The financial viability and sustainability of the aged care sector

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Table of Acronyms

Table 1 List of acronyms used in this paper and their full expression

Acronym	Full expression
ACFA	Aged Care Financing Authority
ACFI	Aged care funding instrument
ACSA	Aged and Community Services Australia
AIHW	Australian Institute of Health and Welfare
CACP	Community aged care package
CBO	Community benefit organisation (religious, charitable or community based)
CDC	Consumer directed care
CPI	Consumer price index
DAP	Daily accommodation payment
DoHA[1]	Australian Government Department of Health and Ageing
DVA	Department of Veterans' Affairs
EACH	Extended aged care at home package
EACHD	Extended aged care at home dementia package
EBITDA	Earnings before interest, tax, depreciation and amortisation
EBITDAR	Earnings before Interest, tax, depreciation, amortisation and rent
FP	For-profit
GPFR	General purpose financial reports
GT	Grant Thornton
HACC	Home and community care program
IRR	Internal rate of return
LLLB	Living Longer Living Better
MPIR	Maximum permissible interest rate
NFP	Not-for-profit
PBD	Per bed day
NPBT	Net Profit Before Tax
PBY	Per bed year
PC	Productivity Commission
RAC	Residential aged care
RAD	Refundable accommodation deposit
ROA	Return on assets
ROE	Return on equity
ROI	Return on investment
RRR	Required rate of return
WACC	Weighted average cost of capital

[1] Portfolio responsibility for aged care has moved from DoHA to the Department of Social Services under the recent change of government.

Definition of commonly used terms

Table 2 Definition of terms used in this paper

Terms used	Definition
Allocative efficiency	Allocative efficiency is achieved when resources are allocated so as to maximise the welfare of the community (Palmer & Torgerson 1999). In relation to aged care services, allocative efficiency is achieved when the allocation produces the combination of health and aged care services that best meets users' demands and results in an efficient overall level of aged care spending (Productivity Commission 2011, p. 96)
Charitable	An organisation that intends social value or utility to the general community or an appreciable section of the public, and that is not established primarily to provide profit, gain or benefit to its individual owners or members.[2]
Client	Generally a client is a person who receives paid care (often called the *care recipient*) but may also be the carer of a care recipient where the carer is in receipt of services from a funded service provider.
Community based	An organisation formed for a particular common purpose by members of an identifiable community based on locality, ethnicity or some other identifiable affiliation, whose activities' may be carried out for the benefit of its members but which does not provide financial profit or gain to its individual owners or members[1].
Community Benefit Organisation	Collectively, these are community based, religious and charitable organisations that do not seek to make a profit from their activities, previously referred to as not-for-profit (NFP[3]) organisations.
Consumer	A consumer of services may be a person receiving formal care, the carer of a person receiving formal or informal care or a person making an enquiry about the receipt of care
Consumer Directed Care	'CDC is a way of delivering services that allows consumers to have greater control over their own lives by allowing them to make choices about the types of care they access and the delivery of those services, including who will deliver the services and when. Under a CDC approach, consumers are encouraged to identify goals, which could include independence, wellness and re-ablement. These will form the basis of the Home Care Agreement and care plan' (Australian Government Department of Health and Ageing 2013c, p. 8).
Daily Accommodation Payment	An amount paid by a care recipient towards their accommodation costs in a residential aged care facility calculated on a daily basis (Aged Care Financing Authority 2013).
EBITDA (R)	Refers to earnings before interest, tax, depreciation and amortisation (and rent). It gives an indication of how much profit or surplus an organisation makes with its present assets and current operations. It is a standard measure of the current operational profitability of the organisation.
Formal or paid care	This is care provided by a person who is paid to provide that care generally by an organisation in receipt of government funding but the person may also be paid directly by the person receiving care or their carer

[2] The definitions of local and state governments, not for profit, for-profit, religious, community based and charitable were sourced from the DoHA (Australian Government Department of Health and Ageing 2009).
[3] The term not-for-profit, or NFP, is used in this paper where there is a direct quote from the original source which used this term or the context requires that this terminology is used.

Terms used	Definition
For-profit	A for-profit organisation is one which operates primarily for the financial profit or gain of its owners, members or shareholders. For-profit organisations include private incorporated bodies that are registered by the ASIC or publicly listed companies that are listed on the Australian Stock Exchange[1]
General purpose financial reports (GPFR)	The GPFR are provided annually to the Department of Health and Ageing by residential aged care providers as part of the eligibility requirements for the Conditional Adjustment Payment (CAP) under the Aged Care Act 1997. They are not a complete set of data for the industry.
Informal care	This is care provided to a care recipient by a person who is not paid to provide that care and generally includes family, friends and neighbours of the person receiving care
Internal rate of return	The IRR is the discount rate that is used in capital budgeting to measure and compare the profitability of investments. It is also called the rate of return (ROR) and when applied to savings and loans the IRR is also called the effective interest rate. The term internal refers to the fact that its calculation does not incorporate environmental factors such as the market interest rate or inflation. When it is applied to estimation of the net present value of a stream of payments from an investment it returns a value of zero (0).
Living Longer Living Better	LLLB is the name given to the Australian Government's Aged Care Reform Package announced in April 2012 in response to the Productivity Commission's Report - Caring for Older Australians. The new Coalition Government has branded their future aged care platform as Healthy Life, Better Ageing.
Local government	A body established for the purposes of local government by or under a law of a State or Territory[1].
Maximum Possible Interest Rate	The MPIR is the interest rate calculated in accordance with subsection 23.3(2) of the User Rights Principles 1997. It is used in calculating interest applicable on the day after the resident should have been refunded their accommodation bond balance or entry contribution balance in accordance with the legislated timeframes or Formal Agreement (Australian Government Department of Health and Ageing 2013b).
Net Profit Before Tax	The NPBT is determined by revenue minus expenses except for taxes (Aged Care Financing Authority).
Not-for-Profit	A not-for-profit organisation is one which does not distribute operating surpluses for the profit or gain of its individual owners or members; whether these gains would have been direct or indirect. This applies both while the organisation is operating and when it winds up. The Australian Taxation Office accepts an organisation as not-for-profit where its constituent or governing documents prevent it from distributing profits or assets for the benefit of particular people[1].
Opportunity cost	Is the value of a benefit forgone in the process of adopting an alternative policy, course of action, etc., which can be taken to be a cost of the alternative adopted (Macquarie Library & Butler 2012)
Productive efficiency	Productive efficiency refers to the maximisation of outcomes for a given cost, or the minimisation of cost for a given outcome. If a different type of input or combination of inputs can achieve the same or better outcomes for the same cost then it will have superior productive efficiency.

Terms used	Definition
Refundable Accommodation Deposit	An amount paid as a lump sum by a care recipient for their accommodation costs in a residential aged care facility (Aged Care Financing Authority 2013).
Religious	An organisation whose objectives and activities reflect its character as a body instituted for the promotion of religious objectives and the beliefs and practices of whose members constitute a religion[1].
Resident	The term resident refers to a person who permanently or temporarily resides in a residential aged care facility
Return on Equity	ROE calculates how much profit or surplus an organisation generates on shareholders' equity.
Return on investment	ROI is a measurement of how efficiently an organisation allocates its capital. It is expressed as a percentage; for example, an organisation with an ROI of 15% has created, for the year in review, 15 cents of income for every $1 of capital invested. Organisations with an ROI greater than their WACC are creating value for their owners; conversely those with an ROI below their cost of capital are losing their owners value.
Service provider	This is the organisation that is providing an aged care service and who receives a payment either from the government, another funder or the care recipient or carer to provide care. Service providers in receipt of government funding must be approved or meet certification or standards before being funded.
State/Territory government	Includes State or Territory Government authorities, instrumentalities and local health authorities established under State or Territory legislation[1].
Sustainability	Sustainability is the combined viability of aged care services within the sector, or parts of the sector, to the level that the numbers of providers continuing to operate are sufficient to enable the sector to continue functioning to a level that will achieve social and financial objectives that are acceptable to the community or have been agreed.
Technical efficiency	Technical efficiency refers to the relation between resources (capital and labour) and outcomes and is achieved when the maximum possible improvement in outcome is obtained from a set of resource inputs. A service is technically inefficient if the same (or greater) outcome could be produced with less of one type of input (Palmer & Torgerson 1999).
Viability	Viability refers is the financial capacity of an organisation to provide sufficient financial return to satisfy the requirements of the operators to the extent that the owners or operators of the organisation are prepared to continue to operate the service both in the short and long term. The determination of the viability of an organisation may be based on its current operational performance measured by its EBITDA or its project return on investment.
Weighted average cost of capital	WACC is the rate of return against the initial investment that an organisation is expected to pay, on average, to satisfy its security holders. It is the minimum return that the organisation must earn on an existing asset base to satisfy its creditors, owners, and any other providers of capital (Wikipedia 2013). It is particularly useful for decision makers to assess the capacity of the organisation to meet the expectations of investors (from both debt and equity) using the expected future available income that can be used to repay the cost of the investment. It is calculated taking into account the relative

Terms used	Definition
	weights of each component of the capital structure and requires a number of assumptions to be made concerning risk and the expectations of investor.

Executive Summary

Overview

This report examines the financial viability of the Australian aged care sector at the beginning of the LLLB reforms and identifies issues that will impact on its sustainability in the future. The Aged Care Financing Authority estimates that the residential aged care sector will require investment of $25 billion in the coming decade to cater for demand for aged care from Australia's ageing population. The viability of individual providers - whether they be for-profit providers (37% of all providers) or community benefit organisations (CBOs) (62% of all providers) - and the ability of the sector as a whole to meet growing demand for aged care at a price, quality, and proximity that is acceptable to the community, requires providers to be able to achieve sufficient profit or surplus such that they can draw that level of investment into the sector.

Analyses of the current viability and the future sustainability of the sector by the Aged Care Financing Authority (2013), KPMG (2013a, 2013b, 2013c) and by Deloitte Access Economics, Allen Consulting, Grant Thornton, Stewart Brown, and Bentleys, are clouded by the lack of uniformity of financial performance indicators across different publications. Indicators include EBITDA(R), profitability measured in earnings, average weekly earnings per bed per year, average return on assets (ROA), return on investment (ROI), average net worth/equity per resident, internal rate of return (IRR) and weighted average cost of capital (WACC) as well as Net Profit Before Tax (NPBT).

The ACFA reports that only 70% of providers were profitable in 2011-12 and 16% had a negative EBITDA, with EBITDAs per bed year across the sector ranging from –$3,646 to $21,081 for the financial year 2011-12, with major variations in profitability and viability according to location, facility size, wealth client profile, care type, state and provider type (FP or CBO). While the most financially viable services are predominantly for-profit facilities of 61-100 beds with mostly high care beds in metropolitan Australia, there were high performing facilities and providers in all locations and service categories. In all income bands, the EBITDA achieved by the top quarter of facilities is three to five times higher than the average.

Improving Trend in Viability

KPMG find, based on analysis of the Department of Health and Ageing's (DoHA's) general purpose financial reports (GPFR), that while 30% of providers made a loss in 2011-12, profitability is recovering from the downturn associated with the GFC. In the 12 months to April 2013 total value of aged care building work was $1.2 billion compared to $823 million in the previous year (an increase of 45%). These analyses of the current knowledge of viability suggest the following issues face the sector.

Issue 1 – consistency in agreed measures of viability

There is significant variability in the way that indicators of financial performance are measured and reported for annual returns. **Should there be a consistent measure of financial viability agreed within the sector and endorsed by the ACFA for the future reporting of financial viability of the residential aged care industry?**

Issue 2 – an agreed level of performance for a sustainable sector

The Inaugural Report by ACFA suggests that the Authority does not appear to be concerned by the fact that 30% of all residential aged care facilities were not profitable, nor that for-profit providers demonstrate higher financial performance on a number of indicators than CBOs although CBOs are the majority of providers. While it is to be expected that in any year a number of providers will not be profitable for a variety of reasons there does not appear to be a consensus on what is an acceptable percentage of unprofitable services in a sustainable sector. **What is the acceptable percentage of providers with negative profits or low EBIDTAs for the sector as a whole to be assessed as sustainable; and under what conditions should unprofitable facilities be supported to continue operating?**

Issue 3 - Data limitations for assessing viability and sustainability

The assessments of viability and sustainability provided by the different reports analysed in this paper are based on different data making it difficult to compare findings. While the largest dataset is the centrally collected GPFR data supplied by the Department of Health and Ageing and analysed by KPMG. **Is there a need for a national minimum data set on financial indicators that will provide reliable and consistent indictors of viability and sustainability while protecting the confidentially of the data on individual operators? If there is such a need, this national minimum data set needs to be delivered within the broader context of an overall reduction of red tape in the sector.**

Issue 4 – Identifying the reasons for large variations in financial performance

There is significant variability across the sector in the financial performance of different services. The best performing services are not just marginally better, but significantly better than the average performing services and this variation is unexplained with current knowledge. In addition, there appears to be significant variability in financial performance across operators in both the short and long term. **Is there a need for a much closer examination of the reasons for the difference in financial performance between the highest quartile and the lowest quartile to determine the extent of the differences due to structural or management factors?**

Issue 5 – improving the performance of the lowest quartile

The facilities in the top quartile of financial performance could be used as examples to poor performers where other factors are equal. The challenge appears to be to encourage the poor performers (in both quality and financial performance) to raise their performance to the same standard as the viable performers. **What can the sector do to encourage and assist poor performers to improve their performance?**

Issue 6 – Services in outer regional, rural and remote locations

There appears to be variation in financial performance based on location – both between states and territories and by degree of remoteness. As services in outer regional, rural and remote locations tend to be smaller on average they may face structural financial challenges because of their location and size that may not be completely overcome by the current reforms to financial arrangement. **Is it acceptable to the Australian community to have a two tiered system, based around location, where services based in cities and major regional centres have a greater opportunity to be financially viable and sustainable in the long term while those in rural and remote locations are financially insecure? Do different funding arrangements flow from this situation such as the use of block funding in rural and remote locations?**

Issue 7 – structural change to outer regional, rural and remote services

Long-term solutions to the challenges faced by RRR services may be around structural changes (multi-purpose services, consolidation of ownership, etc.), and increased financial supplements; or a combination of both. **What are acceptable solutions to the challenges to performance faced by many (but not all) RRR services? How do we support services with identified community benefit but which have little if any chance of being financially viable over the long term?**

Issue 8 – variation based on the size of services

There may be variation in financial performance based on the size of facilities. **How do we achieve a system where facilities are all of a size that achieves financial viability while also responding to client preference?**

Sustainability

To be sustainable into the future the aged care sector will need to attract new capital investment. The accepted theory of investment is that organisations with an IRR greater than their WACC will attract investment. Deloitte Access Economics (2011a) estimated that for high care the average IRR is 2.4% and the WACC is 9.8% (25 year investment), and for low care the IRR is 8.4% and WACC is 8.6%. On these numbers they argue that there is no incentive for investment in either type of bed. Deloitte Access Economics report that investors are demanding a 12% rate of return.

Estimates by other analysts give a similarly bleak picture of sector sustainability, hence the importance of getting the accommodation payments settings right under LLLB. Deloitte Access Economics (2013) estimated that the daily accommodation payment (DAP) required to break even (in the base case of 50% of people using the refundable accommodation deposit (RAD) option) is $61.37 and $64.42 where all accommodation revenue is derived from DAPS. They estimated the average RAD size under the base case 50% scenario at $361,689, noting that providers are permitted to increase the price of accommodation to compensate for loss of income (interest and retentions) from reduced RAD balances, including for 'increased cost of debt'.

The key question is whether these arrangements will create a level of return on investment sufficient to create a sustainable system. KPMG (2013a & 2013b) and ACFA (2013) conclude that while the new arrangements 'may reduce the value of new RADs from low care and extra service residents by $402.8 million in 2014-15' (KPMG 2013a, p. 11), RADs for High Care will provide HC providers with 'the opportunity to increase their lump sum accommodation payments by $3.4 billion', resulting in 'increased income and avoided cost of debt from new RADs and DAPs from high care residents' of $93.5 million in 2014-15 (KPMG 2013a, p. 11) with further income benefits thereafter (p. 12). They estimated that there will be a significant increase in persons paying accommodation charges above the maximum government accommodation subsidy of $52.84 from virtually no one to about 36% (p. 48).

However, they also conclude that low care providers, small providers, regional rural and remote (RRR) providers, and providers with a high proportion of supported residents will not significantly benefit from these changes (p. 12). This analysis suggests that the following issues related to sustainability appear to face the sector.

