Report on the residential aged care sector

Current state and potential impacts from LLLB financial arrangements

Prepared by KPMG for:

Aged Care Financing Authority (ACFA)

July 2013
Disclaimer

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The findings in this report have been formed on the above basis.

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The branded pdf version of the paper remains the definitive version of this paper.
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Executive Summary

On 20 April 2012 the federal government released the Living Longer Living Better (LLLB) aged care reform package. This was in response to the Productivity Commission’s Caring for Older Australians report, the recognised need by consumers, industry and government to reform the aged care sector, and opportunities to enhance the framework to deliver aged care solutions to a growing market.

The LLLB reforms aim to address recognised challenges in the aged care system. This includes changing selected financial arrangements in order to meet increased needs and changing preferences of an ageing population, and to mitigate financial pressures on providers and the federal government.

The federal government is working with the aged care sector to develop and implement a 10 year plan to address the aged care reforms. The first five years of the program will be dedicated to implementing immediate changes to the aged care system. There will be a major review after five years to assess how the system has changed and adapted, and the ability to make further changes. This staged approach will give time for aged care providers to adjust to the reforms and any new market structure that may be created.

The purpose of this report

KPMG was commissioned by ACFA to develop a report on the impact of aged care financing arrangements on access to quality care, sustainability, industry viability and the aged care workforce. This includes:

- developing a framework to measure and monitor the impact of Living Longer Living Better (LLLB) reforms and other industry developments;
- collecting baseline data on the current state of the aged care sector, in terms of sector viability, access to care, workforce and sustainability; and
- suggesting action items for ACFA to consider on accommodation payments, additional amenity fees for additional services in the context of the pricing policy.

Given that the proposed LLLB financing reforms do not come into effect until July 2014, this report describes the current state of the aged care sector. It also establishes baseline data and a framework to independently and transparently assess the actual and potential impacts of a change to financing arrangements (including the LLLB reforms).

The purpose of this report is to inform ACFA’s development of its first annual report to the Minister for Mental Health and Ageing (the Minister). This report primarily focuses on residential aged care providers as more data is currently available for this sector. It is expected that future ACFA reports will expand the focus on Home Care providers. Overall, however, there is limited data on providers for both residential care and care delivered in the home.

Accompanying modelling report

In addition to this report, KPMG was commissioned by ACFA to model (through scenario analysis) the potential impact of selected Living Longer Living Better (LLLB) financial arrangements on residential aged care providers.

More detail on the Living Longer Living Better reforms can be found at (http://www.livinglongerlivingbetter.gov.au/)
The model tested alternative scenarios associated with selected LLLB financial arrangements expected to impact partially supported and non-supported residents in residential care. Financial arrangements that were evaluated include:

- requiring providers to publish accommodation payment prices and the ability of residents to choose their accommodation payment type 28 days after they have entered a facility; and
- removing the ability of providers to retain prescribed amounts from lump sum accommodation payments; and
- creating consistent accommodation pricing by removing daily accommodation charges and allowing providers to ask residents entering high care to pay either a refundable accommodation deposit (RAD), daily accommodation payment (DAP) or combination of both.

This report refers to modelling results presented in the final modelling report titled Scenario analysis of selected LLLB financial arrangements – Interim report (KPMG 2013), and should be referred to for more detail on the modelling methodology and results.

The residential care sector

In 2011-12 aged care funding was approximately $14.9 billion, with the federal government providing around three quarters of total funding. This accounted for approximately $11.3 billion.

The largest amount of federal government aged care expenditure was associated with residential care. In 2011-12 government expended $8.7 billion on residential aged care compared to $1.1 billion on community care packages. An additional $1.5 billion was spent on the HACC program, including the Commonwealth HACC program and the federal government’s contribution to funding in Victoria and Western Australia.

Residential care providers received approximately $13.1 billion in total revenue in 2011-12 from government, residents and other funding sources. Providers also received funds for capital expenditure from residents (bonds), financial institutions (loans), federal government (zero real interest loans and capital grants), and investors (equity investments).

In 2011-12 there were 1,103 residential aged care providers. Religious, charitable and community-based providers owned 58.2 per cent of operational residential care places. For-profit providers owned 35.9 per cent while the remainder were owned by state and local governments.

There was also large variability in financial characteristics across residential aged care providers. On average for-profit providers had greater earnings before interest, tax, depreciation and amortisation (EBITDA) per resident per annum than not-for-profit and government owned providers. However, they were more reliant on debt, with approximately 14.0 per cent of total finance made up of equity in 2011-12, compared to 43.2 per cent for not-for-profit providers.

Given the variability in financial characteristics, LLLB reforms may impact residential aged care providers differently. The impact on each provider will depend on its capital structure and profitability, its business model and the capacity of the provider to adapt to changes within the sector arising from the reforms.

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2 Non-supported residents have a combination of assessable income and assets at a level where the federal government deems they can afford to pay all of their accommodation costs. Partially supported residents have a combination of assessable income and assets at a level where the federal government deems they can afford to pay part of their accommodation costs. In discussing the impact of selected LLLB financial arrangements on residents, this report refers to the impact on partially supported and non-supported residents in residential care.

3 Of those, 1,054 provided General Purpose Financial Reports (GPFRs).
The LLLB reforms

Given the remit of ACFA and limited data on care provided in the community, this report primarily focuses on the potential impact of LLLB financial arrangements on the residential care sector. These include:

- increased pricing transparency by requiring providers to publish all accommodation prices, and allowing residents 28 days after entering a facility to decide how to pay for their accommodation.
- removing the ability of providers to retain prescribed amounts from accommodation payments;
- establishing an Aged Care Pricing Commissioner and associated Level 1, 2 and 3 accommodation payment price thresholds;
- creating consistent accommodation pricing, thereby allowing providers to offer new non-supported residents, including high care residents, the choice between a refundable accommodation deposit (RAD), daily accommodation payment (DAP), or a combination of both;
- increasing the accommodation supplement for residents with low means (i.e., supported residents) from approximately $32 per day to $52.84 per day for residents living in newly built residential facilities or residential facilities significantly refurbished on or after 20 April 2012; and
- allowing draw downs on RADs where the resident has requested the deduction in writing.

This report has also explored the potential impacts from changes to optional additional services and to Extra Service regulations, and potential impacts of other non-financial LLLB reforms that are expected to impact viability, access to quality care, the workforce, and sector sustainability.

Industry viability

Current viability

Overall, the viability of the residential care sector has improved over recent years. This includes increased earnings and profitability, some improvements in balance sheet items, and increased returns on assets.

There has been strong growth in EBITDA per resident per annum of around 18 per cent per year across all providers between 2006-07 and 2011-12. The proportion of providers with a negative EBITDA in 2011-12 was the same as the previous year at 16 per cent. However, this represents a substantial reduction compared to 2006-07 where it was 22 per cent.

Growth in EBITDA has not been consistent across the sector. Although regional providers have increased their EBITDA per resident per annum, annual growth has only been 14 per cent on average. Overall, low care providers have experienced an average decrease in EBITDA of nine per cent between 2006-07 and 2011-12, although annual growth varied considerably from year to year.

The average bond per resident was $201,182 in 2011-12, having increased at an average rate of 10 per cent per annum since 2008-09. This is lower than the average value of a new bond, which was $252,000 in 2011-12, suggesting that there is further opportunity to increase bond values as current residents with low value bonds are replaced with new residents.

Return on equity has increased in recent times. In 2008-09 the return on equity was 7.0 per cent, while in 2011-12 it was 15.9 per cent. This is a combination of increased EBITDA and increased liabilities associated with lump sum bonds, leading to reduced equity as a proportion of total finance.
Potential impact of LLLB reforms

A number of LLLB reforms are likely to impact provider viability.

- Providing greater pricing transparency and allowing residents to choose their payment method after they have entered care, may mean some people pay a DAP when they would have otherwise paid a RAD. This would have an impact on provider cash flows and access to lump sum accommodation payments.
  - Modelling suggests 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 (KPMG 2013).

- Removing the ability of providers to retain prescribed amounts from accommodation payments may result in reduced income to some providers.
  - Modelling suggests the 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 (KPMG 2013).

- In response, residential aged care providers may increase the price of accommodation to compensate for income not otherwise received. The extent of the increase will be subject to the ability of providers to raise their accommodation price given wealth constraints faced by residents.

- Allowing draw downs on RADs will also enable providers to generate additional income from RADs because it removes the cap on prescribed retention amounts. The draw down arrangements allows providers to be compensated for any lost income (or increased cost of debt) from reduced RAD balances. The extent will depend on the willingness of residents to allow draw downs.

- Introducing a Level 2 pricing threshold for accommodation payments may see a decline in the total value of lump sum payments for providers where accommodation prices do not reflect the value of the room and permission to charge an accommodation price above the Level 2 threshold is not granted. For these providers there may be an increased need for commercial debt or equity. The impacts of the Level 2 pricing threshold on providers were not estimated given pricing guidelines are not finalised.  

- Allowing providers to offer residents entering high care a choice of paying accommodation through a RAD, DAP or a combination of both will provide high care providers with the opportunity to increase their lump sum accommodation payments, increase the associated income, and reduce their cost of debt.
  - Modelling suggests new RADs from high care residents could provide an additional $3.4 billion to providers delivering high care in 2014-15. The associated increased income and avoided cost of debt from new RADs and DAPs from high care residents is estimated to be $93.5 million (KPMG 2013).

- The estimated increase in RADs from high care residents is more than enough to offset the estimated decrease in RADs associated with a switch from RADs to DAPs for low and extra services residents. The results also suggest high care providers may be able to increase their income and reduce their cost of debt by removing the pricing cap currently associated with accommodation charges.

- As more people leave residential care there will be greater opportunity to offer new high care residents a RAD, DAP or combination of both. This is expected to increase the ability of high

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4 Any changes will only affect new residents with charges fixed for existing residents.
care providers to increase their lump sum values, annual income and avoided cost of debt beyond 2014-15 as the current cohort of residents are replaced.

- Although there is estimated to be a net increase in RADs in 2014-15, the impact will vary across the sector. For example, providers delivering low care only, small providers, providers in non-metropolitan areas, and providers with a high proportion of supported residents may not experience the same change in accommodation payments compared to the rest of the sector.
- The potential change in the distribution of accommodation payments will be unique for each provider. It will primarily depend on the accommodation payments currently received, and composition and characteristics of their residents, including the proportion of low care residents, high care residents, and supported residents.

**Actions for consideration**

There are several actions related to provider viability that could be further considered by ACFA in monitoring and evaluating the impacts for financial arrangements on the residential care sector. These include:

- monitoring the implications for viability of the new regulations governing accommodation payments by non-supported residents, in particular the potential shift from RADs to DAPs and the potential increase in RADs from new high care residents;
- monitoring the mix of Level 1, 2 and 3 accommodation payments and applications and approvals provided by the Aged Care Pricing Commissioner;
- determining why there is large variability in financial performance of providers across and within ownership types;
- determining whether the large variability in financial performance is an issue for sustainability, pricing and quality, and whether there is a case for an adjustment package delivered by the federal government to improve the viability of some providers;
- quantifying and monitor the extent of dependence on cross subsidisation, including cross subsidisation of overall care costs from income derived from accommodation payments by self-funded residents, and cross subsidisation of supported residents and residents in low home value regions from high value accommodation payments;
- highlighting the need for more up-to-date data on the financial performance of residential care providers to assist monitoring of the impacts from financial arrangements; and
- analysing potential mechanisms to review the range and extent of opt in opt out services being offered by providers and whether these arrangements have an impact on the quality of services provided.

**Access to quality care**

**Current access to quality care**

Growth in operational aged care places seems to be keeping pace with population growth. The number of operational aged care places per 1,000 people aged 70 years and over increased by six per cent between 2006 and 2011, while the number of residential aged care places has increased by 18,800 over the same period. This partly reflects the decision in 2007 to increase the provision ratio to 113 places per 1,000 people aged 70 years and over.

Needs of older Australians have been changing, moving towards higher care requirements due to people living longer and the associated increased prevalence of chronic health conditions correlated with older age. The residential aged care sector has shifted towards meeting these needs. In 2012, 73 per cent of operational places were utilised for high care, compared to 65 per cent in 2007.
The median days of waiting between ACAT and entry into residential aged care has fluctuated from year to year, although the trend could be considered relatively flat for high care. The number of patient days used by residents in a hospital has improved, suggesting greater access for people leaving hospital.

Access to residential high care for people with non-English speaking backgrounds increased from 34.4 residents per 1,000 people aged 70 years or over from a non English speaking country to approximately 53.2 residents between 2005-06 and 2011-12.

Access has also been increasing for supported residents. Approximately 41 per cent of new high care residents and approximately 38.2 per cent of residents were supported in 2011-12.

Access to residential aged care is currently lower for Indigenous Australians relative to non-Indigenous Australians. Relative to their population share, Indigenous Australians account for a smaller proportion of aged care residents but a larger share of CACP, EACH, EACH-D recipients and HACC client.

**Potential impact of LLLB reforms**

A number of LLLB reforms are likely to impact access to quality care.

- Changes to accommodation payment arrangements may change the level of income and avoided cost of debt derived from accommodation payments, with an associated change in the ability for some providers to cross subsidise care and the cost of new developments.
  - Modelling suggests 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 (KPMG 2013).
  - Modelling also suggests there may be an increase in income and avoided cost of debt from new RADs and DAPs sourced from high care residents, which was estimated to be $93.5 million in 2014-15 (KPMG 2013).

- Changes to accommodation payment arrangements will change the attractiveness of investment in residential care, with an associated impact on access to residential care, although the potential impact on investment is unknown.
  - Modelling suggests there will be a net increase in the value of new RADs entering the residential care sector in 2014-15, driven by new RADs from high care residents. This will increase the capacity of some providers to access greater amounts of lump sum payments for investment activity (KPMG 2013).
  - There is still uncertainty within the sector on the potential impacts of accommodation payment arrangements and external factors on individual providers, which may currently be limiting investment.

- Changes to provision ratios will result in Home Care places increasing from 27 to 45 packages per 1,000 people aged 70 years and over by 2021-22, and residential care places reducing from 86 to 80 places per 1,000 people aged 70 years and over. This will translate into approximately 64,000 more Home Care places but 23,000 fewer residential care places when compared with projections under current provision ratios.

- The increase in Home Care packages is expected to change the mix between Home Care and residential care, with an associated change in government funding of aged care expenditure. It may also increase the demand for other types of care, such as respite care, day rehabilitation, specialist dementia day care and transition care, and increase competition between the sectors.

- Establishment of the Aged Care Gateway is expected to facilitate improved information and service for consumers and their families, encouraging competition among providers and subsequent improvements in access to care.
**Actions for consideration**

There are several actions related to access and quality care that could be further considered by ACFA in monitoring and evaluating the impacts for financial arrangements on the residential care sector. These include:

- monitoring the take up of new Home Care packages and the implications to residential care providers from any shift towards community care from residential care;
- monitoring any impact from reduced provision ratios for residential care on potential gaps in access to residential care;
- analysing better ways to define and measure quality, noting the federal government has recognised the need for improved quality indicators in the LLLB reforms;
- developing metrics on consumer satisfaction and assess the viability of undertaking annual surveys of residents, their families and carers to collect data on consumer satisfaction with residential care;
- developing metrics to measure the supply of informal care and assess the viability of collecting data on informal care on an annual basis through the Australian Bureau of Statistics (ABS); and
- developing better ways to assess the level of unmet need in the community, and to monitor the proportion of consumers that have received their first choice in accessing services, and any change in unmet need due to LLLB reforms and external factors.

**Workforce**

**Current workforce**

The aged care workforce has been changing, driven by an increased demand for carers, a change in care needs and a change in preferences from the delivery of care.

There has been an increase in direct care employees (in number and full time equivalent (FTE) terms) showing the aged care workforce is growing in response to the increased demand for aged care services. The ratio of employees per aged care place slightly increased between 2006 and 2011 from 1.01 to 1.12.

The direct care workforce in residential care has historically been older than the Australian workforce in general. However, the proportion of workers over the age of 55 years has increased, from 16.9 per cent in 2003 to 27.2 per cent in 2012. There has been an increase in the number of facilities catering to ethnic or cultural groups.

The use of informal carers has decreased from 13 per cent of the population in 2003 to 12.2 per cent in 2009. This suggests more reliance may be placed on formal care in the future.

Staff turnover has remained relatively flat for registered nurses but improved significantly for enrolled nurses, personal care attendants, and allied health workers. The majority of workers are not leaving the aged care sector but moving within the sector to another facility. For example, 71.4 per cent of registered nurses and 63.1 per cent of enrolled nurses had previously worked in aged care before moving into their current job.

While the residential direct care workforce has expanded over the last ten years there is evidence to suggest workforce skills have also been changing. For example, high care residents increased by 15.8 per cent from 2009 to 2012 while FTE registered nurses increased by three per cent over the same period.

However, this has been complemented by an up-skilling throughout the remaining direct care workforce, with a greater proportion of people holding a Certificate III and Certificate IV.
qualifications. For example, the proportion of personal care assistants with the Certificate IV in Aged Care has increased from eight per cent in 2003 to 20 per cent in 2012 (King et al 2013).

### Potential impact of LLLB reforms

The most significant impact on the workforce is likely to occur through impacts to the viability of providers. However, the largest potential direct impact to the workforce will come through the Workforce Supplement and the Aged Care Workforce Plan, which will be developed in 2013.

Aged care providers that meet the terms and conditions of the supplement will be paid an Aged Care Workforce Supplement to pass on to workers as wage increases. According to the Department of Health and Ageing, the aims of the Supplement are to:

- improve the aged care sector’s capacity to attract and retain a skilled and productive workforce; and
- provide funding to assist the sector in delivering fair and competitive wages in the short term.

The Supplement will be available to eligible providers from 1 July 2013. Providers must ensure a minimum annual increase in wages of 2.74 per cent, or the Fair Work Commission annual minimum wage increase, whichever is greater, and maintain minimum margins above relevant award rates for all employees.

### Actions for consideration

There are several issues related to the workforce that could be further considered by ACFA in monitoring and evaluating the impacts for financial arrangements on the residential care sector. These include:

- requesting that data similar to that collected for the Government in the National Institute of Labour Studies at Flinders University be provided annually rather than every four years;
- researching the potential availability of an informal workforce in the future given changes in family structures and mobility of the population, and the implications to both Home Care and residential care providers from a declining availability of informal carers;
- analysing better ways to support informal carers, including providing greater capacity to participate in the workforce through improved flexibility, and offering greater support to reduce the requirement to provide care;
- researching better measures for workforce productivity that includes time provided by informal carers and differences in the quality and skills of the workforce;
- researching into the potential shortage of workers in the future given competing demands for carers, and analyse better ways to attract and retain aged care workers to better compete with other sectors requiring similar skills; and
- considering the scope for the federal government to promote changes to workplace practices to improve productivity, including through the use of new technology and better integration with the health care system.

### Sector sustainability

#### Current sustainability

Overall, investment in the residential care sector has decreased in recent years. For example, new building work completed during the year has decreased from $873 million in 2007-08 to $535 million in 2011-12, although in 2009-10 investment peaked at $1.028 million. Estimated new building work completed during the year decreased by 28.7 per cent in the last year alone.
Some of this investment reduction may be due to the global financial crisis in 2007-08 and the potential a lag effect given the long length of time for new and rebuilding activities. Alternatively, it could reflect the low accommodation prices for supported residents and high care residents, or uncertainty surrounding changes in the aged care sector associated with the Productivity Commission’s review on the aged care sector and the federal government’s response.

Recent data suggest investment may have started to increase. For example, estimated new building work in progress increased 11.6 per cent between 2010-11 and 2011-12. Over the same period estimated upgrading work completed during the year increased by 60.3 per cent, suggesting providers may have been focusing on improving existing facilities in recent years. Estimated rebuilding work in progress has also increased by 18.1 per cent since 2009-10.

An increase in investment in aged care facilities has also been found in the most recent building approval data from the Australian Bureau of Statistics. In the 12 months to April 2013, total value of building jobs completed for aged care facilities was $1.2 billion, compared to $823 million in the previous 12 months.

The expected growth in the demand for residential care will require a substantial amount of investment in new and refurbished facilities in the future. The Department of Health and Ageing estimates providers will need to build an additional 74,000 places in the next decade under current planning policies. Including replacement of current stock, the total investment required is around $25 billion (in 2011-12 prices).

If investment were to remain at the average investment level between 2007-08 and 2011-12, there is a projected investment gap of $15.0 billion in the next decade, equating to around 80,000 places.

**Potential impact of LLLB reforms**

The increase in the accommodation supplement for supported residents in facilities that have been significantly refurbished or newly built on or after 20 April 2012 has the potential to stimulate further investment. The extent of investment will depend on the ability of providers to access funds, either through lump sum payments, commercial debt or equity.

The potential for further investment in residential care will also be determined by impacts on provider viability associated with other accommodation payment arrangements for non-supported residents.

In particular, the extent of any switch from RADs to DAPs and the compensating effect from allowing providers to offer high care residents a RAD, DAP or a combination of both, will determine provider access to relatively cheap funds for building activity.

Modelling suggests the residential care sector could experience a net increase in RADs of approximately $3.0 billion in 2014-15, which would increase the capacity for providers to access greater amounts of capital for investment in building activities. The residential care sector sees RADs as an effective form of funding for increased investment growth, with benefits to the resident, the investor and the industry.

**Actions for consideration**

There are several actions related to sustainability that could be further considered by ACFA in monitoring and evaluating the impacts for financial arrangements on the residential care sector. These include:

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5 The average investment level over five years was used to smooth out potential investment anomalies associated with the global financial crisis and uncertainty surrounding changes to the aged care sector. The average estimated new building work completed during the year between 2007-08 and 2011-12 is $831 million, and the average estimated rebuilding work completed during the year is $166 million.
• monitoring the impact of accommodation payment arrangements on investment, including the impact of the increased accommodation supplement and other accommodation payment arrangements on the propensity to invest;

• analysing the scope for alternative government policies to encourage investment back into the sector, and analyse ways for providers to remove current barriers to investment and to attract new investment sources into the sector (e.g., superannuation trusts);

• analysing the potential for efficiency gains within the residential care sector, such as through the promotion of more efficient business models and technology, better interaction with the health care system, and the potential for greater competition within the sector;

• analysing the scope to improve productivity within the sector through benchmarking and introducing greater competition within the sector to encourage efficiency;

• reviewing the adequacy of using provision ratios to determine supply in the lead up to the five year federal government review on the LLLB reforms; and

• research better ways to manage the cost of residential care to the tax payer, including the cost effectiveness of caring for people in their own home compared to residential care, more appropriate user contributions to care, more emphasis on re-ablement, and the role of price signals and assessment procedures to help manage demand.
1 Introduction

The Australian Government established the Aged Care Financing Authority (ACFA) in August 2012 to provide independent advice to the Minister for Mental Health and Ageing (the Minister) on funding, financing and pricing arrangements within aged care. ACFA is headed by an independent chair and is charged with providing an annual report to the Minister on financing and funding issues in the sector.6

KPMG was commissioned by ACFA to develop a report on the impact of aged care financing arrangements on access to quality care, sustainability, industry viability and the aged care workforce. This includes:

- developing a framework to measure and monitor the impact of Living Longer Living Better (LLLB) reforms and other industry developments;
- collecting baseline data on the current state of the aged care sector, in terms of sector viability, access to care, workforce and sustainability; and
- suggesting action items for ACFA to consider on accommodation payments, additional amenity fees for additional services in the context of the pricing policy.

