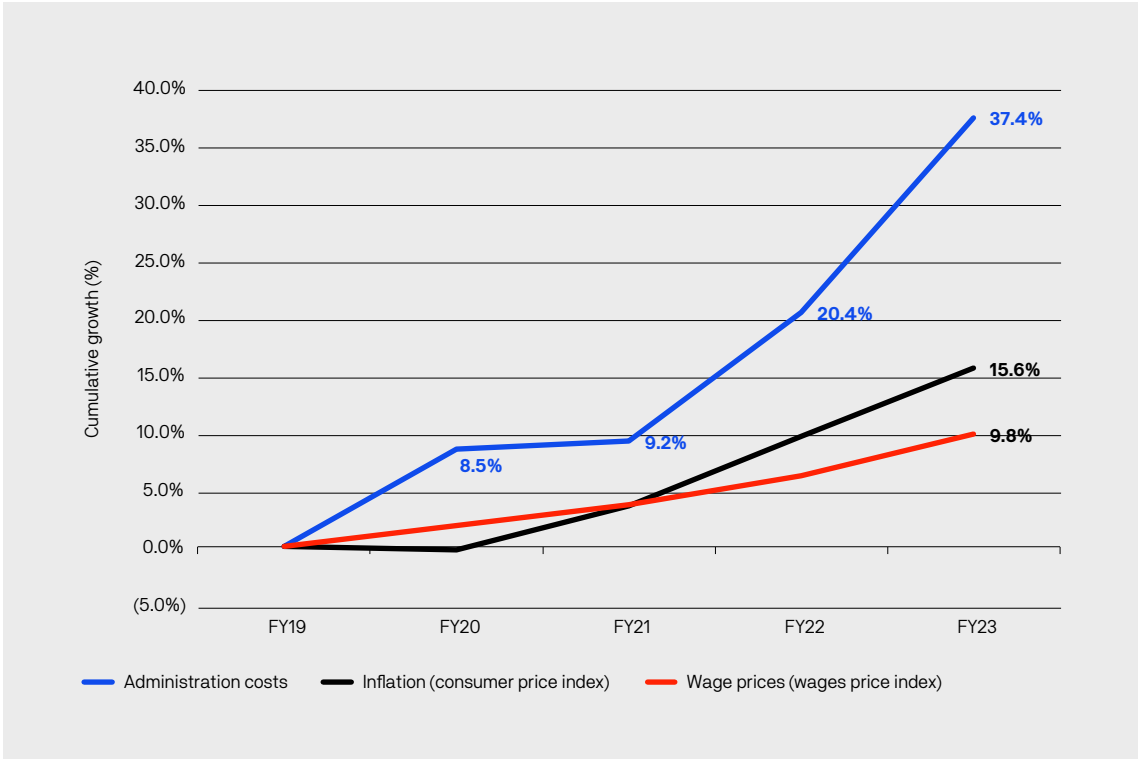


Figure 9 puts the cumulative growth of homes' administration costs in context by comparing it to the cumulative increases in inflation and wages. This shows that in the last four years, the growth in administration costs (37.4%) has far outpaced the growth in prices of consumer goods and services (15.6%)[29] and wages (9.8%).[30]

28. Over the same period administration costs as a percentage of homes' total revenue have grown, on average, from 13% to 15%.
29. Inflation is measured using the Consumer Price Index, based on data from Australian Bureau of Statistics for June 2023.
30. The annual wage price index for health and social assistance was measured using Australian Bureau of Statistics Wage Price Index Data for June 2023.

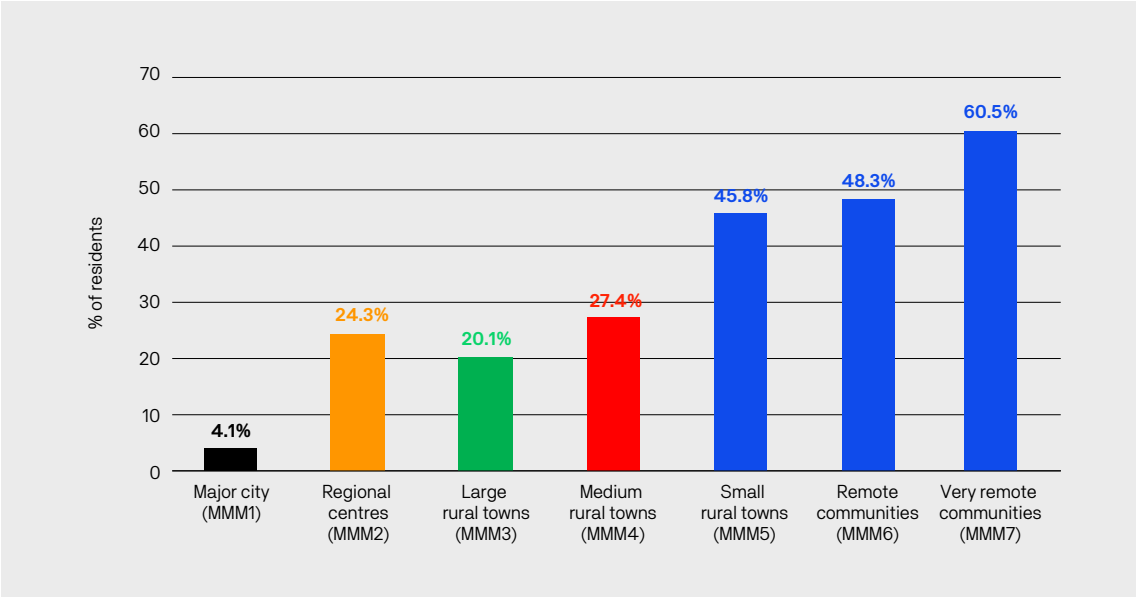
This suggests that a substantial proportion of the growth in administration costs is attributable to non-price effects. Homes have likely implemented additional measures to comply with new quality and safety measures, including changes to their operations and enhanced reporting to the Government. Since 2019, some of the major reform initiatives affecting residential providers include:

- Introduction and expansion of National Mandatory Quality Indicators
- New Aged Care Quality Standard
- New Charter of Aged Care Rights
- New Code of Conduct for Aged Care
- Aged Care Financial Reporting
- Serious Incident Response Scheme
- Worker screening requirements
- New restrictive practices policy
- Quarterly Financial Reporting
- Change to provider governance requirements
- Introduction of Star Ratings
- Monthly reporting of 24/7 registered nurse coverage

Regional disparities in homes' financial outcomes

The financial viability of homes outside major cities is crucial in ensuring accessibility to residential care for older people across non-metropolitan Australia. Older people living outside major cities are already more likely to move and travel further distances for care. For example, evidence presented at the Royal Commission (Figure 10) showed that while only 4.1% of people living in metropolitan areas needed to travel to access permanent residential care, this proportion increased to over 60.5% for those based in very remote communities.[31]

Figure 10: Proportion of people who move for residential care



Homes experiencing viability issues are at greater risk of closure. As recent media reports describe, home closures in a non-metropolitan area can cause significant disruption for residents, families and local communities.[32]

The new AN-ACC funding model includes two adjustments to deliver higher direct care funding for non-metropolitan homes. The classification system relies on the Modified Monash Model (MMM), which classifies areas into seven categories based on geographical remoteness and town size, where MMM1 corresponds to major cities, and MMM7 corresponds to very remote communities. [33]

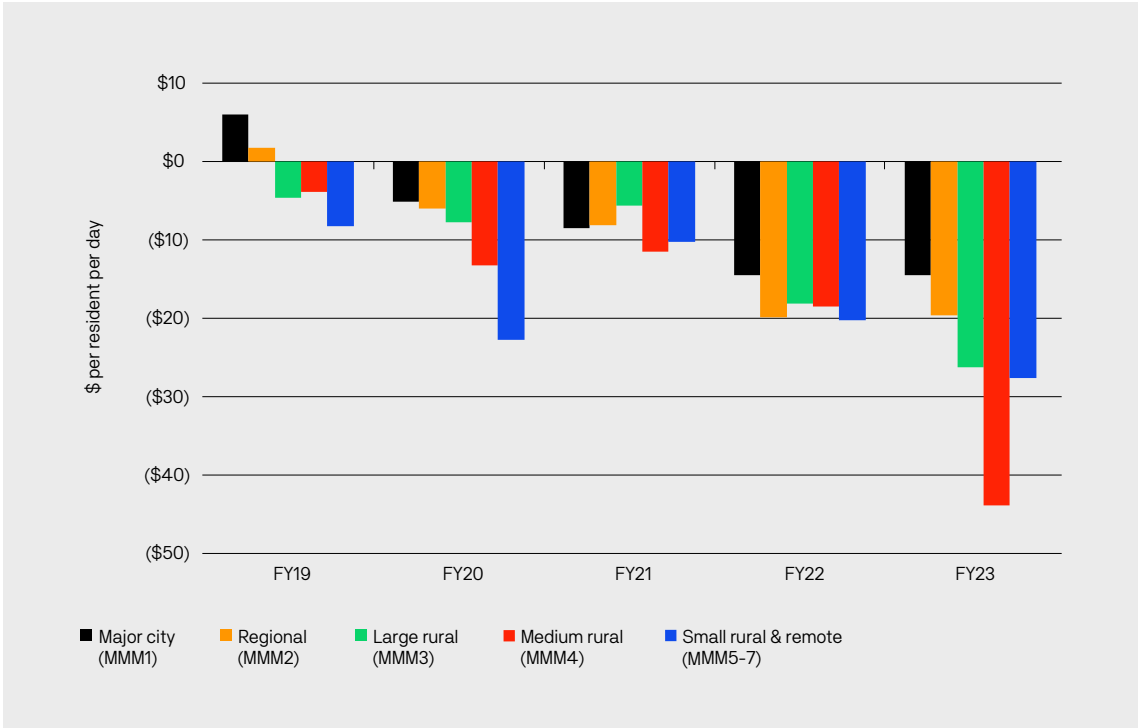
Under AN-ACC:

- Homes in areas MMM5, 6, or 7 receive higher BCT subsidy rates [34]
- Homes in MMM6 and 7 areas receive the BCT based on operational (rather than occupied) places.

31. The Royal Commission of Quality and Safety into Aged Care (2021), Research Paper 16 - *How far do people move to access aged care.*
32. Lack of rural aged care forcing elderly to move away from communities - ABC News; Bombala's only aged care home closes, residents relocated despite community backlash - ABC News; 'All of us are struggling': regional Australia's aged care homes strain to stay viable | Aged care | The Guardian
33. Modified Monash Model | Australian Government Department of Health and Aged Care
34. As of 1 October 2022, the base care tariff subsidy rate for homes in areas MMM1-4 was $106.23 per occupied place, whereas those in areas MMM5 received $119.25 and MMM6 and 7 received $147.42. These rates were even higher for homes that serviced homeless and Aboriginal and Torres Strait Islander peoples.

The long-term trends, depicted in Figure 11, show that non-metropolitan homes mostly have experienced poorer financial outcomes than their major city counterparts, with remote homes typically having the worst financial outcomes.

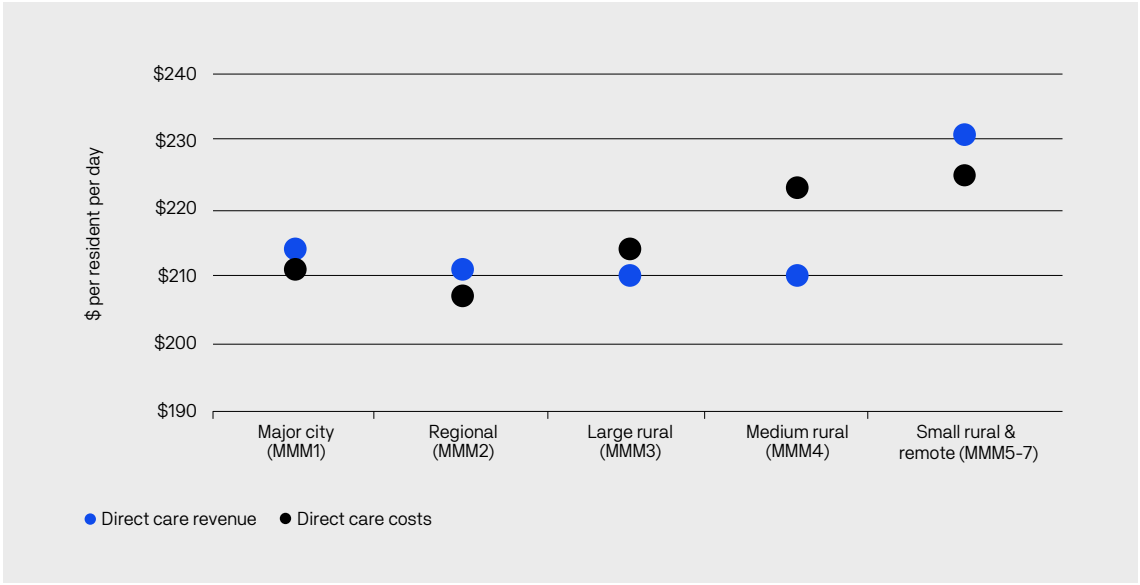
Figure 11: Operating Result, by location, per resident per day



Due to COVID-related funding provisions, homes' average financial outcomes converged during FY21 and FY22; however, in FY23, they became more disparate again. Whereas the financial performance of homes in metropolitan and regional centres appeared to stabilise, it deteriorated for those in rural towns and remote communities. In particular, the homes experiencing the sharpest decline were those in medium rural areas (MMM4), which, in FY23, lost an average of $43.86 per resident per day.

The key factor causing this disparity in homes' financial outcomes is the viability of their direct care services. On average, homes in large and medium rural towns earn the lowest direct care revenue per resident per day. Yet, their direct care costs are almost as high as those of homes in smaller rural and remote locations (see Figure 12).

Figure 12: Direct care revenue and costs, by location, per resident per day



Further analysis by UARC, detailed in Part 2, identifies several key factors causing these disparate direct care results across homes in different locations:

1. **Differing funding outcomes under the AN-ACC model:** Homes in areas MMM5-7 receive more *fixed* funding due to higher BCT subsidy rates, and homes in major cities (MMM1) tend to earn more *variable* funding due to their higher concentration of residents with high care needs. However, homes in between (i.e., in MMM 2, 3, and 4 areas) are funded at the same (low) fixed BCT rates as those in the major cities but also earn lower variable funding because they serve a more diverse resident profile.
2. **Occupancy:** Homes in metropolitan and regional areas tend to have higher occupancy rates, which lower their average cost per resident. By comparison, in FY23, homes in rural towns experienced sharp declines in occupancy down to levels commensurate with more remote homes.
3. **Transitional benefits of AN-ACC funding:** On average, homes in medium rural areas are closest to achieving their incoming care minute targets, meaning they are less likely to benefit from the FY23 transitional effects of AN-ACC funding.
4. **Agency staffing:** Homes in rural and remote locations incur higher direct care labour costs, partly due to high reliance on agency staffing, which is also more expensive outside major cities.

Taken together, while homes in medium and large rural towns face similar operational challenges as their more remote counterparts (i.e. low occupancy, diverse resident profiles, and higher input costs), they remain ineligible for higher BCT funding under AN-ACC. As a consequence, UARC proposes that the Department, informed by advice from IHACPA, consider adopting more granular BCT subsidy rates that differentiate funding for homes in MMM1-4 areas.[35]

35. An alternative option would be to differentiate MMM2-4 homes in the Base Care Tariff, with funding being provided for operational, rather than occupied places. However, this option runs the risk of perverse incentives to game the provision of operational places. Whereas it is a priority to ensure 'capacity availability' in rural and remote areas, this is a less pressing issue in regional areas where there are more homes.

Market consolidation in residential care

This section analyses the ongoing trend toward market consolidation. It assesses the resultant financial performance and makes some preliminary observations about the quality of care. The analysis explores issues of economies of scale in two dimensions:

- economies that may be available to larger providers (as assessed by the number of homes they operate)
- economies available to larger homes (the number of places in each home)

Provider scale trends and financial performance

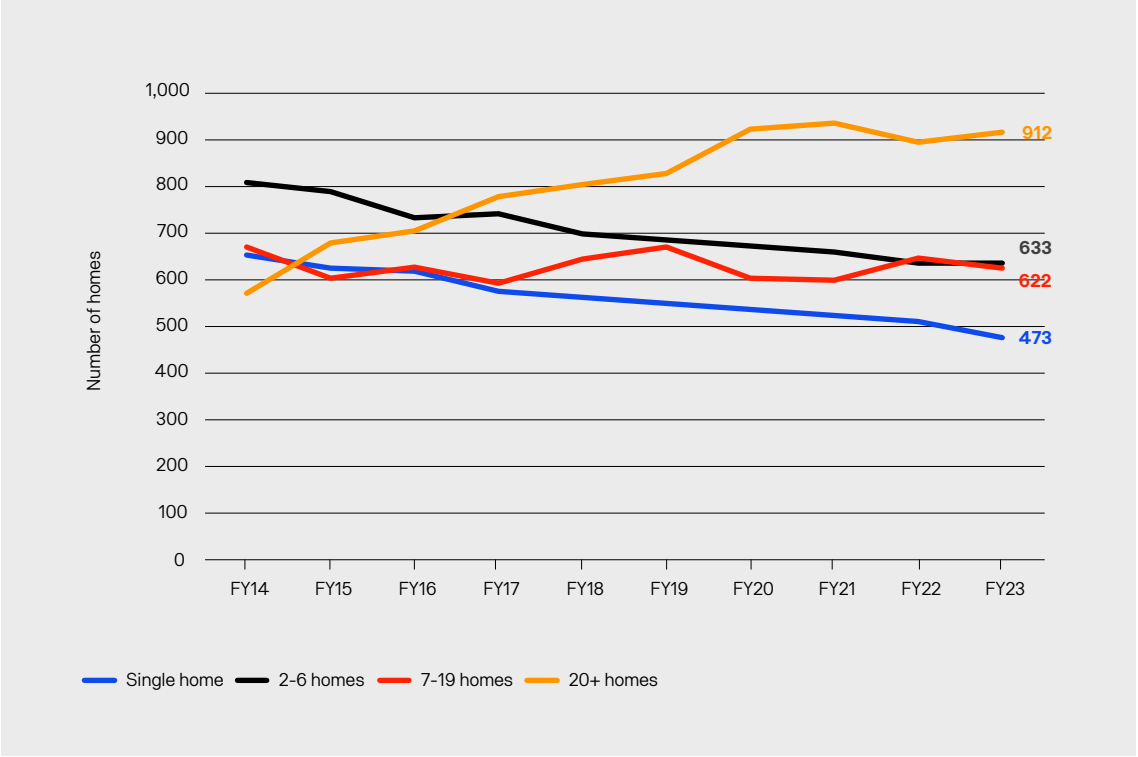
To understand the trend of provider consolidation in residential care, UARC has adapted data on all residential aged care homes from the Aged Care Service listings from FY14 to FY23, which is publicly available from the Australian Institute of Health and Welfare (AIHW).[36]

Over the last decade, there has been a slight decline in the total number of residential homes in Australia. In FY23, there were 2,640 homes, down from a high of 2,722 in FY20 and below the FY14 total of 2,688. Figure 13 illustrates that, despite this declining trend in total homes, the number of homes operated by the largest providers (20+ homes) rose rapidly from 567 in FY14 to over 912 by FY20, and this level has persisted over the most recent four years. In contrast, there has been a continuous decline in the number of homes operated by the two smallest provider categories. Single-home providers, in particular, operated 649 standalone homes in FY14 but only 473 homes by FY23.

In aggregate, across the entire period, the largest providers had a net increase of 345 homes, while standalone and small chain providers reported a net decrease of 176 homes and 172 homes, respectively.

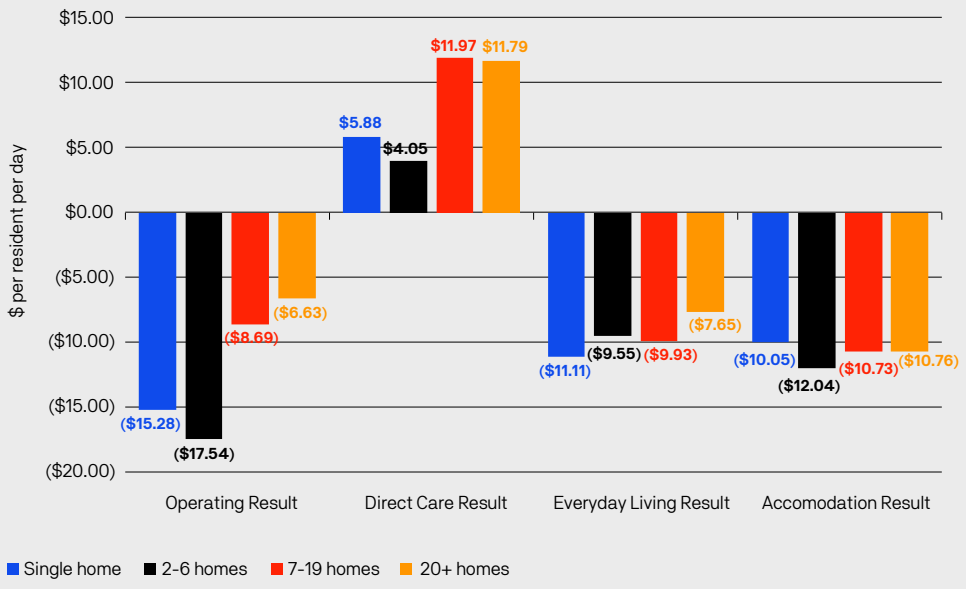
36. Aged care service list - AIHW Gen (gen-agedcaredata.gov.au)

Figure 13: Total number of residential homes, by provider scale



The trend towards larger providers servicing a growing market share raises questions about whether provider scale generates operational and financial advantages. Using aggregated data from the StewartBrown dataset between FY19 and FY23, UARC has analysed the average financial results of homes operated by providers of different scales, both overall and for the three service areas of direct care, everyday living and accommodation. Note that these results represent the average results across five financial years (FY19-FY23).

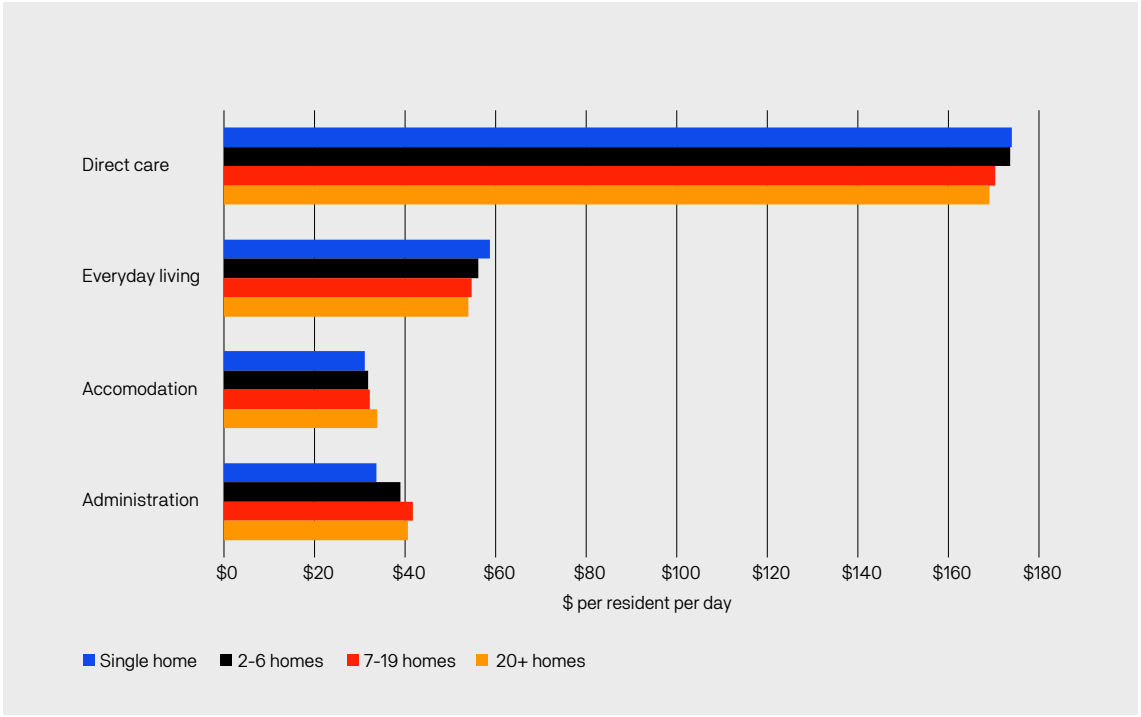
Figure 14: Average financial results (FY19–FY23), by provider scale, per resident per day



These results, depicted in Figure 14, show that while the overall Operating Result remains negative across all provider groups, on average, the losses per resident per day are smaller for homes operated by larger providers (20+ homes). The homes with the worst Operating Result tend to be small chain providers (2-6 homes), closely followed by standalone homes. When these results are disaggregated to the three service areas, homes operating seven homes or more earn substantially higher average direct care margins. The differences between provider groups for everyday living and accommodation are much more minor, with all groups, on average, reporting similar-sized losses for these two service areas.

Larger providers may accrue financial advantages through their ability to maximise revenue or minimise costs through economies of scale. The next level of analysis looks for evidence of the latter. To this end, Figure 15 compares the average daily cost per resident by service area and provider scale. It shows that larger providers have the lowest average direct care and everyday living costs, which may be due to some economies of scale in providing these services. However, accommodation and administration costs are higher for homes of larger providers.

Figure 15: Average costs (FY19–FY23), by provider scale, per resident per day



These results support the notion that larger providers have net overall financial advantages through lower costs (i.e. derive some economies of scale), which, if sustained, may lead to further consolidation. However, if these financial advantages are realised through lower direct and everyday living costs, this may adversely affect the quality of care delivered to residents.

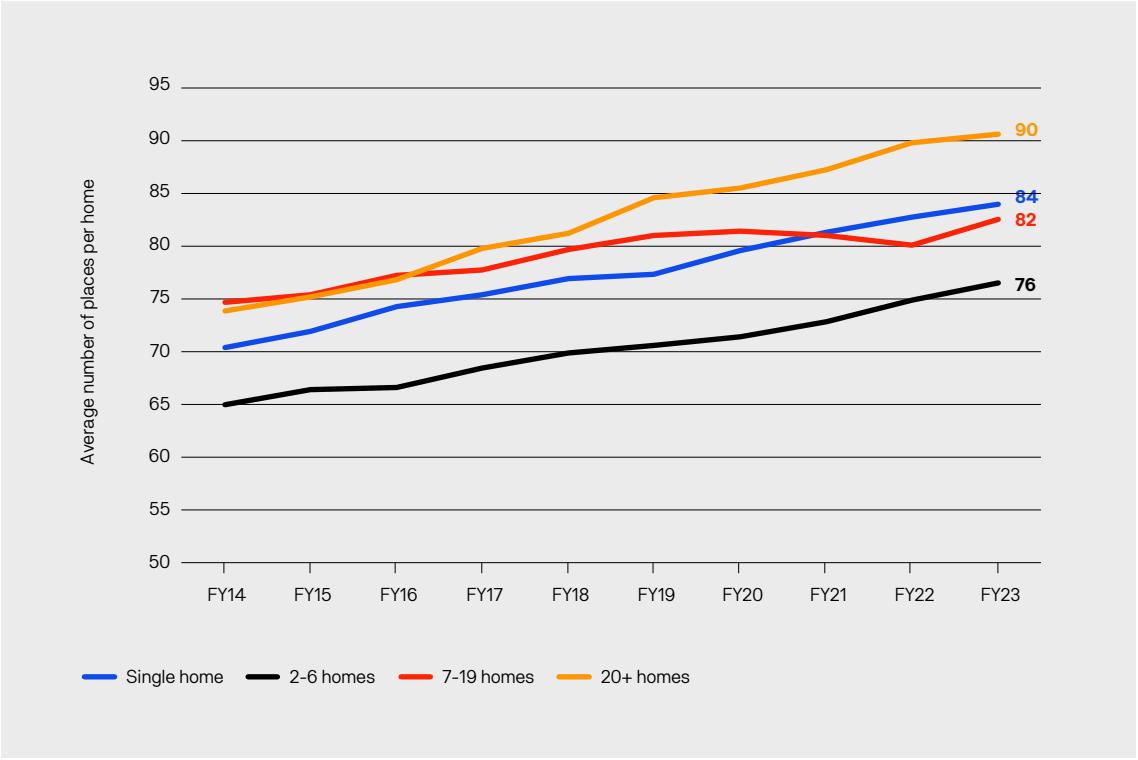
In a recently accepted peer-reviewed academic study, UARC researchers investigated whether acquired homes (i.e., changed provider ownership) had different quality outcomes after acquisition.[37] We found, on average, that homes' quality of care declined in the two years after acquisition, with significant increases in rates of resident complaints and hospitalisations. However, while most acquisitions during the study period (2015-2019) involved a large acquiring provider, the detrimental effects of acquisition tended to be concentrated to instances when the acquiring provider was smaller in scale, for profit, and had lower average quality in their other homes.

37. Article forthcoming in the *Australasian Journal of Ageing*

Trends in home size and financial performance

Another key size-related trend in residential care has been the steady growth in the average size of homes (i.e. the number of operational places). Based on aggregate sector AIHW data, Figure 16 shows a systematic increase in home sizes since FY14, irrespective of the providers' scale.[38]

Figure 16: Average home size, by provider scale



Sector-wide, the average home size increased from 70 places in FY14 to 84 in FY23. However, within this overall national trend are several more granular results worth mentioning. First, the average home size of small chain providers (2–6 homes) is consistently smaller than homes operated by other providers. Second, homes operated by the largest providers have the largest number of places and have grown faster than any provider group since FY14. This trend raises questions about whether there are economies of scale at a home-level, i.e., whether there are financial advantages in having larger homes.

38. Aged care service list - AIHW Gen (gen-agedcaredata.gov.au)

Part 2 of this report presents a detailed analysis comparing the financial performance of homes by size for FY23. It shows that in the last financial year, larger homes (i.e. those with more places) tended to have lower expenses and better overall Operating Result. By comparison, the smallest category of homes (those with fewer than 40 places) have the worst financial performance, incurring substantially higher average daily cost per resident than larger homes.

One possibility is that larger providers may operate larger homes more profitably. UARC has modelled the average Operating Result from FY19-FY23 of differently sized homes overlaid by provider scale (see Figure 17). This reveals that, across all home sizes, larger providers achieve better financial results (smaller deficits) than single-home providers or those operating 2-6 homes. Also, smaller-scale providers do not appear to benefit financially from operating bigger homes. In contrast, the largest providers (those operating 20+ homes) appear to generate much better financial outcomes from their larger homes.

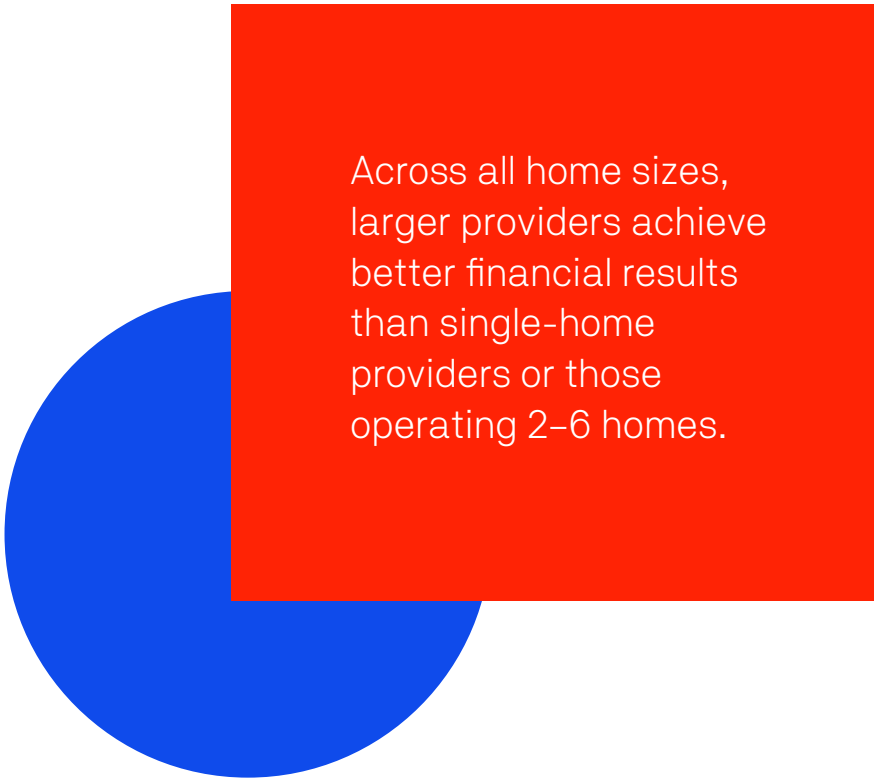
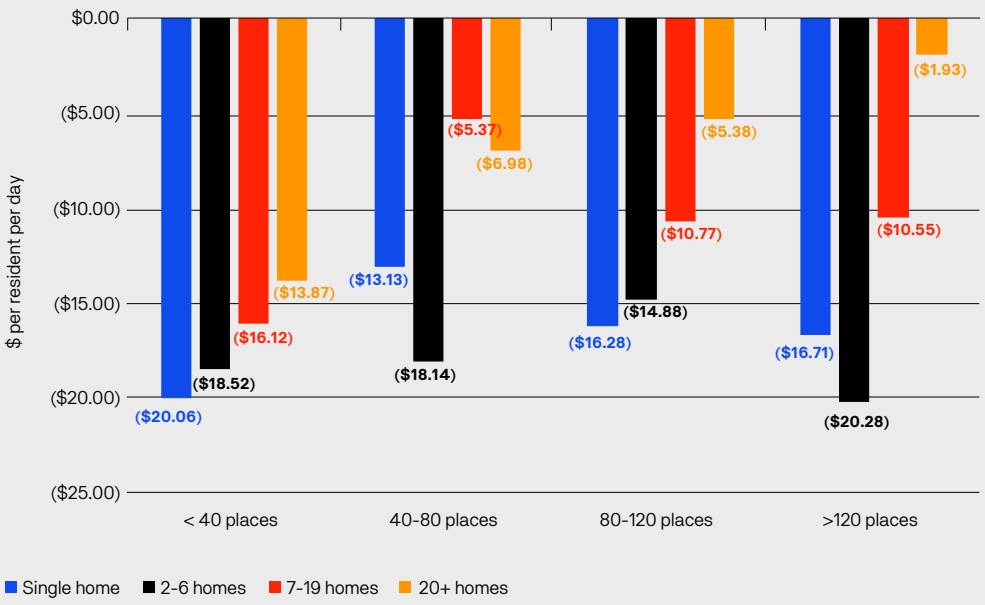


Figure 17: Average financial results (FY19-FY23), by home size and provider scale, per resident per day

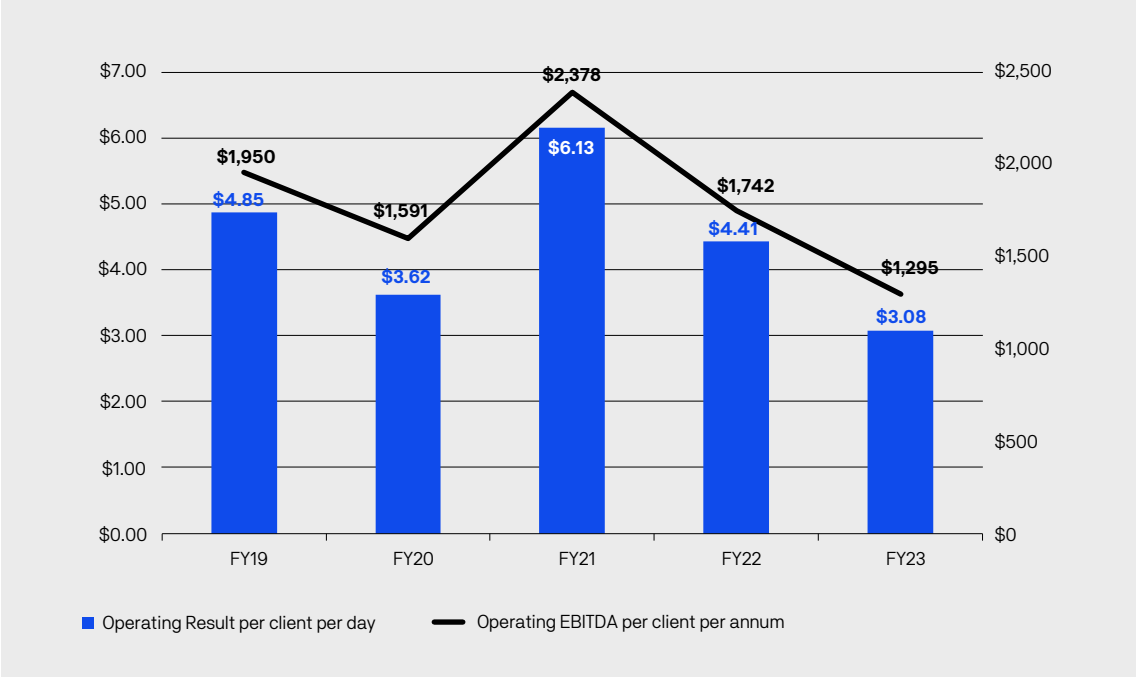


These results provide at least preliminary evidence of economies of scale that exist at both a provider and home-level. However, these cross-sectional trend analyses may be insufficient in explaining whether other factors, such as home location, also contribute to these patterns. To interrogate the issue further, UARC is undertaking a more rigorous multivariate analysis to better isolate the effects of provider scale and home size on homes' financial outcomes after controlling for other factors (e.g. home location, supported resident ratio, ownership status, resident profile and temporal trends).