Issue 9 - impact on small and RRR providers of the three tier bands of accommodation charges

Will the proposed bands of accommodation payments create a three tier (or two tier) system, with varying degrees of financial viability and quality, that may make it difficult to attract providers to rural and remote locations? Will there also be a problem for older facilities that they will have to charge lower rates due to sub-optimal facilities and therefore enter a downward income spiral that will not support 'substantial refurbishments' and new facilities?

Issue 10 – Impact of the proposed accommodation charges

The proposed accommodation payments to be introduced in 2014 may have the result that those sections of the industry that are able to levy an accommodation charge at Level 2 or Level 3 will generate an income sufficient to be sustainable. It is also possible that those beds that levy an accommodation charge at Level 1 for places in two-bed rooms will generate an income above the estimated break-even price Table 10. These changes are likely to have a significant and lasting impact on the sector and should be introduced carefully. **Is there a consistent view among providers that while the proposed accommodation payments may enable providers to operate viable services that meet consumer preferences and create a financially sustainable sector the significance of the change is such that it should only be introduced after future analaysis is completed on the full impact of the change?**

Issue 11 – expected income generating life of a residential aged care facility

The estimates of the WACC appear to be very sensitive to the expected useful life of a RAC facility (see Table 8. above). **Is it reasonable to expect that facilities 30 years old will no longer be able to generate an income and what is a reasonable expected income generating life for the purpose of estimating WACC and other financial performance indicators?**

Issue 12 – balancing quality and financial performance

The available data on performance and sustainability of the sector appears to be based entirely on an assessment of financial metrics. There is no attempt in any of the reports reviewed to balance financial performance, financial viability or system sustainability with quality of care and outcomes for residents, or with community expectations or objectives. These financial estimates appear to make the assumption, but it is not explicitly stated, that all operating RAC service are of equal and acceptable quality. There appears to be a significant gap in our knowledge of the relationship between financial performance and of quality and between staffing levels and quality. **How do we strike a sensible balance between the measures of financial performance with the measures of quality so that we can judge the cost of quality and variation in quality between provider types?**

Improving viability through administrative and allocative efficiency

Accreditation systems and compliance regulatory (police checks, etc.,) have been identified as imposing significant and avoidable regulatory burdens on aged care providers and consumers alike. The PC argued that promoting more competition would promote better practice, lessening the reliance on regulation to ensure high quality services. The move towards CDC is expected to add another layer of costs; however analysts have provided no estimate of the magnitude of these costs, and the issue requires investigation if only because it has an impact on perceptions of industry cost regimes and viability, and therefore on investment.

Sustainability of the entire care system for older Australians can be measured by the system's ability to respond to demand. One measure of this is the delay in entry to care. While there appears to be a lengthening of times from assessment to entry, the data is weak and does not indicate local, regional or jurisdictional variation.

Another measure of responsiveness to demand is extended hospital stays for persons waiting for aged care. The proportion of 'aged care type' patients occupying acute care hospital beds has declined since 2005, which suggests that access to RAC has improved, though the trend is not jurisdictionally uniform. The following issues remain within the industry in relation to administrative and allocative efficiency.

Issue 13 – the cost benefit of regulatory compliance

Based on our current knowledge neither the benefits to residents and clients, nor the financial cost of regulatory compliance is currently known with any certainty. Consequently the impact on efficiency and the viability of the sector is unclear. **What is the real benefits to consumers, what is the real cost to providers, consumers, and what is the cost benefit to the community of the current regulatory and compliance burden on the industry?**

Issue 14 – measuring access to care

In a system of care that relies heavily on funding from taxation there is a reasonable expectation that indicators of access and allocative efficiency will be agreed and measured. **Is there consensus on what is an appropriate wait for access to care and does it serve as a benchmark for the allocative efficiency of the residential aged care system?**

Issue 15 – measure of regional access to care

Current indicators of access to care do not report performance at the regional level. **Should we have publicly reported and agreed measures of access to care on a jurisdictional and regional basis as an indication of local allocation efficiency, and access to care by different categories of providers, rather than rely on aggregated national and jurisdictional analysis?**

Home Care

The LLLB reforms will see the roll out of a four-tier Home Care Packages program and a basic assistance Home Support program based on the current HACC program. The viability of the HCP program is a function of operational costs and care staff costs. Financial results for the average provider of CACPs have been declining since 2006 and the impacts on viability of the extension of CDC also remain uncertain. The following issues are facing the home care sector.

Issue 16 – cross subsidisation of community and home care services

The complex mix of community and home care services suggests that many have a high level of support from governing bodies and related services. **Should we require community aged care services to be financially viable as stand-alone services or is it a reasonable expectation that they will always require cross subsidisation by the provider from resources (buildings, equipment, management and systems) and assets that are funded by other services (residential aged care, HACC etc.) If there is cross subsidisation, it is possible that tighter prudential requirements may call this into question.**

Issue 17 – impact of CDC financial viability of home and community care services

There is the potential that the implementation of CDC will change the level of cross subsidisation within services and between services because of the requirement to quarantine funding to individual clients. There appear to also be an increased administrative cost generated by the creation of individual budgets and regular individual financial reports.

What level of cross subsidisation is acceptable or desirable from both a financial viability and a community viability viewpoint – will cross subsidisation be possible with CDC?

What is the impact of CDC on the financial viability of community aged care services through the increased administrative and transaction costs and through the limits on cross subsidisation?

Option for the future

Government financing and funding policy should aim to produce a viable, sustainable and efficient aged care sector which achieves:

- equity in the distribution of services
- reasonable choice for consumers
- technical efficiency
- quality care
- investment in appropriate technology
- a balance between quality and cost and between government funding and consumer co-payment that is acceptable to the community
- an integrated and stable mix of acute, community and residential care.

A sustainable sector can only be achieved through a funding and financing model that:

- allows service providers to generate sufficient surpluses and profits to maintain their viability and continuing operations
- encourages continuous investment for long term sector sustainability.

The current system shows wide variation in the financial viability of providers such that some are producing surpluses much higher than the average while others are not generating a surplus. Depending on the consumer preference for the DAP and the RAD the changes to the funding for accommodation may achieve long term sustainability for some sections of the industry only.

The following options address issues raised here. Each is discussed in detail in the report

Option 1: Establish acceptable benchmarks to measure viability and sustainability.

Option 2: Create a publicly available, de-identified, universal, national data set to enable assessments of quality and financial performance

Option 3: Encourage early assessment of the impacts of the LLLB reforms

Option 4: Determine the reasons for the variability in financial performance across similar and non-similar providers.

Option 5: Improve efficiency in operations

Option 6: Investigate mechanisms to improve and sustain the viability of services in outer regional, remote and very remote services

Introduction and Background

The purpose of this paper

This paper is produced by Aged and Community Services Australia (ACSA) to aid in the discussion of major policy issues during the current period of aged care reform. Its purpose is to stimulate debate by providing a summary of the ideas currently in the public domain, and new ideas, concerning the financial viability of aged care providers and the financial sustainability of the industry, or parts of it. The current Living Longer Living Better (LLLB) reform process is moving rapidly and the intention with this paper is to inform and stimulate the discussion between decision makers at the level of government, service providers, consumers and workers.

Scope of this paper

This paper is focused on the issues of financial viability of residential and community aged care service providers and the sustainability of the residential and community aged care sectors[4].

Background

The Productivity Commission (2011) has predicted that by 2027 there will be a need for 287,000 residential aged care beds (up from 184,570 in 2012) and about 976,000 HACC individual client services (up from 518,000 in 2007). Similarly the Aged Care Financing Authority (ACFA) (2013)[5] estimates that the residential aged care sector will need to build 74,000 additional beds over the next ten years. They estimate this investment will cost $25 billion (including replacement and refurbishments). The PC estimates are provided in Table 3.

Table 3 Australia: estimate of the number of persons aged 65 year or older receiving care by the nature of the care

Year	2006-07	2016-17	2026-27	2036-37	2046-47
Number of places/persons	*'000*	*'000*	*'000*	*'000*	*'000*
High care residential	108	148	205	303	405
Low care residential	58	60	82	122	162
Total residential	167	208	287	426	567
Community aged care places	31	50	71	100	125
Home care services	518	697	976	1251	1448

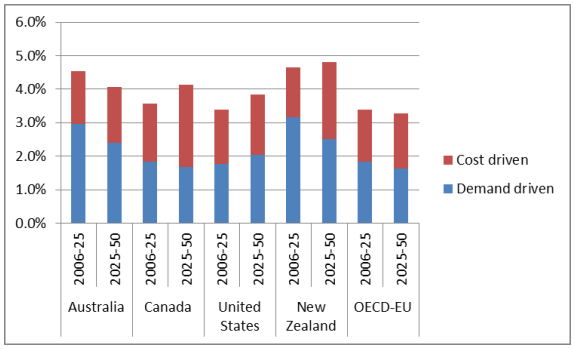
Source: (Productivity Commission 2008, p. 38)

As illustrated in Table 4, the OECD has estimated that Australia will face a higher growth in demand for long term care expenditure and subsequent investment than the USA, Canada and OECD countries in Europe and approximately the same as New Zealand until 2025. Overall growth is a combination of demand-driven expenditure due to the increasing aged population and cost-driven expenditure due to the increasing cost of providing care for the aged.

[4] However, it does not include consideration of the viability of community care services that are funded through the HACC program.

[5] In including these data in its report the ACFA does not cite or reference any publicly available reports from the department in which these data are included.

Table 4 Average estimated growth of long term care expenditure, 2006-25 and 2025-2050: Source: (OECD 2011)



As residential aged care services are predominately provided by non-government organisations (both for-profit and community benefit organisations) these organisations will only continue to provide them on a long term basis if it remains financially viable and, preferably, profitable, for them to do so. However, a number of recent reports have suggested that the aged care system was not viable in the long term under the pre LLLB financial parameters. The LLLB is the Australian Government's framework for reform of the sector. It incorporates a number of short term and long term reforms to the sector. In view of the growing demand and the reported tenuous viability of the sector, it is essential that the governments selects the policy options that will enable existing service providers and groups of service providers to remain viable in the short to medium term, and create the parameters that will achieve long term sustainability of the sector as a whole. In addition to the actions of governments there may be actions that can be taken by individual providers or groups of providers, to improve their own viability and the sustainability of the industry, such as increasing their management skills to improve efficiency, return on investment and quality.

Concepts of viability and sustainability

This section canvasses the concepts of viability and sustainability and the meanings that different analysts have applied to these terms.

Viability

For the purpose of this paper there are three ways to approach the issue of viability:

- viability of an individual provider
- viability of a category of providers; such as those of a particular size, targeting particular groups or operating in particular locations
- the viability of all providers.

Hogan (2004, p. 98), in his report on pricing arrangements in residential aged care, tends to use the term 'viability' to refer to individual providers. For example, in discussing the bed allocation process he reviewed 'whether the allocation would improve the viability of an aged care service through restructuring' and noted that 'lending institutions are as interested in the competence of board members as they are in the financial viability of facilities'. Hogan also uses viability to refer to a class or group of services, such as in recommending the continuation of the viability supplement for rural and remote providers, viz, 'the viability policy must only be to ensure that people in remote areas and from special needs groups have access to care' (2004, p. 193).

KPMG also use the term viability to refer to an individual provider by defining a viable residential aged care provider as one that 'can retain and attract investment by offering rates of return commensurate with risk, and mitigate impacts from negative external economic and financial conditions' (KPMG 2013a, p. 42).

The Productivity Commission uses the term viability to refer both to individual providers and to the sector as a whole as in the sentence 'However, the transition *[to a more competitive market]* must be orderly, to ensure the ongoing delivery of safe, quality care to older people and the viability of the aged care industry, while not protecting individual providers' (Productivity Commission 2011, p. xxxiv). On the other hand the report on 'The viability of residential aged care providers' by Deloitte Access Economics (2011b) focuses on providers, yet the main thrust of the report is on the sector as a whole.

In this paper, provider **viability** is defined as the generation of sufficient profit or surplus such that an individual provider of aged care services is willing to continue to provide services, albeit the parameters of what defines sufficient profit will differ according to organisational mission.

- For-profit (FP) service providers require a return on investment that will enable them to pay an acceptable level of return to their owners (commensurate with the risk of their investment) after appropriate business costs.
- Community Benefit Organisation (CBO) service providers require a return on current and future investment to maintain acceptable financial reserves for future investment after acceptable business costs and to meet their community objectives.
- State and Local government providers require an income from the Australian government and co-payments from consumers that meets their budgetary parameters and political goals.

Providers may also be prepared to operate services at different levels of viability. They may seek to secure sufficient income from parts of their aged care services (either residential or community) to enable them to finance those aspects of their aged care service that may not be financially viable (either temporarily or for the long term) but are socially responsible (such as in particular locations or for particular target groups). This is particularly the case in those situations (such as remote locations or services for particular groups) that will never achieve financial viability but are provided by a CBO organisation as part of their mission and role.

Sustainability

When referring to the whole aged care sector, Hogan tended to refer to the 'sustainability' of the industry (2004, p. 157). The Productivity Commission (2011, p. 97) recognises four types of sustainability; fiscal sustainability, provider sustainability, workforce sustainability and social sustainability [6].

Aged care sector sustainability is important to the broader health services industry, and the community generally, due to the integrated and complementary nature of aged care and health services and the potentially high cost to society if these services did not exist, are not reliable, or do not function efficiently. Frail and disabled aged Australians receive care from both residential and community care services which are complementary; should one of these sectors become dysfunctional due to financial pressures then it will have a significant impact on the other. The acute health care sector is dependent on the responsiveness of the residential aged care sector to take over the care of aged persons who cannot be sent home from hospital. A failure of the residential aged care sector to meet the demands for care for these inpatients will have upstream impact on the efficiency of the public hospital system. Similarly, services funded through other programs such as HACC, housing, welfares services and disability services may also be negatively impacted by an unsustainable aged care system.

The aged care sector contributes to **social sustainability** by providing care of an agreed standard to the frail and disabled aged at an acceptable cost and enabling the community to allocate its resources in an efficient way that best meets the needs of Australian society. The existence of aged care services enables families and carers to contribute to society confident that the aged person of concern is receiving a level and quality of care they alone may not or could not provide. A failure of

[6] 'Productivity Commission (2011, p. 97) recognises four types of sustainability; fiscal sustainability, provider sustainability, workforce sustainability and social sustainability.

- **Fiscal sustainability** — the extent to which financing arrangements can accommodate projected changes in the number of older Australians (in absolute and relative terms) requiring care over the longer term and changes in the value [cost] of that care.
- **Provider sustainability** — the financial viability of aged care providers in the long term. Under current arrangements, aged care providers operate within a highly regulated environment and the design of regulatory and funding arrangements should not undermine the financial viability of providers or distort signals for new investment.
- **Workforce sustainability** — the ability of the aged care industry to attract and retain people with the requisite skills needed to provide the level of quality care expected by the community. This dimension of sustainability focuses on whether future models of care are able to be supported by the available workforce.
- **Social sustainability** — the ability to maintain social harmony within the community concerning the fairness of the distribution and use of available resources.'

the aged care system would have a significant impact on the lives of numerous families and, consequently, on the economic productivity of the Australian economy.

Finally, the explicit cost of care for the increasing number of frail and disabled aged is now an identified and significant component of the economy and, as the Productivity Commission's recent report recognised, the community has an expectation that these resources will be managed efficiently.

> Getting the best 'value' out of the resources devoted to providing care and support to older Australians is also important for taxpayers and for the community more generally because it is about maximising overall welfare and living standards. This requires that resources are used where they give the greatest benefit (allocative efficiency), and that services are produced using the lowest level of resources required to meet a specific quantity and quality standard (technical efficiency). It also requires that investments are made where the stream of future benefits more than outweighs the costs, including the opportunity cost. Another dimension is how aged care services interact with other services that are critical to the health of older Australian, including health, housing and transport services. (Productivity Commission 2011, p. 93)

These definitions of viability and sustainability are also adopted by the Aged Care Pricing Authority in its inaugural report where it states that 'the ongoing viability of residential aged care providers is essential to meeting the objectives of a sustainable sector and to support the delivery of quality care by an appropriately skilled workforce' (Aged Care Financing Authority 2013, p. 24).

Analysis of the current situation

No new analyses have been commissioned to prepare this paper. This section is based on previously released and publicly available data and brings together the concepts of viability and sustainability, measures of, and recent assessments of, financial performance, and the assessment of the likelihood of future viability and sustainability.

There have been several reports and publications on the viability of residential aged care providers in recent years. The most recent report expresses a view of the sector at the start of the LLLB reforms (Aged Care Financing Authority 2013; KPMG 2013b). The focus, method and major findings of these reports and publications have been summarises in Appendix 1.