KPMG has used publicly available information and data supplied by the Department of Health and Ageing to develop this report. A consultation process was also undertaken, including several meetings with ACFA and the Department of Health and Ageing, and consultation with a select number of people affiliated with the aged care sector.

1.1 Context for this report

In framing its advice, ACFA is to consider all relevant factors and take into account the federal government’s broad objectives for aged care financing arrangements, which are set out in ACFA’s operating framework.7 These objectives are to:

- support access, quality care, flexibility and choice for care recipients including those with special needs and living in rural and remote areas;
- recognise that accommodation is essentially a personal responsibility, so that care recipients with sufficient means should pay a reasonable price corresponding to the value of the accommodation services they receive, with appropriate safeguards for people who are marginalised, disadvantaged or have modest means;
- enable efficient aged care providers to:
  - provide quality care for their care recipients, while being appropriately rewarded for the operational risks inherent in operating an aged care business; and
  - make a return on investment that is sufficient to ensure investment will continue to be made in the aged care industry at the rate needed to meet the demand for services;
- ensure that the cost of aged care remains sustainable for the Australian taxpayer;
- support a stable and skilled workforce that can meet the growing demand for aged care services;


7 ACFA’s role does not extend to recommending subsidy rates or care and accommodation prices.
• minimise the regulatory burden placed upon aged care providers;
• maximise competition while ensuring appropriate consumer protection; and
• ensure that the availability, affordability and quality of aged care services meets the broader community’s expectations.

Under the ACFA’s operating framework, advice will be provided to the Minister each year on the impact of financial arrangements on the aged care sector. This is to inform the Minister’s annual review of pricing policy across the sector.

In particular, ACFA will provide advice on:

• the impact of aged care financing arrangements on access to quality care, sustainability, industry viability, and the aged care workforce, including an analysis of revenue, cost and productivity movements in the aged care sector.
• the level, and impact on access to care, sustainability, industry viability, and the aged care workforce, of any accommodation payments that are levied by approved providers for entry to residential aged care; and
• the level, and impact on access to care, sustainability, industry viability, and the aged care workforce, of any additional amenity fees for additional services that are levied by Approved Providers for aged care services.

This report has been developed within the context of the federal government’s objectives and the objectives of ACFA in providing advice to the federal government.

1.2 Purpose of this report

The purpose of this report is to provide information and analysis to ACFA that it can use to help develop its first report to the Minister.

Given that the proposed LLLB financing reforms do not come into effect until July 2014, this report has described the current state of the aged care sector and established a baseline and framework to assess the actual and potential impacts of a change to financing arrangements (including the LLLB reforms). It has also identified key issues for ACFA to monitor over the next 12-24 months.

1.2.1 Focus of this report

This initial report primarily focuses on residential aged care providers as more data is currently available for this sector, although it is expected that future ACFA reports will expand the focus on Home Care providers. Overall, however, there is limited data on providers for both residential care and care delivered in the home.

One objective of this report is to identify potential areas where further data and analysis is required. ACFA will be providing advice to the Minister on cost effective options to improve the collection of the appropriate financial data from aged care providers to allow costing and pricing analysis.

It is expected that future reports will present findings from research and analysis that have been derived from:

• monitoring and modelling the impacts of financing arrangements in a transparent manner, including the LLLB reforms; and
• additional research or data collection undertaken to improve analysis of the aged care sector.
Where data is available, subsequent reports will aim to present actual historical impacts and potential impacts across the short term (next two years), medium term (3-5 years) and long term (5 years and greater).

1.2.2 Interaction with accompanying modelling report

KPMG was commissioned by ACFA to model (through scenario analysis) the potential impact of selected Living Longer Living Better (LLLB) financial arrangements on residential aged care providers.

The model tested alternative scenarios associated with selected LLLB financial arrangements expected to impact partially supported and non-supported residents in residential care.8 Financial arrangements that were evaluated through scenario analysis include:

- requiring providers to publish accommodation payment prices and the ability of residents to choose their accommodation payment type 28 days after they have entered a facility; and
- removing the ability of providers to retain prescribed amounts from lump sum accommodation payments; and
- creating consistent accommodation pricing by removing daily accommodation charges and allowing providers to ask residents entering high care to pay either a refundable accommodation deposit (RAD), daily accommodation payment (DAP) or combination of both.

This annual report refers to modelling results presented in the final modelling report (KPMG 2013), and should be referred to when assessing the modelling methodology and results.

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8 Non-supported residents have a combination of assessable income and assets at a level where the federal government deems they can afford to pay all of their accommodation costs. Partially supported residents have a combination of assessable income and assets at a level where the federal government deems they can afford to pay part of their accommodation costs. In discussing the impact of selected LLLB financial arrangements on residents, this report refers to the impact on partially supported and non-supported residents in residential care.
The aged care sector

The Australian population is ageing at a rapid pace. In 2011 the first of the baby boomers turned 65 years old, with the associated ageing baby boomer bubble expected to increase the prevalence of long term aged related health care conditions.

Over the next forty years the ageing population is expected to result in the number of people aged 65-84 years to more than double and the number of people aged 85 years and over to more than quadruple to 1.8 million people (The Treasury, 2010).

The need for aged care is expected to increase with the ageing population. Increasingly, more people are expected to first use Home Care and shift to residential care over time. This suggests any increase in the demand for aged care from the ageing population will first be felt in Home Care.

By 2031 the first of the baby boomers will turn 85, at which point the demand for high care services is expected to have increased significantly due to an increased prevalence of age related conditions. For example, the prevalence of dementia is expected to increase by approximately 92,000 people by 2020, and by 689,000 people by 2050 (equivalent to 2.8 per cent of the Australian population), driven purely by age (Access Economics, 2010a).

This shift in the composition of the Australian population will require a future aged care sector that is dynamic, flexible and sustainable. The sector will not only require additional investment to meet increased demand, but it will need to accommodate alternative care needs and preferences to a level previously unseen.

2.1 Structure of the aged care sector

The structure of the aged care sector is detailed and complex. This section provides a high level description of the sector, with focus on those characteristics of the aged care sector that have direct implications for those matters on which ACFA has been asked to advise.  

2.1.1 Care provided in the community

Care provided in the community allows people to age in place, offering care services that are flexible and tailored to the care recipient’s specific needs. It includes services such as personal care, allied health care, nursing services, transport, help around the home, preparation of meals, gardening, home modification and other services.

Formal care is primarily delivered in the community through Home and Community Care (HACC), Community Aged Care Packages (CACP), Extended Aged Care at Home (EACH) packages, and Extended Aged Care at Home - Dementia (EACH-D) packages (see Table 2.1).  

TABLE 2.1: TYPES OF FORMAL CARE DELIVERED IN THE COMMUNITY

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More detailed information on the structure and operations of the aged care sector is provided in the Report on the Operations of the Aged Care Act 1997 (which is tabled in parliament every year) and in publications developed by the Australian Institute of Health and Welfare (AIHW).

From 1 August 2013 Community Care will be renamed Home Care and CACP and EACH and EACH-D will be replaced by a new four level categorisation of community care packages with existing packages transitioning to the new arrangements.
Package type

<table>
<thead>
<tr>
<th>Package type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home and Community Care (HACC)</td>
<td>Provides low levels of care in the home such as domestic assistance, personal care, professional allied health care, nursing services and home modification.</td>
</tr>
<tr>
<td>Community Aged Care Packages (CACP)</td>
<td>Provides low levels of care in the home such as personal care, assistance with meals, domestic assistance and transport.</td>
</tr>
<tr>
<td>Extended Aged Care at Home (EACH) packages</td>
<td>Provides high levels of care in the home such as clinical care, personal assistance, transport, continence management, home help, social support, emotional support, therapy services, and home safety and modification.</td>
</tr>
<tr>
<td>Extended Aged Care at Home Dementia (EACH-D) packages</td>
<td>Provides high levels of care in the home similar to EACH packages but specifically tailored for people with dementia.</td>
</tr>
</tbody>
</table>

SOURCE: KPMG.

The HACC program delivers services to the greatest number of people. In 2011, 930,087 people received services under HACC. They included people under the age of 65 years who had difficulty in performing everyday tasks due to a disability (see Table 2.2).

The number of community care packages is determined by a population based formula set by the federal government. It is currently set at 25 packages per 1,000 people aged 70 years and over, comprising four packages for high care and 21 packages for low care. As such, the supply of community care packages is restricted, which has led to gaps between the demand and supply of community care packages in some areas.

Reflecting the provision formula, the CACP program is the largest community care program with 46,588 packages delivered in 2011-12. The number of EACH and EACH-D packages delivered were substantially less, with 8,520 and 4,192 packages respectively.

**TABLE 2.2: NUMBER OF CARE RECIPIENTS AND_ALLOCATED PACKAGES**

<table>
<thead>
<tr>
<th>Type of care</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>Average annual growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>HACC Clients</td>
<td>831,472</td>
<td>862,488</td>
<td>893,224</td>
<td>930,087</td>
<td>n.a.</td>
<td>3.8%</td>
</tr>
<tr>
<td>CACP Packages</td>
<td>39,636</td>
<td>42,694</td>
<td>42,728</td>
<td>45,179</td>
<td>46,588</td>
<td>4.2%</td>
</tr>
<tr>
<td>EACH Packages</td>
<td>4,286</td>
<td>5,515</td>
<td>5,597</td>
<td>8,311</td>
<td>8,520</td>
<td>20.3%</td>
</tr>
<tr>
<td>EACH-D Packages</td>
<td>2,011</td>
<td>2,568</td>
<td>2,583</td>
<td>4,090</td>
<td>4,192</td>
<td>22.3%</td>
</tr>
</tbody>
</table>


Over the last five years there has been steady growth in HACC and community care packages. By far the greatest growth has been in high care packages, with EACH and EACH-D packages growing at an average annual rate of 20 per cent and 22 per cent respectively. This reflects the increased needs and preferences for higher levels of care in the community.
Not-for-profit (NFP) providers (including religious, charitable and community based organisations) are the major providers of community care, delivering 49,683 packages in 2011-12, compared to 4,010 (seven per cent of the total) delivered by for-profit providers and 5,508 packages being delivered by state and local government owner providers (see Table 2.3).

### TABLE 2.3: NUMBER OF PACKAGES BY OWNERSHIP STATUS, 2011-12

<table>
<thead>
<tr>
<th>Package type</th>
<th>Religious</th>
<th>Charitable</th>
<th>Community based</th>
<th>For profit</th>
<th>State govt.</th>
<th>Local govt.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>CACP</td>
<td>16,474</td>
<td>14,299</td>
<td>7,868</td>
<td>2,855</td>
<td>2,450</td>
<td>2,572</td>
<td>46,518</td>
</tr>
<tr>
<td>EACH</td>
<td>3,366</td>
<td>3,154</td>
<td>862</td>
<td>753</td>
<td>240</td>
<td>128</td>
<td>8,503</td>
</tr>
<tr>
<td>EACH-D</td>
<td>1,704</td>
<td>1,559</td>
<td>397</td>
<td>402</td>
<td>82</td>
<td>36</td>
<td>4,180</td>
</tr>
<tr>
<td>Total</td>
<td>21,544</td>
<td>19,012</td>
<td>9,127</td>
<td>4,010</td>
<td>2,772</td>
<td>2,736</td>
<td>59,201</td>
</tr>
</tbody>
</table>

Source: DoHA (2012a).

Other programs supporting aged care that are funded by the federal government include the National Respite for Carers Program (NRCP), Transition Care Program (TCP), Multipurpose Service (MPS) places and Innovative Care.

#### National Respite for Carers Program

The aim of the NRCP is to improve information to informal carers, deliver respite care and fund the Carers Australia National Carer Counselling Program. It is also used to reduce the physical and emotional demands sometimes placed on informal carers from providing care. In 2012-13 the federal government funded more than 500 respite services and 54 Commonwealth Respite and Carelink Centres across Australia, with total funding of approximately $214 million (DoHA 2012f).

#### Transition Care Program

The TCP is a joint federal government and state/territory government program to help older Australians transition from hospital care and sub-acute care to either back into the community or a residential care setting. It offers short term services (maximum 18 weeks) such as low intensity therapy, nursing care and personal care, and can deliver services either in the home or a residential care setting. Over 12,000 people use the TCP each year (AIHW 2011b).

#### Multipurpose Service (MPS) places

MPS places recognise that it may not be viable to provide separate hospital and aged care services in small rural and remote communities. In general MPS operates in hospital settings to provide aged care, home and community care services and funding is provided through a joint initiative of the Australian and state/territory governments. There were a combined 3,337 operational multipurpose places as at 30 June 2012, with federal government expenditure reaching $116.2 million for 2011-12 (DoHA 2012a).

#### Innovative Care Program

The innovative care program seeks to identify flexible models of service delivery in areas where mainstream service delivery is not viable or appropriate. An example includes the TCP (outlined above) that was established after two pilot schemes under the Innovative Pool addressed the interface between aged care and hospital care. There were nine operational services and 107 operational innovative care places as at 30 June 2012. Over 2011-12, the federal government expended $3.2 million on projects funded under this program (DoHA 2012a).
2.1.2 Residential care

Residential aged care comprises low care and high care. Some facilities are approved to offer extra services, which includes accommodation, services and food where standards are higher. Residential aged care is provided either on a permanent basis or a respite basis (temporary short term care).

The number of residential aged care places is also determined by a population based formula set by the federal government. It is currently set at 44 places for low care per 1,000 people aged 70 years and over and 44 places for high care per 1,000 people aged 70 years and over.

In 2011-12 there were 184,570 operational residential care places in Australia. These serviced 171,065 residents on 30 June 2012, including 132,760 residents receiving permanent residential high care. Approximately 30 per cent of high care residents enter residential care as a low care resident and are subsequently moved to a high care place. There were also 34,249 residents receiving permanent residential low care, while the remainder received respite care (DoHA 2012a).

NFP facilities provided the majority of operational residential aged care places in 2011-12 (107,410 places). For-profit providers provided a much greater proportion of residential care with 66,335 places (36 per cent of the total) compared to their share in delivering community care packages. State and local government providers provided the least amount of operational residential care places with 10,825 places (see Table 2.4).

<table>
<thead>
<tr>
<th>Package type</th>
<th>Religious</th>
<th>Charitable</th>
<th>Community based</th>
<th>For profit</th>
<th>State govt.</th>
<th>Local govt.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allocated residential care places</td>
<td>54,544</td>
<td>36,316</td>
<td>26,898</td>
<td>81,442</td>
<td>9,308</td>
<td>1,991</td>
<td>210,499</td>
</tr>
<tr>
<td>Operational residential care places</td>
<td>50,259</td>
<td>32,384</td>
<td>24,767</td>
<td>66,335</td>
<td>8,934</td>
<td>1,891</td>
<td>184,570</td>
</tr>
</tbody>
</table>

Source: DoHA (2012a).

2.1.3 Informal care

Informal care is unpaid care usually delivered by family and friends. It is an important contributor to the care continuum, acting as both a substitute and complement to formal care delivered in the community and within residential care facilities.

There were approximately 2.6 million informal carers providing assistance to disabled and older Australians in 2009. Of these, around 350,000 primary carers provided assistance to older persons aged 65 years or over. Many of these primary carers are family members of the care recipient, and over two-thirds are women (ABS 2010).

Although the number of informal carers is expected to increase in the future, the proportion of informal carers supporting an older population is estimated to decrease. This is due to the higher expected growth in those aged 70 years and over compared to those of working age, a reduced willingness to provide informal care, and demographic change leading to lower number of family members available to provide care, such as lower marriage rates among other factors. An increased length of life for informal carers may offset this decrease to an extent (PC 2010).

Any potential shortage in the supply of informal carers may reduce the sustainability of home care due to the complementary relationship between home care and informal care. This could increase the demand for residential care.
Informal carers are not paid for the care they provide, although they are directly financially supported by the federal government through two means, comprising:11

- a Carer Allowance for people providing daily care to a person who has a disability, medical condition or is frail aged;12 and
- a Carer Payment for people unable to work in paid employment because they are providing full time care to a person who has a disability, medical condition or is frail aged.13

In addition to being highly valued by care recipients, informal carers provide a substantial benefit to the Australian economy. Recognition of the contribution of informal carers has been acknowledged by the federal government through recent changes in the _Fair Work Act 2009_, which will be amended to extend the right to request flexible working to carers of older Australians, similar to those caring for children.

Attempts to value informal carers' time have considered the opportunity cost approach and replacement valuation approach. The economic value of informal care was estimated at $6.5 billion in 2010 using the opportunity cost approach and $40.9 billion using the replacement value approach (Access Economics 2010b). Accordingly, while different approaches result in different valuations, the significance of informal care to the Australian economy is highlighted by both methods.

### 2.2 Interaction with health care

Older Australians rely on the services delivered by hospitals and primary carers such as General Practitioners (GPs) in addition to community care, residential care, flexible care and informal care. Together, hospitals and GPs represent a crucial link in the effective delivery of care across the care continuum, and the co-ordination of services across aged care providers, hospitals and primary care providers is essential for the delivery of cost effective and appropriate care (see Figure 2.1).

#### 2.2.1 Assessment for aged care services

Access to formal aged care is through an assessment. There are different types of assessment processes for alternative types of care needs, with Aged Care Assessment Team (ACAT) assessments being undertaken for the bulk of access to aged care (residential care, CACP, EACH and EACH-D). HACC agency assessments are used to access HACC services.

Once people have been assessed, they are recommended either residential care, flexible care, community care or no care at all. People moving into residential care, flexible care or community care can be reassessed for alternative types of care on a periodic basis or as their care needs change. People can also use acute care and subsequently sub-acute care before they are reassessed and move back into the aged care system.

A person’s aged care pathway is unique, determined by their preferences, informal care support, access to formal care services and their care needs.

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11 Many informal carers are also supported by the federal government through the aged pension and other federal government supplements.

12 The Carer Allowance was $115.40 per fortnight as at 8 May 2013.

13 The Carer Payment was $733.70 per fortnight for a single, $533.10 each for a couple and $733.7 each for a couple separated due to ill health as at 8 May 2013. To be eligible for the payment, carers must meet the care-receiver income and assets test.

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Many people prefer to spend as long as possible being cared for at home, either by their family and friends, through community care packages, or a combination of both. Other people may not have access to enough informal care or community care, either because the demands for care at home are great or they cannot be appropriately cared for at home.

As a person’s care and support needs increase and it becomes no longer viable to be cared for at home, that person may move into residential aged care. For example, a person with early stage dementia and wandering tendencies may be required to enter residential care to ensure their safety. For these people, residential care can offer a safer environment.
2.3 Characteristics of providers

2.3.1 Residential care

LLLB reforms may impact residential aged care providers differently given the variability in provider characteristics. The impact will depend on the capital structure of a provider and their profitability, business model and the capacity to adapt to changes within the sector from the reforms.

In 2011-12 there were 1,054 residential aged care providers that provided General Purpose Financial Reports (GPFRs). Religious, charitable and community-based providers owned 52.4 per cent of operational residential care places. For-profit providers owned 37.2 per cent while the remainder were owned by state and local governments.

Key characteristics of residential aged care include (see Table 2.5 and Chart 2.1):

- the residential care sector is made up of many small providers;
- the residential care sector has been consolidating gradually, with a shift towards providing high care;
- provider earnings have been growing steadily, although there is a large variation in earnings across providers; and
- majority of providers are profitable, although the worst performing providers are struggling to improve.

### TABLE 2.5: PROVIDER STRUCTURE BY OWNERSHIP TYPE, 2011-12

<table>
<thead>
<tr>
<th></th>
<th>Not for profit</th>
<th>For profit</th>
<th>Government owned</th>
<th>All providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of providers</td>
<td>552</td>
<td>392</td>
<td>110</td>
<td>1,054</td>
</tr>
<tr>
<td>No. of facilities</td>
<td>1,623</td>
<td>811</td>
<td>282</td>
<td>2,716</td>
</tr>
<tr>
<td>No. of facilities per provider</td>
<td>2.9</td>
<td>2.1</td>
<td>2.6</td>
<td>2.6</td>
</tr>
<tr>
<td>EBITDA per resident²</td>
<td>$8,176</td>
<td>$13,121</td>
<td>-$1,508</td>
<td>$9,274</td>
</tr>
<tr>
<td>Average bond per resident</td>
<td>$185,581</td>
<td>$233,032</td>
<td>$144,575</td>
<td>$201,182</td>
</tr>
<tr>
<td>Accommodation bonds as % of total finance</td>
<td>45.6%</td>
<td>58.2%</td>
<td>19.9%</td>
<td>48.4%</td>
</tr>
<tr>
<td>Debt as % of total finance³</td>
<td>20.1%</td>
<td>31.7%</td>
<td>15.2%</td>
<td>23.9%</td>
</tr>
<tr>
<td>Equity as % of total finance¹</td>
<td>43.2%</td>
<td>14.0%</td>
<td>75.5%</td>
<td>34.9%</td>
</tr>
</tbody>
</table>

Note: 1. Total financing is the sum of total liabilities and equity. Bonds, debt and equity as a proportion of total finance do not equal 100 per cent because there are other contingencies besides bonds and non-current liabilities that constitute total liabilities (e.g. provisions, trade debts, and other miscellaneous payables). These are not relevant for these ratios and are therefore not included. Furthermore, balance sheet information is subject to each provider’s measurement rule and may not necessarily reflect their true position as there is inconsistent treatment of bonds in current/non-current liabilities. 2. Earnings before Interest, Taxation, Depreciation and Amortisation (EBITDA) per resident per annum. 3. Debt comprises non-current liabilities only and excludes bonds.
CHART 2.1: SELECTED CHARACTERISTICS OF RESIDENTIAL AGED CARE PROVIDERS

- Number of providers
- Number of beds
- Region

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Source: Unpublished data supplied by the Department of Health and Ageing
There is large variability in characteristics across residential aged care providers. On average for-profit providers have a higher EBITDA per resident per annum than NFP and government owned providers. For profit providers are more reliant on debt, having:

- the largest average bond per resident at $233,032;
- the greatest proportion of total financing made up of bonds at 58.2 per cent; and
- the greatest proportion of other debt (non-current liabilities) to total financing at 31.7 per cent.