Viability of home care

Home care providers continue to experience worsening financial performance, adding to ongoing concerns about the viability of home care service provision at a sector-level. In FY23, home care providers' average Operating Result[39] reached a 5-year low of $3.08 per client per day. Operating EBITDA and provider profit margin show a corresponding decline. At the aggregate level, the decline in Operating Result and provider profit margin appears to be driven by increasing costs in the context of stagnating revenues. These aggregate figures are explored in greater detail in Part 2 of this report.

Figure 18: Financial results of home care providers



For the FY23 results, UARC's analysis and reporting of home care data relates to the home care provider. This is a change from the methodology employed in previous reports, which analysed and reported on data as it relates to the home care service.[40] Of particular interest is looking ahead to implementing the Support at Home reforms, now scheduled to begin in 2025 with full unification no earlier than 2027, and considering the likely impact of those changes on different home care business models.[41]

In this section, providers are differentiated by:

- size (total number of home care packages)
- package mix (proportion of Level 1 & 2 packages out of the total number of home care packages)

39. Operating Result refers to the Net Profit Before Tax (NPBT) earned by a home care service provider.
40. This change enables a better understanding of trends in overall provider viability, rather than that of individual service locations, and to distinguish the financial performance of different provider types.
41. A change to the planned implementation of the Support at Home program was announced by the Minster for Aged Care, the Hon Anika Wells MP on 28 November 2023. The roll out of the new program will now take place in two stages, with Support at Home replacing Home Care Packages and Short Term Restorative Care Programme from 1 July 2025 and the Commonwealth Home Support Programme from no earlier than 1 July 2027. Support at Home to be rolled out in two stages | Health Portfolio Ministers | Australian Government Department of Health and Aged Care

The first step was to distinguish between *large providers* (more than 1,000 packages) and small providers (fewer than 1,000 packages). Large providers tend to service a mix of all four package levels, so they are not differentiated further.

Smaller providers were further categorised according to the average level of care that they provide across their packages. *Small, high-care* providers service a relatively low proportion (<40%) of Level 1 & 2 packages; while *small, low-care* providers service a relatively high proportion (>60%) of Level 1 & 2 packages. *Small, diversified providers* service mix of package levels (Level 1 & 2 packages make up between 40-60% of all packages, with a category average of 49.1%).[42]

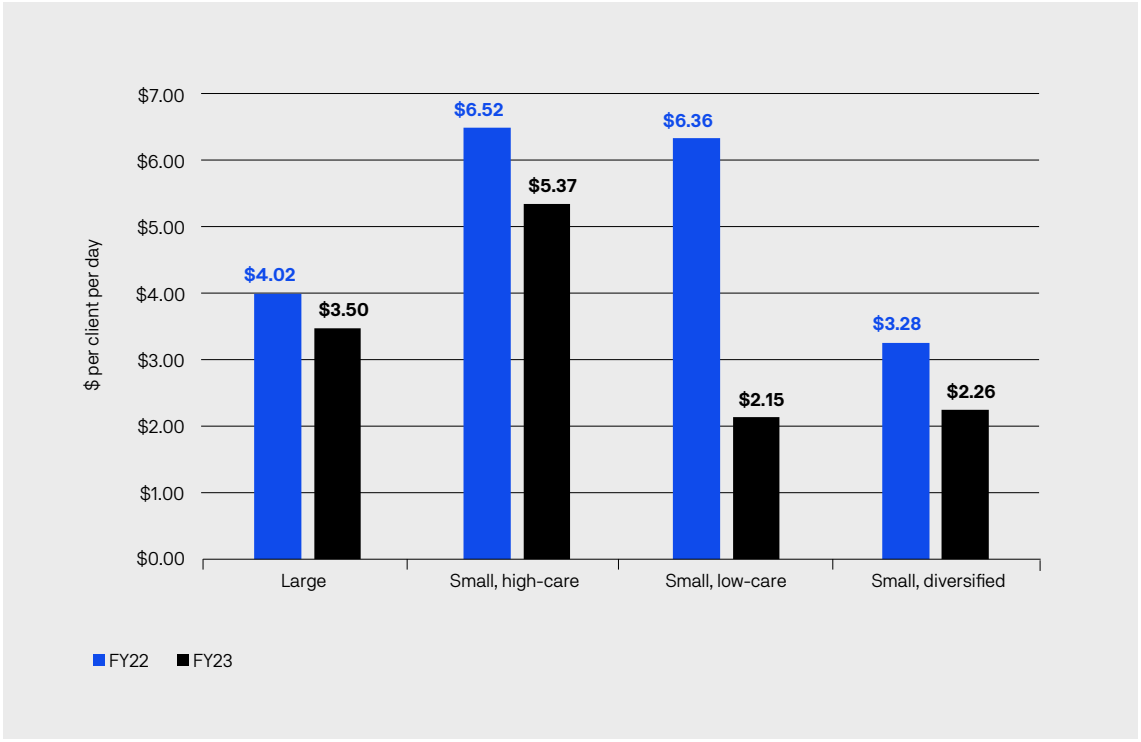
Operating result

UARC's analysis by provider type reveals differences in the performance of different home care business models. Figure 19 shows that large home care providers returned a slightly above-average Operating Result of $3.50 per client per day. This is above the performance of small provider types, except for small high-care providers, which returned the highest Operating Result, averaging $5.37 per client per day.

In terms of policy development and future sector viability, the poor financial performance of small, low-care providers is of most concern when looking ahead to the transition to the Support at Home program.

42. This provider-level analysis is based on the full sample of 96 home care providers represented in the 2022–23 StewartBrown survey. Breaking down this sample into the four types described above produces subsamples of between 13-46 providers within each type. It is important to note that the relatively small size of these sub-samples limits the power and scope of statistical analysis relative to other analyses in this report, with small variations in the performance of types potentially attributable to sample size rather than meaningful differences in business models.

Figure 19: Operating Result, by home care provider type, per client per day



Small diversified providers show a below-average Operating Result at just $2.26 per client per day. However, the lowest Operating Result was experienced by the small, low-care providers, which achieved an average of just $2.15 per client per day in FY23, down from $6.36 in FY22. While the strong positive FY22 result for this group may have been an anomaly (such as from high COVID payments), the effects on the FY23 result from falling revenue and high reliance on third-party brokered and subcontracted services are examined below.

In terms of policy development and future sector viability, the poor financial performance of this group is of most concern when looking ahead to the transition to the Support at Home program. When fully implemented, Support at Home will see the consolidation of Home Care Packages program with Commonwealth Home Support Progamme (CHSP) and Short Term Restorative Care (STRC) under one umbrella. Nearly 80% of those participants will be coming from CHSP. Currently, more than half of CHSP participants receive only one service, with few receiving more than two.[43] Furthermore, given that 78% of CHSP grants (in 2021) were for less than $500,000, many providers operate on a comparatively small scale. Thus, within a Support at Home model, many providers will likely be similar to these small, low-care providers.

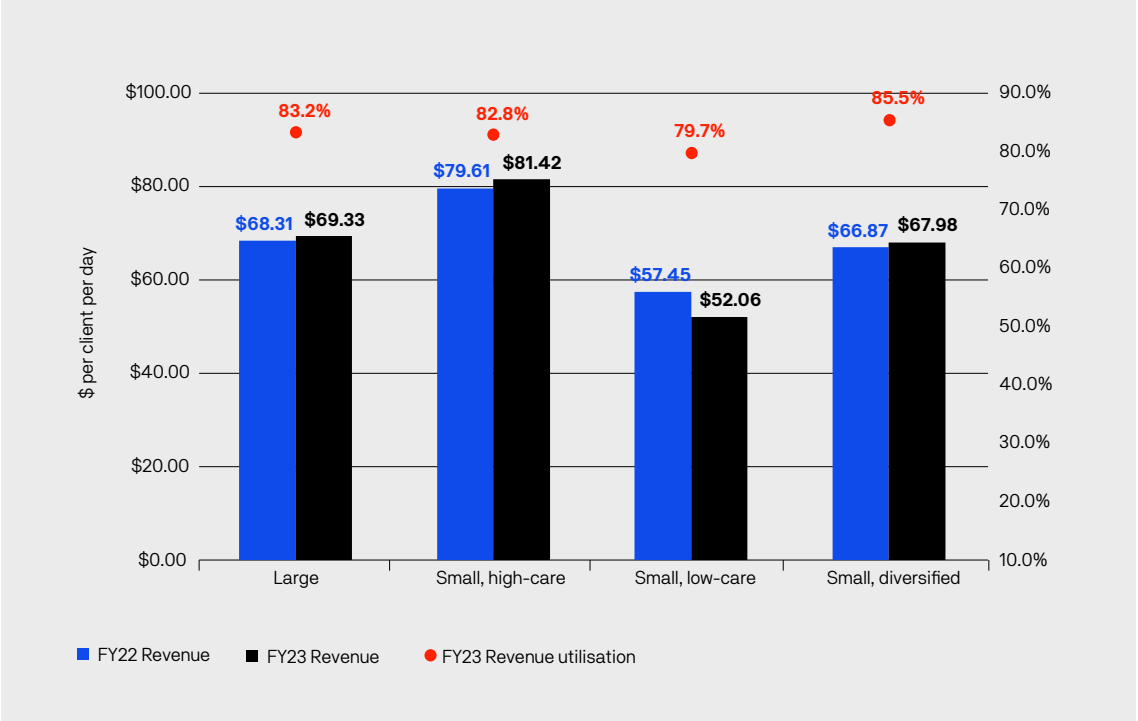
43. Australian Institute of Health and Welfare 2023. *GEN fact sheet Commonwealth Home Support Programme (CHSP) 2021–22.*

Revenue

While aggregate analysis indicates that revenue was broadly stable across surveyed home care providers between FY22 and FY23, Figure 20 shows slightly different trends by provider type. In fact, revenue per client per day increased slightly for all provider types except for small, low-care providers. These latter providers have the lowest revenue per client per day by nature of their predominantly Level 1 & 2 package mix. However, these providers experienced a 9.4% year-on-year decline in revenue per client per day, from $57.45 in FY22 to $52.06 in FY23.

Figure 20 also shows that small, low-care providers have the poorest revenue utilisation amongst the provider types.

Figure 20: Revenue and utilisation, by home care provider type, per client per day



Costs

UARC analysed cost sub-categories as a proportion of revenue, finding remarkable similarities across provider types. One exception was that small low-care providers had the highest rates of non-direct care expenditure (i.e. on care management, advisory, administration and support), averaging 38% of total revenue compared to 34-35% for other provider types. In particular, their spending on care management and advisory (16% of revenue) was much higher than other provider types (10-11%). This could occur, for instance, if these providers are new entrants to aged care. Higher spending on non-direct care may also reflect scale issues (noting that these providers tend to service fewer clients) to the extent that some non-direct care costs are fixed.

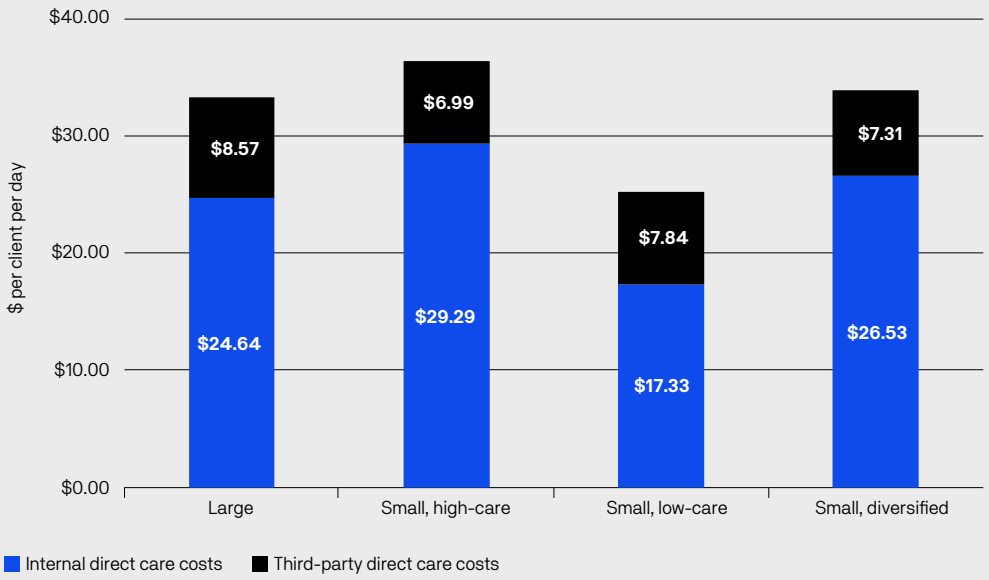
Reliance on third-party brokered and subcontracted services

One potential factor influencing providers' costs is the reliance on third-party services, in which home care package services are delivered through brokered and subcontracted service arrangements.[44] While Part 2 of this report details long-term trends, UARC's modelling has also identified cross-sectional differences across provider types.

Figure 21 shows that small high-care providers are the least reliant on third-party services, at around 20% of their direct care costs. In contrast, small low-care providers have by far the highest reliance on third-party services, at more than 30%. Given the limited scope of many of these provider business models, they may rely on third-party businesses to deliver specialist and clinical care and support services.

High reliance on third-party services may be another risk factor for providers regarding their viability under the Support at Home program. It is not yet clear if or how such a business model would operate in an environment where all registered providers can invoice directly for the services they provide to a client (currently, this is facilitated by a single approved provider). However, current challenges with recruitment and retention of the home care workforce and issues of economies of provider scope and scale suggest that reliance on a diversity of limited-scope service providers will continue to be a feature of the home care landscape.

Figure 21: Direct care costs, by home care provider type, per client per day



44. While there are technical and legal differences between brokered and sub-contracted arrangements, this analysis does not distinguish between different types of third-party service delivery models.

Workforce issues

Key messages

- Workforce issues, while economy-wide, remain a major challenge for the aged care sector as providers struggle to recruit and retain sufficient numbers of appropriately qualified and skilled care staff.
- UARC's latest analysis shows that, as of March 2023, only 21.4% of homes were meeting both their total and registered nurse service-level care minute targets.
- Although the Department data indicates that in July 2023 86.0% of homes reported having a registered nurse on-site 24/7, UARC's shift-level modelling suggests that homes may be experiencing coverage challenges, particularly for the overnight shift.
- Workforce pressures are evident in homes' increased reliance on high-cost agency staff and changes to their staffing mix away from ancillary staff roles.
- The Fair Work Commission has set further hearing dates for December 2023 on outstanding issues in Phase 3 of the aged care work value case.

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 staff.

For this edition, UARC's analysis focuses on the impact of the (now mandatory) minimum staffing standards in residential care. Specifically, these minimum standards require providers to ensure that:

1. a registered nurse is on-site and on duty 24 hours a day, seven days a week, unless an exemption has been granted for up to 12 months (from 1 July 2023);
2. residents receive, on average across the sector, at least 200 minutes of total direct 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 of 215 minutes per resident per day for total direct care, including at least 44 minutes per resident per day from a registered nurse.

Our analysis addresses the following issues:

- Direct care minute targets
- 24/7 registered nurse coverage
- Evidence of workforce pressures
- Update on the Fair Work Commission wage case

Direct care minute targets

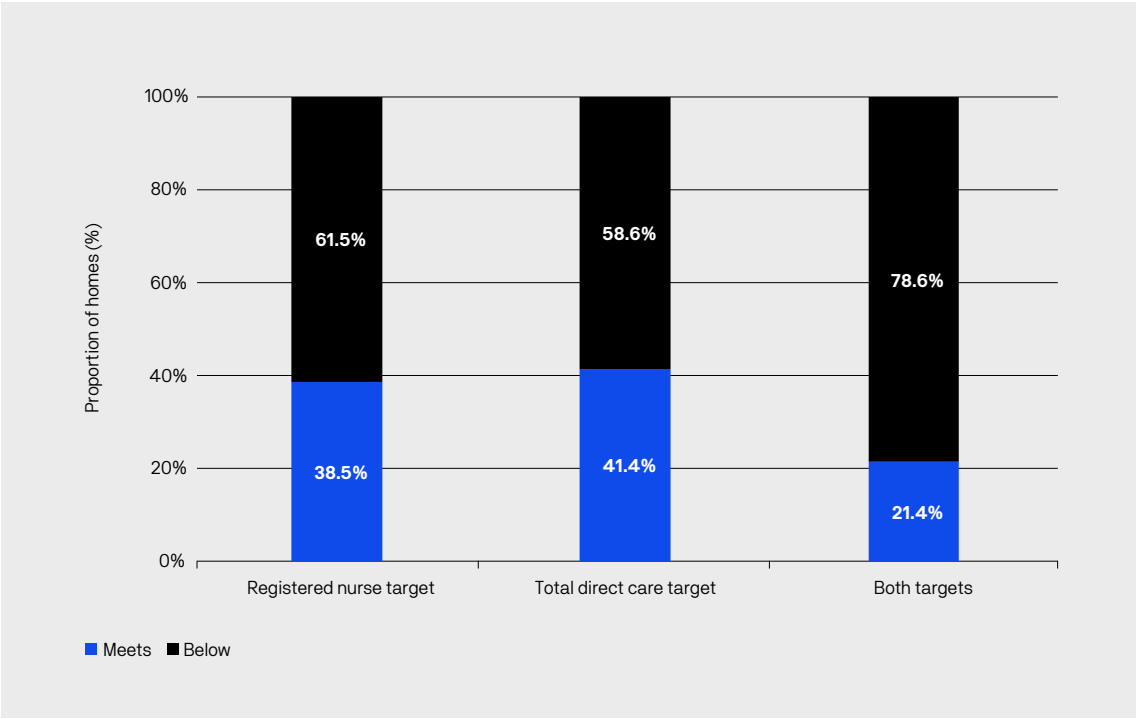
As of 1 October 2023, each home must meet two care minute targets for direct care staffing - one for registered nurses and the other for all direct care workers (registered nurses, enrolled nurses and personal care workers).[45]

Each home's care minute targets are adjusted each quarter to account for differences in the relative needs of their residents, as assessed using the AN-ACC funding classification.[46] This means that homes with residents with more complex needs will have higher care minute targets, whereas homes with residents with less complex needs have lower care minute targets.

Each home's performance relative to their service-level targets is assessed under the "Staffing" sub-category of Star Ratings published on the MyAgedCare website. For example, to obtain a 5 Star Rating, a home must exceed its target for registered nursing time by at least 25% and exceed its total direct care time target by at least 5%.[47]

Based on the most recent Star Ratings data published by the Department (for Quarter 3 FY23), UARC has modelled the extent to which homes across the sector are meeting their care minute targets.[48]

Figure 22: Proportion of homes that meet care minute targets (Q3 FY23)



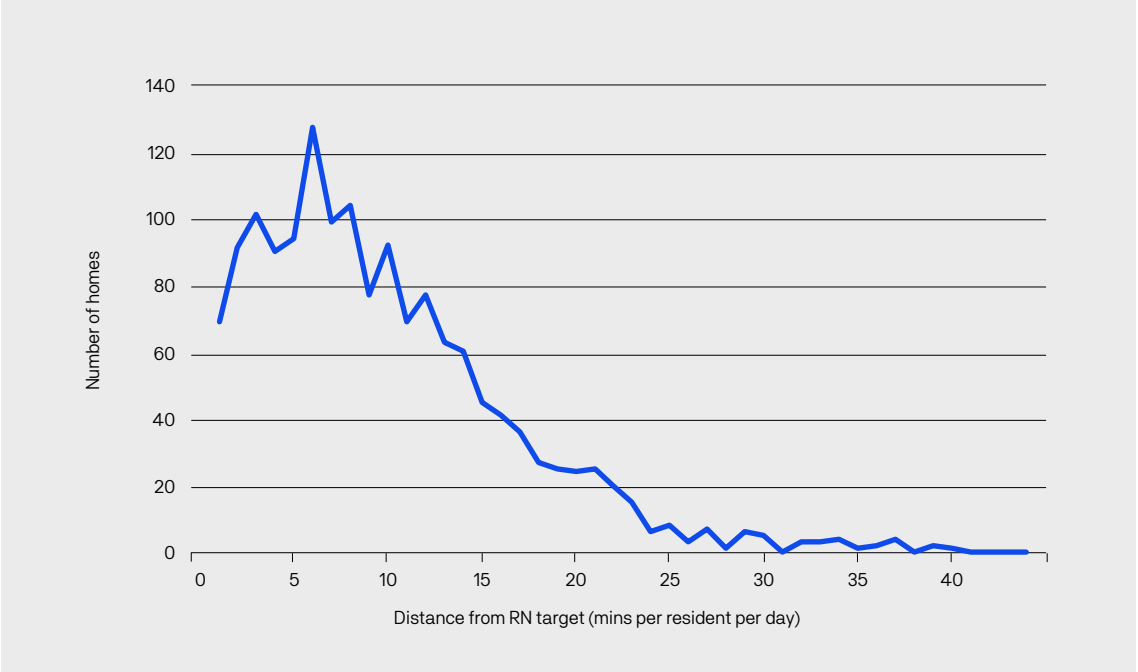
45. Care minute targets are expressed as minutes per resident per day.
46. Care minutes and 24/7 registered nurse responsibility guide | Australian Government Department of Health and Aged Care
47. Star Ratings Provider Manual | Australian Government Department of Health and Aged Care
48. This analysis was conducted using data from 2,486 aged care services which received a Star Rating for Staffing in Q3, FY23. Note that there may be very minor differences in the unit of analysis, where a single home (or facility) may be separated into two co-located services for the purpose of care minute reporting.

This analysis, summarised in Figure 22, shows that as of March 2023, less than half of homes have the staffing to meet their registered nurse target (38.5%) or their total direct care minutes target (41.1%). Overall, only 21.4% of homes have sufficient direct care staffing to meet both service-level care minute targets (the right column of Figure 22).

About four out of five homes across the sector (approximately 2,000 homes) will need to lift their direct care staffing minutes for registered nurses, other direct care, or both in the six months between March and October 2023. As discussed in Part 1, the required uplift in direct care staffing will likely increase homes' direct care labour costs.

Nonetheless, as the sector has approached the start of mandatory minimum standards, there have been gains in direct care staffing. For example, as detailed in Part 2, there has been a 6.5% increase in the average total direct care staffing time in the last year and an 18.3% growth in average registered nurse time.

Figure 23: Number of homes below registered nurse target, by distance to target (Q3 FY23)



Although most homes are still below their targets, a substantial proportion are reasonably close. For example, Figure 23 shows how far homes are from meeting their targets for registered nursing. Approximately half (50.7%) require 8 minutes or less of registered nurse time, per resident per day, to reach their target. Regarding total direct care (not shown), half the homes below their service-level target require a further 20 minutes of direct care or less.

24/7 registered nurse coverage

The other new mandatory staffing requirement is for residential care providers to ensure that a registered nurse is on-site and on duty 24 hours a day, seven days a week (i.e. '24/7'). All homes must comply with this requirement from 1 July 2023 unless eligible for a 12-month exemption.[49]

Data published by the Department indicates that in July 2023, 86.0% of homes reported having a registered nurse on-site 24/7.[50]

Separately, UARC has been tracking the staffing of residential homes for several years. Previously, data constraints meant we could only develop approximate estimates by calculating the average registered nurse hours worked per day.[51] Newly available shift data from StewartBrown enables a more granular analysis of aged care homes' coverage for each of the three shifts per day, including:

- morning shift (7am-3pm)
- afternoon shift (3pm-11pm)
- overnight shift (11pm-7am)

Under a shift-based approach, UARC judges a home as able to 'meet' the 24/7 requirement if the average registered nurse hours worked per shift is 8 hours or more for all three shifts. Based on Quarter 4, 2022–23 staffing data from the StewartBrown dataset,[52] UARC's shift-level analysis indicates that only 45.6% of surveyed homes have average staffing levels for each shift across the quarter sufficient to meet the 24/7 requirement (see Table 2).

Table 2: Shift-level analysis of registered nurse hours worked (Q4 FY23)

				Average hours worked per shift		
Shift-level analysis	**Number of surveyed homes**	**%**	**Average RN hours per day**	**Morning (7am-3pm)**	**Afternoon (3pm-11pm)**	**Overnight (11pm-7am)**
Exemption eligible	21	2.6%	13.9	6.5	4.6	2.8
Meet	374	45.6%	56.4	27.3	17.5	11.6
Below	425	51.8%	34.0	18.2	10.0	5.9
Total	820	100%	43.7	22.0	13.3	8.4

Homes were classified as 'Exemption eligible' if they were located in MMM5-7 areas and had 30 operational places or less; 'Meet' if their average registered nurse hours worked per shift was 8 hours or more for all three shifts; 'Below' if their average registered nurse hours worked per shift was less than 8 hours for any of the three shifts.

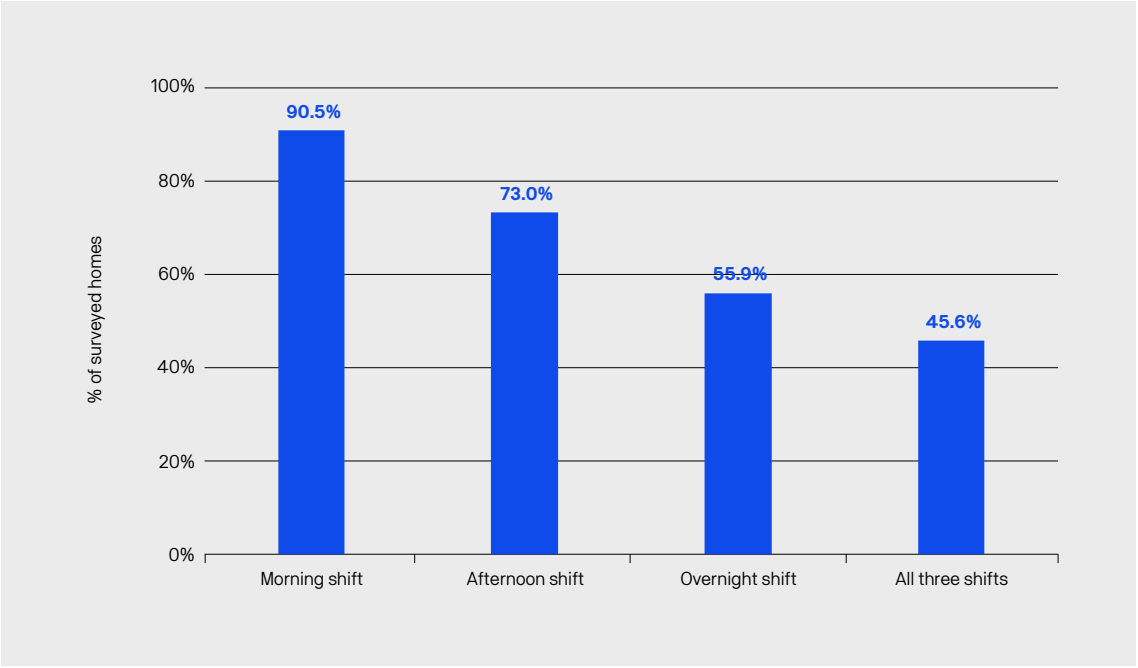
49. Homes eligible to apply for an exemption are those with 30 operational places or less and located in small rural towns, remote communities and very remote communities.
50. Registered nurse coverage in residential aged care dashboard | Australian Government Department of Health and Aged Care
51. Total hours worked include those designated as 'normal hours', 'overtime', 'agency' and 'contracted'. Total hours worked is the same figure used to calculate care minutes per resident per day.
52. The analysis was based on 820 surveyed homes that participated in both the Q3 and Q4 2023 StewartBrown surveys. This sample excludes homes that were removed in either survey due to the StewartBrown data cleansing processes, such as homes with abnormal operating circumstances (e.g. newly built or refurbished homes or homes under sanction) or data integrity problems, or did not provide appropriate breakdowns of shift data in either survey (e.g. allocated all registered nurse staffing hours to a single shift). Furthermore, the analysis excluded homes that reported unusual abnormal changes in their year-to-date staffing between Q3 and Q4. As the sample is derived from the StewartBrown dataset, it is weighted towards not-for-profit homes, underweighted in terms of for-profit providers and does not contain government providers. However, sample characteristics are representative of the population of aged care homes in Australia regarding the proportion of homes from different MMM remoteness locations and home sizes.

The shift-level analysis also revealed substantial variation in the hours worked, depending on the time of day. Although homes classified 'Below' provided an average of 34.0 registered nurse hours per day, more than half of these hours (18.2 hours) were worked in the morning shift. By comparison, these homes reported an average of 5.9 hours during the overnight shift.

This pattern is also evident in the number of surveyed homes with at least 8 hours per shift (see below Figure 24). While 90.5% of surveyed homes reported at least 8 hours of average registered nurse staffing for the morning shift, this proportion fell to 73.0% for the afternoon shift and only 55.9% for the overnight shift.

This suggests that homes may be experiencing challenges in consistently covering all three shifts throughout the 24 hours, particularly the overnight shift.

Figure 24: Proportion of homes with 8+ hours of registered nurse staffing per shift (Q4 FY23)



Several reasons potentially explain the divergence between the Department's and UARC's results. First, each draws from different datasets with different-sized samples, applying a different approach to assess 24/7 coverage. For example, the UARC analysis estimates actual registered nurse hours worked based on averages constructed using quarterly data. By comparison, the Department's figures are based on monthly reports from providers of instances in which a registered nurse was not on duty and on-site for every occasion of 30 minutes or more.

Also, as the UARC analysis relies on an average across Quarter 4 (i.e. April – June 2023), it does not necessarily indicate the staffing arrangements that homes have in place as of 1 July 2023 when the 24/7 registered nurse requirement became mandatory. There is also the possibility that UARC's results reflect issues in how homes have reported their shift data. Although UARC excluded homes that allocated 100% of their staffing in the morning shift, such results may still arise if homes have inadvertently reported a disproportionate share of hours worked in the morning shift.

Finally, the Department has outlined several circumstances when a registered nurse on-site and on duty does not necessarily contribute to the actual registered nurse hours worked data analysed by UARC.[53] Such circumstances include:

- **Co-located services:** If a provider operates two or more residential services within the same residential facility or if an aged care service is co-located within a dual-purpose health facility, then each service may be compliant as long as there is at least one registered nurse on-site and on duty at a time across the facility as a whole.
- **On-break:** A registered nurse may be considered on duty during breaks if they remain on-site,[54] assuming breaks are taken within a continuous work period and are prescribed in the nurse's employment conditions.
- **Care managers:** In some circumstances, a person employed in another role, such as a care manager, may also contribute towards the 24/7 requirement. This person needs to be engaged by the provider as a registered nurse, with their prime purpose for that shift being to provide care to residents and oversee other staff.

Quantifying the effects of these considerations is challenging without matched data about service-to-facility arrangements, care manager qualifications and shift allocations. On balance, however, the Department's requirement for providers to report any period of 30 minutes or more when a registered nurse was not on duty is a more rigorous test than that applied by UARC. Therefore, the provider data supplied to the Department should produce a lower figure for compliance, not higher.[55] Nonetheless, like the Department, UARC will continue to monitor registered nursing trends, anticipating that a more precise picture will emerge as the data matures.

53. Care minutes and 24/7 registered nurse responsibility guide | Australian Government Department of Health and Aged Care

54. According to the Care minutes and 24/7 registered nurse responsibility guide, on-site means a registered nurse must be within the confines of the residential facility or the immediate surrounds and on duty means the registered nurse must be available to provide care to care recipients and oversight of the care provided by other care staff as needed.

55. In this sense the UARC approach is likely to be more lenient than the Department's, meaning that a higher proportion of homes would expected to be assessed as 'meet' by UARC compared to the Department (not vice versa, as the data shows). As the UARC approach takes the average hours worked per shift, as calculated over a 3-month period, it will not detect instances where there has been a coverage shortfall for a single shift if this is offset by higher staffing on another day. Furthermore, the UARC analysis does not account for times when two or more registered nurses worked concurrently, such as when there is more than one nurse per shift or for time spent in overlapping shifts and handover. By comparison, the Department figures should capture every instance when a home has not had 24/7 registered nurse coverage. That is, if a home has just one occurrence when a registered nurse was not onsite and on-duty for 30 minutes or more it should be recorded as having not met the 24/7 coverage for that month.

Evidence of workforce pressures

Achieving the minimum standards during a challenging labour market has created some acute workforce pressures for residential aged care providers. This section explores how these pressures may translate into adverse outcomes for providers, workers and residents.

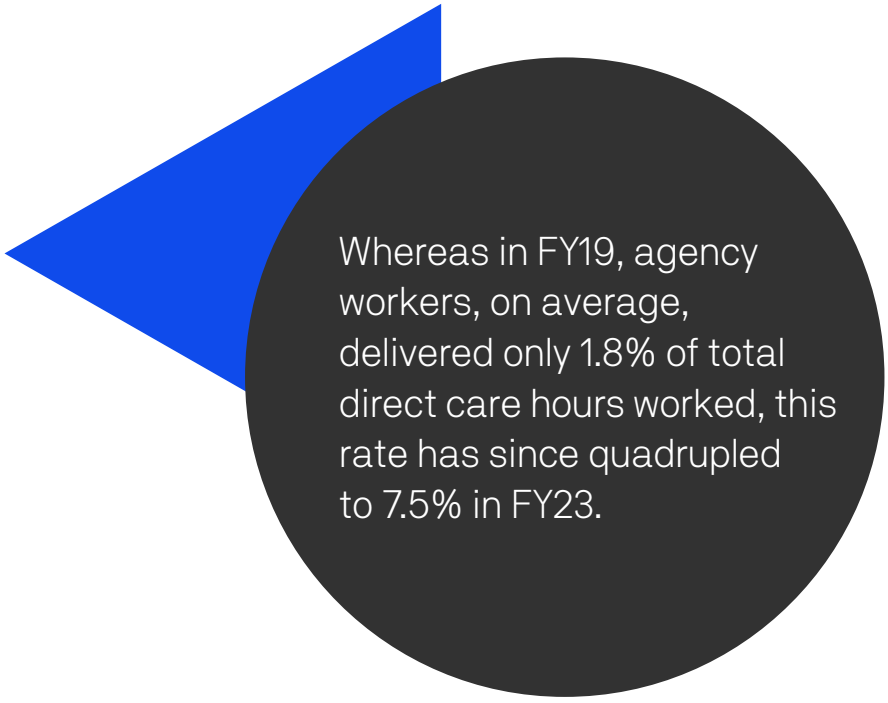
Agency staffing

One of the most prominent symptoms of the challenges residential providers face in sourcing direct care workers is their increased reliance on agency workers. Agency workers are externally contracted workers employed by third-party labour hire agencies who work across different aged care homes (or in other sectors). As this employment arrangement can help homes deal with short-term fluctuations in demand and staffing shortfalls, it is unsurprising that as the demand for care workers has become more acute, this workforce strategy has become more commonplace.