There are fewer analyses of the viability of community aged care services than for residential aged care services; however, some reports make reference to a range of issues associated with community aged care services.

This section firstly examines the viability of recent and current operators[7]. It then examines the issue of future investment. Some of the reports considered here focus on combined income and costs of both care and accommodation (Bentleys (Qld) Pty Ltd 2012; Stewart Brown and Co 2013). Others restrict their analysis of overall viability to future capital investment (Deloitte Access Economics 2011a; Grant Thornton 2011) excluding the contribution (loss or surplus) that operations (care provision) make toward overall profit or surplus.

While the terminology used within these reports is reasonably consistent there is the potential for some confusion in attempting to compare them and comment are made in the discussion below where this may occur. Measures of financial performance that are used as indicators of viability and sustainability across different publications include:

- earnings before interest, tax, depreciation and amortisation (EBITDA) with some variations (Aged Care Financing Authority 2013)
- profitability measured in earnings (Bentleys (Qld) Pty Ltd 2012; Shonhan 2013; Stewart Brown and Co 2013)
- average weekly earnings per bed per year (Ansell 2012),
- average return on assets (Aged Care Financing Authority 2013)
- Average net worth/equity per resident (Aged Care Financing Authority 2013)
- the internal rate of return (Access Economics 2009; Deloitte Access Economics 2011a; Hogan 2004),
- the weighted average cost of capital (Access Economics 2009; Ansell 2012; Deloitte Access Economics 2011a; Hogan 2004).

None of the papers provides any substantial discussion of the viability of the community care sector.

[7] With the exception of the recent report by KPMG (KPMG 2013a) a number of these reports appear to assume that operators require all of their services to be financially viable, all the time, to continue to operate them; however, this may not necessarily be true of all community benefit organisations and all government operated services.

Viability of current RAC providers

Overall Financial performance

A common and comparable measure of the financial performance of residential aged care facilities across reports is earnings before income tax depreciation and amortisation (EBITDA). The level of EBITDA vary from one year to the next and a poor performance in one year may not necessarily lead to a conclusion that a service or sector is not financially viable over the medium to long term. To form a medium term picture of the viability of RAC services it is necessary to look at reported profitability across a number of years.

In his 'Pricing Review' Hogan (2004) estimated that the EBITDA average for his sample of 781 facilities in 2002 was $2,001 (equivalent to a return on investment (ROI) of 5.1%). Subsequently Bentleys (2006) reported an EBITDA of $2,610 per high care place (ROI of 2.2%[8]) and $3,288 for each low care place (ROI 2.7%) for the FY 2004/05; and $3,671 for high care (ROI 2.2%) and $4,686 for low care in 2006/07 (ROI 2.7%). They commented that these results were a substantial improvement on previous years. However, by 2009 the Stewart Brown aged care survey reported an average negative EBITDA of -$1460 across all facilities (Stewart Brown and Co 2012), although this negative result was short lived. In June 2011 their survey indicated an EBITDA of $4,745. More recently they reported the 'average facility' EBITDA was $7,621 for the FY to June 2012 and $7,166 for the twelve months to December 2012. Bentleys' reports an average EBITDA of $8,015 for the FY to June 2012 (Shonhan 2013).

Stewart Brown estimate that 72% of all facilities in their survey to June 2012 made an overall surplus which was higher than 2010 (63.5% of all facilities), however, they also report that 14.8% of facilities had a negative EBITDA in the June 2012 quarter. This is similar to the results of an analysis of the general purpose financial reports (GPFRs) of 1,054 providers by KPMG (2013a) and reported by the ACFA. The ACFA reported that 70% of providers were profitable in 2011-12 and 84% had a positive EBITDA (2013, p. 9). These analysts reported[9] an average EBIDTA per resident across all providers of $9,274 with a range from -$3,646 to $21,081 for the financial year 2011-12. These estimates, by KPMG on behalf of ACFA, of the dollar value of EBITDA are noticeably higher than the other benchmarking reports based on survey data for the same period. Table 5 details for comparison the recent reports of the dollar values of estimated average EBITDA for the four most recent reports and illustrates considerable variation in performance, presumably as they are based on different samples of services.

The ACSA has previously argued in submissions to the ACFA that the reduction in ACFI subsidy level effective from 1 July 2012 will have an unknown impact on the viability of the sector and the full impact of that reduction will not be known until the results on the financial performance of the sector for the whole of 2012/13 are available.

[8] This ROI is based on Bentleys estimate of the value of the capital cost for one place (either high care and low care) but they do nor report if this is historical value or current value.

[9] KPMG comment on the limitations of the GPFR data, viz : it is incomplete as not all providers supply data, the data supplied is inconsistent in quality and level of detail, providers with multiple services may not allocate costs consistently across their different businesses, and there are inconsistencies in the treatment of balance sheet items such as bonds.

Table 5 Estimate of annual average earnings

Report	High Care	Mixed	Low Care	Comments
Ansell (2012) [Grant Thornton]	$6,725		$4,896	Estimated actuals for 2010 and EBITDAR
	$32,203 (tax payers) 26,523 (non-tax)			Estimated 'adequate return on investment for combined cost of capital and care'
Stewart Brown (2012)		$7,166 (average) $7,450 (overall)		EBITDA on 'average' facility YTD Dec 2012
		$7,621 (Average) $7,994 (overall)		EBITDA on 'average' facility FY 2011-12
Bentleys (2012)		$8,022		2011-12 national averages, all homes, based on EBITDA of $21.98 per day
Shonhan (2013)		$12,080		EBITDA per place of the typical aged care provider
Shonhan (2013)		7.82%		Net profit margin
KPMG (2013a)	$10,364	$5,812	$2,454	$9,274 (all providers) $13,121 (FP providers) $8,176 (NFP providers) -$1,508 (government providers). Estimates are of EBIDTA based on an analysis of 1,054 GPFR reports for 2011-12.

Variation in financial performance by location

It is reasonable to expect that not all RAC services will return the same level of financial performance and one factor may be location. Location may have an impact on financial performance because of the different costs of providing services and the varying levels of incomes and wealth of residents in different part of the county. Hogan found significant variation in aggregate performance measured by EBITDA across the states – with the highest EBITDA in Tasmania and the lowest in Victoria (which he attributed to the high proportion of state government operated facilities in Victoria) (2004, p. 34). More recently the Stewart Brown survey reported that facilities in Victoria had the lowest level of financial performance for the six months to December 2012, however, due to the small sample size in that state the authors caution against giving too much weight to the results. Bentleys have consistently reported variations in financial performance between states.

Hogan reported also on the variation in performance on EBITDA *within* geographical locations (capital cities, other metropolitan locations, remote and rural) and reported there was evidence of high performing facilities in all locations including small rural services. The survey results by Bentleys, Stewart Brown and Grant Thornton tend not to report variation in financial performance by location.

KPMG (2013a) report that 'regional' providers had an average EBITDA of $6,663 compared with $10,369 for 'metropolitan' providers, although they note that some regional providers appeared to generate 'large' profits, although they do not provide details to support this claim. They also report growth in average EBIDTA across all facilities of 18% between 2006-07 and 2011-12 compared with growth of 14% in regional locations across the same period.

Variation in financial performance based on size

Hogan reported differences in financial performance based on the size of the facility (number of beds) and found facilities in the 61 to 90 bed range performing best (but this may have been due to a weakness in his sample). Stewart Brown survey report for FY 2011/12 reported that facilities in the 60 to 80 bed range had the highest EBITDA at $23.07 per bed day ($8,419 for a year) followed by those in the 80 to 100 bed range at $22.05 ($8,097). The least performing group were those with more than 100 beds producing an EBITDA of $20.13 ($7,386). On the other hand Bentleys report that in 2011/12 the most profitable bed size was 100+ with an EBITDA of $23.79 per bed day ($8,683 for a year) followed closely by facilities in the 61 to 80 bed size range at $22.92 ($8,365). They report that the worst performing facilities were in the 'less than 40 beds' group. These findings on the performance by bed size are consistent with the conclusions of Grant Thornton (2009) who argue that the bed size of 76 to 100 beds is the most profitable and those with fewer than 25 beds the least profitable.

Unexplained variation in overall financial performance

Hogan (2004) concluded that while there was a proportion of residential aged care facilities with negative EBITDAs, and others that were marginal, there were examples in almost all types of RAC services (based on size, ownership and location) that reported a viable surplus or profit. This variation in performance across facilities appears to have continued in the years since Hogan reported.

From their survey, Bentleys found that in 2011/12 the top 25% performing facilities, based on EBITDA, had net income after expenses of $25.93 per bed day ($9,464 per bed year) and that this result was three times higher than the average performing facility ($8.86; $3,233). Similarly Stewart Brown reports on the differences in the performance of the top quartile within each of the five bands (based on income) into which they divide their sample. Within all of the bands the value of the EBITDA achieved by the top 25% is between three and five times higher than the average. They observe that the difference in performance between the highest performing quarter of services and the average performers was approximately $850,000 for the year (using an 80 bed facility in Band 5 – the Band with the highest average income) (Stewart Brown 2013).

Variation based on ownership type

The analysis by KPMG of the profitability of the industry suggests a higher EBIDTA on average for FP providers compared with CBOs. Although FP providers tend to have lower occupancy rates compared to CBOs (90.4% compared with 94.7% (KPMG 2013a, p. 87), they represent 62.1% of all providers in the top quartile of EBIDTA performance in 2011-12 although they are only 37.2% of the total of providers (KPMG 2013a, p. 44).

Trends in the overall assessment of viability

Table 6 below is reproduced from the recent KPMG report commissioned by the Aged Care Financing Authority (ACFA) and reports their assessment of the trends in the viability of the sector based on their analysis of the general purpose financial reports (GPFR). While this Table indicates a number of favourable trends and the findings of this report indicate higher levels of EBIDTA than other reports, it is important to note that 30% of providers made a loss in 2011-12 and 16% had a negative EBIDTA. High care providers appear also to generate more cash from operation than low care providers. Amber indicates some trend in a favourable direction, green as having improved and red as not improved.

Table 6 Indicator of measures of viability used by KPMG 2006-07 to 2011-12

Indicator	Is the trend in viability improving?	Has viability improved in the last year of measurement?
Profit and loss account indicators		
EBITDA per resident per annum - Sector	🟢	🟢
EBITDA per resident per annum – Regional providers	🟢	🟢
EBITDA per resident per annum – Low care providers	🔴	🔴
Providers reporting profit	🟢	🟢
Providers reporting negative EBITDA	🟢	🟡
Balance sheet indicators		
Average bond per resident	🟢	🟢
Bonds as a proportion of total financing	🟢	🟢
Equity as a proportion of total financing	🟡	🟡
Return on equity	🟢	🟢

Source: KPMG (2013a, p. 43 table 4.1)

Issues arising from the analysis of financial performance

A number of issue are suggested from the analysis above which should be addressed in the interests of continuing viability across all sectors of the industry. These issues are listed below.

Issue 1 – consistency in agreed measures of viability

There is significant variability in the way that indicators of financial performance are measured and reported. **Should there be a consistent measure of financial viability agreed within the sector and endorsed by the ACFA for the future reporting of financial viability of the residential aged care industry?**

Issue 2 – an agreed level of performance for a sustainable sector

The Inaugural Report by ACFA suggests that the Authority does not appear to be concerned by the fact that 30% of all residential aged care facilities were not profitable, that for-profit providers demonstrate higher financial performance on a number of indicators than Community Benefit Organisations although CBOs are the majority of providers. While it is to be expected that in any year a number of providers will not be profitable for a variety of reasons there does not appear to be a consensus on what is an acceptable percentage of unprofitable services in a sustainable sector. **What is the acceptable percentage of providers with negative profits or low EBIDTAs for the sector as a whole to be assessed as sustainable; and under what conditions should unprofitable facilities be supported to continue operating?**

Issue 3 - Data limitations for assessing viability and sustainability

The assessments of viability and sustainability provided by the different reports analysed in this paper are based on different data making it difficult to compare findings. While the largest dataset is the centrally collected GPFR data supplied by the Department of Health and Ageing and analysed by KPMG. **Is there a need for a national minimum data set on financial indicators that will provide reliable and consistent indictors of viability and sustainability while protecting the confidentially of the data on individual operators?**

Issue 4 – Identifying the reasons for large variations in financial performance

There is significant variability across the sector in the financial performance of different services. The best performing services are not just marginally better, but significantly better than the average performing services and this variation is unexplained with current knowledge. In addition, there appears to be significant variability in financial performance across operators in both the short and long term. **Is there a need for a much closer examination of the reasons for the difference in financial performance between the highest quartile and the lowest quartile to determine the extent of the differences due to structural or management factors?**

Issue 5 – improving the performance of the lowest quartile

The facilities in the top quartile of financial performance could be used as examples to poor performers where other factors are equal. The challenge appears to be to encourage the poor performers (in both quality and financial performance) to raise their performance to the same standard as the viable performers. **What can the sector do to encourage and assist poor performers to improve their performance?**

Issue 6 – Services in outer regional, rural and remote locations

There appears to be variation in financial performance based on location – both between states and territories and by degree of remoteness. As services in outer regional, rural and remote locations tend to be smaller on average they may face structural financial challenges because of their location and size that may not be completely overcome by the current reforms to financial arrangement. **Is it acceptable to the Australian community to have a two tiered system, based around location, where services based in cities and major regional centres have a greater opportunity to be financially viable and sustainable in the long term while those in rural and remote locations are financially insecure?**

Issue 7 – structural change to outer regional, rural and remote services

Long-term solutions to the challenges faced by RRR services may be around structural changes (multi-purpose services, consolidation of ownership, etc.), and increased financial supplements; or a combination of both. **What are acceptable solutions to the challenges to performance faced by many (but not all) RRR services? How do we support services with identified community benefit but which have little if any chance of being financially viable over the long term?**

Issue 8 – variation based on the size of services

There may be variation in financial performance based on the size of facilities. **How do we achieve a system where facilities are all of a size that achieves financial viability while also responding to client preference?**

Sustainability of the current system

Deloitte Access Economics (2011b, p. 29) defined the RAC sector as sustainable if it could attract new capital investment. The PC (2011) noted that the (then) current accommodation charge was too low for long term sustainability and argued that the (then) current system was not sustainable as evidenced by a lack of investment in some areas, particularly in high care services. The PC enquiry recognised that FP providers are disadvantaged compared with CBOs (NFP) providers through a number of taxation arrangements especially the differences in the treatment of Fringe Benefits Tax (FBT) between the two sectors (Productivity Commission 2011, p. 126).

Return on investments

There are a number of estimates for return on investments used by those reporting on RAC services. These estimates include:

- **return on investment (ROI**); which is generally estimated based on the EBITDA per bed for the year in review as a percentage of the investment in that bed
- **return on assets (ROA)**; used by Stewart Brown but not defined and by KPMG as EBIDTA/Total Assets
- **return on equity (ROE)**; defined by Bentleys as the rate that equity investors will receive and by KPMG as the EBIDTA/Net Worth.

The results of recent assessments of ROI, ROA and ROE are provided in Table **7**. Over much of the past decade estimates of the ROI across the RAC sector have ranged between 2.7% and 6.19%. The recent estimates of ROA and ROE report by KPMG (2013a) appear to report higher performance than the reports based on industry surveys. KPMG argue that the relative high ROE by FP providers compared with CBOs and government providers is a result of their greater reliance on debt and accommodation bonds. They also assess that the increase in the ROE across the sector in the five years to 2012 is a result of the decrease in equity as a proportion of total financing and conclude that there is uncertainty about the optimal mix of equity within the sector.

Table 7 Recent estimated returns on investment of the RAC in Australia

Report	Mean estimated ROI/ROA/ROE	Comments
Bentleys 2004/05 (2006, p. 6)	2.2% (high care) 2.7% (low care)	ROI based on capital cost of: High care $120,000 low care at $120,000
Bentleys 2006/07 (2008, p. 5)	2.2% (high care) 2.7% (low care)	ROI based on capital cost of: High care $175,000 low care at $175,000
Access Economics (2009)	3.1 (20 Years) to 6.19 (30 years)	ROI
Stewart Brown (2012, p. 1)	3.8% (December 2012) 4.25% (June 2012)	ROI
Shonhan (2013) [Bentleys]	2.85%	ROI
	6.57%	ROE
KPMG (2013a, pp. 85-8)	5.5% (2011-12) all providers	ROA [range -1.9% to 11.2%]
	15.9% (2011-12) all providers	ROE [range -4.7% to 35.2%]
	7.4% (2011-12) FP providers	ROA [range -1.2% to 11.7%]
	53.2% (2011-12) FP providers	ROE [range 46.3% to 60.8%]
	5.1% (2011-12) CBO providers	ROA [range -1.2% to 10.4%]
	11.7% (2011-12) CBO providers	ROE [range -3.1% to 19.5%]
	-0.8% (2011-12) Govt. providers	ROA [range -4.1% to 13%]
	-0.7% (2011-12) Govt. Providers	ROE [range -0.7% to 21.2%]

Assessments of the WACC

There has been a great deal of interest in the calculation of the WACC for residential aged care in the past couple of years. This reflects concerns over the adequacy of the income generated by future accommodation charges and from refundable accommodation deposits (RADs) to meet the future cost of capital investment. WACC is the rate of return against the investment that an organisation is expected to pay, on average, to all its security holders. It is calculated taking into account the relative weights of each component of the capital structure and requires a number of assumptions to be made concerning risk and the expectations of investor.