2.3.2 Community care

Approximately 83 per cent of community care packages were delivered by religious, charitable and community based providers in 2011-12. The remaining 16 per cent were delivered by for-profit providers and state and local governments (DoHA 2012a).

There is limited data on the financial characteristics of community care providers. A survey undertaken by Stewart Brown provides information on profitability in the community care sector (Stewart Brown 2012). Based on a sample of the community care sector, key findings include:

- declining profitability for CACP operators from June 2006 until December 2012 compared to increasing profitability for EACH and EACH-D. Increasing staff costs contributed to lower profitability in CACP;
- top quartile operators in CACP are nearly four times more profitable than the average, with profits of $8.39 per client day over the past financial year compared to the survey average result of $2.24 per client day;
- earnings are greater for EACH-D compared to residential aged care, with EBITDA of an EACH-D package at $9,316 per client per day compared to $7,166 per bed day in residential aged care and $7,103 per client per day for an EACH package; and
- profit for EACH-D operators in the top quartile was $46.45 per client per day compared to the average profit of $24.97 per client per day across EACH-D providers in the survey.

The results from Stuart Brown (2012) must be considered in the context of the sample and may not be representative of the sector given a limited number of self-selecting survey participants and greater representation of not-for-profit organisations.

2.4 Funding arrangements

Aged care funding was approximately $14.9 billion in 2011-12, with the federal government providing around three quarters of total funding. This accounted for approximately $11.3 billion.

The largest amount of federal government aged care funding was associated with residential care. In 2011-12, government expended $8.7 billion on residential aged care compared to $1.1 billion on community care packages. An additional $1.5 billion was spent on the HACC program, including the Commonwealth HACC program and the federal government’s contribution to funding in Victoria and Western Australia (see Table 2.6).

Funding growth rates for community care packages have been greater on average than funding growth rates for residential aged care. In particular EACH and EACH-D have experienced significant increases in funding, which reflects the increased growth in the supply of these types of packages.

The increased funding growth for community care is representative of the shift in focus by the federal government on services delivered in the community. There is expected to be future substantial growth in funding for community care packages under the LLLB reforms given the announced increase in community care packages.
Government funding for both community and residential care is paid in advance. For community care this is based on the number and type of community care packages allocated to the provider. For residential care, this is based on assessed care needs of each resident and their capacity to pay. Allocating funds to providers in advance has implications for working capital. It provides greater liquidity and allows providers to reduce their short term liabilities.

### TABLE 2.6: GOVERNMENT RECURRENT EXPENDITURE ON AGED CARE, 2007-08 TO 2011-12

<table>
<thead>
<tr>
<th></th>
<th>2007-08</th>
<th>2008-09</th>
<th>2009-10</th>
<th>2010-11</th>
<th>2011-12</th>
<th>Nominal average annual growth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$(mil)</td>
<td>$(mil)</td>
<td>$(mil)</td>
<td>$(mil)</td>
<td>$(mil)</td>
<td>%</td>
</tr>
<tr>
<td>HACC ²</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>1,502</td>
<td>n.a.</td>
</tr>
<tr>
<td>CACP</td>
<td>448</td>
<td>480</td>
<td>509</td>
<td>532</td>
<td>562</td>
<td>5.8</td>
</tr>
<tr>
<td>EACH</td>
<td>141</td>
<td>173</td>
<td>206</td>
<td>247</td>
<td>337</td>
<td>24.5</td>
</tr>
<tr>
<td>EACH-D</td>
<td>58</td>
<td>84</td>
<td>100</td>
<td>118</td>
<td>160</td>
<td>29.5</td>
</tr>
<tr>
<td>Total - Community care packages</td>
<td>647</td>
<td>736</td>
<td>814</td>
<td>897</td>
<td>1,058</td>
<td>13.1</td>
</tr>
<tr>
<td>Residential care</td>
<td>6,003</td>
<td>6,474</td>
<td>7,097</td>
<td>7,954</td>
<td>8,738</td>
<td>9.9</td>
</tr>
<tr>
<td>Total – Community care and residential care</td>
<td>6,650</td>
<td>7,210</td>
<td>7,911</td>
<td>8,851</td>
<td>9,797</td>
<td>10.2</td>
</tr>
</tbody>
</table>

Note: 1. Includes funding through the Department of Veterans’ Affairs and state and territory expenditure. 2. HACC expenditure relates to aged care only. Data on HACC expenditure specifically related to aged care were not available for years prior to 2011-12.

Source: DoHA (2012a), (SCRGSP 2013).

### 2.4.1 Residential aged care

Residential aged care funding is complex, with providers receiving funds from multiple sources, including government, care recipients, financial institutions, equity investors, and other sources such as charities and donations from the community (see Figure 2.2).

**Accommodation**

The federal government pays an accommodation supplement set at the same level for all regions for those with limited means. Most providers currently receive the bulk of their funding from non-supported residents through income and retention amounts derived from lump sum bonds, although some receive funding from periodic payments.
FIGURE 2.2: SOURCES OF FUNDING TO RESIDENTIAL AGED CARE PROVIDERS, 2011-12

Operating revenue

- Federal government
  - Aged care expenditure $4,862.8 M

- Care recipient
  - Acc payments $278.2 M
  - Retention amounts $216.6 M
  - Basic daily fee $2,504.1 M
  - Income tested fee $315.4 M
  - Extra service fee $169.5 M

- Other funding
  - Donations $278.2 M
  - Other funding $527.5 M

Residential care providers

- Profit/loss
  - Pre tax net profit / loss $726.1 M
  - Tax $58.5 M
  - Post tax net profit / loss $667.6 M

- Revenue $13,072.8 M
  - Expenditure $12,346.7 M

Balance sheet

- Debt $16,440.1 M
- Assets $28,052.3 M
- Net worth / equity $9,612.1 M

Capital

- Federal government
  - Capital grants $9,612.1 M
  - Zero interest loans $645.5 M

- Financial institutions
  - Loans $12,966 M

- Investors
  - Investment $527.5 M

Note: 1. Residential aged care expenditure represents the entire industry whereas in care recipient section represents only those providers who have given their GPFRs (approximately 95.6 per cent of the sector) 2. The extra service fee is an estimated amount which includes the claw back amount adjustment. 3. The amount of bonds held as at 30th June 2012 (i.e. not annual flow) by those providers who provided a GPFR. 4. Up to $58.5 million in capital grants was made available nationally to providers in the 2011 Aged Care Approvals Round. Once executed, capital grants cease to be a liability. 5. The total amount outstanding was $172.2 million on 28 June 2013 6. The amount of tax and net profit/loss after tax is not

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provided in the GPFR data at the residential aged care segment level. 7. The amount of un-appropriated profit flowing to the balance sheet is not given by providers at the residential aged care segment level. 8. CAP is the Conditional Adjustment Payment which is paid to eligible providers who meet certain criteria including encouraging staff training, submitting a GPFR and participating in the workforce census. 9. Other funding source mainly comprise of interest income (including interest from accommodation bonds), asset revaluations, trust distributions and other income.
Only an accommodation charge can be levied in high care, except where the place is an extra service high care place, in which case a lump sum bond, periodic payment or both can be levied. The federal government also provides capital grants and zero real interest loans to some providers.

For the most part, providers use bonds, which form part of the provider’s debt structure to fund capital expenditure. This can also be supplemented by loans from financial institutions. Bonds accounted for 48.4 per cent of total financing in 2011-12, while debt accounted for 23.9 per cent.

Living expenses

Funding is also provided for living expenses. This is paid by residents through the basic daily fee and covers expenses related to hotel type services, such as food, utilities and laundry. The basic daily fee is capped at 85 per cent of the annual single basic aged pension for all residents regardless of their income or wealth.

Care

Federal government funding is also provided for delivering care through the Aged Care Funding Instrument (ACFI) and care recipients through income tested care fees. Funding levels are the same across people with the same care needs, although a viability supplement is paid for smaller rural and remote services and services targeting disadvantaged groups such as older homeless people. The federal government may also provide additional supplements to providers for oxygen and enteral feeding supplements.

In 2011-12 basic care subsidies accounted for 94 per cent of the total $8.7 billion in recurrent residential aged care funding. Primary care supplements, hardship supplements, accommodation supplements and other supplements relating to grand-parenting accounted for the remaining seven per cent (DOHA 2012a).

Other types of funding

Providers may also receive funds from investors in the form of equity. The debt to equity ratio for all residential aged care providers was approximately 1.91 in 2011-12, although this varied significantly across providers, both within and across ownership types. For example, for-profit providers have around 14.0 per cent of equity compared to total finance on average, whereas not-for-profit providers have around 43.2 per cent.14

2.4.2 Community care (home care) providers

The federal government provides subsidies on behalf of individual care recipients to approved providers for CACPs, EACH packages, and EACH-D packages.

Community care providers can negotiate additional daily fees with the care recipient, up to a legislated maximum of 17.5 per cent of the basic single basic age pension, and 50 per cent of any income above the single rate of basic age pension (DoHA 2012a).

From 1 August 2013 these packages will become part of a new Home Care Packages Program, with four levels of care. There will also be new supplements to support people with dementia and veterans with accepted mental health conditions.

14 Unpublished GPFR data supplied by the Department of Health and Ageing.
2.4.3 Home and Community Care providers

The federal government has assumed responsibility for funding HACC services for people over the age of 65 and Aboriginal and Torres Strait Islander people over 50 for all states/territories except Victoria and Western Australia, where HACC continues to be funded using a 60:40 split between federal and state governments.

Federal government funding for HACC in 2011-12 for participating states totalled $1.04 billion, and the federal government’s contribution for the HACC program in Victoria and Western Australia was $462.7 million (DoHA 2012a). User contributions currently vary across states and territories, and in most cases are minimal relative to total funding.

In May 2013, and as part of an agreement to implement DisabilityCare Australia (previously known as the National Disability Insurance Scheme), the Victorian and federal governments agreed to split the management of HACC from July 2015 along the same age cohorts as the HACC participating states.

2.5 Resident contributions

Residential care facilities may charge a series of fees to residents in order to contribute to daily care and accommodation costs. In summary these may include a basic daily fee, an income tested fee, and an accommodation payment in the form of a lump sum bond, periodic payment, a combination of both, or an accommodation charge.

The government sets the arrangements, caps and thresholds of these various fees. The maximum basic daily fee and income tested fee are presented in Table 2.7.

<table>
<thead>
<tr>
<th>TABLE 2.7: SCHEDULE OF RESIDENT FEES AND INCOME TESTED FEE THRESHOLDS</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Category of resident contribution</th>
<th>Maximum basic daily fee</th>
<th>Maximum daily income tested fee</th>
<th>Income tested fee thresholds per fortnight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard resident contribution (incl. respite residents)</td>
<td>up to $44.54</td>
<td>up to $70.74</td>
<td>$914.10</td>
</tr>
<tr>
<td>Protected resident contribution</td>
<td>up to $40.61</td>
<td>up to $70.74</td>
<td>$785.30</td>
</tr>
<tr>
<td>Phased resident contribution</td>
<td>up to $44.54</td>
<td>up to $70.74</td>
<td>$914.10</td>
</tr>
<tr>
<td>Non-standard resident contribution</td>
<td>up to $50.57</td>
<td>up to $70.74</td>
<td>$914.10</td>
</tr>
</tbody>
</table>

Note: 1. Categories of resident is determined by the date the person entered permanent care and income criteria. Data relates to March 2013. 2. A basic daily fee supplement is payable to aged care providers on behalf of non-pensioners who do not hold a Commonwealth Seniors Health Card and who were in permanent residential care on 30 June 2012. The supplement reduces the Maximum Basic Daily Fee in each category by $0.52. To receive the supplement, providers must notify the Department of Human Services that they will charge eligible residents no more than the rates shown in this table. Income Tested Fee Thresholds shown are for Singles. Thresholds for each member of a couple are $18 less than the figures shown in the table. A resident’s income is usually assessed by Centrelink and uses the same rules as for means tested pensions. 3. Source: DoHA (2013).

A resident may also be charged an accommodation bond if their assessable assets exceed $43,000 and they enter low care or extra services high care. Providers are able to retain a prescribed amount from the accommodation bond. Monthly retention amounts are capped and providers are not permitted to retain amounts after five years of residence. Residents entering high care pay an accommodation charge, which is also capped (see Table 2.8).
### TABLE 2.8: MAXIMUM DAILY ACCOMMODATION CHARGE AND BOND RETENTION AMOUNTS

<table>
<thead>
<tr>
<th>Accommodation payment type</th>
<th>Maximum daily accommodation charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-supported residents (assets of at least $112,243.20)</td>
<td>$33.29</td>
</tr>
<tr>
<td>Supported residents (assets less than or equal to $112,243.20)</td>
<td>(Asset value minus $43,000) / 2,080</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maximum monthly bond retention amounts</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>For bonds in excess of $38,760</td>
<td>$323</td>
</tr>
<tr>
<td>For bonds no more than $20,040</td>
<td>$167</td>
</tr>
</tbody>
</table>

Note: As at 9 May 2013.  
*Source: DoHA (2013).*

Maximum permissible interest rates (MPIR) on accommodation bonds are determined in accordance with relevant legislation (see Table 2.9). The MPIR on accommodation bonds can be charged for residents:

- on lump sum accommodation bonds paid after their due date;
- on periodic payments that are not paid in a timely manner;
- on prescribed retention amounts owed; and
- in some cases when the resident leaves the facility within two months of entering.

The maximum permissible charge interest rate is also determined in accordance with relevant legislation, and can be applied to overdue accommodation charge payments.

### TABLE 2.9: MAXIMUM PERMISSIBLE INTEREST RATES

<table>
<thead>
<tr>
<th>Type of maximum rate</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum permissible interest rate</td>
<td>6.95%</td>
</tr>
<tr>
<td>Maximum permissible charge interest rate</td>
<td>5.0%</td>
</tr>
</tbody>
</table>

Note: As at 9 May 2013.  
*Source: DoHA (2013).*
3 LLLB funding reforms

On 20 April 2012 the Australian Government released the Living Longer Living Better (LLLB) aged care reform package. The LLLB package aims to address recognised challenges in the aged care system, including:

- capacity to meet increased needs and changing preferences of an ageing population;
- financial pressures on providers and the federal government;
- barriers to choice and innovation faced by care recipients and their carers;
- inefficiency in service delivery;
- limited access to information on the aged care sector for care recipients and their carers;
- inconsistencies and inequities in access to aged care services;
- the need to emphasise preventative care and re-ablement; and
- the need to secure a sustainable and appropriately skilled workforce.

The LLLB reforms were developed in the context of findings from the Productivity Commission’s Caring for Older Australians report and consultations undertaken by the federal government with providers, the workforce, care recipients and their carers.

The Australian Government is working with the aged care sector to develop and implement a 10 year plan to address the aged care reforms. The first five years of the program will be dedicated to implementing immediate changes to the aged care system. There will be a major review after five years to assess how the system has changed and adapted, and the ability to make further changes.

3.1 Residential care funding reforms

The LLLB reforms will change the funding and financing arrangements for aged care from 1 July 2014 in a number of ways.

Some funding reforms will have a positive impact on provider revenue (e.g., an increase in accommodation supplements), others will reduce funding to providers compared to what they would have otherwise received (e.g., removal of prescribed retention amounts), while some reforms will have an uncertain impact on funding (e.g., changes to accommodation payment arrangements) (see Figure 3.1).

Given there are several funding reforms expected to impact providers in different ways, the impacts from any one reform should be viewed in the context of the LLLB package in its entirety.
FIGURE 3.1: POTENTIAL DIRECT IMPACT ON RESIDENTIAL CARE PROVIDERS DUE TO LLLB REFORMS UNDER CURRENT AGED CARE ENVIRONMENT, 2011-12

<table>
<thead>
<tr>
<th>Operating revenue</th>
<th>Aged care expenditure</th>
<th>Residential care providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal government</td>
<td>Acc1 subsidy $90,982.8 M</td>
<td>Profit / loss</td>
</tr>
<tr>
<td>Care recipient</td>
<td>Basic fee $2,504.1 M</td>
<td>Revenue $13,072.8 M</td>
</tr>
<tr>
<td>Care recipient</td>
<td>Income tested fee $315.4 M</td>
<td>Pretax net profit / loss $726.1 M</td>
</tr>
<tr>
<td>Care recipient</td>
<td>Extra service clawback $335.9 M</td>
<td>Tax1</td>
</tr>
<tr>
<td>Care recipient</td>
<td>Donations</td>
<td>Post tax net profit / loss</td>
</tr>
<tr>
<td>Care recipient</td>
<td>Other funding $527.5 M</td>
<td>Bond3 $12,966 M</td>
</tr>
<tr>
<td>Capital</td>
<td>Acc2 payments $278.2 M</td>
<td>Loans</td>
</tr>
<tr>
<td>Financial institutions</td>
<td>Acc3 supplements $316.8 M</td>
<td>Capital grants4</td>
</tr>
<tr>
<td>Federal government</td>
<td>Acc4 supplements $1,061.1 M</td>
<td>Zero interest loans5</td>
</tr>
<tr>
<td>Investors</td>
<td>Acc5 supplements $5,013.9 M</td>
<td>Investment</td>
</tr>
</tbody>
</table>

Note:
1. Residential aged care expenditure represents the entire industry whereas in care recipient section represents only those providers who have given their GPFRs (approximately 95.6 percent of the sector).
2. The extra service fee is an estimated amount which includes the clawback amount adjustment.
3. The amount of bonds held as at 30th June 2012 (i.e., not annual flow) by those providers who provided a GPFR.
4. Up to $58.5 million in capital grants was made available nationally to providers in the 2011 Aged Care Approvals Round. Once executed, capital grants cease to be a liability.
5. The total amount outstanding was $172.2 million on 28 June 2013.
6. The amount of tax and net profit/loss after tax is not

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provided in the GPFR data at the residential aged care segment level. 7. The amount of un-appropriated profit flowing to the balance sheet is not given by providers at the residential aged care segment level. 8. CAP is the Conditional Adjustment Payment which is paid to eligible providers who meet certain criteria including encouraging staff training, submitting a GPFR and participating in the workforce census. 9. Other funding source mainly comprise of interest income (including interest from accommodation bonds), asset revaluations, trust distributions and other income.
3.1.1 Accommodation payments

There are several accommodation payment arrangements that will change under the LLLB reforms. These include:

- increased pricing transparency and consumer discretion over payment type;
- removing prescribed retention amounts;
- establishing an Aged Care Pricing Commissioner and introducing accommodation pricing thresholds;
- creating consistent accommodation pricing;
- increasing the accommodation supplement; and
- allowing draw downs on lump sum accommodation payments.

All of these financial arrangements (except the increase in the accommodation supplement) are expected to impact partially supported and non-supported residents only. Each financial arrangement change is further discussed below.

Increased pricing transparency and consumer discretion over payment type

New rules governing the disclosure of accommodation prices will be introduced under the LLLB reforms, requiring providers to publish all accommodation prices and greater information explaining alternative accommodation payment options.

Aged care providers will not be able to distinguish between residents on the basis of how they elect to pay for their accommodation. All residents will have the choice of paying for their accommodation through a fully refundable accommodation deposit (RAD), a rental style daily accommodation payment (DAP), or a combination of both.

Residents will have a 28 day period after entering the residential care facility to decide how to pay for their accommodation.

Removing prescribed retention amounts

The LLLB reforms will remove the ability of providers to retain prescribed amounts from accommodation payments.

Consistent accommodation pricing

The distinction between low and high level residential care will be removed, allowing providers to offer those entering high care a choice of a RAD, DAP or a combination of both. This means that all new residents after 1 July 2014 will be subject to the same accommodation payment arrangements. Existing arrangements for respite care will continue to apply. All approvals of residents for residential care will become non-lapsing (unless they are expressly time limited).

Increasing the accommodation supplement

Non-supported residents have a combination of assessable income and assets at a level where the federal government deems they can afford to pay all of their accommodation costs. Partially supported residents have a combination of assessable income and assets at a level where the federal government deems they can afford to pay part of their accommodation costs. In discussing the impact of selected LLLB financial on residents, this report refers to the impact on partially supported and non-supported residents in residential care.
The federal government will increase the accommodation supplement for residents with low means to an estimated $52.84 per day for residents living in newly built residential facilities or residential facilities significantly refurbished on or after 20 April 2012.

Establishing an Aged Care Pricing Commissioner and introducing accommodation pricing thresholds

The accommodation payments framework announced by the federal government sets out three levels of accommodation payments (see Table). The greatest change for providers will be the need to receive permission from the Aged Care Pricing Commissioner (ACPC) to charge bonds greater than the Level 2 threshold.

### TABLE 3.1: ACCOMMODATION PAYMENT LEVELS

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>From $0 to the amount of the maximum government accommodation supplement, estimated to be $52.84 per day from 1 July 2014, or an equivalent RAD based on the MPIR.</td>
</tr>
<tr>
<td>Level 2</td>
<td>From the maximum government accommodation supplement to a lump sum of $406,037, or an equivalent DAP based on the MPIR.¹</td>
</tr>
<tr>
<td>Level 3</td>
<td>RADs greater than $406,037 (or the DAP equivalent) will need to be pre-approved by the Aged Care Pricing Commissioner.</td>
</tr>
</tbody>
</table>

Note: ¹ This estimated lump sum amount reflects the value as at 21 December 2012 when the Minister announced that the upper threshold for Level 2 prices would be a DAP of $85. It was calculated using the MPIR at that time. On 1 July 2013, the MPIR will decrease to 6.82 per cent, which would give a RAD of $453,666.

Source: Department of Health and Ageing.

Allowing draw downs on lump sum accommodation payments

Under section 52J-7 of the Aged Care (Living Longer Living Better) Bill 2013, an approved provider will be able to deduct a daily payment from a RAD paid by a person if:¹⁶

- the person has requested the deduction in writing; and
- the daily payment is payable by the person.