As Figure 25 shows, there has been a dramatic increase in the proportion of direct care time provided by agency workers over the last five years, particularly in FY22 and FY23. Whereas in FY19, agency workers, on average, delivered only 1.8% of total direct care hours worked, this rate has since quadrupled to 7.5%.

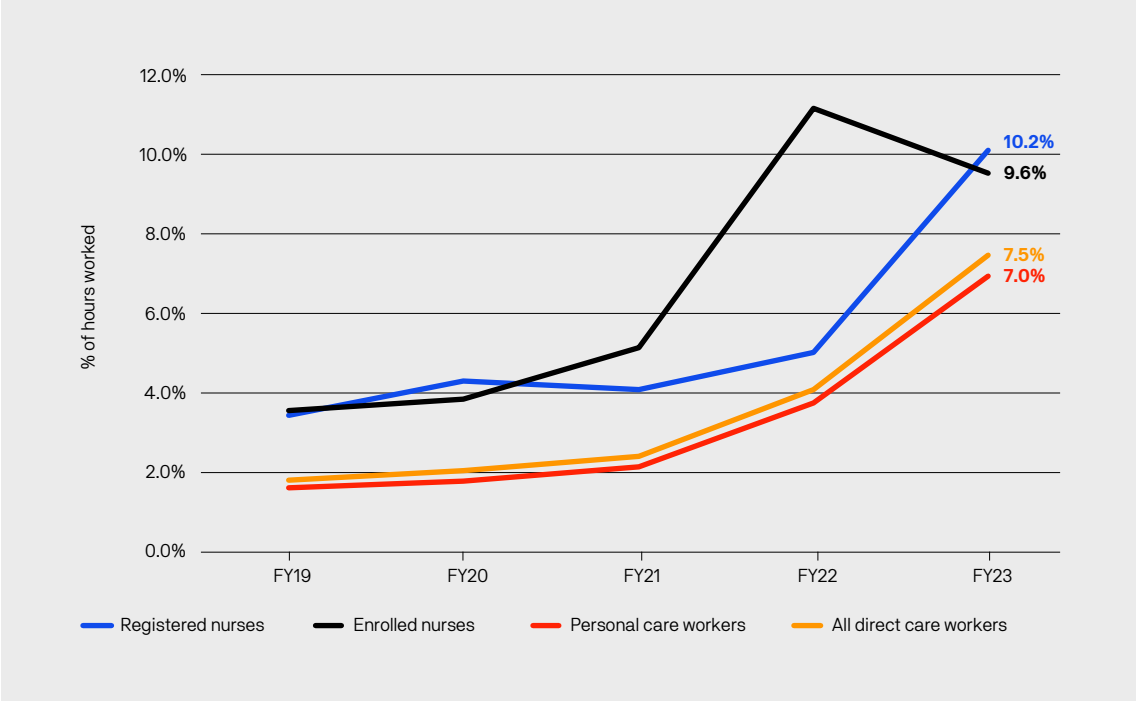
By staffing category, agency workers now deliver, on average, 10.2% of registered nurse time, 9.6% of enrolled nurse time and 7.0% of personal care worker time.

UARC notes that this increase in agency staff has occurred despite policy considerations since the Royal Commission about requiring providers to preference direct employment of personal care workers and nursing staff.[56]



56. Aged care employment - Commissioned study - Productivity Commission (pc.gov.au)

Figure 25: Agency staffing as proportion of direct care hours

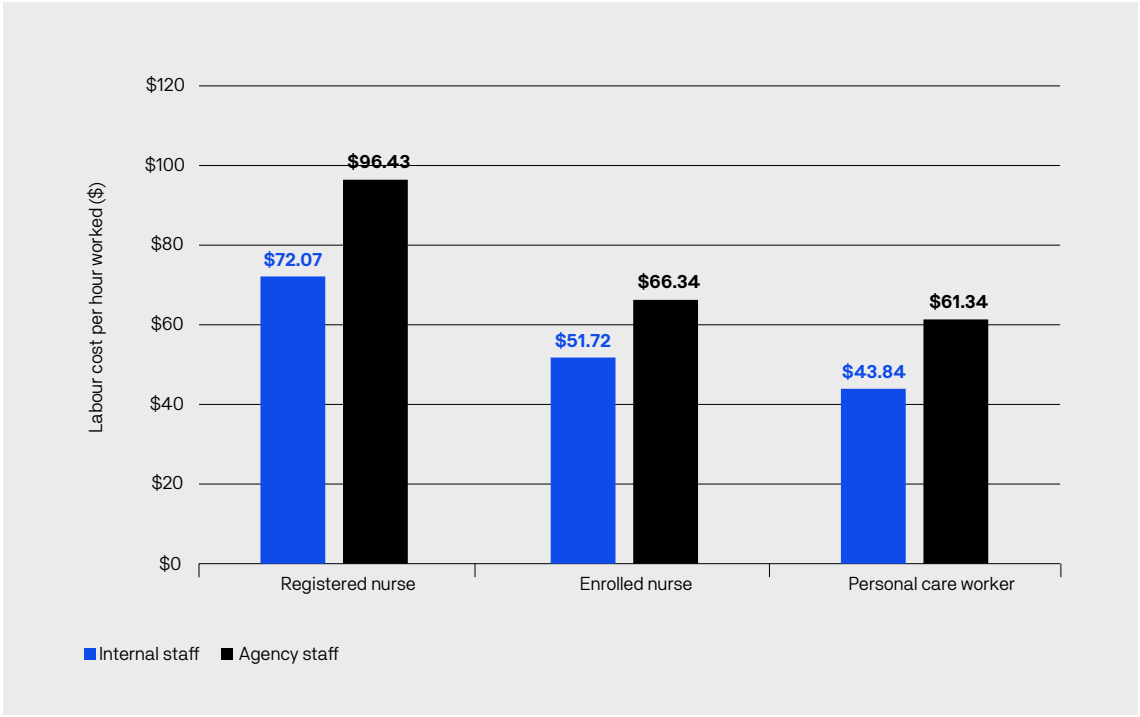


Agency workers have long been a small but enduring component of the aged care workforce. For example, according to the 2016 Aged Care Workforce Census, agency workers represented approximately 9% of all direct care workers within residential care, with 41% of homes engaging agency care workers at some point.[57] Nonetheless, the recent acceleration of homes' reliance on agency direct care workers raises several concerns.

First, homes' reliance on agency workers comes at a substantial financial cost. Figure 26 indicates the comparative 'input price' for workers, reporting the median labour cost per hour by role and employment mode. This shows the substantial premium paid for agency workers compared to internal staff. In FY23, the cost of agency direct care staff per hour worked was 34% higher for registered nurses (compared to internal staff), 28% higher for enrolled nurses and 40% higher for personal care workers.

57. Mavromaras K, Knight G, Isherwood L, et al (2017). *The Aged Care Workforce, 2016: National Aged Care Workforce Census and Survey*. Department of Health and National Institute of Labour Studies at Flinders University.

Figure 26: Median labour cost per hour worked, by role and employment mode



These premium rates and increasing reliance on agency staff have caused rapid growth in homes' total agency labour costs. In the last year alone, it has doubled from $8.21 per resident per day (FY22) to $17.35 (FY23) and is now almost four times the $4.65 paid five years ago.

Second, UARC's research shows that greater reliance on agency staff in Australian residential care is associated with poorer quality of care outcomes and that a skilled and stable workforce provides a higher quality of care.[58] These works, published in 2022, were based on data from 1,709 unique Australian residential aged care homes between FY15 and FY19. The findings showed that homes with a greater reliance on agency staff (greater than 5%) had lower quality of care, with higher rates of hospitalisations, complaints, reportable assaults, missing persons and accreditation flags. These results accord with other findings that the intermittent nature of agency work can make it challenging to ensure continuity of care, deliver person-centred care and establish familiarity with residents.[59]

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

59. Castle NG, Engberg J. (2007) The influence of staffing characteristics on quality of care in nursing homes. *Health Services Research*; 42(5):1822-1847.

Third, high reliance on agency staffing may also negatively impact other staff. For example, if agency workers require additional supervision, this may negatively impact job satisfaction, stress, and retention of permanent care workers. Providers may be caught in a vicious cycle when the use of agency staff to fill short-term vacancies contributes to further turnover of permanent workers.[60]

Given the potential risk of adverse outcomes from high agency staffing, further investigation is warranted to explore why so many aged care workers prefer the agency employment mode. Such research could disentangle how preferences reflect workers' attitudes about pay rates, working conditions and flexibility. This could better inform providers' approaches to offering attractive permanent employment opportunities.

Capacity constraints

Another potential adverse outcome of the current workforce pressures is reports of capacity constraints. In a recent report, the Committee for Economic Development of Australia (CEDA) indicated that workforce pressures contributed to low occupancy across the sector by preventing homes from operating at full capacity despite demand for residential places.[61] These observations align with concerns expressed by the Australian Medical Association about hospital 'exit blocking', caused by delays in discharging people to residential aged care services.[62]

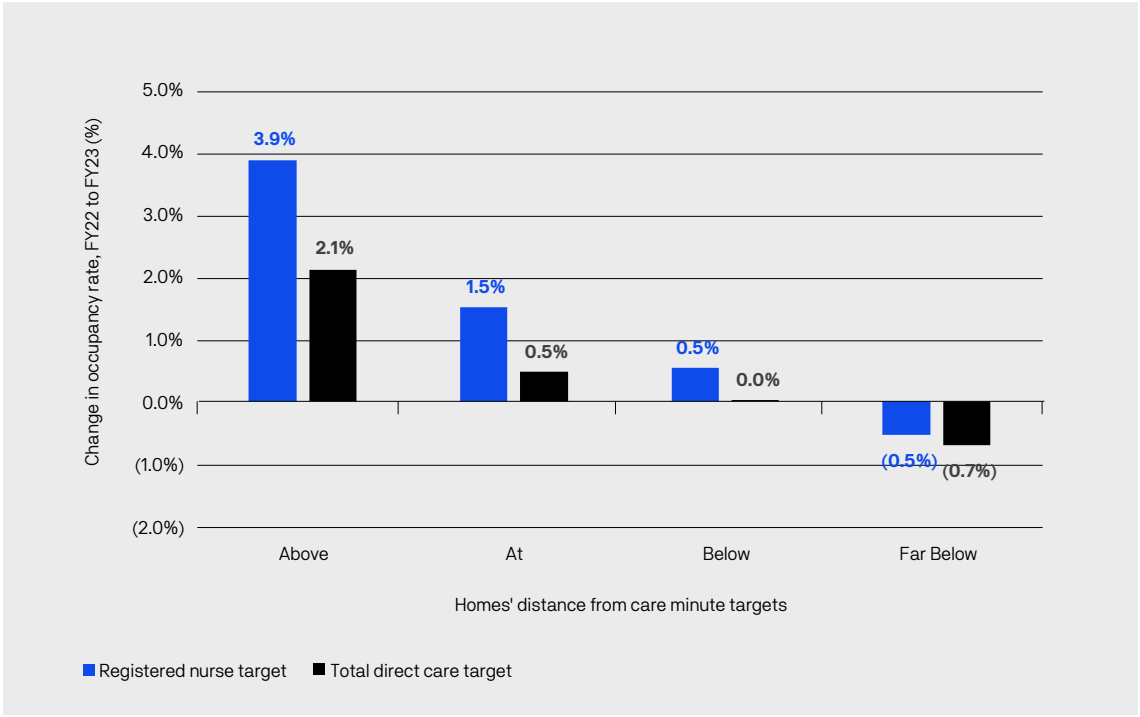
To investigate this issue further, UARC conducted analysis comparing the year-on-year change in occupancy rates of homes between FY22 and FY23. Despite CEDA's concerns, at a sector-level, occupancy rates appear to have stabilised, with mature homes reporting an average occupancy rate of 91.1% in FY23, the same as the prior year.[63] However, as detailed in Part 2 of this report, there is variation in occupancy trends across the sector.

In our analysis, we further classified homes into four groups based on the size of the gap between their direct care staffing in FY22 and their incoming service-level care minute targets for 1 October 2023.[64] This classification is designed to give some approximation for workforce pressures by separating groups based on how they would likely need to change their staffing to meet their care minute targets:

- Above: Average care minutes in FY22 was 108% or higher compared to their care minute target (1 October 2023)
- At: Average care minutes was between 100-108% of their care minute target
- Below: Average care minutes was between 90-99% of their care minute target
- Far below: Average care minutes was less than 90% of their care minute target[65]

60. King D, Svensson S, Wei Z (2017) Not always a quick fix: the impact of employing temporary agency workers on retention in the Australian aged care workforce. *Journal of Industrial Relations*; 59(1):85-103
61. CEDA (2023), *Duty of Care: Aged-care sector running on empty*, p.6-7
62. Australian Medical Association (2023), *Hospital exit block A symptom of a sick health system*.
63. The rate measured in StewartBrown's residential care dataset differs slightly from how occupancy is measured by the Department. In this case, occupancy is measured in terms of the available places within the dataset of aged care homes, which excludes places that have been allocated but are not operational. This measure of occupancy differs from the estimates published by the Department, which measures occupancy as the proportion of total allocated places, including those that might not necessarily be operational.
64. This classification is applied retrospectively, in that providers would not have known their service-level care minute targets until late 2022, noting targets were further updated in May 2023. Also, as homes were classified based on their staffing minutes averaged over the entire 2021–22 year, there is the possibility that some homes may have been misclassified as 'below' if, for example, they had increased their staffing levels very close to the end of FY22.
65. UARC conducted this analysis for both registered nurse staffing time and total direct care staffing time.

Figure 27: Annual change in occupancy rates, by homes' initial distance from care minute targets



Homes classified into these four groups exhibited distinct changes in their occupancy for FY23 compared to FY22, as shown in Figure 27. For example, those homes that were initially above their incoming care minute targets for registered nurses increased their occupancy in FY23 by an average of 3.9%. Also, those initially above their direct care target minutes increased their occupancy by an average of 2.1%. Homes already at those targets showed a similar, but more muted, pattern of occupancy growth. Homes that were classified as initially below their registered nursing care minute targets (within 10%) also experienced a slight increase (0.5%) in their average occupancy rates.

In contrast, homes initially far below their incoming care minute targets experienced decreased occupancy rates during FY23. For example, those far below their registered nurse targets experienced an average decline of occupancy of 0.5%, and those far below total direct care target targets saw occupancy fall by an average of 0.7%.

Our results partially support CEDA's claims. We observe that homes requiring the largest increases in their direct care staffing (i.e. those most likely to be experiencing workforce pressures), on average, experienced slight contractions in their occupancy rates in the last year. However, our results also show that this experience is not endemic across the sector, as other homes experienced increased operational capacity.

This suggests that the issue of capacity constraints may either not be as significant as initially thought or, more likely, are concentrated within particular homes. UARC notes, for example, recent media reports about capacity constraints, particularly for homes in regional areas.[66] UARC has conducted preliminary analysis that indicates that there are much larger declines in occupancy for non-metropolitan homes that are below or far below their care minutes targets.

In addition, our results also point to a possible distributional effect of the care minute targets, whereby more residents are being serviced in homes with greater staffing capacity.

UARC acknowledges that our classification provides only an approximation of homes' staffing gaps insofar as we have not accounted for how homes' care minute targets changed, either due to the update of the AN-ACC classifications in May 2023 or as homes' resident case mix may have changed over time. Likewise, we have not accounted for the effect of workforce pressures arising from the 24/7 registered nurse requirement.

Given the significance of this issue, UARC will continue its monitoring as further data updates are made available about homes' actual direct care staffing and care minute targets. In addition, noting that homes may operate in part in response to their local labour market trends, we will also explore the extent to which these patterns hold for homes in different geographic regions.

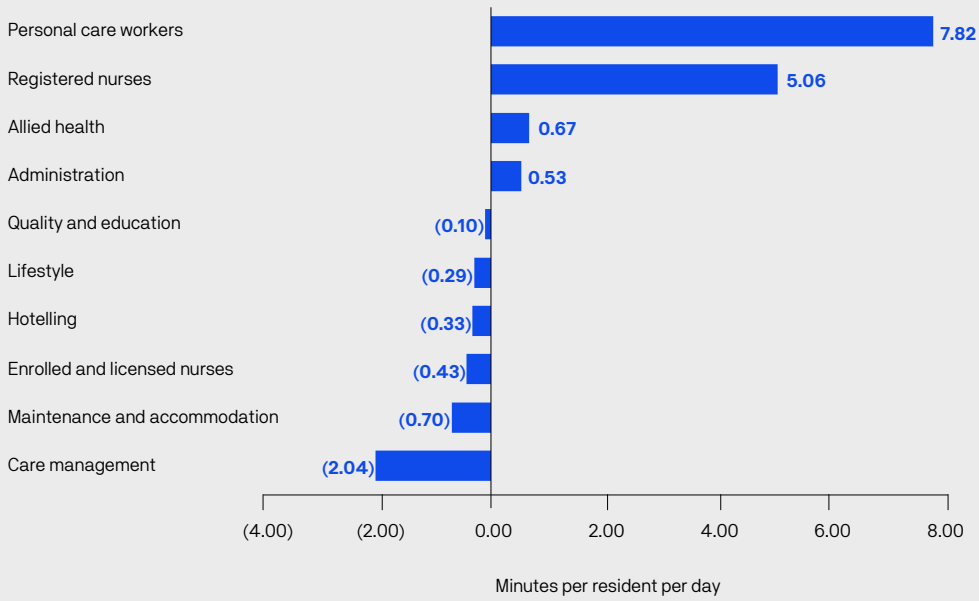
Changes in homes' staffing mix

Much of the recent policy focus on aged care staffing has been on direct care workers, as reflected in homes' obligations to meet direct care minute targets and the 24/7 registered nurse requirement. However, staff in many other roles help deliver care and support services in residential homes. For example, the staffing mix within an aged care home will also include people responsible for cleaning, catering, laundry, recreational activities, administration, care management and maintenance. In FY23, on average, these roles comprised 28.6% of homes' total staffing time.

There is a concern that with the tightening policy for direct care, resource-constrained homes may have less incentive to maintain staffing in other roles.

66. On any day, 550 people are in hospital with no clinical reason (smh.com.au); Illawarra, Shoalhaven hospitals have worst aged care bed block in nation, and there's no easy fix - ABC News

Figure 28: Annual change in average staffing minutes, per resident per day



UARC has modelled the annual change in homes' staffing mix by estimating the year-on-year difference in the average staffing minutes per resident per day for each staffing role. This analysis, depicted in Figure 28, shows how the composition of homes' average staffing profile has changed across the period. Unsurprisingly, there has been growth in the average time of personal care workers (7.82 minutes per resident per day) and registered nurses (5.06 minutes), likely driven by the need to lift staffing to meet the incoming minimum standards.

There has also been a slight uptick in average allied health and local administration time, with the latter likely reflecting the increasing administrative load that homes face to comply with the sector reform agenda.[67]

At the other end of the scale, there was a decline in the average time of care managers (2.04 minutes). This may reflect, in some part, some reclassification effects, where care managers (who also include clinical managers and care coordinators) may be more involved in direct care as registered nurses to meet care minute targets. Enrolled nurse time also contracted slightly (0.43 minutes). As UARC has reported in prior editions, this likely reflects the design of the minimum standards, which do not ring-fence minutes specifically for enrolled nurses.

Of note, all of the roles associated with more ancillary activities (e.g. quality and education, lifestyle, hotelling, maintenance) experienced declines in average staffing time compared to the previous year. UARC is currently undertaking research in this area to understand the implications of this emergent trend, particularly in how it may relate to residents' quality of care.

67. Note that administration time only includes hours reported by local staff in aged care homes and does not include time of corporate administration roles or external consultants.

Update on the Fair Work Commission wage case

As of 30 June 2023, a 15% wage increase as applicable to three awards covering aged care workers was handed down by the Fair Work Commission (FWC).[68] This has applied to the following workers:

- **Aged Care Award:** personal care workers and recreation/lifestyle activities officers
- **Nurses Award:** nursing assistants, enrolled nurses, registered nurses, nurse practitioners working in aged care
- **SCHADS Award:** home care workers working in aged care.
- **Senior food services employees at levels 4-7**, covered by the Aged Care Award, working at an aged care facility or site.

Clarification was provided that the increase did not include other employees within the sector, such as those working in administration, laundry, cleaners or chefs and cooks who are not at a senior-level.

Stage 3 of this work value case is ongoing. An issues paper released in August 2023 provided a summary of outstanding matters.[69] Further announcements are expected on technical issues such as the classification of roles and whether the increase will extend to other support services employees such as laundry workers, cleaners and maintenance workers in aged care.

Hearings about outstanding wage adjustment issues (including revisiting the direct care rates) are set to occur from 4th to 8th December 2023 before the FWC's Expert Panel for pay equity in the Care and Community Sector. The hearing dates for classification and allowance issues are from 11th to 15th December 2023. Some providers recommend a 25% wage increase for everyday living workers in residential aged care and a further 10% increase for direct care services. [70] These increases are believed to be necessary to aid in retaining staff and mitigating issues of perceived unfairness and inequity within teams, affecting morale.

Both the Health Services Union[71] and United Workers Union[72] have echoed these views. Their submissions highlighted that everyday living workers are regularly called on to contact families, respond to complaints, and interact with residents. They also often need to respond to those with complex care needs, such as those living with dementia, through implementing de-escalation techniques for those with behavioural issues. They are also required to undertake mandatory training in the Aged Care Quality Standards. Submissions also noted that in household models of care delivery, it may be more challenging to distinguish direct care and everyday living roles.

UARC is currently conducting research on the quality benefits provided by everyday living staff in aged care homes. reliminary findings indicate a positive impact of various roles, such as hotelling, maintenance and quality and education..

68. 15% wage increase for aged care sector - Fair Work Ombudsman
69. Stage 3 issues summary - revised (fwc.gov.au)
70. SUBMISSION OF ANGLICARE SYDNEY |(fwc.gov.au)
71. SUBMISSIONS OF THE HEALTH SERVICES UNION |(fwc.gov.au)
72. SUBMISSIONS OF THE UNITED WORKERS UNION |(fwc.gov.au)

Quality and Star Ratings

Key messages

- The new Star Rating system commenced in FY23.
- As of March 2023, 97% of residential care homes had an overall rating of acceptable or better (a Star Rating of 3 or higher).
- In terms of rating sub-categories, the vast majority of homes were rated as acceptable or better (3 stars or higher) for resident experience (93%), compliance (98%) and clinical quality (90%).
- However, only 44% of homes were rated as acceptable or better (3 stars or higher) for staffing.
- Consumer research indicates that 84% of individuals would only consider homes rated 4 stars and above.
- On average, homes rated 3 stars overall achieved the highest financial outcomes in FY23.
- While there appears to be a financial cost associated with poor compliance ratings, homes with the highest staffing ratings tend to have the worst financial performance.

As part of the Government's response to the Royal Commission, Australia now has a Star Ratings system that publishes comparable, up-to-date information about the quality of individual residential homes.

The primary purpose of Star Ratings is to assist older people and their families in making more informed decisions when choosing an aged care home. By making quality more transparent and comparable, the ratings are also seen as one approach to stimulating competitive incentives for providers to enhance the quality of their services.

In addition, Star Ratings may also allow providers to benchmark the quality of their homes across their organisation and the sector. The ratings may support policymakers and regulators by providing another source of information to monitor sector quality, identify systemic issues, and track the implementation of reforms to improve quality across the sector.

Each home is assigned an overall Star Rating between one and five stars as well as ratings for four sub-categories: resident experience, compliance with regulatory standards, direct care staffing levels, and clinical quality of care. The Department has provided detailed information on its website about how the Star Ratings are calculated.[73]

Star Ratings have been calibrated to correspond to the following:

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

Star Rating information is updated quarterly on the MyAgedCare website, which is searchable through the "Find a provider" tool.[74]

In addition, UARC has recently developed a Star Ratings Dashboard, which is freely available online.[75] The Dashboard aims to complement MyAgedCare by presenting Star Ratings data in an accessible visual format that is relevant to sector stakeholders, including older Australians and their families, aged care providers, policymakers and peak bodies.

Currently, the UARC Dashboard allows all users to:

- search ratings by provider and service name
- analyse the results by characteristics (ownership, home location, provider size)
- view homes geographically on a map
- compare homes and providers side by side

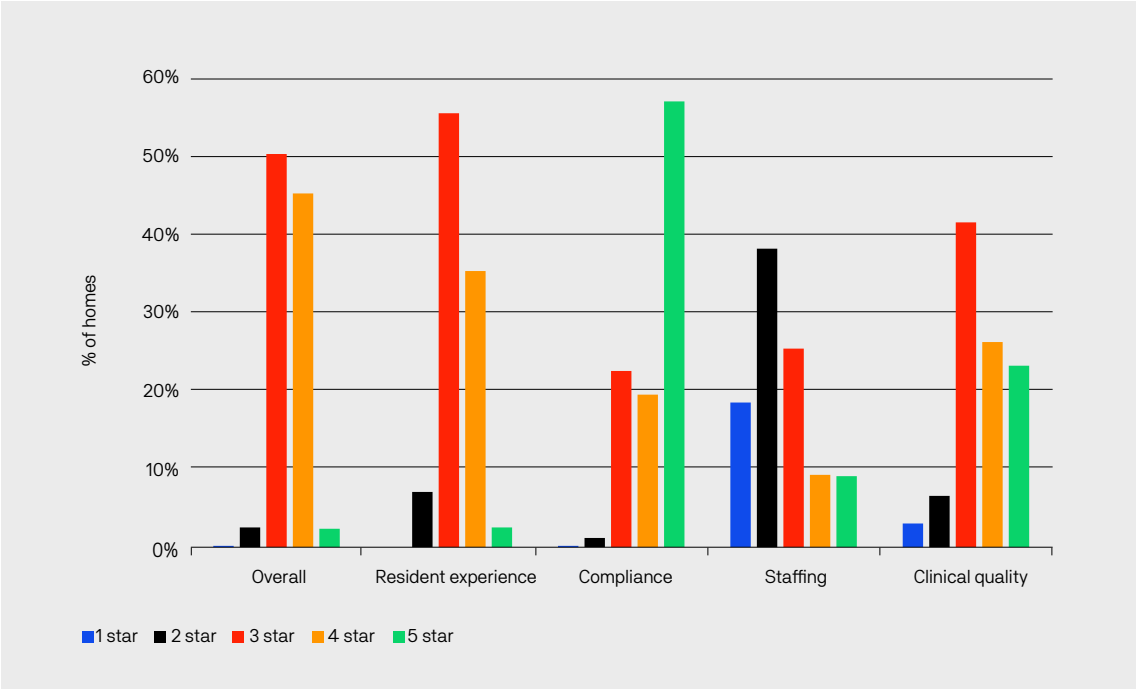
Future iterations of the Dashboard will include trend data showing changes in ratings over time. UARC would welcome user feedback to help inform future development iterations of the Dashboard.

73. Star Ratings Provider Manual | Australian Government Department of Health and Aged Care
74. https://www.myagedcare.gov.au/find-a-provider-choice
75. UARC Star Rating Dashboard

Latest Star Ratings results

The most recent quarterly update (Quarter 3 FY23) shows that the vast majority (97%) of aged care homes in Australia received an overall Star Rating of acceptable or better (3 stars or higher). [76] As depicted in Figure 29, only a very small minority of homes received ratings below acceptable, with 0.2% rated at 1 star and 2% rated at 2 stars.

Figure 29: Distribution of homes, by Star Rating (Q3 FY23)



In terms of the sub-categories, most homes were rated as acceptable or better (3 stars or higher) for resident experience (93%), compliance (98%) and clinical quality (90%). However, in contrast, only 44% of homes were rated as acceptable or better for staffing, with 56% of homes receiving either 1 star or 2 stars. The staffing Star Rating is constructed based on the extent to which homes' direct care staffing minutes fall below or above their service-level targets. Thus, homes will have received a 1 or 2 star rating if they have delayed increasing their direct care staffing until later in 2023 when their service-level targets become mandatory.

76. This analysis was conducted using sector-wide Star Ratings data for Q3, FY23, which was published by the Department of Health and Aged care: Star Ratings quarterly data extract – August 2023 | Australian Government Department of Health and Aged Care

While these recent results generally portray a positive picture of residential care quality, there is a question about how prospective residents and their families may interpret Star Rating values, given the prevalence of ratings in other service industries, such as hotels and restaurants. A recent large-scale consumer research survey, *The Catalyst Report* asked participants, 'What is the minimum rating a provider would need to have for you to consider an aged care facility?'.[77] The study found that only 13% would consider a 3 star home, 59% would require at least 4 stars, and 25% would only consider 5 star homes.[78] Put another way, 84% of participants would only consider homes rated 4 stars and above.

These results point to a potential misalignment between consumer expectations and the information conveyed by Star Ratings. Specifically, consumers may negatively interpret the quality of homes rated as 3 stars, even though achieving this rating will require homes to meet regulatory requirements for staffing and service compliance, the national average (or better) for clinical quality measures and positive consumer experience reports.

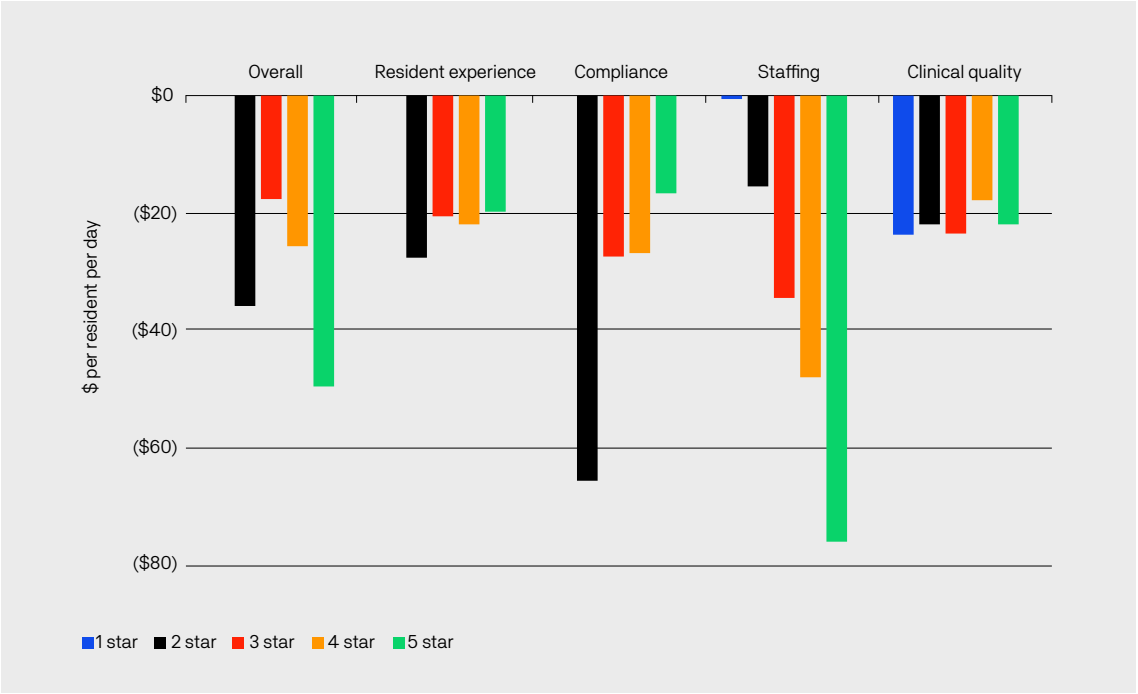
Furthermore, preliminary results from the same survey in 2023 indicate that the awareness of Star Ratings remains low amongst prospective residents and their families.[79]

77. Catalyst Research (2023), *The Catalyst Report – Residential Aged Care Insights 2022*.
78. Catalyst Research (2023), *The Catalyst Report – Aged Care insights 2022*. The remaining 3% reported considering homes rated at least 1 or 2 stars. The 2022 survey results are based on responses from 4,904 respondents, (20 residents, 2,317 family members and 2,537 shoppers). Interim results from Catalyst's 2023 survey indicate the pattern is stable over time.
79. Catalyst Research (2023), *The Catalyst Report – Residential Aged Care Insights 2023*.

Star Ratings and financial performance

A further consideration is how much homes' Star Rating results align with their financial outcomes. UARC has modelled the average Operating Result of homes in FY23, split by their Quarter 3 FY23 Star Ratings (see Figure 30).[80]

Figure 30: Operating Result per resident per day (FY23), by Star Rating (Q3 FY23)



Given that Star Ratings have only recently been implemented, this analysis should be considered preliminary. Nonetheless, there are several emergent findings worth noting:

- On average, homes rated 3 stars overall achieved the highest financial outcomes (i.e. smallest operating deficit), generating an average operating deficit of $17.80 per resident per day in FY23. By comparison, 5 star homes lost an average of $49.90 per resident per day.
- There appears to be a financial cost of regulatory non-compliance. Homes that received a 2 stars for compliance reported substantially larger operating losses (averaging $65.91 per resident per day) than those with 3 stars and above.
- In contrast, there appears to be a financial cost of being highly rated for staffing. On average, each incremental star is associated with lower financial outcomes.
- There are no evident associations between financial outcomes and ratings for resident experience and clinical quality.

80. This analysis was conducted using the Q3 FY23 Star Ratings of 1,130 de-identified homes in the StewartBrown FY23 Residential Care Dataset. Rating categories which were represented by fewer than 10 homes were disregarded (e.g. 1 star overall, 1 star resident experience, 1 star compliance).

Update on the Support at Home Program

Key messages

- The full roll out of the Support at Home program has been delayed further, with the replacement of CHSP deferred until no earlier than 1 July 2027.
- The replacement of Home Care Packages and Short Term Restorative Care programs will proceed as scheduled on 1 July 2025.
- IHACPA and the Aged Care Taskforce are developing inputs to the design of the program and pricing of services.
- Consumer awareness of the upcoming changes is low, but support for the key design feature of the ability to choose services from multiple providers is very high.

The Support at Home reforms have been further delayed, with an announcement from the Minister of Aged Care, the Hon Anika Wells MP, confirming that existing CHSP arrangements will continue until at least 1 July 2027. This means that while the Home Care Packages and Short Term Restorative Care progams will be replaced on 1 July 2025, full unification of home care services remains more than two years away.[81]

The most recent public guidance regarding the proposed design of the program was released by the Department over a year ago, in October 2022. [82] That guidance outlined some proposed key features, including:

- a service-agnostic integrated assessment process
- separated schemes for the provision of ongoing services and for short-term supports, including Goods, Equipment & Assistive Technologies and Home Modifications
- the ability of older Australians to choose multiple providers to deliver their services
- a mixed funding model underpinned by a Service List and fixed price schedule.