A comparable measure of investment is the internal rate of return (IRR). The IRR is calculated by estimating the rate at which the net present value of all future cash flows (both positive and negative) is zero (0). The accepted theory is that organisations with an IRR greater than their WACC are creating value for their owners. Similarly it has been argued that the RAC sector is unsustainable when the average IRR is less than the average WACC (Deloitte Access Economics 2011a) (Access Economics 2009).

Table 8 provides the estimates of the IRR calculated by Deloitte Access Economics. A key variable used by Deloitte Access Economics is the expected useful life of the RAC facility; 20, 25 and 30 years. Using these parameters they estimated that the IRR will range between 0.6% (high care for an investment life of 20 years) to 9.0% (low care for 30 years). Table 9 summaries the estimates of the WACC by different reports with a range between 7.7% and 13.0%. Access Economics argued for a WACC of 9% (Access Economics 2009, p. 23). Deloitte Access Economics (2011a) estimated that for high care the IRR is 2.4% and the WACC is 9.8% (25 year investment), and for low care the IRR is 8.4% and WACC is 8.6%. On these numbers they argue that there has been no incentive for investment in either type of bed. Only low care with a life of 30 years showed the IRR to be higher than the cost of capital. There were no scenarios where the investment in high care beds was positive and no scenarios calculated with an expected income generating life of a residential aged care facility of more than 30 years.

Table 8 Estimates of the Internal Rate of Return by Deloitte et al 2011

Report	Estimate of IRR	Comment
(Deloitte Access Economics 2011a) NB: From survey results they report that a 12% rate of return is demanded by investors	High Care 0.6% (20 years) 2.4% (25 years) 3.4% (30 years) Low care 7.2% (20 years) 8.4% (25 years) 9.0% (30 years)	Internal rate of return under the then current (2011) policy regime

Table 9 Past estimations of the WACC for RAC in Australia

Report	Estimated WACC	Comments
Hogan 2004	10%	
(Access Economics 2009)	8.14%	Recommends $43.65 a day for accommodation costs
Grant Thornton (Ansell 2012)		**Cost of capital per bed day**
	11.5% for high care tax payers	$88.23 high care tax payer
	13.0% for high care non tax	$72.70 high care non-tax
	10.94% for mixed tax payers	$84.73 mixed care tax payer
	12.20% for mixed non tax	$69.11 mixed non tax
(Deloitte Access Economics 2011a)	8.6% high care tax payers	Nominal post tax WACC of the current system
	10.5% high care non-tax payers	
	9.8% high care average	
Current system	8.2% mixed tax payers	Recommends a daily high care charge of $64.62 or an accommodation bond of $238,240 for an investment to be viable.
	9.8% mixed non tax	
	7.7% low care tax payers	
	9.1% low care non tax	
	8.6% low care average	
(Deloitte Access Economics 2011a)		Estimates of future a daily fee charge where 50% paid bonds $56.07 for non-metropolitan areas $69.99 for metropolitan areas

The estimates of IRR and WACC use the daily accommodation payment (DAP) and equivalent lump sum payments in the form of a RAD. Access Economics (Access Economics 2009) argued in 2009 that the DAP needs to be around $43 a day to cover the capital and depreciation costs. Using a simple indexation based on CPI for the four years to 2013 of 9.7% (Australian Bureau of Statistics (ABS) 2013) this would equate to $47.2 a day in 2013. In a more recent report Deloitte Access Economics estimated that the DAP required to break even in the base case (50% of people using the bond option) was estimated to be $61.37. They concluded that 'assuming all accommodation revenue was derived from periodic payments [DAPS], the breakeven periodic payment was estimated to be $64.42 [a day]. Assuming all accommodation revenue was derived from bonds the equivalent breakeven periodic payment was estimated to be $58.20' (2011a, p. iii). The full range of these estimates is provided in Table 10.

Table 10 Deloittes Access Economics 2011 Summary of daily accommodation charges based on a 25 year investment horizon

Scenario and sensitivity	No accommodation bonds	50% accommodation bonds (base case)	100% accommodation bonds
Baseline	$64.42	$61.37	$58.20
Scenario			
Two-bed room	$54.93	$52.17(a)	$49.47
Metropolitan	$73.69	$69.99	$66.37
Regional	$59.04	$56.07	$53.16
Sensitivity			
12% WACC	—	$76.60	—
15% WACC	—	$94.35	—
Cost of building$250,000	$80.62	$76.57	$72.61
Excluding the value of land(b)		$57.86	

Note: (a) In a one-bed room non-supported residents would pay $67.74 to cross-subsidise 20% supported residents, or $71.09 to cross-subsidise 40% supported residents. (b) This refers to excluding the cost of land in determining the cost of accommodation for the base case scenario only. Source: Deloitte Access Economics' calculations.

Deloitte Access Economics also calculated the accommodation bond sizes (or equivalent RAD and DAP combination) that would be required under the base case outline above. This they estimated at $361,689. They noted that

> 'the large increase in the bond amount compared to the required bond amount to break even under current policy (i.e. $238,240) is due to the removal of a provider's capacity to retain part of the bond principal under the Productivity Commission recommendations. Consequently, more income must be earned from interest. Assuming all accommodation revenue was derived from accommodation bonds, the equivalent breakeven average bond was estimated to be $344,428. As this is higher than the average bond currently provided, future residents wishing to provide bonds may not be able to afford a bond of this size. This would reduce the stock of bonds. Larger bonds are required on average when fewer bonds are supplied to a provider because the benefit of reducing interest payments is shared between those providing a bond and those paying periodically.' (Deloitte Access Economics 2011a, p. iv).

Proposed accommodation payments

The proposed model for accommodation payments for RAC recently announced will introduce, from 1 July 2014, the following arrangements (Australian Government Department of Health and Ageing 2013a):

- greater transparency in the publication of accommodation costs to residents and prospective residents and other stakeholders;
- residents will pay for accommodation costs through a refundable accommodation deposit (RAD) or a non-refundable daily accommodation payment (DAP); or a combination of both, and the arrangements will be formally agreed within 28 days of the resident entering the RAC;

- accommodation payment will be one of three levels
    - Level 1 – up to the level of the maximum Government accommodation supplement ($50 per day (2012 prices) and paid in part or full by the Government accommodation supplement for residents with 'low means')
    - Level 2 – Prices between Level 1 and an upper threshold of $85 per day (2012 prices) (which are set by providers following a self-assessment of the value of the accommodation on offer using the guidelines established by the Aged Care Pricing Commissioner)
    - Level 3 – Prices above the Level 2 threshold (for example, for a large modern private room with private ensuite and pre-approved by the Aged Care Pricing Commissioner).
- In addition, following agreement with the resident, providers will be able to charge, on an 'op-in opt-out' basis, an 'additional amenity fee' for amenities and services that are not included in basic services, the accommodation charge or 'extra service' charge;
- the amount of the DAP will be derived from the RAD price using the 'maximum permissible interest rate' (MPIR) – which will be subject to review in 2017;
- accommodation prices are to be set taking into consideration the privacy of the room, quality of the room and facility, and other factors including location, design and services (other than care services and services charged for through an extra service fee).
- RADs will still be subject to a minimum permissible asset value test, prudential requirements, restrictions on use and regulations regarding refunds;
- providers will not be allowed to deduct regular 'retention amounts' from the RAD but will be able to deduct amounts owing for 'additional amenities' or for periodic payments or to top up the DAP (following agreement with the resident); and
- providers will retain any interest earned on the RAD and this income may be used for any purpose approved under the prudential compliance safeguards.

Assessment of future sustainability

The key question is whether these arrangements will create a level of return on investment sufficient to create a sustainable system. From the two reports by KPMG for the Aged Care Financing Authority (KPMG 2013a, 2013b) and the Inaugural Report of the Authority (Aged Care Financing Authority 2013) the following conclusion were drawn:

- Increased price transparency (publication of accommodation prices) and consumer choice of payment method with up to 28 days' grace after entry 'may mean that some people pay a DAP when they would have otherwise paid a RAD.'
    - This 'may reduce the value of new RADs from low care and extra service residents by $402.8 million in 2014-15' (KPMG 2013a, p. 11).
    - However, RADs for High Care will provide HC providers with 'the opportunity to increase their lump sum accommodation payments by $3.4 billion', resulting in 'increased income and avoided cost of debt from new RADs and DAPs from high care residents' of $93.5 million in 2014-15 (KPMG 2013a, p. 11) with further income benefits thereafter (p. 12).
        - Low care providers, small providers, RRR providers, and providers with a high proportion of supported residents will not significantly benefit from these changes (p. 12).
        - KPMG estimate that one-third of potential RADs will shift to DAPs in 2014-15 (p. 46), but this will largely depend on whether the unsold family home can generate rental income sufficient to cover the DAP (p. 47).
    - Removal of retentions may reduce income from low care and extra service residents by $68.4 million in 2014-15. However, providers are permitted to increase the price of accommodation (RADs and DAPs) to compensate for this loss of income from reduced RAD balances, including for 'increased cost of debt' (p.11).
- The estimated increase in incomes from high care entrants is more than enough to offset predicted losses from transfers from RADs to DAPs in low and extra service residents (KPMG 2013b, p. 47). High care providers 'will be able to increase their income and reduce the cost of debt' (p. 48) and the reforms will also 'provide greater access to lump sum payments' across the whole service system (p.47). They estimated that there will be a significant increase in persons paying accommodation charges above the maximum government accommodation subsidy of $52.84 from virtually no one to about 36% (p. 48).
- Level 2 pricing threshold for accommodation payments may hold down accommodation prices when the ACPC does not grant permission for a price above that threshold to be applied based on the 'value of the room'.
- Net increase in value of new RADs from 2014-15 will support greater investment activity, but this will differ according to individual provider circumstances (p.13)

- Overall investment in new residential aged care building stock (which was in significant decline from 2009), has started to increase with new building work *in progress* increasing by 11.6%, upgrading work increasing by 60.3% between 2010-11 and 2011-12, and rebuilding work increasing by 18% since 2009-10 (p.16). In the 12 months to April 2013 total value of aged care building work was $1.2 billion compared to $823 million in the previous year (an increase of 45%) (p.16).

KPMG averaged investment in new facilities and rebuilding for the five years 2007-8 to 2011-12 inclusive, and obtained an average figure of $997 million/annum. Were that level of investment to be retained each year for the decade 2012-13 to 2021-22, there would be 'a projected investment gap of $15.0 billion across the decade equating to around 80,000 places (p.16).

'If investment in residential care does not change, the demand for residential care has the potential to outstrip supply in the near future' (p.73)[10]*.* Overall, the ACFA predicts positive investment into the industry in general, driven by strong demand for care places and increased funding directed to the industry through the LLLB reforms but different segments will be differently attractive to investors (Aged Care Financing Authority 2013, p. 67).

However, there may be concerns with these positive estimates of the impact of the proposed changes. The estimates by KPMG are based on a number of assumptions about consumer preferences, including that aged consumers make predictable and economically rational choices concerning the maximisation of their wealth, and on the level of RADs that the current stock of high care facilities will be able to attract. Some of those assumptions may need to be subject to further testing and public scrutiny to generate confidence that their assessment of the outcome of the proposed reforms is sufficiently robust. There may be a case a delay in their implementation to enable further testing of the proposed changes to occur.

Issues arising from the assessment of sustainability

The following issues arise from this discussion of accommodation payments and of the level of sustainability of the sector.

Issue 9 - impact on small and RRR providers of the three tier bands of accommodation charges

Will the proposed bands of accommodation payments create a three tier (or two tier) system, with varying degrees of financial viability and quality, that may make it difficult to attract providers to rural and remote locations? Will there also be a problem for older facilities that they will have to charge lower rates due to sub-optimal facilities and therefore enter a downward income spiral that will not support 'substantial refurbishments' and new facilities?

[10] *However this investment average is calculated across the GFC years and the 'waiting for reform' years when, arguably, providers were deliberately withholding investment to see where the reforms were going. KPMG (2013a, p. 74) noted that there was a severe downturn in completed building work in 2010-12 which may have created a lower than expected five year average.*

Issue 10 – Impact of the proposed accommodation charges

The proposed accommodation payments to be introduced in 2014, may have the result that those sections of the industry that are able to levy an accommodation charge at Level 2 or Level 3 will generate an income sufficient to be sustainable. It is also possible that those beds that levy an accommodation charge at Level 1 for places in two-bed rooms will generate an income above the estimated break-even price (Table 10). These changes are likely to have a significant and lasting impact on the sector and should be introduced carefully. **Is there a consistent view among providers that while the proposed accommodation payments may enable providers to operate viable services that meet consumer preferences and create a financially sustainable sector the significance of the change is such that it should only be introduced after future analysis is completed on the full impact of the change?**

Issue 11 – expected income generating life of a residential aged care facility

The estimates of the WACC appear to be very sensitive to the expected useful life of a RAC facility (see Table 8 above). **Is it reasonable to expect that facilities 30 years old will no longer be able to generate an income and what is a reasonable expected income generating life for the purpose of estimating WACC and other financial performance indicators?**

Issue 12 – balancing quality and financial performance

The available data on performance and sustainably of the sector appears to be based entirely on an assessment of financial metrics. There is no attempt in any of the reports reviewed to balance financial performance, financial viability or system sustainability with quality of care and outcomes for residents, or with community expectations or objectives. These financial estimates appear to make the assumption, but it is not explicitly stated, that all operating RAC service are of equal and acceptable quality. There appears to be a significant gap in our knowledge of the relationship between financial performance and of quality and between staffing levels and quality. For example, it is sometimes suggested that not for profit entities enjoy greater staffing ratios than for-profit entities and that this does contribute to higher quality. **How do we strike a sensible balance between the measures of financial performance with the measures of quality so that we can judge the cost of quality and variation in quality between provider types?**

Summary of financial viability and sustainability

Reports of EBITDA across the industry over the past decades suggest wide variation in performance. Assessments for the same year by different analysts also report significant differences, presumably because of different samples and methods of calculation. The most recent, and arguably the most comprehensive assessment as it is based on data from all providers, is the data from KPMG based on GPFR data. These data suggest that the viability of providers, based on assessment of EBITDA, is improving but that there are concerns with some segments of the industry as 16% of providers reported a negative EBIDTA[11]. A similar picture emerges of a variation in estimations of return on investment, return on assets and return on equity across different analyst reports and an apparent lack of consensus on what level of returns will constitute a viable service in the long term and a sustainable industry.

The assessment by KPMG of the changes to be introduced in 2014 to accommodation deposits and daily charges, which has been accepted by the ACFA, reports confidence that these reforms will generate increased income to the industry. However there is still a degree of uncertainty in the mix of payment methods consumers will choose between RADs and DAPs and a mixture of both and the impacts that this will have on some providers, particularly small and rural and regions providers.

Administrative and allocative efficiency

Administrative efficiency

The PC argued that the (then) current system did not achieve administrative efficiency due to features which were duplicative, excessive and unnecessary and which resulted in high compliance costs. The PC report particularly highlighted concerns about the accreditation and quality assurance systems particularly the continual reliance on paper systems for evidence to satisfy accreditation. These quality systems identified good process but not good outcomes, and the regulatory initiatives associated with compliance procedures (police checks, etc.,) were identified as having imposed significant and avoidable regulatory burdens (Productivity Commission 2011, p. 101). As the Commission argued, many compliance tasks 'relate to quantity and price restrictions and over-reaction to specific incidents' (Productivity Commission 2011: p. XLVI) and 'distort the nature of the services provided in ways that do not benefit the clients' (PC 2011 p.127).