Furthermore, an approved provider may deduct the following from a RAD:

- the amounts specified in the Fees and Payments Principles that may be deducted when the person leaves the service;
- any amounts that the person has agreed in writing may be deducted; and
- such other amounts (if any) as specified in the Fees and Payments Principles.

These amendments are an alternative to regulated retentions, and may be particularly beneficial in regions where RADs are relatively low (e.g., rural and remote areas where home values are relatively low) if residents cannot afford the published RAD.

3.1.2 Changes to extra services funding arrangements

The federal government will clarify the circumstances under which providers will be allowed to offer optional additional services, where providers can offer optional additional services for a fee. Residents will be able to opt in or out of these additional services at any time. This clarification may encourage more residents and providers to consider such options, although providers may be limited in the scope of optional services offered due to the opt-in opt-out nature of the arrangements.

The federal government will also continue to allow approved providers to apply for Extra Service Status whereby a provider will be given authority by the Department of Health and Ageing to enter into a contract with a resident for extra services for a fee. Extra Service is currently restricted to a whole service or dedicated wing. Under the LLLB reforms, this approval may be given for individual rooms irrespective of where they are located.

Finally, there will also be changes to the extra services claw back. Under current Extra Service arrangements, the Government reduces the amount of the care subsidy by 25 per cent of the government approved Extra Service fee. Under the LLLB reforms, the federal government will no longer make this reduction after 1 July 2014.

3.1.3 Means testing arrangements

Change will be made to the way co-contributions to care are calculated for a resident entering residential care on or after 1 July 2014. This will include a new combined income and assets test for residential care.

Under the new arrangements, the federal government will assess whether the care subsidy for a resident should be reduced based on their assessable income and means-testable assets, rather than only on their assessable income, which is the current arrangement.

Assessable income will include federal government payments such as the age pension, and ordinary income as determined by the age pension income test. Assessable assets will include the resident’s share of property or any valuable item they or their partner own (in full or in part), including a RAD. Means-testable assets will include all assessable assets, but the value of their share of their principal residence will be capped at $144,500 (indexed over time).

The level of the daily care fee for a resident will be calculated by subtracting the maximum rate of the accommodation supplement from 1/364th of the sum of:

- An income tested amount equal to 50 per cent of the resident’s income in excess of the maximum assessable income level for a full pensioner ($22,701);\(^\text{17}\) plus
- An asset test amount equal to:
  - $0 if the amount of the resident’s means-testable assets is less than Minimum Permissible Asset level ($40,500);
  - 17.5 per cent of the amount of the resident’s means-testable assets in excess of the Minimum Permissible Asset level but less than $144,500;
  - $18,200 plus 1 per cent of the amount of the resident’s means-testable assets in excess of $144,500 but less than $353,500;
  - $20,290 plus 2 per cent of the amount of the resident’s means-testable assets over $353,500.

Calculating a resident’s care fee on their means-testable assets and capping the principal residence value at $144,500 (while including the entire value of RADs), will mean residents can

---

\(^{17}\) The income and means tested asset thresholds are March 2012 rates and will be indexed on a biannual basis.
lower their care fees by choosing a DAP if the provider has asked for a RAD greater than $144,500.\textsuperscript{18}

**Caps on means tested care fees**

There will also be new annual and lifetime caps on means tested care fees. This includes a $25,000 (indexed) cap on the total amount of care fees a resident can pay in a year, and a lifetime cap of $60,000 (indexed). Once a resident reaches the cap their care fees will be set to zero.

**3.1.4 Other changes to financial arrangements**

There will also be an increase in other types of supplements. For example, from 1 August 2013, an additional dementia and severe behaviour supplement and a new veteran's supplement will be paid to providers who care for eligible residents. There will also be increased viability supplements to providers in remote locations or who provide services to Indigenous Australians and older people who are homeless.

**3.2 Community care funding reforms**

In addition to increasing the number of Home Care packages, the LLLB reforms will reduce the amount of federal government subsidy payable in Home Care based on an income test.

Under current fee arrangements, providers are able to charge care recipients an income tested care fee set at 50 per cent of incomes above the basic age pension. However, the federal government does not adjust the amount it contributes to the care recipient's care costs irrespective of how much the care recipient is paying.

Under the LLLB reforms the federal government will reduce its contribution to the care costs of part pensioners and self-funded retirees from 1 July 2014 based on an income test. The provider will be able to recoup fees from the care recipient. The current basic fee where the service provider can ask care recipients to contribute up to a maximum of 17.5 per cent of the single basic pension will also remain.

Similar to the current arrangements, the income tested care fee for part-pensioners will be calculated as 50 per cent of their total income above the maximum income a full age pensioner can receive but the reforms introduce a cap on care fees of $5,000 a year.

The annual income tested care fee for self funded retirees will be $5,000 plus 50 per cent of their total income above the income level at which an age pension is no longer payable. The reforms introduce a cap on income tested care fees for self-funded retirees of $10,000 per year.

No care recipient’s care fee can be greater than the level of government subsidy and primary supplements payable in respect of their Home Care package.

All care recipients will have a lifetime cap of $60,000 (indexed) on income tested care fees to protect care recipients who receive care for a longer period of time. Care fees paid in residential aged care will also be taken into account in calculating lifetime care expenditure.

The income testing arrangements and the care subsidy reduction will be administered by the Department of Human Services. Means testing will require greater responsibility among providers to collect fees, although some providers may already be collecting fees based on current income testing arrangements. Increased consolidation may occur among providers in

\textsuperscript{18} Changes to the means testing arrangements have been explicitly incorporated into the model to ensure the associated financial incentive to select a DAP (i.e., to avoid additional care fees) impacts the choice between a RAD and a DAP and is therefore included in the scenario analysis results.
order to improve services and invest in administration systems. Increased fees are likely to raise consumer expectation of service and may lead to improvements in quality.

While providers in community care can currently ask for an income tested care fee, the majority do not, and even where they do the amount the federal government pays in respect of that care recipient is not reduced.

3.3 Other LLLB reforms

While funding arrangement changes under the LLLB reforms are expected to alter the aged care sector substantially, they must be considered within the wider LLLB reform package. There are many other LLLB reforms unrelated to financial arrangements that are expected to impact all parts of the aged care sector, including community and residential care providers, the workforce and care recipients.19

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19 More detail on the Living Longer Living Better reforms can be found at (http://www.livinglongerlivingbetter.gov.au/)

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4 Industry viability

One of the many objectives of the LLLB reforms is to ensure that the aged care industry is viable through appropriate levels of income and a stable balance sheet. A viable residential aged care provider can retain and attract investment by offering rates of return commensurate with risk, and mitigate impacts from negative external economic and financial conditions.

4.1 Indicators to measure viability

The viability of residential aged care providers has been assessed using metrics derived from the General Purpose Financial Reports (GPFR) supplied by the Department of Health and Ageing (see Appendix A, B and C). Indicators include:

- profit and loss account indicators;
- balance sheet indicators; and
- other viability indicators.

In addition to financial metrics, providers measure their success in achieving non-financial outcomes. For example a provider may measure success by meeting stated mission objectives, such as providing care for those most in need. These objectives may conflict with viability measured through financial metrics, such as profitability.

There is no available data that measures whether providers can meet non-financial targets. Consequently, caution should be taken when interpreting the viability of the sector as the usual financial threshold of what is considered ‘viable’ may not apply. Even if the rate of return seems low this may be an acceptable rate of return for investors with social objectives in mind and readily available access to capital.

4.2 Current industry viability

Overall, the viability of the residential care sector seems to have improved over recent years. This includes increased earnings and profitability, some balance sheet improvements, and increased returns on assets.

Table 4.1 presents traffic light indicators of changes to viability in residential care, based on metrics defined in Appendix B and data presented in Appendix C. These indicators use historical data derived from the General Purpose Financial Reports supplied by the Department of Health and Ageing.

Further discussion on each indicator is provided in the subsequent sections, including profit and loss indicators, balance sheet indicators and ‘other’ viability indicators.

<table>
<thead>
<tr>
<th>TABLE 4.1: INDICATORS TO MEASURE VIABILITY¹</th>
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<tr>
<td>Indicator²</td>
</tr>
<tr>
<td>Profit and loss account indicators</td>
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### EBITDA per resident per annum

<table>
<thead>
<tr>
<th>EBITDA per resident per annum - Sector</th>
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</thead>
<tbody>
<tr>
<td>EBITDA per resident per annum – Regional providers</td>
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<td>EBITDA per resident per annum – Low care providers</td>
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<tr>
<td>Providers reporting profit</td>
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<td>Providers reporting negative EBITDA</td>
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#### Balance sheet indicators

<table>
<thead>
<tr>
<th>Balance sheet indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average bond per resident</td>
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<tr>
<td>Bonds as a proportion of total financing</td>
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<tr>
<td>Equity as a proportion of total financing</td>
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<td>Return on equity</td>
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</table>

#### Other viability indicators

<table>
<thead>
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<th>Other viability indicators</th>
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<tbody>
<tr>
<td>Occupancy rates</td>
</tr>
<tr>
<td>Current ratio</td>
</tr>
<tr>
<td>Interest coverage</td>
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</tbody>
</table>

Note: 1. Traffic light indicators should be interpreted with caution as some indicators may be deemed more important to the residential care sector than others. Indicators will continue to be developed through subsequent annual reviews. 2. Definitions of financial metrics are provided in Appendix B. Source: See Appendix C for data underlying each traffic light.

### 4.2.1 Profit and loss account indicators

Across all residential aged care providers, approximately 70 per cent made a net profit before tax in 2011-12, while 84 per cent of providers had a positive EBITDA.\(^{20}\)

GPFR data supplied by the Department of Health and Ageing does not include the level of provider profit. Consequently, there was no indication whether profit made by some providers was viable from an industry perspective. For example, a provider that made one dollar of net profit before tax may be considered profitable, but not viable.

\(^{20}\) An EBITDA greater than zero may not necessarily translate into a profitable provider given capital expenditure, taxes and interest are not included in the metric.
A change in profit will reflect a change in interest costs and hence the relative financial benefits of lump sum accommodation payments versus commercial debt, which cannot be directly determined from EBITDA. Determining profit range that equates to a viable business is an area for potential further work for ACFA.

High care providers had the highest EBITDA per resident per annum, with an average $10,364 in 2011-12 compared to $2,454 for low care and $5,812 for mixed care. Other characteristics of residential aged care providers with relatively greater EBITDA include the following.

- They operate primarily in metropolitan regions. Regional providers receive the lowest EBITDA per person per annum, with $6,663 in 2011-12 compared to $10,369 for metropolitan providers. Providers in the top quartile received the largest EBITDA in regional areas, suggesting some providers generated relatively large profits in some regional areas.

- Are for-profit providers. For example, for profit providers earned a greater EBITDA on average in 2011-12, with $13,121 compared to $8,176 for NFPs. Government providers generated the least EBITDA on average.

There has been strong growth in EBITDA per resident per annum of around 18 per cent per year across all providers between 2006-07 and 2011-12. The proportion of providers with a negative EBITDA in 2011-12 was the same as the previous year at 16 per cent. However, this represents a substantial reduction compared to 2006-07 when it was 22 per cent.

However, growth in EBITDA has not been consistent across the sector. Although regional providers have experienced an increase in EBITDA per resident per annum, annual growth has only been 14 per cent on average between 2006-07 and 2011-12. Overall, low care providers have experienced an average decrease in EBITDA of nine per cent, although annual growth varied considerably from year to year.

The introduction of the Aged Care Funding Instrument (ACFI) in 2008 (which replaced the former Resident Classification Scale) seems to have improved EBITDA. Average annual growth in EBITDA per resident per annum between 2006-07 and 2008-09 was approximately 4.0 per cent, while growth between 2008-09 and 2011-12 was 28.9 per cent.

For-profit providers make up 62.1 per cent of all providers in the top quartile (by EBITDA per resident per annum) in 2011-12, while only accounting for 37.2 per cent of all providers. This is despite for-profit providers having the lowest average occupancy in all quartiles.

NFP providers have a greater share in the second and third quartiles compared to the overall proportion of NFP providers, and have the same proportion of NFP providers in the lowest quartile. Government owned providers have a disproportionate share of providers in the lowest quartile, and on average have a negative EBITDA per resident per annum.

Trends in EBITDA suggest high care providers and for-profit providers are generating more cash from trading compared to low care providers. Growth in EBITDA per person per annum has occurred for all quartiles between 2006-07 and 2011-12, although it was strongest in the second and third quartiles. This must be considered in the context of any change in maintenance capital expenditure, which could not be determined using GPFR data. The worst performing providers (quartile 4) have not grown as strongly relative to all other providers.

4.2.2 Balance sheet indicators

The average bond per resident has increased at an average of 10 per cent per annum over 2008-09 to 2011-12, when it was $201,182. This is much lower than the average value of a new bond, which was $252,000, suggesting that there is further opportunity to increase bond values as current residents with low value bonds are replaced with new residents.

Bonds as a proportion of total financing have also increased in recent years, from 40.2 per cent in 2008-09 to 48.4 per cent in 2011-12.
For-profit providers have been more reliant on commercial debt and lump sum bonds compared to NFP providers. For example, for-profit providers had an average 14.0 per cent of total financing made up of equity, compared to 43.2 per cent for NFP providers and 75.5 per cent for government owned providers in 2011-12.21

Although equity as a proportion of total financing has decreased, from 41.4 per cent in 2008-09 to 34.9 per cent in 2011-12, there is uncertainty around what is the optimal mix of equity within the sector (hence the amber rating). This decrease, combined with the increased EBITDA earned by providers has improved the return on equity, increasing from 7.0 per cent in 2008-09 to 15.9 per cent in 2011-12.

4.2.3 Other viability indicators

Overall, occupancy rates have remained stable since 2008-09 at 93.0 per cent. There is some variability in occupancy rates across states and territories, with the Northern Territory having the lowest occupancy rate at 91.6 per cent and South Australia having the highest at 95.2 per cent in 2011-12.

Although occupancy is important for ensuring profitability, higher occupancy does not necessarily translate into higher profit. For example, for-profit providers had on average the highest EBITDA per resident per annum in 2011-12, yet the lowest average occupancy at 90.4 per cent.

The current ratio has increased from 0.47 to 0.50 between 2008-09 and 2011-12. This suggests current assets have grown faster than current liabilities. A current ratio of less than one for the sector suggests some providers may have a negative working capital with potential for some liquidity issues. However, many providers have the support of larger organisations (e.g. a parent company or diocese) that can be called upon to service short term debt. Furthermore, the current ratio is also affected by the increasing bond liabilities, which are treated as current liabilities. Providers also receive federal government subsidies in advance, which have significant bearing on working capital requirements.

4.3 Potential changes to viability

4.3.1 Impacts from accommodation payments reform

There are several accommodation payments reforms affecting non-supported residents that have the potential to change the financial viability of providers. These include:

- increased pricing transparency;
- removing prescribed retention amounts;
- establishing an Aged Care Pricing Commissioner and accommodation pricing thresholds;
- creating consistent accommodation pricing; and
- allowing draw downs on lump sum accommodation payments.

The potential impact of each financial arrangement change is further discussed below. These should be considered not in isolation but as a package as there will be competing impacts on viability.

21 The proportion of equity in residential care is relatively low compared to other industries, and some could consider this to be a high risk capital structure. However, this risk is ameliorated somewhat by the composition of debt being mostly made up of lump sum bonds. Notwithstanding that bonds are treated as short term liabilities, there is a practical expectation of their continual renewal commensurate with turnover of residents. This has the effect of bonds acting as a revolving line of short or medium term financing.
Increased pricing transparency

The LLLB reforms are expected to increase accommodation pricing transparency through the need for providers to publish accommodation prices and provide a 28 day period (from entering a facility) where residents can consider their payment option. The aim is to give residents choice of their preferred payment option.

Providing greater pricing transparency may mean some people pay a DAP when they would have otherwise paid a RAD. A shift to DAPs will depend (in part) on the attractiveness of investing in a RAD compared to other investment options, such as keeping the home. This may be an attractive option given:

- the age pension has income and asset exemptions for the former principal place of residence;
- there are capital gains exemptions; and
- only $144,500 of the value of the home which is retained is included in the asset test when determining the contribution to care fee, whereas if the residence is sold, the entire proceeds from the sale (including any RAD paid) will be assessed.

Results from scenario analysis suggest that increased transparency around accommodation prices may reduce the value of new RADs by $402.8 million in 2014-15 (or 9.7 per cent), with these RADs shifting to DAPs (KPMG 2013). The number of RADs estimated to switch to DAPs is approximately 33.1 per cent in 2014-15, with the distribution of RADs switching over presented in Chart 4.1.

However, each resident situation will be unique and there are many factors to consider when deciding between accommodation payment types. It may not be a decision simply based on expected wealth. Moving into residential care is an emotional time for the resident and family, and the family home often has a significant emotional attachment. Many people also have alternative objectives to wealth maximisation when planning their estate.

A switch to DAPs will also depend on whether the resident can afford to pay the DAP. In most cases this will depend on whether the home can generate enough rental income. Most pension income is used for daily living costs, residential care costs and accommodation payments (e.g., living expenses can be 85 per cent of the single aged pension and most residents can be expected to incur other expenses).

CHART 4.1: DISTRIBUTION OF RADs ESTIMATED TO SWITCH OVER TO DAPs, 2014-15

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22 The lump sum bond provides a return in the form of accommodation, while the family home provides a return in the form of rental income and capital gains. Given accommodation is a guaranteed return, keeping the family home could be considered a riskier investment.

23 Lump sum accommodation payments are also exempt from the age pension asset test.

24 Approximately 89 per cent of permanent residents received a government pension, either from Centrelink (72 per cent) or the Australian Government Department of Veterans’ Affairs (DVA) pension (17 per cent) (AIHW 2012).
The relatively large number of RADs switching to DAPs compared to the total value of the shift highlights an important driver in choosing between accommodation payment types within the scenario analysis. Although most residents would prefer to pay a DAP based on their estimated wealth, in the majority of cases the estimated income earned from renting out the home was not enough to cover the estimated DAP.

Factors influencing the choice of payment option will not remain constant. For example, the desire to keep the home will fluctuate as housing prices change. Furthermore, any switch to DAPs may be compensated by other changes to accommodation payments, such as allowing providers to offer a RAD to new non-supported high care residents, and the increase in accommodation supplements for supported residents in significantly refurbished or newly built facilities.

Removing prescribed retention amounts

The LLLB reforms will remove the ability of providers to retain prescribed amounts from accommodation payments. Modelling suggests the 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 (KPMG 2013).

Removing retention amounts may result in residential aged care providers increasing their price of accommodation to compensate for income not otherwise received. Any increase in price will be subject to the ability of providers to raise their accommodation prices given wealth constraints of residents, and the willingness of residents to allow draw downs on RADs. For some providers, it may be difficult to increase accommodation prices, especially for providers in rural and remote regions where the average house value is substantially lower.25

25. The increase in price will reflect the expected rate of return from lump sum accommodation payments. This could be either income from investing the RAD, or avoided costs of debt from using RADs to extinguish commercial debt. The lower the expected return the greater the required increase in accommodation prices.
Establishing the Aged Care Pricing Commissioner and accommodation pricing thresholds

The accommodation payment framework announced by the federal government sets out three levels of accommodation payments. Although this will not affect most lump sum payments, RAD amounts greater than the Level 2 threshold (or the DAP equivalent) will need to be pre-approved by the Aged Care Pricing Commissioner.

Chart 4.2 shows the distribution of bonds exceeding the Level 2 threshold when applied to new low and extra services bonds received in 2011-12.26 Applying this threshold to the distribution of new low and extra services bonds (lump sum and periodic payments) in 2011-12 suggests:

- approximately 2,435 new low and extra services bonds (13.3 per cent) exceed the Level 2 threshold, consisting of:
  - 2,010 lump sum bonds;
  - 112 periodic payments; and
  - 313 combination lump sum bonds / periodic payments.
- the value of new low and extra services bonds exceeding the Level 2 threshold is estimated to be $303.6 million; and
- the income and avoided cost of debt associated with new low and extra services bonds exceeding the Level 2 threshold is estimated to be $26.8 million (KPMG 2013).

Providers that currently receive some bonds greater than the Level 2 threshold may see a decline in the total value of their lump sum payments where prices do not reflect the value of the room and permission to charge an accommodation price above the Level 2 threshold is not granted.

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26 This assumes a RAD threshold of $406,037 using an MPIR of 7.64 per cent. On 1 July 2013, the MPIR will decrease to 6.82 per cent, which would give a RAD of $453,666.

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Note: The Level 2 threshold has been based on an MPIR of 7.64 per cent.
Source: KPMG (2013).

If there is a reduction in the total value of accommodation payments there may be an increased need for commercial debt or equity. If an increase in commercial debt is required, this would have flow-on impacts to the cost of debt as the required rate of return on debt is generally greater than the required rate of return for residents.

A changing MPIR will vary the Level 2 DAP threshold due to the method proposed to ensure equivalence. At this stage the impact of the Level 2 pricing threshold on providers cannot be determined given guidelines on receiving permission to charge greater than the Level 2 threshold are not finalised. Any changes will only affect new residents with charges fixed for existing residents.

Creating consistent accommodation pricing for low and high care residents

The distinction between low and high level residential care will be removed, allowing providers to offer residents entering high care a choice of a RAD, DAP or a combination of both. This will remove accommodation charges and the associated cap on accommodation pricing for non-supported high care residents.

As accommodation charges are currently capped, offering non-supported high care residents a RAD, DAP or combination of both will enable providers the potential to increase their lump sum accommodation payments, increase the associated income, reduce their cost of debt.

However, it is unclear whether non-supported high care residents will choose a RAD, DAP or a combination of both. The choice may be impacted by the expected length of stay for residents considering it takes time to sell a home. Data from the Department of Health and Ageing show the average total length of stay for people entering high care was 2.7 years compared to 3.5 years for low care. Over half (54 per cent) of people entering high care stayed at least 12 months compared to 72 per cent of those that enter low care.

The combination of entering into high care and paying a lump sum is not without precedent. For example, 82 per cent of people entering extra service high care paid a lump sum bond. The remainder either paid a periodic payment only or a combination of both.

Modelling the potential increase in RADs from changes to funding arrangements for new high care residents suggests:

- the value of new RADs from high care residents is estimated to increase by $3.4 billion in 2014-15; and
- increased income and avoided cost of debt from new RADs and DAPs from high care residents is $93.5 million in 2014-15 (KPMG 2013).