While no additional guidance has been provided to date, further details are anticipated in a December 2023 webinar update on the New Aged Care Act and Support at Home reforms.[83]

Concurrent work on the Support at Home pricing framework is being undertaken by IHACPA, which is required to provide pricing advice to inform Government policy and decisions relating to the new program. IHACPA is currently developing a Support at Home Aged Care Pricing Framework Consultation Paper, which will seek feedback from sector stakeholders on a range of issues, including: [84]

- proposing pricing principles for developing aged care costing and pricing advice
- methodology for pricing advice relating to the Support at Home program
- design features of the Support at Home program
- appropriate adjustments to account for legitimate and unavoidable cost variations
- priorities for future developments and areas of work.

Initial costing studies by IHACPA were due to be completed in November 2023, with a larger follow-up study to commence by early 2024. A public consultation is scheduled for mid-2024, with pricing advice due to the Minister in late 2024.

The Aged Care Taskforce will also provide input to the design and funding of the Support at Home program. Among the issues that the Taskforce will consider are the inclusion and exclusion of services within the Support at Home Service List, means-testing arrangements, and consumer contributions for in-home care. These matters are discussed further in the Sector Funding section of this report.

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81. Support at Home to be rolled out in two stages | Health Portfolio Ministers | Australian Government Department of Health and Aged Care
82. Department of Health and Aged Care, *A new program for in-home aged care – Discussion paper*, October 2022
83. Webinars for the aged care sector | Australian Government Department of Health and Aged Care
84. Update provided by Genevieve Donnelly (Executive Director, Aged Care Policy and Communications, IHACPA) to the ACCPA National Conference 2023.

Consumer responses to Support at Home

Recent analysis in *The Catalyst Report – Home care insights 2023* suggests that awareness of the upcoming Support at Home changes is limited amongst current home care participants and those considering taking up in-home aged care and support.[85] Of the 5,102 respondents to the Catalyst Home Care survey, 59% indicated that they were unaware of the changes, while a further 34% indicated that they had heard there were changes but were not across the detail. While this finding likely reflects the early stage of the Support at Home program design, it also highlights the significant communication and education task ahead. Current and future participants must receive timely and targeted information about the changes, which will include new processes for assessment, provider selection, and service mix management, as well as rights and responsibilities under a new Act and consumer payments where appropriate.

The Catalyst Report survey respondents were also asked to reflect on the proposed changes with the Support at Home reforms. Respondents were highly supportive of the ability of people to choose services from multiple providers, with 81% indicating their agreement with this proposal. Less clear support was signalled for other design features, including the need for means-testing of subsidies (51% agreement); the expectation that people with lower needs should self-manage their own care (43% agreement); and that technology should be a key tool in organising home care (40% agreement).

Several of these sentiments align broadly with the position of consumer peak body Council on the Ageing (COTA). In its submission in response to the Department's October 2022 Discussion Paper, COTA affirmed its support for developing a User Contribution policy that is fair and equitable both intergenerationally and across all aged care consumers. COTA also expressed strong support for an in-home aged care program that enables consumers to choose services between a range of providers across service types. However, COTA advocates for a spectrum of self-management, including a right to shared management, such that "all older people and their carers should have the *choice* [emphasis added] to self-manage part or all their care services, or to have them managed for them". [86]

85. Catalyst Research (2023), The Catalyst Report – Home Care Insights 2022

86. COTA Australia, November 2022. *Submission to the Australian Government Department of Health and Aged Care "A New Program for In-Home Aged Care: Discussion Paper"*, page 15.

Legislation update

Key messages

- A new Aged Care Act is slated for commencement on 1 July 2024, with the Draft Bill expected in December 2023.

- The Department's recent consultation paper on the foundations of the new Act reveals that the legislation will be framed as rights-based and person-centred, drawing on international conventions for its constitutional validity.

- UARC supports a right-based approach but considers that the Act should also focus on the sustainability of the aged care system, align more closely with existing State and Territory laws on decision-making and clarify the duty of care requirements.

- The Office of the Inspector-General of Aged Care has commenced operation as an independent statutory agency to oversee the aged care system and its associated regulatory bodies.

New Aged Care Act

In the Mid-year 2023 Aged Care Sector Report published in May this year, UARC noted that the Department had released a consultation paper that proposed a new model for regulating aged care. It focused on provider registration, obligations, regulatory oversight and complaints processes.

Subsequently, in August 2023, the Department released a further consultation paper on the foundations of the new Aged Care Act, which is expected to commence on 1 July 2024.[87] A core matter addressed in the paper is the change in the constitutional basis for the Government's funding and regulation of aged care. Aged care is not explicitly identified in the Constitution as a Commonwealth (Australian) Government function. As such, the Government had relied on its corporations power to enact the law in its current form. This arrangement has limited the Government's jurisdiction over other businesses, such as sole traders, partnerships or other unincorporated organisations in the aged care sector.

The Department has shifted the basis of the Act to the external affairs power of the Constitution to remove this barrier and thus support a wider range of aged care providers to enter the market. This new constitutional basis points to reliance on international conventions such as the Convention on the Rights of Persons with Disabilities and the International Covenant on Economic, Social and Cultural Rights, which the Department claims will ensure a strong foundation for person-centred legislation.

UARC strongly supports the concept of rights-based legislation, which aims to enhance the standard of care for older persons. However, it considers that the legislation should balance these rights with a recognition that the aged care system needs to be sustainable. Much can be learnt from the policy shortcomings and delivery inefficiencies identified in the operation of the disability support system and NDIS.

The creation of a new Aged Care Act is a once-in-a-generation opportunity for the new legislation to set out the key objectives of the aged care system, namely, that it is a system whereby the Government subsidises and appropriately regulates services that provide high-quality care for older people in need. The objectives should also establish the need for the system to be sustainable, both for taxpayers and older people who can contribute to funding their services. Specific reference should be made to how the system should focus on effective and equitably available services that are delivered efficiently.

UARC's submission to the Department details these issues and is available on its website.[88]

Other matters raised in the Department's latest consultation paper, which UARC addressed in the above submission, include the proposed nominee framework and how it will interact with existing laws around Appointments of Enduring Guardian and Enduring Powers of Attorney. This area is complex, as uniform nationwide legislation covering substitute decision-making powers for people who do not have capacity to make decisions about managing their affairs has not yet come to fruition. Nonetheless, the Standing Council of Attorneys-General issued a consultation paper in September on *Achieving Greater Consistency in Laws for Financial Enduring Powers of Attorney*.[89]

87. Resources on the new Aged Care Act | Australian Government Department of Health and Aged Care
88. UARC Response Foundations of New Aged Care Act | UARC
89. Achieving greater consistency in laws for financial enduring powers of attorney - Attorney-General's Department - Citizen Space (ag.gov.au)

Another significant issue is the increased responsibilities of providers through the proposed inclusion of a new statutory duty of care, which is expected to impact providers' risk and compliance management frameworks. So, too, are the changes to whistleblower protections and complaints pathways within the ambit of a risk-based regulatory model. In short, providers knowing whom to liaise with about a person in their care, how complaints are managed, and statutory responsibility for 'serious failures' to act in a manner consistent with a duty of care will form some of the most pressing issues in the reform agenda at an operational level.

Further details on the new Act and regulatory framework are expected in mid-December 2023 when a Draft Bill is expected.

Inspector-General of Aged Care

The Office of the Inspector-General of Aged Care was established on 16 October 2023 through the Inspector-General of Aged Care Act.[90] As an independent statutory agency, it oversees the administration, regulation and funding of the aged care system. The Office of the Inspector-General of Aged Care will not duplicate the regulatory functions of existing government bodies that administer aged care but rather act to oversee the Department, IHACPA and the Aged Care Quality and Safety Commission (ACQSC) to monitor for systemic issues. The Acting Inspector-General is Ian Yates AM, who has previously held various senior positions across the sector.

The functions of this new agency apply at an aged care system level and are not intended to investigate singular exercises of power under aged care legislation or standalone complaints. Its scope of review is geared towards the sector as a whole, and the in-depth reviews it provides to the Government will seek to pinpoint deficiencies in the system's functioning and make recommendations. It will also provide updates on how the Royal Commission recommendations are being implemented and other ad-hoc reporting on critical areas of interest, such as how the aged care system responds to meet the objectives of the new Aged Care Act and other relevant legislation.

90. New statutory agency to investigate systemic issues in aged care | Australian Government Department of Health and Aged Care

Sector funding

Key messages

- The 2023 Intergenerational Report demonstrates that the Government will experience high debt and strong fiscal constraints for at least the next few decades.

- As taxpayer spending on aged care is projected to soon reach 1.5% of GDP (and 2.1% by 2062), the Government has a strong imperative to improve the sustainability of aged care services.

- The Aged Care Taskforce has provided some guidance on its approach, highlighting that the Government should focus on funding direct care and other safety nets as appropriate. However, everyday living and accommodation services are matters for personal contributions, particularly for older people with greater financial means.

- Carrying this principle through to the design of the Support at Home program would see the Government largely funding direct care, with clients having greater funding responsibility for domestic and home support.

The challenge of funding subsidised aged care and support services remains at the heart of the debate on sustainability. A sustainable aged care system is one in which costs are contained to what is necessary to meet the Government's objectives while ensuring that funding is affordable over the longer term. Thus, clear objectives provide an essential foundation, and the new Act should enshrine them in legislation.

Cost containment will be supported by improving the general well-being of older people and thus attenuating the growth in demand for aged care services. Also, on the supply side, sustainability will be supported by ensuring that only effective services are subsidised and that their delivery is efficient, while recognising the fundamental importance of quality, safety and equity of access. These endeavours require substantial progress, as detailed previously in UARC's *2022 Sustainability Discussion Paper.*[91]

In recent months, there have been two important updates concerning the sustainability of aged care funding, each of which is discussed below:

- Release of the 2023 Intergenerational Report
- Establishment of the Aged Care Taskforce.

A sustainable aged care system is one in which costs are contained to what is necessary to meet the Government's objectives while ensuring that funding is affordable over the longer term. Thus, clear objectives provide an essential foundation, and the new Act should enshrine them in legislation.

91. Sustainability of the Aged Care Sector | UARC

Fiscal sustainability: Insights from the 2023 Intergenerational Report

Given the substantial contribution of taxpayer funding to the aged care system, the sector features prominently in each Intergenerational Report (IGR), including the most recent update released in August 2023.[92]

The 2023 IGR makes clear that in the coming decades, the Government will have little room to increase Budget spending on any of its services, as Government debt will remain high over the next four decades and equate to over 30% of GDP by the end of the period.[93]

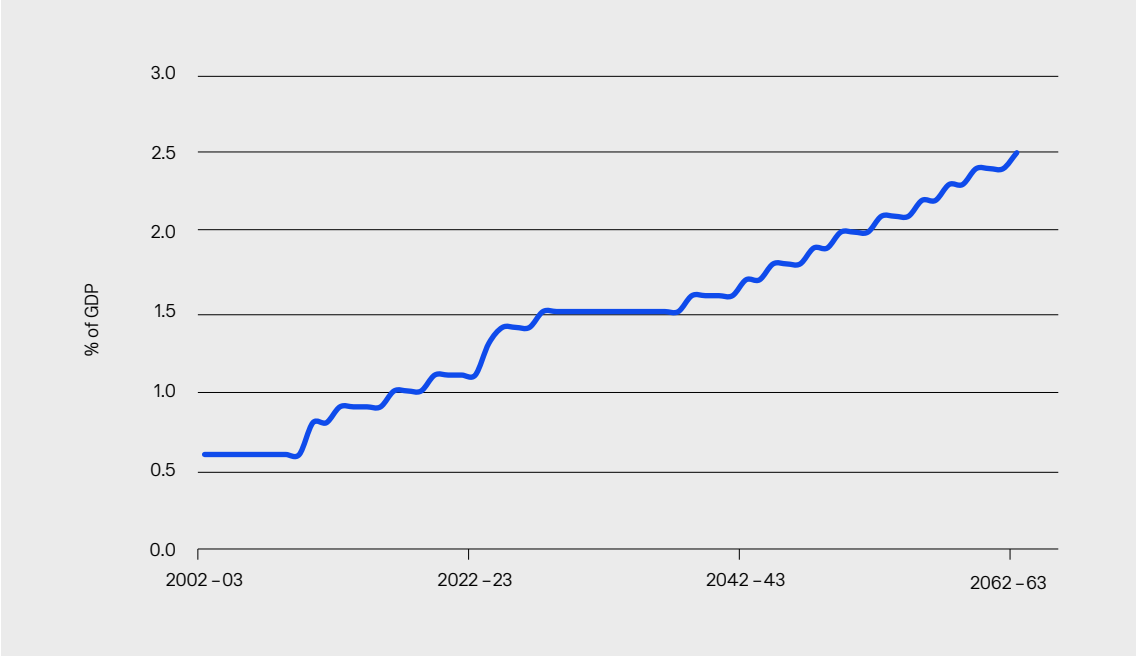
Further, population ageing will constrain workforce participation while increasing labour force demands for delivering care services. The IGR 2023 forecasts that labour productivity will remain below the levels recorded in the 1980s and 1990s, in part because of the changing structure of the economy towards care services sectors.

Aged care continues to be one of the five big budgetary pressures, along with health, NDIS, defence and interest payments. These five areas are projected to increase from about one-third of total Government expenditure in 2022–23 to one-half by 2062-63.

The 2023 IGR's more detailed analysis of aged care expenditure (Figure 31) projects it to rise from 1.1 % of GDP (2022–23) to 2.5 % by 2062–63.[94] UARC notes that separate from the IGR, the Government's 2023-24 Budget estimated that aged care spending will reach 1.5% of GDP by 2026-27.[95]

92. 2023 Intergenerational Report | Treasury.gov.au
93. Treasury (2023), *2023 Intergenerational Report: Australia Over the Next 40 Years*, p.xiv
94. Treasury (2023), *2023 Intergenerational Report: Australia Over the Next 40 Years*, p.161
95. Commonwealth of Australia (2023), *Budget 2023-24, Budget Strategy and Outlook, Budget Paper No. 1.*

Figure 31: Projected Government aged care spending as a share of GDP



Treasury attributes the projected aged care expenditure growth to a range of factors, including demographic changes, demand for higher quality care, wage growth, changing burdens of frailty and disease, ongoing demand to age at home, and government policy settings. [96] Furthermore, the IGR noted that "additional future demand for aged care will require funding approaches that support a fair and equitable aged care system",[97] a perspective that has since been echoed in the remit of the Aged Care Taskforce.

96. 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.
97. Treasury (2023), *2023 Intergenerational Report: Australia Over the Next 40 Years*, p.159

A salutary lesson from the funding of the NDIS

A final point worth noting from the 2023 IGR is the projected Government expenditure on the National Disability Insurance Scheme (NDIS). The disability program has become larger in scope and more expensive than anticipated at its commencement. For example, there are currently 33% more participants than were estimated in the 2013–14 Budget, and per-participant package costs have recently increased by 6% annually.[98]

In April 2023, the National Cabinet agreed to a NDIS Financial Sustainability Framework to limit overall expenditure (numbers of participants and package costs) to no more than 8% annually by 2026, with further growth moderation as the scheme matures.[99] Without the Framework, the IGR noted that Government expenditure on NDIS could reach 6.3% of GDP by 2062–63.[100] An independent review has been undertaken to address these savings through improvements to the Scheme's design, operations and sustainability. To avoid a similar fate, the aged care sector would do well to keep sustainability at the forefront of mind.

Review of consumer contributions by the Aged Care Taskforce

A critical factor influencing the fiscal sustainability of aged care is the extent to which a more equitable funding model can be achieved, whereby individuals with the financial means are required to make greater personal contributions to the services they receive.

In June 2023, the Government announced the Terms of Reference and membership for an Aged Care Taskforce, giving it a remit to '*provide Government with advice on funding arrangements for aged care to ensure that the aged care system is fair and equitable for all Australians*.' [101]

To date, the Taskforce's formal consultation process has involved releasing aged care funding Draft Principles and conducting a series of selective and ad-hoc roundtable consultations. In addition, a generalised summary of matters raised in the 180 submissions was released in November, although these did not include a final set of Principles.[102] Unfortunately, the interim advice has not been made public, which has limited further opportunities for sector stakeholder feedback before the Taskforce produces its final recommendations to the Government.

98. Treasury (2023), *2023 Intergenerational Report: Australia Over the Next 40 Years*, p.152
99. National Cabinet commits to a sustainable NDIS | Department of Social Services Ministers (dss.gov.au)
100. Treasury (2023), *2023 Intergenerational Report: Australia Over the Next 40 Years*, p.158
101. Aged Care Taskforce Terms of reference | PM&C (pmc.gov.au)
102. Aged Care Taskforce consultation - Ageing and Aged Care Engagement Hub (health.gov.au)

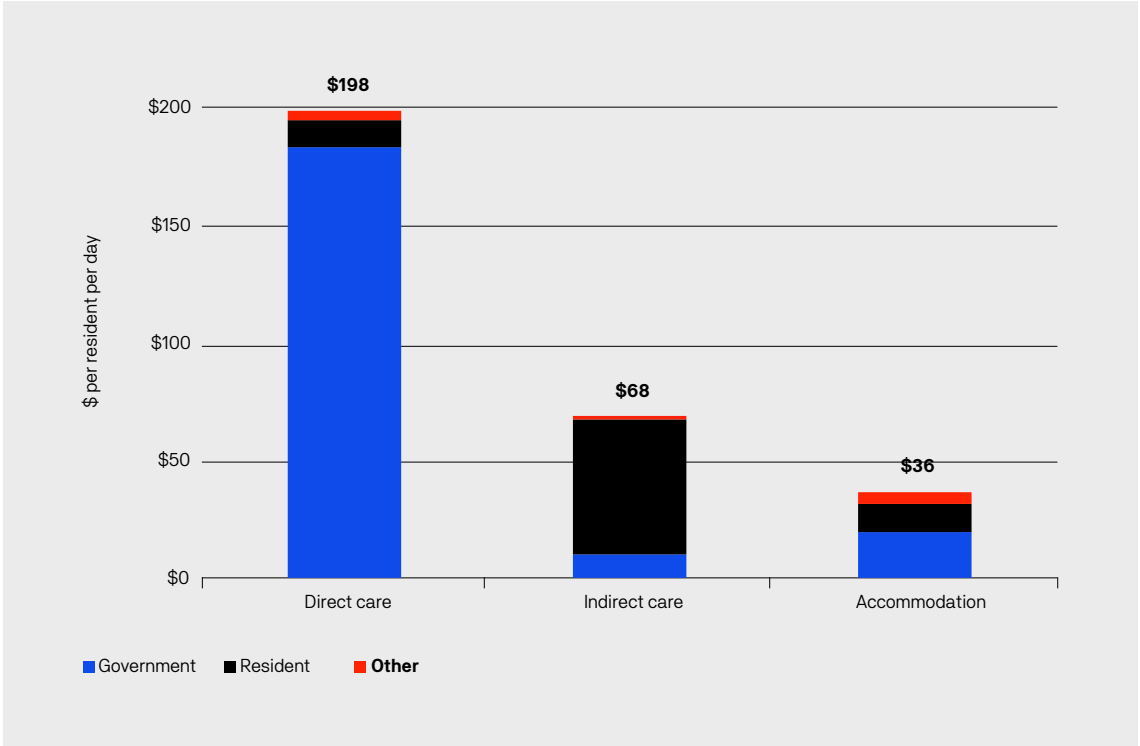
UARC's response to the Taskforce's Draft Principles is available on its website.[103]

The Taskforce's six Draft Principles referred to criteria including simplicity, sufficiency for quality and capital investment, and provider accountability. They also offered insight into the Taskforce's approach to pursuing a fair and equitable system for all Australians. Expressly, Draft Principle 3 specified that:

> *'Government funding should be focused on (direct) care costs. Personal contributions should be focused on accommodation and everyday living costs with a sufficient safety net.'*[104]

As Figure 32 demonstrates, this principle is already reflected in the existing funding pattern for residential care, where direct care is largely taxpayer-funded with further personal contributions for other service areas.[105] However, as discussed under the Financial Viability section of Part 1 of this report, further funding is required to ensure the viability of service delivery, particularly for everyday living and accommodation.

Figure 32: Residential care provider operational revenue, by source, per resident per day (FY22)



103. Woods, M., Sutton, N., Debono, D. (2023) Aged Care Taskforce consultation about funding principles: UARC response. UARC, The University of Technology Sydney.

104. Aged Care Taskforce - Ageing and Aged Care Engagement Hub (health.gov.au)

105. Department of Health and Aged Care (2023), Financial Report on the Australian Aged Care Sector 2021-22.

As discussed earlier, the policy settings for direct care services are currently delivering funding which is close to break-even on average. These policy settings will continue to be adjusted and refined over time, with IHACPA providing objective and independent advice on AN-ACC pricing and the Department remaining responsible as system steward for the funding model. As such, the Taskforce may not offer any major changes to current residential direct care funding arrangements.

Given that everyday living is one of the two loss-making service areas in residential care, it will likely attract significant attention from the Taskforce. UARC has joined StewartBrown in arguing that the funding for these services needs to increase substantially so that the service breaks even (including a modest return to providers). Given that the Taskforce's Draft Principles identified these services as being a focus for personal responsibility, it may consider that taxpayers should not meet some of these costs other than as a safety net for pensioners and others of low means.

One option to achieve this outcome would be to redistribute the Government funding which is currently spent on the hotelling supplement, to become a safety net to top-up the personal contributions of pensioners up to an efficient viable level of funding for providers. The safety net would be tapered down for part pensioners, with all residents with sufficient means paying the full regulated amount for their everyday living services.

The other major residential care issue for the Taskforce is the funding of accommodation services, which is the largest (and longstanding) source of losses in residential care. Again, if its draft Principles are any guide, the Taskforce can be expected to explore options for more viable levels of funding from non-supported residents, together with a similarly viable Government payment for supported residents.

Capital financing for the sector has received considerable attention over many years, including in reports by the former Aged Care Financing Authority and in the Woods/Corderoy Report on the impact of abolishing Aged Care Approval Rounds (ACAR) and bed licences to increase provider competition and give residents greater choice and control. A current version of the debate concerning non-supported residents, which UARC supports, would see the progressive reduction of RADs in favour of a rental model and replacing the distortionary MPIR arrangements with a more stable and sustainable expected return on investment. In addition, policy settings should retain appropriate incentives to ensure equitable access for low-means residents.

For home care packages (which include both direct care and everyday living support), the Taskforce may focus on the meagre 2.2% of personal contributions[106]. More specifically, given that its remit includes issues of the Service List and pricing for the new Support at Home program, there is an opportunity for the Taskforce to argue for differential consumer contributions for in-home care services, dependent on whether they are for health and personal care (which should be largely taxpayer-funded) or for everyday living support (funded predominantly by personal contributions subject to safety nets). UARC considers that this would enhance the alignment of funding models between in-home care and residential care.

106. Department of Health and Aged Care (2023), Financial Report on the Australian Aged Care Sector 2021-22.

A critical factor influencing the sustainability of aged care is the extent to which a more equitable funding model can be achieved, whereby individuals with the financial means make greater personal contributions to the services they receive.

Part
2

Analysis of the StewartBrown sector Dataset

Part 2 of this report draws primarily on the 2022–23 *StewartBrown Aged Care Financial Performance Survey* (ACFPS), a de-identified large-scale dataset 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 AIHW.

The data covers the 2022–23 (FY23) financial year. To enable meaningful trend comparisons, previous years' figures relate to the same reporting period (i.e. 1 July - 30 June) of each year.

The analyses have been conducted at three levels:

Approved providers

Residential aged care homes

Home care package providers[107]

The dataset does not cover the care and support provided by state government-owned agencies, the CHSP, or other subsidised programs such as STRC.[108]

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.

107. Many participant contributors to the dataset 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.

108. From mid-2025, the Government intends to amalgamate the home care package program and CHSP, with Short-term Restorative Care and residential respite, into a single unified 'Support at Home' Program. The dataset will be amended from that point in time to cater to the new program's design, funding, and reporting requirements.

Approved providers

Approved provider analysis

Overview

- The financial performance of participating providers for FY23 shows some improvement compared to the prior year, with positive revenue growth across their businesses that, on average, outpaced growth in expenses.

- Nonetheless, many financial challenges remain, with 61.0% of providers operating at a loss in FY23.

- Providers' median Operating EBITDA margin was just 1.5%, which would generate just $1.50 for every $100 of revenue earned before interest, tax, depreciation and amortisation expenses.

- Aged care providers' future operational returns will likely need to be higher to cover the cost of required capital upgrades.

- Providers' median liquidity (32.6%) and capital adequacy (34.8%) measures remained steady. However, there is substantial variation by providers of different scopes and scales.

Approved provider profiles

The analysis at the approved provider level examines the financial outcomes of organisations that provide residential and/or 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.[109]

Furthermore, care should be taken when interpreting average (mean) results from a dataset containing providers that vary considerably in their scopes, scales 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 shown separately.

This section analyses the outcomes of 223 approved providers who contributed to the 2022–23 StewartBrown full-year dataset, representing 15.6% of Australia's 1,432 residential and home care package providers.[110] As shown in Table 3, most (91.5%) of these providers are not-for-profit, and the remainder (8.5%) are private, for profit providers.[111] Across FY23, contributing providers employed an average of 715 people (468 FTE staff).

109. 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.

110. Department of Health and Aged Care (2023), *Operational providers, 30 June 2023*, Australian Institute of Health and Welfare.

111. Several of the latter are now operated by not-for-profit providers, including Japara and Allity.

Approved providers

Almost all surveyed providers (95.1%) offered residential aged care services, each operating an average of 4.7 homes and 387 places. About half (50.2%) of surveyed providers operate predominantly in metropolitan areas.[112] The geographic spread of providers in the dataset is consistent with sector-level statistics for all residential care providers in Australia.[113]

As with the general trend across all residential care providers,[114] most (50.2%) 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, providers that operated 20 or more homes comprised only 4.9% of the total number of providers in the dataset but operated 37.2% of all the operational places.

In FY23, 105 of the surveyed providers (47.1%) offered home care services. The average number of home care packages per provider (645) is roughly double that of the home care sector overall.[115] This indicates that the dataset is weighted towards larger providers with significant scale in their business segments, including home care services. In addition, 61.9% of providers offered seniors housing (also called retirement villages).

112. Provider 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.

113. According to the Department of Health and Aged Care's Fin*ancial Report on the Australian Aged Care Sector (2021–22),* as of 30 June 2022, 406 (50.4%) of all residential providers are located in metropolitan areas; 310 (38.5%) in regional areas; and 89 (11.1%) in metropolitan and regional areas.

114. The relative distribution of residential care providers in Australia, based on scale, is single home (63.0%), 2-6 homes (27.3%); 7-19 homes (6.8%) and 20+ homes (2.9%). These statistics are reported in the Department of Health and Aged Care's *Financial Report on the Australian Aged Care Sector* (2021–22).

115. As of March 2023, there are 248,957 home care packages provided by 931 providers, which is equivalent to 267 home care packages per provider. Department of Health and Aged Care (2023), *Home care packages program, data report 3rd Quarter 2022–23*, Australian Institute of Health and Welfare.

Table 3: Profile of surveyed approved providers

	FY22	FY23
Number of providers in dataset	223	223
Ownership:		
For profit	8.5%	8.5%
Not-for-profit	91.5%	91.5%
Staffing:		
Average number of staff (headcount)	679	715
Average number of full-time equivalent staff (FTEs)	441	468
Providers with residential aged care homes (%)	95.5%	95.1%
Average number of residential aged care homes	4.5	4.7
Average number of operational places	367	387
Location:		
Metropolitan	49.5%	50.2%
Regional	39.2%	39.7%
Metropolitan and regional	11.3%	10.1%
Provider scale:		
Single home	50.2%	50.2%
2-6 homes	29.6%	29.1%
7-19 homes	10.3%	10.8%
20+ homes	5.4%	4.9%
No residential homes	4.5%	4.9%
Providers with home care operations (%)	47.1%	47.1%
Average number of home care packages	585	645
Providers with seniors housing (%)	61.4%	61.9%
Average number of retirement villages	6.3	6.5
Average number of retirement village units	305	318

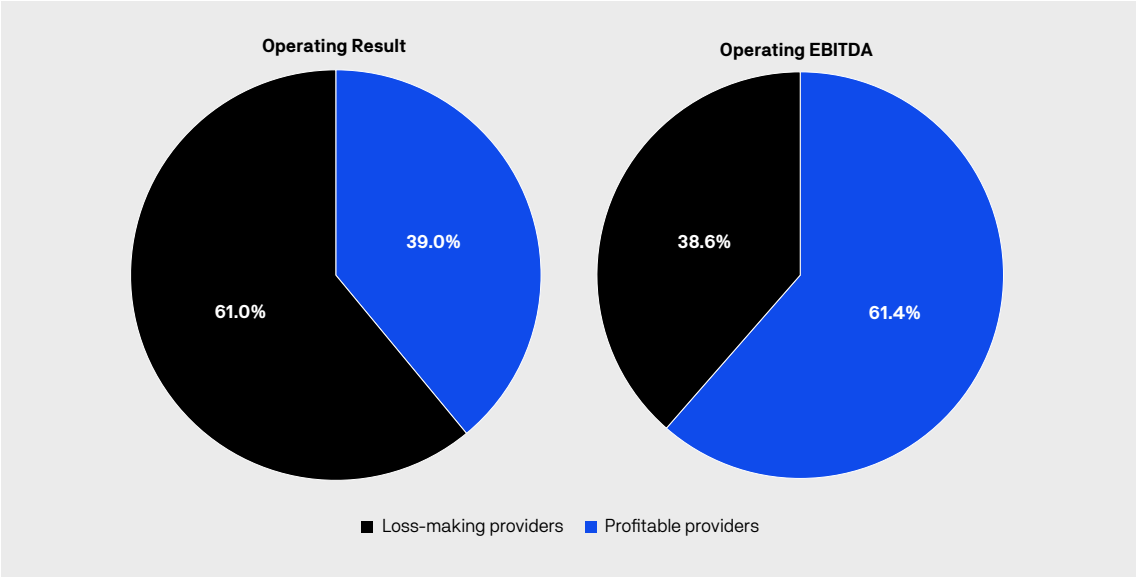
Approved providers

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 can be clouded by different measures of profitability, which reveal different aspects of organisations' financial performance.

The left panel of Figure 33 shows that nearly two-thirds (61.0%) of providers within the 2022–23 dataset had an operating loss. These providers reported a negative Operating Result[116] (also known as 'Net Profit Before Tax') for 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.[117]

Figure 33: Proportion of loss-making providers, Operating Result and Operating EBITDA



A second measure of profit or loss is Operating EBITDA[118] (Earnings Before Interest, Taxation, Depreciation and Amortisation). This measure allows for greater comparability between providers with different corporate structures, financing arrangements, tax obligations and depreciation rates. Furthermore, it tends to convey providers' profitability from operations, somewhat akin to cash flow. However, as it excludes depreciation expenses, there is a danger in relying solely on Operating EBITDA as a measure of viability, as it does not account for the need for an organisation to generate sufficient margins to replenish its capital infrastructure. Like the Operating Result, Operating EBITDA excludes non-recurrent items, including fundraising revenue, revaluations, donations, capital grants and sundry revenue.[119]

116. 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.

117. 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.

118. Earnings Before Interest, Taxation, Depreciation and Amortisation (EBITDA) 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 EBITDA' also excludes all non-recurrent revenue and expenditure, including fundraising revenue, revaluations, donations, capital grants and sundry revenue.

119. When non-recurrent items are included, 29.1% of participating providers reported a negative total EBITDA for FY23.

The right panel of Figure 33 shows that 38.6% of providers reported an Operating EBITDA loss in FY23. Although this proportion is lower than the Operating Result figure, it is still a cause for concern as it indicates that many surveyed providers are not generating a positive cash flow from their operations.

Nonetheless, Table 4 shows some improvement in participating providers' average profit and loss results compared to FY22. The average reported Operating Result reduced from an average deficit of $4.4m per provider in FY22 to $3.5m in FY23. Likewise, while the Operating profit margin and return on assets ratios are still negative (2.7% and 0.8%), they have moved closer to zero.

Table 4: Approved provider average profit and loss results

	FY22	FY23	Change (%)
Revenue			
Service revenue ($ '000)	$56,482	$63,646	12.7%
Investment revenue ($ '000)	$695	$1,212	74.3%
Total operating revenue ($ '000)	$57,178	$64,857	13.4%
Expenses			
Employee expenses ($ '000)	$40,921	$45,831	12.0%
Depreciation and amortisation ($ '000)	$4,399	$4,246	(3.5%)
Finance costs ($ '000)	$706	$1,027	45.5%
Other expenses ($ '000)	$15,534	$17,279	11.2%
Total operating expenses ($ '000)	$61,561	$68,384	11.1%
Operating Result ($ '000)	($4,383)	($3,526)	19.5%
Net non-recurrent income ($ '000)	$1,775	$2,549	43.6%
Total Result ($ '000)	($2,607)	($977)	62.5%
Operating EBITDA ($ '000)	($373)	$130	134.7%
Net non-recurrent income ($ '000)	$1,775	$2,549	43.6%
EBITDA ($ '000)	$1,402	$2,678	91.0%
Ratios (Medians):			
Profit margin (Operating Result)	(5.8%)	(2.7%)	3.1%
Profit margin (Operating EBITDA)	(0.1%)	1.5%	1.7%
Return on assets (Operating Result)	(1.6%)	(0.8%)	0.8%
Return on assets (pperating EBITDA)	(0.1%)	0.4%	0.5%
Wages to revenue	72.4%	71.3%	(1.1%)
Median employee expense per FTE	$90,028	$95,152	5.7%
Depreciation expense (as % of property assets)	3.3%	3.3%	(0.0%)

Approved providers

The average reported Operating EBITDA results likewise show an improvement in providers' financial performance. For FY23, the average Operating EBITDA was a positive $130K per provider, a marked improvement compared to a $373k deficit a year prior.

Furthermore, the median Operating EBITDA profit margin increased to 1.5%. Nonetheless, this comparatively small margin suggests that a given provider will generate just $1.50 of margin for every $100 of revenue earned before accounting for further costs relating to interest, tax, depreciation and amortisation.

The median Operating EBITDA return on assets remains low at just 0.4% in FY23. This modest (low) return on investment substantiates persistent 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 improved because revenue has grown faster (13.4% year-on-year growth) than expenditure (11.1% 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.[120]

In the last financial year, total employee expenses grew by 12.0% from an average of $40.9m in FY22 to $45.8m in FY23, significantly outpacing the 6.3% annual growth in full-time equivalent (FTE) staff. Wage pressures are evident in the growth of the median employee expense, which grew 5.7% from $90,028 per FTE in FY22 to $95,152 in FY23.[121]

Depreciation and amortisation expenses contracted to an average of $4.2m per provider in FY23, partly due to the write-down of bed licenses in the last 18 months. However, the depreciation expense remains persistently low as a proportion of property assets, with a median rate of just 3.3%. This rate implies that providers are expensing long-term assets (including buildings, equipment and furniture), assuming an average useful lifetime of approximately 30.6 years.[122]

As this likely exceeds the realistic timeframe when capital infrastructure may need to be replaced or refurbished (15-20 years), providers' depreciation rates likely underestimate their actual future capital infrastructure and financing needs. In doing so, current depreciation expenses may act as poor proxies for the true cost of replacing and refurbishing the capital infrastructure required to deliver quality care. Thus, aged care providers' future operational returns will likely need to be higher to cover the cost of required capital upgrades.