The Productivity Commission's *Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services* (2009) found that:

> The regulatory framework is complex and fragmented due to the existence of several programs regulated by numerous government departments across three tiers of government resulting in an unnecessary cost imposition on providers. ... [S]ome existing regulations have shown little concern for minimising compliance costs to providers ... . The extensive increase in regulation in recent years does not reflect the high standards of care [provided] by the vast majority of providers (p. 19).

[11] One limitation of these reports is that the assessment of EBIDTA is based on provider data not on services data which is the basis of the benchmark reports of the other analysts. This has the effect of reduced analysis of performance by location and service, where large providers operate geographically diverse services across both high and low care yet report as one entity.

It argued that 'unnecessary complexity gives rise to avoidable costs for providers and consumers alike' (2009, p. 23) and excessive regulation and the rationing of aged care places prevents providers achieving efficiencies in 'scale and scope' (25 2009); together these two forces create administrative inefficiencies. However, the report provided no estimate of the cost of the regulatory burden. The Commission argued that promoting more competition in any locality would promote better practice (and innovation) and displace less efficient (and less compliant) services, lessening the reliance on regulation to ensure high quality services (2009, p. 25), however it did not produce data to support this assertion.

Overall, there appears to be little concrete data on the cost of the existing compliance system. When, as part of the aged care reform package Regulatory Impact Statement (DoHA 2012), the aged care sector was invited to provide details of estimated costs of compliance to assist the government to accurately gauge the cost of the new measure, no data-supported responses were provided. Deloitte Access Economics (2011a, p. 46) state that compliance costs are one factor in relatively high WACC's in aged care but they do not offer any estimate of the cost impact of over-regulation. They also argue that the move towards CDC across aged care will increase the burden of reporting and compliance (p. 60), however they are of the view that this will be countered by the efficiencies to be gained from more competition across the sector (p.58).

In summary all parties appear to agree that the impact of compliance costs on the financial performance and financial viability of the sector is significant but there is no agreement on the amount. Clearly, the impact of the regulatory burden on viability requires further investigation, if only because it has an impact of perceptions of industry cost regimes and viability, and therefore on investment.

Access and allocative efficiency

One indicator of allocative efficiency of the residential aged care system used by the Productivity Commission is length of time taken to access care for persons who have been assessed as in need of residential aged care by an aged care assessment team (ACAT). Data on elapsed time are illustrated in Figure 1 and Figure 2 below ((SCRGSP (Steering Committee for the Review of Government Service Provision) 2012, p. 13.55). These figures may be one measure of sustainability in the system as they can indicate the comparative tightness of supply. The PC in 2012 concluded that

> 'Overall, 23.0 per cent of all people entering residential high care during 2010-11 did so within 7 days of being approved by an ACAT compared with 25.2 per cent in 2009-10. In 2010-11, 51.0 per cent entered within one month of their ACAT approval and 74.0 per cent entered within 3 months of their approval (figure 13.23), compared with 53.7 per cent and 77.2 per cent respectively in 2009-10 (table 13A.67). The median time for entry into high care residential services was 28 days in 2010-11 compared with 26 days in 2009-10 '(SCRGSP (Steering Committee for the Review of Government Service Provision) 2012, p. 13.55 Table 13A.67).

However, in their Inaugural Report, the ACFA used only median days of waiting between an ACAT assessment and entry into residential care and reported that 'it remains relatively unchanged in high care and is decreasing in low care' (2013, p. 52). This appears to be a less granular interpretation of the data than Figure 1 and Figure 2 below suggest. The trend in these data shows a slight deterioration in the time to access care as the percentage of people accessing care within 7 days, one month and three months has declined – that is a smaller percentage of assessed persons

entered residential aged care within three months. There were also a higher percentage of persons accessing residential care after nine months for both high care and low care.

Figure 1 Elapsed time between ACAT approval and entry into residential care for high care residents 2005-06 –to 2010-11

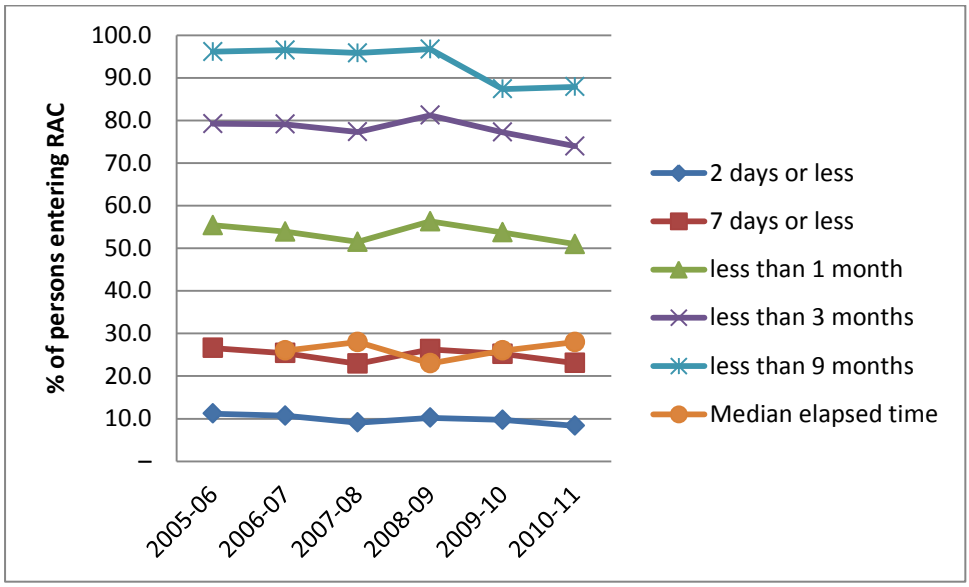
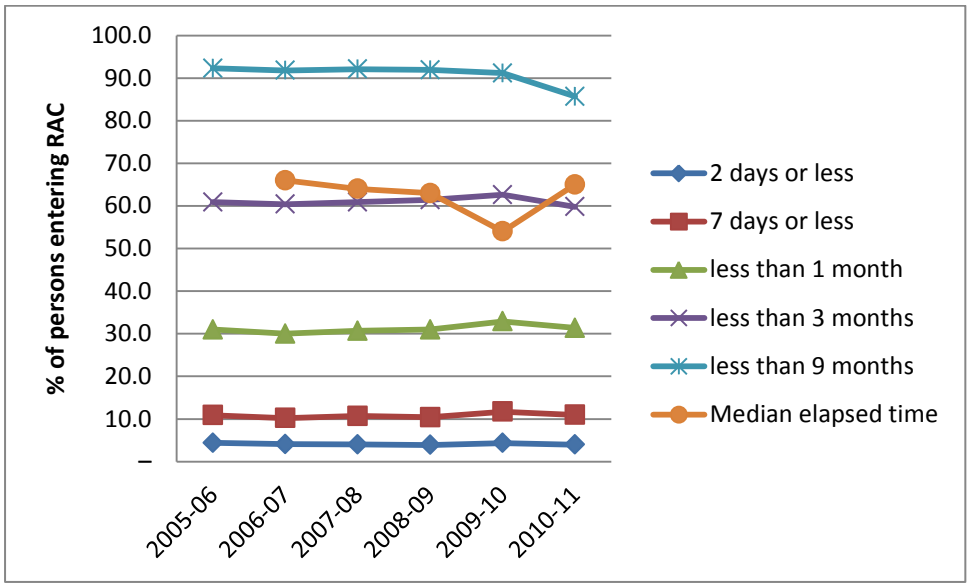


Figure 2 Elapsed time between ACAT approval and entry into residential care for low care residents 2005-06 –to 2010-11

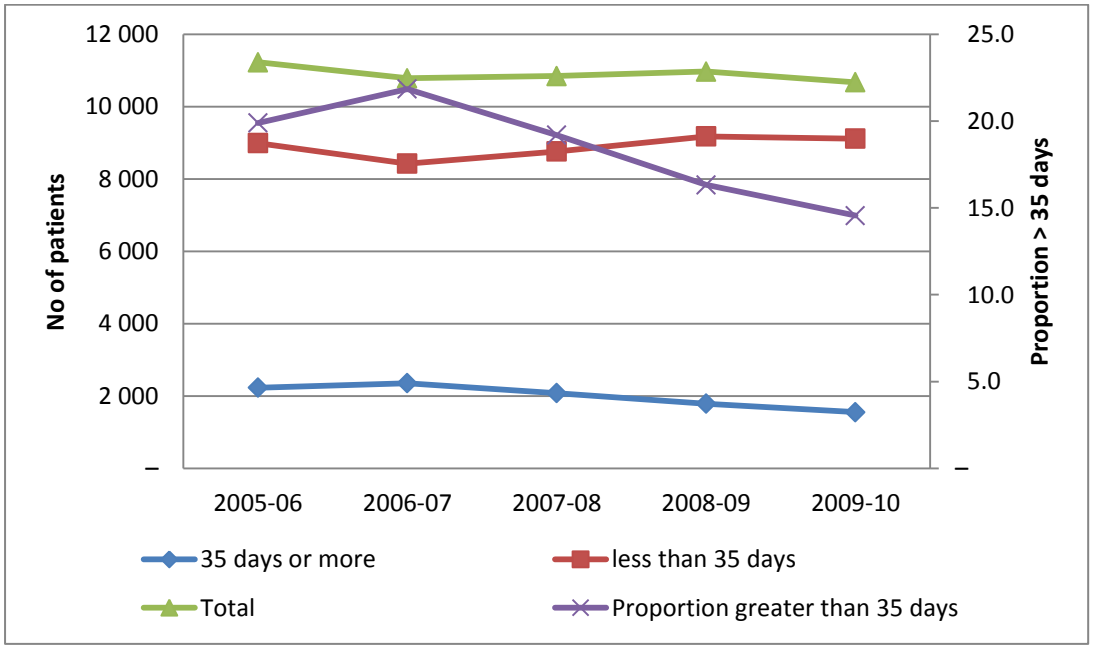


While there may be multiple explanations for this delay in admission to residential care, including the growth in community care places over the same period, one explanation may be a restriction in supply of available beds within the RAC sector. Restriction of supply would be expected to increase occupancy; however, this is not reflected in average bed occupancy. Across Australia bed occupancy has declined steadily over this period (Australian Government Department of Health and Ageing 2012b).

In addition, what these aggregate figures do not indicate is local, regional or jurisdictional variation. As the majority of services are located in major cities or inner regional locations the performance of these services will dominate these statistics. What is needed is a more granular set of indicators to illustrate differences in performance by location and type of provider.

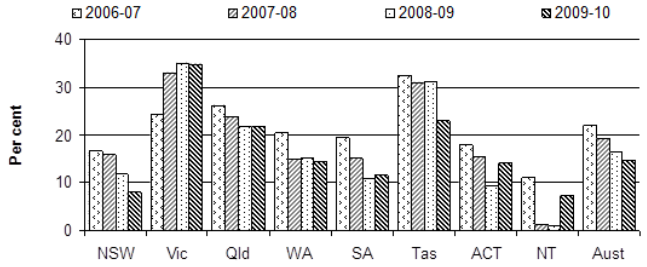
Another indicator of access to care used by the Productivity Commission is the waiting time for hospital patients classified as 'aged care type' whose length of stay was greater than 35 days. In contrast to the data above, the proportion of all patients classified as maintenance and whose length of stay is more than 35 days has declined over the period 2005 to 2010 (SCRGSP (Steering Committee for the Review of Government Service Provision) 2012). This suggests that access to RAC for person in acute hospitals has improved over the five years to 2010.

Figure 3 Public hospital separations for care type "maintenance" for people aged 70 years and over and Indigenous people aged 50-69 2005-06 to 2009-10



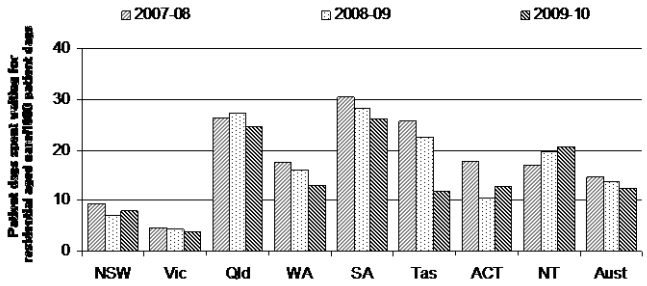
There is variability between jurisdictions across Australia in the proportion of separations for 'aged care type' patients (those with a length of stay of over 35 days in hospitals) and in the number of bed days used by patients waiting for transfer to a RAC facility. While Victoria had a higher proportion of 'aged care type patients' discharged from hospital the number of days spent in hospital was low in comparison with other states. Conversely, while the proportion of persons in South Australia classified as 'aged care type' patients was close to the national average, the number of bed days spent in hospital by patients waiting for transfer to a RAC facility was much higher than the national average. These variances are detailed in Figure 4 and Figure 5.

Figure 4 Proportion of separations for 'aged care type' public hospitals patients that were 35 days or longer



Source (SCRGSP (Steering Committee for the Review of Government Service Provision) 2012 Figure 13.26)

Figure 5 Hospital patient days used by patients waiting for residential aged care



Source: (SCRGSP (Steering Committee for the Review of Government Service Provision) 2012 Figure 13.27)

System sustainability requires each of the different components of the system of care for the aged to be efficient and effective in working together. There appears to be differences across the states and territories in access to residential aged care.

Issues related to administrative and allocative efficiency

The following issue are suggested from this discussion of administrative and allocative efficiency.

Issue 13 – the cost benefit of regulatory compliance

Based on our current knowledge neither the benefits to residents and clients, nor the financial cost of regulatory compliance is currently known with any certainty. Consequently the impact on efficiency and the viability of the sector is unclear. **What is the real benefits to consumers, what is the real cost to providers, consumers, and what is the cost benefit to the community of the current regulatory and compliance burden on the industry?**

Issue 14 – measuring access to care

In a system of care that relies heavily on funding from taxation there is a reasonable expectation that indicators of access and allocative efficiency will be agreed and measured. **Is there consensus on what is an appropriate wait for access to care and does it serve as a benchmark for the allocative efficiency of the residential aged care system?**

Issue 15 – measure of regional access to care

Current indicators of access to care do not report performance at the regional level. **Should we have publicly reported and agreed measures of access to care on a jurisdictional and regional basis as an indication of local allocation efficiency, and access to care by different categories of providers, rather than rely on aggregated national and jurisdictional analysis?**

Home and community aged care services

Structural changes to home care services

Major structural changes for community and home care services for the aged are being implemented as part of the LLLB suite of reforms which may have a significant bearing on future operational income and expenditure.

These reforms include the following:

- the introduction of new tiers of services to the community care services provided under the Aged Care Act 1997 (CACP, EACH, EACHD etc.,) which are now called the Home Care Packages Program
- a new Commonwealth Home Support Program to commence from 1 July 2015 which will incorporate the existing Commonwealth HACC Program, the National Respite for Carers Program (NRCP), the Day Therapy Centres (DTC) Program, and the Assistance with Care and Housing for the Aged (ACHA) Program
- new levels of interface between the Home Support Program and the Home Care Packages Program; although these are yet to be announced, general guidelines are currently available (Australian Government Department of Health and Ageing 2013c)
- the introduction of consumer directed care (CDC) policies and procedures progressively over the two years to 2015.

The following changes to home care provided under the Aged Care Act 1997 (as amended) came into effect on 1 July 2013:

- there will be four new levels of home care
    1. Basic care package
    2. Low level care package
    3. Intermediate care package
    4. High level care package
- there are five possible supplements
    - an additional 10 percent dementia or veterans supplement for the additional costs associated with eligible care recipients with dementia
    - oxygen supplement
    - homeless supplement
    - enteral feeding supplement
    - viability supplement
- there will be an aged care workforce supplement (subject to conditions yet to be announced by the Australian Government)
- from 1 July 2014 a consumer fee will be charged and the government subsidy for that care recipient will be reduced according to the 'income tested fee payable' (Australian Government Department of Health and Ageing 2013c, p. 55)
- care recipients will need to be assessed by an Aged Care Assessment Team (ACAT) and approved as eligible for RAC but who choose to, and are able to, stay at home

- all new packages must be delivered on a Consumer Directed Care (CDC) basis[12] (Australian Government Department of Health and Ageing 2013c)
    - the approved provider is the fund holder for packages delivered on a CDC basis and administers the funds (taking account of the list of excluded services and items) on behalf of the care recipient and all CDC packages must have an individualised budget (specifying administrative costs, core advisory and case management services, and service and support provision and/or purchasing)
    - the consumer must be provided with a copy of the budget and monthly statements
    - unspent funds can be retained by the provider under defined circumstances
    - consumers can agree with the provider to 'top up' their packages by purchasing additional services
- providers will be allocated a specific number of home care places which will attract subsidies.