The estimated increase in RADs from high care residents is more than enough to offset the estimated decrease in RADs associated with a switch from RADs to DAPs for low and extra services residents. This is a potential benefit to providers delivering high care as it allows greater access to lump sum payments.

Most providers delivering high care will be able to increase their income and reduce their cost of debt due to increased RADs. Allowing providers to offer new high care residents a RAD, DAP or a combination of both removes the pricing cap currently associated with accommodation charges. This is shown in Table 4.2, which presents actual high care accommodation charges for 2011-12 to the equivalent daily payment associated with estimated new RADs and DAPs in 2014-15.
As more people leave residential care there will be greater opportunity to offer new high care residents a RAD, DAP or combination of both. This is expected to increase the ability of providers to increase their lump sum values, annual income and avoided cost of debt beyond 2014-15 as the current cohort of residents are replaced.

Although there is estimated to be a net increase in RADs in 2014-15, the impact will vary across the sector. For example, providers delivering low care only, small providers, providers in non-metropolitan areas, and providers with a high proportion of supported residents may not experience the same change in accommodation payments compared to the rest of the sector.

The potential change in the distribution of accommodation payments will be unique for each provider. It will primarily depend on the accommodation payments currently received, and composition and characteristics of their residents, including the proportion of low care residents, high care residents, and supported residents.

**TABLE 4.2: ACTUAL HIGH CARE ACCOMMODATION CHARGES FOR 2011-12 AND EQUIVALENT DAILY PAYMENTS ASSOCIATED WITH ESTIMATED NEW RADS AND DAPS IN 2014-15**

<table>
<thead>
<tr>
<th>Distribution of accommodation charges in 2011-12</th>
<th>Distribution of equivalent daily payments for estimated RADs and DAPs 2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than or equal to $30.55</td>
<td>8,028</td>
</tr>
<tr>
<td>Greater than $30.55 but less than or equal to $32.38</td>
<td>7,640</td>
</tr>
<tr>
<td>Greater than $32.38 but less than or equal to $32.58</td>
<td>4,447</td>
</tr>
<tr>
<td>Greater than $32.58 but less than or equal to $52.84</td>
<td>43</td>
</tr>
<tr>
<td>Greater than $52.84 but less than or equal to $85.00</td>
<td>8</td>
</tr>
<tr>
<td>Greater than $85.00</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20,166</strong></td>
</tr>
<tr>
<td></td>
<td><strong>16,003</strong></td>
</tr>
</tbody>
</table>

Note: The total for the distribution of equivalent daily payments for estimated RADs and DAPs in 2014-15 does not equal the total for the distribution of accommodation charge. This is because there were 4,076 people paying a daily accommodation charge of less than $30.55 per day in 2011-12 that were excluded from the scenario modelling due to the assumption these people were partially supported residents. Furthermore, 87 high care residents were accommodated by providers in LGAs for which no low and extra services high care data were available.

Source: KPMG (2013).

**Allowing draw downs on lump sum accommodation payments**

The impact of removing prescribed retention amounts may be alleviated by federal government moves to allow DAP amounts to be deducted from RADs under section 52J-7 of the Aged Care (Living Longer Living Better) Bill 2013.
Providers will be able to generate income through draw downs on RADs. This provides an opportunity to increase income from RADs because it removes the cap on prescribed retention amounts. The draw down arrangements also allows the provider to be compensated for any loss of income or increased cost of debt from a reduced RAD balance. This may be particularly beneficial for providers that have relatively low RADs, or where residents cannot afford to pay the published RAD.

4.3.2 Impacts from changes to optional additional services and to Extra Service regulations

Under the LLLB reforms, the federal government will clarify the circumstances under which providers will be allowed to offer optional additional services, where providers can offer optional additional services for a fee. Residents will be able to opt in or out of these additional services at any time. This clarification may encourage more residents and providers to consider such options, although providers may be limited in the scope of optional services offered due to the opt-in opt-out nature of the arrangements.

The federal government will also continue to allow approved providers to apply for Extra Service Status whereby a provider will be given authority by the Department of Health and Ageing to enter into a contract with a resident for extra services for a fee. Extra Service is currently restricted to a whole service or dedicated wing. Under the LLLB, this approval may be given for individual rooms irrespective of where they are located.

Under current Extra Service arrangements, the Government reduces the amount of the care subsidy by 25 per cent of the government approved Extra Service fee. Under the LLLB reforms, the federal government will no longer make this reduction after 1 July 2014.

4.3.3 Impacts from other LLLB reforms

Changes to the Aged Care Funding Instrument (ACFI)

A range of changes to the Aged Care Funding Instrument (ACFI) were introduced during 2012-13 to bring future growth in per capita residential daily care subsidies into line with real growth rates of 2.7 per cent over the period 2012-13 to 2016-17.

Changes were made due to the higher than expected growth in government funding per resident since its introduction in 2008, which were considered unsustainable by the federal government. These changes were introduced on 1 July 2012, 1 February 2013 and 1 July 2013. According to the Department of Health and Ageing, they were developed following consultation with a range of key stakeholders in the aged care sector, and were designed to target specific areas of high growth in funding claims within the ACFI.

The first set of ACFI changes involved:

- a change to the scores in question 3 of the Activities of Daily Living (ADL) domain from 1 July 2012; and

- a change to the Complex Health Care (CHC) matrix from 1 July 2012.

In addition, a one-off price change took effect from 1 July 2013, which when taken with the indexation that applied at the same time, resulted in ACFI subsidy rates remaining unchanged from 2011-12 to 2012-13.

The aim of these changes was to slow the growth in aged care subsidies to bring future growth in line with historic growth rates. The revised scoring arrangements implemented on 1 July 2012.

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27 The resident must have requested a deduction in writing and agreed to the amount to be deducted.
resulted in some residents receiving a lower ACFI score and therefore the provider receiving lower funding compared to what would have otherwise been received.

However, overall subsidies for providers continue to grow. Subsequent changes introduced on 1 February and 1 July 2013 reinforced the original intent of the ACFI and strengthened evidence requirements. According to the Department of Health and Ageing, this will assist to ensure a sustainable level of growth in future subsidies.

An ACFI Monitoring Group consisting of industry, clinical and consumer representatives has been established to monitor whether the target growth rate is achieved and whether reducing the growth rate has a disproportionate impact on some sub-groups of residents.

Data supplied by the Department of Health and Ageing indicates that average subsidies for July 2012 to January 2013 were $135.07 which is 4.39 per cent higher than the average for the same period the preceding year. Excluding indexation, the growth rate was 2.75 per cent, which is close to the projected target real growth rate to 2016-17 of 2.7 per cent per annum.

### Increased supplements

Other LLLB reforms are expected to directly impact the viability of residential care providers in addition to accommodation payments reform and extra services. These include the following.

- Continuation of the increased viability supplements to smaller providers in regional, rural and remote locations, and providers that provide services to Indigenous Australians and people who are homeless with the government providing an additional $108.0 million over five years.
- Introduction of an additional dementia and severe behaviour supplement and a new veteran’s supplement to providers who care for eligible care recipients.

These increased supplements are expected to increase the income of those providers eligible for the supplements, with the potential to increase viability.

### 4.4 Actions for consideration

There are several actions related to viability that could be further considered by ACFA in monitoring and evaluating the impacts for financial arrangements on the residential care sector.

- Monitor the implications for viability of the new regulations governing accommodation payments by non-supported residents, in particular the potential shift from RADs to DAPs and the potential increase in RADs from allowing providers to request a RAD, DAP or combination of both from new non-supported high care residents.
- Monitor the mix of Level 1, 2 and 3 accommodation payments and applications and approvals provided by the Aged Care Pricing Commissioner to better understand how Level 3 pricing guidelines are being applied.
- Determine why there is large variability in financial performance of providers within the industry, including the divergence in profitability and EBITDA, the nature of services that populate each quartile, and whether the variability in financial performance is normal compared to similar industries. This could also include research to determine the characteristics of better performers and the barriers to improved performance.
- Determine whether the large variability in financial performance is an issue for sustainability, pricing and quality.
- Quantify and monitor the extent of dependence on cross subsidisation, including cross subsidisation of overall care costs from income derived from accommodation payments by self-funded residents, and cross subsidisation of supported residents and residents in low home value regions from high value accommodation payments.
• Highlight the need for more up-to-date data on the financial performance of residential care providers to assist monitoring of the impacts from financial arrangements. This could include standard and compulsory segment data, better financial data for Home Care, and better service level financial data to ameliorate current data inadequacies.

• Analyse potential mechanisms to review the range and extent of opt in opt out services being offered by providers and whether these arrangements have an impact on the quality of services provided.

• Monitor the trends in ACFI indexation, national FWA wage case and productivity changes, and their associated impacts on viability.
5 Access to quality care

Access to quality aged care is essential for the health and wellbeing of older Australians. Early access can help people avoid decline in their health and allow them to live independently within their community.

Appropriate access to aged care allows people to obtain aged care and support services in a timely manner, which meets assessed needs irrespective of disability, capacity to pay, location and cultural background.

However, access to aged care is not sufficient on its own to ensure that older Australians have the opportunity to maximise their health and wellbeing. Care must be of sufficient quality that meets accreditation and community requirements, including adequate levels of safety. Quality considerations for standards of effective care and care experience are also important. Quality aged care requires consumer focus, flexibility and must help improve the continuum of care provided at home, in hospital and in aged care facilities.

5.1 Indicators to measure access to quality care

5.1.1 Access indicators

Several indicators to measure changes to access were sought from a range of government publications. These included:

- availability of beds (occupancy rates) compared to population need;
- access to residential care, including assessment and waiting times; and
- representation of special needs groups.

5.1.2 Quality indicators

Indicators were also investigated to measure changes in quality. These fit into two broad groups, including output and outcome indicators. Output quality indicators measure residential care outputs that lead to better outcomes, such as accreditation of residential care facilities. For these to be useful there must be a strong link between the output and outcome. Outcome quality indicators measure outcomes desired by residents, such as improved health and wellbeing and greater satisfaction with care and facilities.

Although outcome measures are generally preferred in measuring quality, they can be difficult to accurately measure given confounding factors that can impact aged care outcomes. For example, if differences in the health of residents across facilities are not accounted for when measuring care outcomes, then facilities caring for people with relatively complex health care needs may be seen as delivering less quality care due to worse health outcomes.

There are several additional quality indicators that have been developed to measure quality in residential aged care. These include indicators used by the Australian Institute of Health and Welfare (2008), indicators developed by Campbell Research and Consulting (2007), and indicators developed and used by the Victorian government for public sector residential aged care services (Victorian Department of Human Services 2008).

Although these indicators are useful, they are either not updated on an annual basis, do not cover the entire residential aged care sector, or suffer from limitations in the interpretation of their results due to confounding factors. Consequently, their use for measuring quality changes associated with changes to financial arrangements is limited and has not been included in this report.

5.1.3 The future of access and quality indicators

The need for better quality indicators has been recognised by the National Aged Care Alliance in their review of quality of care, noting that a national set of quality indicators should be developed, including a review of the definition of quality, and a strategy to collect data and use outputs appropriately (NACA 2013).

The federal government has also recognised the need for improved quality indicators in the LLLB reforms. This includes $9.1 million in funding to improve data collection and dissemination through a new centralised Aged Care Data Clearing House. Some of the funding will be provided to the Australian Bureau of Statistics for the Survey of Disability and Aged Care (SDAC) to expand the survey and increase its frequency from every six years to every three years starting in 2014-15.

The federal government is also aiming to develop quality indicators that will provide a basis for comparing aged care service providers. These will be developed in consultation with stakeholders and will be published on the My Aged Care website for residential care from 1 July 2014 and for Home Care services from 1 July 2016.

A rating system is also being developed to assist consumers in making informed decisions by providing better information about services. The rating system will enable service providers to benchmark their own services and may provide more market-based incentives to improve the services they offer.

5.2 Current access to quality care

The Survey of Disability Ageing and Carers (SDAC) shows self-reported unmet need fell between the 2003 and 2009 (ABS 2010). The share of people whose needs are completely unmet has fallen across all age groups, both for people with needs relating to their core and non-core functions. Results from the SDAC suggest unmet needs have increased for those aged 85 years and older (ABS 2010).

It is unclear from the SDAC what is driving the reduction in unmet need for the population aged under 85 years, or the increase in need for people aged 85 years and over. It could be a change in need, or a change in access to community and residential aged care services and informal aged care. Indicators suggest there has been some improvement in access to residential care (see Table 5.1).

TABLE 5.1: INDICATORS TO MEASURE ACCESS

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Does the trend suggest access is improving?</th>
<th>Has access improved in the last year of measurement?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of beds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average residential occupancy rate</td>
<td><img src="#" alt="Green" /></td>
<td><img src="#" alt="Green" /></td>
</tr>
</tbody>
</table>

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| Operational aged care places (per 1,000 people) |  |  |
| Number of operational residential aged care places ('000) |  |  |

### Assessment and waiting for residential care

| Total aged care assessments |  |  |
| Indigenous aged care assessments |  |  |
| Median days of waiting between ACAT and entry into residential aged care (high care) |  |  |
| Median days of waiting between ACAT and entry into residential aged care (low care) |  |  |
| Hospital patient days used by those eligible and waiting for residential aged care |  |  |

### Representation of special needs groups

| Aged care recipients from non-English speaking country (high care) |  |  |
| Supported aged care residents (% of total residents) |  |  |
| Indigenous aged care recipients (high care) |  |  |
| Indigenous aged care recipients (low care) |  |  |

Note: 1. Traffic light indicators should be interpreted with caution as some indicators may be deemed more important to the residential care sector than others. Indicators will continue to be developed through subsequent annual reviews. 2. Aged care assessments of persons aged 70 years or over and Indigenous persons aged 50–69 years. 3. Per 1,000 Indigenous persons aged 50 years or over. 4. Rate per 1,000 patient days. 5. Per 1,000 people aged 70 years or over from a non-English speaking country.

Source: See Appendix D for data underlying each traffic light.

#### 5.2.1 Indicators on the availability of beds

Several indicators show that the demand for residential aged care is strong. For example, occupancy rates have been high at over 90 per cent and up to 98 per cent in some jurisdictions. However, in the last five years this has tapered off slightly, with occupancy rates generally falling, although occupancy rates increased in the last year of measurement.

Growth in operational aged care places seems to be keeping pace with population growth. The number of operational aged care places per 1,000 people increased by six per cent between 2006 and 2011, while the number of residential aged care places has increased by 18,800 over the same period. This partly reflects the decision in 2007 to increase the provision ratio to 113 places per 1,000 people aged 70 years and over.
The needs of older Australians have been changing, moving towards higher care requirements due to people living longer and the associated increased prevalence of chronic health conditions correlated with older age.

The residential aged care sector has shifted towards meeting these needs. The proportion of providers offering low care only decreased from 16 per cent to 6 per cent between 2006-07 and 2011-12 (DoHA 2012a). There was a small decline in operators offering mixed care, but an increase in providers offering high care only from 45 per cent to 64 per cent.

The share of operational places occupied by high care residents has also increased. There has been approximately a 50:50 split in the allocation of residential places to high and low care every year over the past five years, yet there has been a growth in the utilisation of operational places for high care. In 2012, 73 per cent of operational places were utilised for high care, compared to 65 per cent in 2007 (DoHA 2012a; DoHA 2007).

### 5.2.2 Indicators on assessment and waiting times

Access to residential care was proxied by access to aged care assessments given a person must be assessed before entering residential care. The number of assessments has declined recently, although some of this decline can be explained by changes to administrative requirements in 2009 (hence the amber rating in Table 5.1).

However, total aged care assessments have declined since this change from 78.1 in 2009-10 to 74.0 in 2010-11, suggesting other factors may be driving the decline.29

The median days of waiting between ACAT and entry into residential aged care fluctuated from year to year, although the trend could be considered relatively flat for high care. In 2011-12 there was a median wait of 28 days, which was unchanged from the prior year. For low care the median waiting times have decreased, from 66 days in 2006-07 to 56 days in 2011-12, suggesting access has improved.

Residents are also required to wait for residential aged care if leaving hospital. The number of patient days used by residents in a hospital has improved, suggesting greater access for people leaving hospital. In 2007-08 the rate was 14.6 days per 1,000 patient days, reducing to 11.7 days in 2010-11.

### 5.2.3 Indicators representing special needs groups

Access to residential care for people with non-English speaking backgrounds increased from 34.4 residents per 1,000 people aged 70 years or over from a non-English speaking country, to approximately 53.2 residents between 2005-06 and 2011-12. The increase has been subdued in the provision of low care.

Access has been increasing for supported residents.30 Approximately 41 per cent of new high care residents and approximately 38.2 per cent of all residents were supported in 2011-12 compared to 29.5 per cent in 2005-06. The proportion of new supported residents has increased in high and low care, although the increase has been more pronounced in low care.

Access to residential aged care is currently lower for Indigenous Australians relative to non-Indigenous Australians. Relative to their population share, Indigenous Australians account for a

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29 Per 1,000 people aged 70 years and over and Indigenous persons aged 50-69 years.

30 The criteria for being deemed a supported resident are based on the date of the resident’s entry to care, home ownership and occupancy, receipt of income support and the level of assets held at entry. The federal government planning guidelines aims for providers to offer a minimum proportion of residential places for supported residents. Targets range from 16 per cent to 40 per cent of places, depending on the region where the provider is located.
smaller proportion of aged care residents but a larger share of CACP, EACH, EACH-D recipients and HACC client (SCRGSP 2013). However, there has been an increase in the proportion of Indigenous Australians aged 50 years and over accessing high care.

5.3 Potential changes to access

A number of LLLB reforms are likely to impact access to quality care. Potential changes may arise from accommodation payments reforms outlined in Chapter 4, and other financial arrangements, such as the increase in the accommodation supplement for partially supported residents within a facility significantly refurbished or newly build on or after 20 April 2012.

In addition, LLLB reforms unrelated to financial arrangements will impact access to quality care. For example, the My Aged Care website and a national call number that will increase access to information on aged care services and assist people accessing services are key components of the Aged Care Gateway, which is to be built over time. Although not the remit of ACFA, non-financial arrangement reforms are discussed in this chapter to provide context.

5.3.1 Impacts from accommodation payments reform

Access to quality care may be impacted through a change in:

- care recipient contributions through a change in the price of accommodation; and
- ability of providers to cross subsidise care and accommodation costs in low home value regions with accommodation income from higher socio-economic regions.

Change in care recipient contributions

Removing the distinction between low and high care and the ability to charge residents entering high care a RAD or DAP will remove the current accommodation charge cap. This is expected to increase the amount of income generated from high care resident accommodation.\(^{31}\)

Any increase in income from high care resident accommodation will improve the attractiveness of investing in high care. Even if high care residents choose to pay periodically, providers have the ability to charge a greater DAP compared to the current capped accommodation charge.

If providers do charge high care residents amounts greater than the current accommodation charge, high care residents will face an increase in the amount they need to contribute to their accommodation. For most people this may not be problematic. People entering high care will be faced with the same decision to either pay a DAP, RAD or combination of both just in the same way people entering low care.

There is evidence that cross subsidisation for accommodation occurs within some facilities and across services. For example, some providers seek a large bond from those people capable and willing to pay, and a smaller bond for those less wealthy.

There is uncertainty around the future scope for cross subsidisation in accommodation within the sector. A large proportion of providers may not be able to access high value bonds from some of their residents.

The introduction of the Level 2 threshold on accommodation payments and the new regulatory arrangements for Level 3 prices may reduce the ability of some providers to cross subsidise the less wealthy residents if some of their Level 3 accommodation prices are not approved by the Aged Care Pricing Commissioner. For those care recipients that would have otherwise paid a

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\(^{31}\) The equivalent RAD based off an accommodation charge of $32 is approximately $168,000,\(^ {31}\) which is much lower than the average new RAD value of $259,600 in 2011-12.
higher RAD, this change represents a decrease in cost for accommodation and therefore an increase in access to residential care.

Providers that do not have some of their RADs approved by the Aged Care Pricing Commissioner may seek to increase their lower value RADs in order to maintain their average RAD value. However, the extent of this will depend on whether being able to access RADs from high care residents is sufficient to maintain their average RAD value.

If lower RAD values are increased this may reduce access to people that have enough wealth to disqualify them from being classified as a supported resident but not enough wealth to meet increased RAD values. There could be a gap in access to accommodation for ‘lower middle’ wealth people.

The potential for reduced access to these people may be alleviated by federal government moves to allow for daily accommodation payments to be deducted from RADs (see Section 3.1.1). These amendments are an alternative to regulated retentions, and may be particularly beneficial in regions where RADs are relatively low (e.g., rural and remote areas where home values are relatively low) if residents cannot afford the published refundable deposit.

Ability of providers to cross subsidise care
The objective of the accommodation pricing regulations being introduced by the federal government is to ensure that accommodation prices reflect the underlying value of the accommodation.

Changes to accommodation payments regulations may impact quality of care if providers currently cross subsidise care with income from accommodation payments (or alternatively face an increased cost of debt).

If changes to accommodation payments lead to more income (or a reduced cost of debt), providers may increase expenditure on care through additional cross subsidisation thereby increasing quality. This is especially the case considering quality will be more easily compared across providers once the My Aged Care website is developed and quality indicators are published.

If changes to accommodation payments lead to reduced income (or an increased cost of debt), providers may try to increase or maintain return on investment by reducing costs elsewhere. This may lead to a reduction in spending on care, either in absolute terms or per resident terms. However, providers will need to balance this with any impact on the demand for care. There is also the need to maintain accreditation.

5.3.2 Impacts from optional additional services reform
Clarifying the circumstances under which providers may offer optional additional services for a fee and allowing providers to seek extra service status for rooms (rather than just whole buildings or dedicated wings) may provide greater access to a higher standard of amenities and hotel-type services for residents who can pay higher fees. Caps on total extra services places through the allocation rounds will be maintained.

5.3.3 Impacts from other LLLB reforms
Other LLLB reforms are expected to also impact access to quality care, including:

- increasing the supply of aged care places with increased emphasis on Home Care;
- changing the accommodation supplement, resulting in an increase to approximately $52.84 for facilities ‘significantly refurbished’ or newly built on or after 20 April 2012;
- building the Aged Care Gateway over time; and
• introducing the Better Health Care Connections Program to develop sub-acute care capability in residential care facilities and to promote innovative care programs.

Change to the residential care provision ratio

Under the LLLB reforms the provision target for aged care places will increase from 113 to 125 per 1,000 people aged 70 years and over by 2021-22, with a significant rebalancing of the proportion of residential and Home Care places.