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

121. The increase in employee expenses also contains an adjustment made by some participating providers to their employee leave provisions, as a result of the Fair Work Commission wage case.

122. In practice, assumed useful life estimates may be even higher if providers record their property assets at their historical cost values.

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 RADs. Furthermore, providers are expected to maintain sufficient capital adequacy, which means they have sufficient net assets to absorb unexpected losses.

On 1 July 2023, the responsibility for monitoring the financial health of approved aged care providers transferred from the Department to the ACQSC. This move allows the ACQSC to monitor and regulate the providers' financial and prudential reporting responsibilities and ensure that viability risks do not compromise the quality of care services.[123]

Much of the existing prudential requirements relate to providers' responsibilities in managing, using and reporting about their RADs. However, their responsibilities will expand under the Government's new Financial and Prudential Monitoring, Compliance and Intervention Framework. Recent policy adjustments have focused on providers' financial reporting responsibilities (e.g. Aged Care Financial Reports, Quarterly Financial Reports, Annual Prudential Compliance Statements, and General Purpose Financial Reports) and the permitted uses of RADs. The next phase will coincide with the new Aged Care Act in 2024 and is expected to include minimum liquidity and capital adequacy requirements.[124]

Importantly, 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 quality aged care services into the future.

123. About the Financial and Prudential Standards | Aged Care Quality and Safety Commission

124. Financial and Prudential Monitoring, Compliance and Intervention Framework | Australian Government Department of Health and Aged Care

Approved providers

Table 5: Approved provider average balance sheet figures

	FY22	FY23	Change (%)
Assets			
Cash and financial assets ($ '000)	$34,845	$35,167	0.9%
Operating assets ($ '000)	$15,187	$10,821	(28.7%)
Property assets ($ '000)	$142,845	$152,873	7.0%
Right of use assets ($ '000)	$2,125	$3,054	43.8%
Intangibles – other ($ '000)	$1,805	$2,323	28.7%
Intangibles – bed licences ($ '000)	$2,322	$1,473	(36.6%)
Total assets ($ '000)	$199,128	$205,711	3.3%
Liabilities			
Refundable loans – residential ($ '000)	$61,018	$65,666	7.6%
Refundable loans – retirement living ($ '000)	$47,611	$50,811	6.7%
Home care packages unspent funds liability ($ '000)	$1,429	$1,202	(15.9%)
Borrowings ($ '000)	$10,989	$10,369	(5.6%)
Other liabilities ($ '000)	$20,432	$20,453	0.1%
Total liabilities ($ '000)	$141,479	$148,501	5.0%
Net assets ($ '000)	$57,649	$57,210	(0.8%)
Net tangible assets ($ '000)	$53,523	$53,414	(0.2%)
Ratios (Medians):			
Liquidity	32.6%	32.6%	(0.0%)
Capital adequacy	35.3%	34.8%	(0.6%)
Property assets as a proportion of total assets	67.8%	66.5%	(1.3%)

Table 5 reports approved providers' average balance sheet figures as of June 2023. It shows that providers' total asset base grew 3.3% over the last 12 months. While cash and property assets increased, operating assets contracted.[125] The results show that bed licenses continue to decline, reflecting the impairment and write-down of these intangible assets during the period leading to the end of ACAR in 2024.

Regarding providers' debt position, Table 5 shows a 5.0% annual increase in the average value of total liabilities, which has been driven up by increases in refundable loans and borrowings. The results also show a continued 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.

125. These year-on-year results partly reflect a reclassification of assets from other assets to property assets, as a result of acquisition activity by participating providers during FY23.

The key balance sheet ratios (expressed as medians) show liquidity[126] and capital adequacy[127] remaining steady compared to the prior year. Both ratios are well above the generally expected 15–20% threshold. However, as will be shown below, these ratios vary across different types of providers.

Analysis by provider type

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 at the provider level somewhat challenging. To address this issue, UARC has developed the following typology (Figure 34). 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).[128]

Figure 34: 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 6 shows the key financial indicators of providers within the 2022–23 full-year 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.

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

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

128. Diversification is measured by a provider's 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.

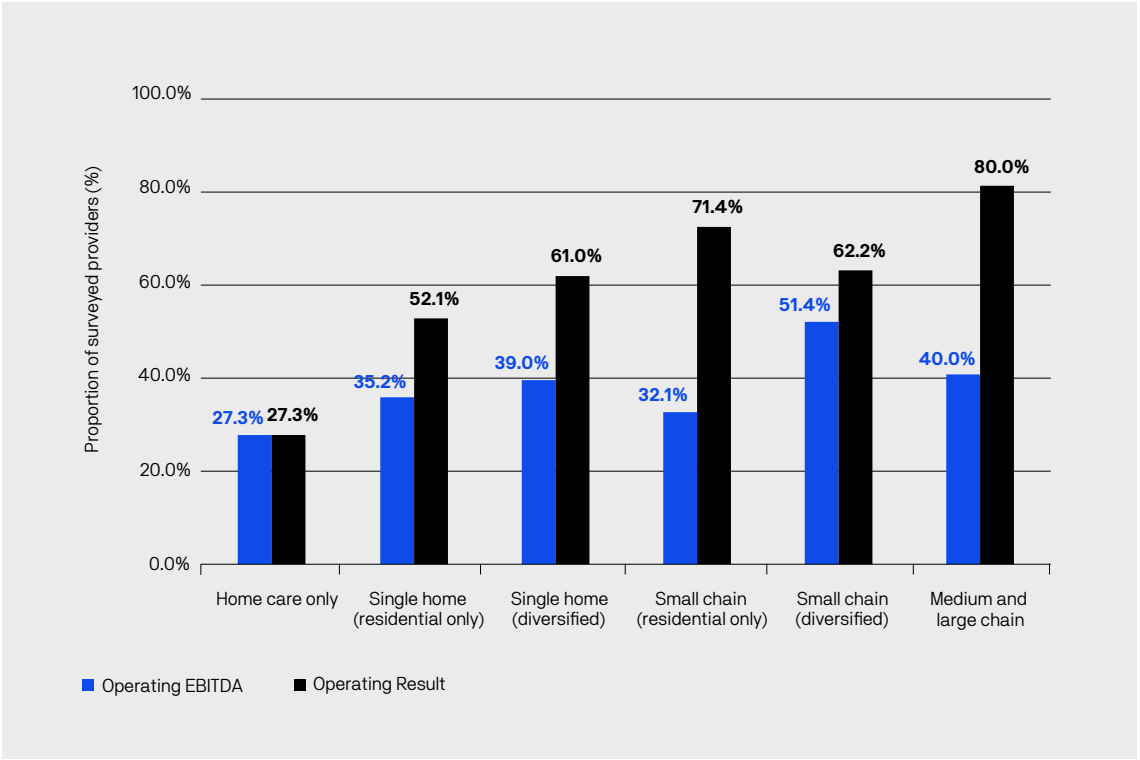
Approved providers

Table 6: 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 dataset	11	71	41	28	37	35
Financial performance:						
Proportion of loss-making providers (Operating Result)	27.3%	52.1%	61.0%	71.4%	62.2%	80.0%
Proportion of loss-making providers (Operating EBITDA)	27.3%	35.2%	39.0%	32.1%	51.4%	40.0%
Profit margin (Operating Result)	1.8%	(0.4%)	(2.4%)	(3.8%)	(2.9%)	(5.7%)
Profit margin (Operating EBITDA)	2.0%	1.5%	3.4%	3.7%	(0.7%)	1.0%
Return on assets (Operating Result)	0.7%	(0.1%)	(0.5%)	(1.1%)	(1.4%)	(1.9%)
Return on assets (Operating EBITDA)	4.5%	1.4%	1.7%	1.3%	0.7%	1.0%
Liquidity	89.0%	59.3%	34.6%	18.8%	23.5%	17.9%
Capital adequacy	62.1%	38.4%	38.3%	16.1%	33.0%	27.8%
Depreciation expense as % of property assets	4.0%	3.7%	3.4%	3.9%	2.5%	2.9%
Staffing:						
Average number of staff (headcount)	1,116	128	153	389	513	2,786
Average number of full-time equivalent staff (FTEs)	757	83	94	187	321	1,799
Wages to revenue	61.6%	71.9%	69.8%	70.8%	71.6%	72.4%
Median employee expense per FTE	$103,473	$91,215	$90,172	$100,626	$92,332	$102,584

In terms of operational performance, the most comparable measure of profit across providers is Operating EBITDA, as this removes the effects of differences in financing arrangements, tax status and accounting assumptions. According to this measure, the providers experiencing the most significant financial difficulty are 'small chain diversified' providers, i.e., those that operate between two and six residential homes and other aged care services (see Figure 35). Over half (51.4%) of these providers reported a negative Operating EBITDA for FY23.

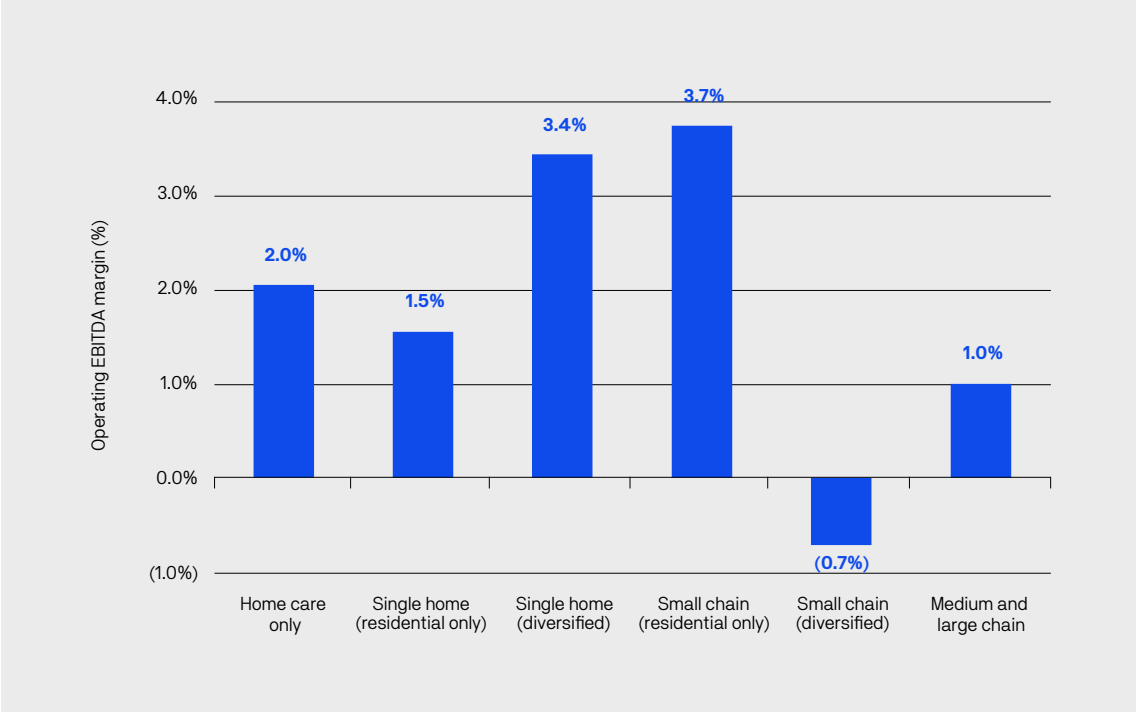
Figure 35: Proportion of loss-making providers, by provider type



Likewise, as shown in Figure 36, the median Operating EBITDA margin of small chain diversified providers is negative 0.7%, whereas all other categories have a positive EBITDA profit margin. Medium and large chain providers (also diversified) reported comparatively small Operating EBITDA, with a median profit margin of 1.0%.

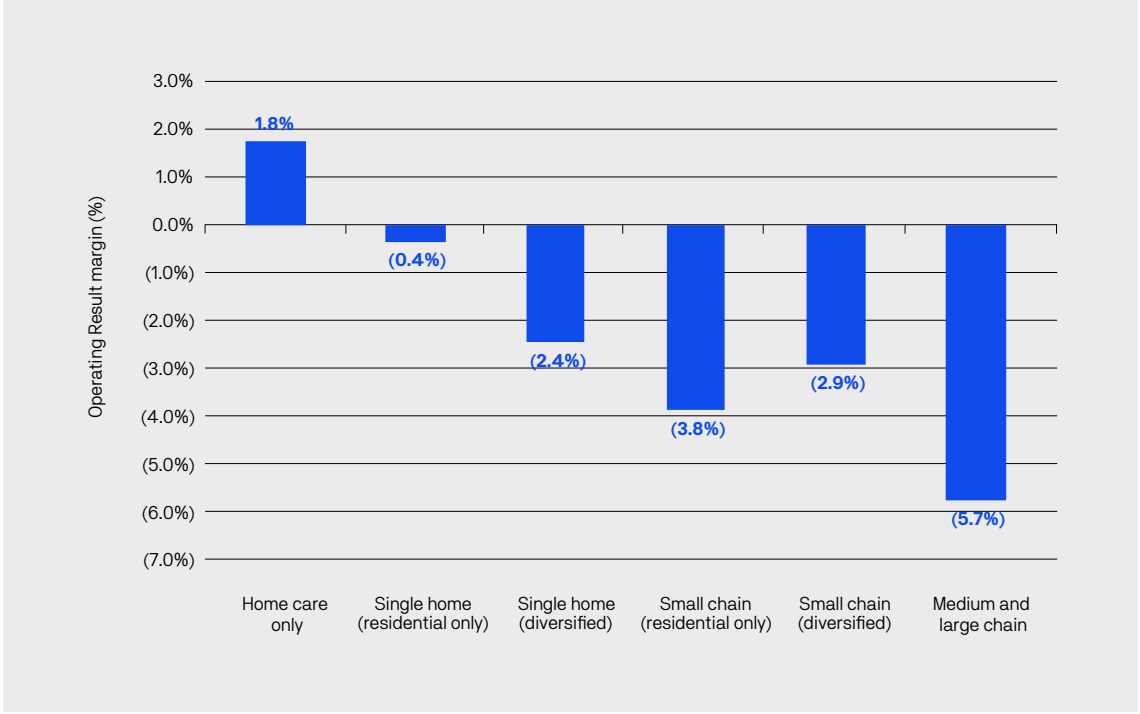
Approved providers

Figure 36: Operating EBITDA margin (%), by provider type



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 35 shows a slightly different pattern emerging when profit is measured using Operating Result (Net Profit Before Tax). Many small chain providers, both residential and diversified, are operating at a loss (62.2 – 71.4%), as are medium and large chain providers (80.0%).

Figure 37: Operating Result margin (%), by provider type



This pattern is also reflected in Figure 37, which shows the median Operating Result margin by type. This shows that, generally, as providers grow larger, their operating margins decline, with the lowest margins reported by medium and large chains (negative 5.7%). These results from FY23 depict a slightly different result compared to the 5-year home-level averages reported in the analysis of provider scale in the Market Consolidation section in Part 1. These differences may arise for several reasons, including recent temporal effects of the new funding model for residential care, provider-level diversification effects, and the geographic spread of providers of large providers.

Regarding diversification, the results show providers that do not have residential care homes ('home care only providers') tend to have better financial performance than most other categories. These providers tend to have lower rates of loss-making and higher rates of profit margins and return on assets.

Residential aged care homes

Residential care analysis

Overview

- Residential aged care homes continue to report poor financial performance. In FY23, over 66% of homes operated at a loss, with an average deficit of $19.56 per resident per day.
- Homes have incurred larger deficits despite substantial increases in government funding, including through the hotelling supplement and the new AN-ACC funding model, which provided transitional benefits for direct care in FY23.
- Occupancy of available places has stabilised at a national average rate of 91.1%.
- Direct care staffing minutes have increased but are still below the sector average target of 200 minutes. Across the year, homes provided an average of 189.6 minutes per resident per day.
- Homes' poor average Operating Result comprised a very slim positive margin of $1.58 per resident per day for direct care services, consumed by larger losses for everyday living (loss of $7.63) and accommodation (loss of $13.49).
- Administration costs have grown 14.1% in the last year, averaging $47.55 per resident per day.
- The homes experiencing the highest rates of financial distress are those located in areas classified as medium rural (MMM4) and those that are small in size (less than 40 operational places).

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. The 2022–23 StewartBrown residential dataset comprises 1,197 homes,[129] representing 45.3% of Australia's 2,640 residential aged care homes and 44.6% of the 221,467 operational places.[130]

Table 7: Profile of surveyed residential aged care homes

	FY22	FY23
Number of homes in dataset	1,202	1,197
Total number of places in dataset	98,345	98,709
Average home size (number of places)	82	82
Ownership:		
For profit	11.7%	6.5%
Not-for-profit	88.3%	93.5%
Location:		
Major city (MMM1)	64.0%	63.2%
Regional (MMM2)	8.3%	8.6%
Large rural (MMM3)	11.0%	10.9%
Medium rural (MMM4)	7.2%	7.1%
Small rural and remote (MMM5-7)	9.5%	10.2%
Provider scale:		
Single home	11.6%	9.6%
2-6 homes	21.5%	19.3%
7-19 homes	32.4%	31.3%
20+ homes	34.5%	39.8%
Home size:		
Less than 40 places	8.9%	9.4%
40-80 places	44.4%	41.6%
80-120 places	29.3%	31.9%
More than 120 places	17.4%	17.0%

129. In total 1,237 residential aged care homes participated in the 2022–23 StewartBrown survey, however as part of the data cleaning and analysis process 40 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.

130. Department of Health and Aged Care (2023), *Aged care data snapshot—2023, Second release*, Australian Institute of Health and Welfare.

Residential aged care homes

As shown in Table 7, the average size of each home in the 2022–23 full-year dataset was 82 operational places, comparable to the national average of 84.[131] Most (88.3%) surveyed homes are operated by not-for-profit providers.[132]

The dataset is also consistent with sector-level statistics of the overall geographic spread of homes by remoteness category (i.e. the Modified Monash Model, MMM), with almost two-thirds located in major cities.[133]

Regarding the scale of the providers operating the aged care homes, the dataset is weighted towards homes operated by larger providers. For example, while standalone single homes comprise 17.9% of all aged care homes nationally, they represent 9.6% of homes in the dataset. Conversely, while homes operated by large providers (20+ homes) comprise 34.5% of all homes nationally, they account for 39.8% of the dataset.[134]

Likewise, in terms of home size, the dataset is underweighted for small homes (less than 40 places). These homes comprise 14.2% of all aged care homes nationally; however, they represent only 9.4% of homes in the dataset. Nonetheless, the proportion of homes larger than 80 places (49.0%) is similar to that in the national statistics (50.4%).[135]

131. Department of Health and Aged Care (2023), *Aged care data snapshot—2023, Second release*, Australian Institute of Health and Welfare.

132. The weighting towards non-for-profit providers is due to the absence of several large listed for-profit providers from the survey and the recent acquisition of for-profit homes by large non-profit providers. State government-operated homes are also not included in the dataset.

133. Australian Institute of Health and Welfare (2023), *Aged care service listing 30 June 2023*.

134. These statistics relate to population characteristics in June 2022, as reported in the Department of Health and Aged Care (2023), *Financial Report of the Australian Aged Care Sector 2021–22*.

135. Department of Health and Aged Care (2023), *Financial Report of the Australian Aged Care Sector 2021–22*.

Key performance indicator summary

Table 8: Key performance indicators of residential aged care homes

	FY22	FY23
Operating Result (per resident per day)	($16.13)	($19.56)
Operating Result (per place per annum)*	($5,030)	($6,133)
Operating EBITDA (per place per annum)*	$1,631	$969
Proportion of loss-making homes (Operating Result)	67.2%	65.8%
Proportion of loss-making homes (EBITDA)	41.9%	43.4%
Occupancy rate	91.1%	91.1%
Supported resident ratio	45.4%	45.6%
Average direct care revenue (per resident per day)	$195.12	$214.74
Average direct care costs (per resident per day)	$193.88	$213.16
Direct care expense ratio	99.4%	99.3%
Average direct care minutes (per resident day)	178.0	189.6
Average value of full RADs held at reporting date	$395,526	$414,787
Average value of new full RADs taken during period	$442,580	$452,808

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

Residential aged care homes

Financial performance

The full-year results from FY23 show that there has continued to be a substantial decline in the financial performance of residential aged care homes. As shown in Figure 38, on average, homes' Operating Result[136] was a deficit (loss) of $19.56 per resident per day.[137] Extrapolated to an annualised figure, this means that in the last year, homes lost an average of $6,133 for each place they operated. However, given the distribution of the operating results across homes, in FY23, 65.8% of homes in the dataset were operating at a loss compared to a higher 67.2% in FY22.[138]

These poor financial results are likely conservative estimates, representing the average results of only the 'mature' homes that participated in the FY23 StewartBrown dataset. As part of the data cleaning and analysis process, 40 homes experiencing substantial disruptions to their operations have been excluded (e.g., newly built and still ramping up, undergoing major refurbishment or subject to sanction). If these homes were included, the average Operating Result for FY23 would fall to a deficit of more than $23 per resident per day.

The results reveal a long-term trend of worsening financial performance of residential aged care homes. Although there was some stabilisation in FY21 (partly due to additional pandemic-related funding flows), there have been declines since, despite substantial ongoing increases in government funding, such as through the Basic Daily Fee supplement (now called the 'hotelling' supplement) in FY22 and the new AN-ACC funding model, which provided some transition benefits (described in Part 1) in FY23.

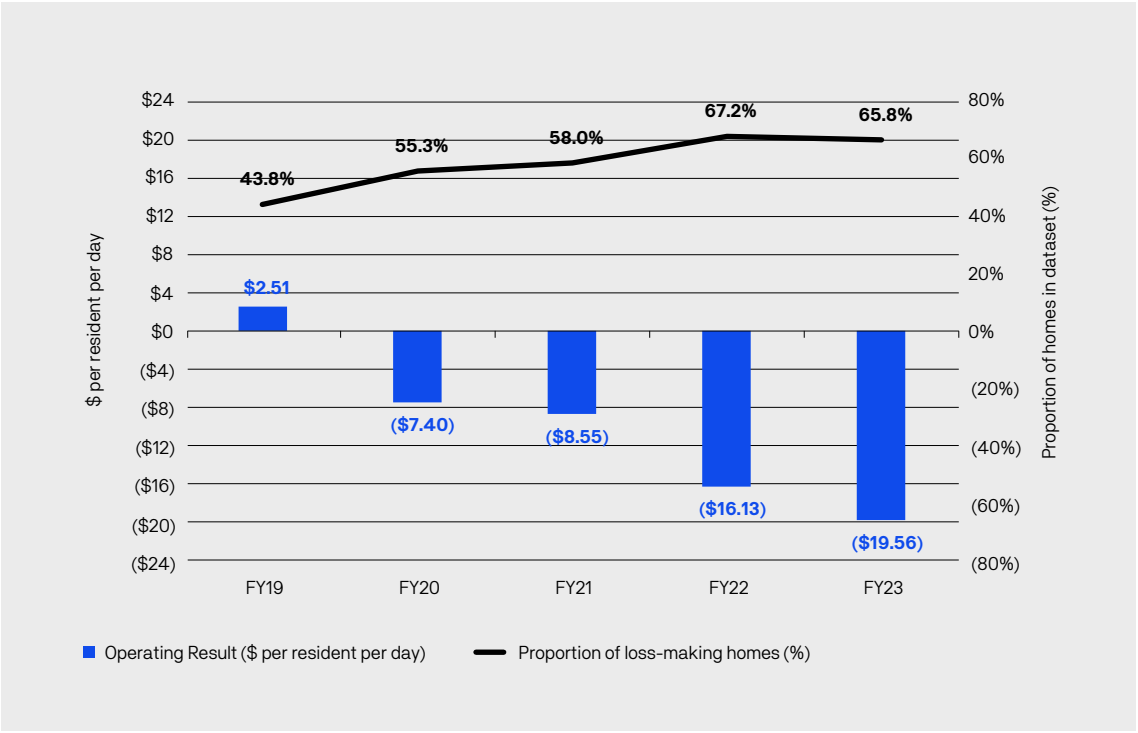
On average, homes' Operating Result was a deficit (loss) of $19.56 per resident per day. Extrapolated to an annualised figure, this means that in the last year, homes lost an average of $6,133 for each place they operated.

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

137. The UARC estimate for average Operating Result (negative $19.56 per resident per day) is $3.02 lower than the StewartBrown estimate (negative $16.54 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 place-level average. For more information please see the methodological guidance provided in Appendix.

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

Figure 38: Operating Result, per resident per day, and proportion of loss-making homes

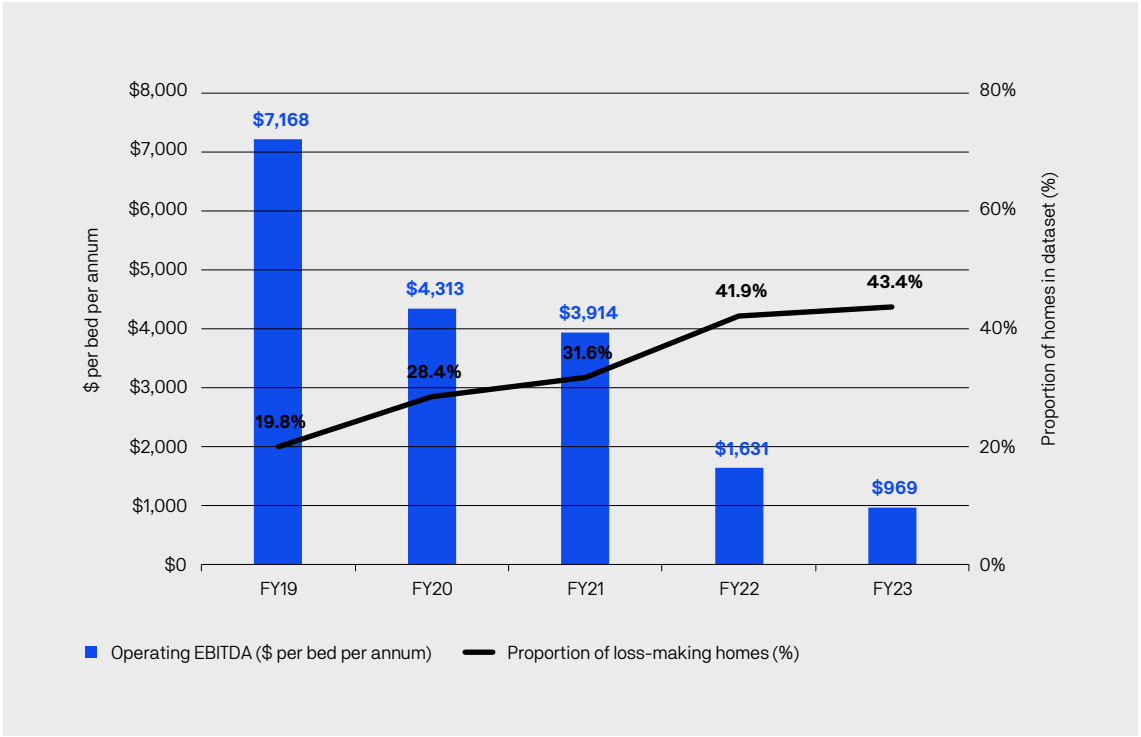


The financial performance of aged care homes directly impacts the sector's overall sustainability. Although unprofitable homes may continue to operate if owned by larger providers that can cross-subsidise losses with margins earned from providing other services such as home care, this might not be possible 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 is cause for considerable concern.

Residential aged care homes

Figure 39: Operating EBITDA, per resident per day, and proportion of loss-making homes



The Operating EBITDA of aged care homes[139] has exhibited a similar trend over the last five years (Figure 39). Operating EBITDA declined by 40.6% relative to the prior year, to an average of $969 per place per annum. For FY23, 43.4% of homes reported a negative Operating EBITDA result[140], slightly up from 41.9% in FY22.

The rising proportion of homes recording Operating EBITDA losses is equally concerning as this measure of profitability generally reflects the cash surplus from operations 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 investing 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.

139. In general, Earnings Before Interest, Taxation, Depreciation and Amortisation (EBITDA) 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 EBITDA' also excludes all provider-level revenue and expenditure, including fundraising revenue, revaluations, donations, capital grants and sundry revenue.

140. An Operating EBITDA loss occurs when an aged care home's Operating EBITDA is below zero.

Figure 40: Operating Result, top 25% vs remaining 75%, per resident per day

Although homes' financial performance has been declining on average, there remains substantial variation across the sector. Figure 40 shows, for example, trends in the profitability of the top 25% of homes (based on their Operating Result) compared to the remaining 75% of homes. This shows that the operating margin of the top 25% has been largely stable, while 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, $68.18 more per resident per day than the remaining 75% during FY23.

Several factors could explain this variation in homes' financial outcomes. For instance, substantial differences exist in the Operating Result 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.

Some differences between the top 25% and the remaining 75% also reflect the transitionary effects of AN-ACC funding discussed in Part 1.[141] Both categories (top 25%, remaining 75%) have similar average service-level care minute targets (199.7 and 201.9 minutes per resident per day, respectively, for total direct care). However, as Figure 41 shows, homes classified as being in the top 25% (i.e. the most profitable homes) are much less likely to be meeting their staffing care minute targets.[142] For example, during April – June 2023, only 12.9% of homes

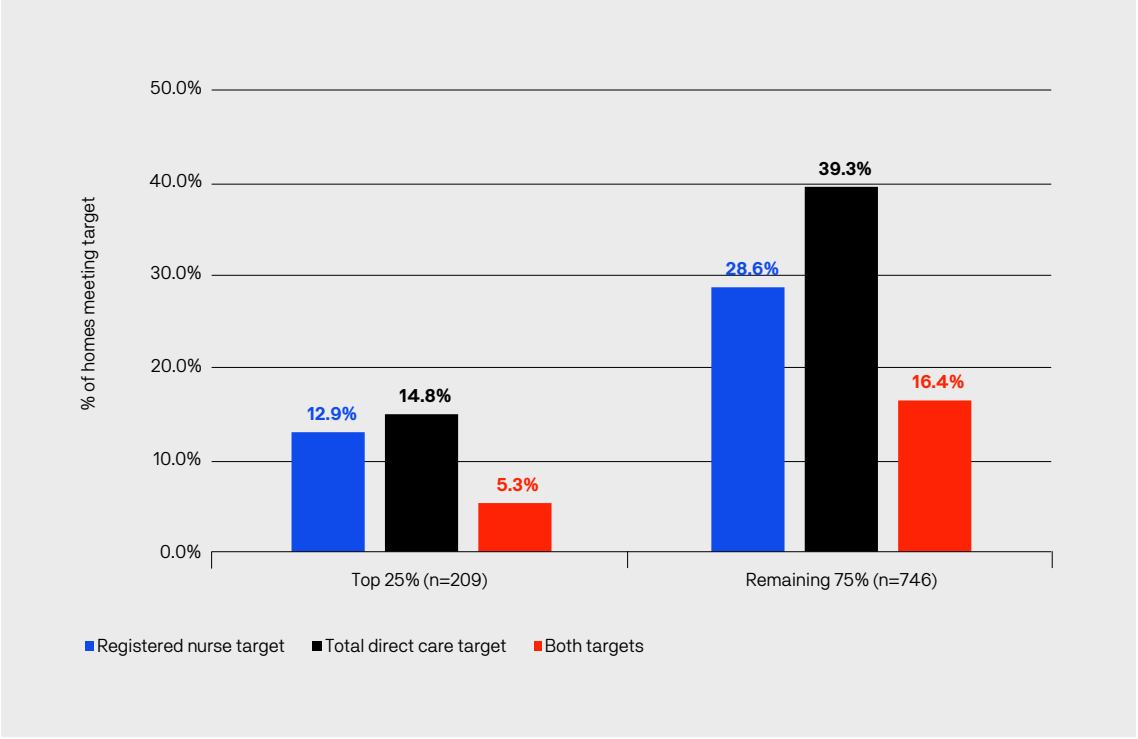
141. This transitional effect arises because AN-ACC has delivered higher care subsidies since 1 October 2022, to fund additional direct care staffing, even though direct care minute targets are not mandatory until 1 October 2023.

142. This analysis was completed using a subsample of 955 homes in the StewartBrown FY23 dataset. Actual staffing minutes are based on the average care minutes reported in Q4 FY23 (i.e. April – June 2023) and the target care minutes are based on service-level targets for 1 October 2023, published by the Department of Health and Aged Care: Care minutes targets in residential aged care by service | Australian Government Department of Health and Aged Care

in the top 25% were meeting their registered nurse target minutes, compared to 28.6% of the remaining homes. Likewise, for total direct care, only 14.8% of top homes were meeting their target minutes, compared to 39.3% for remaining homes. When both targets are considered in combination, only 5.3% of homes in the top 25% were meeting both their targets, meaning that 94.7% of the most profitable homes will need to lift their staffing to meet their targets when they become mandatory on 1 October 2023, as compared to 84% of homes in the remainder.

These patterns suggest that homes in the top 25% had a better financial performance in FY23 partly because they benefited more from the AN-ACC transition effect. UARC anticipates that in FY24 the margin of the top 25% will reduce somewhat relative to the remaining 75% of homes as they increase their staffing levels by a greater amount to meet the mandatory care minute targets.

Figure 41: Proportion of homes meeting care minute targets, top 25% vs remaining 75%



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 and locations relative to others.

Figure 42: Occupancy rate, by State

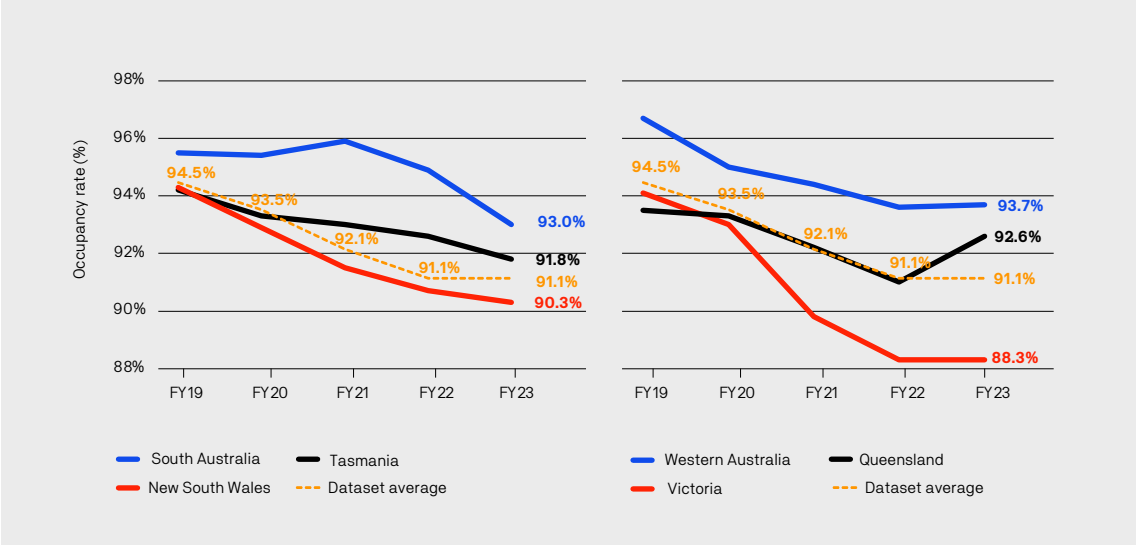


Figure 42 shows that the average occupancy rate across all mature homes in the StewartBrown dataset has stabilised in FY23 at 91.1%, the same as the year prior.[143] However, there are different patterns by state. Occupancy in Western Australia and Victoria appears to have stabilised, noting that, on average, Victorian homes still have the country's lowest occupancy rates. Queensland experienced a modest rebound. By comparison, South Australia, Tasmania and New South Wales each saw a decline in average occupancy rates in FY23.