Viability of current community care services

In recent years there has been less focus by reviewers on the financial viability of the community aged care sector than on the viability of the residential aged care sector in Australia and consequently there is less data on which to base an assessment of the sustainability of the community aged care sector. The major difference between the sectors, which may explain the lower level of interest in financial viability of community care, is the absence of major (or any) capital cost involved in establishing new community care services as virtually all costs (building equipment and motor vehicles) can be leased and accounted for as operational costs. The question of viability and long-term sector sustainability therefore relate almost exclusively to the question of operational costs and most particularly care staff costs.

A summary of the Stewart Brown report on their survey of providers of CACPs, EACH and EACHD services for the December quarter 2012 is provided in

Table 11. This survey consisted of responses from 363 community care providers which collectively operated 11,215 community aged care places. They reported that the average EBITDA per annum for each package CACP package was $962 or 5.2% of income, for EACH, $18.80 or 14.2% of income, and for EACHD $24.97 or 17.7% of income. These EBITDA, in dollars, for EACH and EACHD compare favourably with the EBITDA for residential care despite the absence of investment in capital and on a percentage basis suggest a higher rate of return on income than residential care (about 3.8% for residential care).

Table 11 Stewart Brown survey of providers of CACP – selected results December 2012

	Six months to December 2012	Top Quartile performers six months to December 2012	Twelve months to June 2012

[12] CDC will involve the care recipient (or carer/guardian) identifying the goals they seek from care, signing a Home Care Agreement and agreeing a care plan, and some level of involvement with managing of their care; and care may involve 'innovative ways to meet the consumer's goals and care needs' within the overall value of the package (Australian Government Department of Health and Ageing 2013c, p. 27).

	Six months to December 2012	Top Quartile performers six months to December 2012	Twelve months to June 2012
CACP			
Net operating results	$2.24	$8.39	$2.14
Results as a % of income	5.2%	19.4%	5.09%
EBITDA per annum per package	$962	$3,189	$960
EACH			
Net operating results	$18.80	$42.09	$19.52
Results as a % of income	14.2%	31.6%	14.9%
EBITDA per annum per package	$7,102	$15,580	$7,450
EACHD			
Net operating results	$24.97	$46.45	$23.15
Results as a % of income	17.7%	31.9%	16.44%
EBITDA per annum per package	$9,316	$17,065	$8,763

While the result, for the average provider of CACPs, was favourable ($2.24) for the December 2012 quarter, Stewart Brown (2013) reports that the average results per day in the June 2006 quarter were almost $4.00 a day. They report that while there are fluctuations from one quarter to another there is a general downward trend in operational performance over the past six years for CACPs. Conversely, this report indicates that the financial performance, on average for EACH and EACHD has shown an increase in the six years to 2012; EACH from about $11.00 per client day to nearly $20.00 per client day, and EACHD from approximately $17.00 a day to nearly $25.00 a day.

Of course it is important to consider these programs in context both in terms of the size of the programs and the size of the services. At 30 June 2012 there were 46,588 CACPs, 8,520 EACH and 4,192 EACHD operational places across Australia compared with 184,570 operational residential places (Australian Government Department of Health and Ageing 2012b). Community care packages are provided by approximately 2,040 services[13] across Australia (Australian Institute of Health and Welfare 2012). According to the AIHW (2012) most of the services offering EACH and EACHD packages (78% and 83% respectively) provided between 1 and 20 packages, while of those providing CACP, 43% provided 1–20 packages, 27% 21–40 packages, 13% 41–60 packages, and 4% more than 120 packages. The picture emerges of a sector dominated by providers of small community aged care services where their viability, were they to be provided on a stand-alone basis, would be an important issue. However, while there may be a small number of providers which provide only one type of community aged care service, or provide only community aged care services, the majority of community aged care providers provide more than one type of service; that is, more than one community service (HACC and community aged care) or, as is the case with the majority of

[13] The Australian Government Department of Health and Ageing counts a separate service where a provider receives funding for a category of aged care. Consequently one provider may receive funding for more than one service.

community aged care providers, provide residential aged care and community aged care services (Baldwin 2013). This raises the question of the financial viability of these services were they to stand alone and the extent to which there is cross subsidisation of different services provided by the same operator.

Impact of the Aged Care Workforce Supplement

In the December quarter of 2012 Stewart Brown report that expenditure on salaries and wages of care staff in community aged care services is 68% of all costs for CACP 63% for EACH and 62% for EACHD. Some submissions to the PC enquiry argued that the increase in staffing costs were not matched by indexation to the subsidies (Productivity Commission 2011, p. 126). Details of the changes to the Workforce Supplement package introduced by the previous Australian Government have been foreshadowed by the current Government but the details of these are not available at the time this paper was prepared and consequently their impact is uncertain.

Impact of CDC on the viability of community aged care providers

The (draft) guidelines for the operation of CDC packages limit the use of the funds by consumers and community aged care providers (Australian Government Department of Health and Ageing 2013c) and place certain obligations on service providers.

In summary, the consumer is limited to choosing services that are within the scope of the Home Care Packages Program and providers can refuse to purchase services that:

- have not been shown to be effective, are ineffective or potentially harmful, where there have been previous difficulties or negative experiences or will result in a consumer going without necessary clinical services
- may cause the provider to fail to comply with its legal responsibilities
- are outside the provider's preferred list of service providers and it is not possible to agree a contract or the cost of the service/item is beyond the scope of the available funds.

There are a number of obligations places on community aged care providers in relation to CDC. These include the following:

- All CDC packages must have an individualised budget identifying
    - the full amount of the government subsidy for the package level;
    - all funding from relevant government supplements[14], eg Dementia, Veterans', Oxygen and Enteral Feeding Supplements (where applicable); and
    - any consumer contribution/fee
    - any small "contingency"
- The expenditure plan in the budget should include:
    - administrative costs;
    - core advisory and care management services; and
    - service and support provision and/or purchasing
- the consumer must be provided with a monthly statement of income and expenditure in a format that is consistent with the individualised budget, that enables the consumer to understand and which shows where funds have been expended and the balance of funds

[14] Funding paid to the approved provider through the Aged Care Workforce and Viability Supplements (if applicable) does not have to be included in the individualised budget.

- the provider should arrange for the individualised budget, plan and regular statements to be made available to the consumer in a language other than English if necessary
- unspent funds
    - stay with a consumer moving to a new package with the same providers
    - can be retained if the consumer moves to a different approved provider
    - can be retained where the consumer is deceased
    - should be used to support service delivery for other consumers, or for infrastructure purposes.

These new policy and procedural arrangements for CDC also appear to reduce the flexibility previously available to community aged care providers to accumulate the subsidies for all community aged care clients into a single account from which assessed care is paid; that is, using pooled income to enable cross subsidisation between clients generating the same income but where some (at a point in time) have fewer needs and others have more needs. There also could be significant limitations placed on the use of accumulated income from community care for cross subsidisation of other services – eg one type of community care service to another, between community and residential care, between services operated by the same provider but in different locations etc..

A number of issues related to cost and viability have been reported in the international literature and that may arise with the introduction of CDC

- increased administrative costs due to the increased need for budgeting, reporting, invoicing, upgrading IT systems and transacting brokered services thereby placing a large burden on small providers
- care recipients were more likely to use direct payments to request additional services (such as cleaning, short notice care, gardening etc.,) which may allow providers to expand the type of services they offer
- providers face greater competition from self-employed carers but did not face a high level of competition from other providers (Baxter et al. 2008; Stevens et al. 2011; Wilberforce et al. 2011).

Additional issues have been identified by Deloitte Access Economics (2011a, p. 59)

- assistance required by those consumers and carers who face difficulties in managing a care budget
- administrative time associated with those consumers or carers who may wish to choose inappropriate care and care with little or poor health outcomes
- there may be excessive pricing of CDC services in a region that has little competition and barriers to entry, for example in rural or remote areas.

Issues related to home and community aged care services

The following issues arise from the discussion of the viability and sustainability of the home and community aged care services and the potential impact of the current reforms.

Issue 16 – cross subsidisation of community and home care services

The complex mix of community and home care services suggests that many have a high level of support from governing bodies and related services. **Should we require community aged care services to be financially viable as stand-alone services or is it a reasonable expectation that they will always require cross subsidisation by the provider from resources (buildings, equipment, management and systems) and assets that are funded by other services (residential aged care, HACC etc.)**

Issue 17 – impact of CDC financial viability of home and community care services

There is the potential that the implementation of CDC will change the level of cross subsidisation within services and between services because of the requirement to quarantine funding to individual clients. There appear to also be an increased administrative cost generated by the creation of individual budgets and regular individual financial reports.

What level of cross subsidisation is acceptable or desirable from both a financial viability and a community viability viewpoint – will cross subsidisation be possible with CDC?

What is the impact of CDC on the financial viability of community aged care services through the increased administrative and transaction costs and through the limits on cross subsidisation?

Goals and objectives of a viable and sustainable aged care system

Goals of the aged care program

These goals of the Australian Government in establishing the Aged Care Program are contained in the Aged Care Act and are, inter alia;

- to promote high quality care and accommodation,
- to protect the health and well-being of recipients of care,
- to target those most in need,
- to facilitate access to care, to meet the needs of recipients of care, to facilitate independence and choice, and
- to have due regard to limited resources (*Aged Care Act 1997*, p. 3).

Two years after introducing the Act the Australian Government commissioned a review and specified that the review examine the goals of the Act, naming them as;

- access and equity of access to groups and in different locations;
- affordability;
- quality, having regard to (inter alia) user rights;
- efficiency; and
- industry viability (Gray 2001).

In his review of pricing arrangements in RAC in Australia, Hogan (2004, p. 9) argues that the Australian government follows four goals in relation to RAC namely:

- quality,
- equity,
- efficiency and
- sustainability.

The Productivity Commission (2011), as part of its review of aged care policy in Australia, argued that government subsidies should;

- promote independence and wellness among the aged;
- ensure access to services for those who need them;
- provide consumers with choice and control;
- treat consumers with dignity and respect;
- be affordable for individuals and society and;
- provide incentives to ensure the efficient use of resources (Productivity Commission 2011, p. 71).

These attributes were supported by a number of submissions from stakeholders to the Commission (Productivity Commission 2011, p. 73).

It is interesting to note that only Gray and Hogan specifically mention viability and sustainability as specific goals of the system, although it could be argued that only viable operations in a sustainable

industry can achieve the other goals. Consequently it is worth developing a specific set of goals that could be pursued by the industry in seeking to achieve business viability and sector sustainability.

Possible goals for viability and sustainability in the aged care sector

Possible goals to achieve a sustainable sector will need to retain notions of efficiency, equity of access and quality as these concepts underpin the Australian aged care system and retain strong community support. Consequently, government financing and funding policy should aim to achieve the following goals in relation to aged care:

- an efficient sector which achieves;
    - allocative efficiency where there are **no major distortions to the distribution of services** (*that is, where some groups enjoy potential oversupply while others have a deficiency of services, e.g., between rich and poor communities, between major cities and smaller communities, majority and special needs groups, etc.)* and where there is **reasonable choice** between different individual operators and organisational types
    - technical efficiency **by maximising outputs and outcomes** in relation to inputs
    - administrative efficiency by the **minimising of costs and barriers to operations** through excessive regulation
    - the adoption of **quality care practices and appropriate technology** that will lead to better care and efficiency
- a socially viable sector where
    - the **mix and quality of service** is acceptable to the community
    - the balance **between quality and cost**, and between government funding and consumer co-payment is acceptable to the community
    - there is an **integrated and stable mix** of acute, community and residential care
- a sustainable sector achieved through a funding and financing model that
    - allows service providers to generate **sufficient surpluses** and profits to maintain their viability and continuing operations
    - **encourages continuous investment** for long term sector sustainability.

Assessment of the current systems against these goals

The following table assesses the current system against these goals based on the material provided in the section above on the current issues. In the column headed 'current performance' cells couloured 'amber' suggest this is partially achieved, 'red' not achieved and 'green' achieved under the current system.

Table 12 Assessment of the current system against the goals of the system

Goal	Current performance	Comments
No major distortions to the distribution of services and where there is reasonable choice		Variations in the financial performance of services based on service location and sizes threatens achievement of this goal
Reasonable choice between different individual operators and organisational types		Choice between operators and organisational types may be limited in rural and remote locations
Technical efficiency by maximising outputs and outcomes in relation to inputs		Past studies have suggested there is the capacity for efficiency improvements to increase viability and sustainability
Administrative efficiency by the minimising of costs and barriers to operations through excessive regulation		There is some evidence that excessive regulation is a burden on the financial performance of current operators
The adoption of quality care practices and appropriate technology that will lead to better care and efficiency		There may be a relationship between financial viability and investment in appropriate technology.
The mix and quality of service is acceptable to the community		The mix of services is currently regulated by government planning and community acceptance is poorly measured
The balance between quality and cost, and between government and consumer payment is acceptable to the community		There is a need to closely evaluate the impact on consumers of the future charges for accommodation in residential care and co-payments for community care
An integrated and stable mix of acute, community and residential care.		There is some evidence of a deterioration in the interface between acute care services and residential care measured by time to access care [and management stays in hospital beyond 35 days] There is evidence of great inefficiencies in the management of the interface between acute care and residential/ community care
Allows service providers to generate sufficient surpluses and profits to maintain their viability		There are conflicting reports on the viability of current operation; some providers appear to be producing large surpluses and other do not appear to be viable in the short time. There may need to be investment in better leadership and management to achieve gains here.
Encourage continuous investment for long term sector sustainability		Depending on the consumer preference for the DAP and the RAD the changes to the funding for accommodation may achieve long term sustainability for some sections of the industry only.

What options are available to achieve a viable and sustainable system?

The following options are suggested to address the issues raised in this report.

Option 1: Establish acceptable benchmarks to measure viability and sustainability

There are varying assessments of performance of viability and sustainability used by government and non-government analysts and stakeholders. In the absence of agreed benchmarks on what is acceptable minimum performance, different conclusions can be arrived at by different analysts from assessment of the same data. While it is unrealistic to anticipate that all stakeholders will agree on the same acceptable level of performance, an improvement to the current system may emerge from a consensus within the industry on the range of measures that most clearly indicate performance. For example, the dominant current financial metric used by most stakeholders is EBITDA rather than a metric such as NPBT. EBITDA does not include the depreciation of new facilities as they get old. As the sector consolidates and moves to a model based on creating and refurbishing facilities to cater for consumer demand rather than government grant availability, it will be increasingly important to properly account for the cost of replacing new for old.

This option would involve an exercise to gain consensus on the range of indicators and the levels of those indicator that would measure minimum desirable or minimum acceptable performance of financial viability and sustainability. The agreed indicators may result in an increase in the supply of data by providers and this may add to their regulatory burden and costs. There would need to be separate indicators for the residential aged care sector and the home and community aged care sector. For some indicators it may be agreed that different minimum desirable or acceptable levels could apply depending on some factors such as location or organisational type.

Issues addressed by this option: Issue 1, Issue 2, Issue 3, Issue 10, Issue 11

Option 2: Create a publicly available, de-identified, universal, national data set to enable assessments of quality and financial performance

Reports on financial viability and sector sustainability in recent years have not only used different indicators and methods of assessing them but they have also based their calculations on different data bases. What is needed is a single national database that collects a range of data on resources, financial performance, quality indicators from all publicly funded residential, home and community aged care services and, in turn, makes the data publicly available.

Issues addressed by this Option: Issue 4, Issue 5, Issue 6, Issue 7, Issue 8, Issue 10, Issue 12, Issue 13, Issue 14, Issue 15, Issue 16

Option 3: Encourage early assessment of the impacts of the LLLB reforms

The ACFA and others have suggested a number of actions to monitor and analyse the impacts of the LLLB reforms. These actions should include the following:

- assess the impact of the reforms on the viability of different classes of providers and across the sector
- monitor the mix levels and values of DAPs, the value of RADs, the shifts between the RADs and DAPs and the range of arrangement made where a combination of payments between RADs and DAPs are agreed to determine the impact that these arrangements have on the viability of services and the sustainability of the sector
- monitoring the impact of the accommodation charges on RRR services and the adequacy of the viability supplement to enable these services to remain viable
- monitoring the impact of the introduction of CDC on the capacity of service to cross subsidise across clients, locations, programs and services
- monitor the impact on quality of service of the 'opt in/opt out' services to be offered to residents
- assessing the impact of price signals on demand for both residential and home and community aged care and the impact of changes to accommodation payments on access to care
- monitoring the impact of the reforms on the workforce

Issues addressed by this Option: Issue 1, Issue 6, Issue 8, Issue 9, Issue 10, Issue 13, Issue 14, Issue 16, Issue 17

Option 4: Determine the reasons for the variability in financial performance across similar and non- similar providers.