Over the next decade the ratio of Home Care places will increase from 27 to 45 packages per 1,000 people aged 70 years and over, and the ratio of residential care places will reduce from 86 to 80 places. This change will lead to approximately 85,000 additional Home Care packages and 75,000 residential care places by 2021-22. This will translate into approximately 64,000 more Home Care places but 23,000 fewer residential care places when compared with projections under current provision ratios (see Chart 5.1).

CHART 5.1 PROJECTED CARE PACKAGES AND OPERATIONAL PLACES PRE AND POST LLLB REFORMS

The impact on unmet need from changing the provision ratio will need to be monitored carefully. The increase in Home Care packages is expected to change the mix between Home Care and residential care, with an associated change in government funding of aged care expenditure.

The shift towards Home Care may also increase the demand for other types of care, such as respite care, day rehabilitation, specialist dementia day care and transition care. It may also increase the demand for informal carers when the supply of informal care is decreasing, due to the complementary nature of Home Care and informal care.

Increase in accommodation supplement for supported residents

The increase in the accommodation supplement for facilities ‘significantly refurbished’ or newly built on or after 20 April 2012 may improve quality of facilities by encouraging providers to undertake refurbishments. It may also encourage further investment in additional beds within a facility if it meets the definition of 'significant refurbishment'.

However, its impact on investment must also be considered in light of other LLLB funding arrangement reforms. In some cases it may complement other reforms to further encourage
investment, such as the capacity to charge high care residents a lump sum accommodation payment. In other cases it may be negated by uncertainty around the outcomes of reforms, such as whether there will be a significant shift from RADs to DAPs.

Ultimately the impact of the accommodation payment will depend on the unique circumstances of each provider, with some providers likely to be encouraged to undertake further investment, while other providers may be unwilling or constrained (e.g., through limited access to debt or equity).

The Aged Care Gateway

The Productivity Commission (2010) highlighted problems with access related to the complexity of procedures and lack of information about pricing and services provided by facilities.

In order to facilitate improved information and service for consumers and their families, a major feature of the federal government’s LLLB reforms is the establishment of an aged care gateway. This is aimed at improving access to aged care services by providing a single entry point to the aged care system. The federal government has budgeted $198.2 million over five years from 2012-13 to build the Gateway.

According to the Department of Health and Ageing, key elements of the Gateway will include:

- a national contact centre, including the My Aged Care website and a single national phone number;
- an assessment service to identify needs based upon a nationally consistent assessment framework and standardised tools;
- a central client record to support appropriate information collection and sharing; and
- a Linking Service targeting vulnerable people with multiple needs.

The Department of Health and Ageing has also noted the key objectives of assessment through the aged care Gateway are:

- to provide a streamlined and standardised assessment process for entry into aged care programs;
- develop an efficient and effective service delivery model for Aged Care Assessment that provides the best value for money under the purchaser provider arrangements;
- provide a means to benchmark aged care service provision enabling ongoing improvement and innovation whilst ensuring an efficient and cost effective use of resources; and
- to ensure that client needs are consistently identified and matched to services in a fair and equitable manner.

Part of the Gateway is the development of the My Aged Care website. This will publish a ratings system of aged care homes so that people can make a more informed choice about their care by comparing services in their area. This improved consumer information has the potential to encourage competition among providers, which should encourage improvements in access to care and encourage improvements in efficiency.

Better Health Care Connections program

Another potential change to accessing care in residential aged care facilities is the increasing use of episodic care, such as sub-acute care. The federal government is promoting improved links between hospitals and aged care facilities to deliver more efficient and more appropriate care through the Better Health Care Connections program.
This program will provide $80.2 million over five years for specialist palliative care and projects with a focus on prevention of hospitalisation for older Australians and improved access to complex health care (DoHA 2012a).

The shift from hospital care to more appropriate sub acute care delivered in residential care facilities provides an opportunity for providers to diversify their revenue. There could be large demand for these types of services to be delivered by residential aged care providers in the future if local health districts (LHDs) look for ways to reduce their costs to meet efficient prices under the newly adopted activity based funding framework introduced by the federal government in July 2012.

5.3.4 Changes to community care arrangements

Part of the community care (Home Care) program expansion includes new packages in order to provide a greater continuum of care.

From 1 August 2013 Home Care will replace community care and some forms of flexible care. There will be four levels of Home Care packages to provide for a better continuum of care at home. Existing care packages currently delivered in the form of CACP (community care under the Act), EACH and EACH-D (flexible care under the Act) will transition to Home Care packages.

From 1 August 2013 a new Dementia and Cognition Supplement will also be available across any of the four levels of Home Care Packages to consumers who meet the eligibility criteria. The Dementia Supplement will provide an extra 10 per cent funding on top the basic subsidy level for the relevant Home Care Package.

There will also be a new funding supplement for veterans with an accepted mental health condition. Like the Dementia and Cognition Supplement, the Veterans’ Supplement will provide an extra 10 per cent funding on top of the basic subsidy level for the relevant Home Care Package level for eligible consumers. Veterans with a Department of Veterans’ Affairs accepted mental health condition will be eligible for the supplement and providers will automatically receive the supplement for eligible consumers from 1 August 2013. An approved provider can receive either the Dementia and Cognition Supplement or the Veterans’ Supplement in respect of an eligible consumer.

LLLB reforms will also introduce consumer directed care (CDC) into mainstream aged care program delivery. CDC involves tailoring services to care recipients’ preferences, including greater flexibility in the timing and scheduling of services and how care is shared between informal and formal carers.

Based on evaluation results from CDC program pilots, all new Home Care packages allocated after 1 August 2013 will be offered on a CDC basis. All existing Home Care packages will be offered CDC from 1 July 2015. LLLB reforms also include funding for a CDC pilot program in residential aged care, which will include evaluating the best way to implement CDC in residential care.

5.4 Actions for consideration

There are several actions related to access and quality care that could be further considered by ACFA in monitoring and evaluating the impacts for financial arrangements on the residential care sector.

- Monitor the extent to which people take up new Home Care packages and the implications of any shift towards community care from residential care in light of reduced provision ratios for residential care, including potential gaps in access to residential care.
• Analyse better ways to define and measure quality and request annual data be collected by the federal government to measure changes to quality, noting the federal government has recognised the need for improved quality indicators in the LLLB reforms.

• Develop metrics on consumer satisfaction and assess the viability of undertaking annual surveys of residents, their families and carers to collect data on consumer satisfaction with residential care.

• Develop metrics to measure the supply of informal care and assess the viability of collecting data on informal care on an annual basis through the Australian Bureau of Statistics (ABS).

• Develop better ways to assess the level of unmet need in the community, and request annual data to be collected by the federal government to monitor the proportion of consumers that have received their first choice in accessing services, and any change in unmet need due to LLLB reforms and external factors.
6 Workforce

An ageing workforce, together with a growing number of older people with increasing rates of complex chronic conditions and expectations for improved standards of care are placing greater demands on the aged care workforce.

In addition, increasing demand for both informal and formal care in complementary areas such as health and hospital care and disability care is creating increasing competition for carers, nurses and medical staff in the aged care sector.

The competition for resources and a skilled workforce, including the labour intensive nature of current care delivery arrangements, means that aged care providers will need to focus on improving productivity including adopting new technologies, upskilling staff, and adopting attractive workplace practices.

An adequate aged care workforce will be flexible enough to provide an appropriate number of workers with the right skills mix, to deliver quality care and meet the growing demand for care requirements and changing preferences.

6.1 Indicators to measure workforce

Indicators that were investigated to measure changes in the aged care workforce include:

- the number of direct care employees;
- employees per residential care place;
- facilities with at least one person on Workcover;
- proportion of the workforce aged 55 years and over;
- facilities catering to ethnic or cultural groups;
- staff turnover;
- time to fill vacancies; and
- skills gaps.

The ABS Labour Force series provides aggregate data on employment in the health care and social sectors including residential aged care services on long term employment trends. This publication was used for data on employees per residential care place and the cost of labour.

However, the national aged care workforce census and survey conducted by the National Institute of Labour Studies (NILS) at Flinders University on behalf of the Department of Health and Ageing is the main data source on workforce characteristics including both residential and community care.

Three surveys are available from 2003, 2007 and 2012 (Richardson and Martin 2004; Martin and King 2008; King et al 2013). Although the most recent NILS survey provides a good snap shot of the residential aged care workforce, the usefulness of this survey is limited for the purposes of measuring the impacts of financial arrangements on the aged care workforce due to the long period between surveys.

6.2 Current workforce

The aged care workforce is a significant employer within the Australian economy. In 2011-12 there were 202,344 people employed in residential care, with 147,086 of these providing direct care to residents (King et al 2013).
However, the aged care workforce has been changing, driven by an increased demand for carers, and a change in care needs and preferences for the delivery of care. Table 6.1 provides a traffic light representation of trends in the residential care workforce, based off data collected in the previous three national aged care workforce census and surveys. Underlying data is presented in Appendix E.

**TABLE 6.1: INDICATORS TO MEASURE WORKFORCE\(^1\)**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Does the trend suggest the workforce is improving?</th>
<th>Has the workforce improved in the last year of measurement?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General workforce indicators</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FTE direct care employees (number)</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Employees per residential care place</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Facilities with at least one person on Workcover</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Proportion of direct care workforce aged 55 years and over</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Facilities catering to ethnic or cultural groups</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Availability of informal carers</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td><strong>Staff turnover (^2)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered nurse</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Enrolled nurse</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Personal care attendant</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Allied Health</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Direct care workforce actively seeking work (^3)</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

**TABLE 6.2: INDICATORS TO MEASURE WORKFORCE\(^1\) CONTINUED**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Does the trend suggest the workforce is improving?</th>
<th>Has the workforce improved in the last year of measurement?</th>
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</thead>
<tbody>
<tr>
<td><strong>Continued</strong></td>
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</tbody>
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6.2.1 General workforce indicators

There has been an increase in direct care employees showing the aged care workforce is growing in response to the increased demand for aged care services. In 2003 there were 76,006 FTE direct care employees, which have increased to 94,823 in 2012. This represents an increase of 24.8 per cent, or an average annual growth of 2.8 per cent. In addition, growth in the number of persons employed in the residential aged care from 2007 to 2012 was slightly higher than the health care sector, with 29 per cent growth compared to 28 per cent.

The ratio of employees per aged care place slightly increased between 2006 and 2011 from 1.01 to 1.12. This may reflect a response to increasing care needs of residents, or a catch up in staff shortages that have historically characterised the sector.

The number of serious injuries to staff seems to have increased. In 2007 approximately 33 per cent of facilities reported at least one person on Workcover, which increased to approximately 54 per cent of facilities by 2012. Limited industry statistics on lost time injury frequency rates limits benchmarking between providers.

The direct care workforce in residential care has historically been older than the Australian workforce in general. However, over the last ten years the proportion of workers over the age of 55 years has increased, from 16.9 per cent in 2003 to 27.2 per cent in 2012. This suggests there is increased pressure on providers to attract younger people into the sector to ensure the workforce is sustainable.

There has been an increase in the number of facilities catering to ethnic or cultural groups from 10 per cent in 2003 to 25 percent in 2012. In 2012, 79 per cent of aged facilities reported they employed staff with specific language skills or cultural knowledge.

The availability of informal carers has decreased from 13 per cent of the population in 2003 to 12.2 per cent in 2009 (ABS 2010; 2004). Within this period there was an increase in primary carers but a reduction in non-primary carers. The reduction in informal care could be a significant concern for the sector and federal government. A reduced supply of informal care will translate into an increased need for more Home Care and residential care services, placing greater demands on the sector and federal government budget.
6.2.2 Staff turnover indicators

Using the number of people in current job with tenure less than one year, staff turnover has remained relatively flat for registered nurses but improved significantly for enrolled nurses, personal care attendants, and allied health workers.

In 2012, approximately 21.5 per cent of registered nurses were in their current job for less than one year, which compares to 13.3 per cent, 15.1 per cent and 13.4 per cent for enrolled nurses, personal care attendants, and allied health workers respectively.

The majority of workers are not leaving the aged care sector but moving within the sector to another facility. For example, 71.4 per cent of registered nurses and 63.1 per cent of enrolled nurses had previously worked in aged care before moving into their current job. For these occupations the primary reasons for leaving their previous job was for personal circumstances of the employee, to find more challenging work, and to get the shifts or hours desired (King et al 2013).

Looking to the future, approximately 9.2 per cent of direct care employees were actively seeking alternative employment in 2012. This is the first time this data has been collected by the census and survey of the aged care workforce.

6.2.3 Skills gaps indicators

While the residential direct care workforce has expanded over the last ten years there is evidence to suggest workforce skills have also been changing. For example, high care residents increased by 15.8 per cent from 2009 to 2012 while FTE registered nurses increased by three per cent over the same period.

However, this has been complemented by an up-skilling throughout the remaining direct care workforce, with a greater proportion of people holding a Certificate III and Certificate IV qualifications. For example, the proportion of personal care assistants with the Certificate IV in Aged Care has increased from eight per cent in 2003 to 20 per cent in 2012 (King et al 2013).

A gap in high care skills has been found by Health Workforce Australia (HWA). Detailed workforce projections identified a 27 per cent gap in registered nurses by 2025 (HWA 2012). Their report highlights the issues of continued competition for registered nurses in the aged care sector, and the need to identify innovative workforce solutions including training and productivity measures.

A potential gap in the supply of workers is evident within the increasing trend in vacancies between 2003 and 2012, which has been consistent across all direct care occupations. For example, the proportion of facilities reporting registered nurse vacancies increased from 25.7 per cent to 32.7 per cent, while the proportion of facilities reporting vacancies for enrolled nurses nearly doubled to 18.7 per cent in 2012. However, the greatest skills gap is for personal carers, with 36.0 per cent of facilities reporting a vacancy in 2012.

The most common response to ameliorating skills shortages is to ask existing staff work longer, at 63 per cent of responses Approximately 53 per cent of providers indicated they made greater use of agency staff (King et al 2013).

6.3 Potential changes to the workforce

6.3.1 The Workforce Supplement

The most significant impact on the workforce is likely to occur indirectly through impacts to the viability of providers (as discussed in Chapter 4). However, the largest potential direct impact to the workforce will come through the Workforce Supplement and the Aged Care Workforce Plan, which will be developed in 2013.
Aged care providers that meet the terms and conditions of the supplement will be paid an Aged Care Workforce Supplement to pass on to workers as wage increases. According to the Department of Health and Ageing, the aims of the Supplement are to:

- improve the aged care sector’s capacity to attract and retain a skilled and productive workforce; and
- provide funding to assist the sector in delivering fair and competitive wages in the short term.

The Supplement will be available to eligible providers from 1 July 2013. Providers must ensure a minimum annual increase in wages of 2.74 per cent, or the Fair Work Commission annual minimum wage increase, whichever is greater, and maintain minimum margins above relevant award rates for all employees.

The Department of Health and Ageing notes that the Aged Care Workforce Development Plan will consider:

- improved career structure;
- enhanced training and education opportunities;
- improved career development and workforce planning; and
- better work practices.

6.3.2 Potential external impacts on workforce

Significant changes in the broader workforce are expected to impact the supply of workers in residential care. This includes:

- the introduction of a fully functioning national disability insurance scheme, known as DisabilityCare Australia;
- recent announcement on award increases for social and community sector workers; and
- increased home care packages and the need for additional staff to provide care through these packages.

DisabilityCare Australia

On 21 March 2013 the National Disability Insurance Scheme Bill passed through Parliament, with the NDIS being renamed DisabilityCare Australia. This legislation provides a broad framework for operation of the scheme.

In the 2013-14 Budget, the federal government announced it will provide $14.3 billion in new funding over seven years for DisabilityCare Australia, starting in 2012-13. Including the expected current spend on disability, the federal government will provide a total of $19.3 billion to DisabilityCare Australia over seven years.

Once DisabilityCare Australia is fully implemented it will provide funds to around 460,000 people with significant and permanent disability. This will be used to provide better access to disability care and support services.

DisabilityCare Australia will require a large increase in the supply of disability workers, which will compete for with the aged care sector given a large range of skills are interchangeable. The Productivity Commission indicates that upward pressure for these workers is likely to occur, especially to attract young people and skilled workers who may have left either the aged or disability sector due to low wages (PC 2011b).

Award increases for social and community sector workers
The federal government’s recent announcement on award increases for social and community sector workers involves pay increases of between 23 per cent and 45 per cent in nine stages over eight years.

The federal government has committed $3.3 billion but significant funding commitments from the state and territory government are still under negotiation. Some workers received the first stage of increases in December 2012.

Improved remuneration for workers in the social and community sector will help attract new hires. It may also attract some workers from the aged care sector given the improved pay conditions.

**Increased home care packages**

Changes to the Home Care provision ratio is estimated to lead to 84,538 additional Home Care packages and 65,213 residential care places by 2021-22 (see Section 4.3.3).

The substantial increase in Home Care places is more than double the current number of packages being delivered in the community. The Home Care workforce will also need to more than double given there is limited opportunity to reduce the labour requirement associated with delivering Home Care.

As residential care places are also expected to increase there is the potential for a relatively large increase in the demand for direct care workers. The substitutability of residential care workers and Home Care workers means the current skills gap in residential care may be exacerbated in the near future.

### 6.4 Actions for consideration

There are several actions related to the workforce that could be further considered by ACFA in monitoring and evaluating the impacts for financial arrangements on the residential care sector.

- Request that similar data to that collected for the federal government in the National Institute of Labour Studies to be collected annually rather than every four years. This could include data on lost time injury frequency rates (LTIFR) across provider groups to enable providers to benchmark their performance and improve workplace safety outcomes.
- Research the potential availability of an informal workforce in the future given changes in family structures and mobility of the population, and the implications to both Home Care and residential care providers from a declining availability of informal carers.
- Analyse better ways to support informal carers, including providing greater capacity to participate in the workforce through improved flexibility, and offering greater support to reduce the requirement to provide care, such as improved access to respite services and assistive technologies.
- Research better measures for workforce productivity that includes time provided by informal carers and differences in the quality and skills of the workforce.
- Research into the potential shortage of workers in the future given competing demands for carers, and analyse better ways to attract and retain aged care workers to better compete with other sectors requiring similar skills, such as disability care workers, social and community sector workers, and the health care sector.
- Consider the scope for the federal government to promote changes to workplace practices to improve productivity, including through the use of new technology and better integration with the health care system.
7 Sector sustainability

A sustainable aged care sector will only be achieved if providers can meet the growing demands and changing preferences for accommodation and care in an efficient and innovative way. Sustainability will require a view over a longer time horizon given the demand for care and factors that impact sustainability (e.g., investment, capital structure) change slowly compared to profitability and cash flow of a provider.

7.1 Indicators to measure sustainability

Several indicators were sought to measure sustainability of the residential care sector. These included:

- the level of investment in the residential care sector;
- the ability of providers to meet demand; and
- affordability for tax payers and care recipients.

The level of investment in the aged care sector was sourced from the Report on the Operation of the Aged Care Act (DoHA 2012a), which provides a summary of investment in new buildings, rebuilding work, renovations and refurbishment.

Indicators to measure the ability of providers to meet demand were sought through data on ACAR responses and outcomes. However, there was no information available on the number of providers who were unsuccessful in obtaining bed licences, or the number of unallocated bed licences by regions.

Instead the ability of providers to meet demand has focused on long term projections of demand using provision ratios before and after the LLLB reforms, provision ratios recommended by the National Health and Hospital Reform Commission (NHHRC) and population growth projections supplied by the Australian Bureau of Statistics.

Affordability for tax payers and care recipients could not be measured by the amount of copayments made by care recipients as time series data were not available. Hence, an analysis of a change in expenditure by residents and the impact on sustainability could not be undertaken. Instead the analysis focused on changes to means testing arrangements under the LLLB reforms.

7.2 Current sector sustainability

7.2.1 Indicators to measure investment

Overall, investment in the residential care sector has been decreasing in recent years (see Table 7.1). For example, new building work completed during the year has decreased from $873 million in 2007-08 to $535 million in 2011-12, although in 2009-10 investment peaked at $1,028 million. Estimated new building work completed during the year decreased by 28.7 per cent in the last year alone.

<table>
<thead>
<tr>
<th>TABLE 7.1: INDICATORS TO MEASURE INVESTMENT</th>
<th>Is the trend in investment improving?</th>
<th>Has investment improved in the last year of</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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New building activity indicators

<table>
<thead>
<tr>
<th>Description</th>
<th>Green</th>
<th>Yellow</th>
<th>Red</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated new building work completed during the year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated new building work in progress at the end of the year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of homes that were planning new building work</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Rebuilding activity indicators

<table>
<thead>
<tr>
<th>Description</th>
<th>Green</th>
<th>Yellow</th>
<th>Red</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated rebuilding work completed during the year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated rebuilding work in progress at the end of the year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of homes that were planning rebuilding work</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Upgrading activity indicators

<table>
<thead>
<tr>
<th>Description</th>
<th>Green</th>
<th>Yellow</th>
<th>Red</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated upgrading work completed during the year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated upgrading work in progress at the end of the year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of homes that were planning upgrading work</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: 1. Traffic light indicators should be interpreted with caution as some indicators may be deemed more important to the residential care sector than others. Indicators will continue to be developed through subsequent annual reviews. New building is defined as work relating to a new building to accommodate new or transferred aged care places. Rebuilding work is defined as the complete demolition and reconstruction of an approved service on the same site. Upgrading work is defined as renovation or refurbishment of an existing service including extensions.

Source: See Appendix F for data underlying each traffic light.

The reduction in estimated rebuilding work completed during the year was much greater in proportional terms compared to estimated new building work completed, almost halving from $184 million to $93 million over the same period.

Some of this decrease in investment may be due to the global financial crisis in 2007-08 and the potential lag effect given the long length of time for new and rebuilding activities. Alternatively, it could reflect the low accommodation prices for supported residents and high care residents, or uncertainty surrounding potential changes in the aged care sector associated with the Productivity Commission’s review on the aged care sector and the federal government’s response.

Data suggests investment in aged care may be increasing. For example, estimated new work in progress increased by $50 million to $478 million (or 11.6 per cent), and estimated rebuilding work in progress increased $10 million to $255 million (or 4.1 per cent) between 2010-11 and 2011-12. This is in addition to a 13.4 per cent increase between 2009-10 and 2010-11.
Over the same period estimated upgrading work completed during the year increased by 60.3 per cent, suggesting providers may have been focusing on improving existing facilities in recent years. Estimated rebuilding work in progress has also increased by 18.1 per cent since 2009-10.