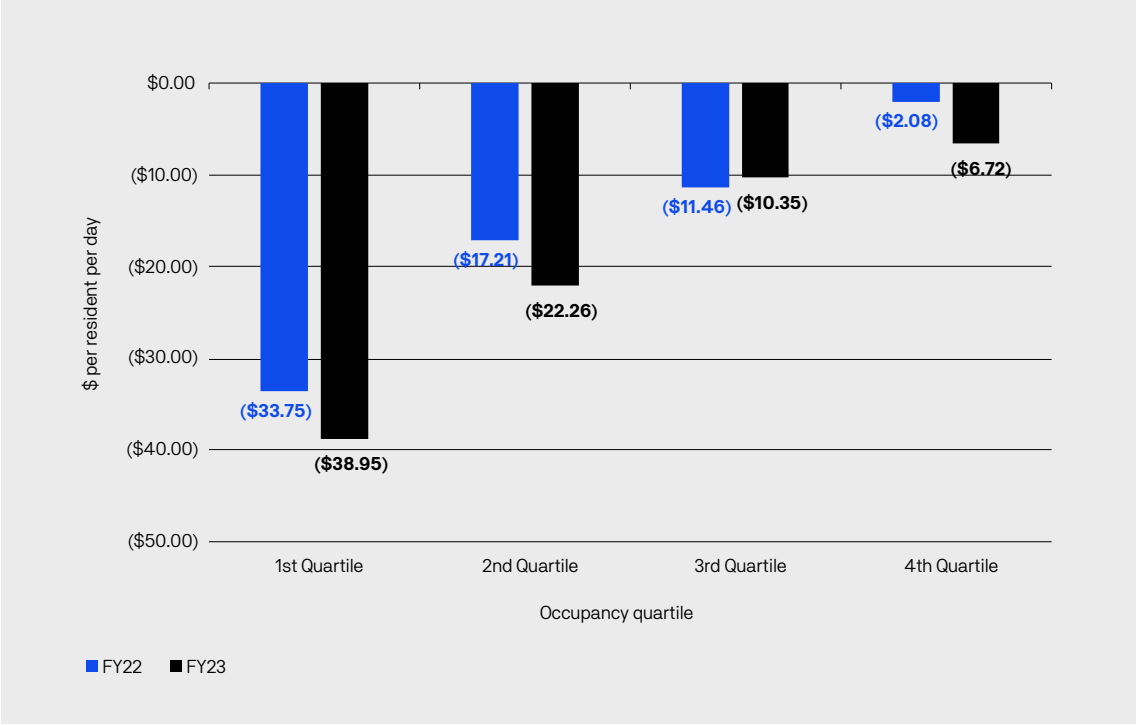
The long-term downward trend reflects a more prolonged structural shift in the demand for residential places coinciding with the Government's release of more home care packages. Future occupancy rates will likely reflect the interaction between various supply and demand factors for residential care, noting that further innovation in accommodation may occur given the abolition of ACAR and bed licences from July 2024. 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.[144]

143. Occupancy measures the rate in which an aged care home's places are used (i.e., occupied) by a resident. In the StewartBrown data occupancy is calculated in terms of the available places, which excludes places that have been allocated but are not operational. This measure of occupancy differs from the estimates published by the Department, which measures occupancy as the proportion of total allocated places, including those that might not be operational.

144. Treasury (2023). *2023 Intergenerational Report: Australia Over the Next 40 Years*.

Residential aged care homes

Figure 43: Operating Result, by occupancy quartile, per resident per day



As noted in previous editions of this report, occupancy is one of the most persistent factors explaining differences in homes' financial performance (Figure 43). This figure shows the average Operating Result (per resident per day) of homes split into quartiles based on occupancy. Homes with the highest occupancy rates (far right column, with occupancy above 96.5%) had an average operating loss of $6.72 per resident per day, while homes with the lowest occupancy rates (left column, with an average occupancy rate less than 88.3%) had an average operating loss of $38.95 per resident per day.

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 places occupied. Furthermore, unless there is a significant and ongoing shift in residents' needs or occupancy, homes find it difficult to alter the configurations and costs of their staff.

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.

Table 9 shows the year-on-year changes in the average staffing time by role, measured as minutes per resident per day. It is important to note that these results are based on year-to-date data. Thus, they represent the average staffing time across the entire financial year rather than the staffing as of 30 June 2023.

There has been a 6.5% increase in direct care staffing time[145] (i.e. registered nurses, enrolled nurses and personal care workers), which on average was 189.6 minutes per resident per day in FY23. This comprised uplifts in registered nurses and personal care workers but also a slight decline in the staffing minutes of enrolled nurses.

Table 9: Staffing time of residential aged care homes, minutes per resident per day

	FY22	FY23
Number of homes in dataset (workforce analysis)	1,163	1,137
Direct care:		
Registered nurses	27.9	33.0
Enrolled and licensed nurses	13.1	12.6
Personal care workers/other unlicensed care staff	136.1	144.0
Imputed agency care minutes*	0.9	0.1
Total direct care staffing time	178.0	189.6
Other care:		
Care management	8.3	6.2
Allied health	5.0	5.6
Lifestyle	7.3	7.0
Total other care time	20.5	18.9
Everyday living, accommodation and administration:		
Hotelling	41.7	41.4
Maintenance and accommodation	4.5	3.8
Administration	10.0	10.6
Quality and education	1.3	1.2
Total everyday living, accommodation and administration time	57.6	57.0
Total staffing time	256.1	265.5

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

145. 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.

Residential aged care homes

While much policy attention has focused on direct care roles, which comprise 71.4% of total staffing time, it is important to recognise the contributions of other types of staff within residential care homes. For example, those in other care-related roles (such as allied health and lifestyle) comprise 7.1% of total staffing time, and those in everyday living, accommodation and administration represent a further 21.5%.

Figure 44: Staffing time, by category, per resident per day

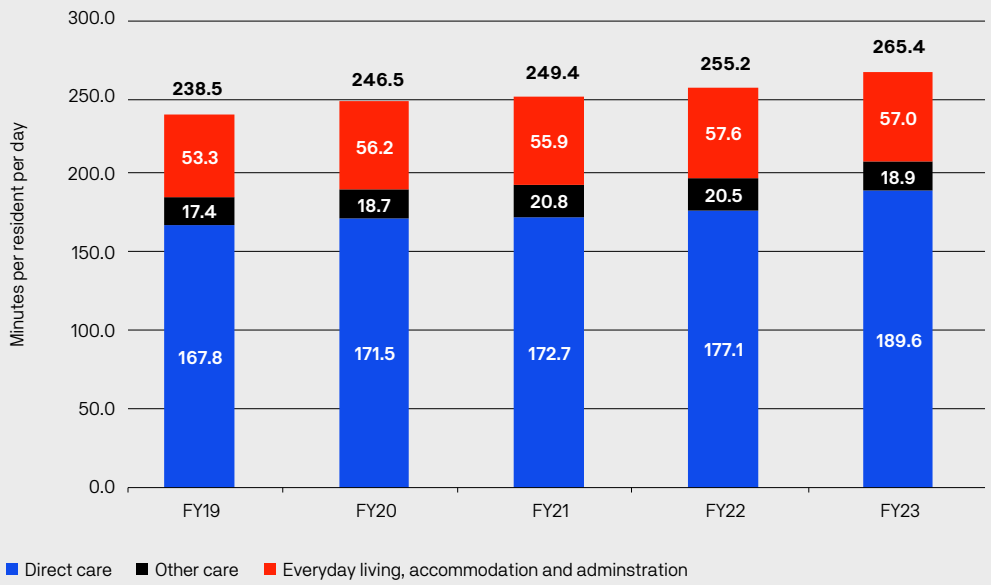
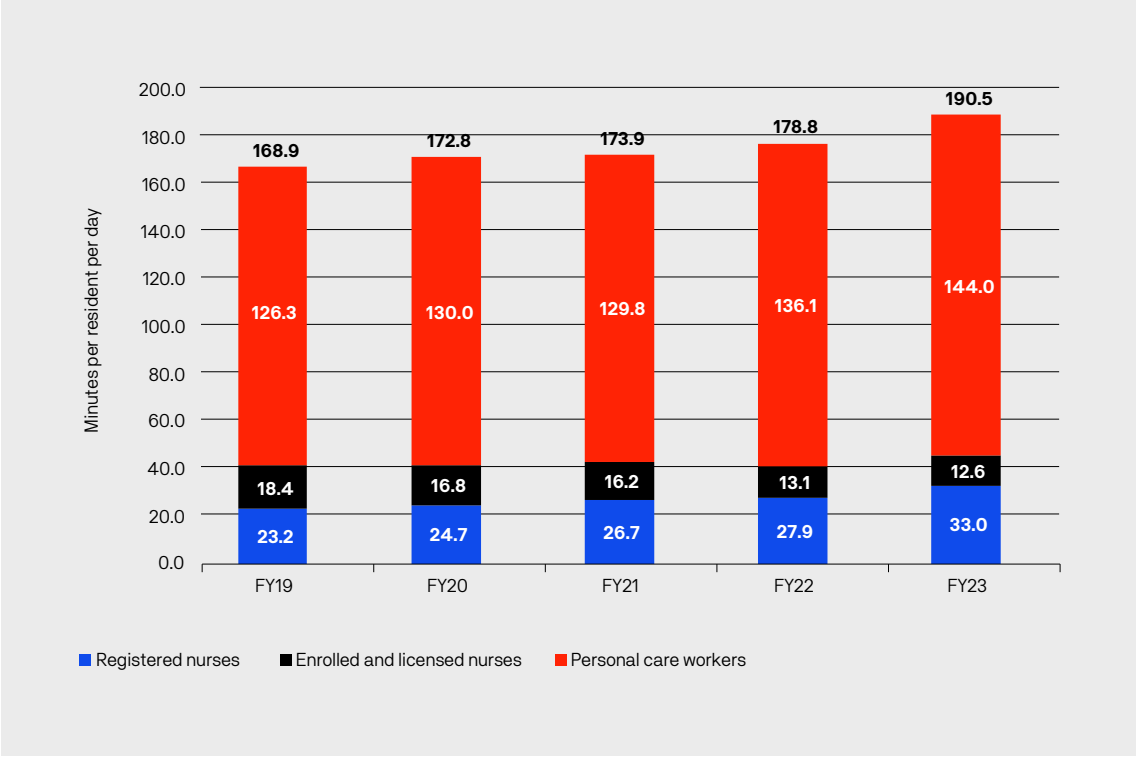


Figure 44 shows the long-term trend in the average composition of homes' staffing. In FY23, the growth in direct care staffing far exceeded that in other roles. This likely reflects the need for homes to raise their direct care staffing levels to comply with the minimum staffing standards, which became mandatory in 2023.

In terms of the care minute requirements, while each home's targets depend on the specific case mix of the residents, 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.[146] In addition, from 1 July 2023, all homes have been required to have a registered nurse on duty at all times, with exemptions for some homes based on location and size.

146. Each home's service-level care minutes targets depend 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 45: Direct care staffing, by role, per resident per day



Disaggregating the direct care data in Figure 44, the five-year trend depicted in Figure 45 shows that growth in registered nurses and personal care workers has accelerated in the last 12 months in the lead-up to the staffing requirements becoming mandatory. As with previous reports, we note the continued contraction of enrolled nurse time, which has declined for the fourth year, representing an aggregate fall of 32.2% since FY19.

Given that these are annual averages, it is likely that the actual staffing levels as of 30 June 2023 are slightly higher still. Based on analysis of a subsample from the Q4 only (i.e. April – June 2023), the average staffing time for registered nurses was 33.9 minutes per resident per day, 14.5 minutes for enrolled nurses and 144.8 minutes for personal care workers. This total of 193.2 minutes is a small increase on the 190.5 minutes in the above figure.[147]

Nonetheless, as discussed in Part 1, aged care homes are still lagging behind the required sector-level averages. This suggests they are encountering substantial challenges in recruiting and retaining staff to meet the minimum care minute targets and 24/7 registered nurse requirement.

147. This subsample analysis was conducted using data from 955 homes in the StewartBrown dataset that had reliable data for both Q3 and Q4 periods.

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 Result, where homes' overall financial outcome is disaggregated into the three service areas:

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

Disaggregating the Operating Result into these three areas (see Table 10) 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, administration costs have been allocated across the three areas for a meaningful comparison between the respective revenues and costs. 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 administration costs.

Table 10 shows that in FY23, homes are operating at a loss because, on average, their total daily revenue per resident per day ($321.14) is less than their total costs ($340.68).

Homes' poor average Operating Result comprised a very slim positive margin of $1.58 per resident per day for direct care services, consumed by larger losses for everyday living (loss of $7.63) and accommodation (loss of $13.49).

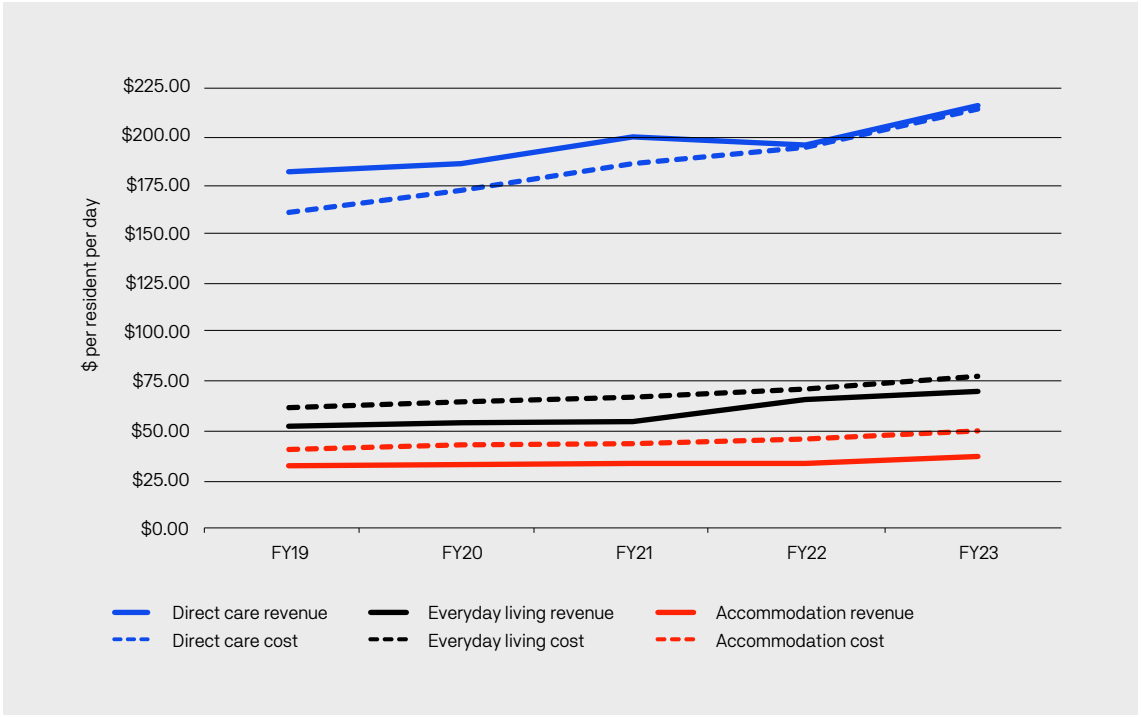
Table 10: Detailed financial results, per resident per day

	FY22	FY23
Direct Care		
Direct care revenue:		
Residents	$7.71	$6.55
Government	$187.42	$208.18
Total direct care revenue	$195.12	$214.74
Direct care costs:		
Direct care labour costs	$138.61	$161.32
Other labour costs	$27.08	$26.31
Other direct care costs	$12.77	$7.95
Allocation of administration costs (37.0%)	$15.42	$17.59
Total direct care costs	$193.88	$213.17
Direct care result	**$1.23**	**$1.58**
Everyday Living		
Everyday living revenue:		
Residents	$55.97	$59.99
Government	$9.95	$9.98
Total everyday living revenue	$65.92	$69.97
Everyday living costs:		
Catering	$34.51	$37.70
Cleaning	$9.74	$10.34
Laundry	$4.31	$4.58
Utilities	$7.43	$7.90
Other	$1.05	$1.09
Allocation of administration costs (33.6%)	$14.00	$15.98
Total everyday living costs	$71.04	$77.59
Everyday Living Result	**($5.13)**	**($7.63)**
Accommodation		
Accommodation revenue:		
Residents*	$12.59	$14.54
Government	$20.51	$21.89
Total accommodation revenue	$33.10	$36.43
Accommodation costs:		
Depreciation	$19.25	$20.56
Property maintenance and rental	$12.33	$13.71
Other	$1.50	$1.68
Allocation of administration costs (29.4%)	$12.25	$13.97
Total accommodation costs	$45.33	$49.92
Accommodation Result	**($12.23)**	**($13.49)**
Operating Result (per resident per day)	**($16.13)**	**($19.56)**
Total revenue (per resident per day)	**$294.14**	**$321.14**
Total costs (per resident per day)	**$310.25**	**$340.68**

*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 46: Service area revenue and costs, per resident per day



This breakdown is also depicted in Figure 46, which shows recent trends in average revenues and costs of each service area, including the allocation of administration costs. These trends are analysed in more depth below, but in summary:

- The historical surplus from direct care services was largely eliminated by FY22, which has continued into FY23.
- The deficit from everyday living services had become smaller by FY22 following the introduction of the Basic Daily Fee supplement (now called the 'hotelling' supplement) but is widening again.
- The deficit for accommodation services has continued to worsen.

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 FY23 results show that aged care homes' direct care results have remained close to breaking even for the second year.[148] On average, homes earned $1.58 per resident per day from direct care services, with 99.3% of direct care revenues expended on direct care costs.[149]

Figure 46 shows direct care revenues and expenses converged in FY22 and have remained there since. Homes' revenue growth, largely driven by the new AN-ACC funding model, has matched similar cost growth.

For example, in FY23, homes earned an additional $20.76 per resident per day from direct care government subsidies.[150] However, as AN-ACC is tied to direct care minutes targets, the costs of direct care services have also increased year-on-year, particularly in terms of staffing. Table 10 shows that direct care labour costs have grown by $22.71 per resident per day (16.4%) in the last financial year. This increase represents a combination of more staffing time per resident (as described earlier) and increases in the input prices of labour for direct care workers.

These labour price increases are evident in Figure 47, which shows the long-term trends in the median labour cost per hour worked. This rate depicts homes' actual expenditures per hour worked (both normal and overtime hours), including:

- Wages and salaries.
- 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.[151]

148. The Direct Care Result represents the net difference between 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 direct care costs, and this includes an allocation of workers compensation and quality and education costs, as well as an allocation of 37.0% homes' administration costs.

149. The direct care expenses ratio is calculated by dividing total direct care costs by total direct care revenue.

150. Most of this relates to the additional funding that commenced on 1 October 2022 (i.e. for the second quarter of FY23), although it may also reflect gradual increases in the average acuity of residents over time.

151. Because of these inclusions, the labour rates depicted in Figure 47 are much higher than the award rates for these roles and the average contractual rates published in the Department's Quarterly Snapshot, which reports the award and contractual rates.

Residential aged care homes

Figure 47: Median labour cost per worked hour, by direct care role

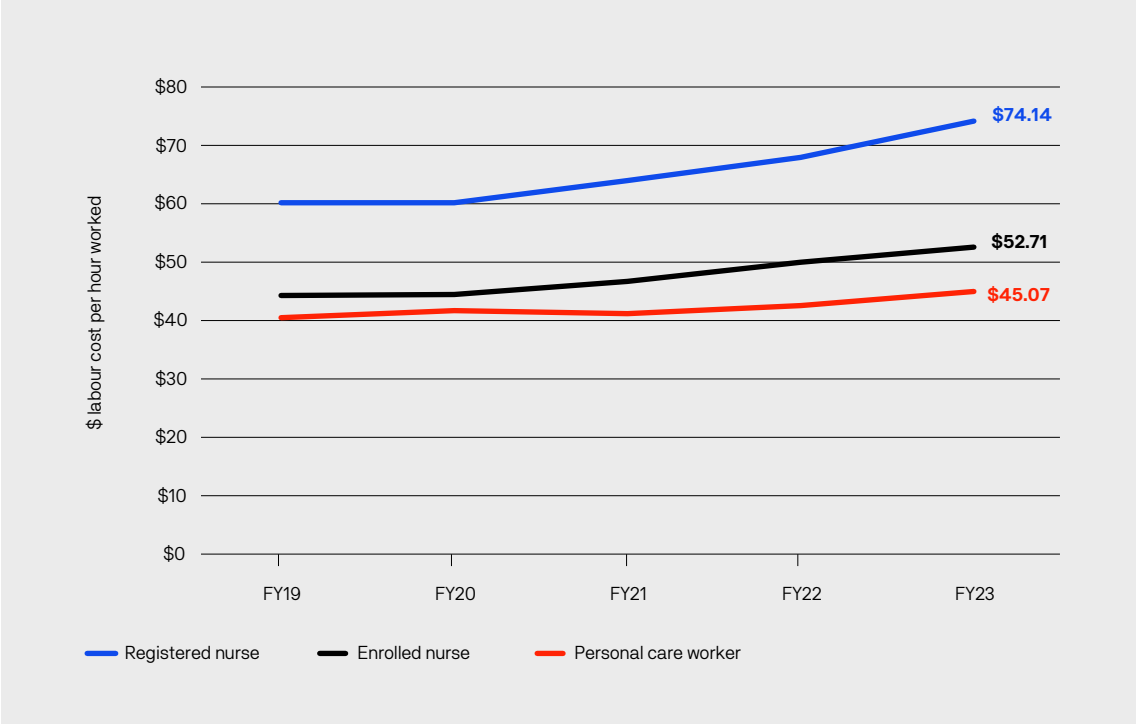


Figure 47 shows that these labour rates have steadily increased over the last four years. For example, in FY23, the median hourly cost for registered nurses ($74.14) was 23.3% higher in nominal terms than in FY19 ($60.14). Furthermore, the growth rates increased in FY23, with the cost of registered nurses growing by 9.0%, enrolled nurses by 5.4% and personal care workers by 5.6%, each outpacing the annual wage growth rate for health and social services (3.3%).[152]

Notably, this growth predates the 15% increase in the award rates for direct care workers, which resulted from the FWC's wage case (which takes effect on 30 June 2023).[153] As discussed in Part 1, it likely reflects the added wage pressures across the sector, as homes increasingly rely on more expensive workforce strategies such as agency staffing.

152. Wage Price Index, Australia, June 2023 | Australian Bureau of Statistics (abs.gov.au)

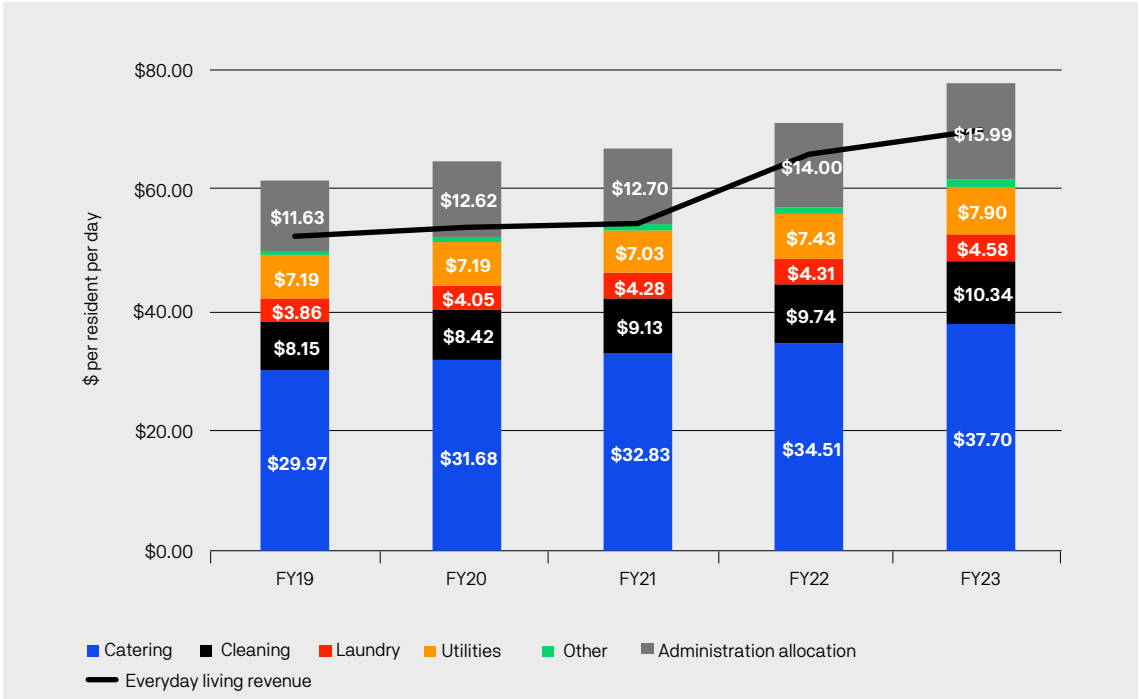
153. However, the direct labour cost does include a one-off increase in expenses relating to the leave provisions for direct care workers as a result of the Fair Work Commission case. StewartBrown analysis estimates this cost across all direct care roles as approximately $0.98 per resident per day, averaged over the entire FY23 financial year.

Everyday living:

Everyday living includes hotel-like services such as food, cleaning, laundry, and other daily amenities. As shown in Table 10, the Everyday Living Result[154] has declined in the last year. Homes now lose, on average, $7.63 per resident per day (compared to losing $5.13 per day in FY22).

As noted in Part 1 of this report, this decline has occurred despite the substantial increase in revenue for everyday living services in the last two years, reflecting additional Government funding and indexation of the Basic Daily Fee. However, as shown in Figure 48, the last two years have also seen substantial growth in spending on everyday living services (16.1% over two years and 9.2% in the last year). The most significant cost area is catering and food, which averaged $37.70 per resident per day in FY23. Year-on-year costs have increased by 9.2%, driven mainly by increases in the labour costs of internal kitchen staff and expenditure on food supplies.

Figure 48: Everyday living revenue and costs, per resident per day



Another sizable cost sub-category is the allocation of everyday living administration costs, averaging $15.99 per resident per day. Hypothetically, if administration costs were excluded, with the recent revenue increases, everyday living services would have generated a margin of approximately $8.35 per resident per day in FY23. However, as there is no other separate revenue stream to cover administration costs, it is essential that the pricing of services be sufficient to cover these costs.

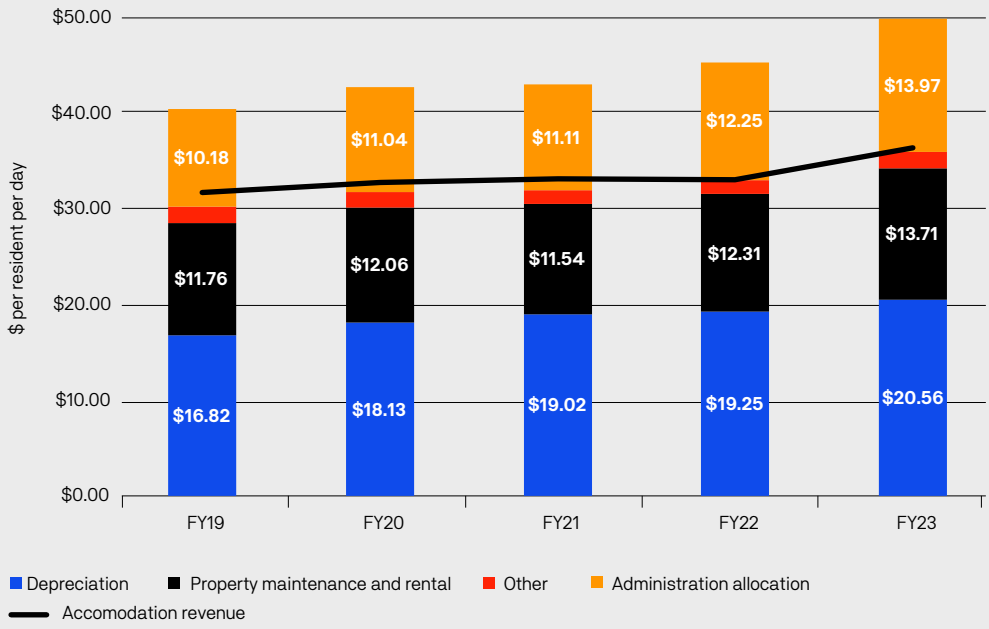
154. The Everyday Living Result includes revenue from Basic Daily Fee, the hotelling supplement as well as extra or additional service fees. The main cost categories include hotel services (catering, cleaning, laundry), utilities, motor vehicles and regular property and maintenance (includes allocation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

Accommodation:

The Accommodation Result[155] shows the net revenues and expenses for providing and maintaining the physical infrastructure of aged care homes, which includes buildings, vehicles and equipment.

In FY23, homes lost an average of $13.49 per resident per day in providing accommodation services as costs continued to exceed revenue (see Figure 49). From a financial perspective, this service area represents the most significant concern within the business model of providing residential care, constituting about 70% of the average total operating losses.

Figure 49: Accommodation revenue and costs, per resident per day



As with everyday living, Figure 49 shows that accommodation services generate losses because current revenue settings are inadequate in covering the total accommodation cost, including appropriate allocation of administration expenses.

Also, even though depreciation is one of the most significant cost categories (averaging $20.56 per resident per day), it likely understates the true cost of replacing or refurbishing physical infrastructure.[156] In the future, if homes need to incur additional expenditure to replace or refurbish their physical assets, accommodation services' losses are likely to grow.

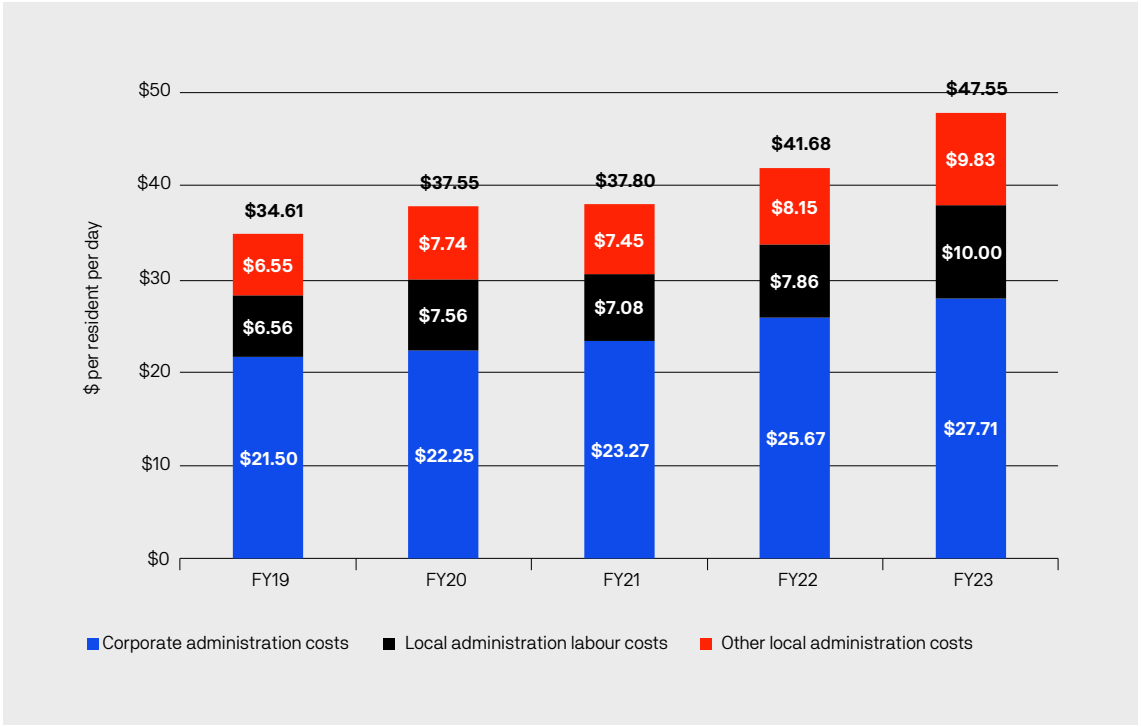
155. The Accommodation Result shows the net difference between accommodation revenue earned from either daily accommodation payments made from non-supported or partially supported residents, and government supplements for supported residents, and expenses related to capital items such as depreciation, property rental and refurbishment costs. The Accommodation Result also includes an allocation of 29.4% homes' administration costs.

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

Administration costs:

The above analysis allocates administration costs to calculate the net results for direct care, everyday living and accommodation. Figure 50 shows the trend in the underlying expense items included in this allocation. In FY23, total administration costs were, on average, $47.55 per resident per day, comprising $27.71 for the corporate administration costs (i.e. an apportion of the provider's corporate head office costs or organisation-wide administration costs), $10.00 for local administration labour and $9.83 for other local administration costs.[157]

Figure 50: Administration costs, per resident per day



Furthermore, administration overhead costs have continued growing and are 37.4% higher, in nominal terms, than in FY19. This growth has accelerated over the last year, up 14.1% compared to FY22. Significantly, the annual growth of both local administration labour costs (27.2%) and other local administration costs (20.7%) has outpaced that of corporate administration allocations (8.0%), which likely reflects the operational demands of implementing the various reforms, as discussed in Part 1.

157. '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.

Results by location

Although most residential aged care homes are in major cities in Australia, close to 40% are in regional, rural or remote locations.[158] 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 government funding models and policies, homes in different locations tend to have different financial and workforce outcomes.

This report analyses these differences by examining the outcomes of homes classified using the MMM remoteness classification, which the Department uses to determine various subsidies and supplements for residential care services.[159]

Whereas in previous reports, we have grouped homes in MMM 2, 3 and 4 areas as one category, important differences in their operational and financial circumstances warrant more granular analyses.

Table 11: Key performance indicators of residential aged care homes, by location

	Major city (MMM1)	Regional (MMM2)	Large rural (MMM3)	Medium rural (MMM4)	Small rural & remote (MMM5-7)
Number of homes in sample	757	103	130	85	122
Average home size (number of places)	88	88	85	71	48
Operating Result (per resident per day)	($14.40)	($19.61)	($26.17)	($43.86)	($27.55)
Operating Result (per place per annum) *	($4,506)	($6,337)	($8,432)	($13,381)	($8,563)
Operating EBITDA (per place per annum) *	$2,810	$245	($1,712)	($6,412)	($1,848)
Proportion of loss-making homes (Operating Result)	62.6%	68.9%	66.9%	82.4%	70.5%
Proportion of loss-making homes (EBITDA)	37.3%	53.4%	50.8%	64.7%	50.8%
Occupancy rate	91.6%	91.2%	90.5%	89.3%	90.2%
Supported resident ratio	44.5%	46.2%	46.2%	47.2%	49.5%
Average direct care revenue (per resident per day)	$213.91	$211.19	$209.95	$210.20	$231.18
Average direct care costs (per resident per day)	$210.87	$207.12	$213.63	$223.29	$224.96
Direct care expense ratio	98.6%	98.1%	101.8%	106.2%	97.3%
Average direct care minutes (per resident day)	189.5	189.5	188.0	189.4	192.5
Average of full RADs held at reporting date	$457,042	$369,176	$350,661	$349,014	$309,745
Average of new full RADs taken during period	$493,528	$393,371	$386,815	$387,603	$345,189

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

158. Department of Health and Aged Care (2023), *Aged care data snapshot—2023, Second release*, Australian Institute of Health and Welfare

159. Modified Monash Model | Australian Government Department of Health and Aged Care

Table 11 shows that aged care homes in all locations had poor financial outcomes in FY23. However, homes in medium rural areas (MMM4) – towns such as Townsville, Cowra, Kempsey, Colac, and Port Augusta – tended to have comparatively much worse outcomes than those in other locations. Over four-fifths (82.4%) of surveyed homes in MMM4 areas operated at a loss, and the average loss across that region was $43.86 per resident per day, almost triple that of homes in major cities ($14.40).