A consistent finding from varying reports over time has been the variability in financial performance as measured by EBITDA(R), profitability, return on investments as well as other indicators. Considering the relative consistency across providers and services of the nature of the residents, the controls on pricing and subsidies, and the cost of labour, the large variability is unexpected and unexplained. While there is some indication that provider type, size and location may have some influence on performance these factors fail to explain all variations. What is needed is an assessment as to whether the large variability in performance is associated with quality of care, pricing and income, management performance or some external factors. Most importantly, there is a need to investigate if the variables that contribute to the performance of the top quartile operators can be adopted by the lowest performing quartile.

Issues addressed with this Option: Issue 4, Issue 5, Issue 6, Issue 8, issue 13,

Option 5: Improve efficiency in operations

There are a number of areas where greater efficiency may be achieved through the adoption of improved business processes and structural changes. These areas include

- greater use of information technology across a range of care and business processes in aged care services
- better interface with the primary and acute care sectors including relations with Medicare Locals, hospitals transfers and the use of nurse practitioners
- encouragement of vertical integration between home and community aged care providers and residential aged care providers especially of small stand-alone services
- providing incentives for better investment in leadership at all levels within the sector with a particular focus on middle and senior management and clinical leadership.

Issues addressed with this option: Issue 5, Issue 6, Issue 8, Issue 13, Issue 16, Issue 17

Option 6: Investigate mechanisms to improve and sustain the viability of services in outer regional, remote and very remote services

A number of the recent reforms announced as part of the LLLB may not be as beneficial to services in RRR as they are to metropolitan and inner regional services. The lower net wealth of non-metropolitan residents limits the amount that providers can charge for both RADs and DAPs. Smaller communities also mean that some RRR services will carry unoccupied beds for longer and have higher difficulty in recruiting staff than services in more populated areas. Options that could be investigated to improve the viability of small RRR services include:

- an assessment of the actual costs of providing care in RRR locations and base the level of viability supplements on actual costs
- the possibility of a subsidy to facilities in lower socioeconomic and remote communities in addition to the existing viability supplements to meet the difference between the accommodation payments that are possible in metropolitan regions and those in RRR locations
- investigate the possibility of structural changes to services in RRR such as consolidation of providers, contracting out management to experienced providers, expansion of the MPS model in rural and remote locations
- basing the supplements for RRR services on a model similar to that used by DEEWR model of funding lower socioeconomic communities
    - provide some block funding for some facilities in defined locations or providing services to defined groups
- provide incentives to RRR providers to improve efficiency and viability through the adoption of new systems and practices e.g. IT,

Issues addressed with this option: Issue 4, Issue 5, Issue 6, Issue 7, Issue 8, Issue 9, Issue 11, and Issue 18.

Appendix 1

Table 13 Summary of major recent and significant reports on the viability of the residential aged care industry (Chronological order)

Author, name of report and year	Intent of the report	Method and sample etc.	Summary of findings/ recommendations

(Hogan 2004) *Review of pricing arrangements in residential aged care*	To
	• examine the longer term prospects for RAC services with respect to future arrangements for private and public funding, performance improvement in the industry and longer term financing
	• recommend ways to bring more capital investment, more operating income and more places into the system
	• examine how to develop a largely deregulated, market-oriented,
		The review
		• collected and analysed financial data from providers of RAC
		• conducted extensive consultations with government, providers and consumers
		• commissioned economic modelling of industry productivity and efficiency, structural and regulatory matters including disincentives, the role of markets in aged care and expectations about future demand and supply
		• considered the legislative and administrative
			Findings
			• Four principles should drive reform: quality, equity, efficiency and 'sustainability'. [15]
			• Nationally, (based on 2002 data) only 71% of 'services' had a 'positive' EBITDA, with the average 4th quartile provider reporting negative returns.
			• Modelling revealed significant level of 'technical inefficiency' with 'scope for a reduction of 17% in input usage while maintaining the same output levels.'
			• Inefficiency was concentrated in:
			  ○ the NFP sector (although Hogan emphasised that 'efficiency' did not necessarily equate with 'best practice)
			  ○ rurality and remoteness due to higher labour costs and government policy commitments to equity
			  ○ higher amenity
			  ○ more beds per room, due to older age of such facilities
			  ○ high respite provision
			  ○ CALD and Indigenous focused services
			  ○ low proportion of concessional residents.
			• 'scale inefficiency' (services too small for optimal efficiency) produced scope for a further reduction of 7% in input usage while maintaining the same output levels.
			• the development of a mature deregulated market-appropriate price signals would be more responsive and produce savings for consumers, providers and governments.
			• A WACC of 10.9% post tax and 10.0% pre-tax would attract investment into RAC
			Recommendations
			• bond debts to be guaranteed by government through an industry funded levy (to an amount determined by actuarial advice),
			• increased Viability Supplement (based on the inability of R&R services to capitalise through bonds)
			• isolate 'accommodation stream' income [capital funds] from operational income, choice at all

[1515] 'Sustainability is used throughout Hogan's Review. The word 'viability' does not appear.

Author, name of report and year	Intent of the report	Method and sample etc.	Summary of findings/ recommendations
	'mature industry' in which the primary relationship is between well informed consumers and providers (rather than between government and providers) • protect the interests of consumers without market power by ensuring that government retained oversight over quality of care, and equity of access.	frameworks surrounding aged care, and potential funding options for residential and community care.	entry levels for all non-concessional incoming permanent residents between a fully refundable, no retentions bond or a daily accommodation charge calculated to match returns on bonds, • scrapping of the 40% concessional resident rate, with one concessional accommodation supplement payment rate for all concessional residents • that the existing pensioner rental assistance payment (accessed by those receiving care at home) be substituted for the 'pensioner supplement', thus enabling the government's contribution to an accommodation payment to be uniform and transferable between at-home care and residential care. • a 'contracting agency to act on behalf of government' to 'secure the most effective prices and arrangements (including minimum and maximums bonds) based on benchmarking against the most efficient providers 'so as to secure gains from productivity to benefit taxpayers and residents'. • the consumer to be 'granted' an authority/voucher to spend an agreed amount (with assistance of case managers/agents if required, and assuming a high level of information and a duty of care) 'on care and accommodation' through the provider of their choice, • the Government should consider an auction system for place allocations
(Australian Government Department of Health and Ageing 2010) *Technical Paper on costs, revenue and productivity trends in residential care, prepared to assist the PC Inquiry 'Caring for*	This paper assessed data on recent cost and revenue growth trends in the residential care sector in unit price terms, taking account of productivity gains made by efficient	The analysis was based on labour cost indices, non-labour cost indices, unit cost indices and revenue components to track typical trends in residential care costs and revenues.	This paper challenged the industry's claims that provider returns have fallen in recent years. It indicates that, to 2010, aged care revenue in all but low care had outstripped rises in aged care costs since the introduction of ACFI, due largely to significant improvements in labour productivity (based primarily on competency inflation (nurse to PCs).

Author, name of report and year	Intent of the report	Method and sample etc.	Summary of findings/ recommendations
Older Australians'	providers, to determine the relative rates of growth of costs and revenue over recent years.		
(Productivity Commission 2011) *Caring for Older Australians, Report No. 53, Final Inquiry Report*,	This Overview report does not comment on provider viability beyond the above statement.	Based on submissions from providers, consumers, unions and others, the Commission considered viability issues for providers only in a systemic framework: in relation to price constraint mechanisms, difficulties in obtaining finance to build new beds, and financial inequities between home and residential care (p.xxi).	The commission advocated the 'opening up of supply' through the removal of supply-side limits' on residential beds and community care services, while maintaining quality standards and provider accreditation (p.xxix) and retaining supported care ratios across regions (p.xxxvii). The distinction between high and low care would be removed. 'The price paid to providers for care services (by way of user co-contributions and public subsidies) should be set by the government at a level which meets the cost of efficiently delivering approved aged care services' (p.xxxiv-xxxv) taking account of 'a reasonable return on equity to maintain and build new facilities' (p.xxxv-xxxvi). Market forces will ensure that 'the price of accommodation would be reflective of its value, rather than of the wealth of the consumer' (p.xxxvi), and enable competing providers to offer a range of accommodation, 'from a basic standard to very high quality' (p.xxxvi). Commented on systemic costings, rather than individual provider sustainability/viability and noted (after Hogan 2004) that 'aged care providers could be around 17 per cent more efficient if they were to operate at the most efficient level (recognising that it is not possible to have all services operating at this level)' and that 'costs could be reduced by a further 7 per cent by making structural adjustments that improved the scale efficiency of the sector' (v.1, ch 6, p.7-8).
(Deloitte Access Economics 2011a) *The viability of residential aged care providers and the potential impact from Productivity Commission recommendations on changes to the aged care system*	to analyse whether the changes to residential aged care funding and regulation recommended by the PC will provide a sustainable financial base for the industry into the future (p.i).	They used public data sources of data, a survey of providers, interviews with providers, financial institutions. Their sustainability/ viability modelling was based on the income streams available to providers and costs	• A brief discussion about the viability of at-home care under the PC future was general and inconclusive. The report called for the inclusion of all cost factors (including land and the cost of capital) when linking income streams to 'the cost of supply' lest income streams go into negative spiral. • Under the current arrangements high care services have a lower rate of return than the WACC on all possible building life spans (20, 25 and 30 years) and low care facilities had a slightly higher rate of return but were only viable on a 30 year building life span. • They asserted that the PC recommendations would increase average bond amounts, causing a decline in bond numbers, and lead to a predominant 'cash flow model' of operation across residential care (p.iv), resulting in higher cost of commercial capital (p.iv). • Using the PC recommendations (removal of distinction between high and low care, removal of

Author, name of report and year	Intent of the report	Method and sample etc.	Summary of findings/ recommendations
	'The industry [is] defined as sustainable or financially viable if it [is] able to attract new capital' (sufficient to meet future demand)(p.29).	benchmarking under the PC proposed changes (p.i). Various sensitivity analyses were applied. The principal benchmark matrix was the average cost per day of providing accommodation for low and high care supported residents [assuming separate income streams for each] based on the initial PC '2-bed room with shared bathroom' standard, with regional cost variations and taking account of different FP and NFP tax regimes (using a Capital Asset Pricing Model-Weighted Average Cost of Capital [CAPM-WACC] model) (p.i).	bond retentions in low care) a breakeven daily accommodation charge of between $61.37 and $94.35 based on the estimated WACC (see tables below for more details) • they recommended that vulnerable residential care providers be buffered by transition arrangements over 10-15 years, to prevent 'cataclysmic' disruption to the system: ○ grandfathering arrangements with highly bond-dependent low care providers ○ reduced supported accommodation quotas for smaller providers (p.vi)
A banker's view of the aged care reform (Gates & Grayson 2012)	ANZ Banker Richard Gates identified positives and negatives in the	Gates' based the conference presentation on ANZ analysis of the	He predicted an expansion of 8,000-10,000 beds a year and maintenance and refurbishment of existing beds with an annual investment into the industry of $2.0b annually, and $5b 'revolving investment'.[16] Increased income streams as a result of the reforms will include: • additional $20/day accommodation supplement for provision in new or substantially

[16] 'Revolving investment' defined by J.M Keynes as 'a revolving fund of a more or less constant amount, one entrepreneur having his finance replenished for the purpose of a projected investment as another exhausts his on paying for his completed investment' enabling a sustained level of economic activity supported by a constant stock of money'.

Author, name of report and year	Intent of the report	Method and sample etc.	Summary of findings/ recommendations
	reforms in relation to viability, as at September 2012.	proposed reforms under LLLB.	refurbished facilities from 1/7/2014; • retention of bed licenses combined with reduction of residential care allocation to 80 places per 1000 persons over 70 years per region and removal of low/high care distinction should raise demand for available beds and improve occupancy rates in medium term; • DoHA's estimate of a 50% increase in bonds (or equivalent periodic payments) for accommodation for new incoming High Care residents, • legitimate optimising of ACFI claiming - at September 2012 Gates noted a trend of 'for profit' providers to 'more efficiently optimise ACFI claiming' than NFPs, resulting in 'a significant uplift in Government revenue per bed', as a result of which providers 'were able to invest in additional staffing and invest in infrastructure'. He particularly emphasised the need for providers to develop improved financial management and transparent capital expansion planning to entice investors. He noted that • with real ACFI growth limited to 2.7% pa., and an 'average revenue loss' (COPO deferral + ACFI revalidation) of 4.2%, the 'capital strike' continued as of late 2012 with $3.5b of projects on hold. • The estimated 50% increase in bonds is countered by loss of bond retentions (average $3,800 pa) and need to insure every new bond (at a rate of 1% of bond value ($2,000 pa) Removal of the 25% 'clawback' of Extra Service fee; • Concern that bond values will be reduced below current levels. He recommended that: • ACFA required approval of bond values should be limited to those exceeding around 75% of LGA average house price in a region, and for relatively high periodic payments (relative to incomes that could be earned from retained real estate) to protect lump sum bonds. • Close management and documentation of liquidity by providers during the transition period, and the separate reporting of different income/cost streams and cost centres, and with EBITDAR 'to be restated to recurrent cash flow'.17 • transparent capital expenditure forward planning for potential investors, including analysis of impact of reforms on individual businesses. He concluded that while the transition stage will be tough, that 'excellence in management will

[17] To a lay person, the variation in these financial definitions and methodologies is astounding: Carlyle's 'dismal science' is also an 'inexact science'.

Author, name of report and year	Intent of the report	Method and sample etc.	Summary of findings/ recommendations
			be the key' to positive outcomes in the longer term (beyond 2015-16).
(Ansell, Dovey & Vu 2012) *Australian Cost of Residential Aged Care Research Service Costs in Modern Residential Aged Care Facilities*	The objective of the research was to determine the income and costs (capital + operational) associated with the delivery of RAC services by an efficient operator in a typical, modern operating environment. Data was based on a sample of providers for the FY 2010.	39 facilities constructed during 2000-2007 spread proportionally to reflect the industry The total cost = cost of capital + cost of operational services. Key cost drivers were identified and baselines established against top two quartile cost regimes. Capital charge modelling utilised the aggregated capital cost of new facilities and the provider's WACC; ranging from 10.94% to 12.98%. Data analysis was complemented by consultations with providers and site visits to validate cost components.	The study found that across the sector returns generated by even the most efficient operators of modern facilities are insufficient to justify new investment on normal commercial grounds. This study found that modern single-bed/room facilities are substantially unviable. The result is a disincentive to build new facilities (except for 'extra service environments'). The average EBITDAR for the sample for year ending June 2010 for HC facilities was $6,726 per bed year; for mixed care facilities $4,896 (p.6). The average EDITDAR for top quartile facilities was $12,830 per bed year (p.25). 'To achieve the required rate of return on this level of investment, a target EBITDAR range of $25,225 to $32,204 per bed per annum is required. This target was not achieved by any of the facilities in the survey' (p.7). The average aggregate capital cost (including construction and commission costs, land costs and fit out) was $225,900 per bed at 25 years (p.7). The average personal care cost component for surveyed HC facilities was 3.5% above the efficiency baseline price. For Mixed care facilities the average operational cost was 4.8% above the efficiency baseline price (graph p.27). The report identified an annual investment gap per bed/year of from $16,200 (mixed care/no tax/50% bonds = $44.38/day) to $22,571 (high care taxable = $61.84/day) (p.7 and 32). Mixed care level facilities produced lower EBITDAs, facilities that were part of a group achieved higher returns, the most efficient size of homes was in the 76-100 bed range.
David Kemp, ACSA: Response to ACFA: Advice on Accommodation Payments and Equivalence of Lump Sum and Periodic	This ACSA submission addressed 14 questions relating to industry viability put to the industry by the Aged Care	ACSA conducted a round-table of industry experts, consulted relevant published papers and sought responses to the ACFA questions from	Kemp argued that • current rates of return for efficient providers are reported in the range 3.4% to 6.7% which is well below the 10% -12% rate of return range considered necessary by industry experts to cover the cost of capital and to ensure future investment: 'some suggest 15%' is required [p.4] • that the accommodation supplement (proposed by ACFA in 2012) of $52.84 for supported residents in facilities 'significantly refurbished' after April 2012 would not cover the real cost of accommodation [p.3]

Author, name of report and year	Intent of the report	Method and sample etc.	Summary of findings/ recommendations
Payments (September 2012)	Financing Authority.	providers.	• 'efficiency' is constrained by regulation, location, size, quality of the built form and layout, past decision-making practices, target population, availability of staff; that across the board, Australian aged care is rated as highly efficient [p. 6], hence there is limited scope for productivity gains to be derived from consolidating smaller providers, or from other restructuring (p. 6, after National Health and Hospitals Reform Commission 2009 & PC 2008). • ACSA's view was that efficiency is independent of what should be a reasonable rate of return on capital investment, which should be 12% at a minimum [p.6.] to ensure sustained investment in the residential aged care. • Equivalence between bonds and periodic payments must be established and maintained. ACFA should publish a schedule of equivalences to ensure transparency for consumers, providers and investors. • The price of a room within any facility should be a matter for public access and providers should be able to negotiate prices downward from publicised prices in response to local markets and/or local mission. • Discounted Cash Flow (DCF) was suggested as an appropriate methodology for ensuring that lump sum accommodation payments and periodic payments are financially equivalent for providers. The appropriate discount rate would be pre-tax WACC. A uniform nominal pre-tax WACC should be estimated for the residential aged care sector [p.6.] • Continuation of retention amounts: to offset the loss of interest that would otherwise be earned on a full bond. • the present bond guarantee scheme is an effective low cost form of insurance, commensurate with the actual level of risk associated with bond repayment defaults, and should be retained. • Foregone incomes to providers now accounted in retention amounts and interest on bonds should be accounted for in equivalence calculations [p. 10] • ACFA should give providers some discretion in the rates they set for individual beds, taking account of the cost of land and building, variable room qualities and room-sharing arrangements, the NFP mission of cross-subsidisation of residents who cannot afford full payment, and a reasonable rate of return after costs. • A national, indexed "threshold" of $500,000 should be set, above which an ACFA approval would be required. Below that level no ACFA approval should be required. Residents would still be subject to maximum bond payments based on assets.