An increase in investment in aged care facilities has also been found in the most recent building approval data from the Australian Bureau of Statistics. In the 12 months to April 2013, total value of building jobs completed for aged care facilities was $1.2 billion, compared to $823 million in the previous 12 months (ABS 2013a).

However, other investment data suggests there is still some investment uncertainty. Although experiencing an increase since 2007-08, the proportion of homes that were planning new and rebuilding work both experienced a decrease between 2010-11 and 2011-12. This does not necessarily indicate lower investment in the future. It may be the case that a smaller proportion of providers will invest relatively large amounts.

Furthermore, upgrade work completed during the year has decreased since 2007-08, from $394 million to $295 million in 2011-12. Over the same period, upgrading work in progress at the end of the year more than halved, from $546 million to $255. Between 2010-11 and 2011-12 both upgrading work completed and upgrading work in progress increased, suggesting providers may have focused on improving existing facilities rather than building new capacity.

**Required investment**

The expected growth in the demand for residential care will require a substantial amount of investment in new and refurbished facilities. The Department of Health and Ageing estimates providers will need to build an additional 74,000 places in the next decade under current planning policies. Including replacement of current stock, the total investment required is around $25 billion (in 2011-12 prices). Additionally, a large number of existing services will need to be significantly refurbished.

Given current investment levels there is the potential for an accommodation supply shortage. For example, the level of investment in new building work completed during 2011-12 was $535 million (see Chart 7.1) and estimated rebuilding work completed during the year was $93 million (DoHA 2012a).

If investment were to remain at the average investment level between 2007-08 and 2011-12, there is a projected additional required investment of $15.0 billion in the next decade, equating to around 80,000 places.

The reduced level of projected investment in residential care compared to need could be a concern for the sector. If investment in residential care does not change, the demand for residential care has the potential to outstrip supply in the near future.

**CHART 7.1: ESTIMATED NEW BUILDING WORK COMPLETED DURING THE YEAR**

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32 These estimates are based on the assumption that current planning policies continue, 78 per cent of rooms will contain a single bed, the median cost of construction is $188,250 per place, real cost of construction grows at 2.5 per cent per year and the average lifetime of a building is approximately 40 years.

33 The average investment level over five years was used to smooth out potential investment anomalies associated with the global financial crisis and uncertainty surrounding changes to the aged care sector. The average estimated new building work completed during the year between 2007-08 and 2011-12 is $831 million, and the average estimated rebuilding work completed during the year is $166 million.
Required rates of return

In order to generate increased investment within the residential care sector, providers will be required to offer an appropriate rate of return to debt and equity investors that is commensurate with the level of provider risk.

The weighted average cost of capital (WACC) represents the weighted average level of return a company pays to its investors. It comprises a weighted average of the cost of equity and the cost of debt. The weight is determined by the proportions debt and equity to total capital.

One primary consideration when deciding on investing in the aged care sector is the risk and return profile compared to other investments. If the expected reward is not commensurate with the perceived level of risk compared to other industries, the aged care sector will not attract investment.

The required rate of return will be variable across the sector, and will vary over time. It will depend on:

- changes to regulatory, funding and economic risks;
- ownership structure of the provider given different tax treatments for not-for-profits;
- risks specific to the provider (e.g., management risk); and
- risks specific to the investment or market (e.g., potential competition from other providers in the area of investment).

Estimated required rates of return at an industry level have varied, and some have suggested that the current return within the industry is not sufficient to attract the necessary investment to cover expected demand. For example, Deloitte Access Economics (2011) estimated a required nominal post tax rate of return of 9.8 per cent compared to an estimated internal rate of return of 2.4 per cent for high care accommodation. Low care accommodation was estimated to have a required nominal post tax rate of return of 8.6 per cent compared to 8.4 per cent internal rate of return.

A similar conclusion around the inadequacy of current rates of return in residential care was made by Grant Thornton (2012). It estimated a required rate of return between 11.49 per cent and 12.98 per cent for high care and an associated EBITDA of $26,536 to $32,204 per bed respectively, compared to only $12,830 EBITDA per bed being earned by the top quartile of high care facilities. A similar result was found for providers of mixed care.
7.2.2 Ability of providers to meet demand

Industry pricing is generally based upon an occupancy rate greater than 90 per cent. Occupancy has been up to 98 per cent in some jurisdictions. However, over 1998-99 to 2009-10 occupancy rates fell in all states except Tasmania.

The Productivity Commission conclude that while the aged care system has improved access to almost all aged care services since 2003, it is not able to provide adequate levels of service to those older Australians aged 85 years and over with core needs, arguably the group most in need (PC 2011a).

Providers are responding to the changing needs of residents. The residential care sector has shifted towards meeting the higher care needs of the population aged 85 years and over, and there has been a significant drop in operators offering low care only.

As part of the LLLB reforms, the ratio for community care will increase from 27 to 45 packages, but reduce from 86 to 80 residential aged care places per 1,000 people aged 70 years and over. The LLLB reforms once implemented will slow the growth in residential age care places while increasing the allocation of Home Care packages.

The reduction in residential aged care places compared to what would have occurred, coupled with an increase in Home Care, will require ensuring adequate residential care places for people with the greatest care needs. People with lower care needs will need to be directed to Home Care.

The preference for staying at home was expressed by care recipients and their carers throughout both consultations associated with the Productivity Commission’s review of the aged care sector (PC 2011a), and consultations undertaken as part of developing the LLLB reforms.

The shift to Home Care is not expected to reduce the viability of existing residential aged care providers. The demand for residential care is expected to grow significantly due to the growth in the number of people aged 85 years and over and people living longer with more long term ailments (e.g., dementia and osteoarthritis).

Pending the five year review into the scope for lifting supply side restrictions, it would be prudent to monitor the balance of care ratios to see whether consumer aspiration to receive care at home reflects the lived experience.

The potential gap between demand and supply of residential care

The potential gap between the supply of residential care under aged care provision ratios outlined in the LLLB reforms and the need for residential care is presented in Chart 7.2. It shows projected residential care places under three alternative growth scenarios, including using the current provision ratio, using the provision ratio developed under the LLLB reforms, and using a growth rate of people aged 85 years and over to better reflect the composition of people in residential aged care facilities, as recommended by the National Health and Hospital Reform Commission (NHHRC 2009).

If the demand for residential aged care places follows the trend in the growth of people aged 85 years and over as suggested by the NHHRC (2009), there is a projected gap in residential care places of approximately 192,600 places by 2050. The gap widens substantially around the year 2029 when the first of the baby boomers turn 85 years old. This suggests that residential care provision ratios may need to be increased over the next 10-15 years to encourage investment in preparation for a significant increase in demand.

CHART 7.2: PROJECTED OPERATIONAL PLACES UNDER ALTERNATIVE PROVISION RATIO SCENARIOS
There is also the question over whether provision ratios are the most appropriate approach to planning aged care given there has been previous revisions to the aged care provision ratios. For example, in 2004-05 there was an increase from 100 to 108 community care packages and bed licenses per 1,000 people aged 70 years or over, and in 2007 there was another increase to the current goal of 113.

The provision ratio for residential care can restrict the supply of places, which can impede competition in areas where there is over subscription for licences. It forms a barrier to entry for new aged care investment allowing less efficient aged care providers to continue operating given the threat of a new entrant is muted. Supply side restrictions can also dampen provider’s response to changing accommodation needs and the desire to innovate.

The proposed five year review of the LLLB reforms scheduled for 2017 will evaluate whether there has been sufficient development of the industry to remove supply side controls.

### 7.2.3 Affordability for taxpayers and care recipients

In the 2010 Intergenerational report (IGR3), total health and ageing pressures was projected to increase total government spending from 22.4 per of gross domestic product (GDP) in 2015-16 to 27.1 per cent of GDP by 2049-50. This will create a fiscal gap of 2.75 percent of GDP in 40 years time (The Treasury 2010).

There is significant pressure on the federal government budget due to increased aged care expenditure requirements. The Commonwealth Treasury indicated spending on aged care is projected to grow from 0.8 per cent of GDP in 2009–10 to 1.8 per cent of GDP in 2049–50 (The Treasury 2010).

Growth in spending on residential aged care will be the main contributor, although spending on community care is also projected to rise substantially due to increased provision ratios. Population ageing is the primary driver of aged care spending over the next 40 years, accounting for around two-thirds of the projected increase in real spending on aged care per person per year (The Treasury 2010).
As future demand increases, so will the need for the federal government to continue to funding the majority of aged care services. There is no policy change in the foreseeable future that can substantially ease the financial pressure from aged care expenditure on the federal government.

Given the federal government will also face pressure to meet the financial needs of other competing sectors (e.g., age pension, education and health), there is the question of whether current and future financial arrangements are sustainable compared to the increased need for care and the expected preferences of care recipients. It can be expected that the federal government will maintain prudent fiscal control over aged care expenditure.

There are two sustainable options to reduce pressure on the federal government budget from aged care expenditure. This includes increased efficiency from aged care providers and increased funding contributions from recipients of care, expecting those that can afford to pay a larger share of their care costs and to meet their daily living expenses and accommodation costs.\(^{34}\)

There is no publicly available data on the efficiency of aged care providers. It can be expected that some providers are more efficient than others, with the potential to improve efficiency within the sector. ACFA could consider analysing the potential to investigate the potential for improved efficiency within the sector, and mechanisms for promoting efficiency.

The need for additional private funding contributions from residents has been recognised by the federal government through changes to income and assets means testing arrangements with a cap on private contributions acting as a safety net (as discussed in Section 7.3.2).

### 7.3 Potential changes to sustainability

#### 7.3.1 Impacts from accommodation payments reform

**Increasing the accommodation supplement**

The maximum level of the accommodation supplement paid by the government will increase for supported and partially supported residents from the current $32.58 per day to approximately $52 per day from 1 July 2014. This increased supplement will only be provided to residential aged care homes that are either significantly refurbished or newly built on or after 20 April 2012.

The extent to which the increased supplement will stimulate investment will depend on the ability of providers to access funds to undertake the upfront investment. Some providers may have large cash reserves they can draw upon to undertake investment in accommodation, while other providers may access debt or equity.

Consequently, the success of the accommodation supplement, and its impact on sustainability, will depend (in part) on the ability of some providers to access debt and equity. This may generate a competitive advantage to providers that have access to cheap funds. Those providers without access to debt or equity may have limited capacity to improve their accommodation to participate in an increased accommodation supplement, which may become a competitive disadvantage as their stock ages.

**Other accommodation payment arrangements**

\(^{34}\) Other options are also available to the federal government but are considered unsustainable. This includes increased taxation, increased debt and a continued shift of funding from other federal government portfolios.
The potential for further investment in the residential care sector will also be determined by impacts on provider viability associated with other accommodation payment arrangements for non-supported residents, as outlined in Section 4.3.1.

In particular, the extent of any switch from RADs to DAPs and the compensating effect from allowing providers to ask new high care residents to pay a RAD, will determine provider access to relatively cheap funds for building activity. The residential care sector sees RADs being an effective form of funding for increased investment growth, with benefits to the resident, the investor and the industry.

Furthermore, removing the accommodation charge and allowing providers to offer a new high care resident a RAD, DAP or combination of both removes the pricing cap currently associated with high care. This is expected to increase income for high care providers, with model estimates suggesting this could result in an additional $93.5 million in 2014-15. This additional income would go some way to improving rates of return on accommodation for high care providers.

### 7.3.2 Affordability for tax payers and care recipients

The federal government has recognised the need to increase the contribution of funding from residents to residential aged care. It will introduce new means testing arrangements that seek additional contributions from care recipients for both Home Care packages and residential care (see Section 3.1.3). This will be based on a care recipient’s income for Home Care packages and income and assets for residential care. 35

These new means testing arrangements may increase the cost of care for some people, through increased care recipient contributions. However, the federal government has also introduced annual caps in both Home Care and residential care. There is also a lifetime cap of $60,000.

Over time the number of full pensioners is expected to decrease (accompanied by a growth in the number of part pensioners) as superannuation balances increase and become a more common source of retirement income. For example, The Treasury projected the average accumulated superannuation member balance to increase from $70,000 in 2009 to $335,000 (nominal) in 2035, or an equivalent 250 per cent increase in real terms (The Treasury 2010a).

However, most care recipient wealth is not locked up in superannuation but in their home. Increased capacity to access housing wealth would allow the federal government to ask people with the means to make an even greater contribution to their aged care (compared to arrangements under the LLLB reforms).

Although some financial products are currently available (e.g., reverse mortgages, debt free equity release products, and bond loans secured on the home), the markets for these products are relatively small. An increase in the use of these products would enable more people with the appropriate means to contribute to their care.

### 7.3.3 Impacts from other LLLB reforms

Many LLLB reforms are intended to have a fundamental impact on the sustainability of the sector. These have been discussed in other sections of this report and include the following.

- Introduction of the Better Health Care Connections program to promote appropriate access to sub-acute care and other types of innovative care for care recipients, while providing providers with the opportunity to diversify their revenue.

35 There is also provision for the five year review to revisit care recipient contribution arrangements, especially the alignment between residential care and Home Care.
• Introduction of CDC for people receiving home care, creating opportunity for residential care providers to diversify into the home care market by creating new and innovative services not currently provided.
• Building the Aged Care Gateway to ensure care recipients have improved access to aged care services, and those with multiple needs are linked to appropriate services.
• Introduction of the Workforce Supplement to improve the working conditions of aged care workers in residential care with the aim of attracting more workers to the sector to meet the expected increase in demand for care.

Sustainability will therefore depend on the interaction of these reforms, along with financial arrangements introduced over the timeline for implementation.

7.4 Actions for consideration

There are several actions related to sustainability that could be further considered by ACFA in monitoring and evaluating the impacts for financial arrangements on the residential care sector.

• Monitor the impact of accommodation payment arrangements on investment within the sector, including the impact of the increased accommodation supplement on the propensity to invest, and the impact of other accommodation payment arrangements on access to lump sum accommodation payments by non-supported residents.
• Analyse the scope for alternative policies to encourage investment back into the sector, and analyse ways for providers to remove current barriers to investment and to attract new investment sources into the sector, particularly from superannuation trusts where long term returns sought from these trusts seem to fit naturally with residential care investment characteristics.
• Analyse the scope to improve productivity within the sector through benchmarking and introducing greater competition within the sector.
• Analyse the potential for efficiency gains within the residential care sector, such as through the promotion of more efficient business models and technology, better interaction with the health care system, and the potential for greater competition within the sector.
• Review the expected supply of residential care places compared to the expected demand for care in the future, and the adequacy of using provision ratios to determine supply in the lead up to the five year federal government review on the LLLB reforms.
• Research better ways to manage the cost of residential care to the tax payer, including the cost effectiveness of caring for people in their own home compared to residential care, more appropriate user contributions to care, more emphasis on re-ablement, and the role of price signals and assessment procedures to help manage demand. This could include exploring mechanisms to facilitate user contributions to aged care costs that recognise individual wealth is predominately tied up in housing.

Other issues for consideration already highlighted in the chapters on viability, access to quality care and the workforce are also relevant for sustainability of the residential care sector.
References


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- 2010, Disability, ageing and carers, Australia: Summary of findings, 2009, Cat no. 4430.0, Canberra


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- 2012e, Efficiency Analysis of Aged Care Providers, January. unpublished report.


NHHRC (National Health and Hospitals Reform Commission) 2009, A healthier future for all Australians, Commonwealth of Australia, Canberra.


Appendices
A Provider financial data

General purpose financial reports (GPFRs) are prepared by residential aged care providers on an annual basis, and are required if the provider would like to receive the new Aged Care Workforce Supplement under the Aged Care Act 1997.

The data is used by the Department of Health and Ageing for financial analysis purposes. The GPFR data provides a range of metrics, including:

- metrics associated with the profit and loss statement, including earnings before interest, tax, depreciation and amortisation (EBITDA), profitability, revenue and expenses; and
- metrics associated with the balance sheet, including current and non-current assets and liabilities, and equity.

The GPFR summary data also provides data on previous years that can be used to measure trends in specific indicators. Data relates to financial years 2006-07 to 2011-12.

A.1 Provider metrics

The GPFR data has been used to assess the viability of the residential aged care sector. Selected data for the most recent year (2011-12) based on ownership type are presented in Table A.1, Table A.2, and Table A.3.

Care needs to be taken when interpreting GPFR data. As detailed balance sheet data is not mandatory at the segment level it is inconsistent in quality and level of detail.

Furthermore, as the data is at the residential aged care segment level (as opposed to the provider level for providers who offer other types of services in addition to residential care), data quality is subject to each provider’s allocation rules (e.g., whether debt is managed at a corporate rather than segment level) and therefore may not necessarily reflect the true balance sheet position of the provider.

Finally, the inconsistent treatment of bonds on balance sheets (whether treated as a current or non-current liability, or both) impacts liquidity metrics such as the current ratio.
### TABLE A.1: CHARACTERISTICS OF ALL PROVIDERS, 2011-12

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<thead>
<tr>
<th></th>
<th>Top quartile</th>
<th>Second quartile</th>
<th>Third quartile</th>
<th>Bottom quartile</th>
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<tr>
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<td>263</td>
<td>263</td>
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<td>EBITDA per resident per annum</td>
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<td>Total assets per resident</td>
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<td>64,449</td>
</tr>
<tr>
<td>Average lump sum bond per resident</td>
<td>$205,983</td>
<td>$201,311</td>
<td>$192,819</td>
<td>$207,430</td>
<td>$201,182</td>
</tr>
<tr>
<td>Net working capital per resident</td>
<td>($37,277)</td>
<td>($61,177)</td>
<td>($36,131)</td>
<td>($35,187)</td>
<td>($45,168)</td>
</tr>
<tr>
<td>Non-current liabilities as % of total financing</td>
<td>22.7%</td>
<td>27.6%</td>
<td>18.5%</td>
<td>25.0%</td>
<td>23.9%</td>
</tr>
<tr>
<td>Accommodation bonds as % of total financing</td>
<td>45.4%</td>
<td>51.8%</td>
<td>50.6%</td>
<td>42.7%</td>
<td>48.4%</td>
</tr>
<tr>
<td>Equity as % of total financing</td>
<td>31.9%</td>
<td>31.6%</td>
<td>39.3%</td>
<td>40.0%</td>
<td>34.9%</td>
</tr>
<tr>
<td><strong>Viability</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current ratio</td>
<td>0.59</td>
<td>0.36</td>
<td>0.54</td>
<td>0.63</td>
<td>0.50</td>
</tr>
<tr>
<td>Interest coverage</td>
<td>8.28</td>
<td>10.81</td>
<td>8.77</td>
<td>(3.51)</td>
<td>7.95</td>
</tr>
<tr>
<td>Net result margin</td>
<td>18.1%</td>
<td>7.3%</td>
<td>2.2%</td>
<td>(12.3%)</td>
<td>5.6%</td>
</tr>
<tr>
<td>Occupancy</td>
<td>93.0%</td>
<td>93.7%</td>
<td>93.5%</td>
<td>90.7%</td>
<td>93.0%</td>
</tr>
<tr>
<td>Return on assets</td>
<td>11.2%</td>
<td>6.4%</td>
<td>3.8%</td>
<td>(1.9%)</td>
<td>5.5%</td>
</tr>
<tr>
<td>Return on equity</td>
<td>35.2%</td>
<td>20.3%</td>
<td>9.6%</td>
<td>(4.7%)</td>
<td>15.9%</td>
</tr>
<tr>
<td>Accommodation bond asset cover</td>
<td>2.20</td>
<td>1.93</td>
<td>1.98</td>
<td>2.34</td>
<td>2.06</td>
</tr>
</tbody>
</table>

Note: 1. GPFR financial metric definitions are provided in Appendix B. 2. Excludes lump sum bonds.

SOURCE: GPFR DATA SUPPLIED BY THE DEPARTMENT OF HEALTH AND AGEING.
<table>
<thead>
<tr>
<th>TABLE A.2: CHARACTERISTICS OF FOR-PROFIT PROVIDERS, 2011-12¹</th>
<th>Top quartile</th>
<th>Second quartile</th>
<th>Third quartile</th>
<th>Bottom quartile</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider count</td>
<td>164</td>
<td>94</td>
<td>75</td>
<td>59</td>
<td>392</td>
</tr>
<tr>
<td>EBITDA per resident per annum</td>
<td>$21,786</td>
<td>$10,599</td>
<td>$5,321</td>
<td>($2,260)</td>
<td>$13,121</td>
</tr>
<tr>
<td>Capital structure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total assets per resident</td>
<td>$186,949</td>
<td>$167,624</td>
<td>$165,775</td>
<td>$182,686</td>
<td>$176,590</td>
</tr>
<tr>
<td>No. of lump sum bonds</td>
<td>8,625</td>
<td>7,964</td>
<td>3,959</td>
<td>2,529</td>
<td>23,077</td>
</tr>
<tr>
<td>Average lump sum bond per resident</td>
<td>$225,794</td>
<td>$227,175</td>
<td>$251,085</td>
<td>$247,896</td>
<td>$233,032</td>
</tr>
<tr>
<td>Net working capital per resident</td>
<td>($61,786)</td>
<td>($59,040)</td>
<td>($69,708)</td>
<td>($73,697)</td>
<td>($63,912)</td>
</tr>
<tr>
<td>Non-current liabilities as % of total financing²</td>
<td>23.1%</td>
<td>50.7%</td>
<td>20.9%</td>
<td>25.3%</td>
<td>31.7%</td>
</tr>
<tr>
<td>Accommodation bonds as % of total financing</td>
<td>51.4%</td>
<td>57.9%</td>
<td>70.2%</td>
<td>68.4%</td>
<td>58.2%</td>
</tr>
<tr>
<td>Equity as % of total financing</td>
<td>19.2%</td>
<td>15.9%</td>
<td>5.2%</td>
<td>(2.7%)</td>
<td>14.0%</td>
</tr>
<tr>
<td>Viability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current ratio</td>
<td>0.43</td>
<td>0.47</td>
<td>0.46</td>
<td>0.54</td>
<td>0.46</td>
</tr>
<tr>
<td>Interest coverage</td>
<td>6.52</td>
<td>8.22</td>
<td>3.86</td>
<td>(1.86)</td>
<td>6.20</td>
</tr>
<tr>
<td>Net result margin</td>
<td>17.8%</td>
<td>8.5%</td>
<td>3.2%</td>
<td>(6.1%)</td>
<td>10.5%</td>
</tr>
<tr>
<td>Occupancy</td>
<td>92.0%</td>
<td>91.3%</td>
<td>88.6%</td>
<td>83.7%</td>
<td>90.4%</td>
</tr>
<tr>
<td>Return on assets</td>
<td>11.7%</td>
<td>6.3%</td>
<td>3.2%</td>
<td>(1.2%)</td>
<td>7.4%</td>
</tr>
<tr>
<td>Return on equity</td>
<td>60.8%</td>
<td>39.8%</td>
<td>60.9%</td>
<td>46.3%</td>
<td>53.2%</td>
</tr>
<tr>
<td>Accommodation bond asset cover</td>
<td>1.94</td>
<td>1.73</td>
<td>1.42</td>
<td>1.46</td>
<td>1.72</td>
</tr>
</tbody>
</table>

Note: 1. GPFR financial metric definitions are provided in Appendix B. 2. Excludes lump sum bonds.