Figure 51: Operating Result, by location, per resident per day

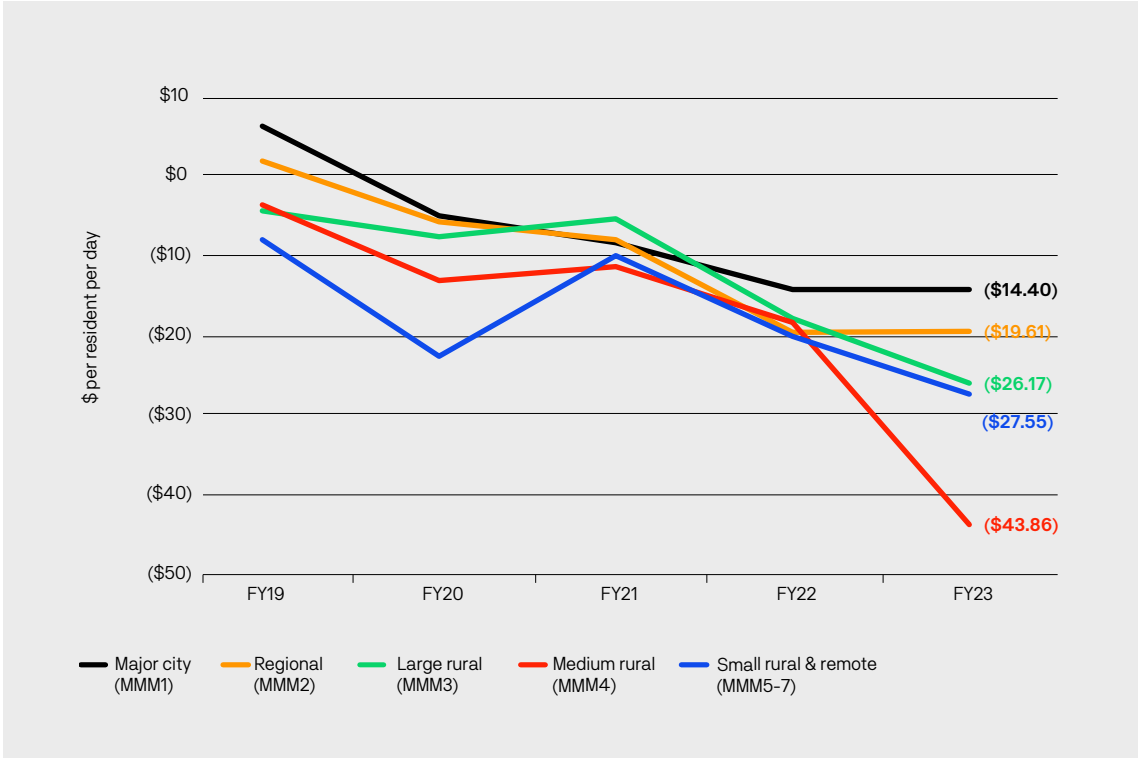
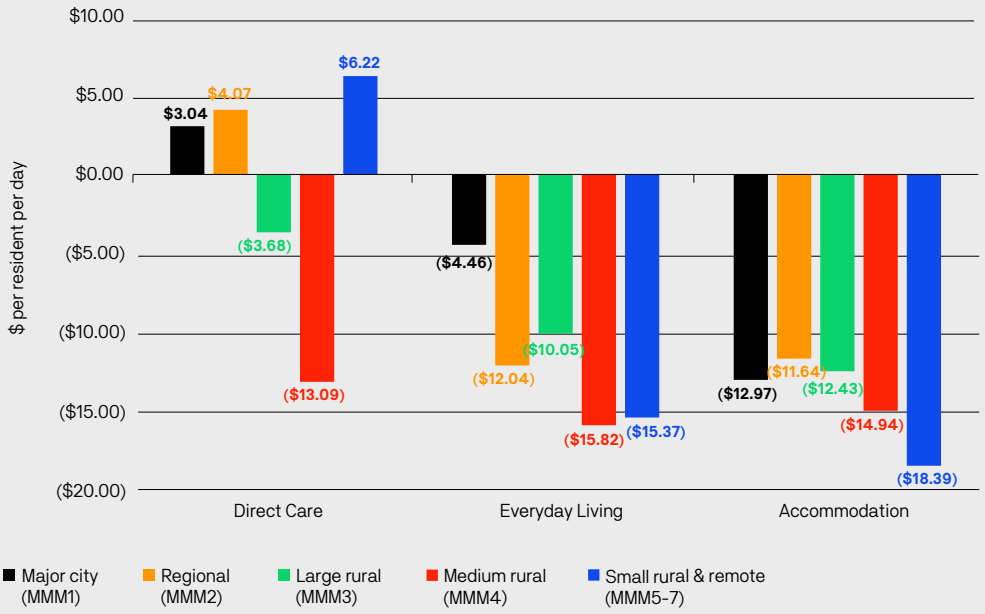


Figure 51 reveals a sustained trend of poor financial outcomes for all homes, noting that non-metropolitan homes tend to have much more variation in their year-to-year results. For example, whereas homes in major cities have experienced a consistent decline in their financial performance until the most recent year, many rural homes experienced a brief uplift in FY21, partly due to larger COVID-related funding provisions during that year, before further declines in the last two years.

A more granular categorisation of non-metropolitan homes reveals several new emergent trends in their financial outcomes. For example, while there has been some stabilisation of the financial performance of homes in regional areas (MMM2), it has continued to decline for homes in large rural areas (MMM3) and small rural and remote areas (MMM5-7). Most significantly, as discussed above, there has been a sharp decline in the financial outcomes of homes in medium rural areas (MMM4).

Figure 52: Financial results, by service area and location, per resident per day



This recent trend can be unpacked further by disaggregating homes' average Operating Result into the three underlying service.[160] As depicted in Figure 52, direct care services produce the largest variation in financial outcomes. In FY23, while homes in MMM1, 2 and 5-7 areas tend to generate modest margins from direct care, homes in MMM3 and MMM4 areas operate at a direct care loss.

Some of these disparities in direct care can be attributed to differences in how homes earn revenue under the new AN-ACC funding model, which comprises three components:

1. Fixed funding: BCT subsidy for services based on location and specialisations for homeless or remote Aboriginal and Torres Strait Islander persons;
2. Variable funding: AN-ACC classification subsidy based on the individual care needs of residents
3. One-off payments: An initial entry adjustment payment for transitioning a permanent resident into a service.

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

As Table 11 shows, homes in small rural and remote areas (MMM5-7) earned the highest direct care revenue, averaging $231.18 per resident per day. Homes in these areas earn more *fixed* funding under AN-ACC through their higher BCT subsidy rates, particularly if they provide services to Aboriginal or Torres Strait Islander care recipients. In addition, the BCT paid to remote homes (MMM6-7) is based on operational places rather than occupied bed days.

Major city homes also earn slightly higher rates of direct care revenue (averaging about $214 per day) than homes in MMM 2, 3 and 4 areas (averaging about $210-211). Homes in metropolitan centres tend to service a more concentrated cohort of residents, including more high-care residents, which generates higher *variable* funding under AN-ACC.

Under AN-ACC, homes in areas MMM 2, 3 and 4 are funded at the same (low) fixed rates as those in the major cities. However, they also earn less variable funding because they serve a more diverse resident profile.

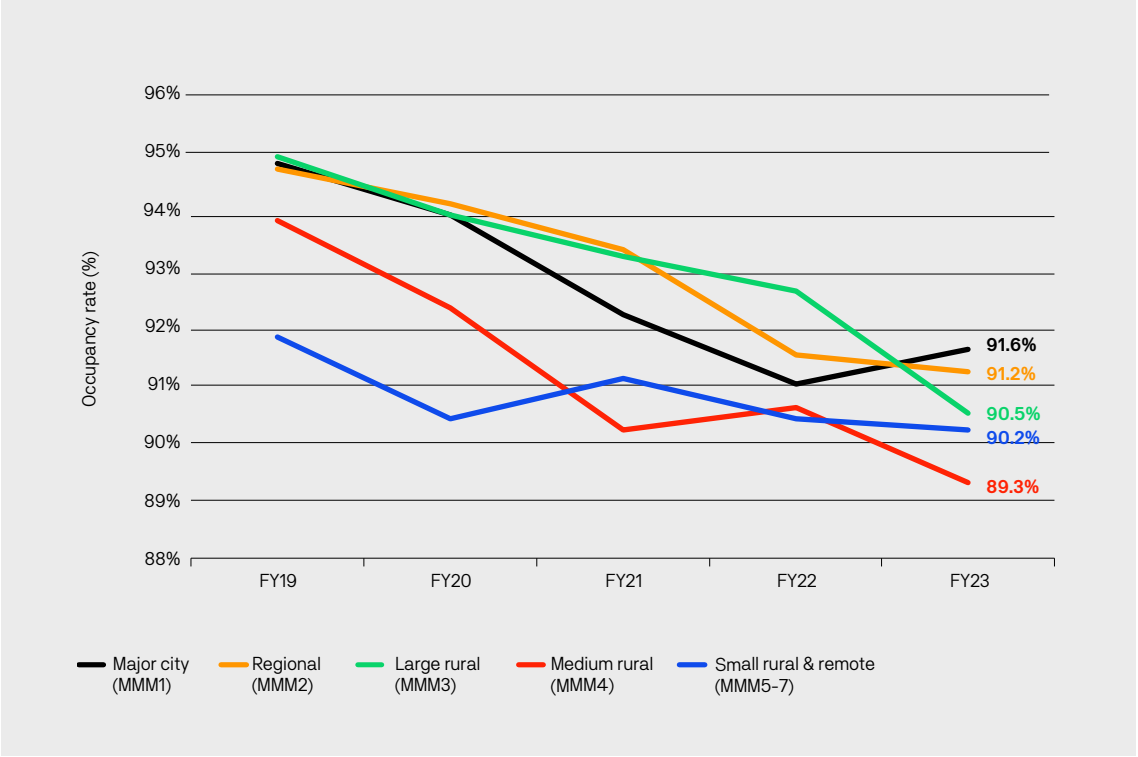
However, the regional differences in direct care outcomes extend beyond the funding model. There are also substantial disparities in the rates of direct care expenditure. Table 11 shows that MMM 3-7 homes report higher direct care costs per resident per day than their metropolitan and regional (MMM1 and 2) counterparts.

A critical factor explaining these cost patterns is occupancy. Homes with higher occupancy can achieve cost efficiencies by spreading their fixed costs across more occupied bed days. Figure 53 shows that homes in major cities (MMM1) and regional areas (MMM2) enjoyed higher occupancy rates in FY23 than homes in other areas.

Under AN-ACC, homes in regional centres, large rural towns and medium rural towns receive Base Care Tariff funding at the same (low) fixed rates as those in the major cities. However, they also earn less variable funding because they serve a more diverse resident profile.

Residential aged care homes

Figure 53: Occupancy rate, by location

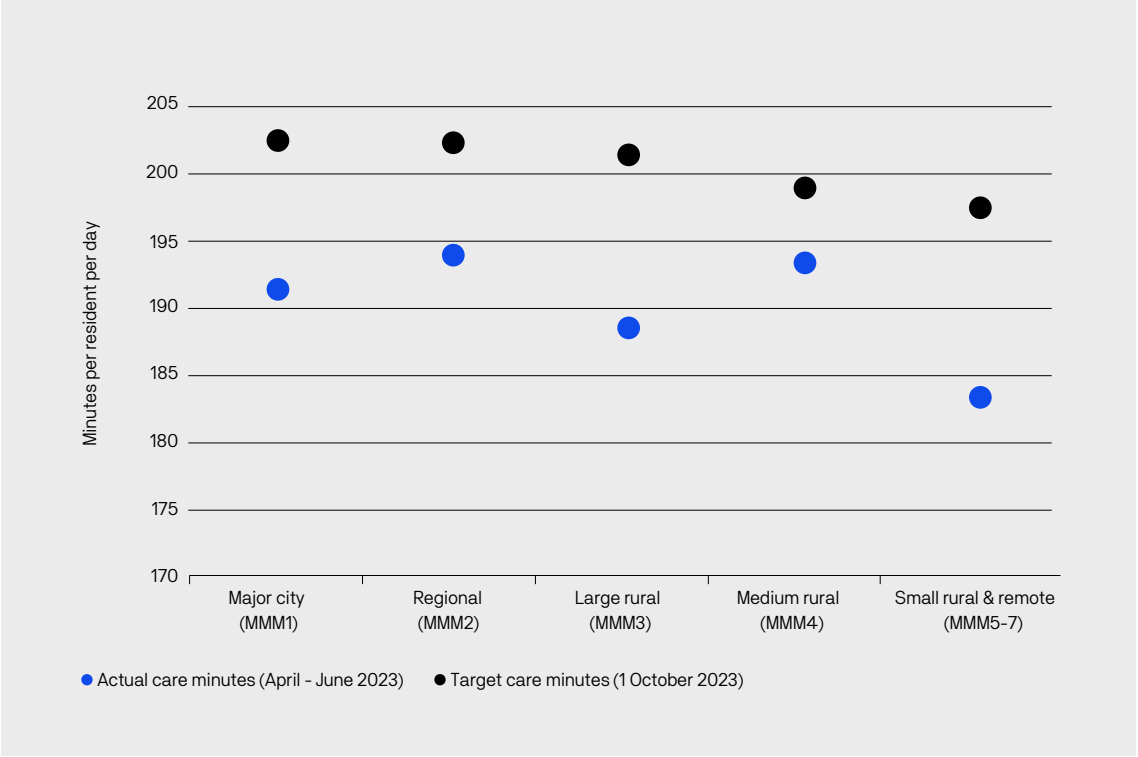


Under AN-ACC, homes in areas MMM 6-7 are protected from some of the financial impacts of low occupancy, as their BCT is paid on operational rather than occupied bed days. However, this protection does not apply to other non-metropolitan homes, even though those in MMM3 and MMM4 experienced sharp declines in their occupancy, down to levels commensurate with MMM5-7.

Additionally, in FY23, disparities in direct care costs also reflect patterns in the extent to which homes' actual direct care staffing levels compare to the targets for which they are funded (i.e. the AN-ACC transitional effect). Figure 54 shows that, on average, homes in MMM4 are closest to achieving their incoming total direct care minute targets. [161] This means they are less likely to benefit from any transitional effects of receiving additional AN-ACC funding before needing to raise their direct care staffing to meet the requirements when they become mandatory in October.

161. This analysis was completed using a subsample of 955 homes in the StewartBrown dataset. Actual staffing minutes are based on the average care minutes reported in Q4 FY23 (i.e. April – June 2023) and the target care minutes are based on service-level targets for 1 October 2023, published by the Department of Health and Aged Care.

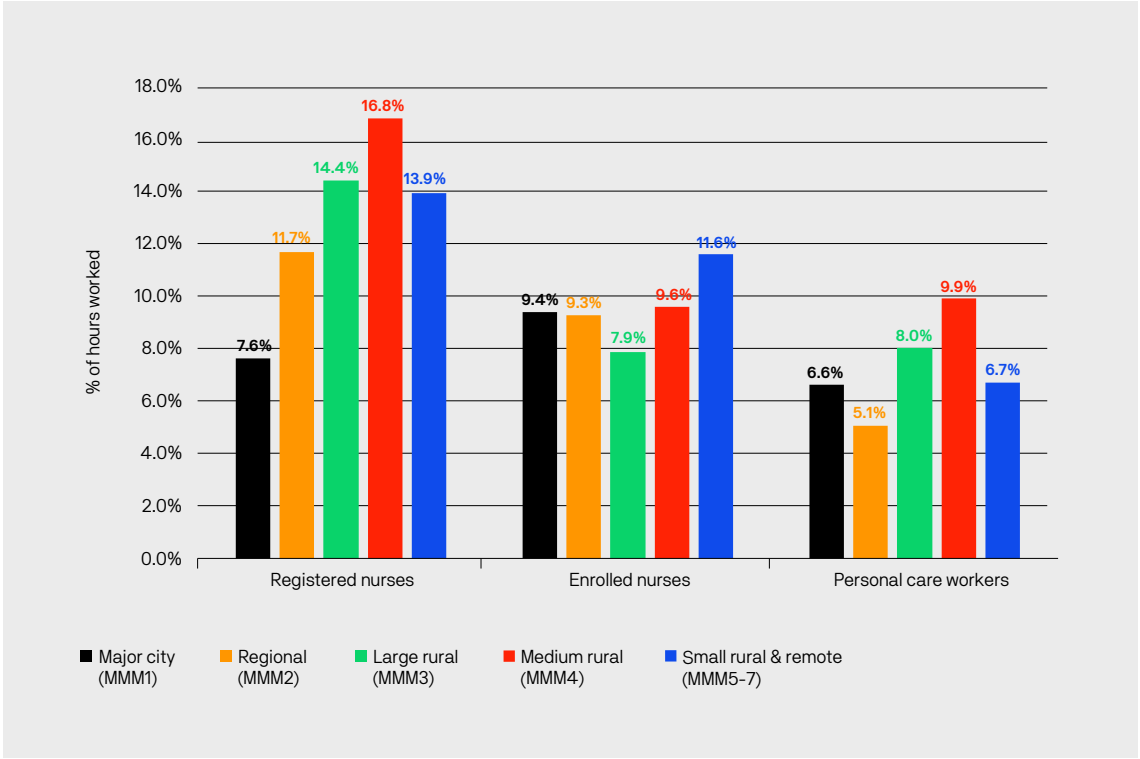
Figure 54: Total direct care minutes, actual (Q3 FY23) vs target (Q2 FY24), by location



A further factor driving rural and remote homes' costs upwards is their need to rely on agency staffing to meet their direct care needs. As shown in Figure 55, homes in rural and remote locations generally have much higher agency staffing rates for direct care roles, particularly for registered nurses. For example, the rate of agency staffing for registered nurses in MMM4 (16.8%) is more than double that of homes in MMM1 (7.6%).

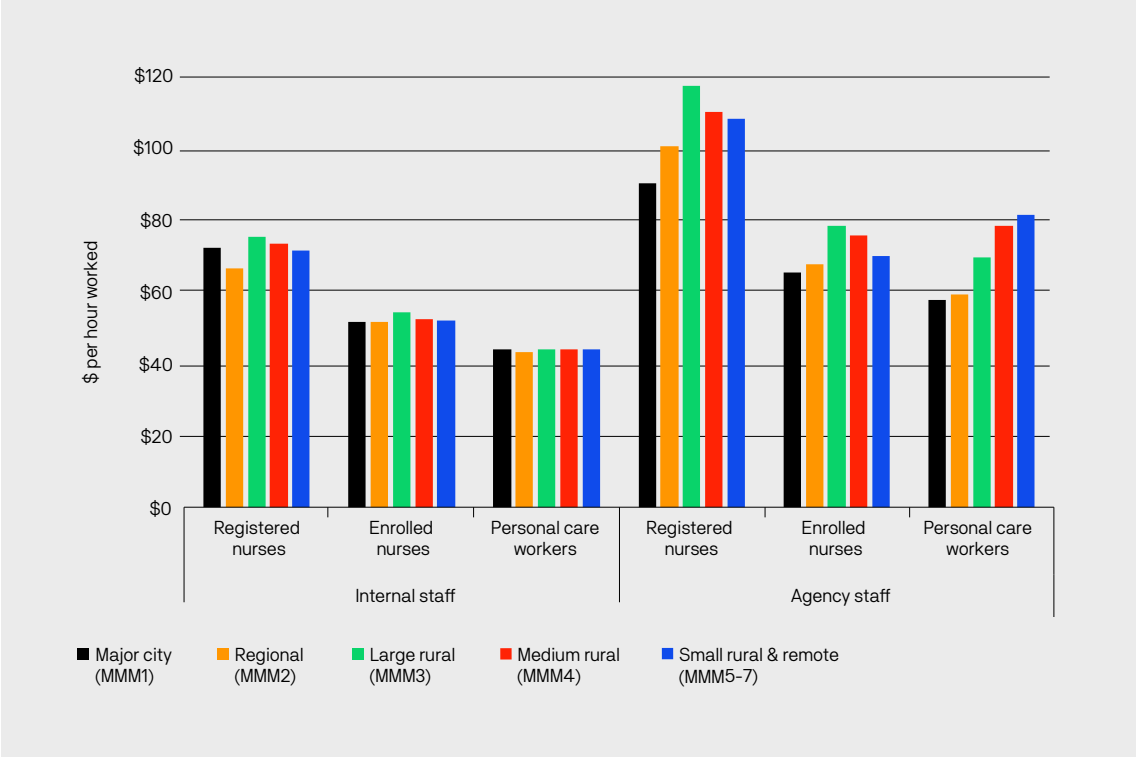
Residential aged care homes

Figure 55: Agency staffing as proportion of direct care hours, by role and location



This high reliance on agency staff is compounded by the additional premium non-metropolitan homes pay for each hour agency staff work. Figure 56 shows the median labour cost per hour worked by staff role (including employment mode) and location. Although for internal staff (i.e. direct employees of the aged care homes), there are only slight cost differences between homes in different locations, the cost per hour worked for agency workers varies dramatically. For example, on average, a home in MMM3 will pay $116.87 per hour for an agency registered nurse, compared to $90.00 for a home in MMM1.

Figure 56: Median labour cost per hour worked, by location



Besides direct care, another notable difference in the operating models of homes in different locations is the smaller deficit of metropolitan homes in delivering everyday living and accommodation services (see Table 12).

For everyday living, while all homes receive the same per revenue per day from the hotelling 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 12, the differences in everyday living results also arise because non-metropolitan homes incur higher average costs, such as for food, catering, and laundry.

In terms of accommodation, all homes incur substantial losses. However, Table 12 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.

Residential aged care homes

Table 12: Detailed financial results, by location, per resident per day

	Major city (MMM1)	Regional (MMM2)	Large rural (MMM3)	Medium rural (MMM4)	Small rural & remote (MMM5-7)
Number of homes in dataset	757	103	130	85	122
Direct Care					
Direct care revenue:					
Residents	$7.14	$4.86	$5.83	$6.37	$5.28
Government	$206.77	$206.33	$204.12	$203.83	$225.90
Total direct care revenue	$213.91	$211.19	$209.95	$210.20	$231.18
Direct care costs:					
Direct care labour costs	$159.41	$156.15	$162.63	$169.18	$170.69
Other labour costs	$26.53	$26.11	$25.46	$27.07	$25.46
Other direct care costs	$7.74	$6.82	$8.14	$8.40	$9.67
Allocation of administration costs (37.0%)	$17.19	$18.05	$17.41	$18.65	$19.14
Total direct care costs	$210.87	$207.13	$213.64	$223.30	$224.96
Direct care result	**$3.04**	**$4.07**	**($3.68)**	**($13.09)**	**$6.22**
Everyday Living					
Everyday living revenue:					
Residents	$61.09	$58.08	$58.67	$58.02	$57.49
Government	$9.99	$9.94	$9.97	$9.99	$9.98
Total everyday living revenue	$71.08	$68.03	$68.64	$68.02	$67.47
Everyday living costs:					
Catering	$36.77	$37.77	$38.79	$40.73	$40.20
Cleaning	10.37	10.27	9.81	11.31	10.15
Laundry	$4.55	$4.58	$4.87	$4.59	$4.51
Utilities	$7.21	$9.95	$8.24	$9.00	$9.32
Other	$1.03	$1.09	$1.17	$1.26	$1.29
Allocation of administration costs (33.6%)	$15.61	$16.39	$15.81	$16.93	$17.38
Total everyday living costs	$75.54	$80.05	$78.69	$83.82	$82.85
Everyday Living Result	**($4.46)**	**($12.04)**	**($10.05)**	**($15.82)**	**($15.37)**
Accommodation					
Accommodation revenue:					
Residents*	$15.19	$14.12	$13.51	$13.77	$12.54
Government	$21.64	$22.53	$22.52	$22.65	$21.68
Total accommodation revenue	$36.83	$36.65	$36.03	$36.41	$34.22
Accommodation costs:					
Depreciation	$20.97	$18.97	$19.92	$21.18	$19.58
Property maintenance and rental	$13.45	$13.53	$13.06	$13.75	$16.17
Other	$1.73	$1.45	$1.65	$1.62	$1.65
Allocation of administration costs (29.4%)	$13.66	$14.34	$13.83	$14.81	$15.21
Total accommodation costs	$49.81	$48.29	$48.46	$51.36	$52.61
Accommodation Result	**($12.97)**	**($11.64)**	**($12.43)**	**($14.94)**	**($18.39)**
Operating Result (per resident per day)	**($14.39)**	**($19.61)**	**($26.16)**	**($43.85)**	**($27.54)**
Total revenue (per resident per day)	**$321.82**	**$315.87**	**$314.62**	**$314.63**	**$332.87**
Total costs (per resident per day)	**$336.22**	**$335.47**	**$340.79**	**$358.48**	**$360.42**

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

Results by home size

In Australia, the size of residential aged care homes is measured by the number of operational places (i.e. places). Across the sector, the average home size is 84 places. However, this can range widely from as small as two places to as large as 333 places. [162]

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 13: 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 dataset	113	498	382	204
Average home size (number of available places)	29	58	97	145
Operating Result (per resident per day)	($31.15)	($21.09)	($17.28)	($13.64)
Operating Result (per place per annum) *	($9,822)	($6,732)	($5,348)	($4,100)
Operating EBITDA (per place per annum) *	($3,752)	$175	$2,048	$3,501
Proportion of loss-making homes (Operating Result)	75.2%	65.3%	65.7%	62.3%
Proportion of loss-making homes (EBITDA)	61.1%	45.2%	40.6%	34.8%
Occupancy rate	90.4%	91.9%	90.8%	90.4%
Supported resident ratio	49.8%	47.6%	43.7%	41.8%
Average direct care revenue (per resident per day)	$231.64	$214.13	$212.34	$211.36
Average direct care costs (per resident per day)	$234.91	$212.82	$210.50	$206.93
Direct care expense ratio	101.4%	99.4%	99.1%	97.9%
Average direct care minutes (per resident day)	201.0	186.1	190.2	191.0
Average of full RADs held at reporting date	$340,221	$388,180	$435,695	$481,689
Average of new full RADs taken during period	$391,872	$428,271	$462,971	$517,095

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

Our analysis of homes of different sizes (summarised in Table 13) reveals substantial differences in operating characteristics and financial performance of homes in FY23. For example, the smallest homes (less than 40 places) tend to have considerably poorer financial results than larger homes. On average, three out of four smaller homes operated at a loss in FY23.

162. Department of Health and Aged Care (2023), *Aged Care Service List—2023*, Australian Institute of Health and Welfare. Note that sector statistics are based on operational places, whereas the StewartBrown dataset reports the number of available places.

Residential aged care homes

Figure 57: Operating Result, by home size, per resident per day

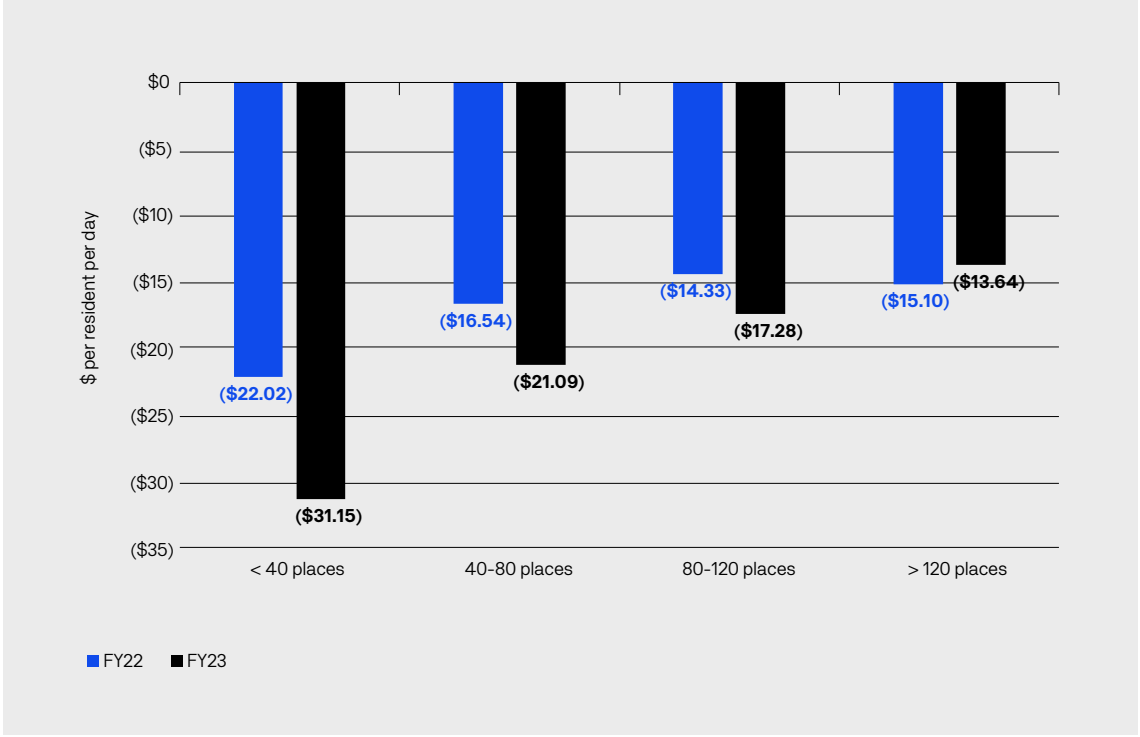
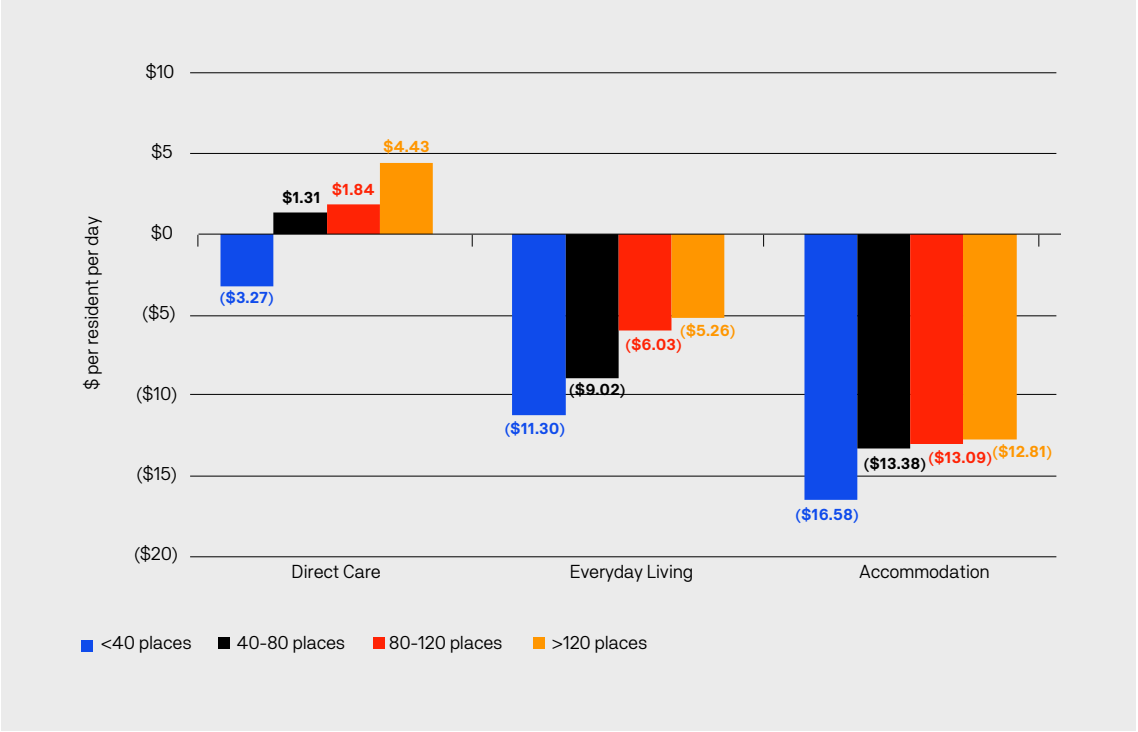


Figure 57 also shows that there now appears to be a monotonic relationship between home size and profitability. This means that the worst financial outcomes are concentrated within the smallest home size category, and the homes with the smallest operating losses tend to operate homes of 120 places or more.

Again, it is worthwhile to consider how much these results may overlap with the geographic differences described earlier. For example, only 49% of the smallest homes (40 places or less) are located in major cities (MMM1). This proportion of homes in major cities rises as homes get larger to 59% (40-80 places), 66% (81-120) and 79% (120 places or more), respectively.

Figure 58: Financial results, by service area and home size, per resident per day



This association between home size and financial outcomes is also apparent when homes' average Operating Result is disaggregated into the three service areas (see Figure 58). In each service area, small homes (<40 places) achieve lower average results than larger homes, with homes' results improving with their size.

The detailed breakdown in Table 14 shows that small homes earn the highest revenue per resident per day. However, they also incur substantially larger average daily expenditures. Compared to homes in the next size bracket (40–80 places), the smallest homes spend an additional $29.58 per resident per day.

The breakdown also reveals the similarity of cost patterns for homes in the three larger categories (40 places and more). These homes have almost the same average daily cost 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) have a greater proportion of higher means residents, which is reflected in higher additional service fees and residential accommodation payments (DAPs).

Residential aged care homes

Table 14: Detailed financial results, by home size, per resident per day

	<40 places	40-80 places	80-120 places	>120 places
Number of homes in dataset	113	498	382	204
Direct Care				
Direct care revenue:				
Residents	$5.98	$5.83	$7.25	$7.34
Government	$225.65	$208.30	$205.09	$204.03
Total direct care revenue	$231.64	$214.13	$212.34	$211.36
Direct care costs:				
Direct care labour costs	$177.26	$158.99	$160.59	$159.57
Other labour costs	$29.94	$27.09	$25.49	$23.90
Other direct care costs	$8.79	$8.71	$7.42	$6.60
Allocation of administration costs (37.0%)	$18.92	$18.04	$17.00	$16.87
Total direct care costs	$234.91	$212.83	$210.50	$206.94
Direct care result	**($3.27)**	**$1.31**	**$1.84**	**$4.43**
Everyday Living				
Everyday living revenue:				
Residents	$58.34	$59.14	$60.66	$61.69
Government	$9.98	$9.98	$9.99	$9.97
Total everyday living revenue	$68.32	$69.12	$70.65	$71.67
Everyday living costs:				
Catering	$38.21	$38.06	$37.02	$37.84
Cleaning	9.63	10.06	10.88	10.42
Laundry	$4.49	$4.64	$4.49	$4.67
Utilities	$9.16	$7.87	$7.74	$7.59
Other	$0.94	$1.11	$1.11	$1.08
Allocation of administration costs (33.6%)	$17.18	$16.38	$15.44	$15.32
Total everyday living costs	$79.61	$78.12	$76.68	$76.92
Everyday Living Result	**($11.30)**	**($9.02)**	**($6.03)**	**($5.26)**
Accommodation				
Accommodation revenue:				
Residents*	$12.68	$13.84	$15.33	$15.82
Government	$22.03	$23.16	$20.83	$20.70
Total accommodation revenue	$34.71	$37.00	$36.16	$36.52
Accommodation costs:				
Depreciation	$17.28	$19.92	$21.40	$22.35
Property maintenance and rental	$17.26	$14.39	$12.75	$11.87
Other	$1.71	$1.74	$1.58	$1.70
Allocation of administration costs (29.4%)	$15.03	$14.33	$13.51	$13.40
Total accommodation costs	$51.28	$50.38	$49.24	$49.32
Accommodation Result	**($16.58)**	**($13.38)**	**($13.09)**	**($12.81)**
Operating Result (per resident per day)	**($31.15)**	**($21.09)**	**($17.27)**	**($13.64)**
Total revenue (per resident per day)	**$334.67**	**$320.25**	**$319.15**	**$319.55**
Total costs (per resident per day)	**$365.80**	**$341.33**	**$336.42**	**$333.18**

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

The homes experiencing the highest rates of financial distress are those located in medium rural towns and those that have less than 40 operational places.