Author, name of report and year	Intent of the report	Method and sample etc.	Summary of findings/ recommendations

LASA: Aged Care Accommodation Payments Position paper (September 2012)	The paper stated LASA's position on accommodation payments in response to the Government's 11 questions on accommodation payments.	The paper outlines LASA's general positions rather than making a case for any particular level of accommodation payments or WACC. The Grant Thornton paper listed above was attached to this submission, so we can assume the analysis is based on that paper.	LASA advocates that:
			• Aged care accommodation prices should be referenced to wider residential market prices in the service catchment with material deviation triggering a review from the regulatory authorities (p.4);
			• Alternative funding arrangements will be necessary to encourage investment in new facilities and sustain existing services in in rural and remote locations (p.4)
			• Any move to reduce bond values from current levels would tend to increase provider WACC's and the returns required from operations to achieve viability (p.5)
			• Historically, efficiency analysis has focused on EBITDA which, paradoxically, rates older, high density aged care facilities with multi bed wards as the most efficient operating environments.
			• Modern, single ensuited rooms are naturally more costly to operate and tend to produce the lowest financial returns.
			• Efficient prices should be based on a 'market based accommodation payment model' (p.7) and should reflect the resources necessarily consumed to deliver high quality and culturally appropriate services to defined user groups in modern, contemporary accommodation.
			• Prices should
			  • take account of the inherent limitations associated with regional and remote locations, scale limitations, resident support needs and other impediments to optimal service efficiency, and support relevant providers with block funding models;
			  • take account of the resources required to avoid unnecessary hospital transfers; and
			  • the adequacy of viability supplements must be reviewed (p.5-6, 9).
			
			Starting with a lump sum is central to financial equivalence for providers. (p.7)
			• Capital and periodic payments must be linked to the quality and form of accommodation provided and this often varies within a facility (p.9).
			• The price of variable accommodation options should respond to market based pricing structures (p.9).
			
			• The application of the WACC is the relevant methodology for ensuring that accommodation payments and periodic charges are financially equivalent for providers (p.7).
			• Risk factors, such as the "cooling off period" (which should be limited to 7 days) should require an increase in the WACC percentage rate (p.7).
			• The retention system must remain until the five year review (p.7).

Author, name of report and year	Intent of the report	Method and sample etc.	Summary of findings/ recommendations
			• LASA rejected the proposed bond insurance scheme (with an indicative cost of insuring bonds in the range of 1% to 3%) arguing instead for continued Government underwriting of bond exposure (p.8). Failing that, LASA calls on Government to develop an industry wide schemes that will minimise premium costs for consumers (p.8). • In the transition to a market responsive pricing system, consumers should be protected from uncompetitive pricing by: • The government setting an accommodation price upper benchmark based on local prices. • bonds at higher than benchmarked levels, should be approved by the regulating authority (p.10). • For rural providers, or in other instances where real estate benchmarks are not relevant, the provision of minimum, cost-based parameters correlated to other [unidentified] funding mechanisms would be required to ensure that returns do not fall below the WACC (p.11). LASA further called for the removal of penalties associated with the 40% concessional ratio (p. 11).
Australian Government Department of Health and Aged Care (2012a)	This is the DoHA's own assessment of the impact both on future national finances and on the forward provision of aged care by the aged care industry, of the proposed reforms. It was released shortly after the release of the final PC report.	The paper provides analysis of the 'global' impacts of the proposed reforms, focusing on national budgetary projections and nation-wide future provision of care issues. Most of the demographic and budgetary data is reiterative, but the 'impact analysis' for both Home Care and residential care (Section 5.2 & 6.2) is of relevance to considerations of	NB: The maximum accommodation charge of $50/day suggested in this internal DoHA RIS of April 2012 is significantly below levels now under discussion. No WACC value is put forward. However, the import of the paper is its clear advice to government that there are real risks to investment in the industry if these levels are set too low, with significant consequences for future national accounts and policy outcomes]. DoHA estimates that: • there was (in 2012) unmet need for 30,000 to 50,000 community care places • declining occupancy levels in residential care since 2002 for low care • demand for high care places and the levels of frailty of new residential entrant is increasing, leading to a higher than predicted increase in ACFI cost of 7% per annum since 2008 • an extra 82,500 places are required over the next decade, entailing an investment of $17b, • the existing 'accommodation payment and [other] funding arrangements' do not provide sufficient incentive for investors and providers to support that level of expansion. • despite the rapid growth of ACFI costs, 'workforce wages have not kept pace with the general increase in provider revenues and profitability' (p.65).

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		industry viability.	The 'Impact Analysis' considered 3 options: • status quo; • PC reform program; • a partially regulated reform program as outlined in DoHA's own submission to the PC. The Department argued that the PC proposals of relaxed supply of community care places there would be a substantial increase in the number of places with potential problems in relation to care quality, governance and financial sustainability to a rapidly expanding sector. the Department proposed: • to retain supply-side restrictions, • to raise the planning ratio from 25 to 45 home care places • a more simplified means testing (• support slower growth than the PC recommended in the number of places enabling providers to better prepare for the expansion of the sector • one-off funding to assist providers with accounting and IT upgrades The overall DoHA preferred option would cost the Government around $426 over five years' partially offset by a reduction in spending on residential care (p 34). For residential care the Department's preferred option was: • a maximum accommodation payment of $50/day (p.42) • accommodation charges/bonds reflecting the cost of accommodation • ACFA will ensure that accommodation bonds and charges will be set at a level to attract investment (p.47) • for accommodation prices to be set after consultation with the industry and with 'independent experts' (p.48).

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Report on the residential aged care sector: Current state and potential impacts from LLLB financial arrangements (KPMG 2013a)	This KPMG backgrounding paper to the ACFA (KPMG) Inaugural Report (30 June 2013) establishes baseline data on the aged care sector and a framework to assess the impact of changes to the financial arrangements under LLLB (p.8). KPMG's 'Scenario Analysis' paper (May 2013) is the third of this set.	This report summarises up-to-date financial data based on 2011-12 General Purpose Financial Reports (GPFRs) returns from providers (DoHA series), and the Report on the Operation of the Aged Care Act 1997 (DoHA 2012) and data projections of the National Health and Hospitals Reform Commission and the ABS (p.71); as such it partially reiterates the other KPMG 2013 reports, but also presents newly modelled results from the series.	KPMG modelling finds that 'growth in operational aged care places seems to be keeping pace with population growth' and changed demand towards high care (p. 12), and that: • Increased price transparency 'may mean that some people pay a DAP when they would have otherwise paid a RAD.' o This 'may reduce the value of new RADs from *low and ES* residents by $402.8 million in 2014-15' (p.11). o However, RADs for High Care will provide HC providers with 'the opportunity to increase their lump sum accommodation payments, by $3.4 billion, resulting in 'increased income and avoided cost of debt from new RADs and DAPs from high care residents' of $93.5 million in 2014-15 (p.11) with further income benefits thereafter (p.12). ▪ Low care providers, small providers, RRR providers, and providers with a high proportion of supported residents will not significantly benefit from these changes (p.12). ▪ KPMG estimate that one-third of potential RADs will shift to DAPs in 2014-15 (p. 46), but this will largely depend on whether the unsold family home can generate rental income sufficient to cover the DAP (p.47). • Removal of retentions may reduce income from *low and ES* residents by $68.4 million in 2014-15 o providers are permitted to increase the price of accommodation (RADs and DAPs) to compensate for this loss of income from reduced RAD balances, including for 'increased cost of debt' (p.11). • Draw downs on RADs effectively 'removes the cap on prescribed retention amounts' (p.11) by allowing incoming residents to give permission for amounts to be drawn down from the lump sum RAD. 'The draw down arrangement [section 52J-7 of the LLLB Bill 2013] allows the provider to be compensated for any loss of income or increased cost of debt from a reduced RAD balance', and 'where residents cannot pay the published RAD' (p.51). • Level 2 pricing threshold for accommodation payments may hold down accommodation prices when the 'value of the room' does not see permission granted by the ACPC to price above that threshold. o Approximately 13.3% of 2011-12 bonds valued at $303.6 million would have exceeded that level (p.48). KPMG did not model the impact as Level 3 guidelines were not finalised, but argues that this may see 'an increased need

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			for commercial debt or equity' (p.11). • Extra Service: [under terms still to be clarified] residents in any part of a residential facility may enter into Extra Service fee agreements. The former 25% 'clawback' on the care subsidy will no longer apply (p.51). • Viability supplements to smaller RRR providers were increased in 2012 (p.52). **Sustainability - the Impact of LLLB reforms on longer term provision and investment in the Sector:** • Net increase in value of new RADs from 2014-15 will support greater investment activity, but this will differ according to individual provider circumstances (p.13) • Overall investment in new residential aged care building stock (which was in significant decline from 2009), has started to increase with new building work *in progress* increasing by 11.6%, upgrading work increasing by 60.3% between 2010-11 and 2011-12, and rebuilding work increasing by 18% since 2009-10 (p.16). o [Figures and the 'traffic light' table at pp.71-74 indicates that while the slump in building extended into *work completed during 2011-12,* the turn-around into growth is evident in the figures for *work in progress at the end of the year 2011-12*: 'Estimated *new building work completed during the year decreased* by 28.7% in the last year alone'; '*rebuilding work completed during the year* ... almost halv[ed] from $184m to $93m over the same period' and *upgrade work completed during the year* ... more than halved from $546 million [in 2007-8] to $255 [in 2011-12].' However, the 'traffic light' Table 7.1 (p. 72) indicates a very recent 'green light' upturn in new building, rebuilding, and upgrading works in progress *at the end of the year* 2011-12. o In monetary terms, in the 12 months to April 2013 total value of aged care building work was $1.2 billion compared to $823 million in the previous year (an increase of 45%) (p.16). **Investment Gap** KPMG averaged investment in new facilities and rebuilding for the five years 2007-8 to 2011-12 inclusive, and obtained an average figure of $997 million/annum. Were that level of investment to be retained each year for the decade 2012-13 to 2021-22, there would be 'a projected investment gap of $15.0 billion across the decade equating to around 80,000 places (p.16): *'If investment in residential care does not change, the demand for residential care has the potential to outstrip supply in the near future' (p.73).*

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Scenario Analysis of Selected LLLB Financial Arrangements. Interim Report (KPMG 2013b)	The purpose of the report is to help inform ACFA develop a response to the Minister for Health and Ageing and the Senate Committee currently considering the Aged Care bills. The focus of the report is on residential care. The model takes into account changes to means testing arrangements whereby the RAD will be included as an assessable asset.	The model assess a resident's decision to choose either a RAD, DAP or a combination of both based on the assumption that the resident will choose the option that maximises wealth. The model was built to estimate impacts on low and extra services care and high care. The results relate to an estimated change in the first year of the new financial arrangements (2014-15). There will be impacts in subsequent years as new people enter residential care and replace current residents. However, owing to data limitations these effects have not been modelled.	Results from the scenario analysis suggest that: • due to changes to the means test for assessable assets there may be an incentive for residents to choose a DAP over a RAD (where the sale of the (exempt) house is required to pay the (exempt) RAD) as an increase in accessible wealth may result in an increase to daily care costs • about 33% of current RAD consumers will switch to a DAP and these will most likely be those with RADs of less than $200,000 • increased pricing transparency may reduce the value of new RADs from low and extra services residents by $402.8 million in 2014-15, with these RADs shifting to DAPs • removal of prescribed retention amounts may reduce income associated with new RADs from low and extra services residents of up to $68.4 million in 2014-15, assuming that providers currently retain the maximum permissible amount from all bonds • the value of new RADs from high care residents is estimated to increase by $3.4 billion in 2014-15 and this estimated increase in incomes is more than enough to offset predicted losses from transfers from RADs to DAPs in low and 'extra service' places (p.13, main p.47) • high care providers 'will be able to increase their income and reduce the cost of debt' (main p. 48) and the reforms will also 'provide greater access to lump sum payments' across the whole service system (main p.47) • there will be a significant increase in persons paying accommodation charges above the maximum government accommodation subsidy of $52.84 (from virtually no one to about 36%. p. 48). Impacts not tested due to limited data; • significant refurbishment issue (who gets and who does not) • the extent to which residents will generate their DAP by drawing downs on their RAD • extra service 'clawback' (the 25% previously cut into care subs, but no longer (p.25), so this is a plus) • extra amenity fees opt in/out (p.11)

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Inaugural Report on the Funding and Financing of the Aged Care Sector (Aged Care Financing Authority 2013)	The purpose of the report is to provide an independent picture of the current state of the aged care industry to serve as a baseline for future analysis, and to offer some initial (predictive) assessment of the possible impacts of the reformed aged care financing arrangements (taking effect on 1 July 2014) on 'sector viability, access to quality care, workforce and sustainability'. The report Aims to identify priorities for future research and key issues for analysis in next 12-24 month timeframe. It focuses mainly on residential care and refers only briefly to the Home Care sector and to the HACC program.	The report is based primarily on KPMG Scenario Analysis of selected LLLB financial arrangements (May 2013) commissioned by ACFA (p.15) and based on General Purpose Financial Reports (GPFRs) covering 99% of residential care places (p.15). The ACFA Inaugural report broadly outlines current state of sector finances (pp. 18-23), before discussing 'Sector Viability' in terms of Net Profit Before Tax (NPBT), EBITDA, and trends in revenue and expenses' against type of ownership, type of care, location and size of provider, sources of finance and investor activity (p.24, table p.25); workforce, sustainability and investment futures.	Recent data from the ABS shows positive signs of increasing investment' across small and large building projects, with 'the total value of building approvals trending upwards since LLLB', with February 2013 having the highest total approvals since 2006 (p. 10, 38). The key features of the LLLB that will impact on sector viability are: • removal of High Care daily payments cap • the introduction of RAD in high care (p.11, 40), • 50%+ increase in accommodation supplements for supported residents in new and significantly refurbished homes (p.11, 40) • impact of changes will vary with business models and financial structures (p.11, 42). In aggregate, the industry will receive: • $3.4 billion increase in RADs in High Care (despite a $403m decrease in LC and Extra Service RADs) • $93m increase in provider income in high care due to removal of price caps • $68m decrease due to loss of retentions, possibly offset by higher payments enabled by combined RAD + DAP arrangements that people may 'choose' to make (p.40). Sector sustainability will require government action on 'those segments of the market which are operating below their cost of capital ... where lenders may not be willing to provide finance to renew obsolete infrastructure' (p.66). 'Efficiency gains' (eg 'technology and adjustments in work practices') will make investment more attractive. 'Funding and financing arrangements [should] encourage efficient providers rather than support inefficient providers' (p.66). Some section of the industry will have to make 'better' use of their strong equity positions; especially the NFP sector and investment performance .and 'the calibre and track record of management teams' will be crucial factors in securing investment (p.68). ACFA predicts positive investment into the industry in general, driven by strong demand for care places and increased funding directed to the industry through the LLLB reforms (p.67), but different segments will be differently attractive to investors.

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