Source: GPFR data supplied by the Department of Health and Ageing.
### TABLE A.3: CHARACTERISTICS OF NFP PROVIDERS, 2011-12

<table>
<thead>
<tr>
<th></th>
<th>Top quartile</th>
<th>Second quartile</th>
<th>Third quartile</th>
<th>Bottom quartile</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider count</td>
<td>92</td>
<td>155</td>
<td>169</td>
<td>136</td>
<td>552</td>
</tr>
<tr>
<td>EBITDA</td>
<td>$19,695</td>
<td>$10,291</td>
<td>$5,726</td>
<td>($2,193)</td>
<td>$8,176</td>
</tr>
<tr>
<td><strong>Capital structure</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total assets per resident</td>
<td>$189,055</td>
<td>$160,008</td>
<td>$143,430</td>
<td>$180,418</td>
<td>$161,686</td>
</tr>
<tr>
<td>No. of lump sum bonds</td>
<td>4,881</td>
<td>17,140</td>
<td>11,258</td>
<td>5,910</td>
<td>39,189</td>
</tr>
<tr>
<td>Average lump sum bond per resident</td>
<td>$172,449</td>
<td>$189,756</td>
<td>$173,310</td>
<td>$207,692</td>
<td>$185,581</td>
</tr>
<tr>
<td>Net working capital per resident</td>
<td>$9,829</td>
<td>($63,139)</td>
<td>($24,984)</td>
<td>($26,356)</td>
<td>($37,020)</td>
</tr>
<tr>
<td>Non-current liabilities as % of total financing</td>
<td>21.7%</td>
<td>16.4%</td>
<td>18.7%</td>
<td>29.1%</td>
<td>20.1%</td>
</tr>
<tr>
<td>Accommodation bonds as % of total financing</td>
<td>36.2%</td>
<td>49.4%</td>
<td>45.0%</td>
<td>45.4%</td>
<td>45.6%</td>
</tr>
<tr>
<td>Equity as % of total financing</td>
<td>53.6%</td>
<td>38.5%</td>
<td>47.1%</td>
<td>38.8%</td>
<td>43.2%</td>
</tr>
<tr>
<td><strong>Viability</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current ratio</td>
<td>1.17</td>
<td>0.30</td>
<td>0.59</td>
<td>0.67</td>
<td>0.51</td>
</tr>
<tr>
<td>Interest coverage</td>
<td>39.91</td>
<td>13.86</td>
<td>17.49</td>
<td>(2.56)</td>
<td>14.00</td>
</tr>
<tr>
<td>Net result margin</td>
<td>18.7%</td>
<td>6.7%</td>
<td>2.0%</td>
<td>(9.5%)</td>
<td>4.5%</td>
</tr>
<tr>
<td>Occupancy</td>
<td>94.9%</td>
<td>94.8%</td>
<td>95.3%</td>
<td>93.0%</td>
<td>94.7%</td>
</tr>
<tr>
<td>Return on assets</td>
<td>10.4%</td>
<td>6.4%</td>
<td>4.0%</td>
<td>(1.2%)</td>
<td>5.1%</td>
</tr>
<tr>
<td>Return on equity</td>
<td>19.5%</td>
<td>16.8%</td>
<td>8.5%</td>
<td>(3.1%)</td>
<td>11.7%</td>
</tr>
<tr>
<td>Accommodation bond asset cover</td>
<td>2.76</td>
<td>2.02</td>
<td>2.22</td>
<td>2.20</td>
<td>2.19</td>
</tr>
</tbody>
</table>

**Note:** 1. GPFR financial metric definitions are provided in Appendix B. 2. Excludes lump sum bonds.

**Source:** GPFR data supplied by the Department of Health and Ageing.
### TABLE A.4: CHARACTERISTICS OF GOVERNMENT PROVIDERS, 2011-12

<table>
<thead>
<tr>
<th></th>
<th>Top quartile</th>
<th>Second quartile</th>
<th>Third quartile</th>
<th>Bottom quartile</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider count</td>
<td>8</td>
<td>15</td>
<td>19</td>
<td>68</td>
<td>110</td>
</tr>
<tr>
<td>EBITDA</td>
<td>$24,419</td>
<td>$10,680</td>
<td>$5,940</td>
<td>($8,607)</td>
<td>($1,508)</td>
</tr>
<tr>
<td><strong>Capital structure</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total assets per resident</td>
<td>$187,298</td>
<td>$184,634</td>
<td>$161,925</td>
<td>$208,788</td>
<td>$193,277</td>
</tr>
<tr>
<td>No. of lump sum bonds</td>
<td>149</td>
<td>268</td>
<td>364</td>
<td>1,402</td>
<td>2,183</td>
</tr>
<tr>
<td>Average lump sum bond per resident</td>
<td>$157,750</td>
<td>$171,722</td>
<td>$162,501</td>
<td>$133,331</td>
<td>$144,575</td>
</tr>
<tr>
<td>Net working capital per resident</td>
<td>$85,398</td>
<td>$20,126</td>
<td>($22,568)</td>
<td>$350</td>
<td>$4,010</td>
</tr>
<tr>
<td>Non-current liabilities as % of total financing</td>
<td>37.3%</td>
<td>12.6%</td>
<td>10.5%</td>
<td>15.8%</td>
<td>15.2%</td>
</tr>
<tr>
<td>Accommodation bonds as % of total financing</td>
<td>29.8%</td>
<td>27.7%</td>
<td>32.3%</td>
<td>16.1%</td>
<td>19.9%</td>
</tr>
<tr>
<td>Equity as % of total financing</td>
<td>61.6%</td>
<td>67.9%</td>
<td>79.3%</td>
<td>76.2%</td>
<td>75.5%</td>
</tr>
<tr>
<td><strong>Viability</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current ratio</td>
<td>33.53</td>
<td>1.36</td>
<td>0.76</td>
<td>1.01</td>
<td>1.08</td>
</tr>
<tr>
<td>Interest coverage</td>
<td>n.a.</td>
<td>15.75</td>
<td>4.72</td>
<td>(21.38)</td>
<td>(9.68)</td>
</tr>
<tr>
<td>Net result margin</td>
<td>21.1%</td>
<td>5.8%</td>
<td>(1.5%)</td>
<td>(22.9%)</td>
<td>(14.1%)</td>
</tr>
<tr>
<td>Occupancy</td>
<td>92.6%</td>
<td>95.9%</td>
<td>90.8%</td>
<td>91.6%</td>
<td>91.8%</td>
</tr>
<tr>
<td>Return on assets</td>
<td>13.0%</td>
<td>5.8%</td>
<td>3.7%</td>
<td>(4.1%)</td>
<td>(0.8%)</td>
</tr>
<tr>
<td>Return on equity</td>
<td>21.2%</td>
<td>8.5%</td>
<td>4.6%</td>
<td>(5.0%)</td>
<td>(0.7%)</td>
</tr>
<tr>
<td>Accommodation bond asset cover</td>
<td>3.35</td>
<td>3.61</td>
<td>3.10</td>
<td>6.21</td>
<td>5.04</td>
</tr>
</tbody>
</table>

**Note:** 1. GPFR financial metric definitions are provided in Appendix B. 2. Excludes lump sum bonds.  
**Source:** GPFR data supplied by the Department of Health and Ageing.
# B GPFR financial metrics

## TABLE B.1: DEFINITION OF FINANCIAL METRICS USED IN THE GPFR

<table>
<thead>
<tr>
<th>Ratio measure</th>
<th>Formulae</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total assets per resident</td>
<td>Total Assets / Total Residents</td>
</tr>
<tr>
<td>Average lump sum bond per resident</td>
<td>Total value of lump sum bonds / no of lump sum bonds</td>
</tr>
<tr>
<td>Net worth per resident</td>
<td>(T. Assets - T. Liabilities) / Total residents</td>
</tr>
<tr>
<td>Net working capital per resident</td>
<td>(Current Assets - Current Liabilities) / Total Residents</td>
</tr>
<tr>
<td>Non-current liabilities as % of total financing</td>
<td>Non-Current Liabilities / (Total liabilities + Net Worth) or Total Assets</td>
</tr>
<tr>
<td>Lump sum bonds as % of total financing</td>
<td>Total value of lump sum bonds / (Total liabilities + Net Worth) or Total Assets</td>
</tr>
<tr>
<td>Equity as % of total financing</td>
<td>Net Worth / (Total liabilities + Net Worth) or Total Assets</td>
</tr>
<tr>
<td>Current Ratio</td>
<td>Current Assets / Current Liabilities</td>
</tr>
<tr>
<td>Interest Coverage</td>
<td>EBITDA / Interest Expenses</td>
</tr>
<tr>
<td>Net Result Margin</td>
<td>Segment result (Pre Tax) / Total Revenue</td>
</tr>
<tr>
<td>Occupancy</td>
<td>Resident Days / Bed Days</td>
</tr>
<tr>
<td>Return on Assets</td>
<td>EBITDA / Total Assets</td>
</tr>
<tr>
<td>Return on Equity</td>
<td>EBITDA / Net Worth</td>
</tr>
<tr>
<td>Accommodation Asset Cover</td>
<td>Total Assets / Total RADs</td>
</tr>
</tbody>
</table>

Source: Department of Health and Ageing.
## C Viability indicator data

### Table C.2: Indicators to measure viability

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2006-07</th>
<th>2007-08</th>
<th>2008-09</th>
<th>2009-10</th>
<th>2010-11</th>
<th>2011-12</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Profit and loss indicators</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EBITDA per resident per annum ($)</td>
<td>4,003</td>
<td>4,442</td>
<td>4,330</td>
<td>6,417</td>
<td>8,054</td>
<td>9,274</td>
<td>GPFR data</td>
</tr>
<tr>
<td>EBITDA per resident per annum ($) - Regional</td>
<td>3,527</td>
<td>4,735</td>
<td>4,015</td>
<td>5,711</td>
<td>4,998</td>
<td>6,663</td>
<td>GPFR data</td>
</tr>
<tr>
<td>EBITDA per resident per annum ($) – Low care</td>
<td>3,878</td>
<td>4,095</td>
<td>3,555</td>
<td>3,088</td>
<td>4,682</td>
<td>2,454</td>
<td>GPFR data</td>
</tr>
<tr>
<td>Providers reporting profit (%)</td>
<td>61</td>
<td>61</td>
<td>57</td>
<td>61</td>
<td>69</td>
<td>70</td>
<td>GPFR data</td>
</tr>
<tr>
<td>Providers reporting negative EBITDA (%)</td>
<td>22</td>
<td>21</td>
<td>25</td>
<td>21</td>
<td>16</td>
<td>16</td>
<td>GPFR data</td>
</tr>
<tr>
<td><strong>Balance sheet indicators</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average bond per resident ($)</td>
<td>n.a.</td>
<td>n.a.</td>
<td>150,467</td>
<td>167,265</td>
<td>185,701</td>
<td>201,182</td>
<td>GPFR data</td>
</tr>
<tr>
<td>Bonds as a proportion of total financing (%)</td>
<td>n.a.</td>
<td>n.a.</td>
<td>40.20</td>
<td>43.8</td>
<td>47.1</td>
<td>48.4</td>
<td>GPFR data</td>
</tr>
<tr>
<td>Equity as a proportion of total financing (%)</td>
<td>n.a.</td>
<td>n.a.</td>
<td>41.4</td>
<td>38.9</td>
<td>36.4</td>
<td>34.9</td>
<td>GPFR data</td>
</tr>
<tr>
<td>Return on equity (%)</td>
<td>n.a.</td>
<td>n.a.</td>
<td>6.9</td>
<td>10.7</td>
<td>13.5</td>
<td>15.9</td>
<td>GPFR data</td>
</tr>
</tbody>
</table>

### Other viability indicators

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<table>
<thead>
<tr>
<th></th>
<th>Occupancy rates (%)</th>
<th>Current ratio</th>
<th>Interest coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
<tr>
<td></td>
<td>93.0</td>
<td>0.47</td>
<td>3.03</td>
</tr>
<tr>
<td></td>
<td>92.5</td>
<td>0.50</td>
<td>6.27</td>
</tr>
<tr>
<td></td>
<td>93.0</td>
<td>0.51</td>
<td>6.57</td>
</tr>
<tr>
<td></td>
<td>93.0</td>
<td>0.50</td>
<td>7.95</td>
</tr>
</tbody>
</table>

**GPFR data**

Note: Definitions of financial metrics are provided in Appendix B.
## D Access to care indicator data

### Table D.1: Indicators to measure access

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Availability of beds</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Average residential occupancy rate</td>
<td>95</td>
<td>94.5</td>
<td>93.6</td>
<td>92.9</td>
<td>92.4</td>
<td>93.1</td>
<td>92.8</td>
<td>SCRGSP (2013)</td>
</tr>
<tr>
<td>Operational aged care places (per 1,000 people)</td>
<td>209</td>
<td>218</td>
<td>229</td>
<td>234</td>
<td>244</td>
<td>255</td>
<td>261</td>
<td>SCRGSP (2013)</td>
</tr>
<tr>
<td>Number of operational residential aged care places ('000)</td>
<td>163.5</td>
<td>167.1</td>
<td>171.8</td>
<td>178.4</td>
<td>179.7</td>
<td>182.3</td>
<td>187.9</td>
<td>SCRGSP (2013)</td>
</tr>
<tr>
<td>Assessment for residential care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total aged care assessments (^1)</td>
<td>86.8</td>
<td>84.5</td>
<td>86.9</td>
<td>87.8</td>
<td>78.1</td>
<td>74.0</td>
<td>n.a.</td>
<td>SCRGSP (2013)</td>
</tr>
<tr>
<td>Indigenous aged care assessments (^2)</td>
<td>37.2</td>
<td>34.5</td>
<td>36.8</td>
<td>42.7</td>
<td>32.9</td>
<td>33.0</td>
<td>n.a.</td>
<td>SCRGSP (2013)</td>
</tr>
<tr>
<td>Median days of waiting between ACAT and entry into residential aged care (high care)</td>
<td>n.a.</td>
<td>26</td>
<td>28</td>
<td>23</td>
<td>26</td>
<td>28</td>
<td>28</td>
<td>SCRGSP (2013)</td>
</tr>
<tr>
<td>Representation of special needs groups</td>
<td>Aged care recipients from non-English speaking country (high care) 4</td>
<td>Supported aged care residents (%)</td>
<td>Indigenous aged care recipients (high care) 2</td>
<td>Indigenous aged care recipients (low care) 2</td>
<td></td>
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</tr>
<tr>
<td>Median days of waiting between ACAT and entry into residential aged care (low care)</td>
<td>n.a.</td>
<td>66</td>
<td>64</td>
<td>63</td>
<td>54</td>
<td>65</td>
<td>56</td>
<td>SCRGSP (2013)</td>
</tr>
<tr>
<td>Hospital patient days used by those eligible and waiting for residential aged care 5</td>
<td>n.a.</td>
<td>n.a.</td>
<td>14.6</td>
<td>13.6</td>
<td>12.4</td>
<td>11.7</td>
<td>n.a.</td>
<td>SCRGSP (2013)</td>
</tr>
<tr>
<td>Aged care recipients from non-English speaking country (high care) 4</td>
<td>34.4</td>
<td>35.6</td>
<td>44.5</td>
<td>46.3</td>
<td>47.2</td>
<td>50.7</td>
<td>53.2</td>
<td>SCRGSP (2013)</td>
</tr>
<tr>
<td>Supported aged care residents (%)</td>
<td>29.5</td>
<td>33.6</td>
<td>33.6</td>
<td>35.2</td>
<td>37.1</td>
<td>37.9</td>
<td>38.2</td>
<td>SCRGSP (2013)</td>
</tr>
<tr>
<td>Indigenous aged care recipients (high care) 2</td>
<td>15.5</td>
<td>15.1</td>
<td>15.2</td>
<td>15.5</td>
<td>16.0</td>
<td>14.8</td>
<td>16.0</td>
<td>SCRGSP (2013)</td>
</tr>
<tr>
<td>Indigenous aged care recipients (low care) 2</td>
<td>7.3</td>
<td>7.1</td>
<td>6.2</td>
<td>6.2</td>
<td>7.4</td>
<td>6.1</td>
<td>5.2</td>
<td>SCRGSP (2013)</td>
</tr>
</tbody>
</table>

Note: 1. Aged care assessments of per 1,000 persons aged 70 years or over and Indigenous persons aged 50–69 years 2. Per 1000 Indigenous persons aged 50 years or over 3. Rate per 1,000 patient days 4. Per 1,000 people aged 70 years or over from a non-English speaking country.
### E Workforce indicator data

#### Table E.1: Indicators to measure workforce

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>General indicators</strong></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FTE direct care employees (number)</td>
<td>76,006</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>78,849</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>94,823</td>
<td>King et al (2013)</td>
</tr>
<tr>
<td>Employees per residential care place</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>1.01</td>
<td>0.95</td>
<td>0.86</td>
<td>1.01</td>
<td>1.10</td>
<td>1.12</td>
<td>n.a.</td>
<td>ABS (2012)</td>
</tr>
<tr>
<td>Facilities with at least one person on Workcover</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>33.0</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>54.0</td>
<td>King et al (2013)</td>
</tr>
<tr>
<td>Proportion of direct care workforce aged 55 years and over</td>
<td>16.9</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>20.8</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>27.2</td>
<td>King et al (2013)</td>
</tr>
<tr>
<td>Facilities catering to ethnic or cultural groups (%)</td>
<td>10.0</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>17.0</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>25.0</td>
<td>King et al (2013)</td>
</tr>
<tr>
<td>Access to informal care (%)</td>
<td>13.0</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>12.2</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td></td>
<td>ABS (2010; 2004)</td>
</tr>
</tbody>
</table>

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| Registered nurse | 21.4 | n.a. | n.a. | 21.4 | n.a. | n.a. | n.a. | 21.5 | King et al (2013) |
| Enrolled nurse   | 17.5 | n.a. | n.a. | 18.8 | n.a. | n.a. | n.a. | 13.3 | King et al (2013) |
| Personal care attendant | 26.0 | n.a. | n.a. | 27.8 | n.a. | n.a. | n.a. | 15.1 | King et al (2013) |
| Allied Health    | 23.5 | n.a. | n.a. | 22.6 | n.a. | n.a. | n.a. | 13.4 | King et al (2013) |
| Direct care workforce actively seeking work | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | 9.2 | King et al (2013) |

**Skills gap**

| Registered nurse vacancies | 25.7 | n.a. | n.a. | 31.3 | n.a. | n.a. | n.a. | 32.7 | King et al (2013) |
| Enrolled nurse vacancies   | 10.8 | n.a. | n.a. | 17.7 | n.a. | n.a. | n.a. | 18.7 | King et al (2013) |
| Personal care attendant vacancies | 23.3 | n.a. | n.a. | 31.4 | n.a. | n.a. | n.a. | 36.4 | King et al (2013) |
| Allied Health vacancies    | 6.3  | n.a. | n.a. | 6.7  | n.a. | n.a. | n.a. | 8.8  | King et al (2013) |

Note: 1. Represented by the number of people with tenure in current job of one year or less 2. Proportion of total direct care workforce. No data is available for previous years 3. Proportion of facilities reporting vacancies.
## Sustainability indicator data

### Table F.1: Indicators to measure investment

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2007-08</th>
<th>2008-09</th>
<th>2009-10</th>
<th>2010-11</th>
<th>2011-12</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New building activity indicators</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated new building work completed during the year ($m)</td>
<td>873</td>
<td>968</td>
<td>1,028</td>
<td>750</td>
<td>535</td>
<td>DoHA (2012a)</td>
</tr>
<tr>
<td>Estimated new building work in progress at the end of the year ($m)</td>
<td>854</td>
<td>731</td>
<td>441</td>
<td>428</td>
<td>478</td>
<td>DoHA (2012a)</td>
</tr>
<tr>
<td>Proportion of homes that were planning new building work (%)</td>
<td>3.4</td>
<td>3.2</td>
<td>3.1</td>
<td>4.2</td>
<td>3.7</td>
<td>DoHA (2012a)</td>
</tr>
<tr>
<td><strong>Rebuilding activity indicators</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated rebuilding work completed during the year ($m)</td>
<td>184</td>
<td>280</td>
<td>155</td>
<td>116</td>
<td>93</td>
<td>DoHA (2012a)</td>
</tr>
<tr>
<td>Estimated rebuilding work in progress at the end of the year ($m)</td>
<td>546</td>
<td>342</td>
<td>216</td>
<td>245</td>
<td>255</td>
<td>DoHA (2012a)</td>
</tr>
<tr>
<td>Proportion of homes that were planning rebuilding work (%)</td>
<td>1.5</td>
<td>1.5</td>
<td>1.7</td>
<td>2.2</td>
<td>2.0</td>
<td>DoHA (2012a)</td>
</tr>
<tr>
<td><strong>Upgrading activity indicators</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated upgrading work completed during the year ($m)</td>
<td>394</td>
<td>322</td>
<td>257</td>
<td>184</td>
<td>295</td>
<td>DoHA (2012a)</td>
</tr>
<tr>
<td>Estimated upgrading work in progress at the end of the year ($m)</td>
<td>530</td>
<td>362</td>
<td>261</td>
<td>231</td>
<td>246</td>
<td>DoHA (2012a)</td>
</tr>
<tr>
<td>Proportion of homes that were planning upgrading work (%)</td>
<td>DoHA (2012a)</td>
<td></td>
<td></td>
<td></td>
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<td>7.2</td>
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<td>6.6</td>
<td>8.6</td>
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<tr>
<td>9.8</td>
<td></td>
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</tr>
</tbody>
</table>

Note: 1. New building is defined as work relating to a new building to accommodate new or transferred aged care places. 2. Rebuilding work is defined as the complete demolition and reconstruction of an approved service on the same site. 3. Upgrading work is defined as renovation or refurbishment of an existing service including extensions.