Home care analysis

Overview

- The financial performance of home care providers declined to an average Operating Result of $3.08 per client per day in FY23, down from $4.41 in FY22. This represents a profit margin of just 4.5%.

- While revenues have remained stable, averaging $68.61 per client per day, provider costs per client per day have increased, thus resulting in a worsening of the overall financial performance.

- Revenue utilisation is persistently low at 83.7%. Unspent funds continue to increase and now average $11,838 per package.

- The proportion of direct care costs attributable to third-party services has increased from 13.0% in FY19 to 38.7% in FY23, likely due to changes in service mix and ongoing workforce pressures.

Home care provider profiles

The following analysis reports on the financial and workforce outcomes of home care service providers that offer subsidised services funded through home care packages. 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 ACFPS dataset does not currently extend to CHSP, STRC and other service providers. However, future changes will align with the proposed new Support at Home program for delivering in-home care as it is progressively rolled out from July 2025.

The following analysis relates to 96 home care providers included in the 2022–23 dataset. This is a change from the methodology in previous reports, which analysed and reported on data as it relates to home care services rather than providers. All comparisons of FY23 with FY22 reflect this change. Table 15 reports the characteristics of home care providers in the dataset.

Table 15: Profile of surveyed home care providers

	FY22	FY23
Number of home care providers in the dataset	98	96
Total number of packages in dataset	60,630	68,129
Ownership:		
For profit	2.0%	3.1%
Not-for-profit	98.0%	96.9%
Average number of funded packages per home care provider	618.7	709.7
Package mix:		
% of Level 1 Packages	6.1%	6.2%
% of Level 2 Packages	41.1%	40.4%
% of Level 3 Packages	30.5%	32.9%
% of Level 4 Packages	22.4%	20.5%

The 2022–23 StewartBrown dataset includes 68,129 home care packages or approximately 26.4% of the total population of 258,374 home care clients as of 30 June 2023.[163] Most providers in the dataset are not-for-profit (96.9%). The dataset does not include home care package providers that are government agencies, which make up a substantial minority of providers in some regions.

Despite a notable 12.4% increase in total package numbers in FY23, the overall mix of packages across participating home care providers has remained relatively stable. The highest represented package recipients are currently receiving a Level 2 package (40.4%) or a Level 3 package (32.9%). The survey package mix in the dataset is consistent with sector-level statistics of the national proportion of people in home care packages, by package level, reported by the Department.[164]

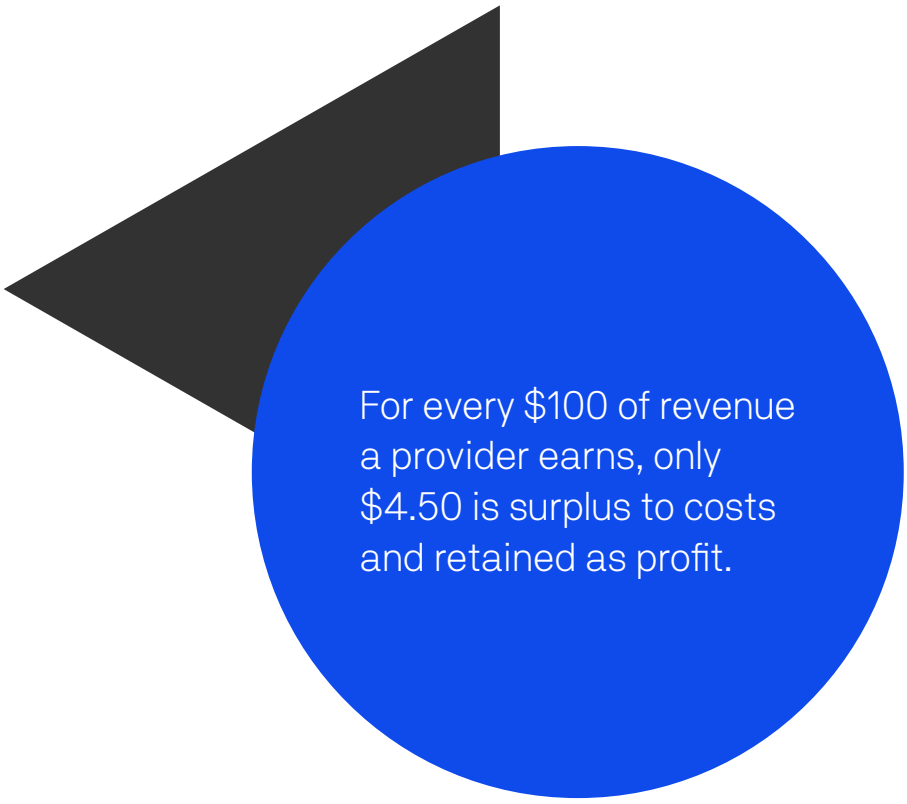
163. Department of Health and Aged Care (2023), *Aged care data snapshot 2023 – Second release*, Australian Institute of Health and Welfare.

164. Department of Health and Aged Care (2023), *Aged care data snapshot 2023 – Second release*, Australian Institute of Health and Welfare.

Key performance indicator summary

Table 16: Key performance indicators of home care providers

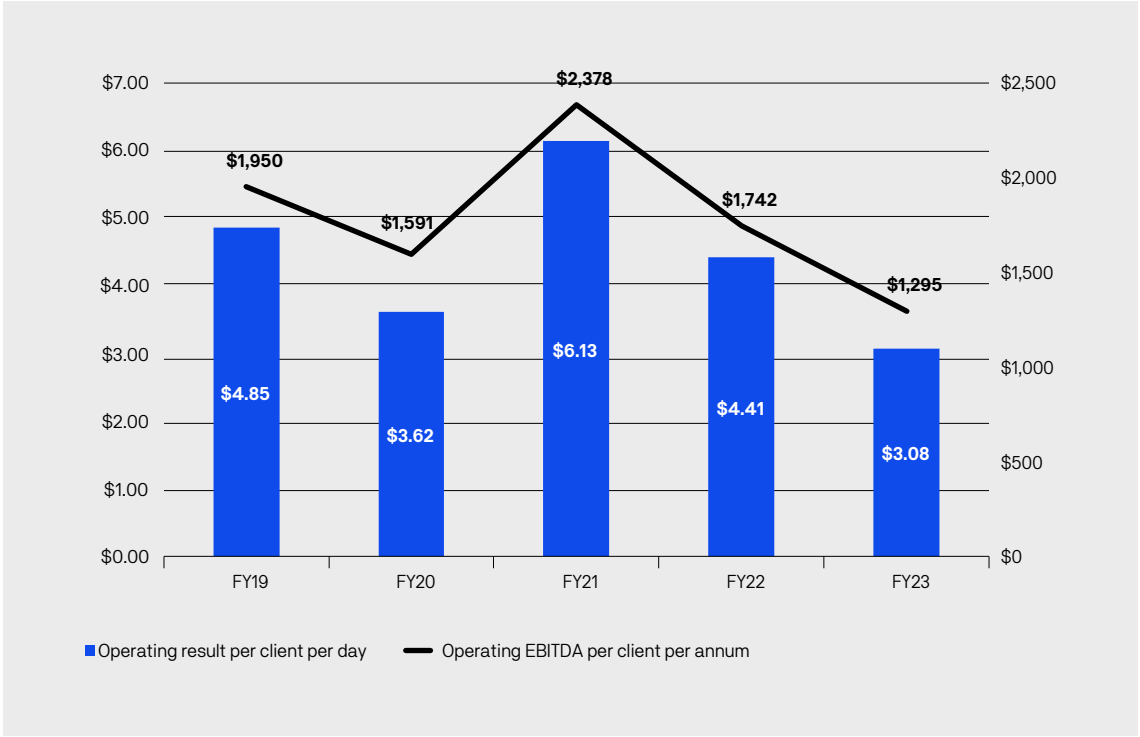
	FY22	FY23
Operating Result per client per day	$4.41	$3.08
Operating EBITDA per client per annum	$1,742	$1,295
Profit margin (Operating Result) (%)	6.4%	4.5%
Revenue:		
Revenue per client per day	$68.66	$68.61
Revenue utilisation rate	83.8%	83.7%
Unspent funds per package	$10,506	$11,838
Costs:		
Direct care and brokered services costs (as % of revenue)	58.5%	60.2%
Care management and advisory costs (as a % of revenue)	11.5%	11.1%
Administration and support costs (as % of revenue)	23.6%	23.9%
Total internal staff hours per client per week	**5.7**	**5.5**



Financial performance

The FY23 full-year results show a continued deterioration of the financial performance of home care providers from a recent peak in FY21.[165] Figure 59 shows that the Operating Result[166] of home care providers has reached a 5-year low of $3.08 per client per day, down from a provider average of $4.41 per client per day in FY22 (a decrease of 30.2%). The Operating EBITDA for home care providers in FY23 was $1,295 per client per annum, down from an average of $1,742 in FY22 (a slightly smaller decrease of 25.7%).

Figure 59: Financial results of home care providers



As shown in Table 16, provider profit margins had a corresponding decline from 6.4% in FY22 to 4.5% in FY23. For every $100 of revenue a provider earns, only $4.50 is surplus to costs and retained as profit. This modest profit margin highlights providers' ongoing viability concerns, which pose potential challenges for capital raising and meeting the future growth in demand for aged care services in the home and community.

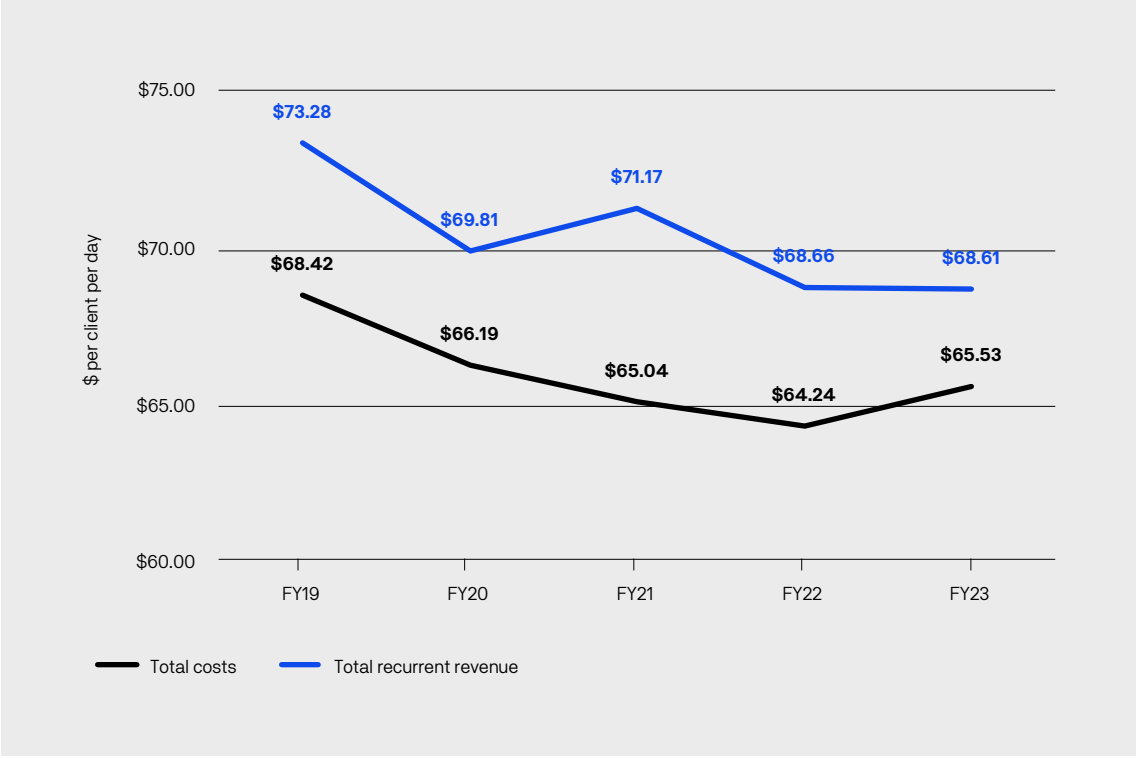
165. Note that the FY22 figures reported in Table 16 and in subsequent analysis may be different to those previously reported in the *Australia's Aged Care Sector: Full Year Report 2021–22* due to the change in unit of analysis from home care service to home care provider.

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

Table 17: Detailed financial results of home care providers, per client per day

	FY22	FY23
Number of providers in dataset	98	96
Revenue		
Direct service revenue	$36.72	$36.45
Subcontracted and brokered service revenue	$11.25	$12.03
Care management revenue	$12.99	$12.11
Package management revenue	$7.64	$8.00
Exit fees	$0.06	$0.01
Total recurrent revenue	**$68.60**	**$68.61**
Expenditure		
Direct care and brokered services:		
Internal direct care:		
Staffing	$21.69	$21.21
Agency costs	$0.69	$1.07
Consumables	$1.24	$0.96
Transport	$1.19	$1.09
Other	$0.92	$1.10
Internal direct care	$25.73	$25.43
External direct service costs	$14.36	$16.04
Direct care and brokered services	**$40.09**	**$41.47**
Care management & advisory:		
Staffing	$7.19	$6.77
Transport	$0.15	$0.12
Care management & advisory	**$7.78**	**$7.27**
Administration & support services:		
Administration recharges	$7.19	$6.77
Staffing	$4.70	$4.98
Other administration	$4.12	$4.56
Administration & support services	**$16.01**	**$16.31**
Depreciation	**$0.36**	**$0.47**
Total costs	**$64.24**	**$65.53**
Total Operating Result	**$4.35**	**$3.08**

Figure 60: Home care revenue and costs, per client per day

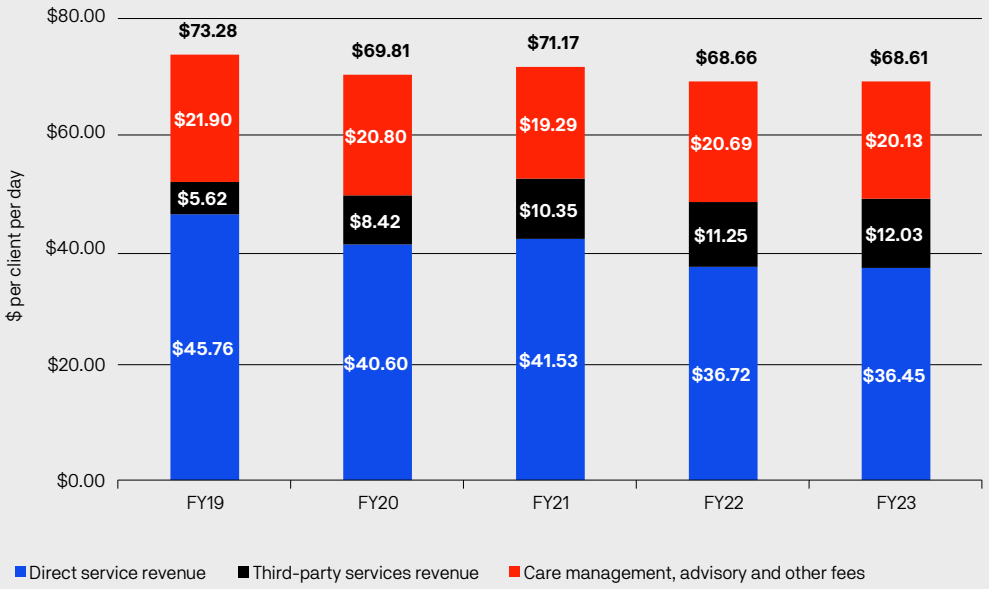


As detailed in Table 17, the recent decline in providers' Operating Result and profit margins have been driven by higher costs in the context of stable revenue. Figure 60 illustrates these as long-term trends. It shows how, on average, provider revenue per client per day has declined and then stagnated, while costs have decreased and then increased in FY23. This increase in costs, in the absence of a corresponding increase in revenue, has produced a sharp decline in overall financial performance.

Revenue analysis

The primary funding sources for home care service providers are government subsidies for home care packages and any income-tested fees and basic daily fees paid by clients.[167] Home care providers earn revenue as charges for delivery of direct services, care management and other advisory services and for services contracted for clients through third-parties (also referred to as subcontracted or brokered services).

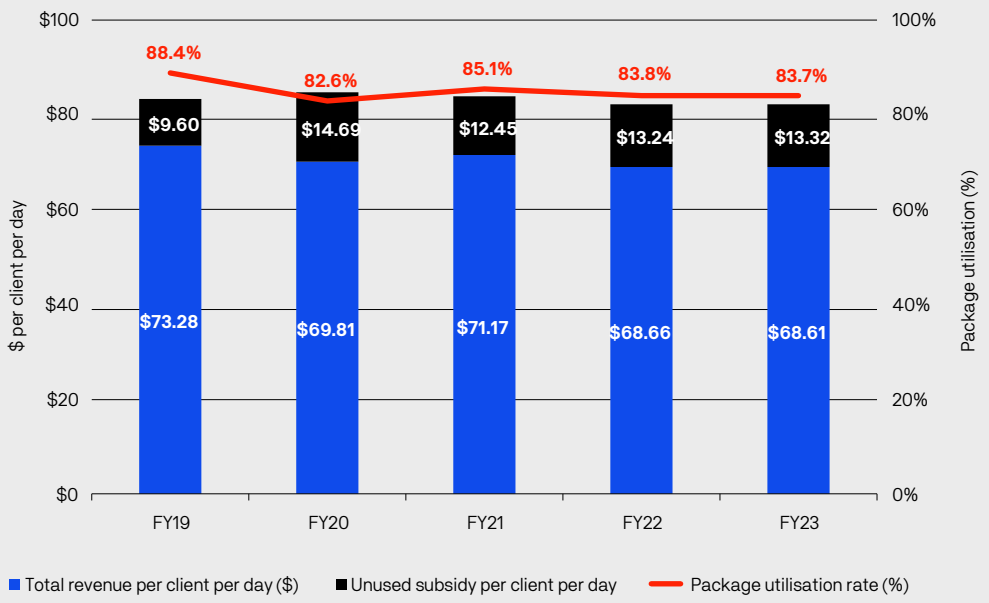
Figure 61: Home care revenue, per client per day



While Figure 61 shows that home care revenue per client per day has remained stable between FY22 and FY23 (now at $68.61), the longer-term trend over the five years is one of decline. Over that period, there has been a large decrease in direct service revenue (from $45.76 per client per day in FY19 to $36.45 per client per day in FY23). This large decrease has been partially – but not completely – offset by a corresponding increase in revenue from third-party services (from $5.62 per client per day in FY19 to $12.03 per client per day in FY23). Over the same period, revenue from care management, advisory and other fees declined by a smaller amount.

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

Figure 62: Revenue per client per day and package utilisation rate



Client unused subsidies continue to place downward pressure on providers' revenue per client day (Figure 62) in the context of total available package funds. It highlights the persistent presence of significant unused subsidies, which in FY23 amounted to $13.32 in unrealised revenue per client per day.

The proportion of allocated subsidies used by home care clients and realised as revenue by providers can be represented as revenue utilisation. Revenue utilisation in FY23 is effectively unchanged from FY22 at a rate of 83.7%. As a longer-term trend, however, revenue utilisation has decreased by 4.7 percentage points since FY19.

Home care package providers

Figure 63: Average value of unspent funds per package

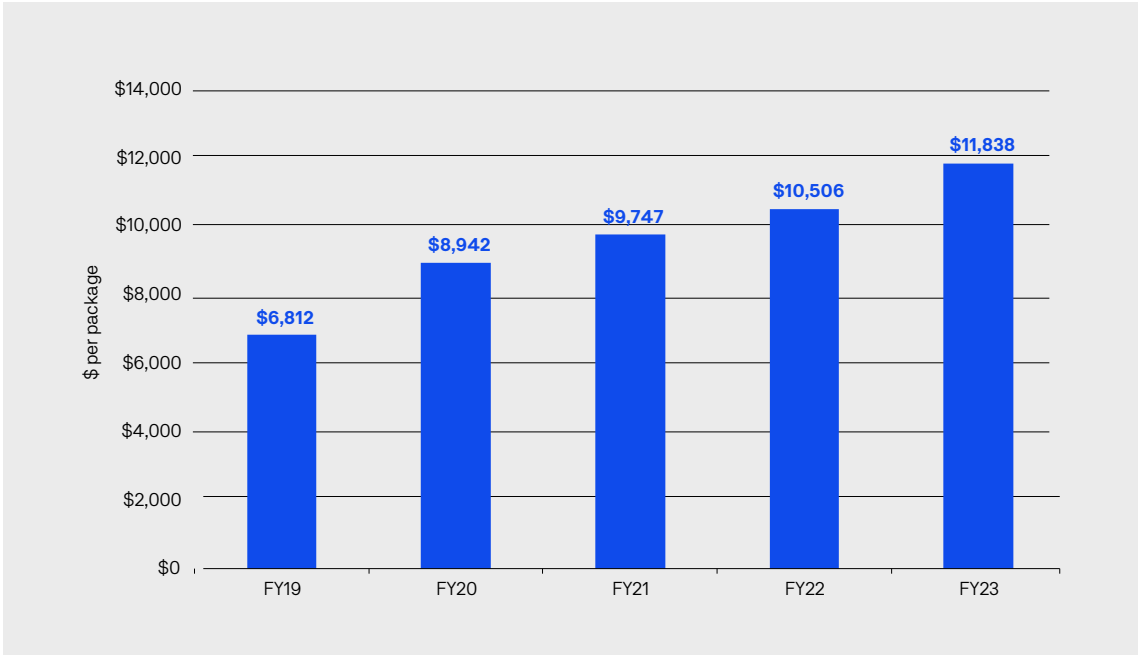


Figure 63 shows that while the revenue utilisation rate did not change year-on-year, the average value of unspent funds has continued to increase and was $11,838 per package in FY23. From a provider's perspective, these unspent funds represent unrealised revenue, a portion of which could have been additional net surplus. Growing amounts of unspent funds are of particular concern for providers in the context of the small profit margins reported earlier and the viability and capital raising challenges these results foreshadow.

Systemic challenges with unused subsidies and revenue utilisation may reflect both supply-side and demand-side factors. Providers continue to face difficulties in maintaining a sufficient workforce to meet the total demand for services, as demonstrated by the growth in package numbers being delivered by providers in the dataset. Workforce insufficiency may also be contributing to a growing waiting period for eligible home care package holders to secure a place with their preferred home care provider and to commence receiving services, especially those that meet their priority needs.

Declines in revenue utilisation may also reflect the preferences and choices of home care clients. Analysis in *The Catalyst Report – Home care insights 2022* highlights a range of demand-side reasons for home care clients to under-spend their package funds:

- 27% indicated that the provider was unable to provide the service required
- 26% were saving up for a significant home care 'spend'
- 21% had made an intentional decision to use as little as possible
- 20% had services cancelled or suspended by the provider
- 16% cancelled or suspended services themselves
- 16% were not sure why they had unspent funds [168]

It is also possible that some home care clients are not aware that they have additional funds available to use. *The Catalyst Report – Home care insights 2022* also indicates that 53% of all home care package recipients (or their informal carers) surveyed did not know if they had unspent funds in their package.[169] 50% of respondents indicated that they did not understand the package funding system, with only 11% indicating that they understood the system "very well".

These responses suggest low confidence among home care clients in navigating the current aged care system. Furthermore, they indicate that assumptions about the demand for self-management in the design of the new Support at Home program must be carefully validated, along with detailed consideration of the communication and transparency required to support consumer self-management of services. Extensive education, outreach and support for clients will be required to enable navigation of the new system.

Cost analysis

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

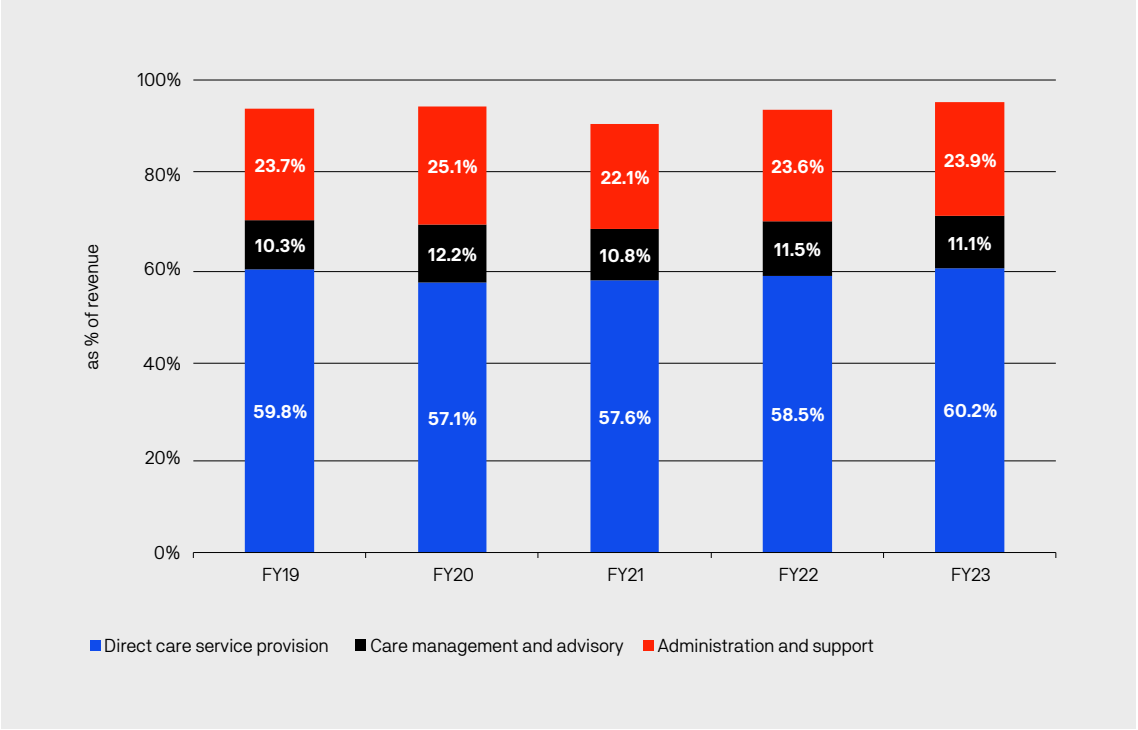
- Direct care service provision (including services provided by third-parties through subcontracted and brokered service arrangements).[170] This typically includes costs of staffing, consumables, travel and home modifications.
- Care management and advisory. This typically relates to the labour and transport costs of staff who help manage and coordinate services for clients, including managing the delivery of services from third-parties.
- 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.

168. *The Catalyst Report – Home care insights 2022* is based on the responses of 5,120 survey respondents, who are either current users of home care services, their family members, "shoppers" considering home care services, and rejectors of home care services. Analysis of unspent funds is based on responses of 324 respondents who currently have unspent home care funding

169. Based on the responses of 1,481 respondents across all regions.

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

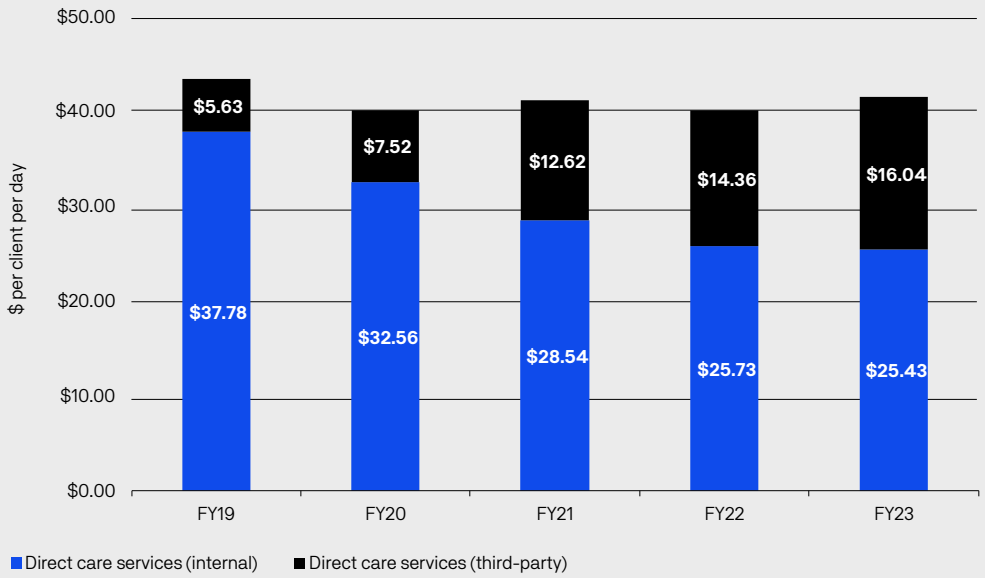
Figure 64: Home care costs, as a proportion of revenue



Provider costs in each of the three categories, as a proportion of provider revenue, are shown in Figure 64. Direct care costs continue to marginally increase as a proportion of revenue from a low of 57.1% in FY20 to 60.2% in FY23. The increase from FY22 to FY23 approximates the decrease in the average profit margin of providers over those two years. Expenditures on care management and advisory, together with administration and support, have remained stable at a combined proportion equivalent to 35% of revenue in FY23.

Brokered and subcontracted staffing are becoming a more significant component of home care delivery.

Figure 65: Direct care costs, internal and third-party, per client per day



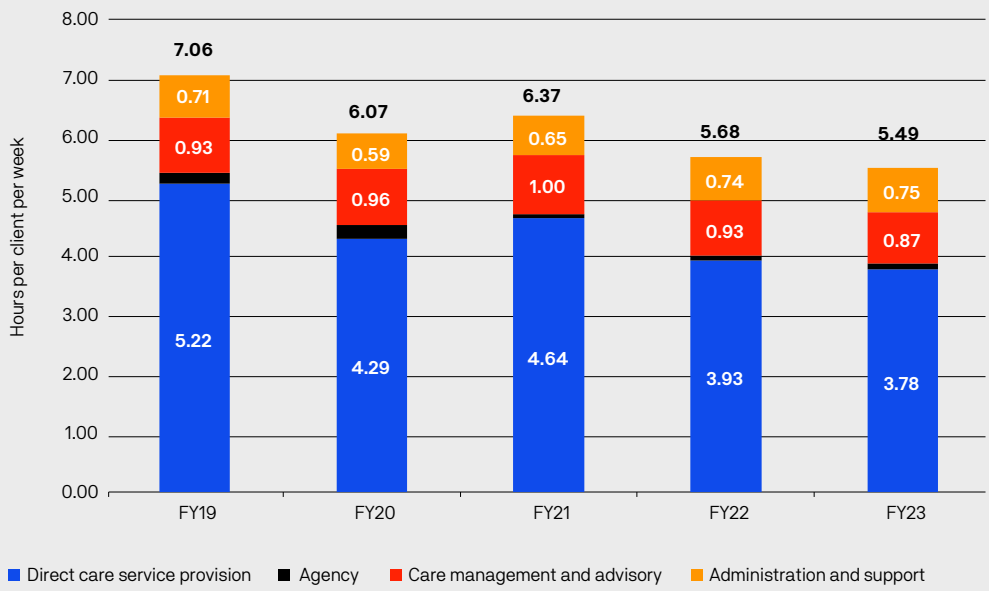
One possible explanation for increasing direct care costs is illustrated in Figure 65, which shows a breakdown of direct care service provision costs by internal service provision (i.e. by the provider) and third-party service provision. The figure shows a stabilisation over the last two years of the cost of providing internal direct care services at $25.43 per client per day (down only slightly from $25.73 in FY22) but a more substantial increase in the cost of providing third-party services at $16.04 per client per day (an increase from $14.36 in FY22). Overall, this results in an almost threefold increase in the proportion of direct care costs attributable to subcontracted or brokered services to 38.7% in FY23 from just 13.0% in FY19.

This trend suggests that home care providers increasingly rely on subcontractors to meet the needs of their clients. Providers may need to re-evaluate their subcontractor relationships and the viability of this form of service delivery within the multi-provider Support at Home program.

Workforce

Home care providers continue to face substantial challenges in attracting and retaining sufficient workers with appropriate knowledge, skills and professional attributes in recent years, including for the last financial year.

Figure 66: Home care internal staffing hours, by category, per client per week



The gradual decline in internal staff hours per client per week over the past five years is evident in Figure 66. These staff hours exclude brokered and subcontracted staffing, which, based on the cost analysis above, are becoming a more significant component of home care delivery. This figure shows that the total internal staffing hours per client per week for home care services have decreased significantly since FY19, from 7.1 hours to 5.5 hours in FY23. This represents a decline of 22%, or 84 minutes per week, over five years.

Editorial board

Professor Michael Woods (Chair)

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

Professor David Brown (Deputy Chair)

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

Grant Corderoy

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

Professor Deborah Parker

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

Research team

Dr Nicole Sutton

Dr Nicole Sutton is a Senior Lecturer in management accounting at the UTS Business School, with expertise in how financial, management and performance systems influence organisations' behaviour and decision-making. Much of her current work focuses on delivering high-quality evidence that informs policy and practice across the aged care sector. She is the Treasurer of Palliative Care NSW.

Dr Nelson Ma

Dr Nelson Ma is a Senior Lecturer in financial accounting at the UTS Business School. His research focuses on understanding the drivers of financial outcomes in organisations and the role of institutions in assuring the quality of financial outcomes of publicly listed companies. He has published research in numerous international journals.

Dr Jin Sug Yang

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

Dr Rachael Lewis

Dr Rachael Lewis is a Senior 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.

Eugenia Tsihlis

Eugenia Tsihlis is a Senior Research Associate within the Law, Regulation & Ethics Theme of the UTS Ageing Research Collaborative. Her key focus areas are access to legal services for older people, the prevention of elder abuse and the evolving regulatory landscape of the aged care sector.

Jiali (Yolanda) Lin

Yolanda is an Accounting PhD candidate at the UTS Business School and a member of the UTS Ageing Research Collaborative. She has research interests in regulation, corporate governance and management accounting. Her current work examines the real disciplinary effects of regulatory monitoring on a firm's compliance behaviour.

Professor Michael Woods

As above

Professor Deborah Parker

As above

Appendix: Methodology

The numbers provided in this report for aged care providers or homes 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 or homes 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 resident per 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 resident per day for each aged care home, and then used to calculate the average rate per resident per day across all homes in the sample.

Home care analysis

For home care, all provider-level averages are calculated, in general, by using the aggregate averages of any one-line item across all home care providers, and dividing by the number of home care providers included in the sample. For many line items, the provider-level raw data is first transformed into a rate per client day, by dividing the raw data submitted for any one line item by the number of client days for that home care provider. For example, the provider-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 providers 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 providers in their sample) and dividing by the aggregate of all individuals (e.g. the total number of clients for home care providers in their sample). This approach provides the average profitability of any given individual, place or client.

By comparison, UARC first calculates the rate for each organisation (e.g. EBITDA per client per annum for each home provider) and then calculates the average of that rate across all providers in the dataset. This approach provides the average profitability of any given provider or 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 providers of different sizes within the sample.

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

For more information

UTS Ageing Research Collaborative (UARC)
Email: uarc_inquiries@uts.edu.au
Website: www.uts.edu.au/uarc

UTS CRICOS: 00099F